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Australian Institute of Health and Welfare

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Aboriginal and Torres Strait Islander Health Performance Framework

Western Australia 2026 report

The AIHW is a corporate Commonwealth entity producing authoritative and accessible information and statistics to inform and support better policy and service delivery decisions, leading to better health and wellbeing.

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Please note that there is the potential for minor revisions of data in this report.
Please check the online version at indigenoushpf.gov.au for any amendments.

Contents

Acknowledgement of Country and People

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Summary

The *Aboriginal and Torres Strait Islander Health Performance Framework Western Australia 2026 report* finds mixed results, with some areas of improvement and other areas of concern for Aboriginal people living in Western Australia across the three tiers. A snapshot of these findings is below.

Areas of improvement

- The age-standardised rate of cardiovascular disease deaths for Aboriginal people in Western Australia decreased by 4.2% between 2016 and 2023, from 340 to 267 per 100,000 population.
- From 2016 to 2023, the incidence rate of rheumatic heart disease (RHD) among Aboriginal people in Western Australia decreased from 50 to 35 new cases per 100,000 population.
- The death rate for Aboriginal infants in Western Australia dropped from 6.7 per 1,000 live births in 2014–2018 to 5.6 per 1,000 live births in 2019–2023.
- Over the period 2011 to 2021, the proportion of Aboriginal people aged 20–24 in Western Australia who had completed Year 12 or equivalent increased from 43% to 61%.
- The rate of Aboriginal young people aged 10–17 in Western Australia who were under youth justice supervision on an average day decreased from 252 per 10,000 in 2016–17 to 152 per 10,000 in 2023–24.

Areas of concern

- In 2023, 78 cases of acute rheumatic fever (ARF) were recorded among Aboriginal people in Western Australia, accounting for 95% of ARF cases diagnosed in Western Australia that year. From 2016 to 2023, incidence rates of ARF among Aboriginal people in Western Australia increased from 50 per 100,000 to 63 per 100,000 population.
- Over the 5 years 2019–2023 there were 578 deaths from injury and poisoning among Aboriginal people in Western Australia. After adjusting for differences in age, Aboriginal people in Western Australia died from injury and poisoning at 2.6 times the rate of non-Aboriginal people.
- In Western Australia, over the period from 2016 to 2023, the age-standardised death rate due to intentional self-harm for Aboriginal people increased by 19%.
- In 2023, 40% of Aboriginal mothers who gave birth in Western Australia reported that they had smoked during their pregnancy, and less than half (48%) had an antenatal visit in the first trimester.
- The age-standardised imprisonment rate for Aboriginal adults in Western Australia increased by 16% between 2016 and 2024, from 3,055 to 4,061 per 100,000 population.

Introduction

Introduction

The *Aboriginal and Torres Strait Islander Health Performance Framework Western Australia 2026 report* provides the latest information on the health and wellbeing of Aboriginal people in Western Australia, compiling key facts from the Health Performance Framework (HPF) measures.

The HPF is made up of 68 measures across 3 levels, or tiers:

- Tier 1: Health status and outcomes (24 measures)
- Tier 2: Determinants of health (22 measures)
- Tier 3: Health system performance (22 measures).

Each HPF measure represents a health-related concept, using various indicators drawn from relevant data sources and research.

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

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).

Terminology

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.

Within Western Australia, and in this report, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

In this report, the term 'non-Aboriginal' is used when referring to non-Indigenous Western Australians/Australians.

In most Australian data collections, 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. For a few data collections, such as those associated with government grants and payments, information on acceptance of a person as being Aboriginal and/or Torres Strait Islander by an Aboriginal community may also be required.

Since 2020, detailed HPF findings and data have been presented together on a dedicated website: indigenoushpf.gov.au. This website contains a range of products including reporting on each of 68 measures, a national summary report, State and Territory reports, feature articles, interactive data visualisations and supplementary data tables. The measures also include sections on research and evaluations, and implications of findings. These provide further context, stories and insights into aspects of health and service delivery that are not usually captured in administrative data sets but can demonstrate characteristics of communities and services that are working well or need improvement. This report contains the latest data available for each measure at the time of writing.

Interpretation of results

While most results are presented for Western Australia alongside national data, in some cases results are restricted to national data only due to insufficient data quality.

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

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 https://www.indigenoushpf.gov.au/Resources/Technical-appendix/Statistical-terms-methods).

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

Note that for rate calculations (unless otherwise indicated in data tables), this report uses estimates and projections (medium series) of the Aboriginal population based on the 2021 Census, as published by the ABS (ABS 2024c). The base population is the Aboriginal and Torres Strait Islander estimated resident population of Australia at 30 June 2021, derived from 2021 Census counts of Aboriginal and Torres Strait Islander people, and adjusted for net undercount as measured by the Post Enumeration Survey. New estimates and projections for the Aboriginal and Torres Strait Islander population, based on 2021 Census counts, were released in July 2024.

For survey data, quality of the estimates has been indicated in footnotes where the relative standard error for the number is between 25% and 50% or greater than 50%, or the proportion has a high margin of error (MoE). Proportion estimates are preceded by a hash (for example, #10.2) if the corresponding MoE is greater than 10 percentage points. An estimate is also preceded by a hash if the MoE is large enough such that the corresponding confidence interval for this estimate would exceed the value of 0% and/or 100%, the natural limits of a proportion. The latter situation will occur if the MoE is greater than the estimate itself, or greater than 100 minus the estimate. All these estimates should be used with caution.

Many measures in this report include results for Aboriginal people in remote and non-remote areas. These categories are based on the Australian Statistical Geography Standard (ASGS) remoteness structure (ABS 2021). In one measure (1.14 Disability) the Modified Monash Model (MMM) is used to indicate remoteness. This classification is used by some government programs, including the National Disability Insurance Scheme, to define eligibility.

For more information, see https://www.indigenoushpf.gov.au/Resources.

Mortality (deaths) data quality considerations

Information about mortality (deaths and causes of death) in this report is mostly drawn from the AIHW National Mortality Database. This database contains Cause of Death Unit Record File data provided to the AIHW by the Registrars of Births, Deaths and Marriages in each state and territory and the National Coronial Information System (NCIS, managed by the Victorian Department of Justice and Community Safety), and includes cause of death coded by the Australian Bureau of Statistics (ABS).

The mortality data presented in this report are influenced by a range of issues which affect the numerator (number of deaths) and the denominator (population used to calculate rates).

The number of deaths for Aboriginal people can be influenced by the accuracy of Indigenous status information in death records and by changes to death forms and/or processing systems. Due to the relatively small size of the First Nations population, these factors can significantly impact the trends over time and between jurisdictions.

In 2022, the Medical Certificate of Cause of Death (MCCD) for deaths registered in New South Wales was made available to the ABS as a secondary source for determining the Indigenous status of the deceased. Previously, identification was based only on information provided on the Death Registration Form, usually completed by the funeral director and the family. This change led to an improvement in recording of Indigenous status in death records, accounting for two-thirds of the 40% increase in the number of First Nations deaths in New South Wales between 2021 and 2022 (ABS 2023a). The same improvement was made to deaths registered in Victoria from 2023, though with a lesser impact due to the smaller number of deaths of First Nations people occurring in Victoria. From 2023, this method is used across all states and territories.

Also in 2023, the ABS received approval to use information recorded in the NCIS to assist in determining a deceased person's Indigenous status (ABS 2024a). This change had already been implemented for New South Wales in 2022. The additional information resulted in a small increase in the number of First Nations deaths across all states and territories, and a second break in the time series for First Nations deaths.

Therefore, 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.

In addition, mortality rates in this report were calculated using the ABS estimates and projections for Aboriginal and Torres Strait Islander people based on the 2021 Census as the denominator. 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 (ABS 2023b). Because the latest population estimates and projections are based on how people identified at the 2021 Census, the estimates for each year are larger compared with the estimates for the same years that had been based on the 2016 Census. Historical rates in this report are therefore lower than those presented in previous HPF reports, with the difference generally being greater for years further from 2021. Further, this change, along with changes in the age and sex structure of the newer population estimates, means that the steepness and in some cases the direction of trend lines is different to those previously published.

There is also potential mismatch between the identification provided in the death records and that provided in the Census, which also impacts the accuracy of the estimated rates.

Comparisons between results for Western Australia and the combined jurisdictions, as well as comparisons over time, should therefore be interpreted with caution.

Demographic and social context

Demographic and social context

In Western Australia at 30 June 2021 there were an estimated 120,006 Aboriginal people, 4.4% of the state's total population. More than one-tenth (12.2%) of the total Aboriginal population in Australia were living in Western Australia at that time.

Table D1: Estimated resident population by Aboriginal status, Western Australia and Australia, 30 June 2021

	Aboriginal		Non-Aboriginal		Total			
	Number	%	Number	%	Number	%	% Aboriginal	% Non-Aboriginal
Western Australia	120,006	12.2	2,629,359	10.6	2,749,365	10.7	4.4	95.6
Australia[(a)]	**983,709**	**100.0**	**24,701,703**	**100.0**	**25,685,412**	**100.0**	**3.8**	**96.2**

(a) Includes 'Other Territories'.

Source: AIHW analysis of ABS population estimates based on 2021 Census.

Aboriginal people are more likely to live in urban and regional areas than remote areas, though the proportion of the total population who are Aboriginal people is generally higher in more remote areas. In 2021, in Western Australia:

- 2 in 3 Aboriginal people (66.8% or 80,177 people) lived in non-remote areas: 45.7% lived in *Major cities*, 8.3% in *Inner regional* areas and 12.8% in *Outer regional* areas
- around 1 in 3 Aboriginal people (33.2% or 39,829 people) lived in *Remote* (12.9%) or *Very remote* areas (20.3%)
- the proportion of the total population in each remoteness area who were Aboriginal increased with remoteness, from 2.5% in *Major cities*, to 37.2% in *Very remote* areas (Table D2).

Table D2: Estimated resident population by remoteness area and Aboriginal status, Western Australia and Australia, 30 June 2021

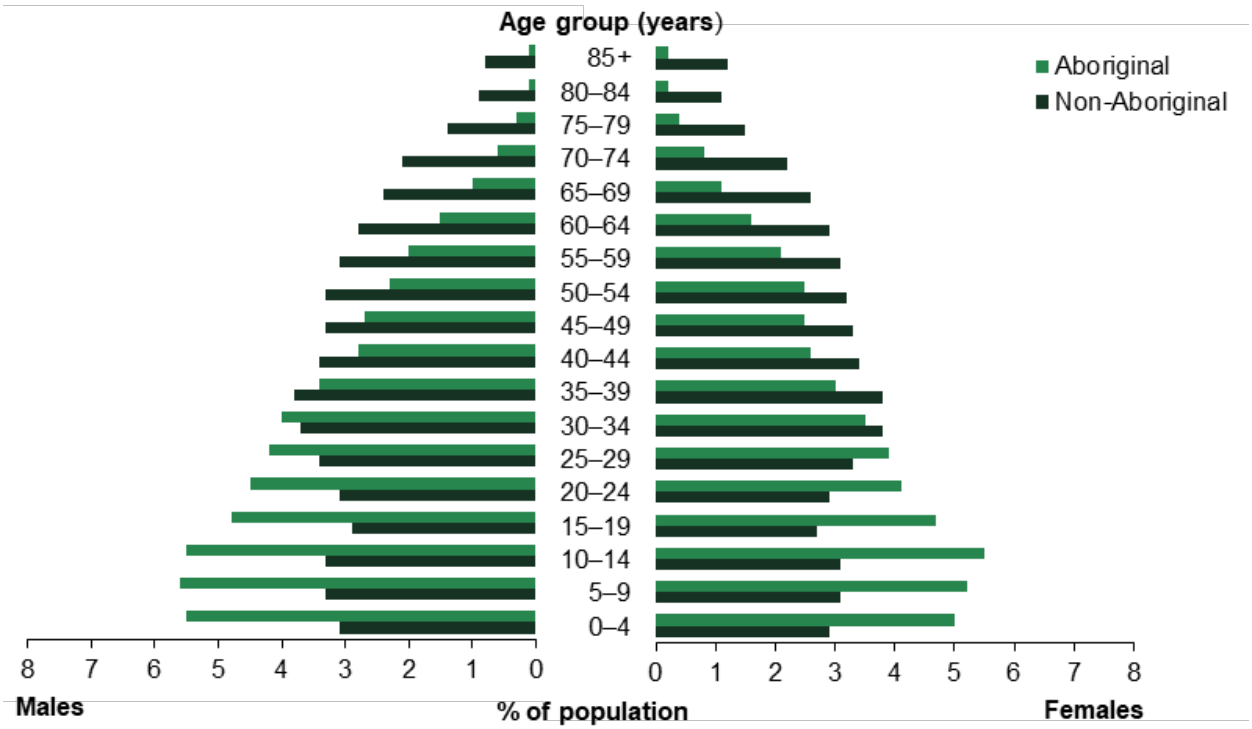
	Aboriginal		Non-Aboriginal		Total			
	Number	%	Number	%	Number	%	% Aboriginal	% Non-Aboriginal
				Western Australia				
Major cities	54,886	45.7	2,106,927	80.1	2,161,813	78.6	2.5	97.5
Inner regional	9,956	8.3	229,298	8.7	239,254	8.7	4.2	95.8
Outer regional	15,335	12.8	175,610	6.7	190,945	6.9	8.0	92.0
Remote	15,441	12.9	76,357	2.9	91,798	3.3	16.8	83.2
Very remote	24,388	20.3	41167	1.6	65,555	2.4	37.2	62.8
Western Australia	**120,006**	**100.0**	**2,629,359**	**100.0**	**2,749,365**	**100.0**	**4.4**	**95.6**
				Australia				
Major cities	401,674	40.8	18,140,963	73.4	18,542,637	72.2	2.2	97.8
Inner regional	244,012	24.8	4,320,337	17.5	4,564,349	17.8	5.3	94.7
Outer regional	187,150	19.0	1,895,705	7.7	2,082,855	8.1	9.0	91.0
Remote	58,727	6.0	241,249	1.0	299,976	1.2	19.6	80.4
Very remote	92,146	9.4	103,449	0.4	195,595	0.8	47.1	52.9
Australia	**983,709**	**100.0**	**24,701,703**	**100.0**	**25,685,412**	**100.0**	**3.8**	**96.2**

Source: AIHW analysis of ABS population estimates based on 2021 Census.

In Western Australia at 30 June 2021, the Aboriginal population had an age structure that was significantly younger than that of the non-Aboriginal population. For example, in Western Australia:

- people aged under 15 accounted for 32% of the Aboriginal population compared with 19% of the non-Aboriginal population
- people aged 65 and over comprised almost 4.8% of the Aboriginal population, compared with 16% of the non-Aboriginal population (Figure D1).

Figure D1: Estimated resident population, by Aboriginal status, age and sex, Western Australia, 30 June 2021

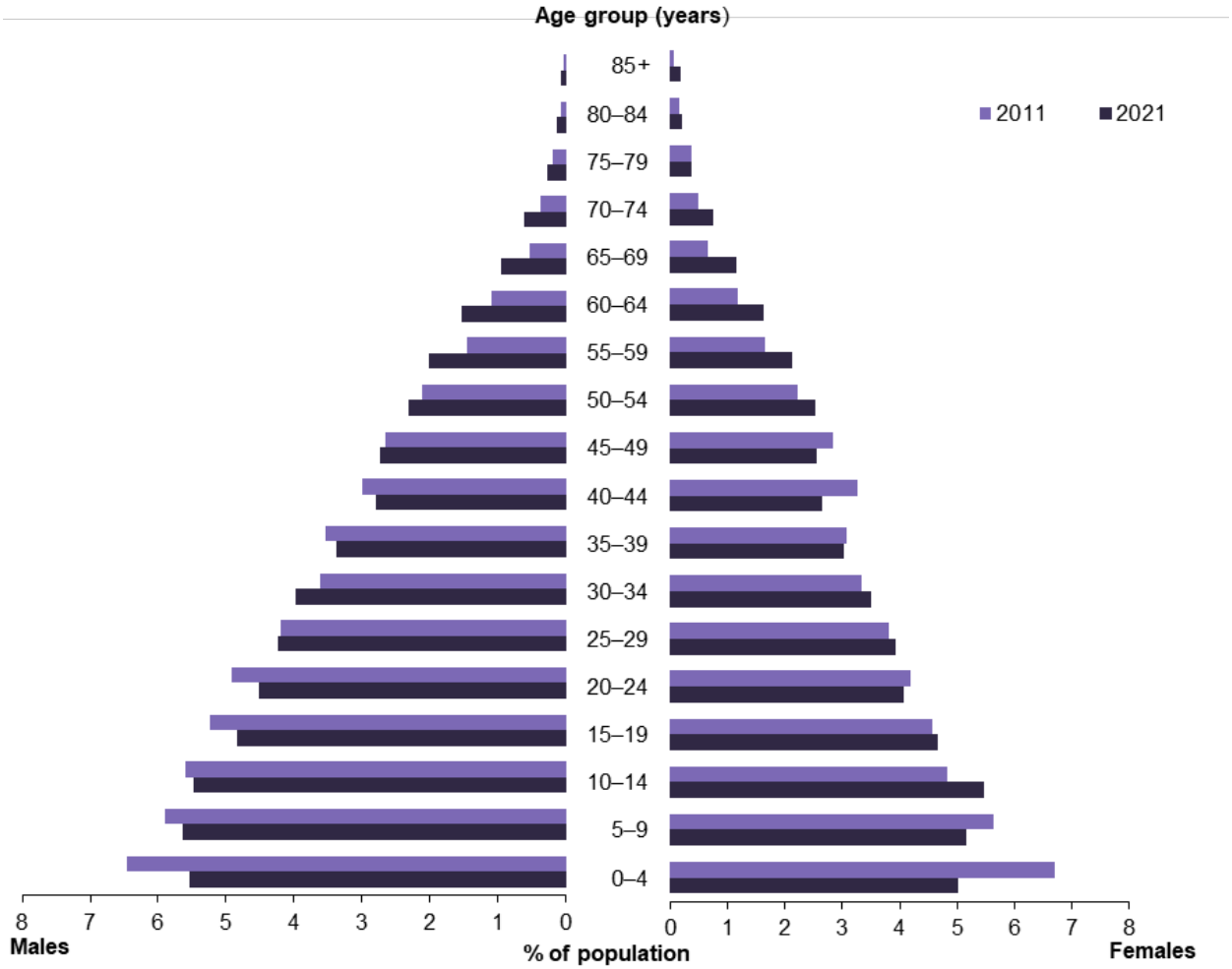


Source: AIHW analysis of ABS population estimates based on 2021 Census (Table D3.1 WA).

In Western Australia at 30 June 2021, the Aboriginal population had an age structure that was slightly older than the Aboriginal population in Western Australia at 30 June 2011 (using population estimates based on the 2021 Census). For example, at June 30 2011:

- people aged under 15 accounted for 35% of the Aboriginal population compared with 32% at June 30 2021
- people aged 65 and over comprised 2.9% of the Aboriginal population in Western Australia, compared with 4.7% at June 30 2021 (Figure D2).

Figure D2: Estimated resident population Aboriginal people, age and sex, Western Australia, 30 June 2011 and 30 June 2021



Source: AIHW analysis of ABS population estimates based on 2021 Census (Table D3.2 WA).

Cultural and social determinants

The cultural determinants of health – including Country and caring for Country, knowledge and beliefs, language, self-determination, family and kinship, and cultural expression – centre an Indigenous definition of health, and have been linked to positive health and wellbeing outcomes. There is growing evidence for the importance of the cultural determinants of health (Bourke et al. 2018; MacLean et al. 2017; Verbunt et al. 2021).

Aboriginal health is deeply rooted in cultural strength: intergenerational family ties, connection to Country, cultural identity and practices, community autonomy, and self-determination collectively foster holistic wellbeing. Each reinforces the others, supporting resilience and improved health outcomes.

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

In contrast to cultural protective factors, racism or racial discrimination are associated with poorer physical and mental health (see, for example, Priest et al. 2011 and Paradies et al. 2014). Colonisation is recognised as having a fundamental impact on disadvantage and health among Indigenous peoples worldwide, through social systems that maintain disparities (see, for example, Paradies & Cunningham 2012 and Paradies 2016).

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

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 & Cunningham 2012).

Between March and May 2017, the Australian Government Department of Health, 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).

My life my lead – report on the national consultations

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

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

Health is also influenced by social determinants – the circumstances in which people grow, live, work, and age (Commission on Social Determinants of Health 2008) – and individual health risk factors. Income, employment, and education are key social determinants of health that account for a large part of the disparity between Aboriginal and non-Aboriginal health outcomes. Obesity and smoking are identified as the 2 most significant key health risk factors. Section 5 (Tier 2 – Determinants of Health) looks at these and other social determinants of health and risk factors.

Recent events

During 2020, 2 major events with global effects occurred – the COVID-19 (coronavirus disease 2019) pandemic, and the Black Lives Matter protests that followed the death of George Floyd, a 46-year-old African American man, during a police arrest in the United States.

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

- continuing health inequalities between Aboriginal people and non-Aboriginal people
- broader social inequalities between Aboriginal people and non-Aboriginal people in areas that can affect health, including housing, education, employment, income, and access to adequate health care and other goods and services
- how well the health system serves the needs of Aboriginal people
- how governments can work in partnership and share decision-making with Aboriginal communities and leadership in identifying and responding to health priorities.

Aboriginal people remain at higher risk of experiencing more severe COVID-19 complications due to higher rates of pre-existing health conditions and challenges in accessing healthcare, particularly in remote areas (Queensland Government 2023). 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 2024b).

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.

More recently in 2023 and 2024, Australia has been experiencing high levels of inflation, with increased cost of living and higher interest rates impacting on housing costs and household disposable income (Reserve Bank of Australia 2024). 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).

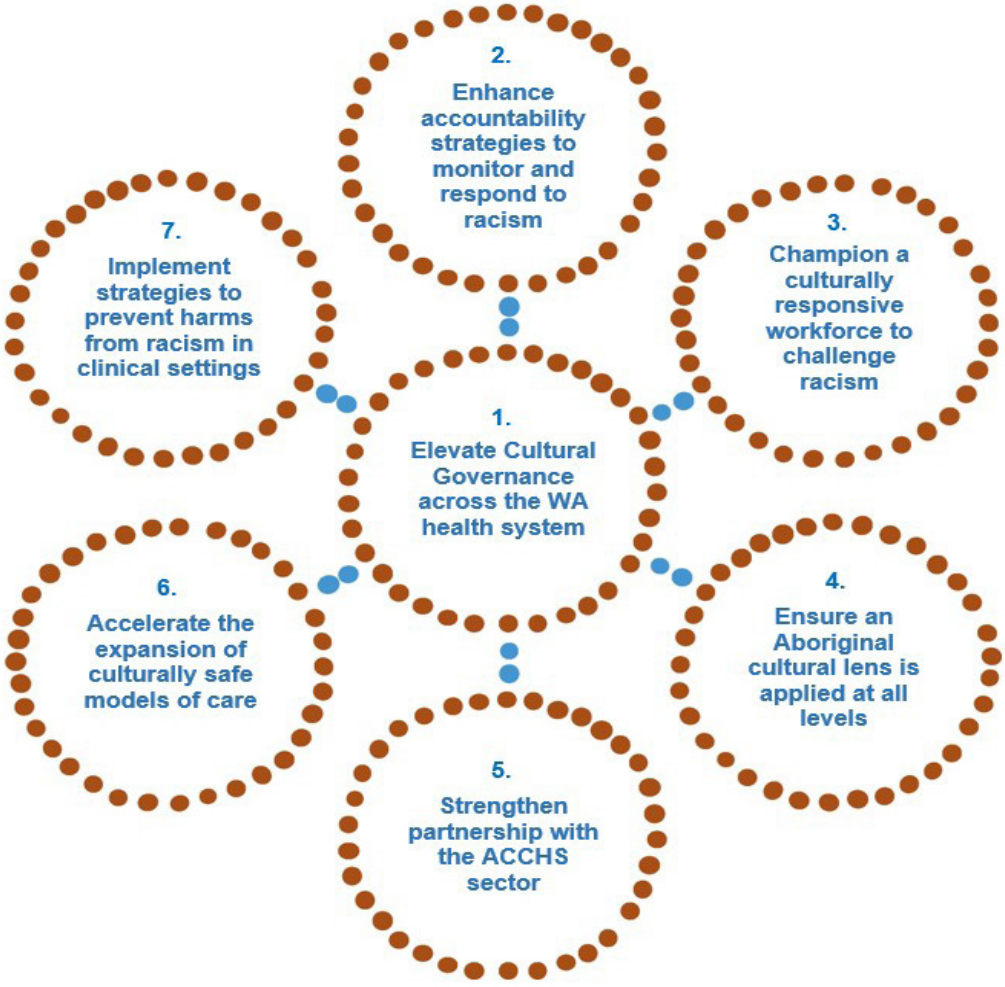
On 14 October 2023, Australians voted in a referendum – the first in the 21st century – on whether to amend the Constitution to recognise Aboriginal and Torres Strait Islander peoples by establishing a body known as the Aboriginal and Torres Strait Islander Voice. The referendum did not pass.

The AIHW is committed to ensuring the National Agreement on Closing the Gap Priority Reforms are implemented in our approaches and processes. The AIHW will continue to produce data, information and insights on the health and wellbeing of Aboriginal people, to inform policy, service delivery and community debate.

In Western Australia, the WA Department of Health stewards the WA health system through the development, implementation and monitoring of strategic frameworks and policies for the improvement of Aboriginal health and wellbeing.

In August 2023, the WA Department of Health hosted the WA Aboriginal Health Executive Roundtable (Roundtable) to elevate the cultural determinants of health and address racism in the WA health system. At the Roundtable, WA Health executives and senior Aboriginal leaders from the WA health system and Aboriginal Community Controlled Health Services informed the development of 7 High-Impact Actions (Figure D3). The first action, *Elevating Cultural Governance across the WA health system* facilitates genuine shared decision making with Aboriginal people and is critical to driving implementation of the remaining high-impact actions.

Figure D3: High-impact actions for elevating the cultural determinants of health and addressing racism in the Western Australian health system



Source: WA Health.

In 2025, WA Health's Aboriginal Data Governance Policy was published following advice and guidance from the Aboriginal Community Controlled Sector. The Policy recognises the rights of Aboriginal people to govern the collection, ownership and use of data about their people and communities in accordance with the United Nations Declaration on the Rights of Indigenous Peoples and the National Agreement on Closing the Gap. The WA Health Aboriginal Data Governance Committee is led and controlled by Aboriginal people and has the authority to direct stakeholders regarding Aboriginal data held within the WA health system.

In addition, the WA Health Aboriginal Health Impact Statement and Declaration Policy was reviewed and amended in 2025. This Policy has been expanded to support implementation of Priority Reform 3 of the National Agreement on Closing the Gap and requires WA health staff to complete an online Impact Statement and Declaration form when a policy, health program or strategy is developed, reviewed, amended, or rescinded. It is intended to support cultural governance and the identification and elimination of structural and systemic racism.

1

Tier 1 – Health status and outcomes

Topic	Number of measures
Health conditions	12
Human function	4
Life expectancy and wellbeing	3
Deaths	5
Total	**24**

1.01 Birthweight

Why it is important

This measure reports on birthweight among Aboriginal 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 (newborns weighing 2,500 grams to less than 4,500 grams) 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.

In 2018, infant and congenital conditions contributed 5% of the total disease burden for Aboriginal people across Australia. The leading causes were pre-term birth and low birthweight complications, accounting for 28% of infant and congenital total burden (AIHW 2022b).

Key findings

Data presented for this measure are based on the Aboriginal status of the baby and refers 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).

Birthweight: In Western Australia, the majority of singleton Aboriginal babies born in 2023 had a healthy birthweight (86.3% or 2,078 babies), with over 1 in 10 born with a low birthweight (12.5% or 301 babies). Low birthweight was 2.6 times as common among Aboriginal babies compared with non-Aboriginal babies in Western Australia (Figure 1.01.1).

Nationally in 2023, 88.9% of singleton Aboriginal babies were born with a healthy birthweight (17,371 babies), and 1 in 10 with a low birthweight (9.7%, 1,891 babies). Low birthweight was twice as common among Aboriginal babies compared with non-Aboriginal babies (Figure 1.01.1).

Low birthweight over time: Between 2017 and 2023 in Western Australia, the proportion of singleton Aboriginal babies born with a low birthweight (less than 2,500 grams) was 11.7% in 2017 and 12.5% in 2023. The proportion of non-Aboriginal babies born with a low birthweight did not change between the years (Figure 1.01.2).

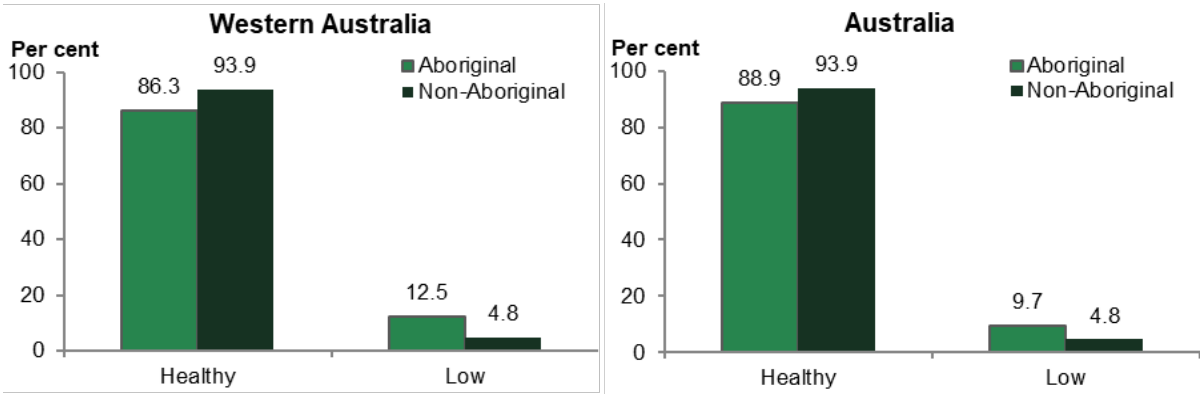
In Australia, the proportion of singleton babies born with a low birthweight remained steady between 2017 and 2023 for both Aboriginal and non-Aboriginal babies (Figure 1.01.2).

Low birthweight and remoteness: In 2023 in Western Australia, the proportion of singleton Aboriginal babies born with a low birthweight in *Major cities* was 11.2% and in *Very remote* areas it was 17.0% (Figure 1.01.3).

Nationally in 2023, the proportion of singleton Aboriginal babies born with a low birthweight in *Major cities* was 8.3% and in *Very remote* areas it was 13.4% (Figure 1.01.3).

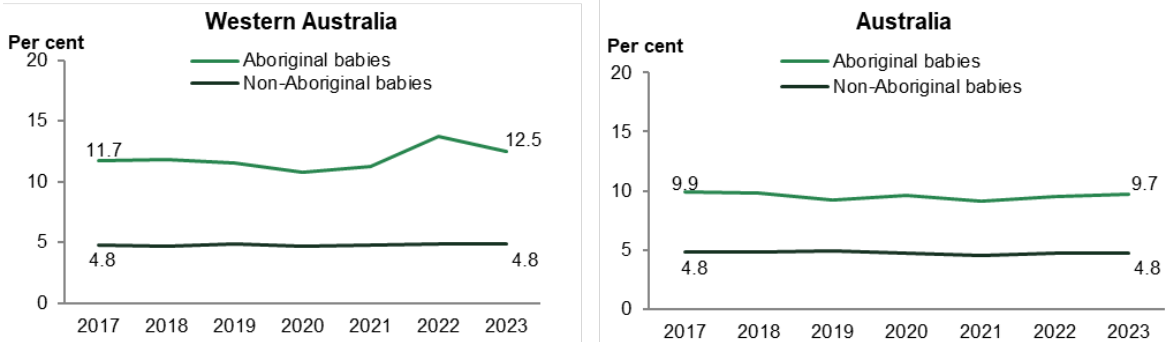
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.01.1: Liveborn singleton babies of healthy birthweight, by Aboriginal status of the baby, Western Australia and Australia, 2023



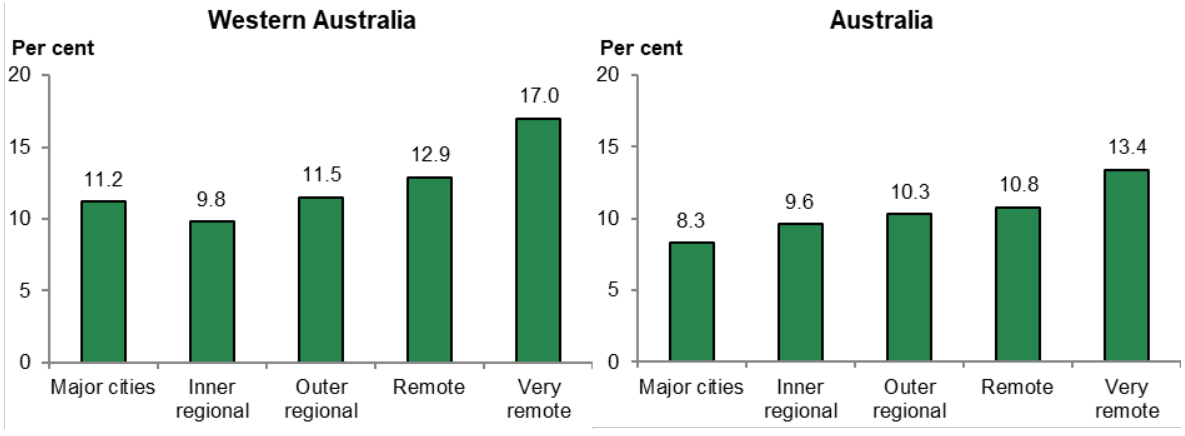
Source: AIHW 2025i Table 6.6

Figure 1.01.2: Liveborn singleton babies of low birthweight, by Aboriginal status of the baby, Western Australia and Australia, 2017 to 2023



Source: AIHW 2025i Table 6.6 and Productivity Commission 2025 Table CtG2A1

Figure 1.01.3: Liveborn Aboriginal singleton babies of low birthweight, by remoteness, Western Australia and Australia, 2023



Source: AIHW 2025i Table 6.7

1.02 Hospitalisation trends and leading causes

Why it is important

This measure provides an overview of the leading causes of hospitalisations for Aboriginal people. Hospitalisation rates reflect the occurrence in a population of serious acute illnesses or conditions that require hospital treatment, and the 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 episodes of care rather than on the number of individual people who are hospitalised.

Key findings

Overall: In Western Australia, between July 2021 and June 2023, the leading cause of hospitalisation for Aboriginal people was care involving dialysis (550 per 1,000 population). Excluding dialysis, there were 88,360 hospitalisations for Aboriginal people, at a rate of 361 per 1,000 population (Table D1.02.1, Table D1.02.5 WA).

Top reasons for hospitalisation: Between July 2021 and June 2023 in Western Australia, after dialysis, the causes with the highest rates of hospitalisation for Aboriginal people were:

- pregnancy, childbirth and the puerperium (64 hospitalisations per 1,000 Aboriginal females)
- injury and poisoning (48 hospitalisations per 1,000 people): for example, fractures, wounds, burns or poisoning due to drugs
- respiratory system disease (34 hospitalisations per 1,000 people): this includes acute upper or lower respiratory infections, influenza, pneumonia, chronic obstructive pulmonary disease (COPD) and other respiratory illnesses.

The 3 leading reasons for hospitalisation for Aboriginal people nationally (excluding dialysis) were 'pregnancy, childbirth and the puerperium', followed by 'injury and poisoning' and then 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', (Figure 1.02.1).

Hospitalisation by age and sex: In Western Australia between July 2021 and June 2023, 58% of total hospitalisations (excluding dialysis) among Aboriginal people were for females (51,189 hospitalisations). Aboriginal females were hospitalised at 1.4 times the rate of Aboriginal males (428 and 298 per 1,000 population, respectively) (Table D1.02.1).

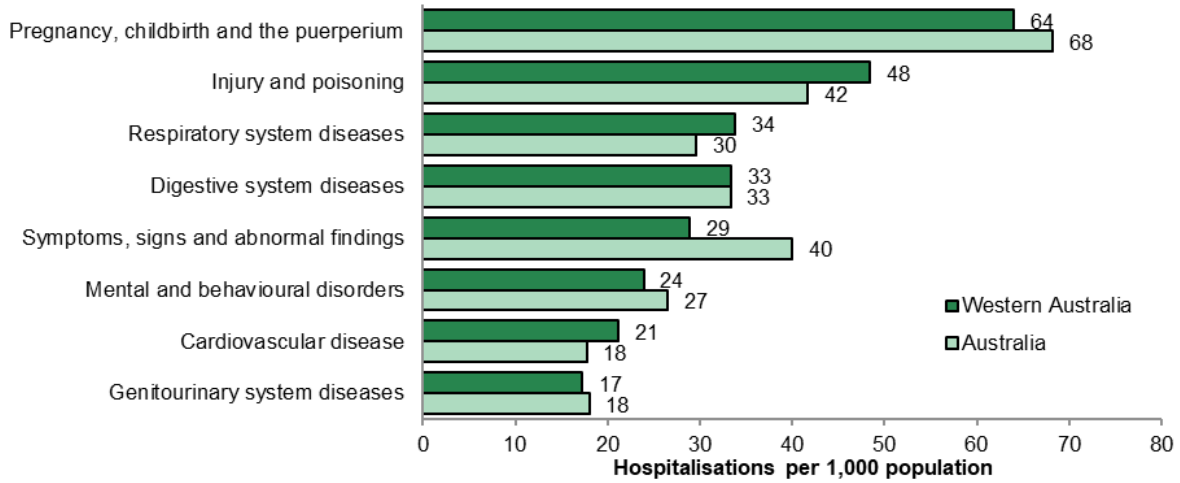
In Western Australia, Aboriginal children aged 0–4 had a hospitalisation rate of 307 hospitalisations per 1,000 population (excluding dialysis) between July 2021 and June 2023. The hospitalisation rate was lowest among those aged 5–14 (109 per 1,000), then increased with age and was highest for those aged 65 and over (890 per 1,000) (Figure 1.02.2).

Trend over time: In Western Australia, 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 3.5% for Aboriginal people and decreased by 7.5% for non- Aboriginal people.

Nationally, over the same period, the hospitalisation rate (excluding dialysis) increased by 16% for Aboriginal people and decreased by 5% for non-Aboriginal people (Figure 1.02.3).

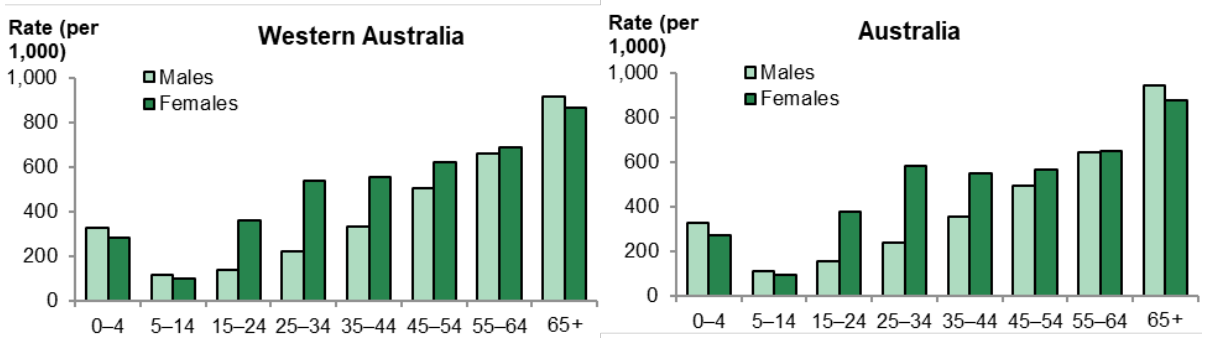
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



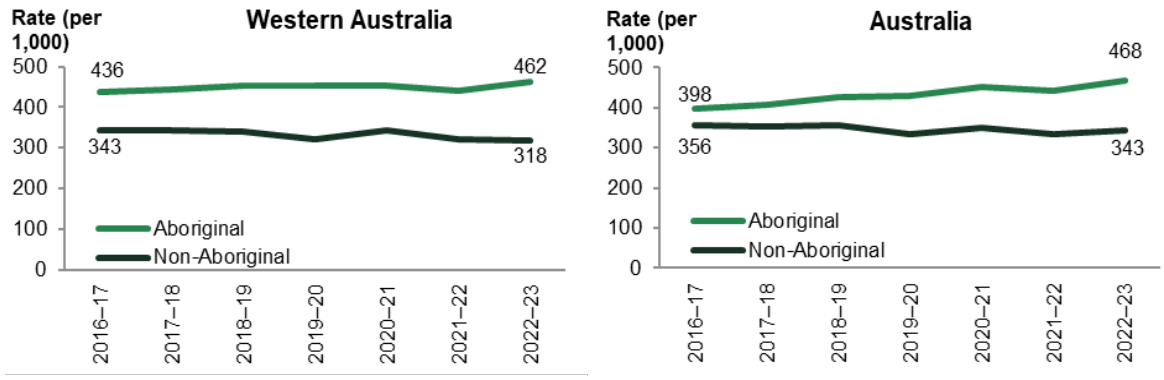
Note: For the category 'pregnancy, childbirth and the puerperium' rates are calculated for females only.
Source: Table D1.02.5 WA.

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



Source: Table D1.02.2 WA.

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



Source: Table D1.02.4 WA.

1.03 Injury and poisoning

Why it is important

This measure reports on death and hospitalisation among Aboriginal people 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).

Injuries were the second leading cause (12%) of the total disease burden for Aboriginal people across Australia in 2018, behind mental and substance use disorders (23%). Injuries were the leading cause of the fatal burden in 2018 (23% of fatal burden) (AIHW 2022b).

Key findings

Death due to injury and poisoning: Over the period 2019–2023, looking at broad causes of death, injury and poisoning was the third leading cause of death among Aboriginal people in Western Australia, accounting for 18% (578) of all deaths. After adjusting for differences in the age structure between the two populations, Aboriginal people in Western Australia died from injury and poisoning at 2.6 times the rate of non-Aboriginal people (Table D1.23.2).

Hospitalisation 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.

From July 2021 to June 2023, there were 11,825 hospitalisations due to injury and poisoning for Aboriginal people in Western Australia – a rate of 48 per 1,000 population. Hospitalisation rates for injury and poisoning in Western Australia were higher for Aboriginal people living in remote areas (78 per 1,000 population) than in non-remote areas (33 per 1,000) (Table D1.03.16).

Hospitalisation by age and sex: In Western Australia between July 2021 and June 2023, Aboriginal males aged under 25 and those aged 55–64 had higher hospitalisation rates for injury and poisoning than females. For Aboriginal males the hospitalisation rates for injury and poisoning were highest for those aged 55–64 (71 per 1,000 males), and for Aboriginal females the highest rate was for those aged 35–44 (82 per 1,000 females) (Figure 1.03.1).

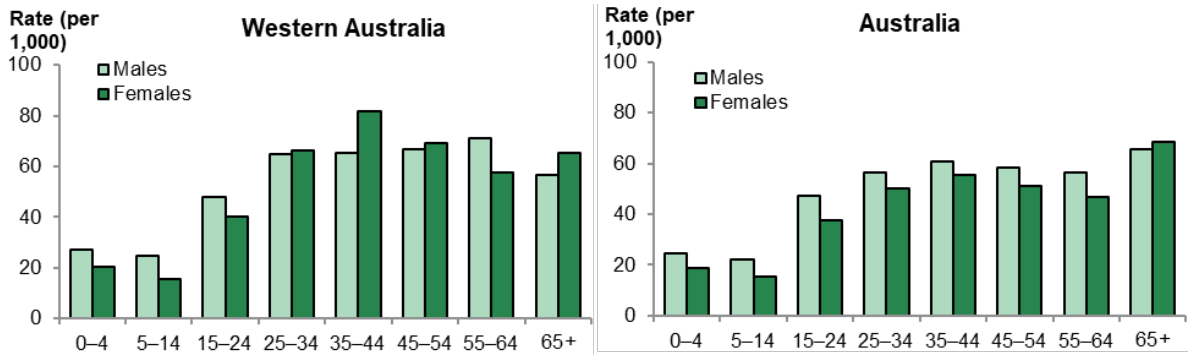
Leading causes of hospitalisation: Between July 2021 and June 2023 in Western Australia, assaults were the leading cause of hospitalisation due to injury and poisoning for Aboriginal males (20%) and females (31%). Falls was the second leading cause of hospitalisation due to injury and poisoning for Aboriginal females (17%) and males (16%). (Figure 1.03.2).

Hospitalisation trend over time: In Western Australia, over the period 2016–17 to 2022–23, the age-standardised hospitalisation rate for injury and poisoning was stable for Aboriginal people and decreased by 10% 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 people (Figure 1.03.3).

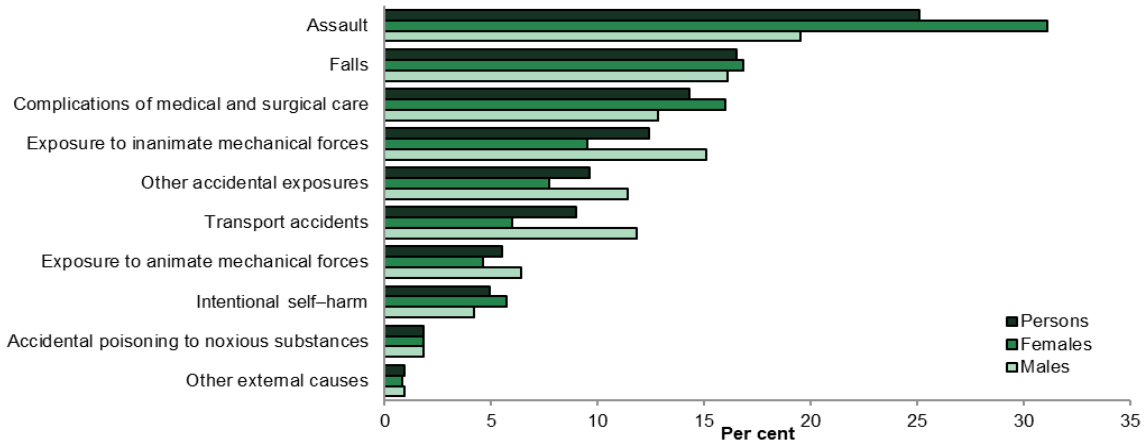
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



Source: Table D1.03.2 WA.

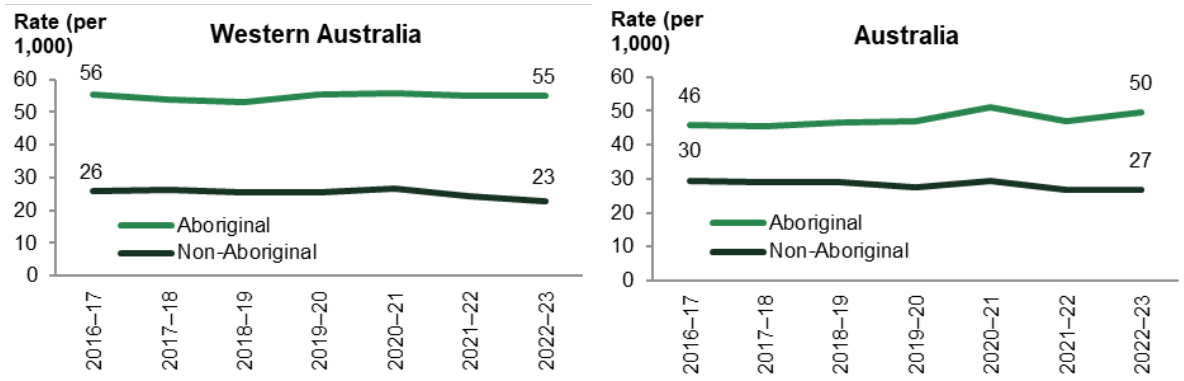
Figure 1.03.2: First reported external causes of hospitalisations for a principal diagnosis of injury and poisoning for Aboriginal people in Western Australia, by sex, July 2021 to June 2023



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

Source: Table D1.03.7 WA.

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



Source: Table D1.03.5 WA.

1.04 Respiratory disease

Why it is important

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 7.5% of the total disease burden for Aboriginal people across Australia in 2018 (AIHW 2022b).

Key findings

Overall prevalence (self-reported): In 2022–23 in Western Australia, an estimated 27% (32,000) of Aboriginal people reported having a respiratory disease that lasted or was likely to last for 6 months or more. In non-remote areas 33% (25,600) of Aboriginal people reported respiratory disease compared with 16% (6,300) living in remote areas (Table D1.04.2).

Nationally in 2022–23, 31% of Aboriginal people reported having a respiratory disease that lasted or was likely to last for 6 months or more. In non-remote areas of Australia 34% of Aboriginal people reported having a respiratory disease compared with 16% living in remote areas (Figure 1.04.1).

Deaths: Respiratory diseases are among the leading causes of death for Aboriginal people in Western Australia and in NSW, Qld, WA, SA and NT combined. During 2019–2023 in Western Australia, there were 223 deaths due to respiratory diseases for Aboriginal people, a rate of 37 per 100,000 population (5th leading cause of death). The rate for Aboriginal people in NSW, Qld, WA, SA and NT combined, for the same period, was 43 per 100,000 population (4th leading cause) (Table D1.23.2).

After adjusting for differences in the population age structures, rates of death due to respiratory diseases were higher for Aboriginal people (both in Western Australia, and NSW, Qld, WA, SA and NT combined) than for non-Aboriginal people living in the same areas (Figure 1.04.2).

Hospitalisations for respiratory disease: From July 2021 to June 2023, there were 8,272 hospitalisations for respiratory diseases for Aboriginal people in Western Australia (a rate of 34 per 1,000 population). Hospitalisation rates for respiratory diseases in Western Australia were higher for Aboriginal people living in remote areas (54 per 1,000 population) than in non-remote areas (23 per 1,000 population).

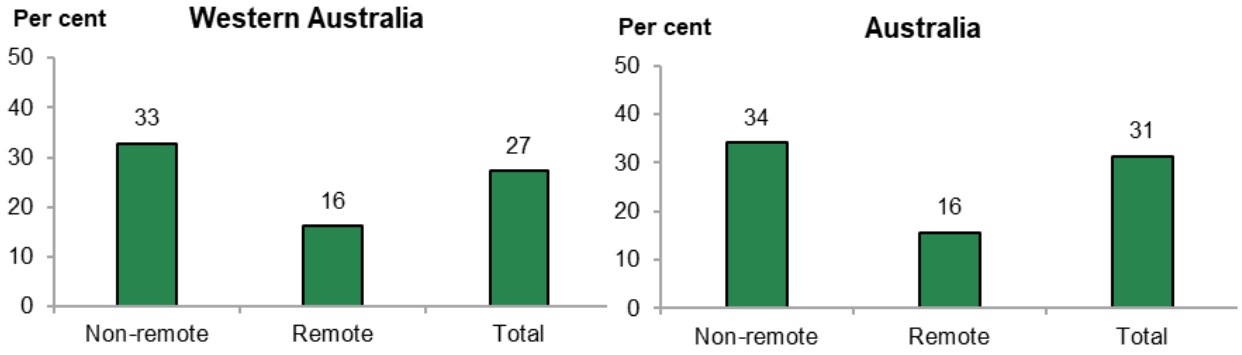
Nationally over the same period, hospitalisations for respiratory diseases for all Aboriginal people were higher for those living in remote areas (51 per 1,000 population) than in non-remote areas (25 per 1,000 population) (Figure 1.04.3).

Hospitalisations by age and sex: In Western Australia between July 2021 and June 2023, the highest rates of hospitalisations for respiratory diseases were for Aboriginal males and females in the 65+ age group (102 and 90 per 1,000 respectively), followed by males in the 0–4 age group (83 per 1,000) and females in the 55–64 age group (79 per 1,000). This pattern was similar for Aboriginal people nationally (Table D1.04.8 WA).

Hospitalisations trend over time: In Western Australia between 2016–17 and 2022–2023, the age-standardised hospitalisation rate for Aboriginal people for respiratory diseases decreased by 23%. This was larger than the national decrease in the age-standardised hospitalisation rate for Aboriginal people (10%) (Table D1.04.11 WA).

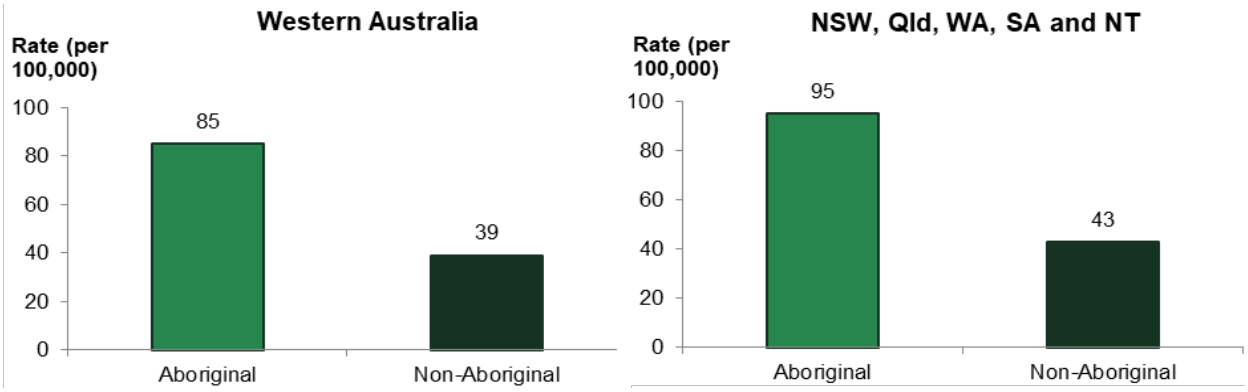
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



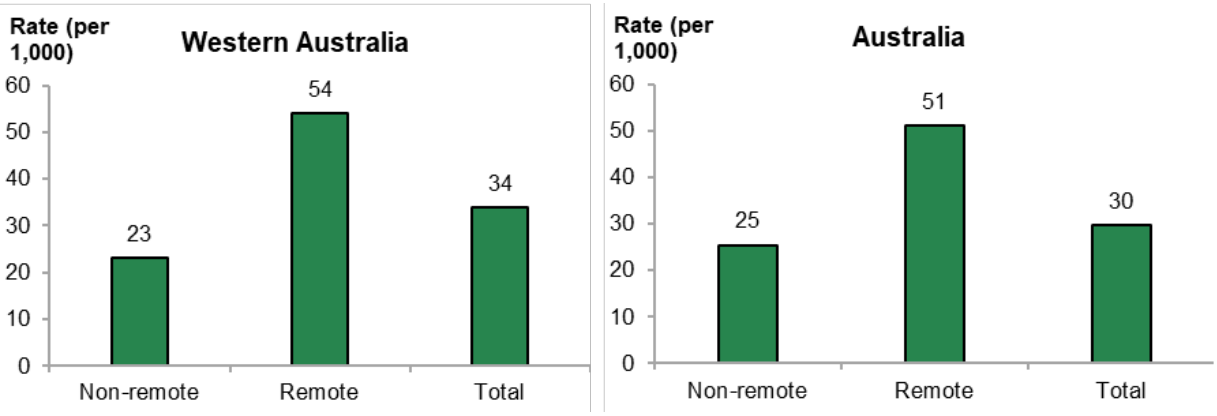
Source: Table D1.04.2.

Figure 1.04.2: Age-standardised death rate for respiratory diseases, by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2019–2023



Source: Table D1.23.2.

Figure 1.04.3: Hospitalisation rate due to respiratory diseases for Aboriginal people, by remoteness, Western Australia and Australia, July 2021 to June 2023



Source: Table D1.04.17.

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 people, and its onset tends to occur between 10 and 20 years younger than for non-Aboriginal people (AIHW 2015a; Bradshaw et al. 2011; Brown 2012; Brown & Kritharides 2017; Katzenellenbogen et al. 2014).

Key findings

For consistency, the term 'cardiovascular disease' has been used throughout this measure.

Overall prevalence (self-reported): In 2022–23 in Western Australia, 12% (13,700) of Aboriginal people reported having cardiovascular disease. In remote areas 15% (6,000) of Aboriginal people reported a cardiovascular disease compared to 10% (7,500) of those living in non-remote areas (Table D1.05.1).

Nationally in 2022–23, 14% of Aboriginal people reported having cardiovascular disease. In remote areas of Australia 16% of Aboriginal people reported having cardiovascular disease compared to 13% of those living in non-remote areas (Figure 1.05.1).

Hospitalisations for cardiovascular disease: From July 2021 to June 2023, there were 5,175 hospitalisations for cardiovascular disease for Aboriginal people in Western Australia (a rate of 21 per 1,000 population). Hospitalisation rates for cardiovascular disease in Western Australia were higher for Aboriginal people living in remote areas (30 per 1,000 population) than those living in non-remote areas (17 per 1,000 population).

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).

Deaths: From 2019 to 2023, cardiovascular disease was the leading cause of death for Aboriginal people in Western Australia (761 deaths or 23% of total deaths). In NSW, Qld, WA, SA and 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).

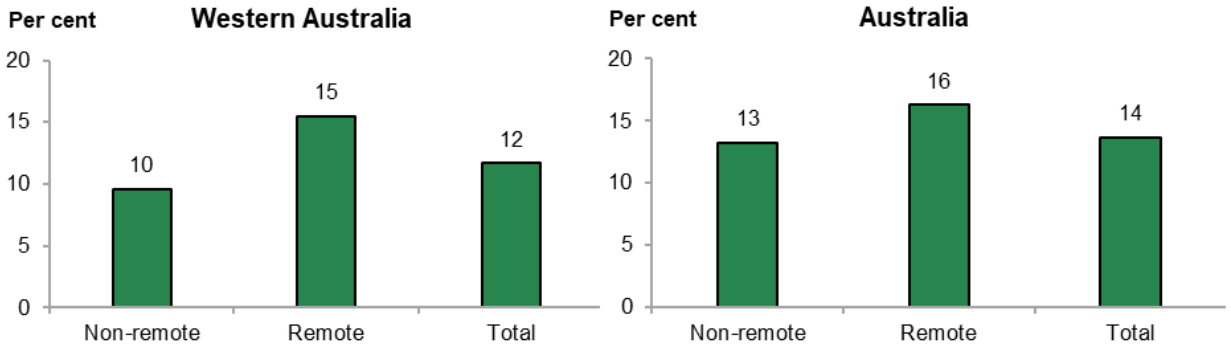
The age-standardised rate of cardiovascular disease deaths decreased for Aboriginal people in Western Australia by 4.2 % between 2016 and 2023 (from 340 to 267 per 100,000 population), while for non-Aboriginal people the rate decreased by 20% over this period (from 145 to 111 per 100,000) (Table D1.23.28).

Change in hospitalisation over time: In Western Australia, between 2016–17 and 2022–23, after adjusting for differences in the age structure between the two populations, the rate of hospitalisation for cardiovascular disease decreased for both Aboriginal people and non-Aboriginal people (3% and 18% respectively).

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

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

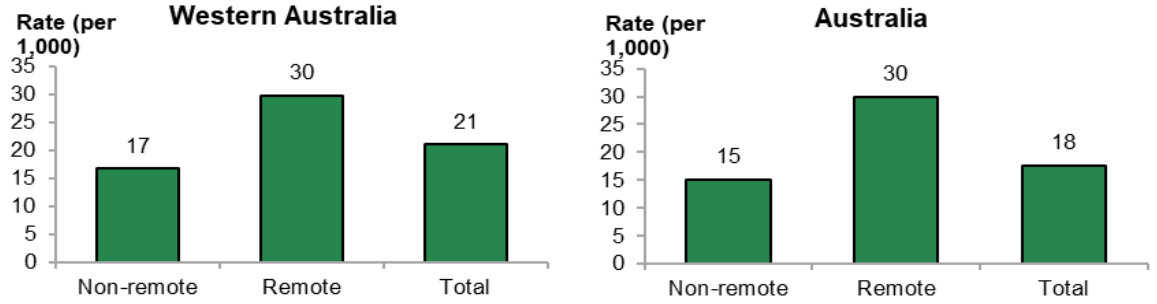
Figure 1.05.1: Aboriginal people reporting cardiovascular disease, by remoteness, Western Australia and Australia, 2022–23



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).

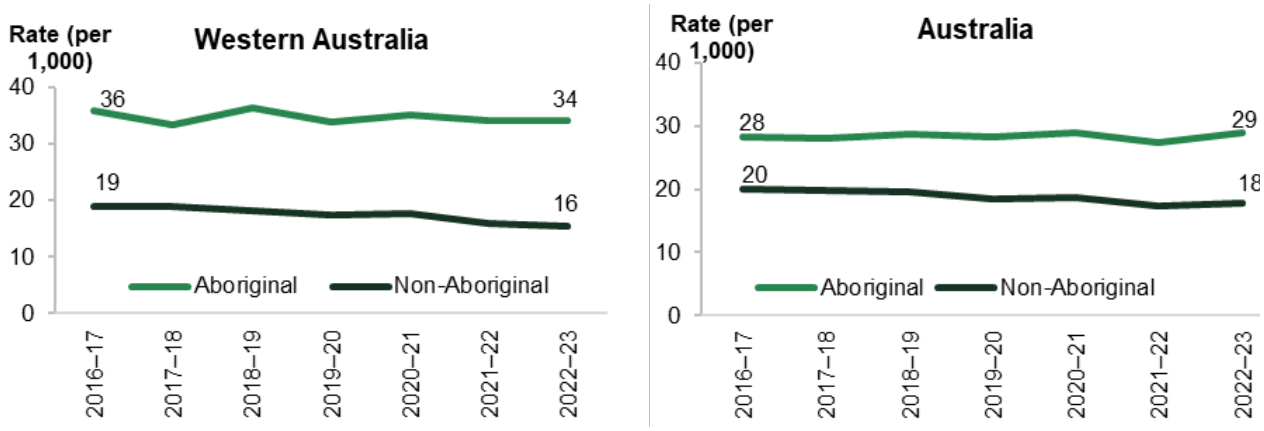
Source: Table D1.05.1.

Figure 1.05.2: Hospitalisation rate for cardiovascular disease (based on principal diagnosis) for Aboriginal people, by remoteness, Western Australia and Australia, July 2021 to June 2023



Source: Table D1.05.12

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



Source: Table D1.05.11 WA.

1.06 Acute rheumatic fever and rheumatic heart disease

Why it is important

This measure reports on cases of acute rheumatic fever (ARF) and rheumatic heart disease (RHD). ARF and RHD are preventable diseases disproportionately affecting Aboriginal people living in regional and remote areas of Australia. ARF symptoms can include arthritis, fever, swelling of the heart and heart valves, and rash (AIHW 2024a). RHD is damage to the valves of the heart caused by one or repeated episodes of ARF (AIHW 2024a). 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 (AIHW 2024a; Ali et al. 2018).

Key findings

Acute rheumatic fever: In 2023, 78 cases of ARF were recorded among Aboriginal people in Western Australia, accounting for 95% of the total number of ARF cases recorded in Western Australia that year (AIHW 2024a). ARF occurs largely in children and young adults, with an incidence rate of 149 per 100,000 Aboriginal children aged 5–14 and 78 per 100,000 Aboriginal young people aged 15–24 in Western Australia in 2023 (Table D1.06.6).

Comparable data on ARF cases are available for 5 jurisdictions: NSW, Qld, WA, SA, and NT. In these jurisdictions combined, 600 cases of ARF were recorded in 2023, with Aboriginal people accounting for 91% of the cases recorded (545 cases). Over two-fifths (43%) of cases among Aboriginal people occurred in children aged 5–14 (232 cases, 140 per 100,000) (AIHW 2024a).

Rheumatic heart disease: As at 31 December 2023, there were 886 Aboriginal people with RHD in Western Australia. Aboriginal people were substantially over-represented among people with RHD, a rate of 712 RHD cases per 100,000 Aboriginal people in Western Australia, compared with 5.1 per 100,000 for non-Aboriginal people (Figure 1.06.1).

Comparable data on RHD cases are available for Qld, WA, SA, and the NT. In these jurisdictions combined, as 31 December 2023, there were 5,657 Aboriginal people with RHD, equivalent to 1,044 cases per 100,000 population. The rate for non-Aboriginal people was 16 per 100,000 (Figure 1.06.1).

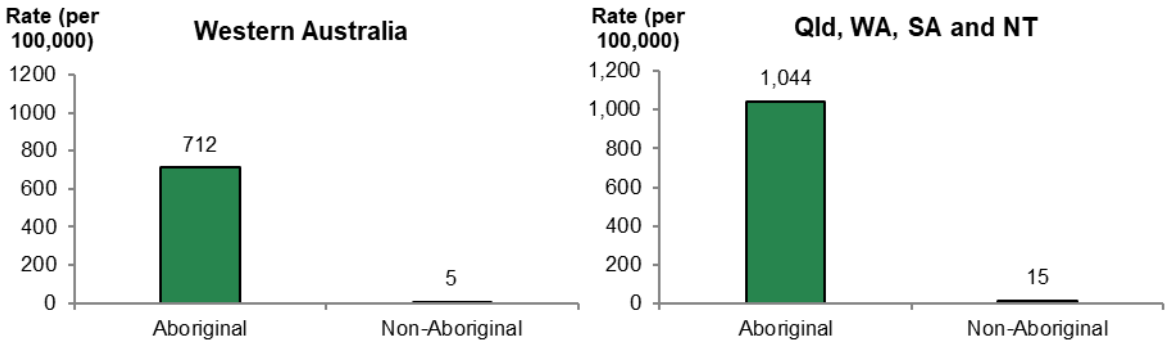
Hospitalisations: Between July 2021 and June 2023, 274 Aboriginal people in Western Australia were hospitalised for ARF or RHD, a rate of 112 hospitalisations per 100,000 population. Hospitalisation rates for ARF or RHD were higher among Aboriginal people living in remote areas (253 per 100,000) than in non-remote areas (41 per 100,000) in Western Australia.

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. 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) (Figure 1.06.2).

Changes over time: From 2016 to 2023, incidence rates of ARF among Aboriginal people in Western Australia increased from 50 to 63 per 100,000. Over the same time period, the incidence rate of RHD among Aboriginal people in Western Australia decreased from 50 to 35 new cases per 100,000 population (Figure 1.06.3).

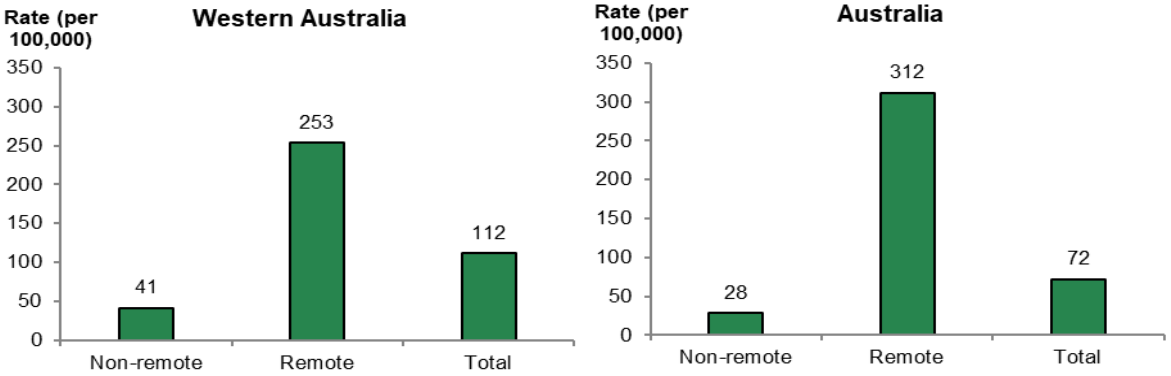
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.06.1: Rheumatic heart disease prevalence by Aboriginal status, Western Australia, and Qld, WA, SA, and NT, as at December 2023



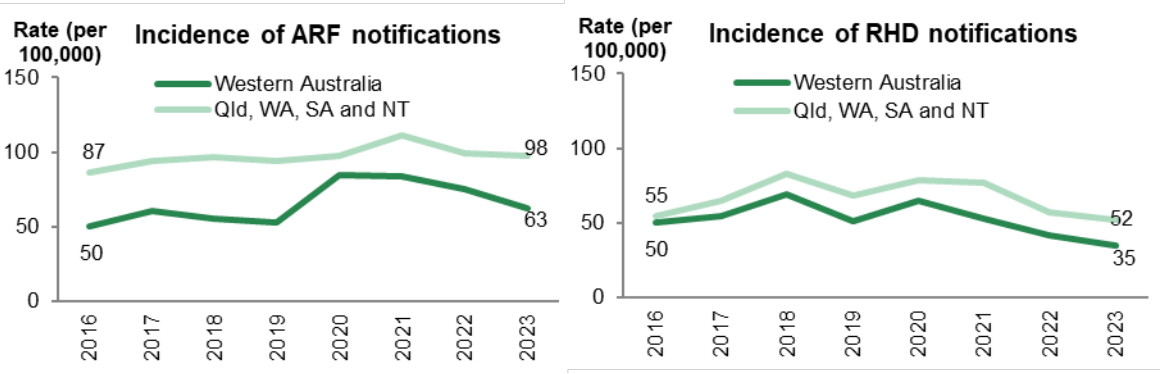
Source: AIHW analysis of National Rheumatic Heart Disease data collection.

Figure 1.06.2: Hospitalisation rate with a principal diagnosis of acute rheumatic fever or rheumatic heart disease for Aboriginal people, by remoteness, Western Australia and Australia, July 2021 to June 2023



Source: Table D1.06.17.

Figure 1.06.3: Incidence of acute rheumatic fever and rheumatic heart disease notifications among Aboriginal people, Western Australia, and Qld, WA, SA, and NT, 2016 to 2023



Source: Tables D1.06.6 and D1.06.15.

1.07 High blood pressure

Why it is important

This measure reports on the prevalence of high blood pressure, also referred to as hypertension, among Aboriginal people. 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).

Key findings

Adults with high blood pressure: In 2022–23, the National Aboriginal and Torres Strait Islander Health Survey collected both measured blood pressure and reported blood pressure. For measured blood pressure, the imputation of values was used to correct for those who did not have measurements collected (ABS 2024e).

In 2022–23, based on both measured and reported data, one-third (33%, 23,800 people) of Aboriginal adults in Western Australia 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 was similar in remote areas and non-remote areas (32% and 34%, respectively) (Figure 1.07.1).

Nationally in 2022–23, based on both measured and reported data, 33% (an estimated 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 areas and non-remote areas (35% and 33%, respectively) (Figure 1.07.1).

Hospitalisation for hypertensive disease: Prolonged high blood pressure could cause damage to the heart and other organs, known as hypertensive disease (AIHW 2022c). Between July 2021 and June 2023, there were 174 hospitalisations of Aboriginal people with a principal diagnosis of hypertensive disease in Western Australia, at a rate of 71 hospitalisations per 100,000. After adjusting for differences in age structure between the two populations, the rate of hospitalisation due to hypertensive disease for Aboriginal people in Western Australia was 3.5 times the rate for non-Aboriginal people (Table D1.07.10).

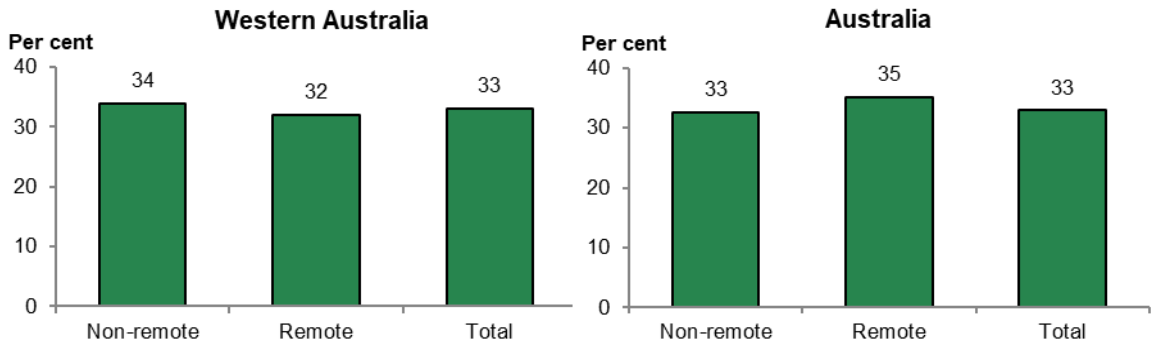
Hospitalisation by age and sex: In Western Australia, between July 2021 and June 2023, the hospitalisation rate for hypertensive disease was higher for Aboriginal females than for Aboriginal males (97 and 46 hospitalisations per 100,000 population, respectively) (Table D1.07.10).

Hospitalisation rates for hypertensive disease increased with age in both Western Australia and nationally (Figure 1.07.2). Between July 2021 and June 2023, both in Western Australia and nationally, Aboriginal people had a higher rate of hospitalisation for hypertensive disease than non-Aboriginal people in all age groups (Table D1.07.9 WA).

Hospitalisation by remoteness: Between July 2021 and June 20231, in Western Australia, the rate of hospitalisations due to hypertensive disease for Aboriginal people was higher in remote than non-remote areas (116 and 49 per 100,000 population, respectively). After adjusting for differences in age structure between the two populations, Aboriginal people living in remote areas of Western Australia were hospitalised for hypertensive disease at 4.4 times the rate for non-Aboriginal Western Australians (Figure 1.07.3).

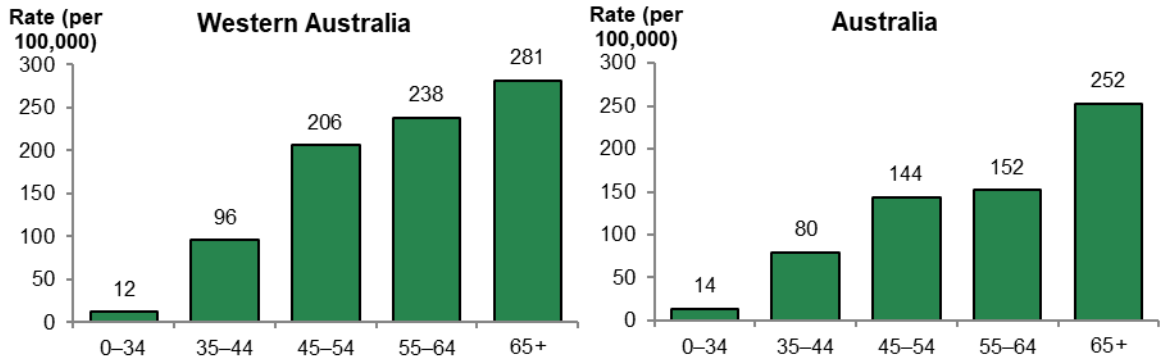
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



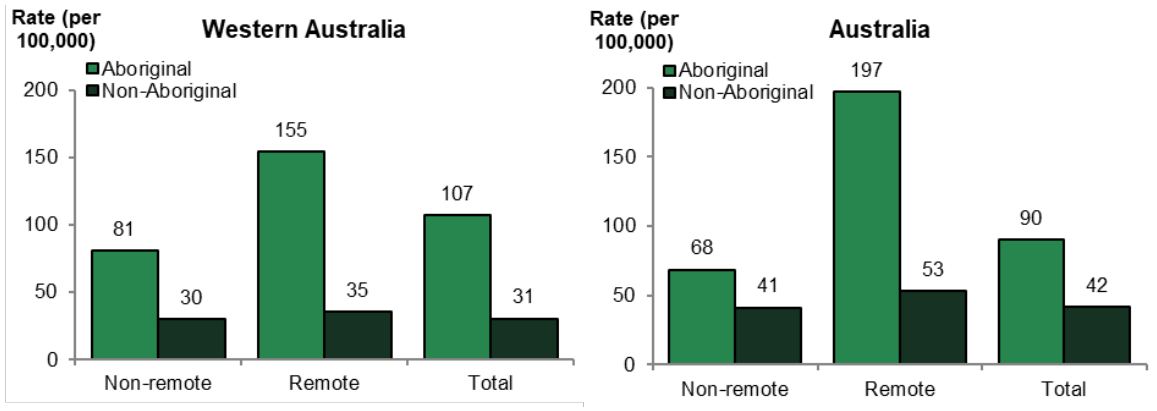
Source: Table D1.07.4.

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



Source: Table D1.07.9 WA.

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



Source: 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 among Aboriginal people. 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).

Key findings

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

In the 5-year period 2014–2018 (the latest data available at the time of writing), there were 1,033 new cases of cancer diagnosed among Aboriginal people in Western Australia, an incidence rate of 205 new cases per 100,000 population. In the 5 jurisdictions combined, there were 9,262 new cases of cancer diagnosed among Aboriginal people, an incidence rate of 257 new cases per 100,000 population in 2014–2018 (Table D1.08.3).

In Western Australia, female breast cancer was the most common, followed by lung cancer then head and neck cancers. In the 5 jurisdictions combined, lung cancer was the most common, followed by female breast cancer, bowel cancer and prostate cancer (Figure 1.08.1).

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

Over the period 2019–2023, cancer and other neoplasms was the second leading cause of death among Aboriginal people in Western Australia, accounting for about a fifth (20%, 645 deaths) of all deaths of Aboriginal people. 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).

Over the years from 2016 to 2023, the age-standardised rate of deaths due to cancer and other neoplasms increased by 14% for Aboriginal people in Western Australia (Table D1.23.29).

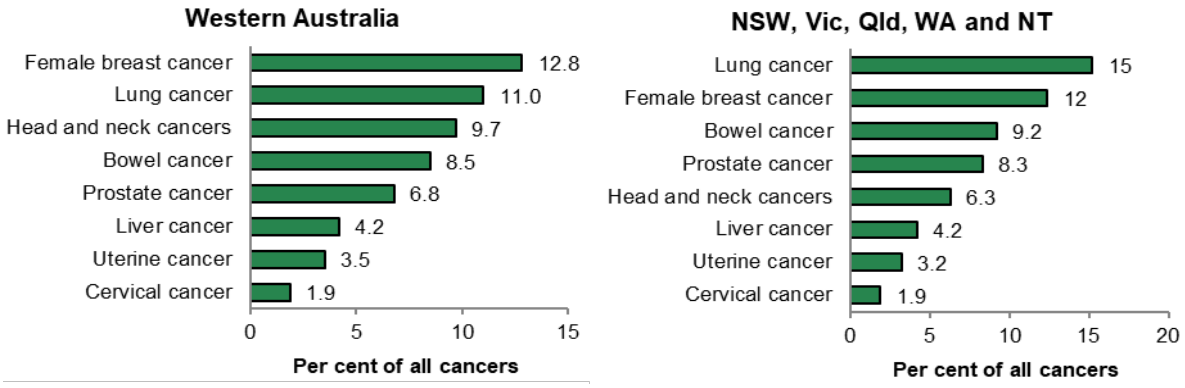
Hospitalisation due to cancer: Cancer-related hospitalisation data include hospitalisations with either a principal or additional diagnosis of cancer.

In Western Australia, between July 2021 and June 2023, the cancer-related hospitalisation rate was slightly lower among Aboriginal people living in remote areas compared with non-remote areas (20 and 24 hospitalisations per 1,000 population). Nationally, cancer-related hospitalisation rates among Aboriginal people were the same in remote and non-remote areas (22 hospitalisations per 1,000) (Figure 1.08.2).

Change in hospitalisation over time: In Western Australia, between 2016–17 and 2022–23, after adjusting for differences in the age structure between the two populations, cancer-related hospitalisations increased by 41% for Aboriginal people and decreased by 1% for non-Aboriginal people. Nationally, over the same time period, cancer-related hospitalisations increased by 36% for Aboriginal people and was stable for non-Aboriginal people (Figure 1.08.3).

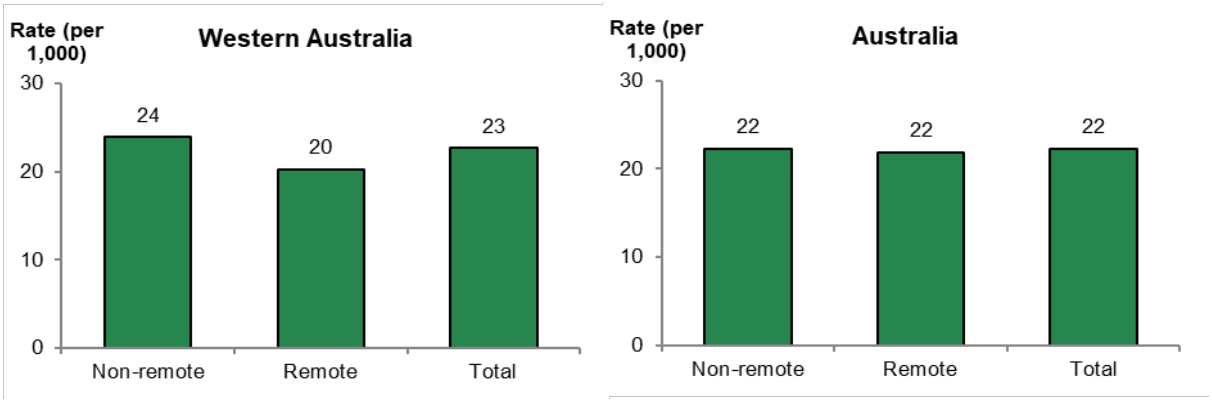
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.08.1: Selected cancers as a proportion of total new cancer cases among Aboriginal people, Western Australia, and NSW, Vic, Qld, WA and NT, 2014–2018



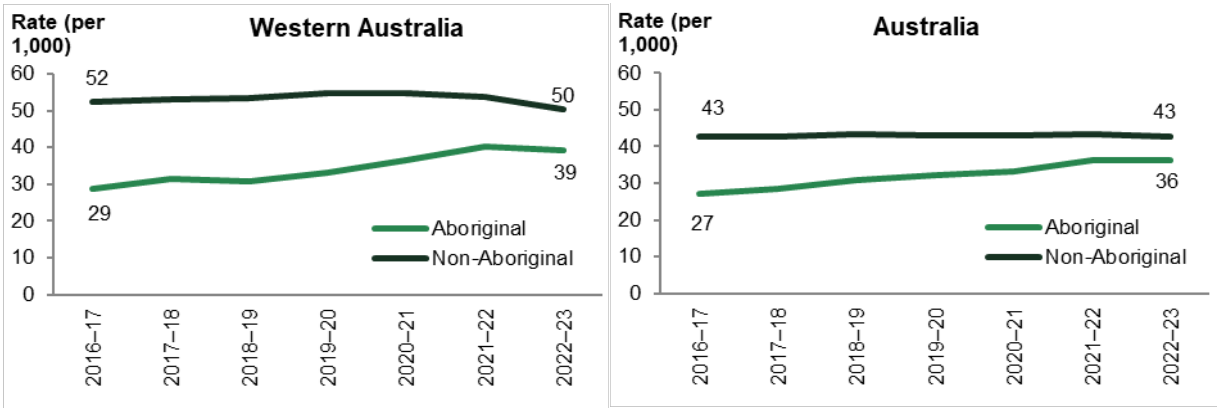
Source: Table D1.08.3.

Figure 1.08.2: Cancer-related hospitalisation rates for Aboriginal people, by remoteness, Western Australia and Australia, July 2021 to June 2023



Source: Table D1.08.17.

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



Source: Table D1.08.15 WA.

1.09 Diabetes

Why it is important

This measure reports on deaths, hospitalisations and the prevalence of diabetes among Aboriginal people. 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 2015a; Burrow & Ride 2016). In 2018, among Aboriginal people across Australia, 7,966 years of healthy life were lost due to endocrine disorders (largely diabetes), accounting for 3.3% of the total disease burden (AIHW 2022b).

Key findings

Prevalence of diabetes: In 2022–23 in Western Australia, 18% (12,800) of Aboriginal adults reported having diabetes or high blood/urine sugar levels (Table D1.09.14). After adjusting for differences in the age structure between the two populations, Aboriginal adults were 3.2 times as likely to report having diabetes or high blood/urine sugar levels as non-Aboriginal people (Figure 1.09.1).

Hospitalisation for diabetes: In Western Australia, between July 2021 and June 2023, there were 1,590 hospitalisations (6.5 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 45,540 hospitalisations (186 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 hospitalisation with a principal or additional diagnosis of diabetes for Aboriginal people was 8.7 times the rate for non-Aboriginal people. Nationally, between July 2021 and June 2023, the age-standardised rate of hospitalisation for diabetes (principal or additional diagnosis) for Aboriginal people was 3.6 times the rate for non-Aboriginal people (Figure 1.09.2).

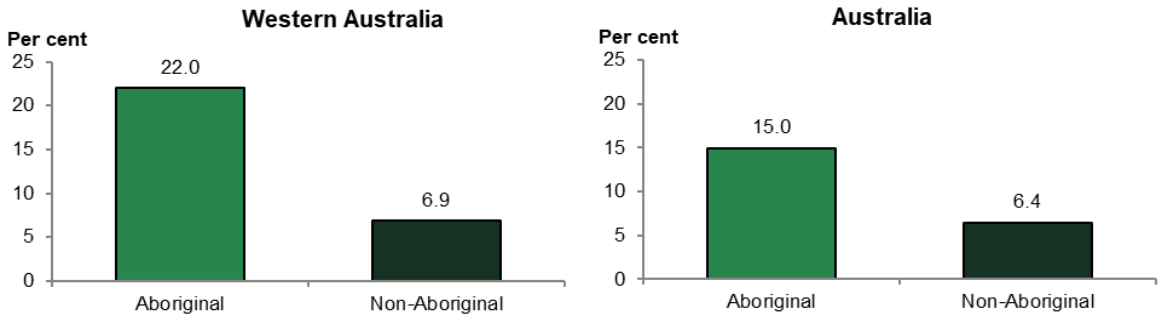
Hospitalisation by age: For both Western Australia and Australia, between July 2021 and June 2023, hospitalisation rates for diabetes (principal or additional diagnosis) increased with age. The relative difference in rates between Aboriginal people and non-Aboriginal people was highest for those aged 45–54. In Western Australia, for this age group, Aboriginal people were 22 times as likely as non-Aboriginal people 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).

Deaths from diabetes: In Western Australia, endocrine, metabolic, and nutritional disorders (which include mostly diabetes) are among the top 5 leading causes of death for Aboriginal people. In Western Australia, in the 5-year period between 2019 and 2023, 8.6% (283) of total deaths of Aboriginal people were due to diabetes (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 7.8 times the rate for non-Aboriginal people.

Deaths data for Aboriginal people are available from 5 jurisdictions: NSW, Qld, WA, SA and NT. In these 5 jurisdictions combined, in 2019–2023, the age-standardised rate of deaths due to diabetes for Aboriginal people was 4.4 times the rate for non-Aboriginal people (Figure 1.09.3).

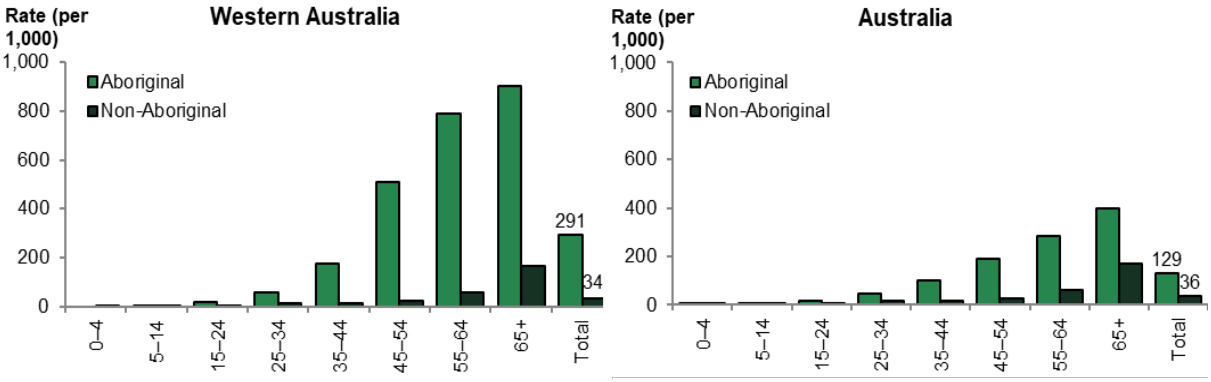
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



Source: Table D1.09.2.

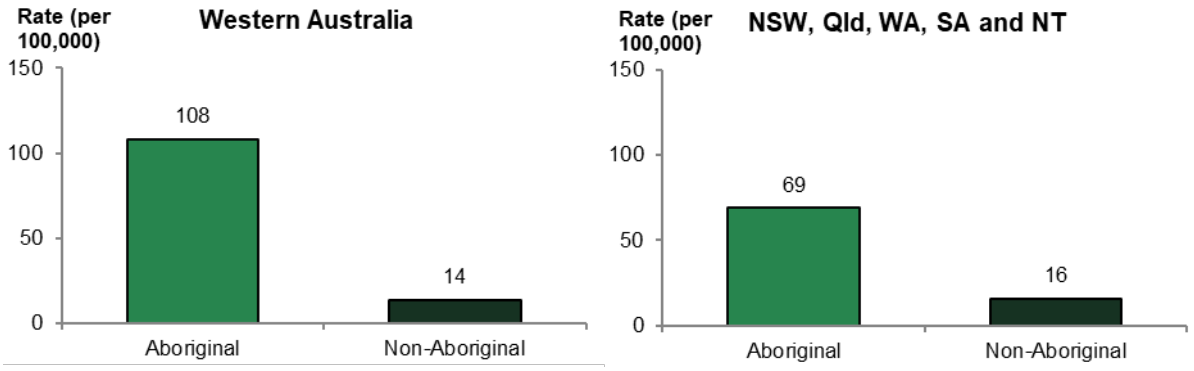
Figure 1.09.2: Hospitalisation rates for diabetes (principal or additional diagnosis), by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



Notes: Total is age-standardised. Categories are based on the ICD-10-AM 12th edition: ICD-10-AM codes E10–14, and O24. The 11th edition with 2021–22 data has been mapped to the 12th edition. 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: Table D1.09.7 WA.

Figure 1.09.3: Age-standardised death rates for diabetes, by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2019–2023



Source: 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 for Aboriginal people. 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 2020). Aboriginal people with kidney disease are less likely to receive kidney transplants than other 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) (Chadban et al. 2005; Devitt et al. 2008; Khanal et al. 2018; Rix et al. 2015).

Key findings

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 the self-reported data from the 2022–23 National Aboriginal and Torres Strait Islander Health Survey, after adjusting for age in both populations, 3.4% of Aboriginal adults in Western Australia had chronic kidney disease. Nationally 2.6% of Aboriginal adults had chronic kidney disease (Table D1.10.1).

Hospitalisation: Between July 2021 and June 2023 in Western Australia, there were 1,360 hospitalisations for chronic kidney disease (excluding dialysis) for Aboriginal people, at a rate of 5.6 per 1,000. Aboriginal females were hospitalised at a higher rate than Aboriginal males (7.5 per 1,000 compared with 3.7 per 1,000, respectively).

Nationally, this pattern was similar, with Aboriginal females hospitalised at a rate of 5.4 per 1,000 compared with 2.7 per 1,000 for Aboriginal males (Figure 1.10.1).

Kidney failure with replacement therapy: During 2020–2022 in Western Australia, for Aboriginal people the incidence rate of kidney failure with kidney replacement therapy was 69 new cases per 100,000 population. The incidence of kidney failure with replacement therapy was slightly higher for Aboriginal females than males (72 per 100,000 compared with 67 per 100,000).

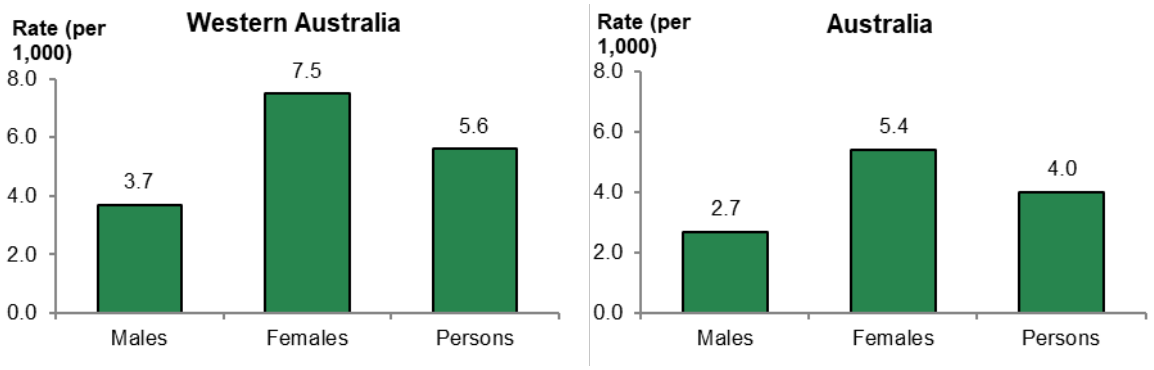
Nationally over the same period, the incidence of kidney failure with replacement therapy was slightly higher for Aboriginal females than for Aboriginal males (39 per 100,000 compared with 33 per 100,000) (Figure 1.10.2).

Kidney failure with replacement therapy over time: The incidence rate of kidney failure with replacement therapy for Aboriginal people in Western Australia decreased by 2% between 2016 and 2022. Nationally over the same time, the incidence rate of kidney failure with replacement therapy for Aboriginal people decreased by 3% (Figure 1.10.3).

Deaths: In 2019–2023 in Western Australia, there were 67 deaths of Aboriginal people where kidney diseases were the underlying cause of death (a rate of 11.1 per 100,000). This was slightly higher than the rate for NSW, Qld, WA, SA and NT combined, for the same time period, of 9.2 per 100,000 (Table D1.23.2).

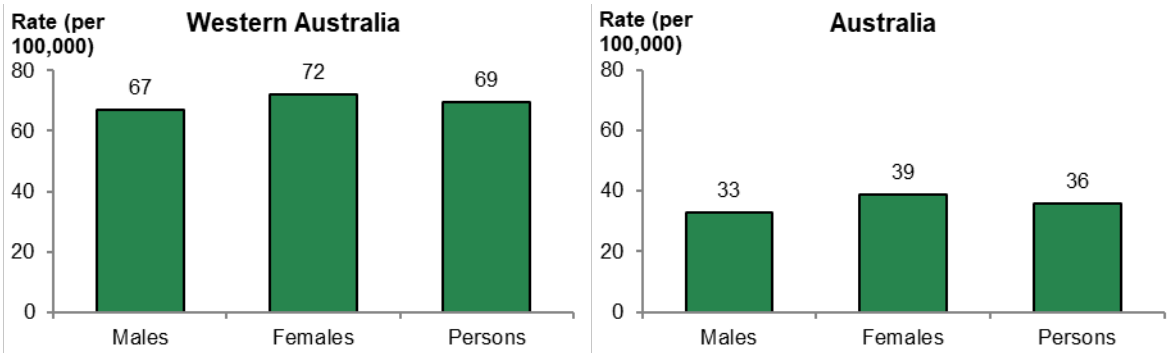
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



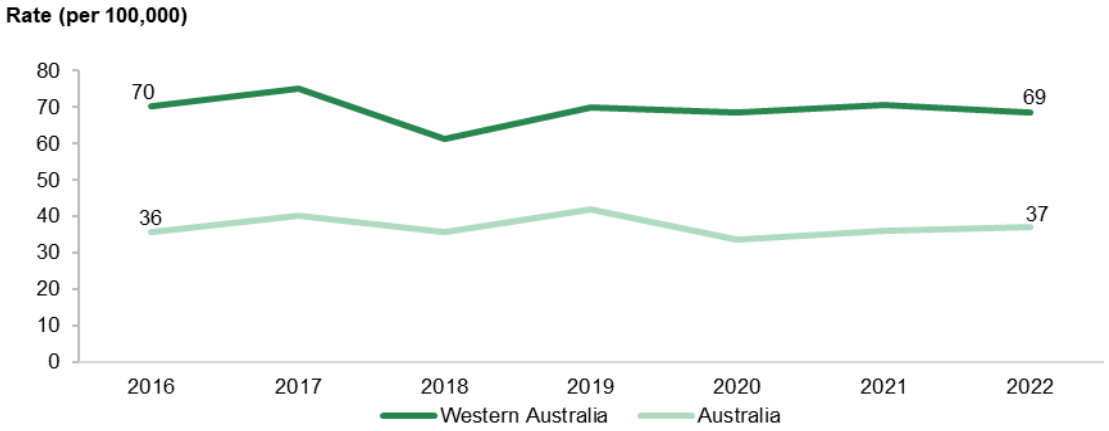
Source: Table D1.10.7.

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



Source: Table D1.10.11.

Figure 1.10.3: Incidence (new cases) of kidney failure with replacement therapy, Aboriginal people, Western Australia and Australia, 2016–2022



Source: Table D1.10.15.

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 among Aboriginal people. 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 & Borgnakke 2008), and stroke (Joshipura et al. 2003).

Key findings

Seen a dentist in last 12 months: Based on data from the 2022–23 National Aboriginal and Torres Strait Islander Health Survey, in Western Australia, more than 46,000 (41%) Aboriginal people aged 2 and over had seen a dentist in the previous 12 months, including 46% of those aged 0–17 and 39% of those aged 18 and over (ABS 2024d, tables 55.1 and 55.3).

Tooth loss: In Western Australia in 2022–23, around 3,900 Aboriginal people aged 15 and over had complete tooth loss (5.2%) (Note this estimate has a relative standard error of 25% to 50% and should be used with caution). Complete tooth loss was 6.0% for those living in non-remote areas compared with 1.8% in remote areas (Figure 1.11.1).

Nationally, an estimated 4.3% of Aboriginal people aged 15 and over had complete tooth loss in 2022–23 (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, 26% of Aboriginal children aged under 15 in Western Australia had teeth or gum problems, compared with 28% of Aboriginal children nationally (Table D1.11.1). More recent data for children is not currently available.

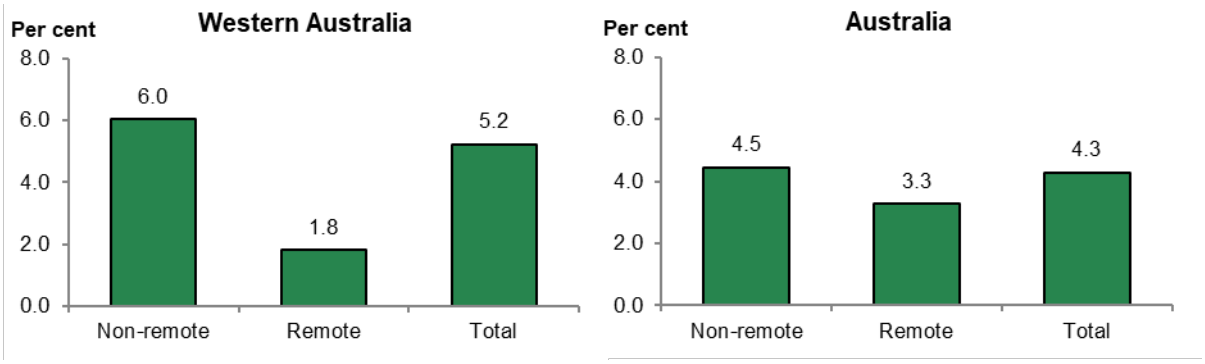
Hospitalisations for dental problems: In Western Australia between July 2021 and June 2023, 1,654 Aboriginal people were hospitalised for dental conditions such as: dental caries; loss of teeth due to accident, extraction or local periodontal disease; or dental examination, at a rate of 6.8 per 1,000 population (Table D1.11.33). Among Aboriginal people, the highest rate of hospitalisation was for those aged 5–14 (12 per 1,000 population). For non-Aboriginal people, the rate was highest for those aged 15–24 (21 per 1,000) (Figure 1.11.2).

Nationally, between July 2021 and June 2023, Aboriginal people were hospitalised for dental problems at a rate of 6.6 per 1,000 population (Table D1.11.33). Rates were highest among Aboriginal people for those 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 1.11.2).

Hospitalisations under general anaesthetic: Dental care under general anaesthetic carries an additional risk and is resource intensive. In Western Australia, between July 2021 and June 2023, there were 1,498 hospitalisations of Aboriginal people for dental procedures that involved general anaesthesia, at a rate of 6.1 per 1,000 population (Table D1.11.34). After adjusting for differences in the age structure between the two populations, rates of hospitalisation for dental procedures involving general anaesthesia were lower for Aboriginal people than for non-Aboriginal people both in Western Australia and nationally (Figure 1.11.3).

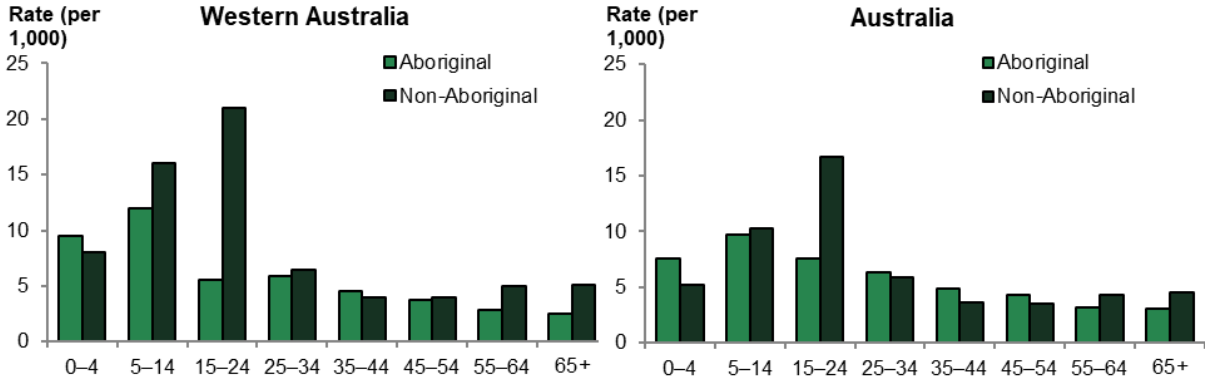
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.11.1: Proportion of Aboriginal people aged 15 and over with complete tooth loss, by remoteness, Western Australia and Australia, 2022–23



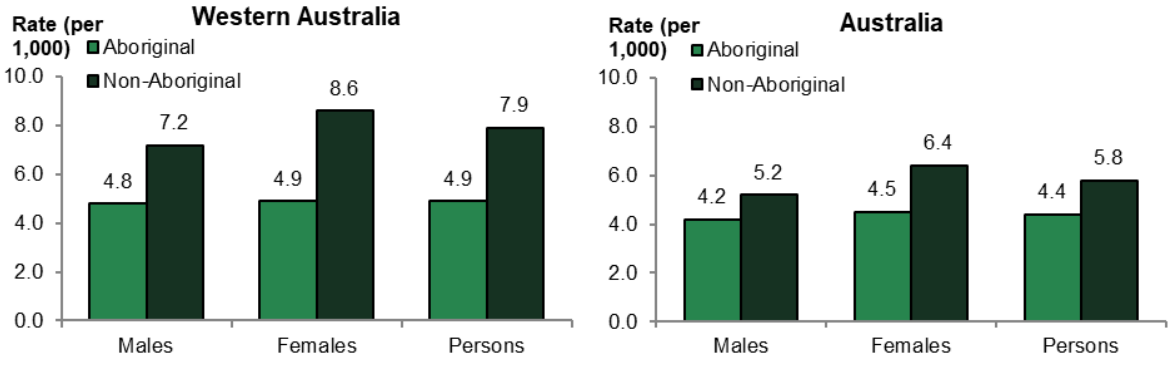
Source: Table D1.11.10.

Figure 1.11.2: Age-specific hospitalisation rates for a principal diagnosis of dental problems, by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



Note: Dental problems category based on ICD-10-AM codes K00 to K14.
Source: Table D1.11.21 WA.

Figure 1.11.3: Age-standardised hospitalisation rates for dental procedures involving general anaesthesia, by Aboriginal status and sex, Western Australia and Australia, July 2021 to June 2023



Source: 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, hepatitis B and C and some bacterial sexually transmissible infections (STIs) including noncongenital infectious syphilis (≤ 2 years duration) (henceforth referred to as 'infectious syphilis'). 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 2024a). Hepatitis causes serious illness and can also progress to cirrhosis of the liver, cancer and premature death (ASHA 2017). STIs can have serious longterm 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 206 notifications of HIV in Western Australia. Of these, Aboriginal people accounted for 7.3% of HIV notifications (4.0 per 100,000 population).

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) (Figure 1.12.1).

Hepatitis B and hepatitis C: In Western Australia over the 3-year period 2022–2024, the notification rates of hepatitis B and hepatitis C for Aboriginal people were 24 and 250 per 100,000 respectively (Table D1.12.1). After adjusting for age, the notification rate for Aboriginal people was 2.2 the rate for non-Aboriginal people for hepatitis B, and 14 times the non-Aboriginal rate for hepatitis C (Figure 1.12.2).

In Qld, WA, SA, ACT and NT combined, the notification rate of hepatitis B for Aboriginal people was 17 per 100,000. In Qld, WA, SA, Tas and NT combined, the notification rate of hepatitis C for Aboriginal people was 154 per 100,000 (Table D1.12.1). After adjusting for age, the notification rate for Aboriginal people was 1.6 times the rate for non-Aboriginal people for hepatitis B, and 9.9 times the non-Aboriginal rate for hepatitis C (Figure 1.12.2).

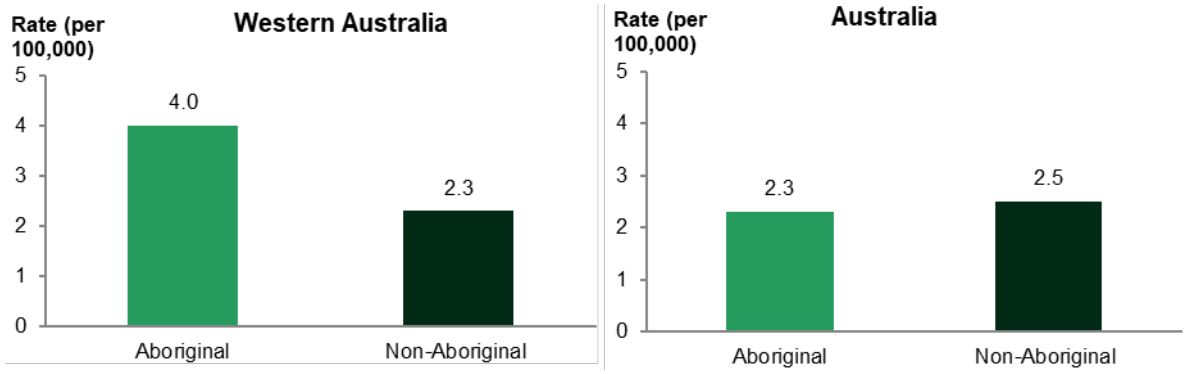
Infectious syphilis: In Western Australia over the 3-year period 2022–2024, there were 873 notifications for infectious syphilis among Aboriginal people, corresponding to 234 notifications per 100,000 population (Table D1.12.1). After adjusting for differences age, the notification rate for Aboriginal people was 15 times the rate for non-Aboriginal people (Figure 1.12.3).

Nationally, 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 age, the notification rate for Aboriginal people was 5.4 times the rate for non-Aboriginal people (Figure 1.12.3).

Other STIs: In 2022–2024 there were 5,559 notifications of chlamydia and 3,866 notifications of gonorrhoea among Aboriginal people in Western Australia, with notification rates 3.3 times and 8.0 times the rate for non-Aboriginal people, respectively.

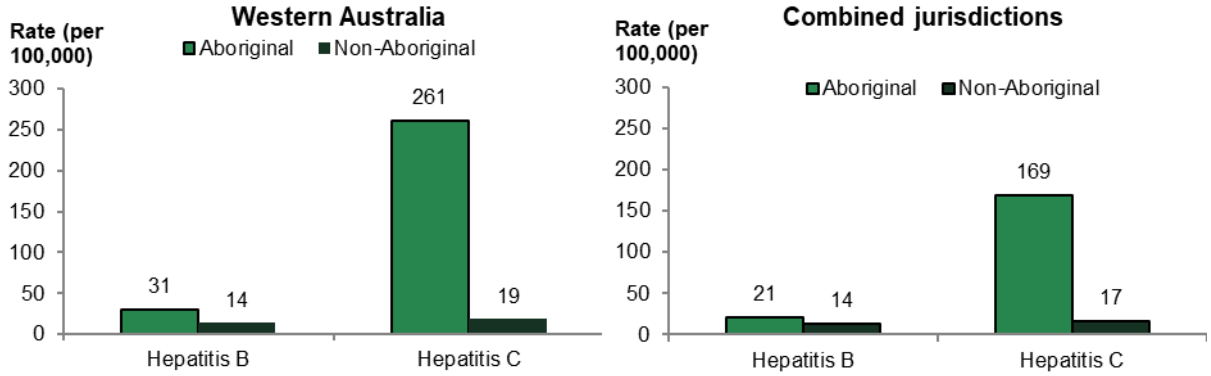
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.12.1: Notification rates for HIV, by Aboriginal status, Western Australia and Australia, 2022–2024



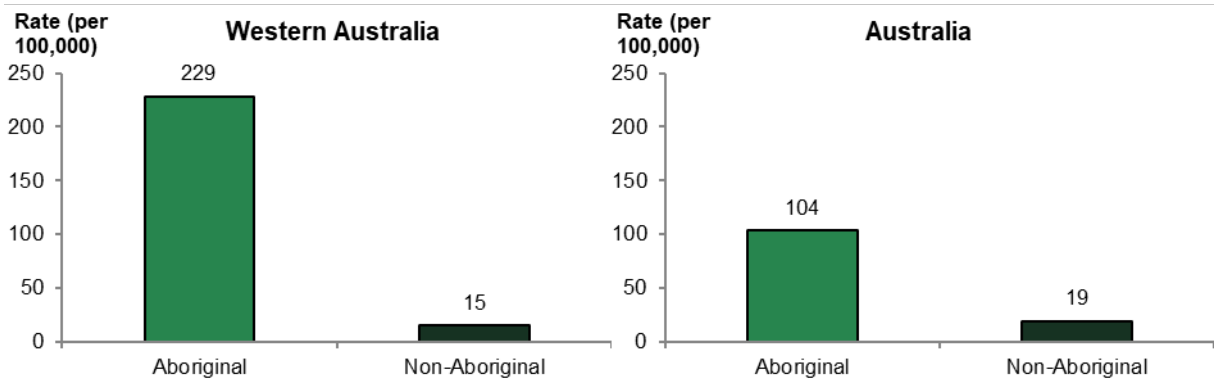
Source: Table D1.12.8.

Figure 1.12.2: Age-standardised notification rates for hepatitis B and hepatitis C, by Aboriginal status, Western Australia and combined jurisdictions, 2022–2024



Note: Combined jurisdictions include data from Qld, WA, SA and NT, plus ACT for hepatitis B and Tas for hepatitis C.
Source: Table D1.12.1.

Figure 1.12.3: Age-standardised notification rates for infectious syphilis, by Aboriginal status, Western Australia and Australia, 2022–2024



Source: 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. The following data therefore cannot be updated.

Key findings

Connectedness to Country, land and history; culture and identity: In 2014–15 in Western Australia, 78% of Aboriginal people aged 15 and over recognised their homelands; 70% identified with a clan or language group; and 69% had attended an Aboriginal cultural event in the previous 12 months.

Nationally in 2014–15, 74% of Aboriginal people recognised their homelands; 62% identified with a clan or language group; and 63% had attended an Aboriginal cultural event in the previous 12 months (Figure 1.13.1).

Resilience: In 2014–15 in Western Australia, 96% of Aboriginal adults had participated in sport, social or community activities in the last 12 months and 84% of those aged 15 and over did not avoid situations due to past unfair treatment. More than half (52%) of employed Aboriginal people aged 15 and over 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 those aged 15 and over did not avoid situations due to past discrimination. About 2 in 5 (41%) employed Aboriginal people aged 15 and over said work allowed them to fulfil cultural responsibilities (Figure 1.13.2).

Having a role, structure and routine: In 2014–15 in Western Australia, 36% 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 Western Australia, of Aboriginal people aged 15 and over, 73% had not experienced physical or threatened violence in the last 12 months, 86% felt safe at home alone after dark and 70% felt safe walking alone in the local area after dark.

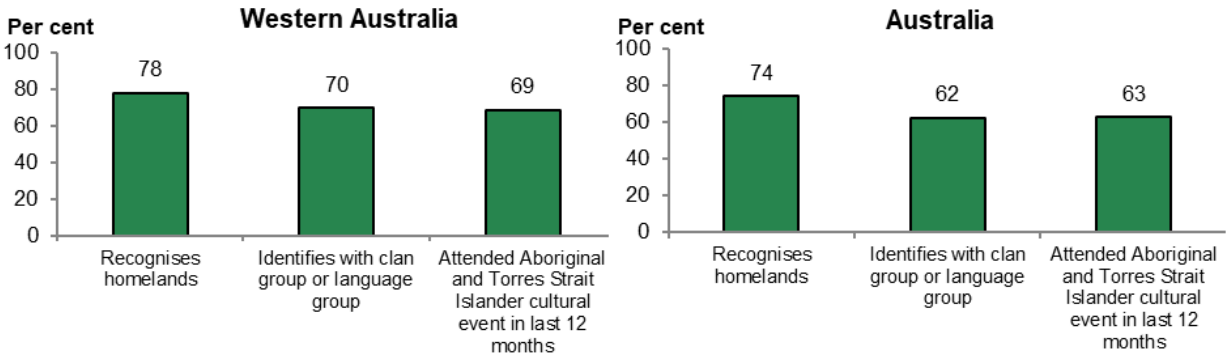
Nationally in 2014–15, 78% of Aboriginal people had not experienced physical or threatened violence in the last 12 months, 87% felt safe at home alone after dark and 68% felt safe walking alone in the local area after dark (Figure 1.13.3).

Vitality: In 2014–15 in Western Australia, of Aboriginal people aged 15 and over, 62% had experienced low/moderate levels of psychological distress in the 4 weeks before the survey, 70% could easily get to places as needed and 73% 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).

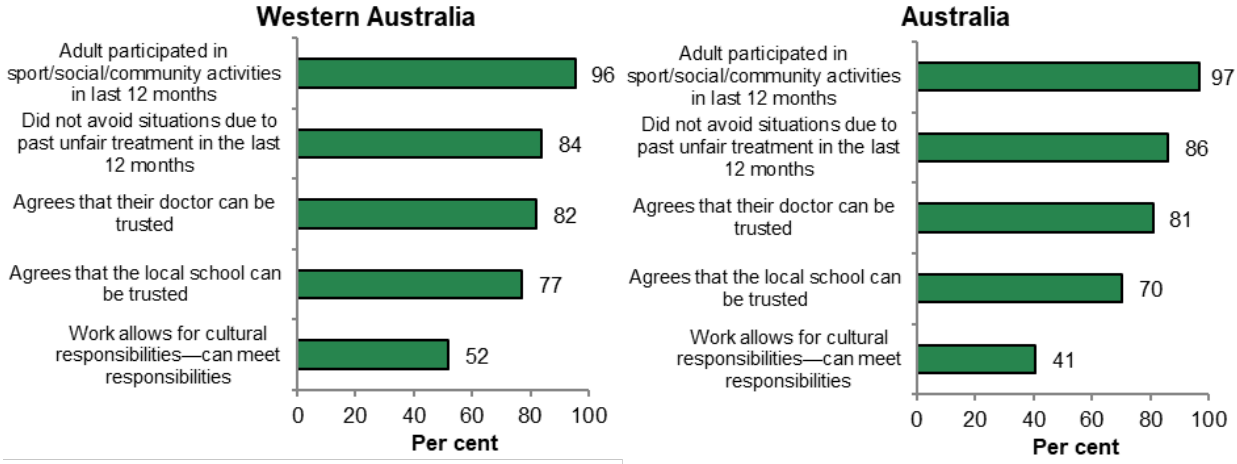
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.13.1: Proportion of Aboriginal people aged 15 and over: connectedness to Country, land and history; culture and identity, Western Australia and Australia, 2014–15



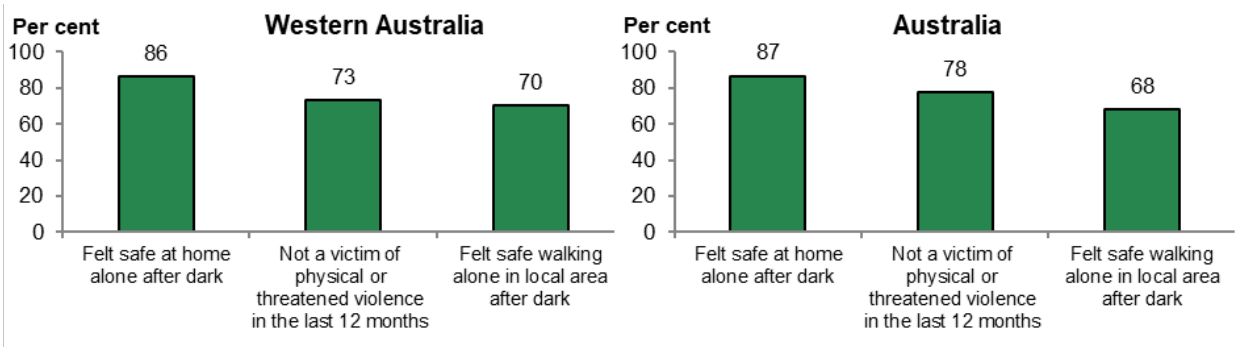
Source: Table D1.13.12.

Figure 1.13.2: Proportion of Aboriginal people aged 15 and over: resilience, Western Australia and Australia, 2014–15



Source: Table D1.13.12.

Figure 1.13.3: Proportion of Aboriginal people aged 15 and over: feeling safe, Western Australia and Australia, 2014–15



Source: Table D1.13.12.

1.14 Disability

Why it is important

This measure reports on the prevalence of disability for Aboriginal people, including children with special needs and users 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 disadvantage.

Key findings

Overall: In 2022–23 in Western Australia, 33% (39,000) of Aboriginal people reported having a disability or restrictive long-term health condition (Table D1.14.2). The age-standardised rate of reporting having a disability or restrictive longterm health condition for Aboriginal people was 1.4 times the rate for non-Aboriginal people (Figure 1.14.1).

Nationally in 2022–23, 37% of Aboriginal people reported having a disability or restrictive longterm health condition (Table D1.14.2). The age-standardised rate of reporting having a disability or restrictive longterm health condition for Aboriginal people was 1.5 times the rate for non-Aboriginal people (Figure 1.14.1).

Assistance with core activities: In 2021 in Western Australia, Census data showed that 6.5% (5,300) of Aboriginal people needed assistance with a core activity (selfcare, mobility or communication) some or all of the time (Table D1.14.12). The age-standardised rate of needing assistance with core activities for Aboriginal people was 2 times the rate for non-Aboriginal people.

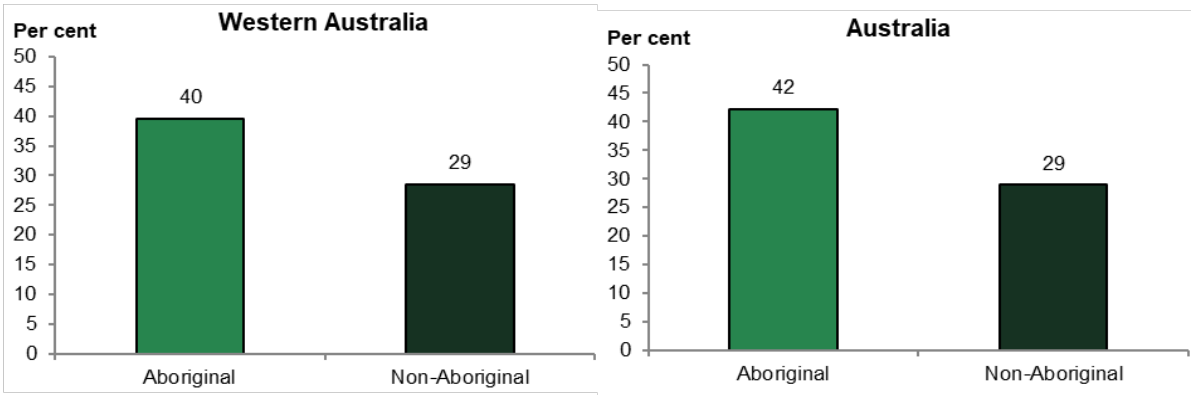
Nationally in 2021, 8.6% of Aboriginal people needed assistance with a core activity. The age-standardised rate of needing assistance for Aboriginal people was 2 times the rate for non-Aboriginal people (Figure 1.14.2).

Users of disability support services: As at 30 June 2025 in Western Australia there were 5,346 Aboriginal people using disability support services – a rate of 41 per 1,000 population (AIHW analysis of NDIA 2025). Over half (52%) of the Aboriginal people using disability support services were in *Major cities* and 27% 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 with a crude rate of 57 per 1,000 (AIHW analysis of NDIA 2025). Almost half (46%) of the Aboriginal people using disability support services were in *Major cities* and 9% were in *Remote and very remote* areas (Figure 1.14.3).

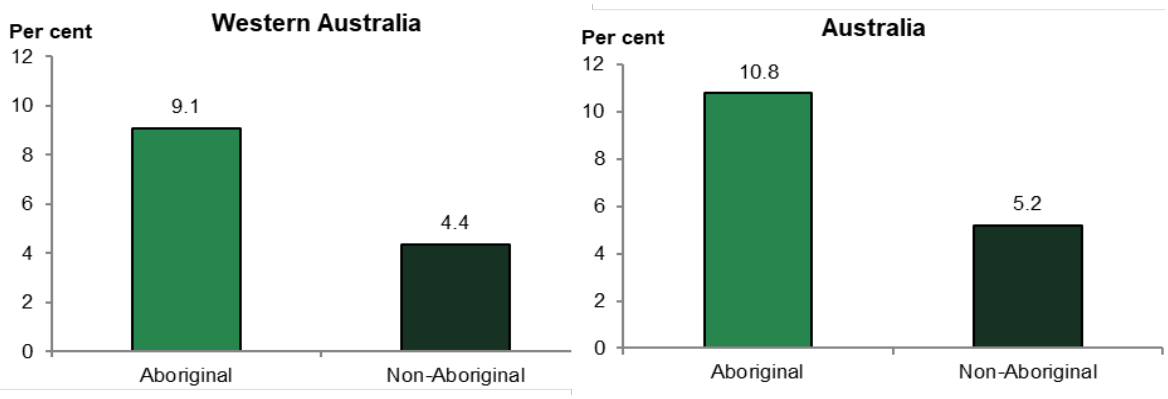
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.14.1: Age-standardised rate reporting disability or a restrictive long-term health condition, by Aboriginal status, Western Australia and Australia, 2022–23



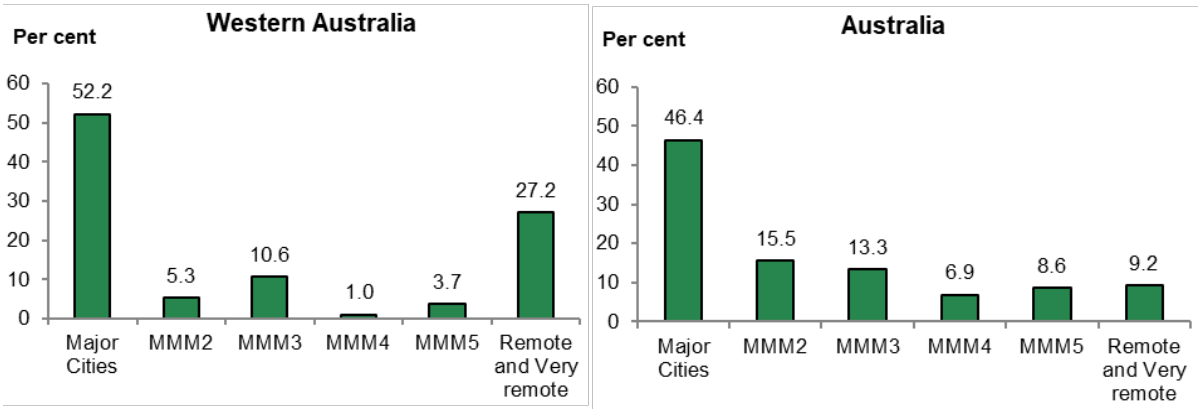
Source: Table D1.14.1.

Figure 1.14.2: Age-standardised rate needing core-activity assistance, by Aboriginal status, Western Australia and Australia, 2021



Source: Table D1.14.12.

Figure 1.14.3: Aboriginal people using disability support services, distribution by remoteness, Western Australia 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 definie eligibility. For more information see https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm.

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

1.15 Ear health

Why it is important

This measure reports on hearing loss in Aboriginal people, including measured and reported hearing loss as well as hospitalisation rates for diseases of the ear and mastoid process. 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).

Key findings

Measured hearing loss: In 2018–19, the National Aboriginal and Torres Strait Islander Health Survey offered a voluntary hearing test for participants aged 7 and over. In Western Australia, an estimated 38,600 (47%) Aboriginal people aged 7 and over were found to have hearing loss in one or both ears.

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

Reported ear and hearing problems: In 2022–23, 13.6% (16,000) of Aboriginal people in Western Australia were reported to have an ear or hearing problem.

Nationally in 2022–23, 13.2% of Aboriginal people were reported to have had an ear or hearing problem (ABS 2024d, tables 54.1 and 54.3).

Hospitalisations for ear disease in children aged 0–14: From July 2021 to June 2023, for Aboriginal children aged 0–14 in Western Australia, there were 831 hospitalisations for diseases of the ear and mastoid process (ear disease); a rate of 10.7 per 1,000 population (Table D1.15.10). After adjusting for age, the hospitalisation rate for ear disease for Aboriginal children was 1.9 times the rate for non-Aboriginal children (Figure 1.15.1).

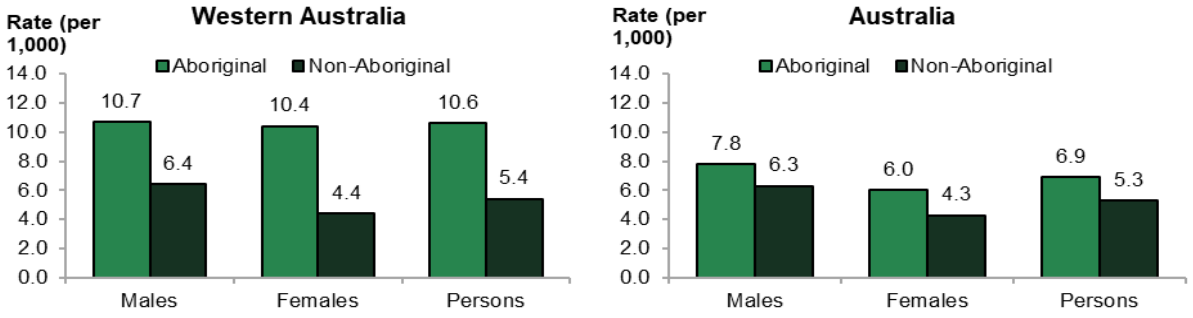
Nationally, from July 2021 to June 2023 for Aboriginal children aged 0–14, there were 4,572 hospitalisations for ear disease; a rate of 7.0 per 1,000 population (Table D1.15.10). After adjusting for age, the hospitalisation rate for ear disease for Aboriginal children was 1.3 times the rate for non-Aboriginal children (Figure 1.15.1).

Hospitalisations for ear disease in Aboriginal people: From July 2021 to June 2023, for Aboriginal people in Western Australia, there were 1,112 hospitalisations for ear disease; a rate of 4.5 per 1,000 population (Table D1.15.12). The age-standardised hospitalisation rate of ear disease for Aboriginal people was 1.5 times the rate for non-Aboriginal people (Figure 1.15.2). In Western Australia from 2016–17 to 2022–23, the age-standardised hospitalisation rate for ear disease among Aboriginal people decreased by 23% (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 of 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% (Figure 1.15.3).

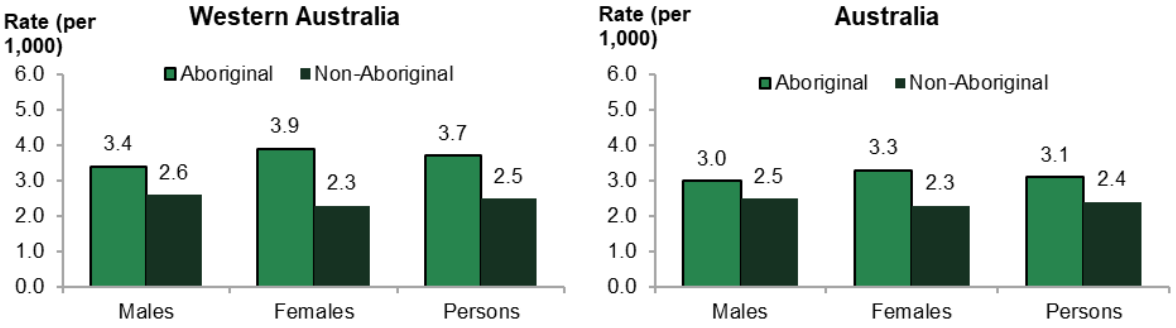
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



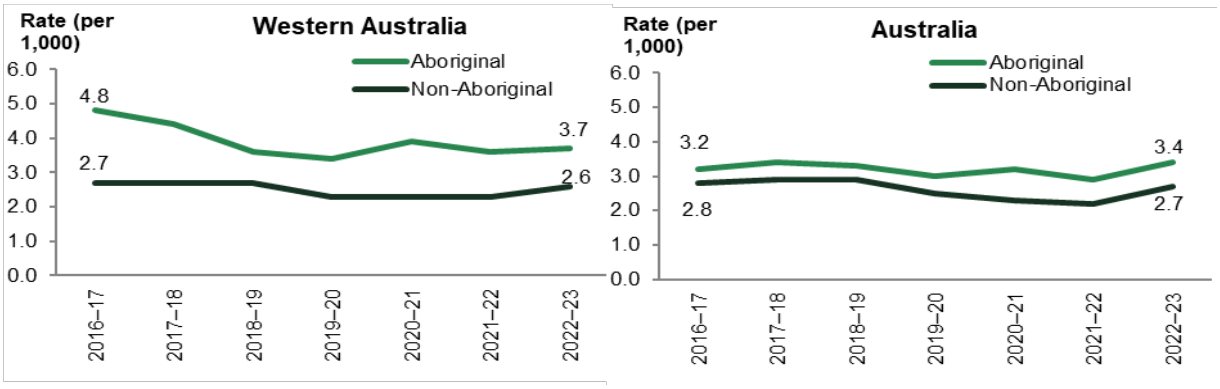
Source: Table D1.15.10.

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



Source: Table D1.15.12.

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



Source: Table D1.15.15 WA.

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 among Aboriginal people. 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 age, the burden due to hearing and vision disorders was 3.3 times as high for Aboriginal people as for non-Aboriginal people (AIHW 2022b).

Key findings

Eye health based on self-reported data: In 2022–23, 39% (45,600 people) of Aboriginal people of all ages in Western Australia reported eye or sight problems. In non-remote areas 43% of Aboriginal people reported eye or sight problems compared to 32% in remote areas.

Nationally in 2022–23, 41% of Aboriginal people reported eye or sight problems. The proportion reporting eye or sight problems in non-remote areas was 43% compared to 29% in remote areas (Figure 1.16.1).

Medicare health assessments: In Western Australia in 2023–24, there were 2,672 Medicare health assessments (which included eye checks) undertaken for Aboriginal children aged 0–4 (22% of children in this age group); 4,928 health checks for Aboriginal children aged 5–14 (21%); 4,701 health checks for Aboriginal people aged 15–24 (22%); 9,799 health checks for Aboriginal people aged 25–49 (26%); and 7,565 health checks for Aboriginal people aged 50 and over (36%) (AIHW 2025g, Table E2).

Hospitalisations: In Western Australia, between July 2021 and June 2023, there were 2,470 hospitalisations of Aboriginal people with a principal diagnosis of diseases of the eye and adnexa (Table D1.16.14). From age 15 to 24 the hospitalisation rate increased with age, from 0.7 per 1,000 for those aged 15–24, to 86 per 1,000 for those aged 65 and over (Figure 1.16.2). The age-standardised hospitalisation rate for diseases of the eye and adnexa was around 20% higher for Aboriginal people than for non-Aboriginal people (18.0 compared with 15.1 per 1,000 population, respectively).

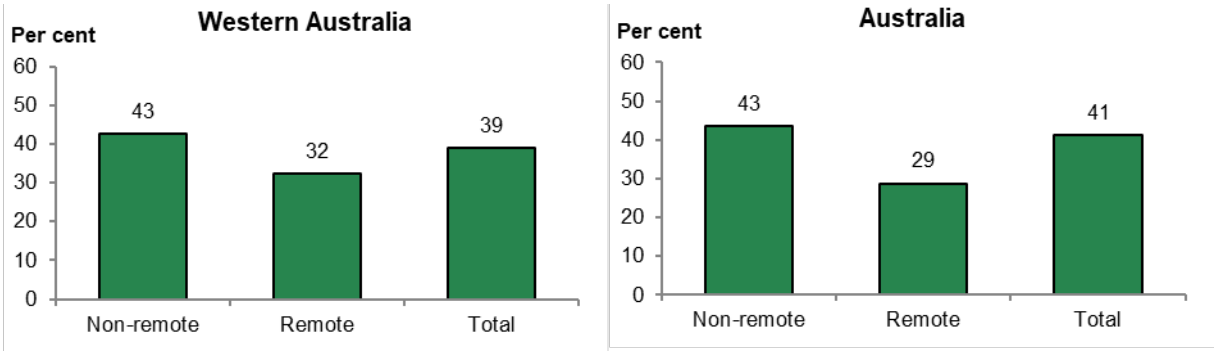
Nationally between July 2021 and June 2023, the hospitalisation rate for diseases of the eye and adnexa was around 10% lower for Aboriginal people than for non-Aboriginal people (11.8 compared with 13.7 per 1,000 population, respectively) (Table D1.16.12 WA).

Changes in hospitalisation over time: In Western Australia, the age-standardised hospitalisation rate for Aboriginal people for diseases of the eye and adnexa almost doubled between 2016–17 and 2022–23 (86% increase), compared with a 17% decrease for non-Aboriginal people. 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 2020–21.

Nationally between 2016–17 and 2022–23, the hospitalisation rate for Aboriginal people for diseases of the eye and adnexa increased by 28%, compared with a decrease of 2% for non-Aboriginal people (Figure 1.16.3).

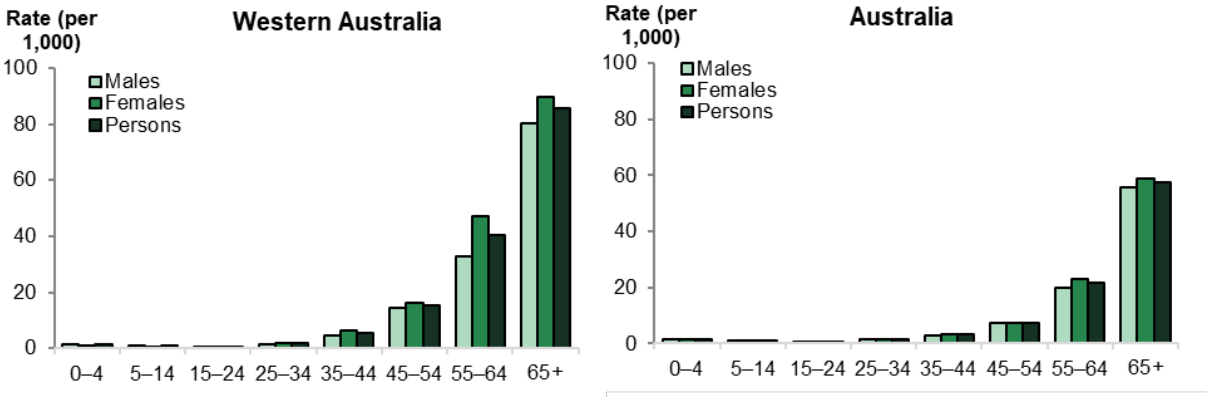
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.16.1: Proportion of Aboriginal people reporting eye or sight problems, by remoteness, Western Australia and Australia, 2022–23



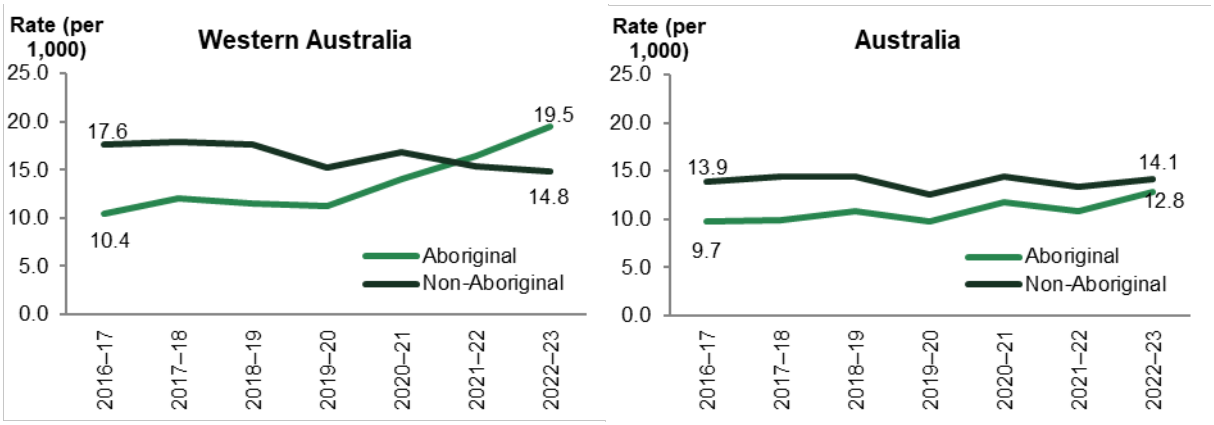
Source: ABS 2024d Tables 54.3 and 2.3.

Figure 1.16.2: Hospitalisation rates for a principal diagnosis of diseases of the eye and adnexa, Aboriginal people, by sex and age group, Western Australia and Australia, July 2021 to June 2023



Source: Table D1.16.12 WA.

Figure 1.16.3: Age-standardised hospitalisation rates for a principal diagnosis of diseases of the eye and adnexa, by Aboriginal status, Western Australia and Australia, 2016–17 to 2022–23



Sources: Table D1.16.18 WA.

1.17 Perceived health status

Why it is important

This measure reports on self-assessed health status of Aboriginal people. Selfassessed 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 2018a; Delpierre et al. 2009).

Key findings

Self-assessed health status: Based on data from the 2022–23 National Aboriginal and Torres Strait Islander Health Survey, an estimated 42% (33,600) of Aboriginal people aged 15 and over in Western Australia reported their health as excellent/very good, 36% (28,400) as good, and 22% (17,700) as fair/poor (Figure 1.17.1). The proportion of people assessing their health as fair or poor was 24% (12,100) in non-remote areas and 18% (5,300) in remote areas (Figure 1.17.2).

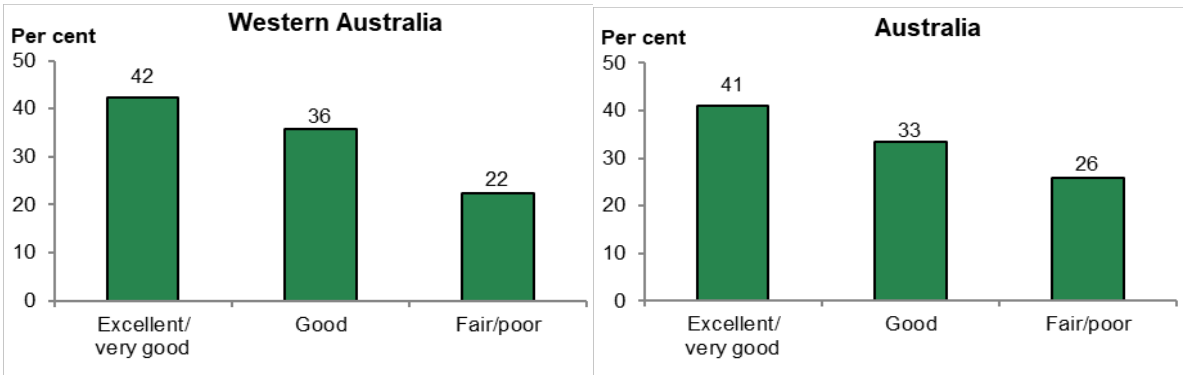
Nationally, 41% of Aboriginal people aged 15 and over reported their health as excellent/very good, 33% as good, and 26% as fair/poor (Figure 1.17.1). The proportion of people assessing their health as fair or poor was 27% in non-remote areas and 18% in remote areas (Figure 1.17.2).

Self-assessed health status over time: The proportion of Aboriginal people in Western Australia aged 15 and over who reported their health as excellent/very good tended upwards between 2002 and 2018–19, from 35% to 45%, but then decreased slightly (but not significantly) to 42% in 2022–23.

Nationally, the proportion of Aboriginal people who reported their health as excellent/very good was relatively stable between 2002 and 2022–23, ranging from 39% to 45% (Figure 1.17.3).

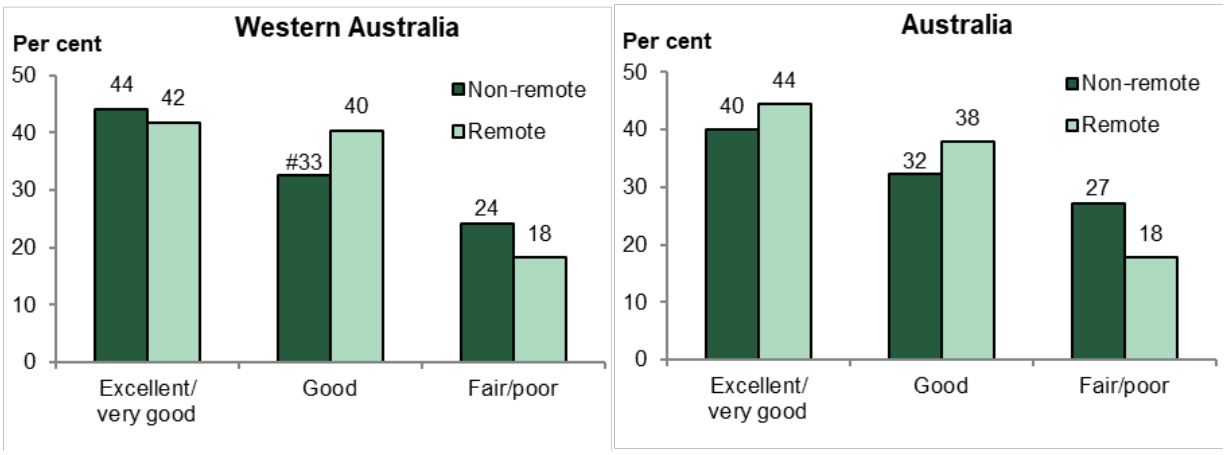
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



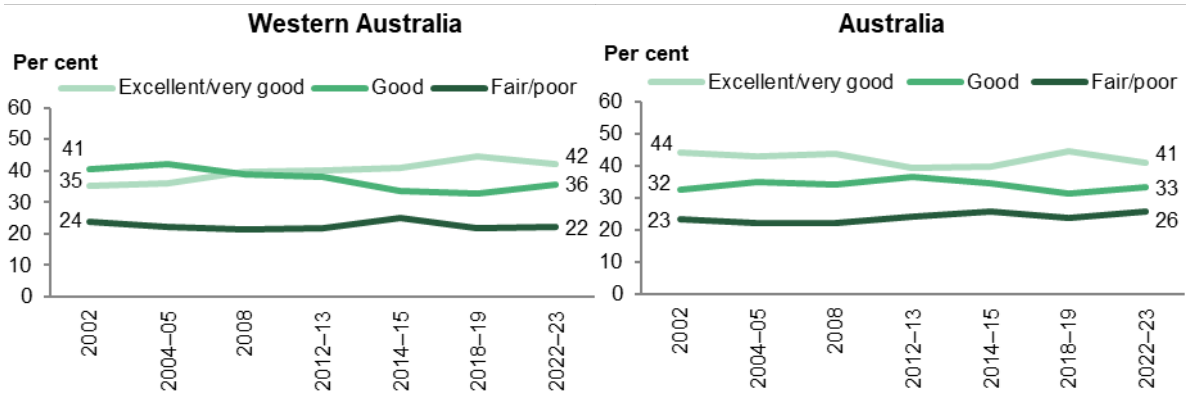
Source: ABS 2024d Table 54.3.

Figure 1.17.2: Self-assessed health status, Aboriginal people aged 15 and over, by remoteness, Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: ABS 2024d Tables 54.3 and 2.3.

Figure 1.17.3: Self-assessed health status of Aboriginal people aged 15 and over, Western Australia and Australia, 2008 to 2022–23



Sources: Table D1.17.8 and ABS 2024d Table 54.3.

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

This measure reports on social and emotional wellbeing, which underpins the physical and mental health of Aboriginal people (PM&C 2017).

Key findings

Psychological distress: The 2022–23 National Aboriginal and Torres Strait Islander Survey showed that 29% (17,700) of Aboriginal people aged 18 and over in Western Australia had high/very high levels of psychological distress.

Nationally, 31% of Aboriginal people aged 18 and over had high/very high levels of psychological distress (Figure 1.18.1).

Mental health-related hospitalisations: Between July 2021 and June 2023, the hospitalisation rate for mental health-related conditions among Aboriginal people in Western Australia was 24 per 1,000 population, and was slightly higher for females (26 per 1,000) than males (23 per 1,000) (Table D1.18.14 WA). Hospitalisations for mental health-related conditions were highest at age 35–44 for males (45 per 1,000) and females (46 per 1,000).

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 WA). Hospitalisations for mental health-related conditions were highest at age 35–44 for males (59 per 1,000) and females (52 per 1,000) (Figure 1.18.2).

Deaths due to intentional self-harm: In 2019–2023, the intentional self-harm death rate was 33 per 100,000 for Aboriginal people in Western Australia. The rate was higher for males than for females (48 per 100,000 compared with 16 per 100,000).

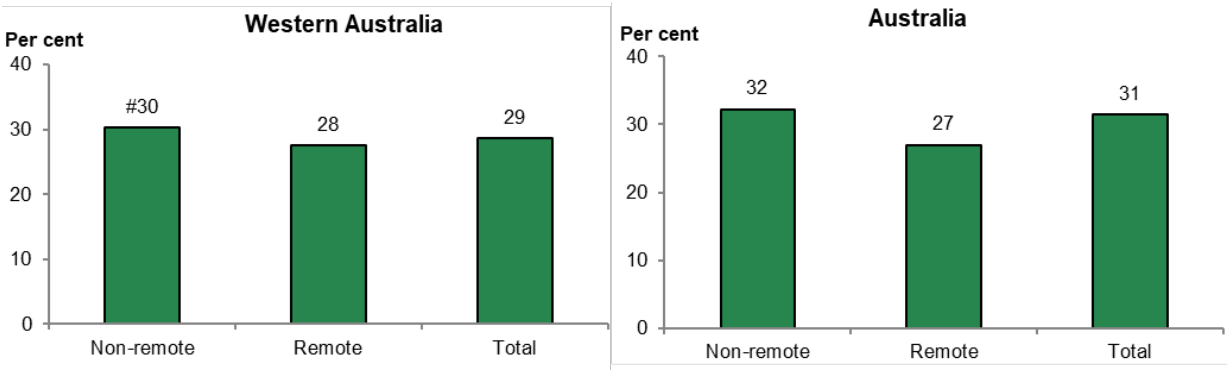
For NSW, Qld, WA, SA and NT combined, in 2019–2023, the intentional self-harm death rate was 24 per 100,000 for Aboriginal people (Table D1.18.30)

Deaths due to intentional self-harm over time: In Western Australia, over the period from 2016 to 2023, the age-standardised death rate due to intentional self-harm for Aboriginal people increased by 19% and decreased for non-Aboriginal people by 6%.

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% and decreased for non-Aboriginal people by 1% (Figure 1.18.3).

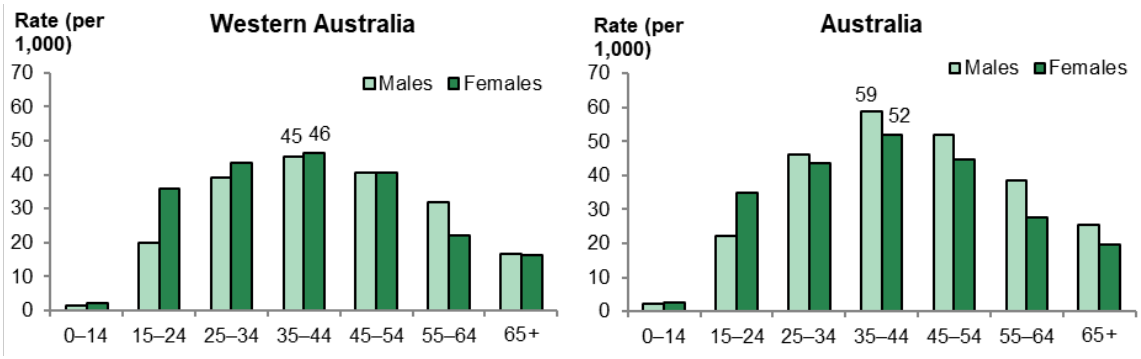
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



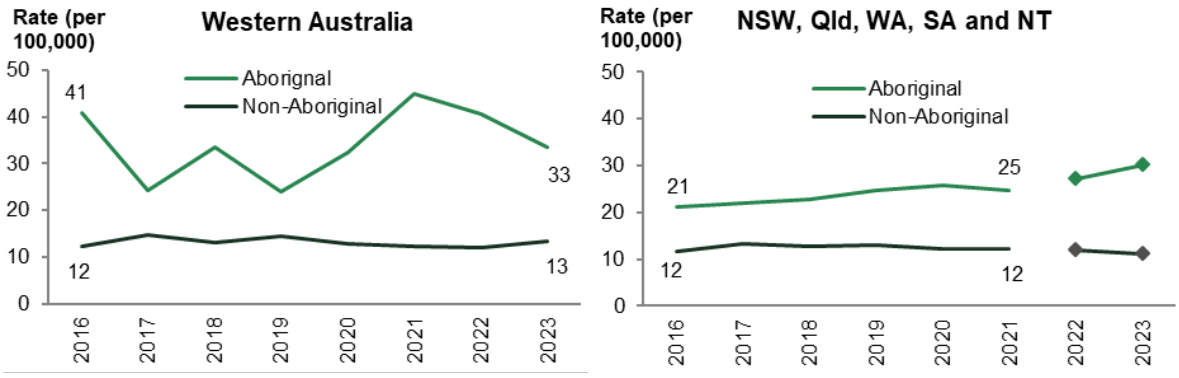
Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D1.18.2

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



Source: Table D1.18.14 WA

Figure 1.18.3: Age-standardised intentional self-harm death rates, by Aboriginal status, Western Australia, 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 a change in the process for deriving Indigenous status for deaths in NSW.
Source: Table D1.18.26.

1.19 Life expectancy at birth

Why it is important

This measure reports on life expectancy at birth for Aboriginal people. 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 they will be throughout their life (ABS 2018). Life expectancy reflects the combined effects of socioeconomic factors, health risk factors and access to high-quality health care services. Variations in life expectancy not only express the expected differences in population longevity but also are indicators of socioeconomic equity and justice.

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

Key findings

Overall: In 2020–2022 in Western Australia, life expectancy at birth for Aboriginal males and females was estimated to be 68.9 years and 72.6 years, respectively. These estimates were lower than for non-Aboriginal males (81.2 years) and females in Western Australia (84.3 years), representing a gap of 12.3 years for males and 11.7 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 people, 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).

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

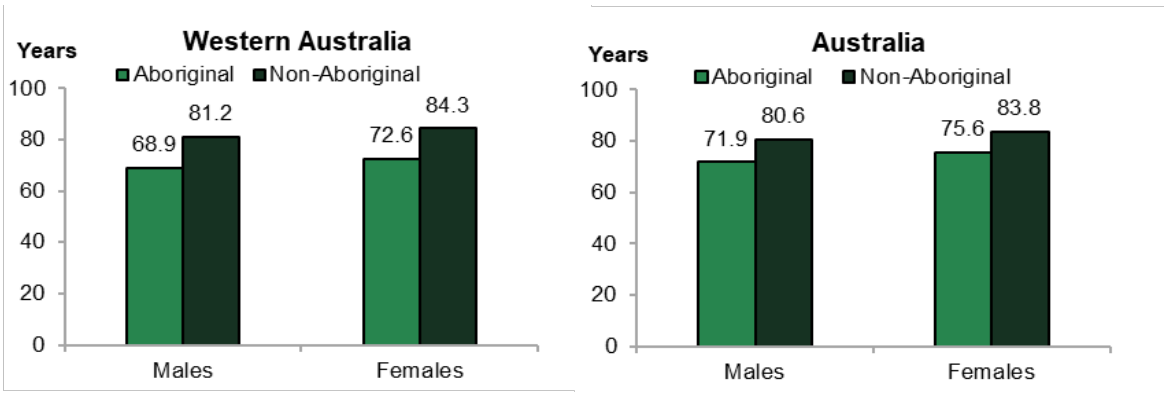
Nationally in 2020–2022, life expectancy for Aboriginal males living in *Major cities* and *Inner and outer regional* areas was higher than for Aboriginal males living in *Remote and very remote* areas (72.5 and 72.8 years compared with 67.3 years, respectively). Similarly, Aboriginal females living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

Socioeconomic areas: Life expectancy estimates that are disaggregated by socioeconomic areas are not available for individual jurisdictions.

In 2020–2022, life expectancy for Aboriginal people living in the least socioeconomically disadvantaged areas was estimated to be 74.6 years for males and 77.0 years for females. Life expectancy decreased progressively with decreasing socioeconomic status and was estimated to be 69.5 years for Aboriginal males and 74.0 years for Aboriginal females living in the most disadvantaged areas. Life expectancy for Aboriginal people was lower than for non-Aboriginal people across all Socio-Economic Indexes for Areas (SEIFA) quintiles. Aboriginal life expectancy in the least disadvantaged areas (top quintile) was lower than that for non-Aboriginal people in the most disadvantaged areas (Figure 1.19.3).

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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

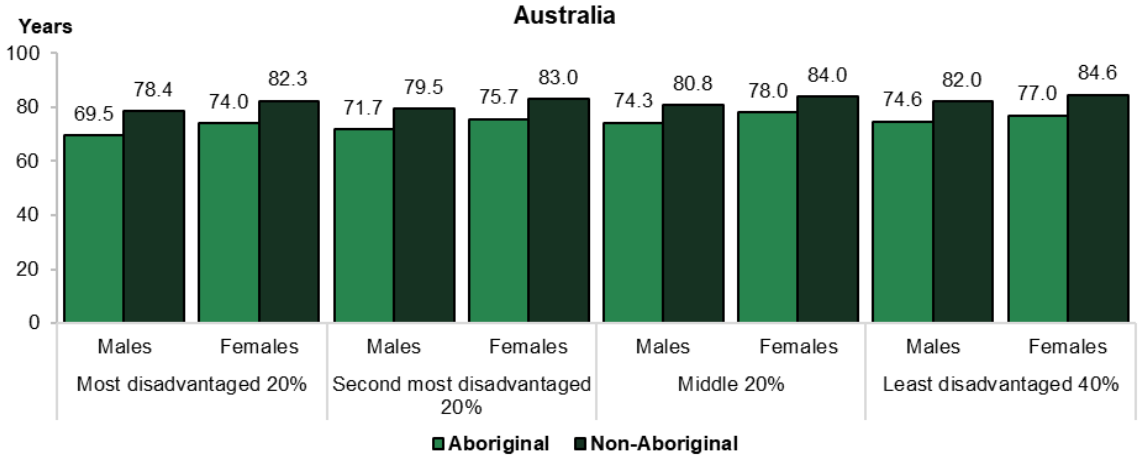


Source: Table D1.19.1.

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

Source: Table D1.19.3.

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



Source: Table D1.19.4.

1.20 Infant and child mortality

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 years. Infant mortality 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.

Key findings

Child mortality: In the period 2019–2023 in Western Australia, there were 97 deaths of Aboriginal children aged 0–4 (150 deaths per 100,000 children aged 0–4) and 393 deaths of non-Aboriginal children of the same age group (50 per 100,000). Among this age group, the death rate for Aboriginal children was 3.0 times the rate for non-Aboriginal children (Figure 1.20.1). In both Aboriginal and non-Aboriginal children, 81% of child deaths were infant deaths.

For NSW, Qld, WA, SA, and NT combined, the death rate for Aboriginal children aged 0–4 was 2.0 times the rate for non-Aboriginal children (Figure 1.20.1).

Infant mortality: Of the 79 Aboriginal infant deaths in Western Australia in 2019–2023, 42 deaths were in the neonatal period (aged under 28 days) which accounted over half (53%) of all infant deaths and 43% of all child deaths (aged 0–4). In non-Aboriginal infants in Western Australia, 67% (214) of the 320 deaths were in the neonatal period. The death rate for Aboriginal infants was 2.6 times the rate for non-Aboriginal infants (Figure 1.20.2).

For NSW, Qld, WA, SA and NT combined, the death rate for Aboriginal infants was 1.8 times the rate for non-Aboriginal infants (Figure 1.20.2).

Trend over time: In Western Australia, the death rate for Aboriginal infants decreased from 6.7 per 1,000 live births in 2014–2018 to 5.6 per 1,000 live births in 2019–2023 (deaths are presented in 5year groupings because of small numbers in each year). The absolute gap (rate difference) between Aboriginal and non-Aboriginal infant death rates narrowed from 4.5 to 3.4 per 1,000 live births (Figure 1.20.3).

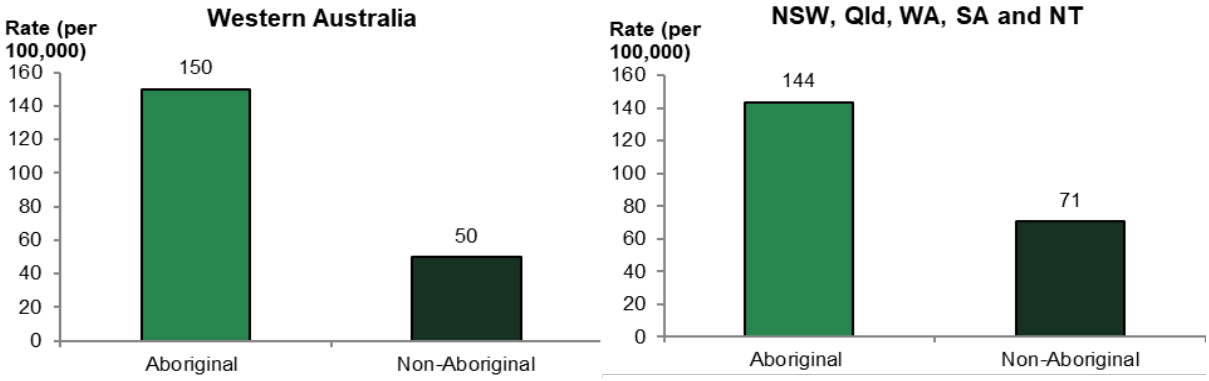
For NSW, Qld, WA, SA, and NT combined, the death rate for Aboriginal infants decreased slightly from 6.0 per 1,000 live births in 2014–2018 to 5.5 per 1,000 live births in 2019–2023. Over the same period, the absolute gap (rate difference) between Aboriginal and non-Aboriginal infant death rates narrowed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

In Western Australia between 2016 and 2023, the death rate for Aboriginal children aged 0–4 increased by 3.6% (from 173 to 206 per 100,000), but this was not statistically significant. For non-Aboriginal children, there was a decrease of 12% (from 56 to 53 per 100,000) but this was 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 Indigenous status for deaths in NSW.

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

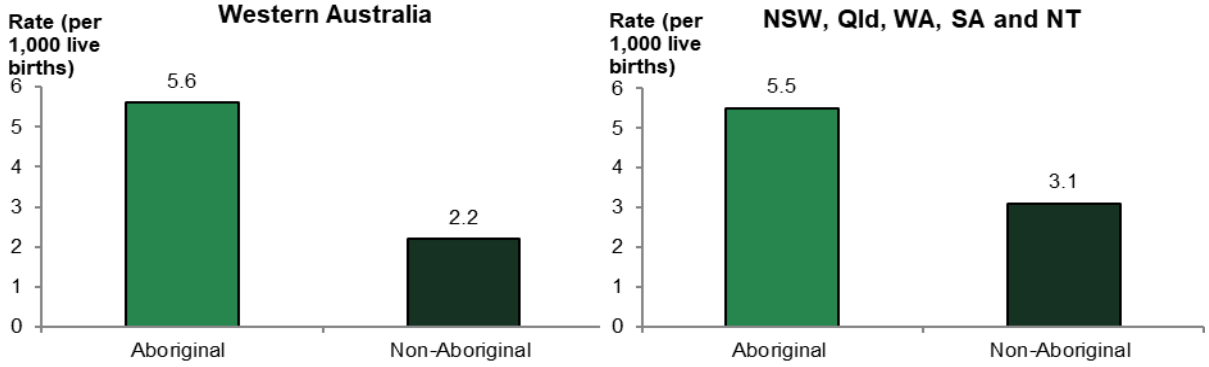
Figure 1.20.1: Death rate of children (aged 0–4), by Aboriginal status, Western Australia and NSW, Qld, WA, SA and NT, 2019–2023



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues. More detail is provided on p3.

Source: Table D1.20.1.

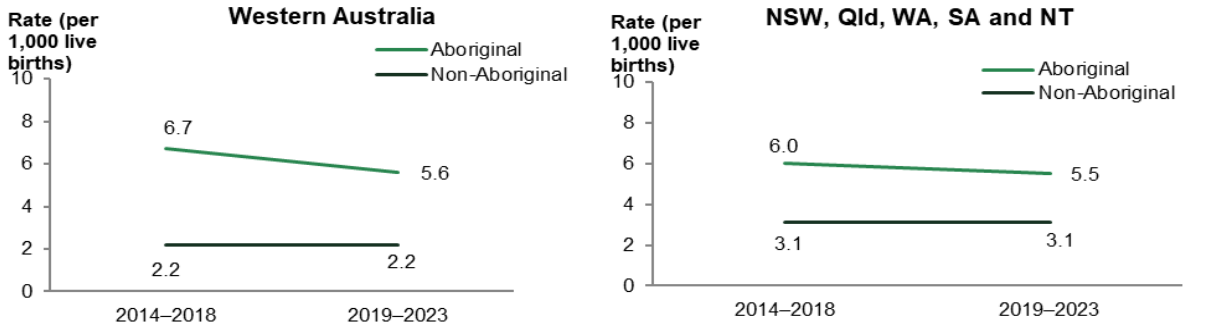
Figure 1.20.2: Death rate of infants (aged less than 1 year), by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2019–2023



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues. More detail is provided on p3.

Source: Table D1.20.4.

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



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues. More detail is provided on p3.

Source: Table D1.20.9.

1.21 Perinatal mortality

Why it is important

This measure reports on the number of deaths in the perinatal period among babies born to Aboriginal women. 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 and OATSIH 2004; Performance Indicator Reporting Committee 2002).

Key findings

Overall: In the 5-year period 2018–2022, there were 161 perinatal deaths among babies born to Aboriginal women in Western Australia (Table D1.21.4). More than three quarters were stillbirths (76%), 10% occurred in the first 24 hours after birth, and the remaining 14% occurred within 28 days of birth (Table D1.21.6).

In Western Australia in 2018–2022, the perinatal death rate among babies born to Aboriginal women was over twice the rate for non-Aboriginal women (17 compared with 7.6 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 Western Australia was 13 per 1,000 births, compared with 6.2 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 Western Australia in 2018–2022, for neonates born to Aboriginal women the death rate as 4.1 per 1,000 births, three times the rate for neonates born to non-Aboriginal women (1.4 per 1,000).

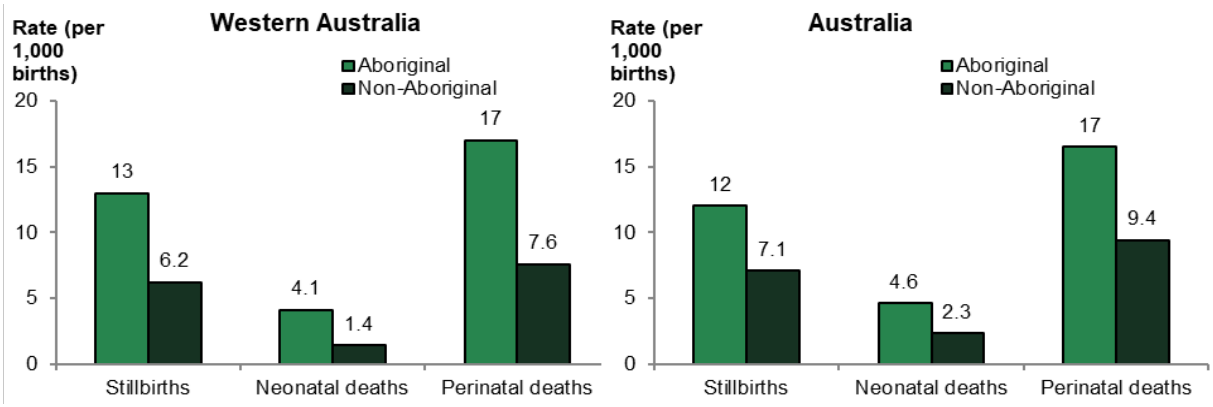
Nationally, the death rate for neonates born to Aboriginal women was twice the rate for neonates born to non-Aboriginal women (4.6 compared with 2.3 per 1,000) (Figure 1.21.1).

Over time: In Western Australia, the perinatal death rate among babies born to Aboriginal women in 2013–2017 was similar to the rate in 2018–2022 (16.8 compared with 17 per 1,000 births). For babies born to non-Aboriginal women in Western Australia, the perinatal death rate in the two periods were also similar (7.8 and 7.6 per 1,000) (Figure 1.21.2).

Nationally, based on linear regression, over the longer term between 2013 and 2022, there was an increase (of 16%) in the perinatal death rate among babies born to Aboriginal women. Over this period, the neonatal death rate decreased (by 23%), and the stillbirth rate increased (by 39%) (Figure 1.21.3). The increase in the stillbirth rate was statistically significant. This pattern was similar to that seen among babies born to non-Aboriginal women (Tables D1.21.2 and D1.21.3).

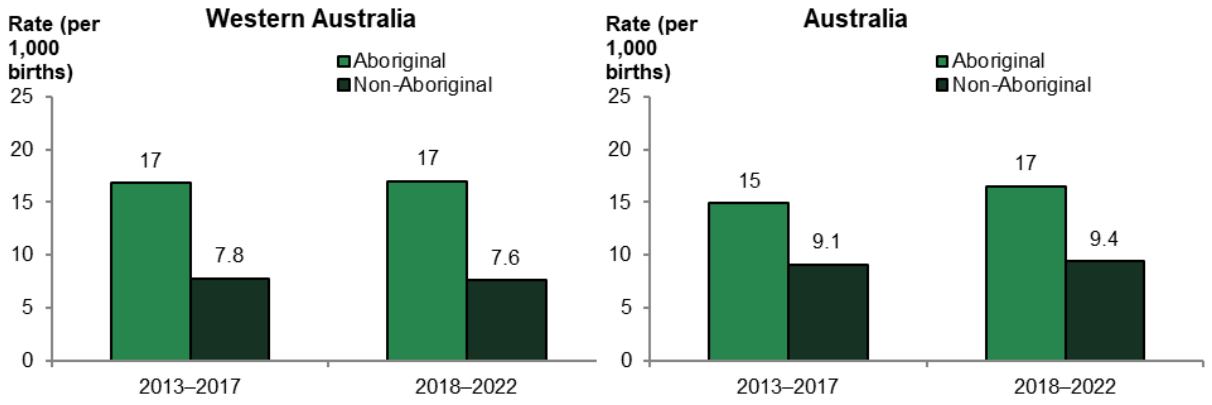
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.21.1: Stillbirth, neonatal and perinatal death rates, by Aboriginal status of the mother, Western Australia and Australia, 2018–2022



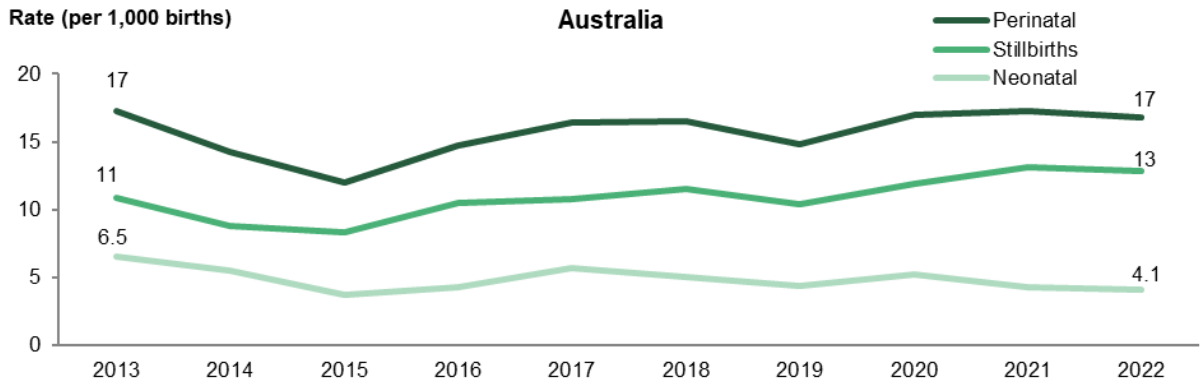
Source: Table D1.21.4.

Figure 1.21.2: Perinatal death rates, by Aboriginal status of the mother, Western Australia and Australia, 2013–2017 and 2018–2022



Source: Table D1.21.4.

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



Source: Tables D1.21.2 and 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 lead to reductions in mortality. In 2019–2023, the age-standardised death rate for Aboriginal people was 1.7 times that for non-Aboriginal people, indicating that the overall health status is worse for Aboriginal people (Table D.1.22.3).

Key findings

Overall: In 2019–2023 in Western Australia, there were 3,278 deaths of Aboriginal people, corresponding to a death rate of 545 per 100,000 population.

In 2019–2023 for NSW, Qld, WA, SA and NT combined, there were 19,993 deaths of Aboriginal people, corresponding to a death rate of 464 per 100,000 population (Table D1.22.3).

Gap between Aboriginal people and non-Aboriginal people: In 2019–2023 in Western Australia, after adjusting for differences in the age structure between the two populations, the death rate for Aboriginal people was 2.3 times the rate for non-Aboriginal people.

In 2019–2023 for NSW, Qld, WA, SA and NT combined, 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 people (Figure 1.22.1).

Trend over time, age-standardised death rate: From 2016 to 2023 in Western Australia, the age-standardised death rate increased slightly from 1,112 to 1,184 per 100,000 for Aboriginal people, while it decreased from 550 to 486 per 100,000 among non-Aboriginal people.

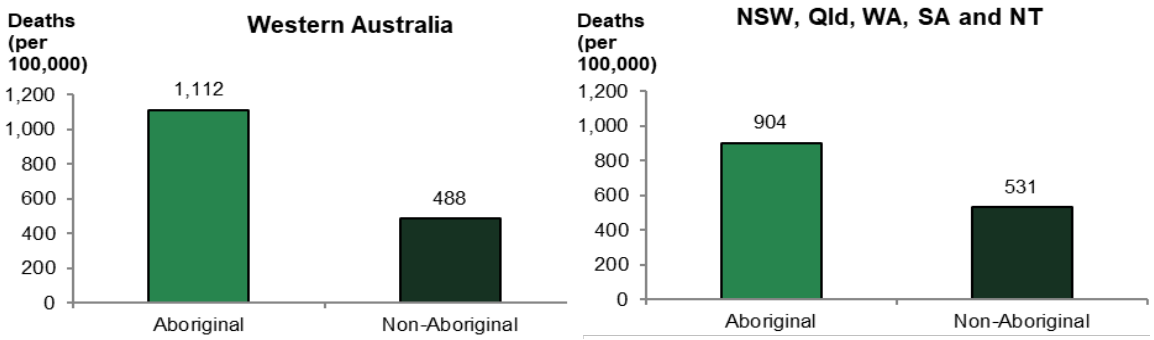
From 2016 to 2021 for NSW, Qld, WA, SA and NT combined, the age-standardised death rate for Aboriginal people increased slightly, from 815 to 839 per 100,000. For non-Aboriginal people, it decreased slightly over the same period from 569 to 526 per 100,000 (Figure 1.22.2). Data from 2022 and 2023 are not comparable to previous years due to a change in the process for deriving Indigenous status for deaths in NSW.

Trend over time, gap between Aboriginal and non-Aboriginal people: From 2016 to 2023 in Western Australia, the absolute gap (rate difference) in the age-standardised death rate between Aboriginal people and non-Aboriginal people increased from 562 to 699 per 100,000. Over the same period, the relative difference (rate ratio) increased slightly from 2.0 to 2.4.

From 2016 to 2021 for NSW, Qld, WA, SA and NT combined, the absolute difference in the age-standardised death rate between Aboriginal people and non-Aboriginal people 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).

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

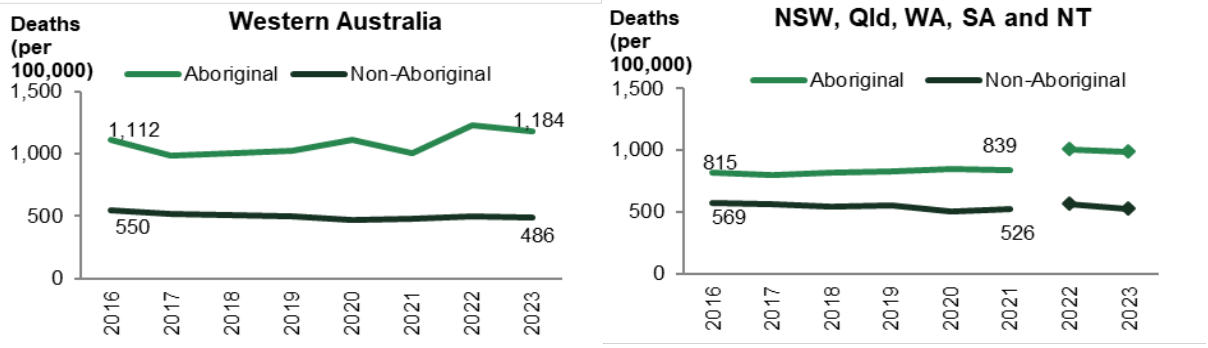
Figure 1.22.1: Age-standardised death rate, by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2019–2023



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues. More detail is provided on p3.

Source: Table D1.22.3.

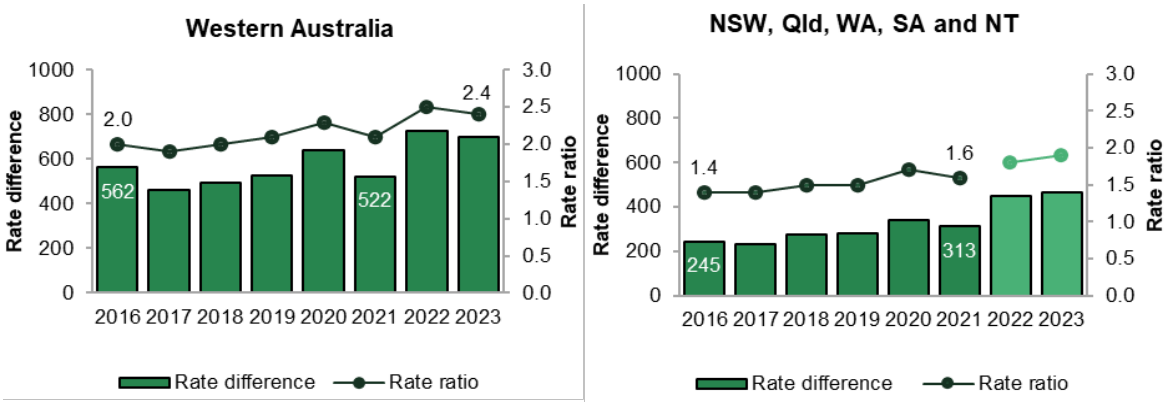
Figure 1.22.2: Age-standardised death rate, by Aboriginal status, Western Australia, and NSW, Qld, WA SA and NT, 2016–2023



Note: Data for the combined jurisdictions from 2022 and 2023 are not comparable to previous years due to data quality issues. More detail is provided on p3.

Source: Tables D1.22.5 and D1.22.6.

Figure 1.22.3 Age-standardised death rate difference and rate ratio in the gap, by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2016–2023



Note: Data for the combined jurisdictions from 2022 and 2023 are not comparable to previous years due to data quality issues. More detail is provided on p3.

Source: Tables D1.22.5, D1.22.6.

1.23 Leading causes of death

Why it is important

This measure reports on the main causes of death among Aboriginal people. Analysis of leading causes of death can provide insights into the overall health status of different populations as well as the contributing factors and indicate areas needing policy focus. Disparities in mortality within the Aboriginal population and between Aboriginal people and non-Aboriginal people for particular causes of death can provide insight into where policy attention is needed to close the gap. The types of diseases causing the most deaths for both Aboriginal and non-Aboriginal people are somewhat similar, although occurring at different rates.

Key findings

Overall: In the 5-year period 2019–2023, for Aboriginal people in Western Australia, the top 5 causes of deaths accounted for 2,534, or 77%, of all deaths (Table D1.23.2). After adjusting for age, these were:

- cardiovascular (circulatory) disease (269 per 100,000 population)
- cancer and other neoplasms (233 per 100,000)
- endocrine, metabolic, and nutritional disorders which include mostly diabetes (126 per 100,000)
- injury and poisoning (125 per 100,000)
- respiratory diseases (85 per 100,000).

For non-Aboriginal Western Australians during the same period, after adjusting for age, the top 5 causes of death were:

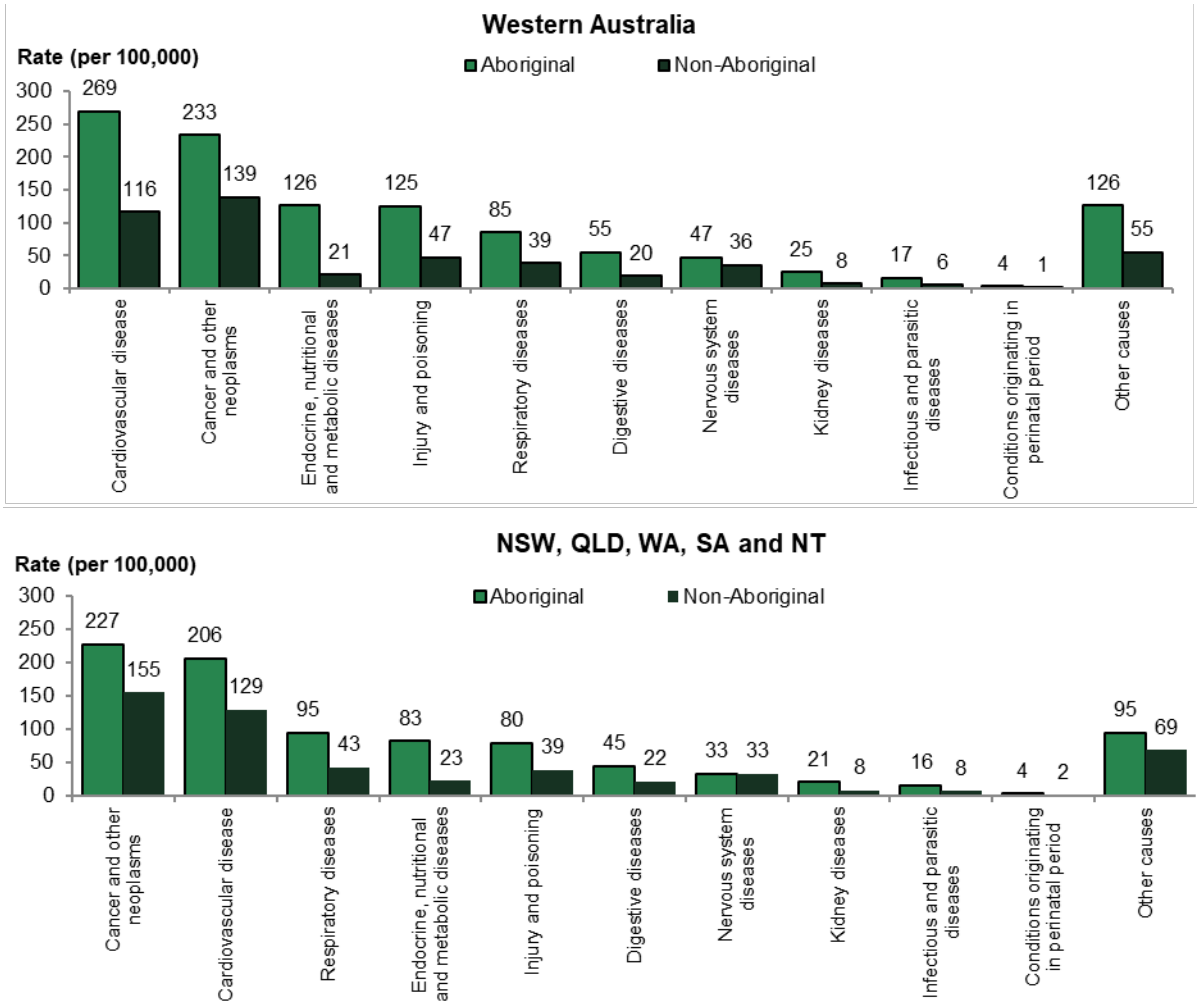
- cancer and other neoplasms (139 per 100,000 population)
- cardiovascular disease (116 per 100,000)
- injury and poisoning (47 per 100,000)
- respiratory diseases (39 per 100,000)
- nervous system diseases (36 per 100,000) (Figure 1.23.1).

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

During the same period, the top 5 causes of death for non-Aboriginal people in NSW, Qld, WA, SA and NT combined, after adjusting for differences age, were cancer and other neoplasms (155 per 100,000); cardiovascular disease (129 per 100,000); respiratory disorders (43 per 100,000); injury and poisoning (39 per 100,000) and nervous system diseases (33 per 100,000) (Figure 1.23.1).

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 1.23.1: Age-standardised death rate, by cause and Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2019–2023



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues. More detail is provided on p3.

Source: Table D1.23.2.

1.24 Avoidable and preventable deaths

Why it is important

This measure reports on potentially avoidable deaths of Aboriginal 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 2025e). 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.

Key findings

Mortality data in this measure are from 5 jurisdictions for which the quality of Indigenous identification in the deaths data is considered to be adequate: namely, NSW, Qld, WA, SA and NT.

Overall: In 2019–2023 in Western Australia, there were 1,659 deaths of Aboriginal people aged 0–74 from avoidable causes, equating to a rate of 280 deaths per 100,000 population (Table D1.24.4). After adjusting for differences in the age structure between the two populations, Aboriginal people in Western Australia died from potentially avoidable causes at 4.5 times the rate of non-Aboriginal people (Figure 1.24.1).

In NSW, Qld, WA, SA and NT combined, 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 of non-Aboriginal people (Figure 1.24.1).

Gap between Aboriginal people and non-Aboriginal people: In 2019–2023 in Western Australia, the gap in the age-standardised rate of potentially avoidable deaths between Aboriginal people and non-Aboriginal people was 317 deaths per 100,000**.**

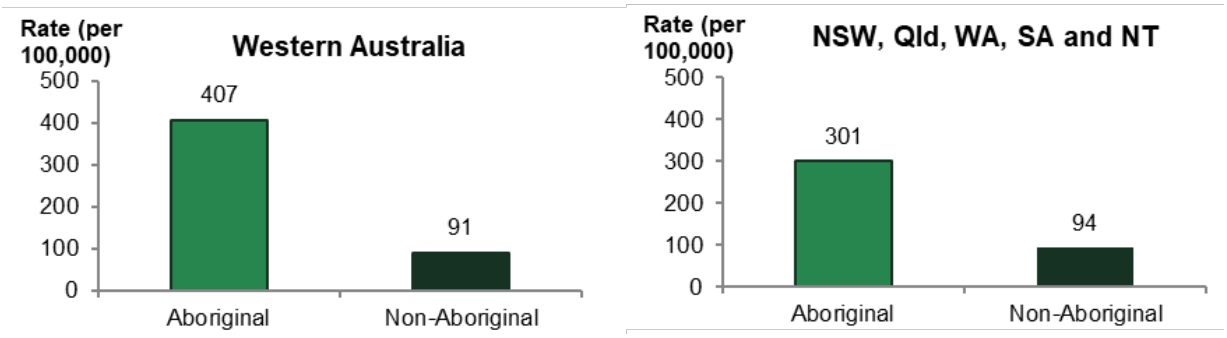
In NSW, Qld, WA, SA and NT combined, the gap in the age-standardised rate of potentially avoidable deaths between Aboriginal people and non-Aboriginal people was 207 deaths per 100,000 (Table D1.24.4).

Trend over time: In Western Australia, the age-standardised rate of potentially avoidable deaths for Aboriginal people did not change significantly from 2016 to 2023, while for non-Aboriginal people it decreased by 12% from 99 per 100,000 in 2016 to 87 per 100,000 in 2023.

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% from 104 per 100,000 in 2016 to 93 per 100,000 in 2021 (Figure 1.24.2). Data from 2022 and 2023 are not comparable to previous years due to changes in the process for deriving Indigenous status. For more detail, see the box ‘Mortality data quality considerations’ on p3 of this report.

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

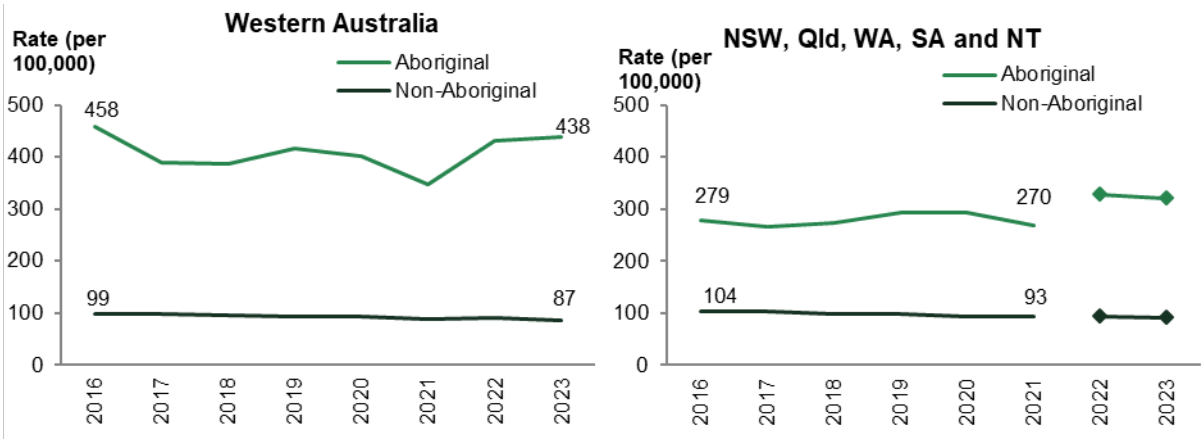
Figure 1.24.1: Potentially avoidable age-standardised death rates, persons aged 0–74 years, by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT combined, 2019–2023



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues. More detail is provided on p3.

Source: Table D1.24.4.

Figure 1.24.2: Potentially avoidable age-standardised death rates, people aged 0–74 years, by Aboriginal status, Western Australia 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. More detail is provided on p3.

Source: Table D1.24.8.

2

Tier 2 – Determinants of health

Topic	Number of measures
Environmental factors	3
Socio-economic factors	6
Community capacities	5
Health behaviours	7
Person-related factor	1
Total	**22**

2.01 Housing

Why it is important

This measure reports on the housing circumstances of Aboriginal people. Housing circumstances 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).

Key findings

Housing tenure: According to data from the ABS Census of Population and Housing, in Western Australia in 2021, 29% (9,400) of Aboriginal households owned their home with a mortgage, 11% (3,700) owned their home outright, 58% (19,100) were renting, and other tenure accounted for the remaining 1.8%.

The proportion of Western Australian households that owned their own home (with or without a mortgage) in 2021 was lower for Aboriginal households than for non-Aboriginal households (40% compared with 71%) (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%. 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).

Appropriately sized housing: In 2022–23 in Western Australia, an estimated 80% (94,300) of Aboriginal people lived in appropriately sized housing – this was lower than for non-Aboriginal people in Western Australia (97%). Aboriginal people were 5.6 times as likely to live in an overcrowded dwelling as non-Aboriginal people. Households where no additional bedrooms are required or that have spare bedrooms, based on the Canadian National Occupancy Standard, are considered to be appropriately sized.

Nationally, 85% of Aboriginal people lived in appropriately sized housing compared with 94% of non-Aboriginal people. Aboriginal people were 2.8 times as likely to live in an overcrowded dwelling as non-Aboriginal people (Figure 2.01.2).

Specialist homelessness services (SHS): In 2023–24 in Western Australia, 4.3% of the Aboriginal population used SHS (986 Aboriginal SHS clients per 10,000 population). After adjusting for age, Aboriginal people were about 21 times as likely to have used SHS as non-Aboriginal people.

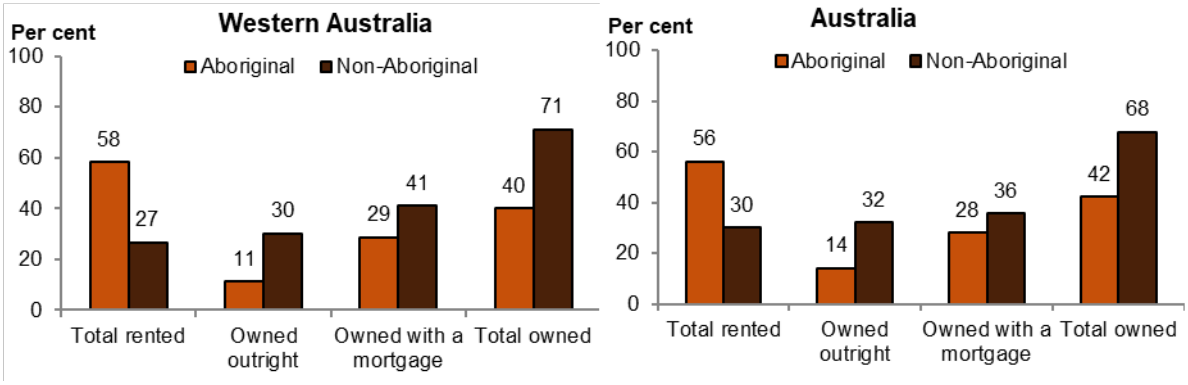
Nationally in 2023–24, 3.8% of the Aboriginal population used SHS (760 Aboriginal SHS clients per 10,000 population). After adjusting for age, Aboriginal people were about 9 times as likely to have used SHS as non-Aboriginal people (Figure 2.01.3).

Trends in overcrowding: In Western Australia, the proportion of Aboriginal people living in overcrowded households fell between 2004–05 and 2022–23 from 33% to 20%.

Nationally, between 2004–05 and 2022–23, the proportion of Aboriginal people living in overcrowded households fell from 27% to 15% (Table D2.01.24).

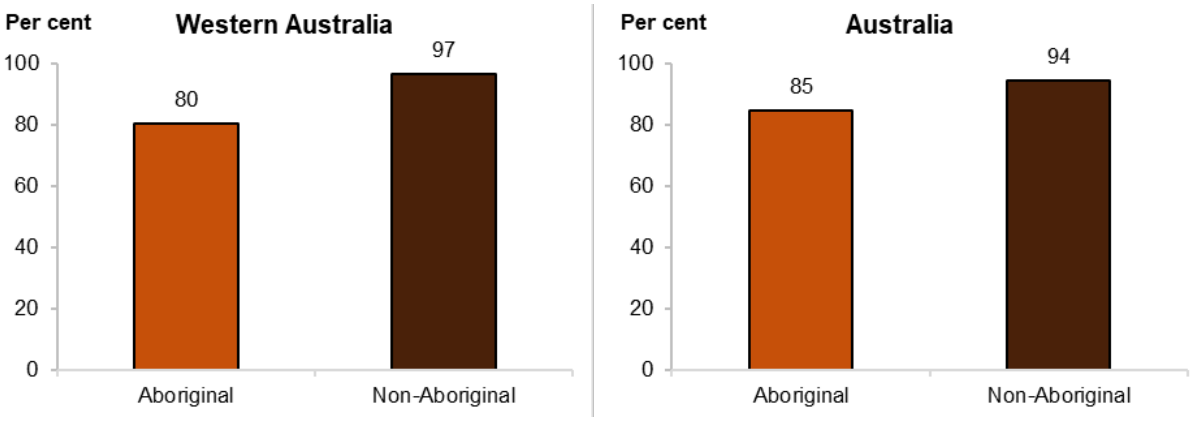
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.01.1: Tenure type of households, by Aboriginal status, Western Australia and Australia, 2021



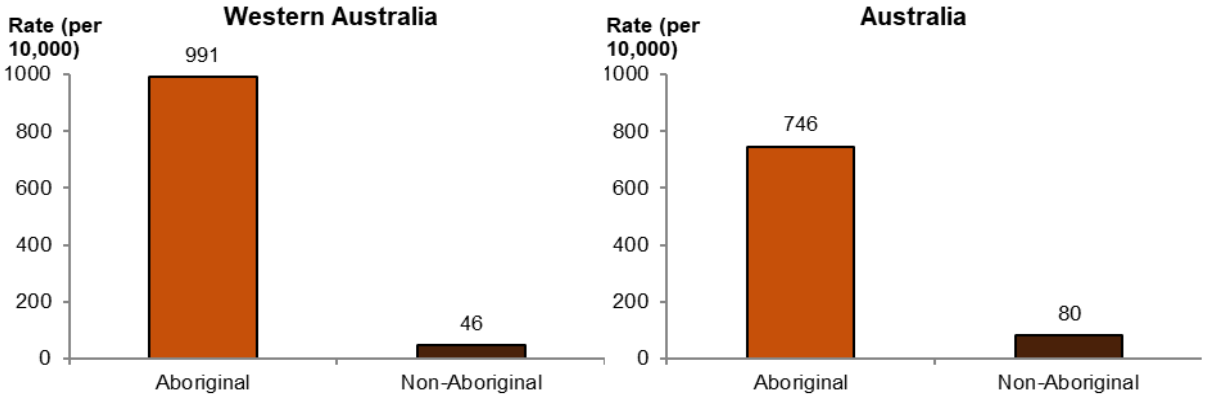
Source: Table D2.01.17.

Figure 2.01.2: People living in appropriately sized dwelling, by Aboriginal status, Western Australia and Australia, 2022–23



Source: Table D2.01.2.

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



Source: Table D2.01.30.

2.02 Access to functional housing with utilities

Why it is important

This measure reports on the functionality of Aboriginal people's 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 people, 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 & Wayte 2006; FaHCSIA 2007; Nganampa Health Council et al. 1987; NSW Department of Health 2019).

Key findings

Major structural problems: In 2022–23 in Western Australia, an estimated 30% (14,900) 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 (13%) and major plumbing problems (9.9%).

Nationally in 2022–23, an estimated 31% 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).

Access to working facilities: In 2022–23 in Western Australia, among Aboriginal households: 99% had access to working facilities for washing people; 97% had access to working sewerage facilities; 96% had access to working facilities for washing clothes and bedding; and 90% had access to working facilities for preparing food.

Nationally in 2022–23, among Aboriginal households: 99% had access to working sewerage facilities; 97% had access to facilities for washing people; 95% had access to working facilities for washing clothes and bedding; and 92% had access to facilities for preparing food (Figure 2.02.2).

Dwellings of acceptable standard: In 2022–23 in Western Australia, 82% 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).

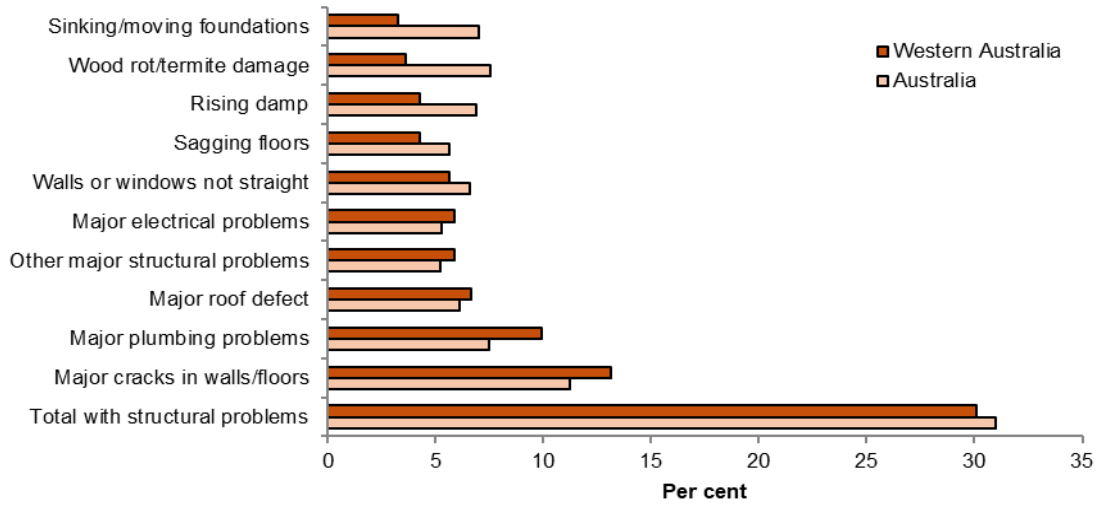
Nationally in 2022–23, 82% of Aboriginal households were living in dwellings of an acceptable standard (Table D2.02.6).

Dwellings of acceptable standard over time: Between 2008 and 2022–23 in Western Australia, the proportion of Aboriginal households living in dwellings of an acceptable standard varied between a low of 74% and a high of 82%.

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).

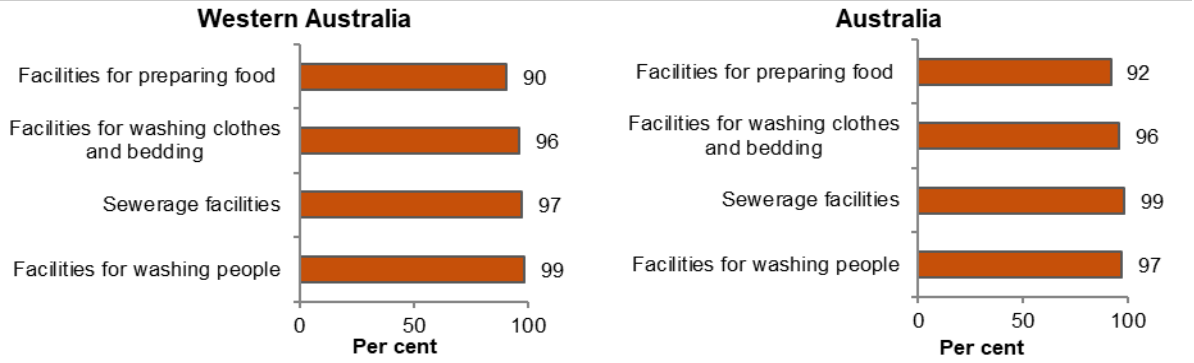
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.02.1: Aboriginal households with major structural problems, Western Australia and Australia, 2022–23



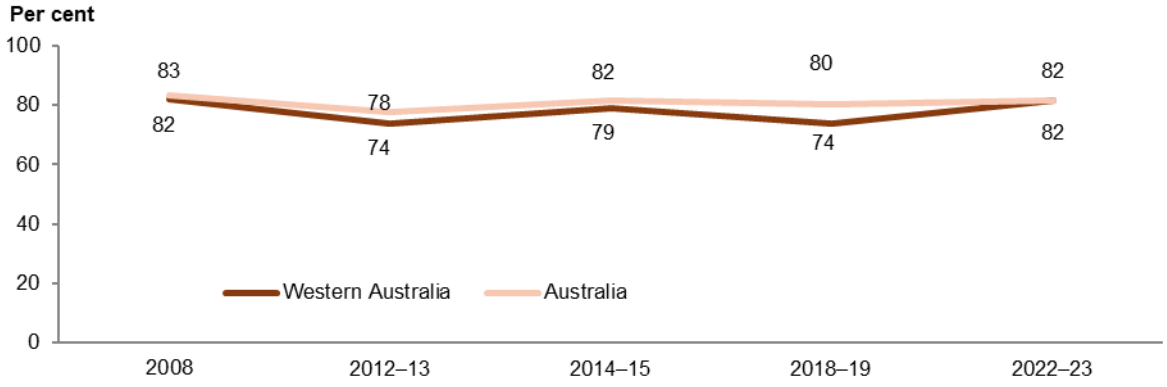
Source: Table D2.02.1

Figure 2.02.2: Aboriginal households with working facilities to support healthy living, Western Australia and Australia, 2022–23



Source: Table D2.02.8.

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



Source: 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 secondhand smoke) is a significant cause of illness and death. There is consistent evidence that second-hand smoke causes lung cancer and ischaemic heart disease. It is also associated with an increased risk of respiratory diseases in adults, an increased risk of Sudden Infant Death Syndrome, 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; McCallum et al. 2016).

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, an estimated 37% (14,200) of Aboriginal children aged 0–14 in Western Australia lived in households with daily smokers. Nationally, 42% of Aboriginal children aged 0–14 lived in households with daily smokers (Figure 2.03.1).

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).

Nationally in 2022–23, the proportion of Aboriginal children aged 0–14 who lived in a household with a daily smoker was 39% in non-remote areas and 69% in remote areas (Table D2.03.7).

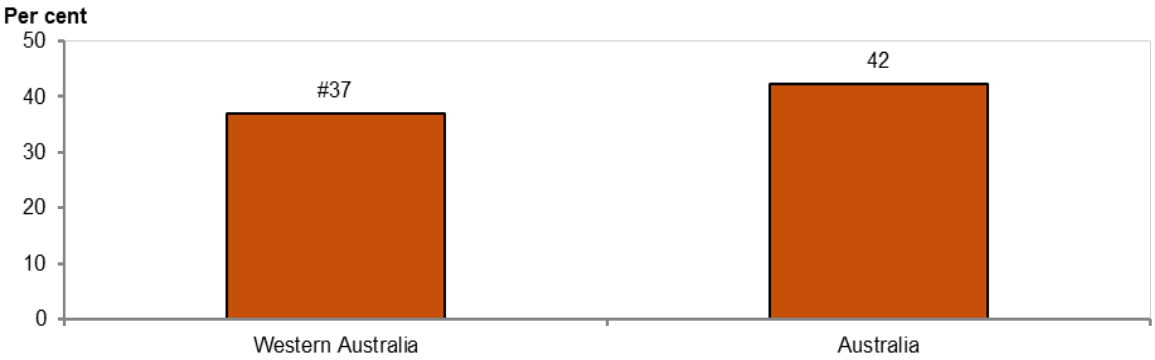
Households with indoor smoking: In 2022–23 in Western Australia, 5.7% (2,200; this estimate has a relative standard error between 25% and 50% and should be used with caution) of Aboriginal children aged 0–14 lived in households where smoking occurred indoors. Nationally, 5.7% of Aboriginal children lived 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 13% for those living in remote areas and 5% for those living in non-remote areas (Table D2.03.5).

Daily smokers over time: Nationally in non-remote areas, the proportion of Aboriginal children who lived in households with daily smokers declined from 65% in 2004–05 to 39% in 2022–23, but in remote areas, this had reduced by only 4 percentage points from 74% in 2004–05 to 70% in 2022–23 (Figure 2.03.3).

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).

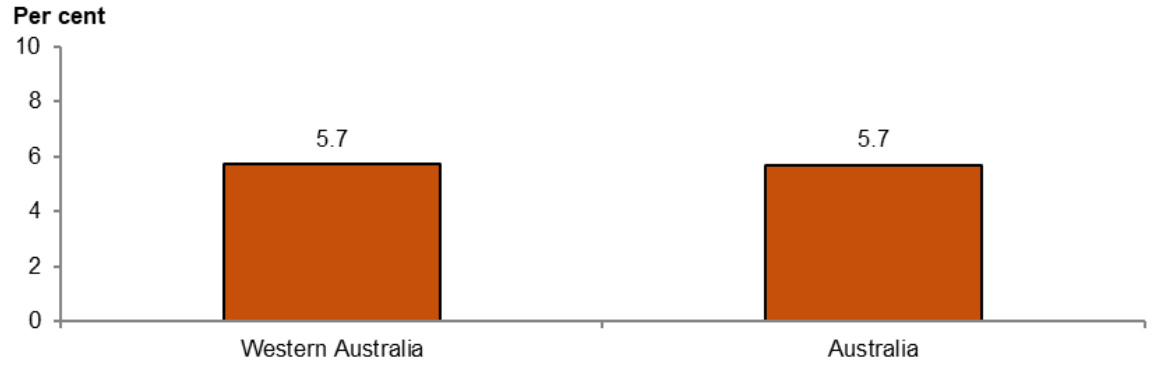
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



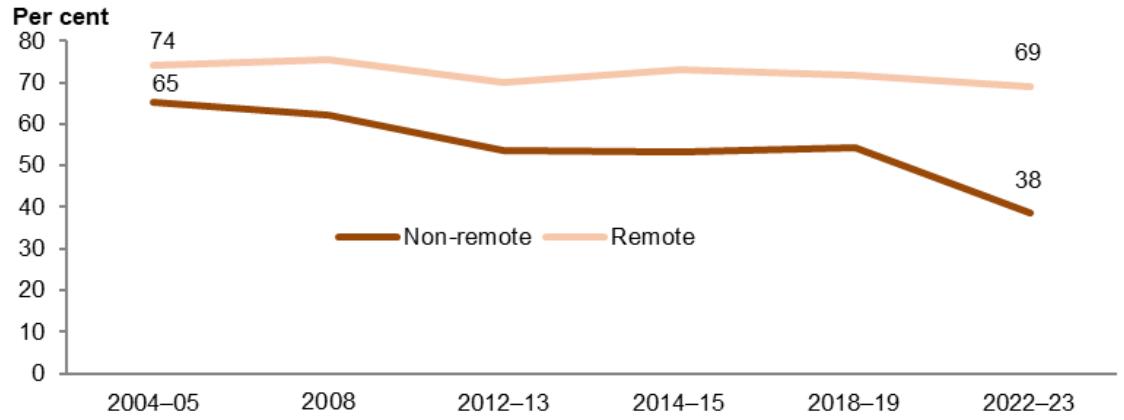
Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D2.03.3.

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



Source: Table D2.03.3.

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



Source: Table D2.03.7.

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 future can influence an individual's access to health care and quality of life (Zajacova & 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 Western Australia in 2023, based on averaging results across the five NAPLAN learning areas, around a quarter of Aboriginal students in each year level met or exceeded proficiency expectations ('Strong' or 'Exceeding'). Around three in ten had results in the 'Developing' category, indicating they were working towards expectations. The remaining had results in the 'Needs additional support' category (Figure 2.04.1). Among the Aboriginal students nationally in 2023, the results were split roughly into thirds across these three proficiency levels (Table D2.04.19).

By learning area: In Western Australia in 2023, the proportion of Aboriginal students who achieved a Strong or Exceeding proficiency level was: highest for reading for students in Year 5; highest for writing for students in Year 3; highest for spelling for students in Year 7; highest for grammar and punctuation for students in Years 5 and 7; highest for numeracy for students in Years 5,7 and 9. The national results for Aboriginal students in 2023 showed similar patterns for the highest proportion of students achieving a Strong or Exceeding proficiency by learning areas for each year level. However, the national proportion was higher than that in Western Australia for all years and learning areas (Figure 2.04.2).

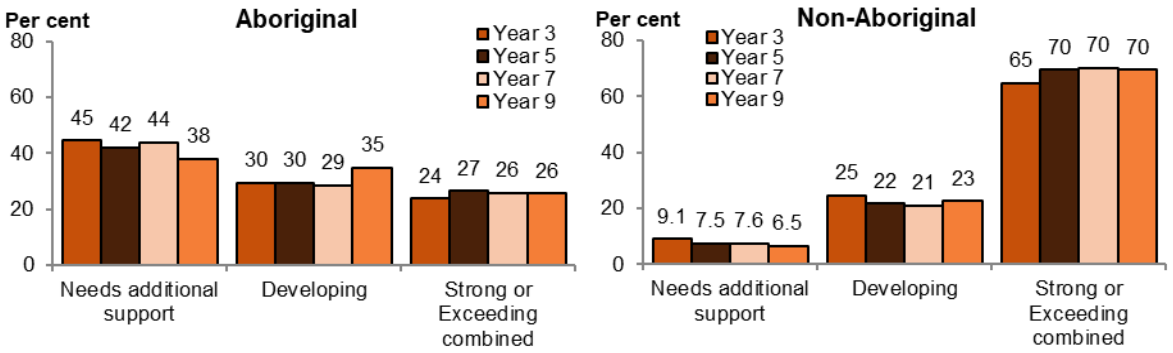
By remoteness area: On average, across all five NAPLAN learning areas, the proportion of Western Australian Aboriginal students achieving Strong or Exceeding proficiency levels was lowest in very remote areas. For example, among Aboriginal students in Year 3, the average proportion achieving Strong or Exceeding proficiency levels across the five learning areas was 30% in *Major cities*, 24% in *Inner regional*areas, 22% in *Outer regional* areas, and 23% in *Remote* areas, compared with 9% in *Very remote* areas.

Conversely, across the five learning areas, a lower proportion of Western Australian Aboriginal students in *Major cities* required additional academic support, ranging from 31% to 34% across different year levels. These figures were notably lower compared with *Very remote* areas, where the range was between 56% and 71% (Figure 2.04.3).

Comparisons with non-Aboriginal students: Averaged across the five learning areas, in Western Australia in 2023, a greater proportion of Aboriginal students needed additional academic support compared with non-Aboriginal students (38–45% across year levels, compared with 6.5–9.0%). Conversely, fewer Aboriginal students were meeting or exceeding proficiency expectations ('Strong' or 'Exceeding') compared with non-Aboriginal students (24–27%, compared with 65–70%) (Figure 2.04.1).

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

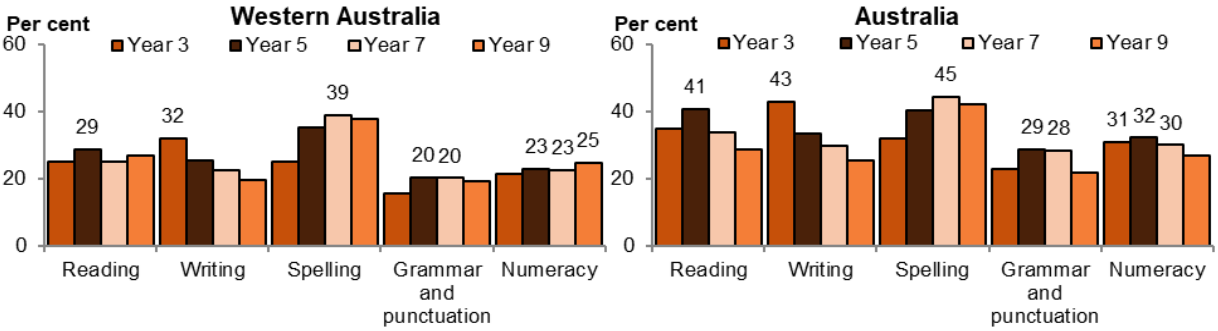
Figure 2.04.1: NAPLAN results, averaged across the five learning areas, by proficiency level, school year and Aboriginal status, Western Australia, 2023



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

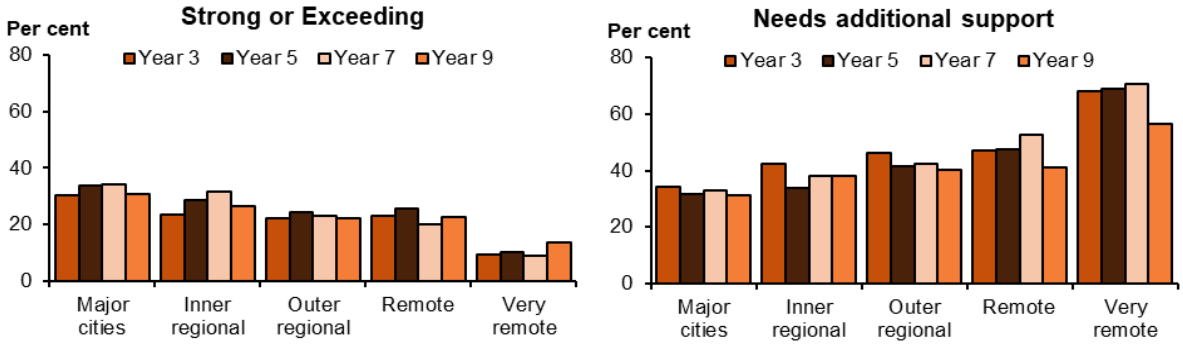
Source: Table D2.04.19.

Figure 2.04.2: Proportion of Aboriginal students achieving strong or exceeding proficiency levels, by NAPLAN learning area and school year, Western Australia and Australia 2023



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

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, Western Australia, 2023



Source: Table D2.04.11 WA.

2.05 Education outcomes for young people

Why it is important

This measure reports on the proportion of Aboriginal 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 status (including 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 & 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 Western Australia in 2024, there were 13,552 Aboriginal students in Years 7 to 12, making up 6.7% of total students in Western Australia (Table D2.05.4, Table D2.05.5). The apparent retention rate from Year 7/8 to Year 12 in Western Australia was 59% for Aboriginal students and 84% for non-Aboriginal students. The apparent retention rate for Year 10 to Year 12 was slightly higher for both Aboriginal and non-Aboriginal students (66% and 85% respectively (Figure 2.05.1). Nationally in 2024, the apparent retention rate from Year 7/8 to Year 12 and for Year 10 to Year 12 was 57% for Aboriginal students, and 81% for non-Aboriginal students (Figure 2.05.1).

Year 12 or equivalent: In 2021 in Western Australia, 4,304 (61%) Aboriginal people aged 20–24 had attained a Year 12 or equivalent qualification (Certificate III or above). The attainment rate was 1.5 times as high for non-Aboriginal people aged 20–24 as for Aboriginal people (90% compared with 61%) (Figure 2.05.2).

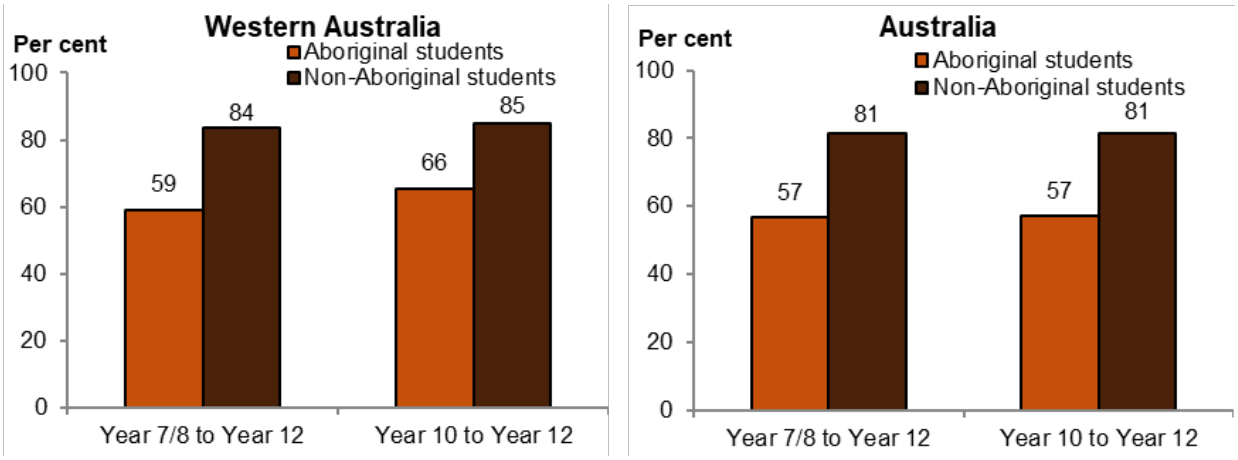
Nationally in 2021, 68% of Aboriginal people aged 20–24 had attained a Year 12 or equivalent qualification. The attainment rate for non-Aboriginal people was 1.3 times as high as for Aboriginal people (91% compared with 68%) (Figure 2.05.2).

Time trends: In Western Australia over the period 2011 to 2021, the proportion of Aboriginal people aged 20–24 who had completed Year 12 or equivalent increased from 43% to 61%. Over the same period, the proportion among non-Aboriginal people in Western Australia increased from 84% to 90%. As rates of Year 12 attainment increased more for Aboriginal people over the period, the gap (rate difference) decreased, from 40 to 29 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).

School attendance: In 2014–15 in Western Australia, 98% of Aboriginal children aged 4–14 usually attended school, and 32% had missed days at school, preschool, or kindergarten in the week before the survey (Figure 2.05.3). Nationally, 96% of Aboriginal children aged 4–14 usually attended school in 2014–15, and 28% had missed days in the week before the survey (Figure 2.05.3).

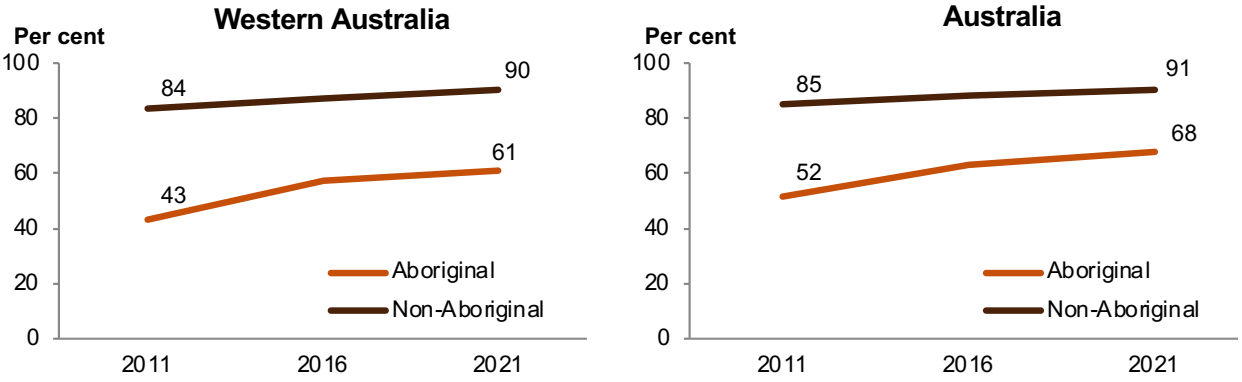
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.05.1: Apparent school retention rates, by Aboriginal status, Western Australia and Australia, 2024



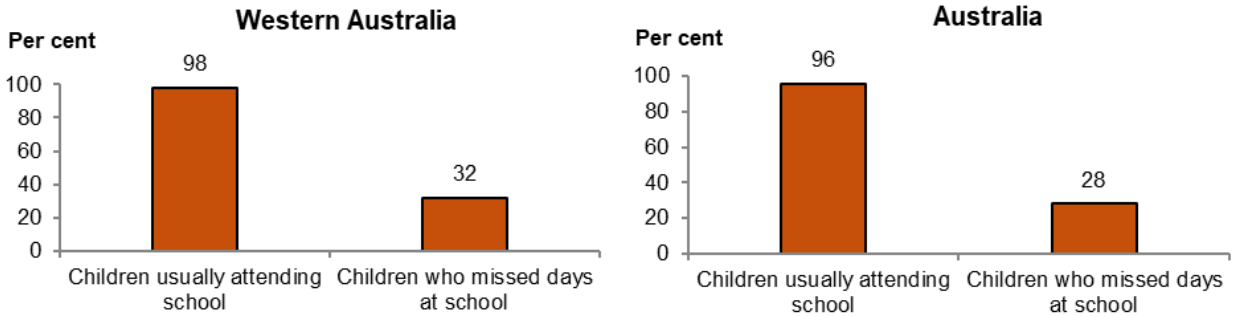
Source: Table D2.05.2.

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



Source: Table D2.05.1.

Figure 2.05.3: School attendance for Aboriginal children (aged 4–14), Western Australia and Australia, 2014–15



Source: Table D2.05.10.

2.06 Educational participation and attainment of adults

Why it is important

This measure reports on educational participation by Aboriginal 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 & Jenkins 2014). The employment gap between Aboriginal people and non-Aboriginal people 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 & McKenzie 2001).

Key findings

Currently studying: In 2021 in Western Australia, 3,823 (7.7%) Aboriginal adults (aged 18 and over) reported that they were currently studying, compared with 10% 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).

VET Completions: In 2024 in Western Australia, 1,320 Aboriginal people aged 15 and over completed Certificate III, or Certificate IV, diploma or higher, out of 2,524 total VET completions. The proportion of Aboriginal people aged 15 and over in Western Australia completing VET courses who completed Certificate III, or Certificate IV, diploma or higher was lower than the proportion for Aboriginal people nationally (52% and 59%, respectively). The proportion of non-Aboriginal people in Western Australia completing VET courses who completed Certificate III, or Certificate IV, diploma or higher was very similar to the proportion for non-Aboriginal people nationally (both 78%) (Table D2.06.16).

Highest level of school completed: In Western Australia in 2021, 36% (18,353) of Aboriginal adults (aged 18 and over) reported Year 12 or equivalent as their highest level of school completed, compared with 64% of non-Aboriginal adults. Nationally, the proportions were 40% of Aboriginal adults and 64% of non-Aboriginal adults (Figure 2.06.1).

Non-school qualification: In Western Australia in 2021, 39% (15,895) 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 70% of non-Aboriginal adults. This gap was due to lower rates of attainment at Bachelor degree and above, with 7.3% (2,925) of Aboriginal adults aged 20–64 having a Bachelor degree or above, compared with 32% of non-Aboriginal adults (Figure 2.06.2).

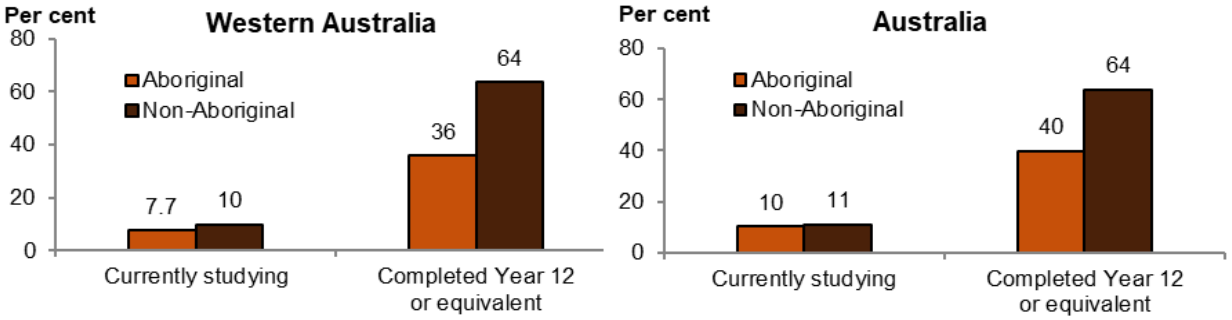
Nationally in 2021, 48% of Aboriginal adults aged 20–64 reported they either had a Certificate III or above, or were studying at any level, compared with 71% of non-Aboriginal adults aged 20–64 (Figure 2.06.2).

Adults aged 25–34: The National Agreement on Closing the Gap includes an outcome 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.

In Western Australia in 2021, 37% of Aboriginal adults aged 25–34 had completed a non-school qualification at Certificate III or above, an increase from 34% in 2016. Nationally, the proportion was 47% in 2021, an increase from 42% in 2016 (Figure 2.06.3).

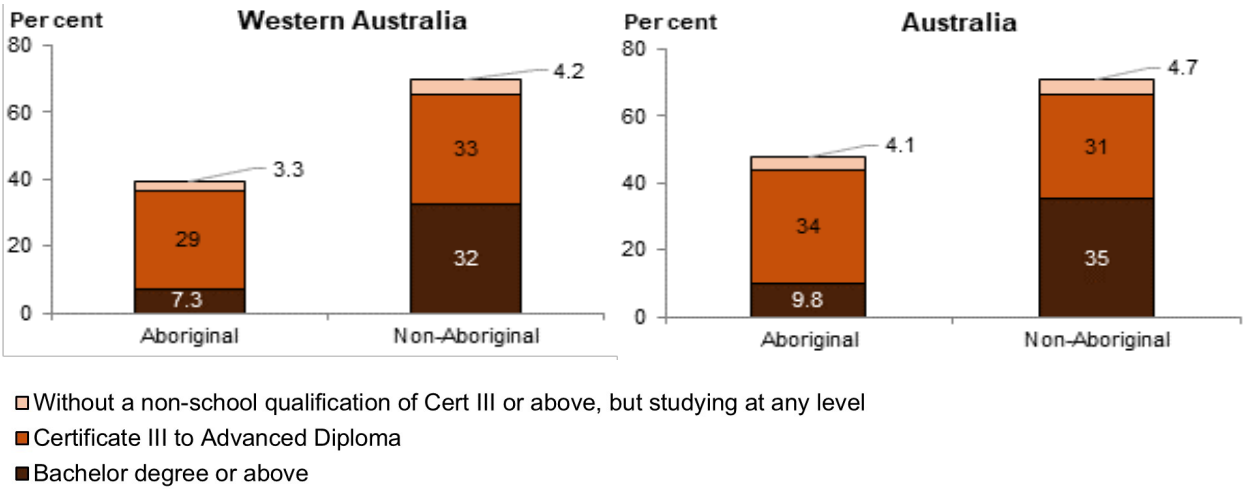
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



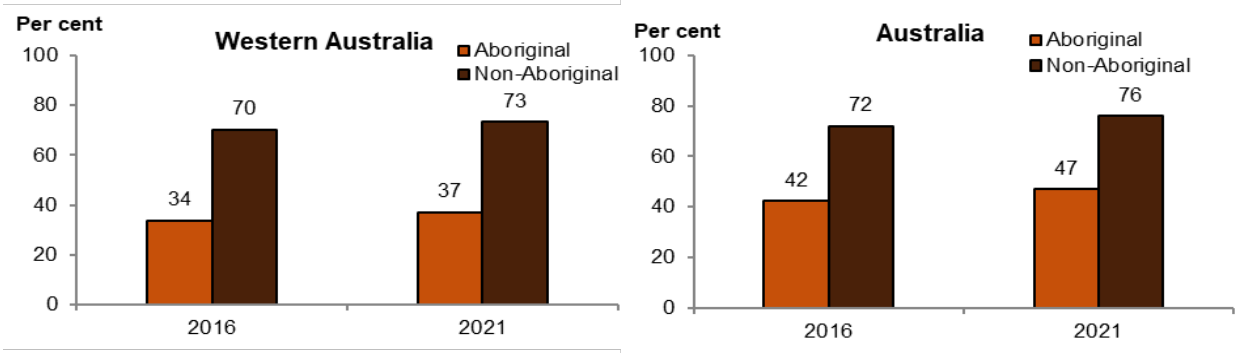
Source: Table D2.06.3, D2.06.7.

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, Western Australia and Australia, 2021



Source: Table D2.06.11.

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



Source: Table D2.06.36.

2.07 Employment

Why it is important

This measure reports on the employment status of Aboriginal people 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 & Moskos 2007; Marmot et al. 2008). Employment and financial security are key drivers of better mental health outcomes, with employed Aboriginal Australians 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 Australians (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 & Kumar 2014).

Key findings

Labour force participation: In 2021 in Western Australia, 55% (28,800) of Aboriginal people of working age (15–64) reported they were in the labour force. In comparison, non-Aboriginal people were 1.5 times as likely to report being in the labour force.

In 2021 nationally, 60% of Aboriginal people of working age (15–64) 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).

Employment: In 2021 in Western Australia, 46% (24,200) of the Aboriginal working age population reported they were employed; 27% (14,100) were working full time and 14% (7,500) part time. For non-Aboriginal people in 2021, 78% of the working age population were employed; 48% were working full time and 25% part time (Figure 2.07.2).

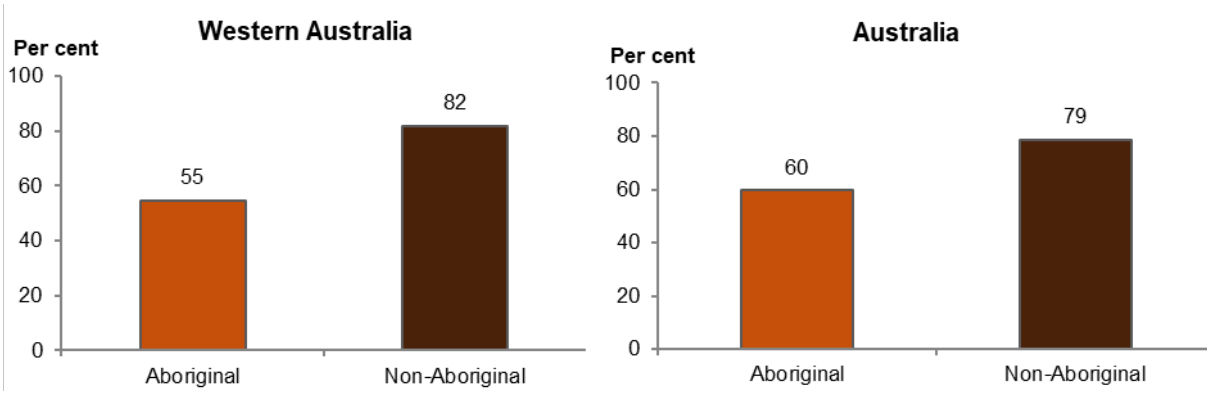
In 2021 nationally, 52% of the Aboriginal working age population reported they were employed; 29% were working full time and 17% part time. For non-Aboriginal people, 75% of the working age population were employed (Figure 2.07.2); 45% were working full time and 24% part time (Table D2.07.5).

Unemployment: In 2021 in Western Australia, there were 4,632 (8.8%) unemployed Aboriginal people of working age (15–64). The reported unemployment rate (that is, the number of people unemployed as a proportion of the number in the labour force) for Aboriginal people (16%) was 3.2 times the rate reported for non-Aboriginal people. In 2021 nationally, the reported unemployment rate for Aboriginal people (12%) was more than double the rate reported for non-Aboriginal people (Figure 2.07.3).

Difficulty in finding work: Nationally in 2014–15, 92% of Aboriginal people 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/distance (32%) (Table D2.07.10).

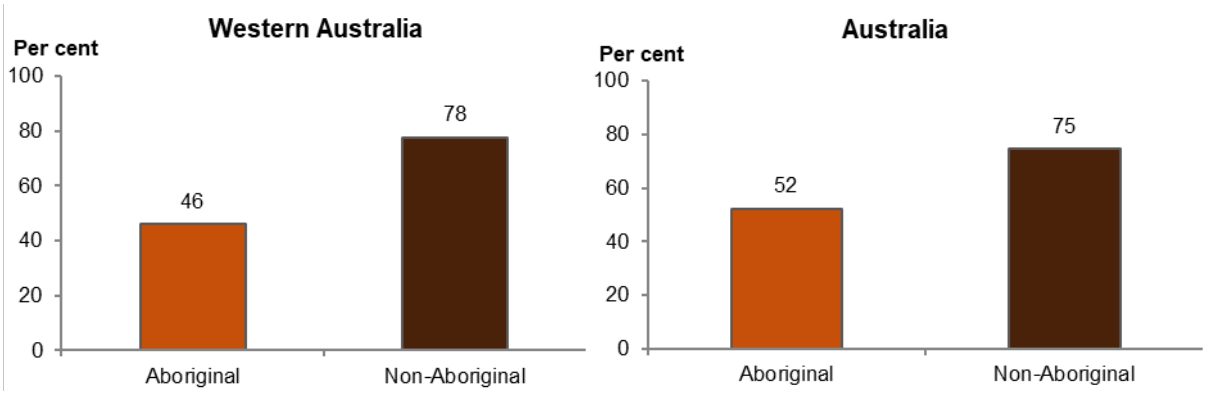
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.07.1: Labour force participation rate, by Aboriginal status, Western Australia and Australia, 2021



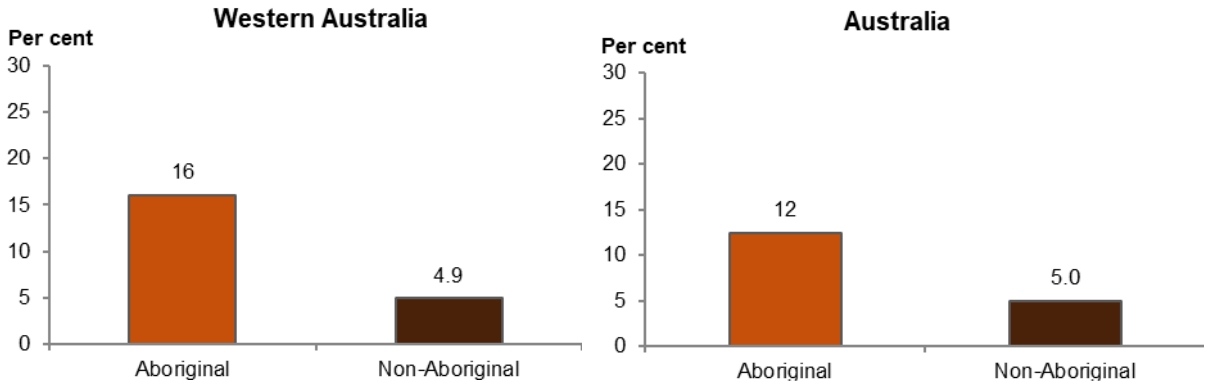
Source: Table D2.07.5.

Figure 2.07.2: Employment rate, by Aboriginal status, Western Australia and Australia, 2021



Source: Table D2.07.5.

Figure 2.07.3: Unemployment rate, by Aboriginal status, Western Australia and Australia, 2021



Source: Table D2.07.5.

2.08 Income

Why it is important

This measure reports on equivalised gross household and individual income of Aboriginal adults. 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 & 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 2016b).

Key findings

Equivalised gross weekly household income: In 2021 in Western Australia, 40% of Aboriginal adults (aged 18 and over) were living in households in the lowest equivalised weekly household income quintile. This was twice the proportion for non-Aboriginal adults (Figure 2.08.1). An estimated 12% of Aboriginal adults lived in households with a weekly income in the highest quintile compared with 22% of non-Aboriginal Adults (Table D2.08.15).

In 2021 nationally, 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). An estimated 10% of Aboriginal adults lived in households with a weekly income in the highest quintile compared with 20% of non-Aboriginal adults (Table D2.08.15).

Median equivalised gross weekly household income: In 2021 in Western Australia, the median equivalised gross weekly household income for Aboriginal adults was reported to be $752, compared with $1,210 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).

To raise $2,000 in a week: In 2022–23 in Western Australia, an estimated 50% of Aboriginal households could not raise $2,000 within a week in an emergency (indicating financial stress). The proportion was 60% in remote areas and 45% in non-remote areas (Figure 2.08.2)

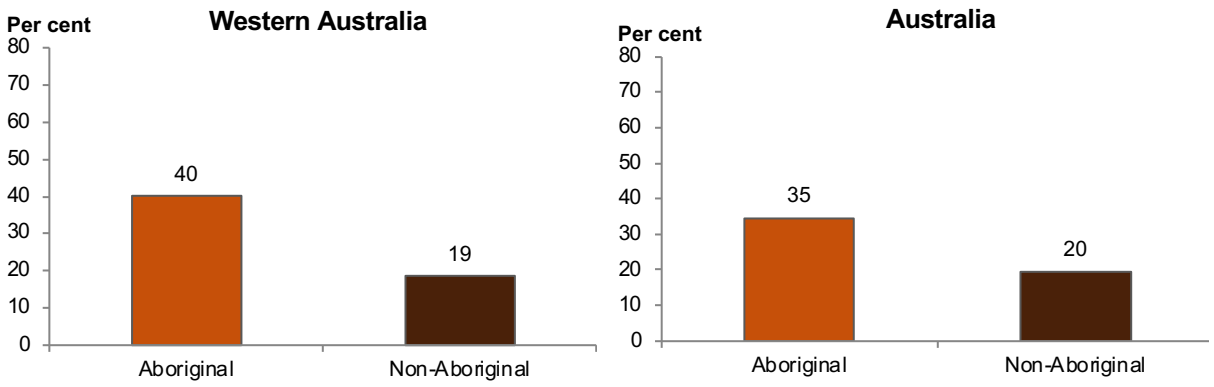
Nationally in 2022–23, an estimated 44% of Aboriginal households could not raise $2,000 within a week in an emergency. The proportion was 60% in remote areas and 42% in non-remote areas (Figure 2.08.2)

Trend over time: In Western Australia, the proportion of Aboriginal adults aged 18 and over who were below the 20th and 50th percentiles of equivalised gross weekly household income fell to 40% and 67% in 2021 from 44% and 74% in 2006, respectively.

Nationally, the proportion of Aboriginal adults aged 18 and over who were below the 20th and 50th percentiles of equivalised gross weekly household income fell to 35% and 67% in 2021 from 40% and 72% in 2006, respectively (Figure 2.08.3).

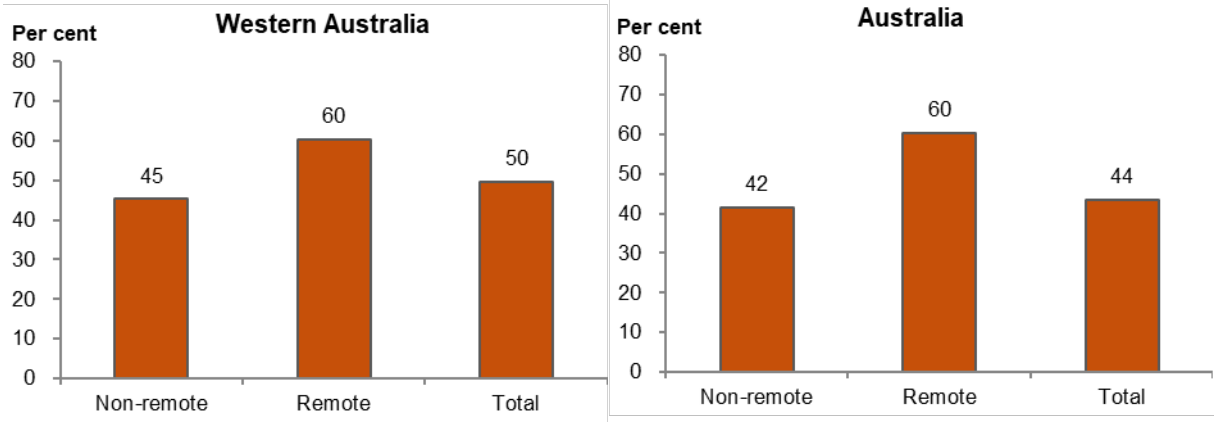
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



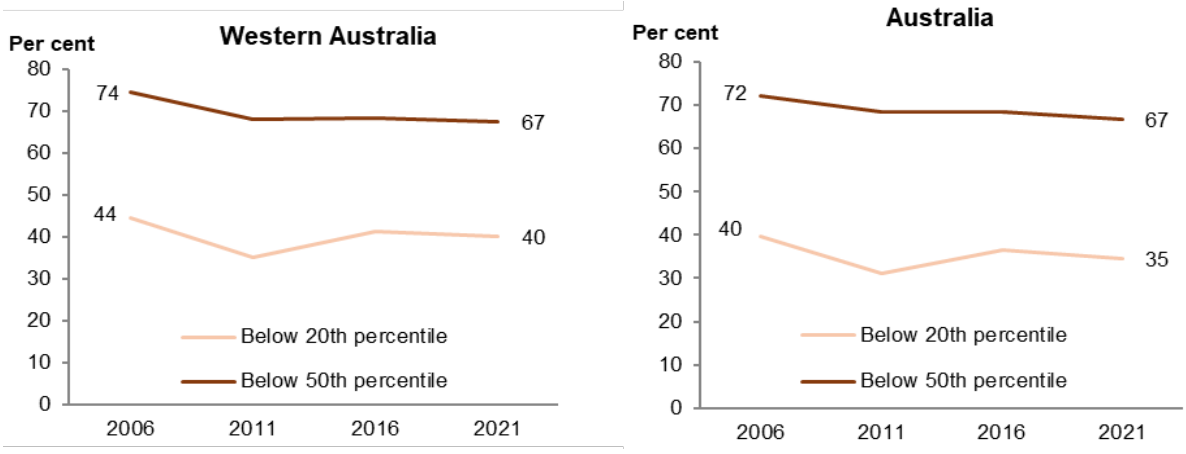
Source: Table D2.08.15.

Figure 2.08.2: Aboriginal households reporting they were not able to raise $2,000 in a week, by remoteness, Western Australia and Australia, 2022–23



Sources: ABS 2024d Table 60.3 and AIHW analysis of ABS 2025.

Figure 2.08.3: Aboriginal adults (aged 18 or over) who were below the 20th and 50th percentiles of equivalised gross weekly household income, 2006 to 2021



Source: Table D2.08.16.

2.09 Socioeconomic indexes

Why it is important

This measure reports on the distribution of Aboriginal 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 & 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 & Carroll 2008). That said, for many Aboriginal people, their culture, community and history also play a fundamental part in their health and wellbeing. Therefore, the socioeconomic indexes only reflect some aspects of the 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 & Firman 2004).

Key findings

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 Western Australia and total Australia, Aboriginal people were over-represented in areas ranked in the most disadvantaged quintiles by the SEIFA and under-represented in more advantaged areas (Figure 2.09.1).

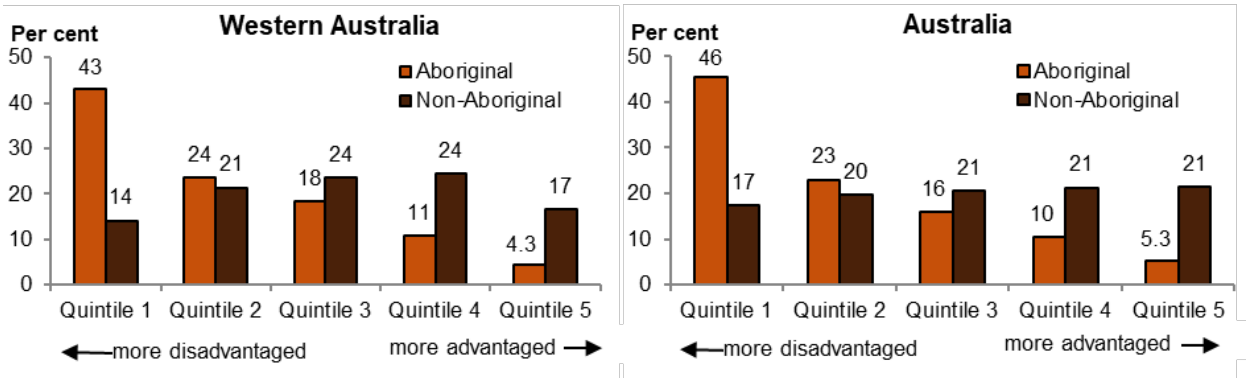
In Western Australia, 43% of Aboriginal people lived in areas ranked in the most disadvantaged quintile, compared with 14% of non-Aboriginal people. Conversely, 4.3% of Aboriginal people in Western Australia lived in areas ranked in the most advantaged quintile, compared with 17% of non-Aboriginal people (Figure 2.09.1).

Nationally, 46% of Aboriginal people lived in areas ranked in the most disadvantaged quintile, compared with 17% of non-Aboriginal people. Conversely, 5.3% of Aboriginal people lived in areas ranked in the most advantaged quintile, compared with 21% of non-Aboriginal people (Figure 2.09.1).

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 the lowest was in Tasmania (0.9%) (Figure 2.09.2).

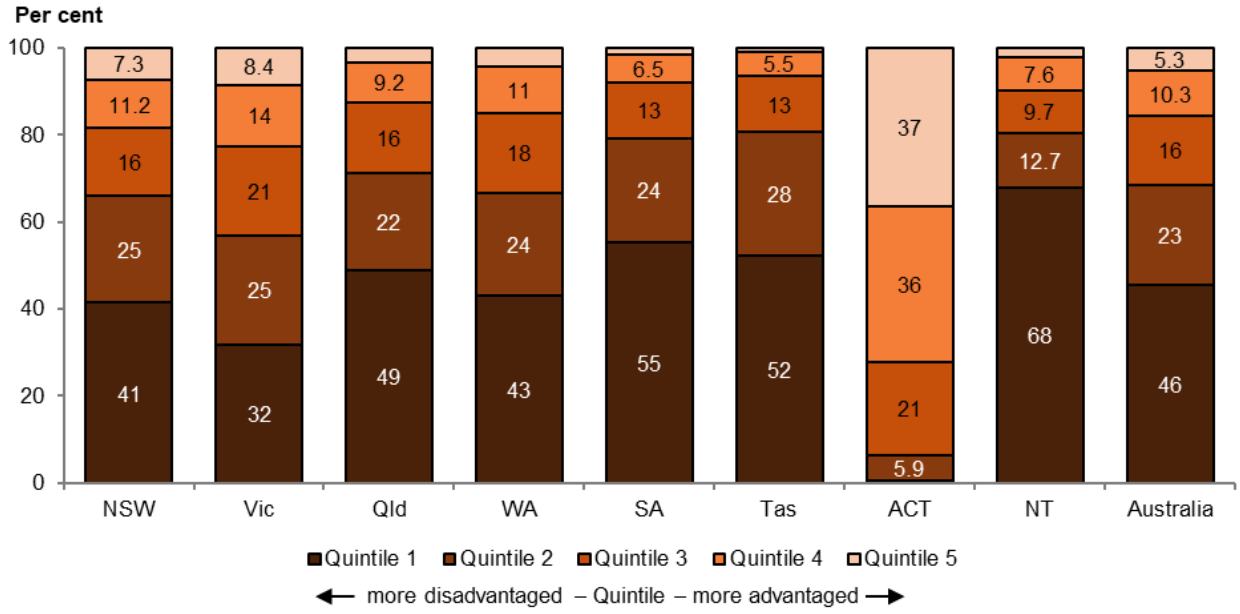
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.09.1: Population distribution by SEIFA advantage/disadvantage quintiles, by Aboriginal status, Western Australia and Australia, 2021



Source: Table D2.09.2.

Figure 2.09.2: Population distribution by SEIFA advantage/disadvantage quintiles, Aboriginal population, by jurisdiction, 2021



Note: Columns may not sum to 100% because not all Census responses could be allocated a SEIFA score.
Source: 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, this service can help: 1800RESPECT on 1800 737 732 or visit the **1800RESPECT** website at www.1800respect.org.au

Why it is important

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).
This measure reports on hospitalisations and deaths due to assault among Aboriginal people. 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 2018b; Coles et al. 2015; Loxton et al. 2019).

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 or other adverse event.

In Western Australia, between July 2021 and June 2023, there were 2,966 hospitalisations due to assault among Aboriginal people, a rate of 1,213 per 100,000 population. For Aboriginal people, rates were 4.7 times as high in remote compared with non-remote areas (tables D2.10.5, D2.10.34). After adjusting for differences in the age structure between the two populations, Aboriginal people were 24 times as likely to be hospitalised for assault as non-Aboriginal Western Australians. Nationally over the same period, Aboriginal people were 13 times as likely to be hospitalised for assault as non-Aboriginal people (Figure 2.10.1).

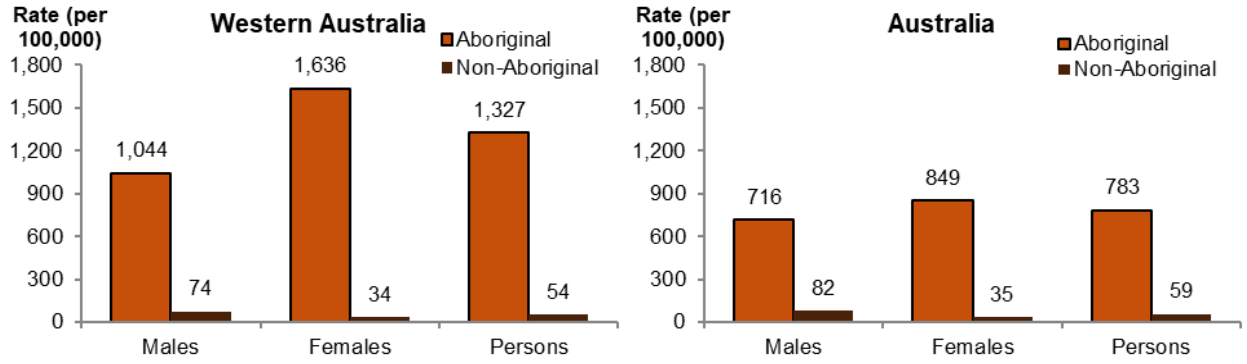
Hospitalisations for family violence-related assaults: This section includes hospitalisations (both fatal and non-fatal) for assault where the perpetrator was recorded as a spouse/domestic partner, parent, or other family member.

Between July 2021 and June 2023, there were 1,660 hospitalisations for family-violence related assaults among Aboriginal people in Western Australia, a rate of 679 per 100,000 population (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 51 times the rate for non-Aboriginal Western Australians. Nationally over the same period, the rate for Aboriginal people was 28 times the rate for non-Aboriginal people (Figure 2.10.2).

Homicide: Homicide data in this section includes murder and manslaughter but excludes driving causing death. In Western Australia in the 5 years 2019–2023, there were 36 deaths of Aboriginal people due to homicide, a rate of 6.0 homicides per 100,000 population (Table D2.10.9). After adjusting for differences in the age structure between the two populations, deaths due to homicide were 8.4 times as high for Aboriginal people as for non-Aboriginal people in Western Australia. In NSW, Qld, WA, SA and NT combined, from 2019–2023, deaths due to homicide were 4.9 times as high for Aboriginal people as for non-Aboriginal people (Figure 2.10.3).

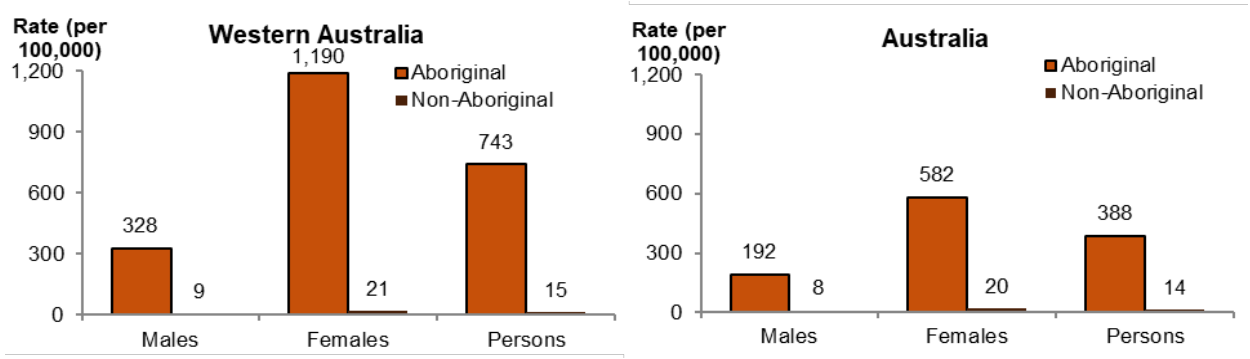
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



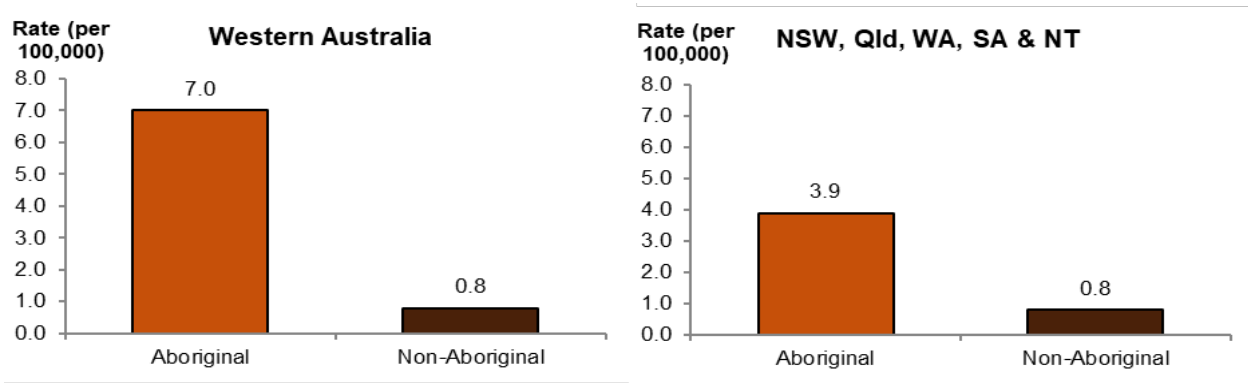
Source: Table D2.10.5.

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



Source: Table D2.10.36.

Figure 2.10.3: Age-standardised rates of homicide deaths, by Aboriginal status, Western Australia, and NSW, Qld, WA, SA and NT, 2019–2023



Source: Table D2.10.9.

2.11 Contact with the criminal justice system

Why it is important

This measure reports on Aboriginal 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.

Key findings

Youth justice supervision: In Western Australia, on an average day in 2023–24, 316 Aboriginal people aged 10–17 were under youth justice supervision (152 per 10,000). For non-Aboriginal people aged 10–17, the rate was 7.2 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).

Prison custody: On 30 June 2024 in Western Australia, 45% of adults in prison custody were Aboriginal (3,507 people, a crude rate of 4,417 per 100,000). The age-standardised rate of Aboriginal adults in prison custody was 20 times the rate for non-Aboriginal people (Figure 2.11.2).

Nationally on 30 June 2024, 36% of people in prison custody were Aboriginal (15,871 people, a crude rate of 2,469 per 100,000). The age-standardised rate for Aboriginal adults in prison custody was 16 times the rate for non-Aboriginal people (Figure 2.11.2).

Trend over time: In Western Australia, the rate of Aboriginal young people aged 10–17 who were under youth justice supervision on an average day decreased from 252 per 10,000 in 2016–17 to 152 per 10,000 in 2023–24. Based on linear regression, this corresponded to a decline of 45% in the rate of supervision for Aboriginal young people.

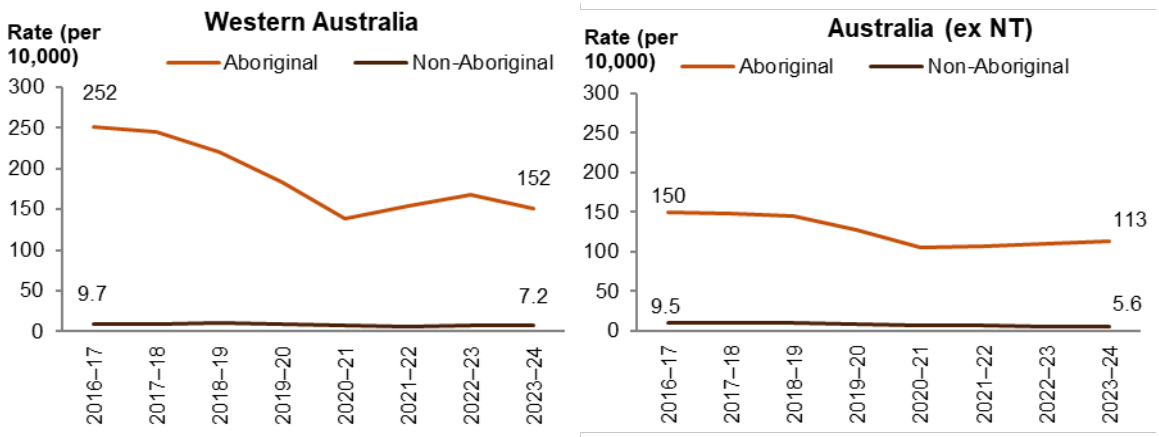
Nationally (excluding NT), the rate of Aboriginal young people aged 10–17 under youth justice supervision on an average day decreased from 150 per 10,000 in 2016–17 to 113 per 10,000 in 2023–24. Based on linear regression, this corresponded to a decline of 33% in the rate of supervision for Aboriginal young people (Figure 2.11.1).

In Western Australia, the age-standardised imprisonment rate for Aboriginal adults increased by 16%, from 3,055 per 100,000 in 2016 to 4,061 per 100,000 in 2024. Over the same period, the non-Aboriginal adult imprisonment rate decreased by 13%, from 213 to 205 per 100,000.

Nationally, the age-standardised imprisonment rate for Aboriginal adults increased by 25%, from 1,730 per 100,000 in 2016 to 2,318 per 100,000 in 2024. Over the same period, the imprisonment rate for non-Aboriginal adults decreased by 14%, from 163 to 146 per 100,000. (Figure 2.11.3).

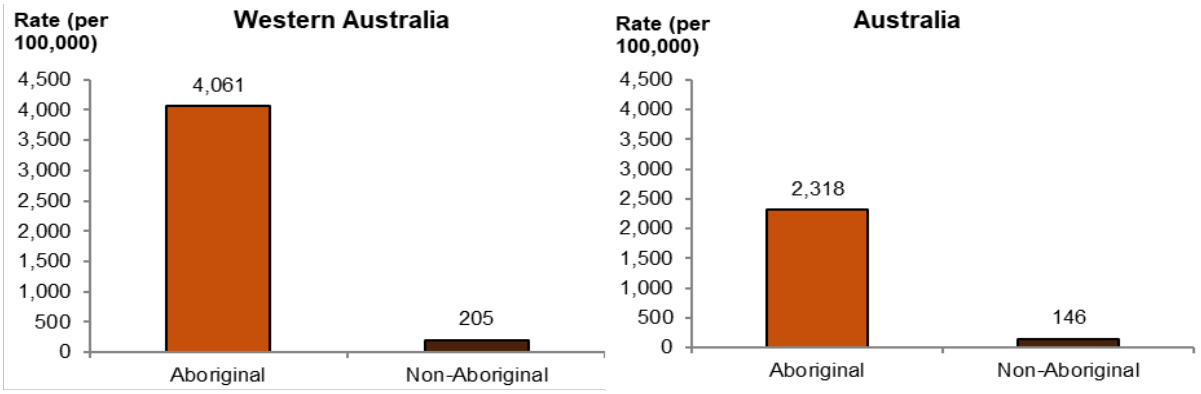
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.11.1: Rate of young people aged 10–17 under supervision on an average day, by Aboriginal status, Western Australia and Australia, 2016–17 to 2023–24



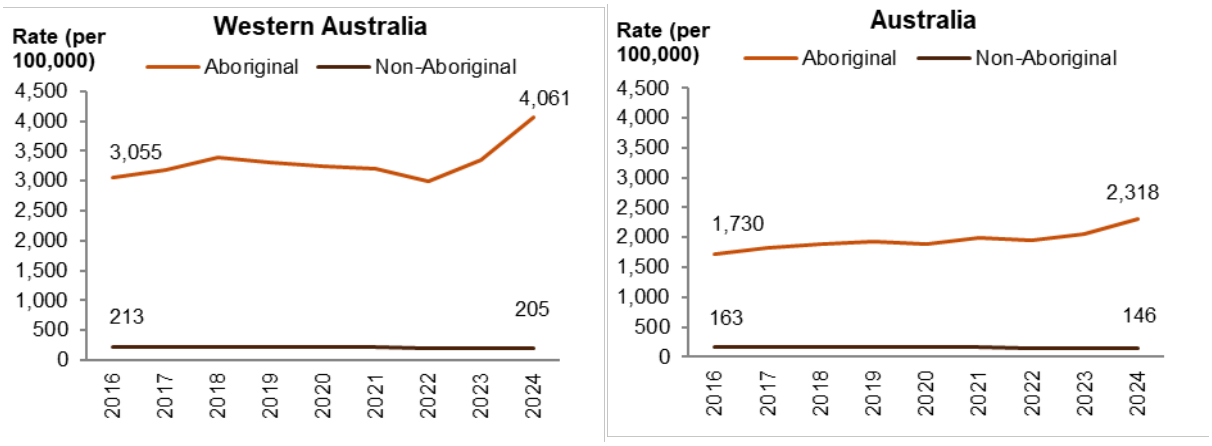
Source: Table D2.11.1.

Figure 2.11.2: Age-standardised adult imprisonment rate, by Aboriginal status, Western Australia and Australia, 30 June 2024



Source: Table D2.11.8.

Figure 2.11.3: Age-standardised adult imprisonment rate, by Aboriginal status, Western Australia and Australia, 2016 to 2024



Source: Table D2.11.12.

2.12 Child protection

Why it is important

This measure reports on Aboriginal 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 maltreatment, 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).

Key findings

Overall: In Western Australia in 2023–24, 8,573 Aboriginal children (aged under 18) came into contact with the child protection system – corresponding to a rate of 182 per 1,000 Aboriginal children (AIHW 2025d).

Substantiated maltreatment: In 2023–24 in Western Australia, 2,186 Aboriginal children were the subjects of substantiated maltreatment (46 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 Western Australia was 11.3 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 no statistically significant change in the rate of substantiated maltreatment among Aboriginal children in Western Australia, however the decrease for Aboriginal children nationally was statistically significant (Figure 2.12.1).

Care and protection orders: At 30 June 2024 in Western Australia, there were 3,389 Aboriginal children on care and protection orders (72 per 1,000 children) (Table D2.12.7). Of these 3,389 children; 20% were aged under 5, 28% were aged 5–9, 32% were aged 10–14, and 20% were aged 15–17 (Table D2.12.6).

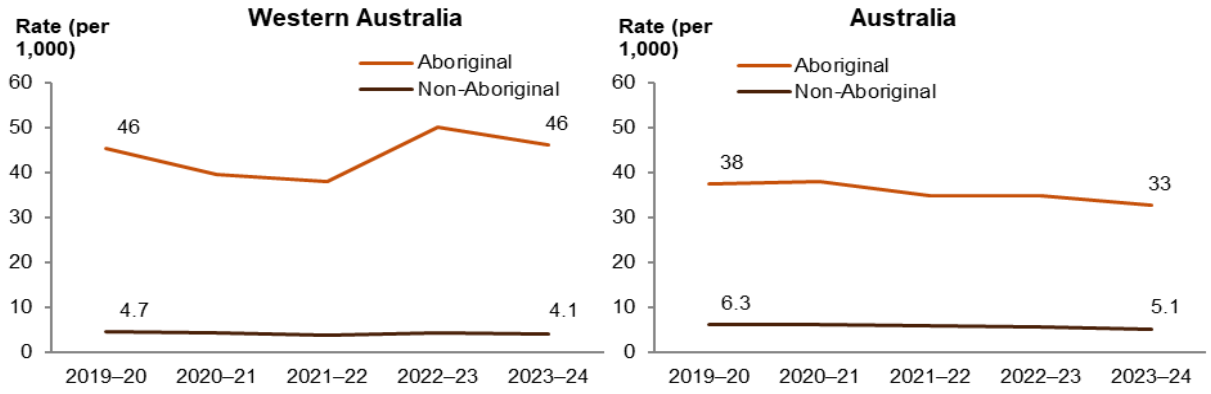
In 2023–24 the rate of Aboriginal children on care and protection orders in Western Australia was 18 times the rate for non-Aboriginal children. Nationally, the rate among Aboriginal children was 9.8 times the rate for non-Aboriginal children (Table D2.12.7).

Care and protection orders 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 Western Australia (from 73 to 71.5 per 1,000), although this decrease was not statistically significant. Nationally, over the same time period, the rate among Aboriginal children increased significantly from 61 to 63 per 1,000 children (Figure 2.12.2).

Out-of-home care: At 30 June 2024 in Western Australia, there were 2,766 Aboriginal children in outofhome care (58 per 1,000 children). Over half (58%) of these children were living with Aboriginal or non-Aboriginal relatives or kin or other Aboriginal caregivers. Nationally, there were 20,023 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).

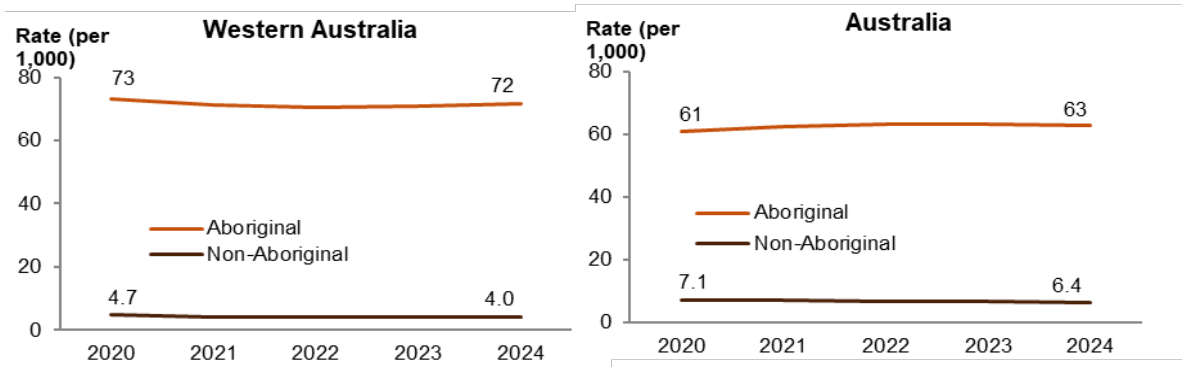
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



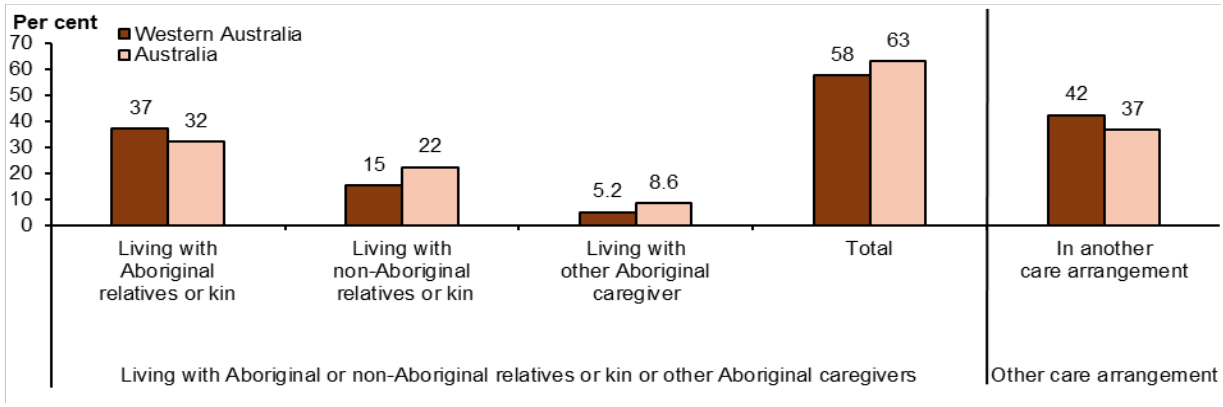
Source: Table D2.12.5.

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



Source: Table D2.12.11.

Figure 2.12.3: Aboriginal children in out-of-home care, by relationship of carer, Western Australia 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: 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 for Aboriginal people. 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 obligations to travel to family commitments (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). Note – 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. The following data therefore cannot be updated.

Key findings

Overall: In Western Australia in 2014–15, an estimated 70% (39,900) of Aboriginal people aged 15 and over reported they can easily get to places needed; as did 86% of non-Aboriginal people. Aboriginal people in Western Australia were 6.8 times as likely as non-Aboriginal people (11% compared with 1.6%) 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 can 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).

Access to a motor vehicle: In Western Australia in 2014–15, an estimated 70% (40,000) of Aboriginal people aged 15 and over reported that they had access to a motor vehicle. This was 0.8 times the proportion for non-Aboriginal people (87%).

Nationally in 2014–15, 75% 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).

Use of public transport: In 2014–15 in Western Australia, an estimated 33% (18,600) of Aboriginal people aged 15 and over (who were not housebound) had used public transport in the last 2 weeks.

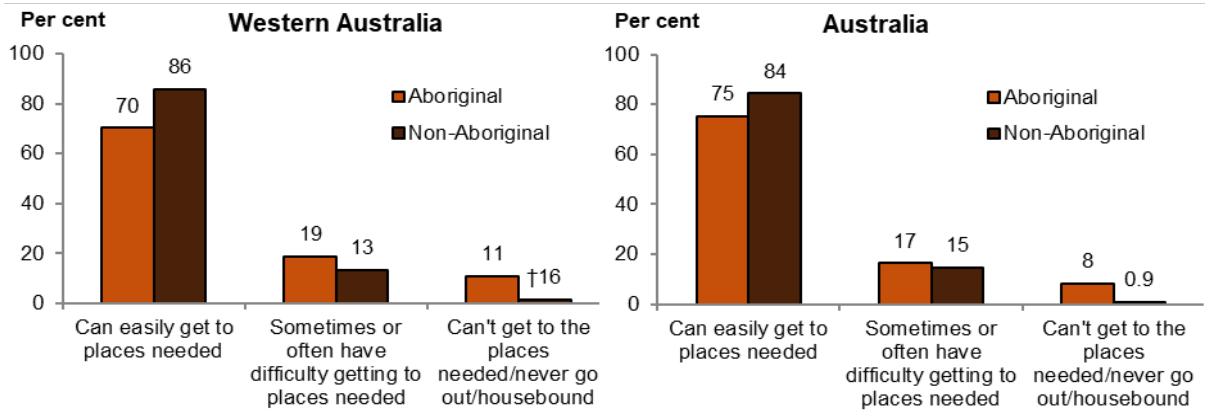
Nationally in 2014–15, 29% of Aboriginal people (who were not housebound) had used public transport in the last 2 weeks (Table D2.13.9).

Access to public transport: In 2014–15 in Western Australia, public transport was available to 74% of Aboriginal people aged 15 and over. Of those who could access it, 81% 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).

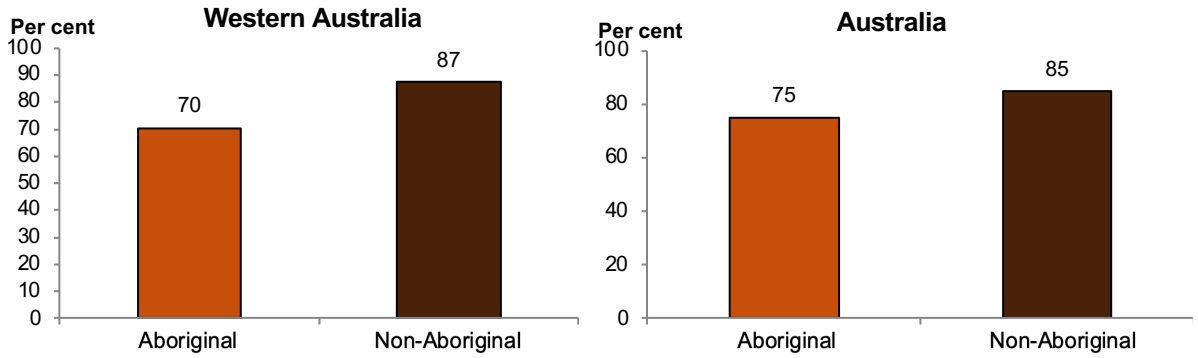
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



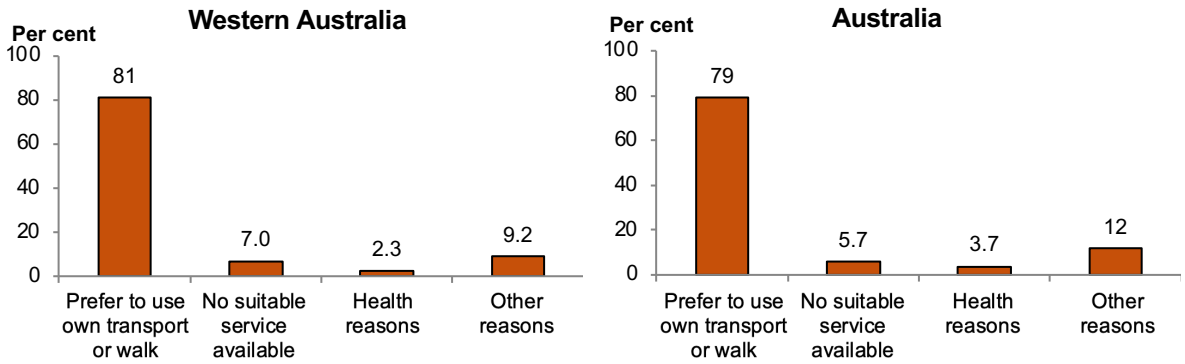
Note: Estimate marked with † has a relative standard error between 25% and 50% and should be used with caution.
Source: Table D2.13.4.

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



Source: Table D2.13.8.

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, Western Australia and Australia, 2014–15



Source: 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: In 2022–23 in Western Australia, an estimated 85% (58,300) 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 87% in remote and 74% in non-remote areas of Australia (Table D2.14.1).

Living on homelands or traditional Country: In 2022–23 in Western Australia, an estimated 27% (18,500) 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 Western Australia, an estimated 54% (36,900) of Aboriginal people aged 18 and over were allowed to visit their homelands or traditional Country, and 0.7% (500) reported not being allowed to visit.

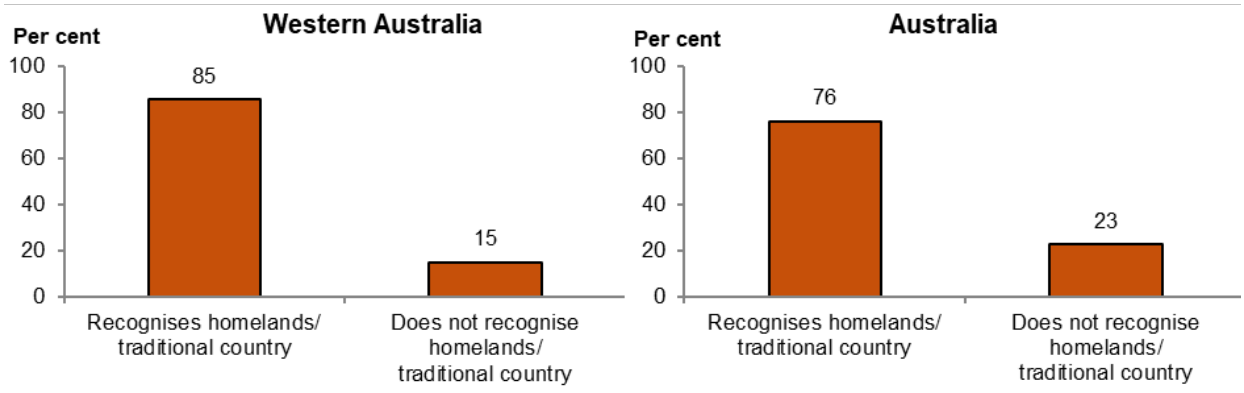
Nationally in 2022–23, 52% of Aboriginal people aged 18 and over were allowed to visit their homelands or traditional Country, and 0.9% reported not being allowed to visit (Figure 2.14.2).

Identifying with clan, tribal or language group: In 2022–23 in Western Australia, an estimated 50,300 (74%) Aboriginal people aged 18 and over identified with a tribal/language group or clan. The proportion that did not identify was 24%.

Nationally in 2022–23, about 2 in 3 (66%) 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).

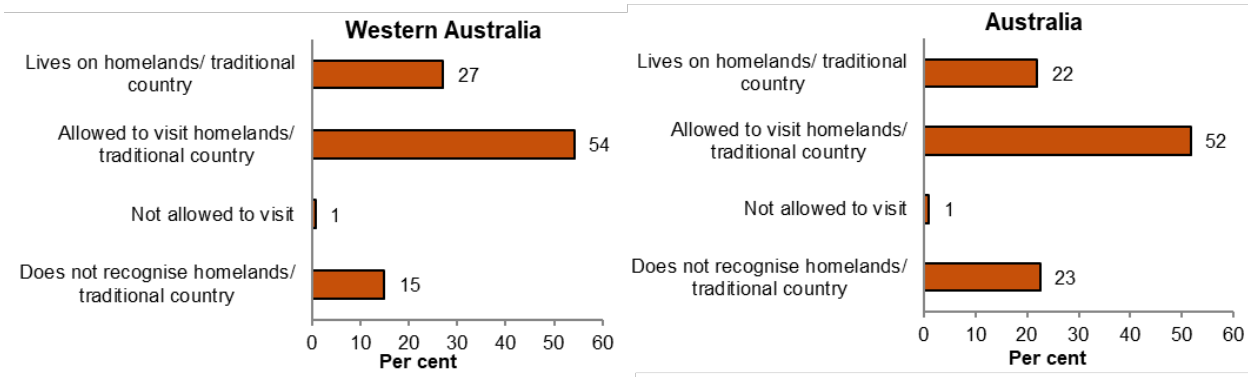
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



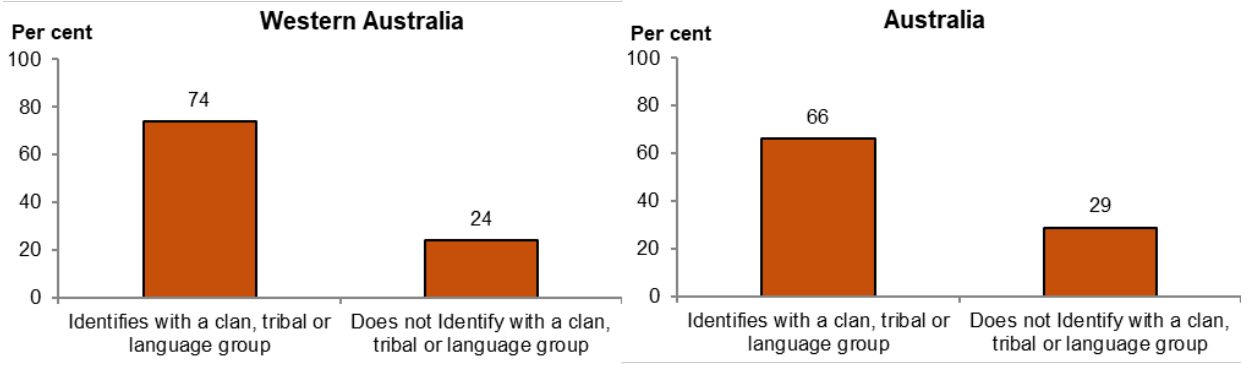
Source: Table D2.14.6.

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



Source: Table D2.14.6.

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



Source: Table D2.14.6.

2.15 Tobacco use

Why it is important

This measure reports on the smoking status of Aboriginal people. 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: In 2022–23 in Western Australia, an estimated 34% (26,800) of Aboriginal people aged 15 and over were current smokers, 26% (20,400) were ex-smokers and two fifths (41%, 32,200) had never smoked. After adjusting for differences in the age structure between the two populations, Aboriginal people aged 15 and over were 3.2 times as likely to be a current smoker as non-Aboriginal people (Figure 2.15.1).

Nationally in 2022–23, 32% of Aboriginal people reported they were current smokers, 1 in 4 (26%) were ex-smokers and just over two fifths (43%) had never smoked. 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 (Figure 2.15.1).

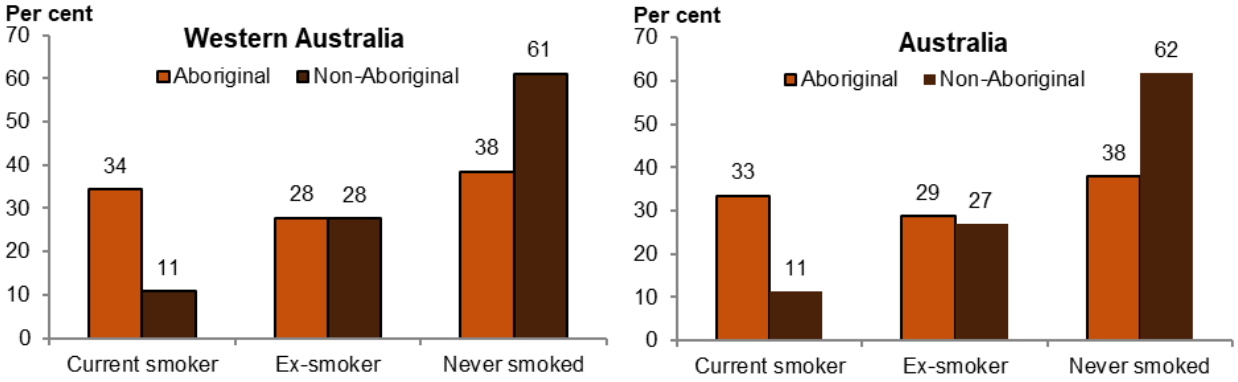
Remoteness: In 2022–23 in Western Australia, an estimated 52% (13,100) of Aboriginal people aged 18 and over in remote areas and 28% (12,800) in non-remote areas were current smokers. Nearly one in five (4,800) Aboriginal people in remote areas were ex-smokers compared with 33% (15,300) in non-remote areas (this proportion has a high margin of error and should be interpreted with caution) (Figure 2.15.2) (ABS 2024d, Table 56.1).

Trend over time: The proportion of Aboriginal people aged 15 and over in Western Australia that were current smokers decreased from 48% in 2002 to 34% 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).

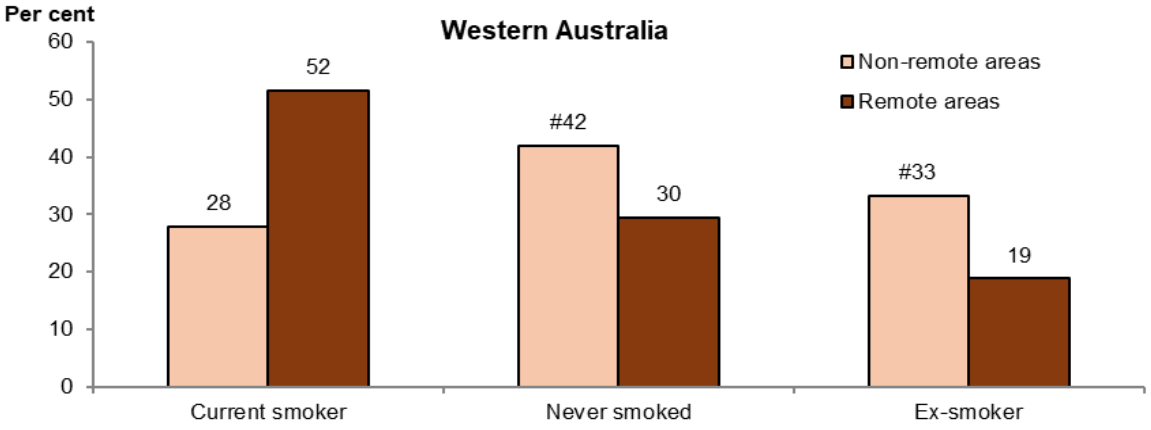
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.15.1: Age-standardised smoking rates by Aboriginal status, people aged 15 and over Western Australia and Australia, 2022–23



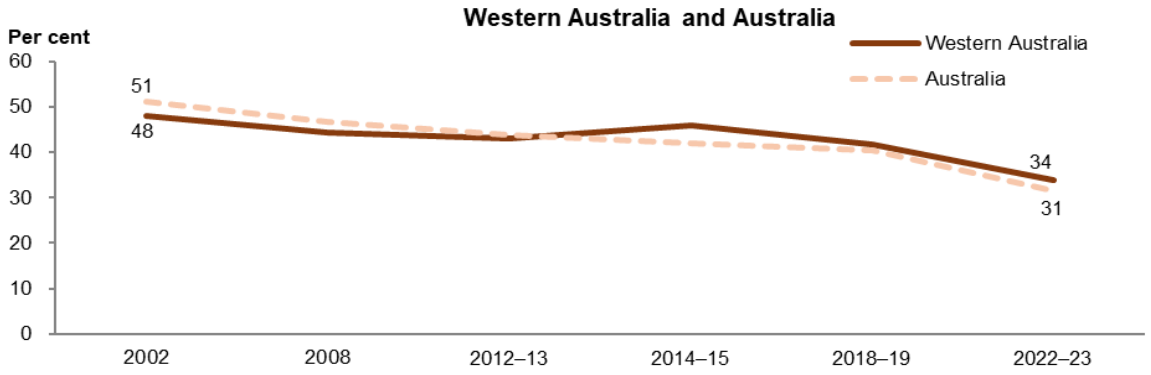
Source: Table D2.15.7

Figure 2.15.2: Smoking status, by remoteness, Aboriginal people aged 18 and over, Western Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: ABS 2024d Table 56.3.

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



Source: Table D2.15.1

2.16 Risky alcohol consumption

Where to find help and support: This measure and the following present information and data on alcohol or other drugs. 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 alcohol consumption levels for Aboriginal people. Excessive consumption of alcohol is associated with health and social problems in all populations (NHMRC 2009). 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). 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. Comparisons with non-Aboriginal Australians are not available in these data.

Key findings

Abstinence: In the Western Australia in 2022–23, an estimated 23% (16,200) of Aboriginal people aged 18 and over reported abstaining from alcohol in the previous 12 months. Nationally, in 2022–23, 18% of Aboriginal people aged 18 and over reported abstaining from alcohol in the previous 12 months (Figure 2.16.1).

Risky alcohol consumption: In Western Australia in 2022–23, 38% (27,000) of Aboriginal people aged 18 and over reported consuming alcohol in quantities that exceeded the guidelines in the past 12 months. Nationally, the proportion was 36% (Figure 2.16.1).

Remoteness: In 2022–23, the proportion of Aboriginal people aged 18 and over in Western Australia who abstained from alcohol in the previous 12 months was 22% (10,000) in non-remote areas and 26% (6,700) in remote areas. The proportion of Aboriginal people aged 18 and over exceeding the alcohol risk guidelines was 36% (16,500) in non-remote areas (this proportion has a high margin of error and should be interpreted with caution) and 43% (10,800) in remote areas (Figure 2.16.2).

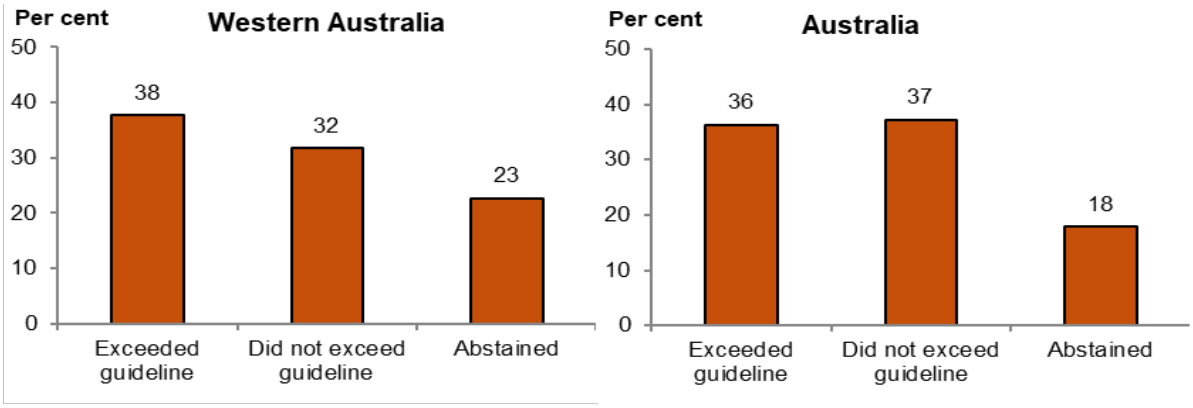
Hospitalisation: Over the period July 2021 to June 2023, in Western Australia there were 2,419 hospitalisations of Aboriginal people with a principal diagnosis related to alcohol use, which corresponded to a rate of 989 hospitalisations per 100,000 population. Hospitalisation rates were higher in remote areas (1,155 per 100,000) than in non-remote areas (767 per 100,000) (Table D2.16.23).

Hospitalisation changes over time: Between 2016–17 and 2022–23, the age-standardised rate of hospitalisation relating to alcohol use for Aboriginal people in Western Australia decreased from 1,464 per 100,000 to 1,169 per 100,000. In contrast, rates for non-Aboriginal people increased from 175 per 100,000 in 2016–17 to a peak of 208 per 100,000 in 2020–21, before declining to 185 per 100,00 in 2022–23.

In Australia, between 2016–17 and 2022–23, the age-standardised hospitalisation rate related to alcohol use for Aboriginal people decreased by 8.4%, from 1,061 per 100,000 to 923 per 100,000. For non-Aboriginal people, the rate increased by 14%, from 252 per 100,000 to 276 per 100,000 over the same period (Figure 2.16.3).

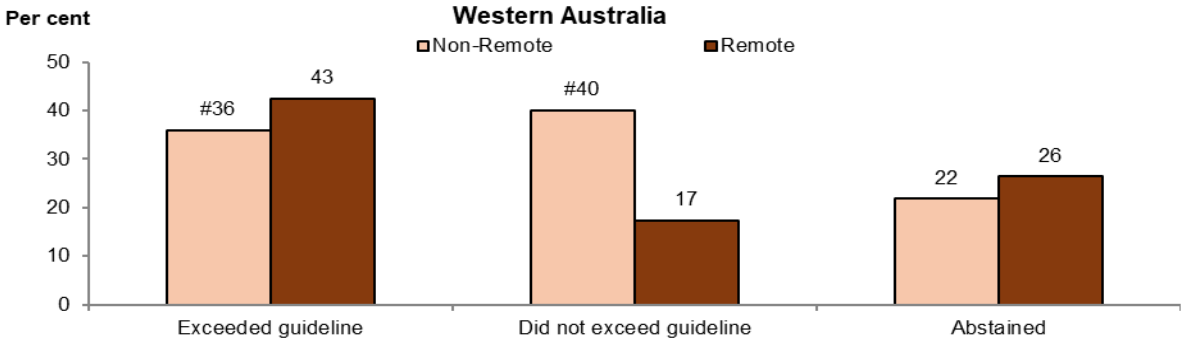
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.16.1: Alcohol risk levels, Aboriginal people aged 18 and over, Western Australia and Australia, 2022–23



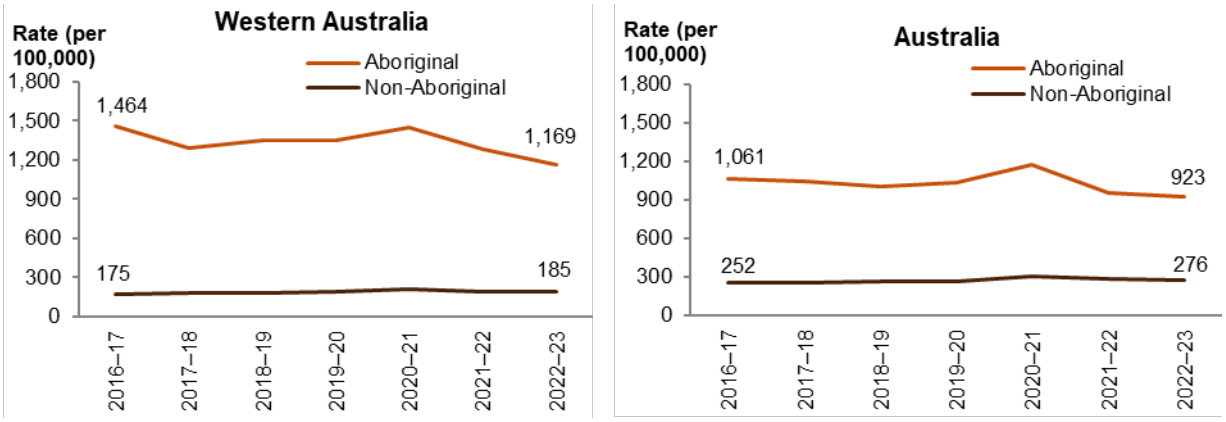
Source: ABS 2024d Table 56.3.

Figure 2.16.2: Alcohol consumption in the last 12 months, Aboriginal people aged 18 and over, by remoteness, Western Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: ABS 2024d Table 56.3.

Figure 2.16.3: Age-standardised hospitalisation rates for alcohol-related hospitalisations by Aboriginal status, Western Australia, and Australia, 2016–17 to 2022–23



Source: Table D2.16.13 WA.

2.17 Drug and other substance use including inhalants

Why it is important

This measure reports on the use of drugs and other substances for Aboriginal people, 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 & 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 Australians' involvement in the criminal justice system (see measure 2.11 Contact with the criminal justice system).

Key findings

Overall: In 2022–23 in Western Australia, an estimated 26% (15,800) of Aboriginal people aged 18 and over reported using substances for non-medical purposes in the last 12 months. An estimated 33% (9,400) of Aboriginal males and 22% (6,900) of Aboriginal females had used substances in the last 12 months (Figure 2.17.1). Nationally, an estimated 26% of Aboriginal people aged 18 and over reported using substances in the last 12 months (ABS 2024d, Table 56.1).

Hospitalisations: In Western Australia, from July 2021 to June 2023, there were 1,410 hospitalisations of Aboriginal people with a principal diagnosis related to drug use, which corresponded to a rate of 577 hospitalisations per 100,000 population. Hospitalisation rates were higher in non-remote areas (584 per 100,000) than in remote areas (449 per 100,000) (Table D2.17.8). After adjusting for age in the two populations, the hospitalisation rate with a principal diagnosis related to drug use in Western Australia for Aboriginal people was 3.7 times the hospitalisation rate for non-Aboriginal people (Figure 2.17.2).

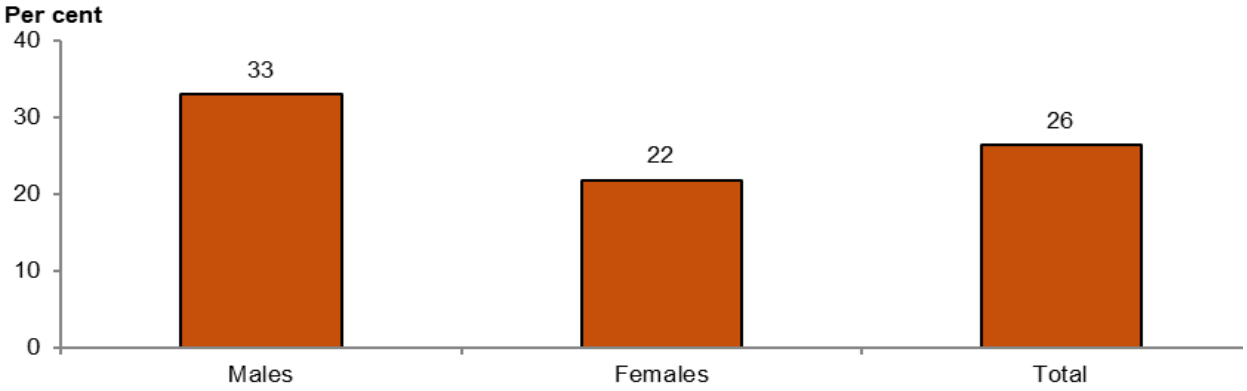
Nationally, from July 2021 to June 2023, there were 12,879 hospitalisations of Aboriginal people with a principal diagnosis related to drug use, which corresponded to a rate of 643 hospitalisations per 100,000 population. Hospitalisation rates were higher in non-remote areas (626 per 100,000) than in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

Police detainees: In 2021, in Western Australia (Perth police watch house), of the 60 Aboriginal detainees who provided a urine sample 88% tested positive to a drug. Among the 151 non-Aboriginal detainees who provided a urine sample the rate was 73% (Table D2.17.12).

Trend over time: From 2012 to 2021, the rate of Aboriginal detainees in Western Australia (Perth) who provided urine during selected state collections, and tested positive to a drug, increased from 75% to 88%. The rate for non-Aboriginal detainees varied between a low of 68% in 2012 and a high of 88% in 2020 (Figure 2.13.3).

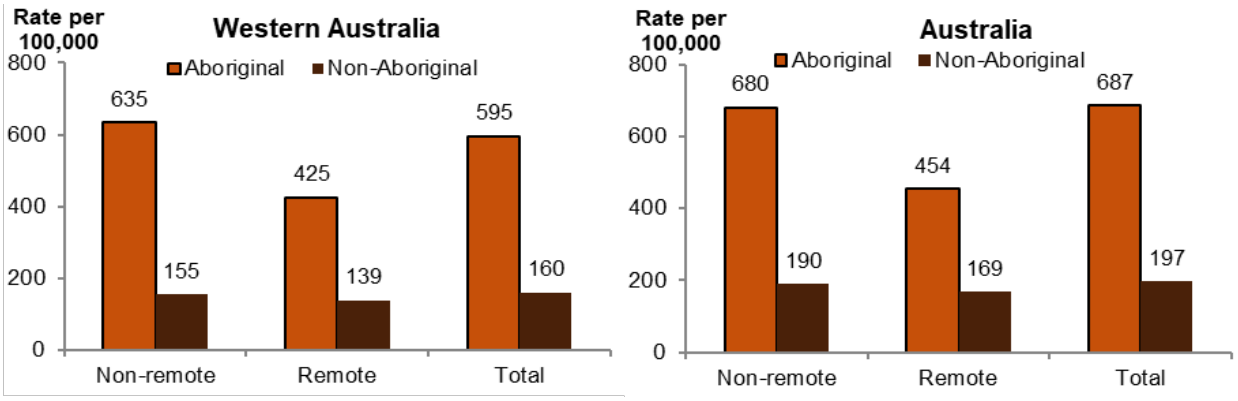
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.17.1: Aboriginal people aged 18 and over reporting substance use in the last 12 months, by sex, Western Australia, 2022–23



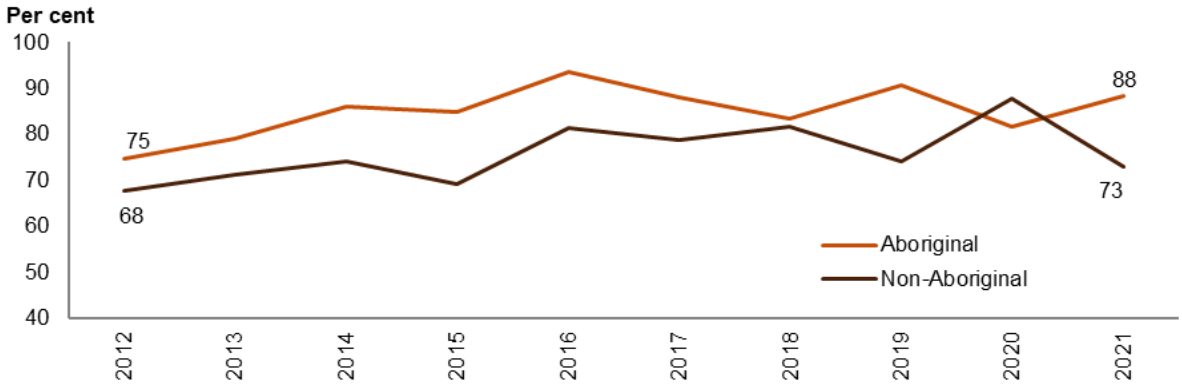
Source: ABS 2024d Table 56.3.

Figure 2.17.2: Age-standardised hospitalisation rates for drug-related hospitalisations, by Aboriginal status, remoteness, Western Australia and Australia, July 2021 to June 2023



Source: Table D2.17.8.

Figure 2.17.3: Detainees who provided urine during selected state collections who tested positive to a drug, by Aboriginal status, Western Australia, 2012 to 2021



Note: Data are collected in Sydney, Brisbane, Perth and Adelaide.
Source: Table D2.17.12.

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 National Aboriginal and Torres Strait Islander Health Survey 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 2024e).

In Western Australia in 2022–23, an estimated 16% (7,900 – this estimate has a relative standard error of 25% to 50% and should be used with caution) of Aboriginal people aged 15 and over living in non-remote areas had undertaken a sufficient level of physical activity in the week prior. Around 1 in 5 (20%; 9,900) had done 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. Around 1 in 5 (19.0%) had done no physical activity in the last week (Figure 2.18.1, Table D2.18.8).

Children's daily activity: In 2014–15 in Western Australia, an estimated 79% of Aboriginal children aged 4–14 had undertaken at least 60 minutes of physical activity every day. This is similar to the proportion in 2008 (80%).

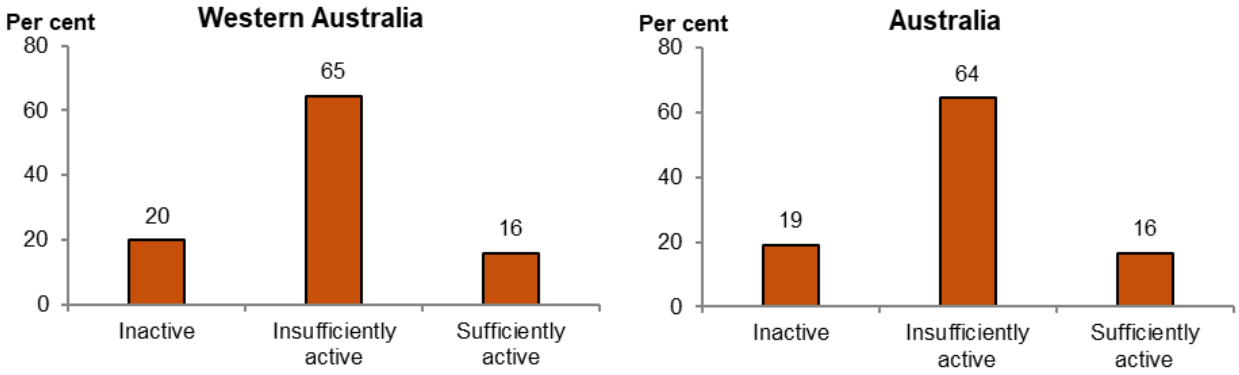
Nationally in 2014–15, 76% of children aged 4–14 had undertaken at least 60 minutes of physical activity every day. This is similar to the proportion in 2008 (74%) (Figure 2.18.2).

Children's days of physical activity: In 2014–15 in Western Australia, an estimated 79% of Aboriginal children aged 4–14 were physically active every day of the previous week, and 12% were active on 4–6 days (this estimate has a relative standard error between 25% and 50% and should be interpreted with caution).

Nationally in 2014–15, 76% of Aboriginal children aged 4–14 were physically active every day of the previous week, and 13% were active on 4–6 days (Figure 2.18.3).

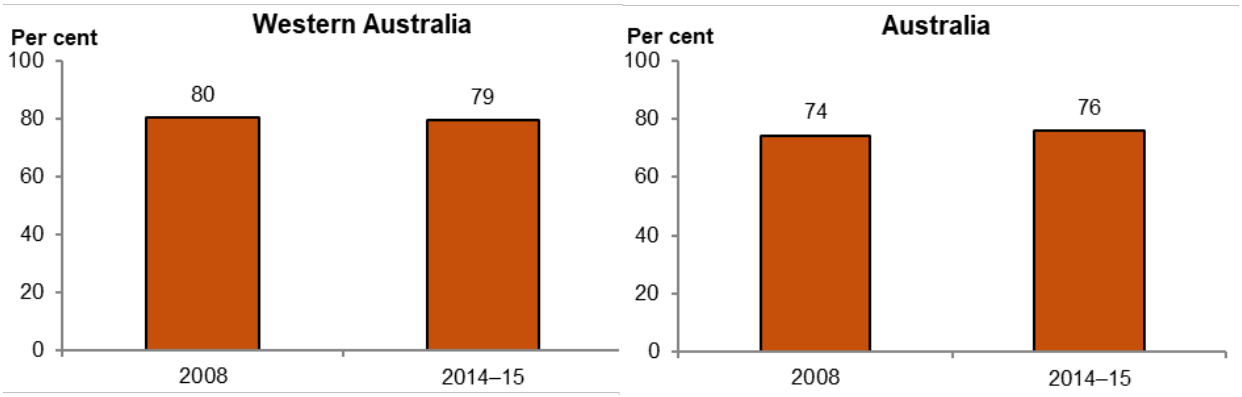
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



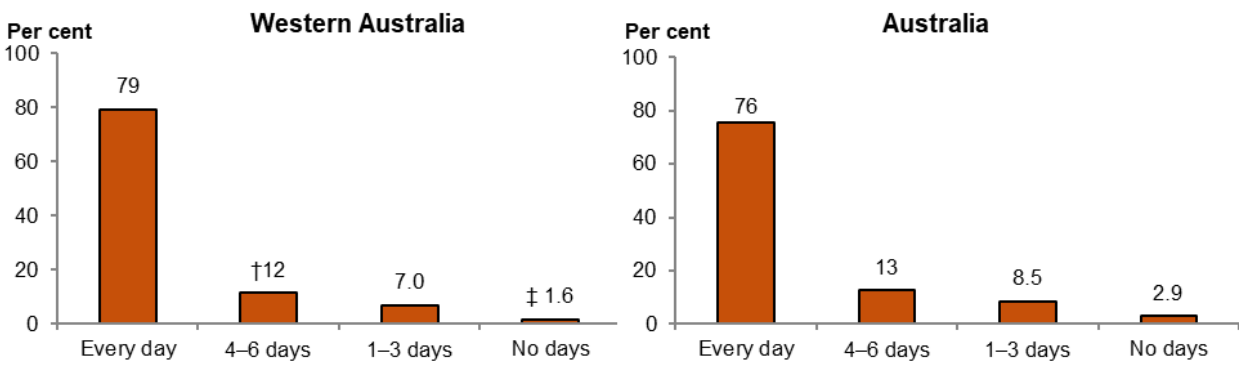
Source: Table D2.18.8

Figure 2.18.2: Proportion of Aboriginal children aged 4–14 undertaking physical activity every day for at least 60 minutes, Western Australia and Australia, 2008 and 2014–15



Source: Table D2.18.3.

Figure 2.18.3: Number of days last week when child was physically active for at least 60 minutes, Aboriginal children aged 4–14, Western Australia and Australia, 2014–15



Note Estimate marked with † has a relative standard error between 25% and 50% and should be used with caution.
Estimate marked with ‡ has a relative standard error greater than 50% and is considered unreliable for general purpose.

Source: Table D2.18.2.

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; NHMRC 2013). 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.

Key findings

Consumption of fruit: In 2022–23 in Western Australia, an estimated 21% (24,000) of Aboriginal people (aged 2 and over) ate less than one serve of fruit a day. Around 1 in 4 Aboriginal people living in remote areas (24%, 9,000) of Western Australia ate less than one serve of fruit a day and 1 in 5 (20%; 14,700) living in non-remote areas ate less than one serve of fruit a day. 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).

Less than half (43% in Western Australia and 44% nationally) of Aboriginal people aged 2 and over ate the recommended daily amount of fruit (Table D2.19.6).

Consumption of vegetables: In 2022–23 in Western Australia, an estimated 6.8% (7,600) of Aboriginal people (aged 2 and over) ate less than one serve of vegetables a day. A similar proportion of Aboriginal people living in non-remote and remote areas of Western Australia ate less than one serve of vegetables a day (7.1% and 7.2%, respectively). 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).

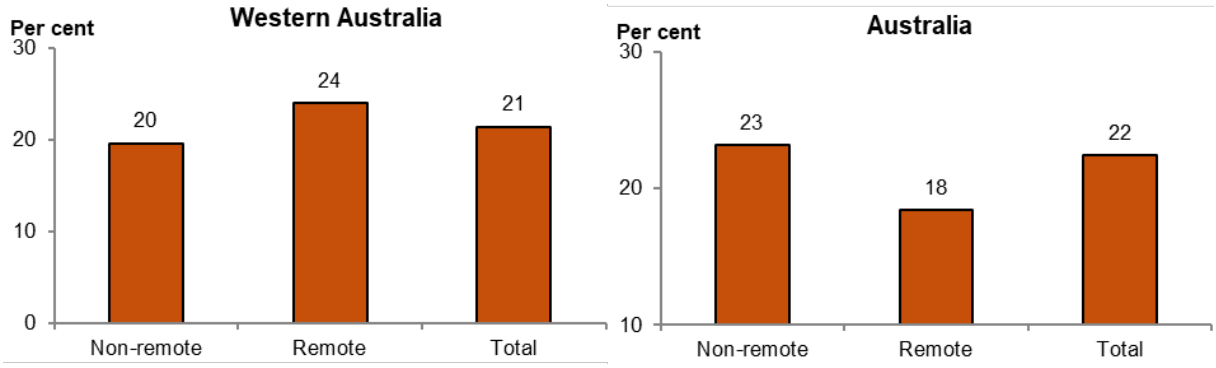
Less than 1 in 10 (6.9% in Western Australia and 5.4% nationally) Aboriginal people aged 2 and over ate the recommended daily amount of vegetables (Table D2.19.6).

Children's consumption of fruit: In 2022–23 in Western Australia, 11% of Aboriginal children aged 2–14 ate less than one serve of fruit a day, 27% ate one serve to less than 2 serves and 62% ate at least 2 serves. Nationally in 2022–23, 8.6% of Aboriginal children aged 2–14 ate less than one serve of fruit a day, 32% ate one serve to less than 2 serves and 60% ate at least 2 serves (Table D2.19.9, Figure 2.19.3).

Children's consumption of vegetables: In 2022–23 in Western Australia, an estimated 10% of Aboriginal children aged 2–14 ate less than one serve of vegetables a day, 30% ate one serve to less than 2 serves and 29% ate 2 serves to less than 3 serves. Nationally in 2022–23, 13% of Aboriginal children aged 2–14 ate less than one serve of vegetables a day, 35% ate one serve to less than 2 serves and 31% ate 2 serves to less than 3 serves (Figure 2.19.3).

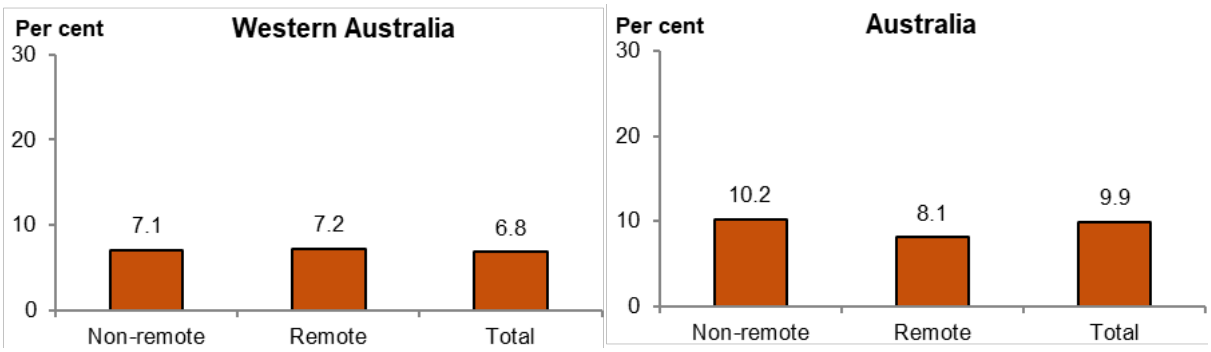
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



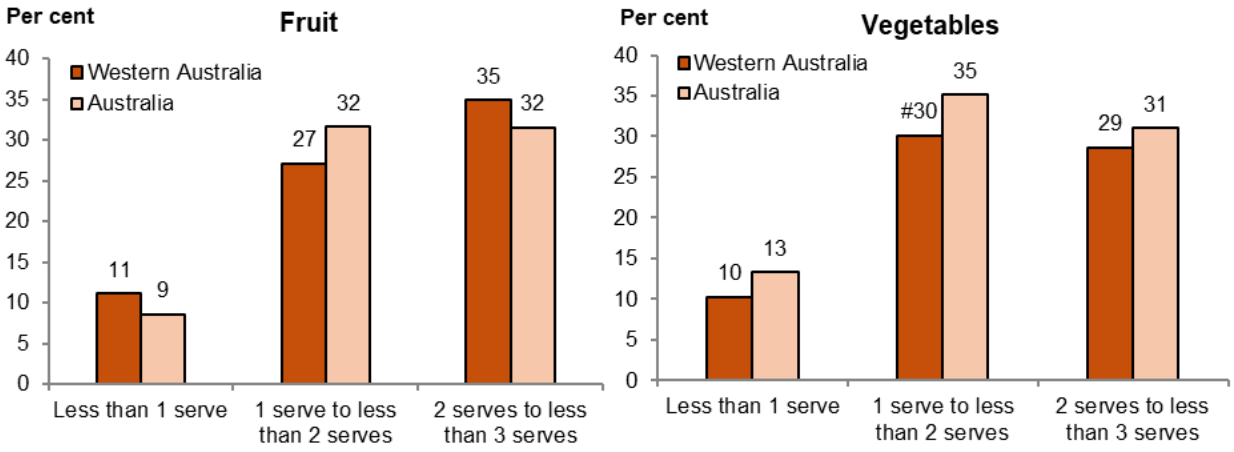
Source: Table D2.19.2.

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



Source: Table D2.19.3.

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



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D2.19.9.

2.20 Breastfeeding practices

Why it is important

This measure reports on 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 et al. 2012; Horta et al. 2015; Kramer et al. 2008)

Key findings

Children aged 0–3: In 2022–23 in Western Australia, approximately 89% (8,600) of Aboriginal children aged 0–3 had ever been breastfed (note this estimate has a high margin of error and should be used with caution). Nationally, an estimated 82% of Aboriginal children aged 0–3 were reported to have been or were currently breastfed (Figure 2.20.1).

Breastfeeding duration (children aged 0–3): In 2022–23 in Western Australia, of Aboriginal children aged 0–3 who were reported to have been breastfed, an estimated 26% were breastfed for 1 month to less than 6 months. For non-Aboriginal children, 24% were breastfed for 1 month to less than 6 months. These estimates have a high margin of error and should be used with caution.

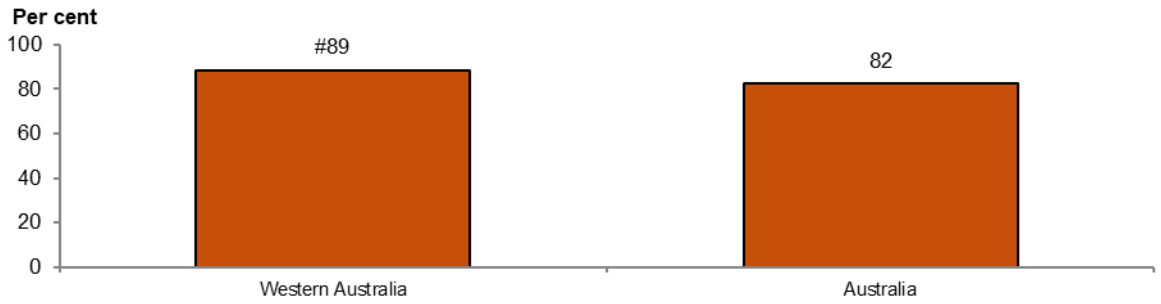
Nationally, for Aboriginal children aged 0–3, 26% were breastfed for 1 month to less than 6 months. For non-Aboriginal children aged 0–3, 16% were breastfed for 1 month to less than 6 months (Figure 2.20.2).

Remoteness (children aged 0–3): Nationally in 2022–23, the proportion of Aboriginal children aged 0–3 who were reported to have been or are currently breastfed was an estimated 84% in non-remote areas and 79% in remote areas (Figure 2.20.3).

Nationally in 2022–23, the proportions 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% in non-remote areas and 37% in remote areas (this proportion has a high margin of error and should be used with caution) (Figure 2.20.3).

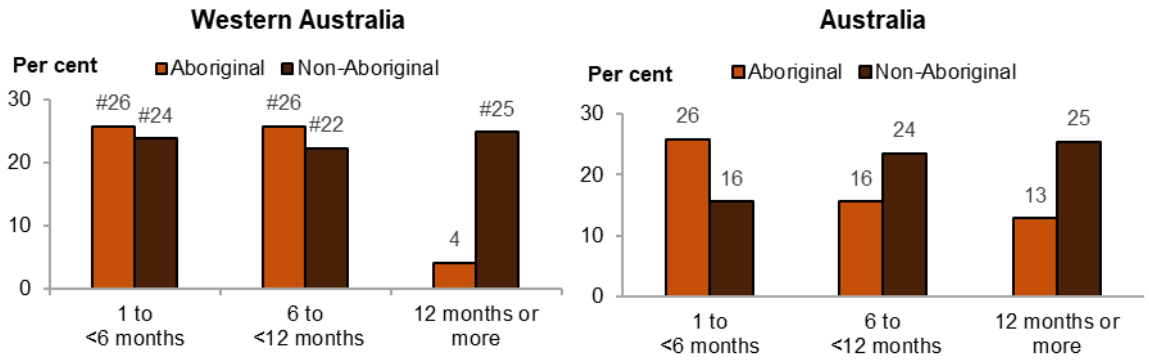
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.20.1: Total ever breastfed (current or ceased), Aboriginal children aged 0–3, Western Australia and Australia, 2022–23



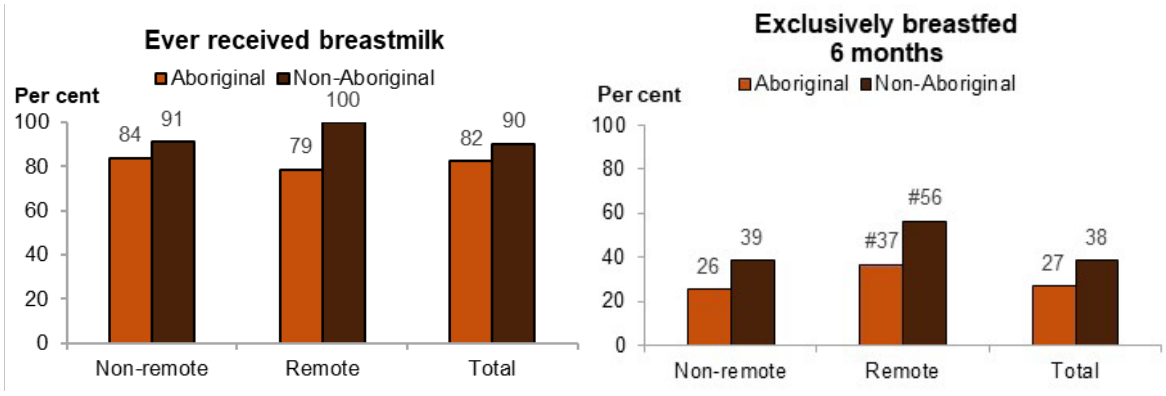
Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D2.20.2.

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



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D2.20.2.

Figure 2.20.3: 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: 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 healthrelated behaviours during pregnancy of Aboriginal women. Many Aboriginal women have healthy pregnancies (Clarke & Boyle 2014). The health and wellbeing of women during pregnancy is vitally important to ensuring healthy outcomes for mothers and their babies (AIHW 2020a; 2025b). 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 low birthweight), and ongoing health concerns.

Key findings

Smoking: In Western Australia, 40% (770) of Aboriginal women who gave birth in 2023 reported that they had smoked during pregnancy. After adjusting for age differences between the two populations, this was 6.3 times the rate for non-Aboriginal women (43% compared with 6.8%).

Nationally, 39% of Aboriginal women who gave birth in 2023 reported that they had smoked during pregnancy. After adjusting for age differences between the two populations, this was 4 times the rate for non-Aboriginal women (39% compared with 9.5%) (Figure 2.21.1).

Smoking and maternal age: In Western Australia, in 2023 the proportion of Aboriginal mothers who smoked was higher compared with non-Aboriginal mothers across all age groups. More than 2 in 5 Aboriginal mothers aged under 20 (44%, 102) and aged 35–49 (47%, 82) smoked during pregnancy.

Similarly in 2023, nationally, the proportion of Aboriginal mothers who smoked was higher compared with non-Aboriginal mothers across all age groups. More than 2 in 5 Aboriginal mothers aged under 20 (42%) and aged 40 and older (41%) smoked during pregnancy (Figure 2.21.2).

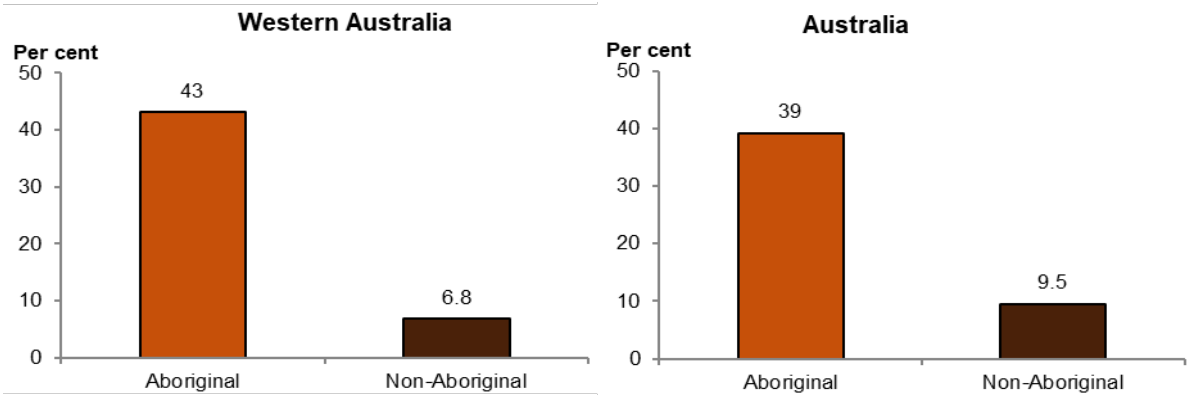
Alcohol and drug use during pregnancy: In 2022–23 in Western Australia, among mothers of Aboriginal children aged 0–3, most (more than 90%) did not consume alcohol or use illicit drugs during pregnancy (Table D2.21.6). These estimates have a high margin of error and should be used with caution.

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

Health behaviours and remoteness: Nationally in 2022–23, mothers of Aboriginal children aged 0–3 years who lived in remote areas were more likely to have used tobacco during their pregnancy compared to mothers who lived in non-remote areas (36% and 17% respectively). Alcohol consumption during pregnancy was reported by 5.0% of mothers in non-remote areas and 13% of mothers in remote areas, while illicit drug use was reported by 7.1% of mothers in non-remote areas and 5.8% of those in remote areas (Figure 2.21.3).

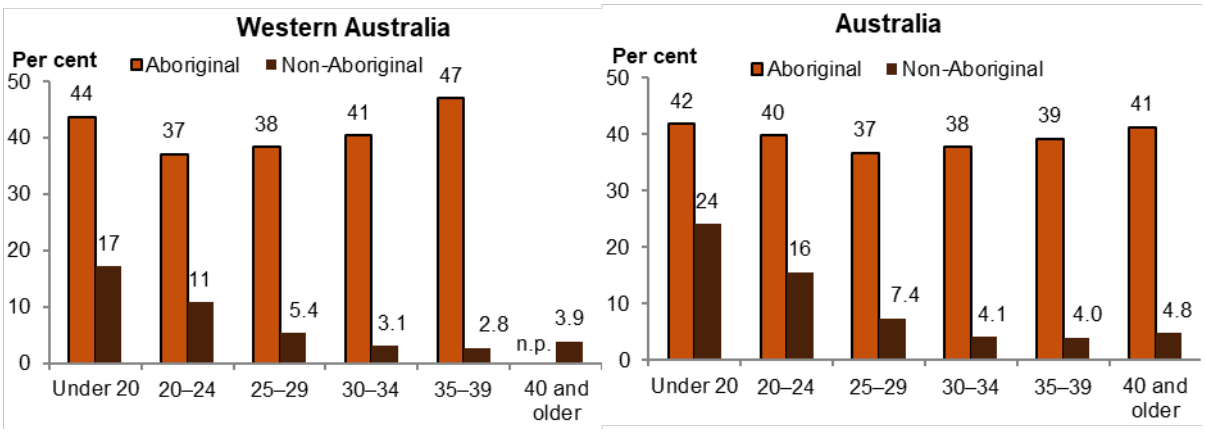
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 2.21.1: Age-standardised rate of smoking during pregnancy, by Aboriginal status of the mother, Western Australia and Australia, 2023



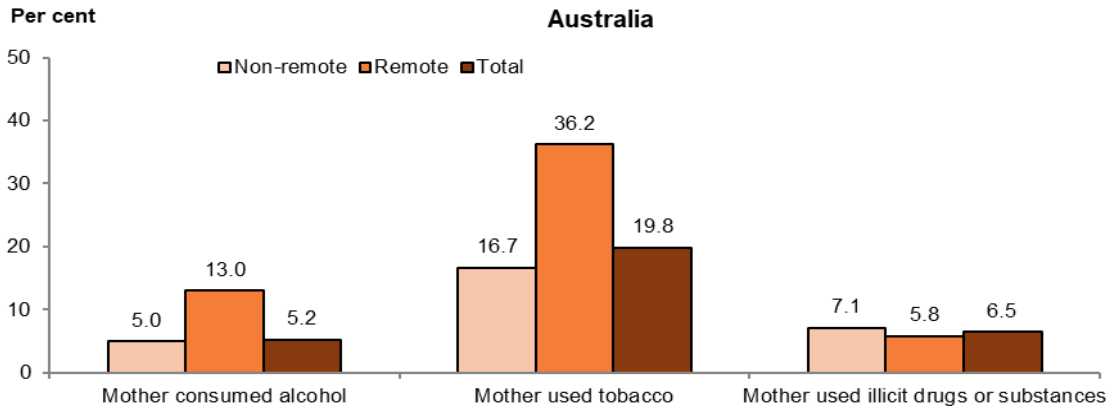
Source: AIHW 2025i Table 6.9.

Figure 2.21.2: Mothers who smoked during pregnancy, by Aboriginal status and maternal age, Western Australia and Australia, 2023



n.p. Not provided due to small numbers
Source: AIHW 2025i Table 6.10.

Figure 2.21.3: Mother's tobacco and alcohol use during pregnancy, Aboriginal children aged 0–3 years, by remoteness areas, Australia, 2022–23



Source: Table D2.21.7.

2.22 Overweight and obesity

Why it is important

This measure reports on the proportion of Aboriginal 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 refers to abnormal or excessive fat accumulation that may impair health (WHO 2024b). 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. Overweight (including obesity) was the third leading risk factor contributing to the burden of disease among Aboriginal people in 2018 (contributing 9.7% of all burden) (AIHW 2022b).

Key findings

The 2022–23 National Aboriginal and Torres Strait Islander Health Survey included height and weight measurements, to allow Body Mass Index (BMI) to be calculated. BMI is used to classify people as underweight (BMI<18.5), normal weight (BMI 18.5–24.9), overweight (BMI 25–29.9) or obese (BMI>30.0).

Overall: In Western Australia in 2022–23, an estimated 71% (51,100 people) of Aboriginal adults (aged 18 or over) had a BMI in the overweight or obese range (25% overweight and 47% obese) (Figure 2.22.1).

Nationally in 2022–23, a similar pattern was seen, with 72% of Aboriginal adults in the overweight or obese range (Figure 2.22.1).

Remoteness: In Western Australia in 2022–23, an estimated 77% (35,200) of Aboriginal adults and 69% of non-Aboriginal adults in non-remote areas were overweight or obese. In remote areas, 63% (15,900) of Aboriginal adults and 59% of non-Aboriginal adults were overweight or obese.

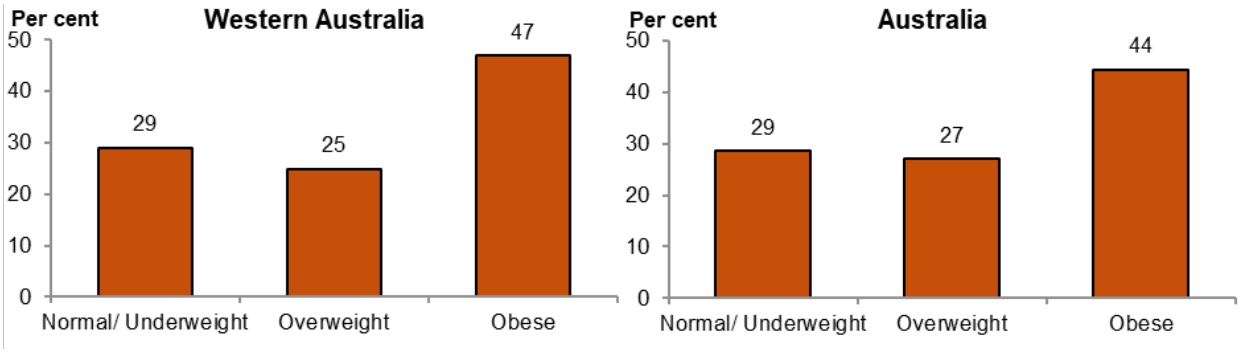
Nationally, an estimated 73% of Aboriginal and 66% of non-Aboriginal adults living in non-remote areas were overweight or obese. In remote areas, 63% of Aboriginal adults and 74% of non-Aboriginal adults were overweight or obese (Figure 2.22.2).

Change over time: The proportion of Aboriginal people aged 15 and over in Western Australia who were overweight or obese was relatively stable over time, at 67% in 2012–13, 73% in 2018–19 and 68% in 2022–23.

The national pattern was similar, with the proportion of Aboriginal people aged 15 and over who were overweight or obese ranging between 66% in 2012–13, 71% in 2018–19 and 68% in 2022–23 (Figure 2.22.3).

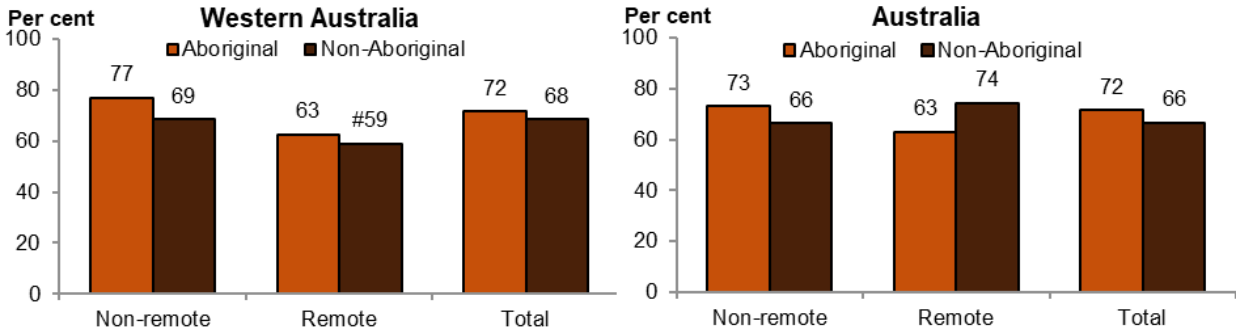
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

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



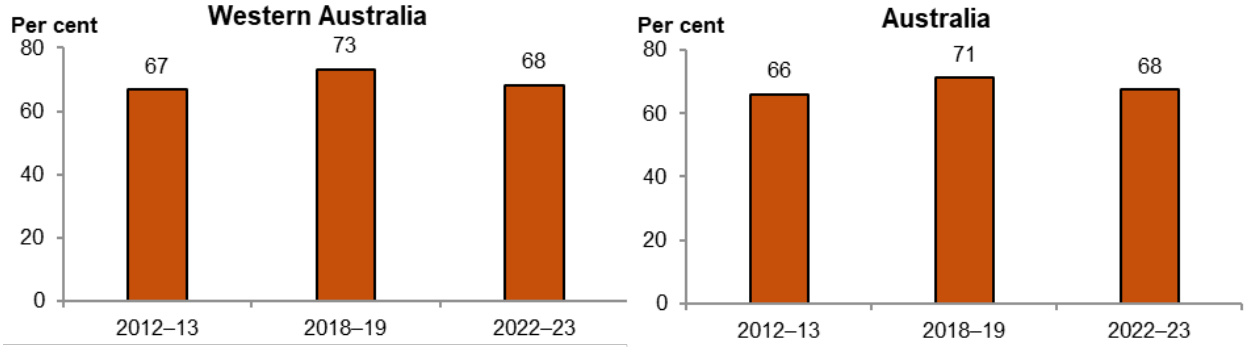
Source: ABS 2024d Table 57.3.

Figure 2.22.2: Proportion of persons aged 18 and over who were overweight or obese, by Aboriginal status and remoteness, Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D2.22.3.

Figure 2.22.3: Proportion of Aboriginal people aged 15 and over who were overweight or obese, Western Australia and Australia, 2012–13, 2018–19 and 2022–23



Source: ABS 2024d, ABS 2019, ABS 2013 Table 3.3.

3

Tier 3 – Health system performance

Topic	Number of measures
Effective, appropriate, efficient	8
Responsive	5
Accessible	3
Continuous	2
Capable	2
Sustainable	2
Total	**22**

3.01 Antenatal care

Why it is important

This measure reports on mothers' use of antenatal care during pregnancy. 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 & Wenitong 2009). Regular antenatal care starting in the first trimester (before 14 weeks gestational age) is associated with better maternal health in pregnancy, fewer interventions in late pregnancy and positive child health outcomes.

Key findings

First antenatal visit: In Western Australia among Aboriginal mothers who gave birth in 2023, 49% (946) accessed antenatal care services during the first trimester (less than 14 weeks) of their pregnancy. After adjusting for age, Aboriginal mothers were 0.8 times as likely as non-Aboriginal mothers to have attended antenatal care services in the first trimester.

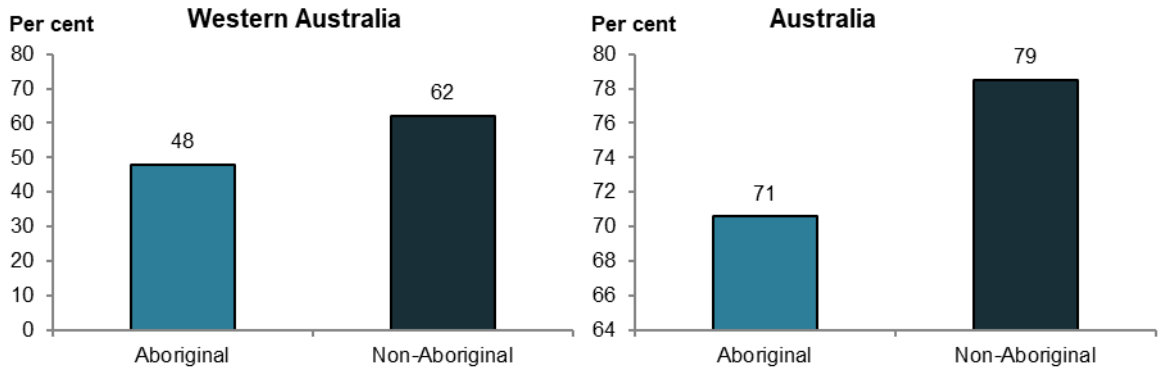
Nationally among Aboriginal mothers who gave birth in 2023, 71% (10,969) accessed antenatal care services during the first trimester of their pregnancy. After adjusting for age, Aboriginal mothers were 0.9 times as likely as non-Aboriginal mothers to have attended antenatal care services in the first trimester (Figure 3.01.1).

Number of antenatal visits: In Western Australia in 2023, among Aboriginal women who gave birth at 32 weeks or more, 85% (1,596) had 5 or more antenatal visits during pregnancy. After adjusting for age, Aboriginal women were 0.9 times as likely as non-Aboriginal women to have had 5 or more antenatal visits.

Nationally in 2023, among Aboriginal women who gave birth at 32 weeks or more, 89% (13,310) had 5 or more antenatal visits during pregnancy. After adjusting for age, Aboriginal women were 0.9 times as likely as non-Aboriginal women to have had 5 or more antenatal visits (Figure 3.01.2).

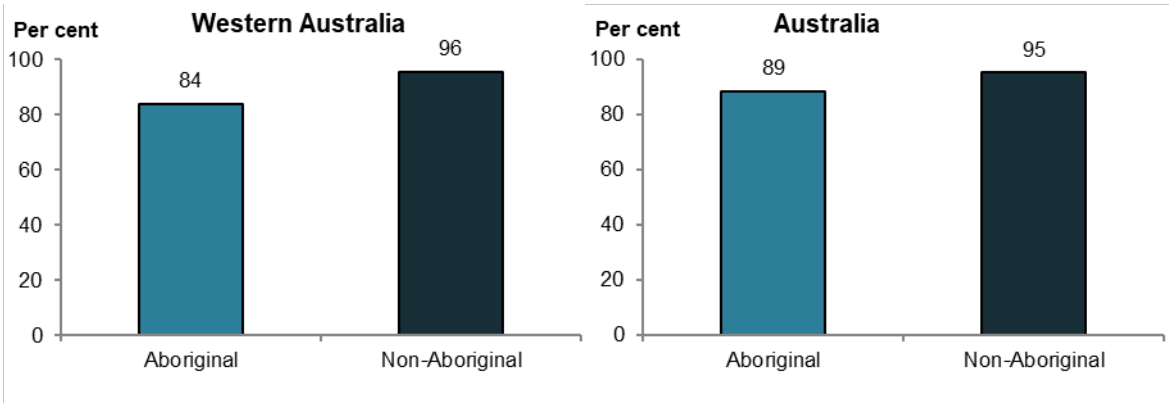
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.01.1: Age-standardised proportion of women who gave birth and had an antenatal visit in the first trimester, by Aboriginal status of the mother, Western Australia and Australia, 2023



Source: AIHW 2025i Table 6.13.

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, Western Australia and Australia, 2023



Source: AIHW 2025i Table 6.12.

3.02 Immunisation

Why it is important

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

Key findings

Overall: At 31 December 2022 in Western Australia, 87% of Aboriginal and 94% of other Western Australian children aged 1 were fully vaccinated (Figure 3.02.1). At age 2, 82% of Aboriginal children were fully immunised compared with 92% for other children (Figure 3.02.2). At age 5, the rate for Aboriginal children who were fully immunised was 94% compared with 93% for other children (Figure 3.02.3).

Nationally at 31 December 2022, vaccination coverage for Aboriginal children aged 1 was 91% compared with 94% for other children (Figure D3.02.1). At age 2, 89% of Aboriginal children were fully immunised compared with 92% for other children (Figure 3.02.2). At age 5, 96% of Aboriginal children were fully immunised compared with 94% for other children (Figure 3.02.3).

At age 1: In Western Australia at 31 December 2022, for children aged 1, coverage for hepatitis B, DTP, polio, HIB and pneumococcal were lower for Aboriginal children (87% to 88% for hepatitis B, DTP, polio and HIB, and 95% for pneumococcal) than for other children (94% and over for all vaccinations). Nationally at 31 December 2022, coverage for hepatitis B, DTP, polio, and HIB for Aboriginal children were lower (91% to 92% for all vaccinations) than for other children (94% and over for all vaccinations). The vaccination rate for pneumococcal was similar, at 96% for both groups of children (Figure 3.02.1).

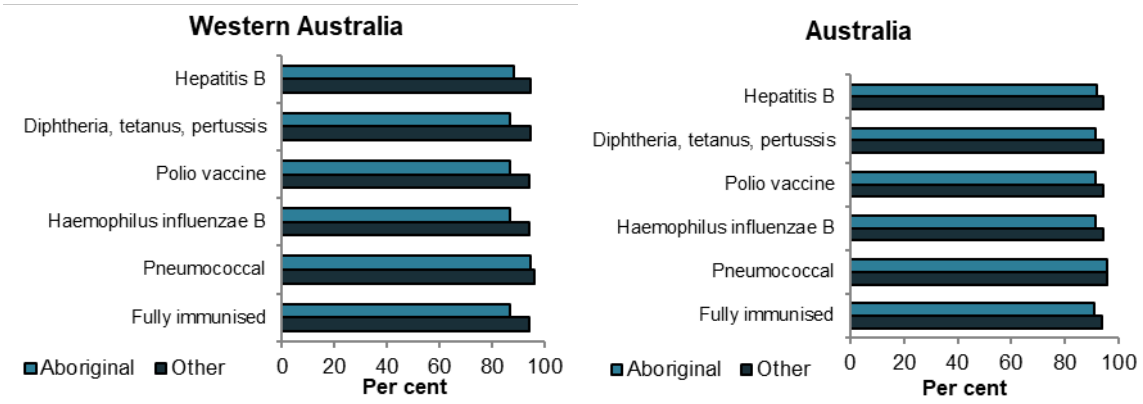
At age 2: In Western Australia at 31 December 2022, for children aged 2, coverage for meningococcal C was slightly higher for Aboriginal children (96%) than for other children (95%). Coverage for polio and hepatitis B was slightly lower for Aboriginal children than for other children (95% and 96%, respectively). Coverage for DTP, MMR, varicella and HIB were lower for Aboriginal children (85%, 87%, 87% and 89%) than for other children (over 92% for all vaccinations). Coverage for pneumococcal was similar for Aboriginal children and other children (95%).

Nationally at 31 December 2022, the vaccination coverage for meningococcal C and pneumococcal at age 2 were slightly higher for Aboriginal children than for other children (96% compared with 95%). Coverage for DTP, HIB, MMR, and varicella were lower for Aboriginal children (90% for DTP, 91% for MMR and varicella, and 93% for HIB) than for other children (93% for DTP and MMR, and 94% for HIB and varicella). Coverage for Hepatitis B and polio were similar for Aboriginal children and other children (Figure 3.02.2).

At age 5: In Western Australia at 31 December 2022, for children aged 5, the vaccination coverage for DTP and polio were higher for Aboriginal children (95% for both) than for other children (93% for both). Nationally at 31 December 2022, coverage for DTP and polio were higher for Aboriginal children (96% for both) than for other children (94% for both) (Figure 3.02.3).

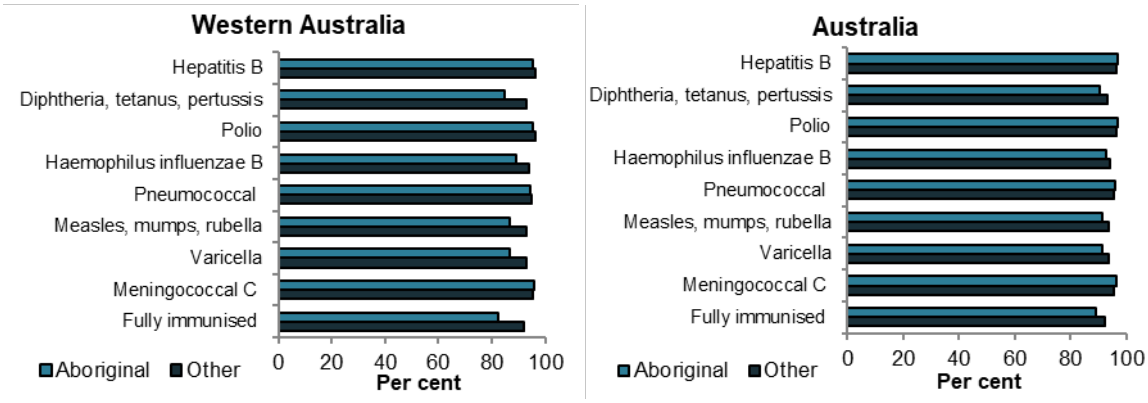
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.02.1: Vaccination coverage estimates for selected diseases for children at age 1, by Aboriginal status, Western Australia and Australia, at 31 December 2022



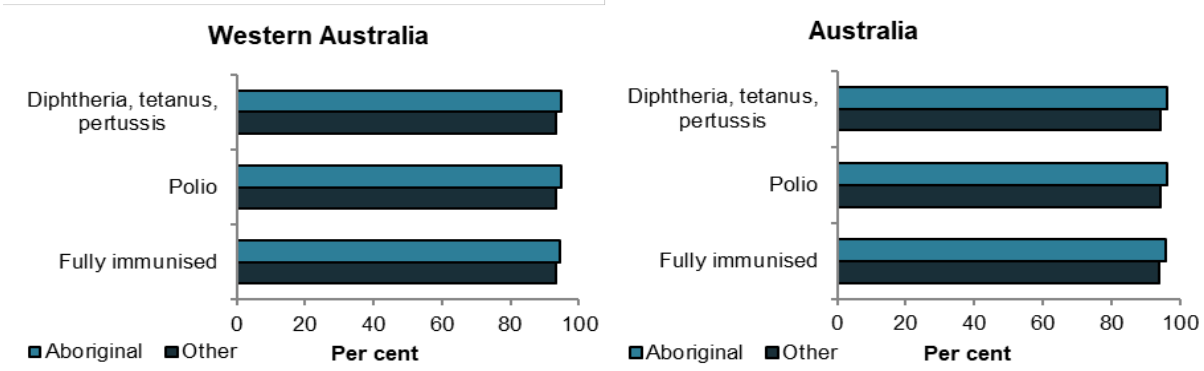
Source: Table D3.02.2.

Figure 3.02.2: Vaccination coverage estimates for selected diseases for children at age 2, by Aboriginal status, Western Australia and Australia, at 31 December 2022



Source: Table D3.02.3.

Figure 3.02.3: Vaccination coverage estimates for selected diseases for children at age 5, by Aboriginal status, Western Australia and Australia, at 31 December 2022



Source: 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 organisation. Aboriginal people currently experience higher levels of morbidity and mortality from potentially avoidable conditions than non-Aboriginal people (see measure 1.24 Avoidable and preventable deaths).

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 (e.g., packaging of cigarettes, seat belt laws); information to support healthy lifestyles (e.g., smoking, alcohol and drug use, physical activity and diet); social marketing (e.g., sunscreen use); and mass media campaigns (e.g., drinkdriving, road safety) (WHO 2008).

Key findings

Consulted a GP or specialist: In Western Australia in 2022–23, an estimated 82% (65,300) of Aboriginal people aged 15 and over reported they had consulted a doctor or specialist in the previous 12 months.

Nationally in 2022–23, 84% of Aboriginal people aged 15 and over reported they had consulted a doctor or specialist in the previous 12 months (Figure 3.03.1).

Lifestyle issues discussed: In Western Australia in 2022–23, 40% (24,700) of Aboriginal people aged 15 and over discussed lifestyle issues with a GP or health professional (Figure 3.03.1). Common issues discussed included eating healthy food or improving their diet (55%), reaching a healthy weight (46%) and reducing or quitting smoking (30%) (note some of these estimates have a relative standard error between 25% and 50% and should be used with caution) (Figure 3.03.2).

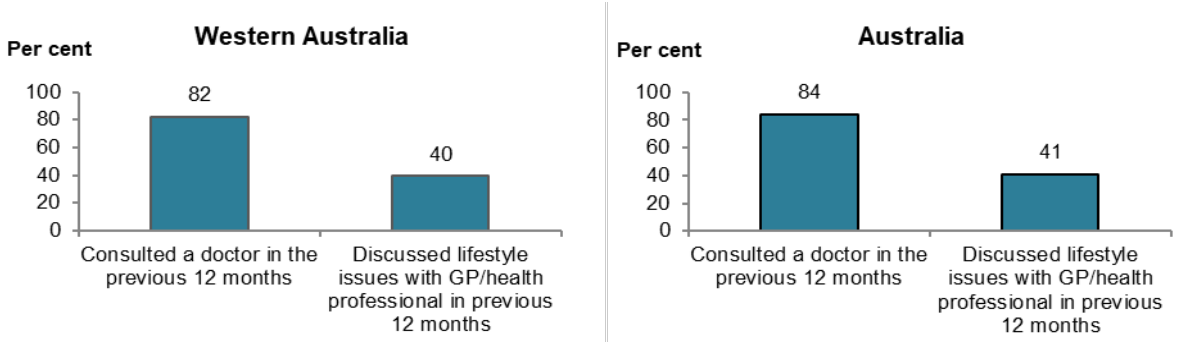
Nationally in 2022–23, 41% of Aboriginal people aged 15 and over discussed lifestyle issues with a GP or health professional (Figure 3.03.1). Common issues discussed included reaching a healthy weight (55%), eating healthy food or improving their diet (43%) and reducing or quitting smoking (31%) (Figure 3.03.2).

Health promotion programs and activities: In Western Australia, between July 2017 and June 2018, the most common type of health promotion activities and programs provided by Aboriginal primary healthcare organisations were tobacco use treatment or prevention groups (81%), women's groups (73%) chronic disease client support groups (69%), maternal and baby/child health (69%) and physical activity or healthy weight programs and activities (69%).

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).

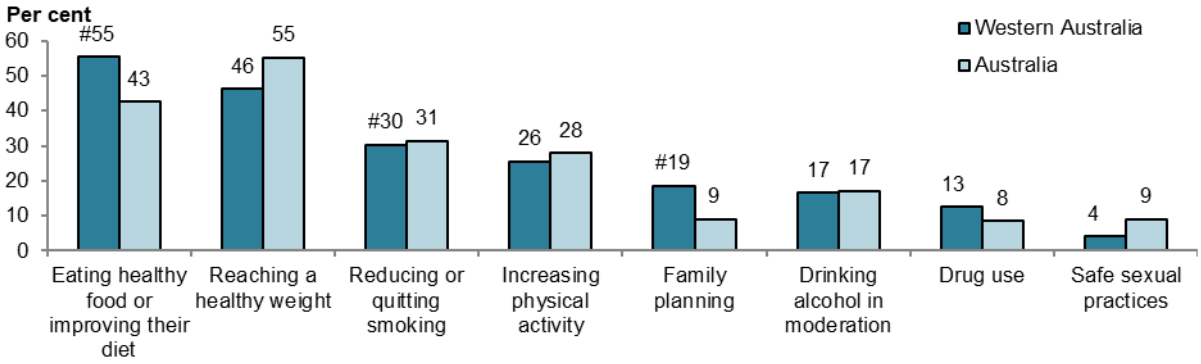
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.03.1: Aboriginal people aged 15 and over who consulted a doctor or discussed lifestyle with a GP or health professional, Western Australia and Australia, 2022–23



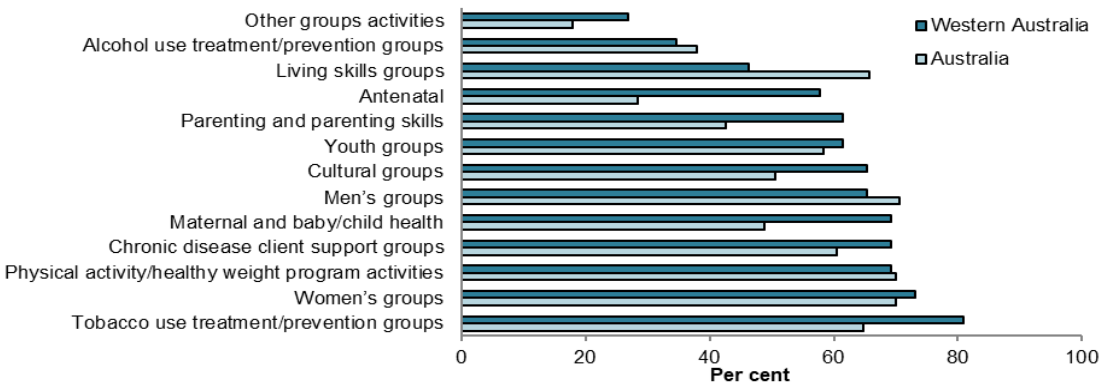
Source: Table 3.03.4.

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, Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table 3.03.4.

Figure 3.03.3: Aboriginal primary health-care organisations providing health promotion, by type of program or activity (multiple responses allowed), Western Australia and Australia, 2017–18



Source: Table 3.03.10.

3.04 Early detection and early treatment

Why it is important

This measure reports on the early detection and early treatment of disease for Aboriginal people. Early detection is the discovery of a disease or condition at an early stage, usually 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 Western Australia, 30,709 health assessments were provided to Aboriginal people. The rate of health assessments was highest among people aged 50 and over (34%) and lowest among people aged 0–14 (19%).

Nationally in 2023–24, 268,572 health assessments were provided to Aboriginal people. The rate of health assessments was highest among people aged 50 and over (35%) and lowest among people aged 0–14 and 15–49 (both 23%) (Figure 3.04.1).

Breast cancer screening: In 2022–23 in Western Australia, the age-standardised rate for Aboriginal women aged 50–74 who had been screened for breast cancer through the BreastScreen Australia program was 29%, compared with 50% for non-Aboriginal women.

In 2022–23 nationally, the age-standardised rates were 36% for Aboriginal women and 51% for non-Aboriginal women (Figure 3.04.2).

Pap smear test: In 2022–23 in Western Australia, an estimated 65% of Aboriginal women aged 25–74 reported they had regular pap smear tests. This estimate has a high margin of error and should be used with caution. 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 Western Australia, 19% (1,600) of Aboriginal males and 6.5% (700) of Aboriginal females aged 50–74 reported they had participated in bowel cancer screening tests. These estimates have a high margin of error and should be used with caution.

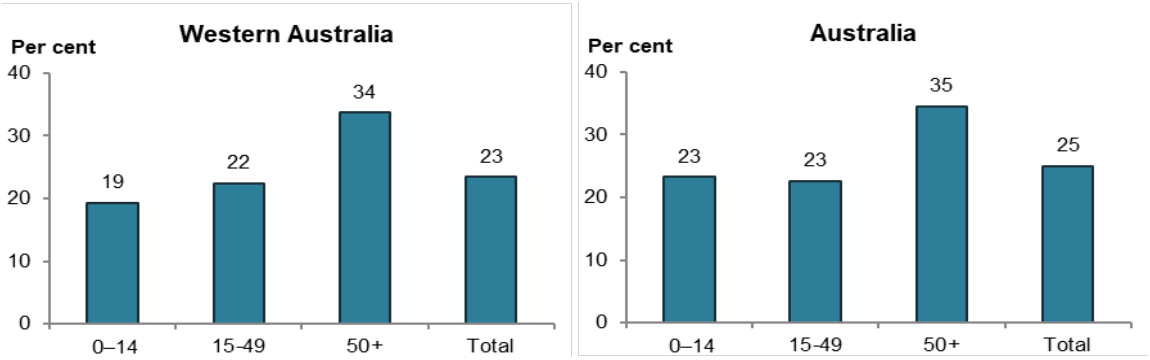
Nationally in 2022–23, 25% of Aboriginal males and 20% of Aboriginal females aged 50–74 reported they had participated in bowel cancer screening tests (Table D3.04.17).

Trend over time: In Western Australia, the rate of Aboriginal-specific MBS health checks claimed showed a marginal increase from 22% in 2015–16 to 23% in 2023–24. Rates remained relatively stable across age groups, with a slight increase in those aged 50 and over (Figure 3.04.3).

Nationally, the rate of Aboriginal-specific health checks claimed increased from 21% in 2015–16 to 25% in 2023–24. Increases were evident in all age groups, with the largest difference in rates observed in those aged 50 and over (Figure 3.04.3).

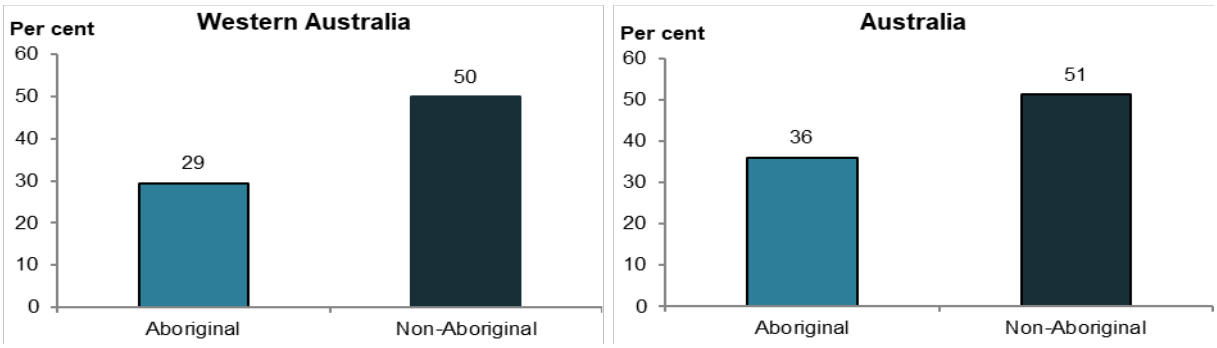
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.04.1: Rate of Aboriginal-specific MBS health checks claimed for Aboriginal people, by age group, Western Australia and Australia, 2023-24



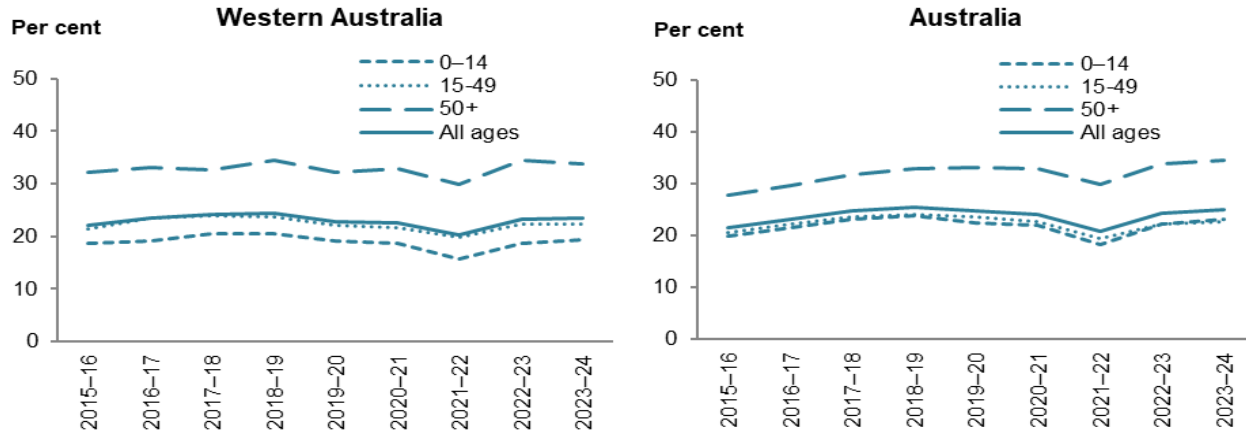
Source: Tables D3.04.1.

Figure 3.04.2: Age-standardised participation rates in BreastScreen Australia programs for women aged 50 to 74, by Aboriginal status, Western Australia and Australia, 2022–2023



Source: Table D3.04.9.

Figure 3.04.3: Rate of Aboriginal-specific MBS health checks claimed for Aboriginal people, by age group, Western Australia and Australia, 2015–16 to 2023–24



Sources: 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 and Torres Strait Islander people and are estimated to be responsible for 70% of the health gap between Aboriginal and non-Aboriginal people (AIHW 2016a). 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 leading to net savings (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 and non-Aboriginal people and 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 Western Australia in 2023–24, for Aboriginal people aged 15 and over, there were 10,192 MBS claims for the preparation of GPMPs and 9,186 for coordination of TCAs (Table D3.05.19).

Including people of all ages in Western Australia in 2023–24, the age-standardised MBS claim rate for Aboriginal patients for GPMP/TCAs combined was 0.9 times the rate for non-Aboriginal patients. The age-standardised claim rate for Aboriginal patients accessing specialists was less than half of the rate for non-Aboriginal patients (261 compared with 581 per 1,000 respectively) (Figure 3.05.1).

Blood tests and foot checks: In 2022–23 in Western Australia, of Aboriginal people with current and long-term diabetes or high sugar levels, an estimated 53% (3,600) reported having undergone HbA1c testing in the previous 12 months (non-remote areas only), 84% (10,700) had their blood glucose level checked, and foot checks had been completed for 73% (8,200). 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, 70% had undergone HbA1c testing, 90% had their blood glucose level checked, and 62% had had their feet checked in the previous 12 months (Figure 3.05.2).

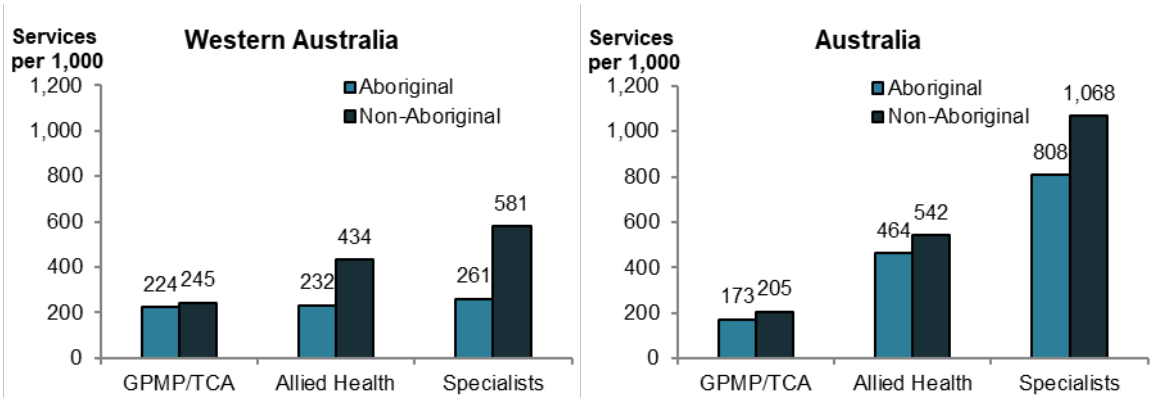
Nationally in 2022–23, 61% of Aboriginal people with current and long-term diabetes or high sugar levels reported having undergone HbA1c testing in the previous 12 months (non-remote areas only), 91% had had their blood glucose level checked and 69% had foot checks completed. For non-Aboriginal people, 70% had undergone HbA1c testing, 92% had their blood glucose level checked and 71% had had their feet checked (Figure 3.05.2).

Health actions taken: In Western Australia in 2022–23, actions Aboriginal people had taken in the previous 2 weeks to manage current and long-term diabetes or high sugar levels included: a lifestyle action such as diet, weight loss or exercise (68%, 7,600); taking medicine or tablets (68%, 7,600); and using insulin (23%, 2,600) (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).

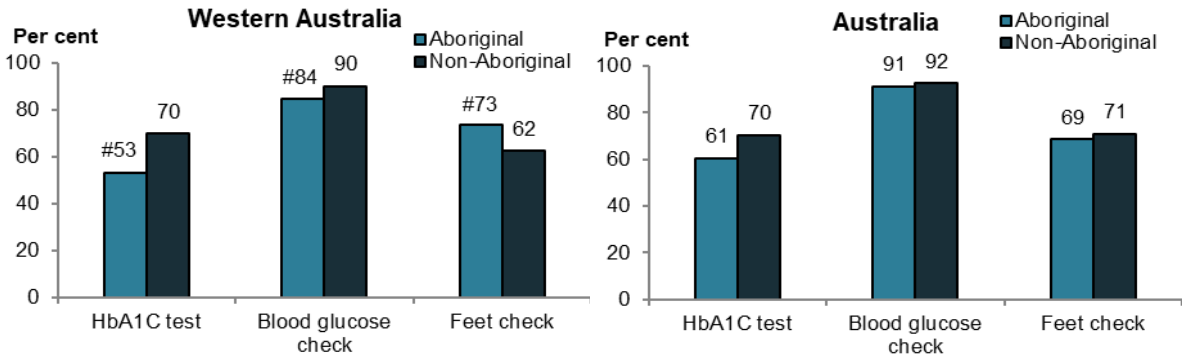
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.05.1: Age-standardised rate of selected MBS services claimed, by Aboriginal status, Western Australia and Australia, 2023–24



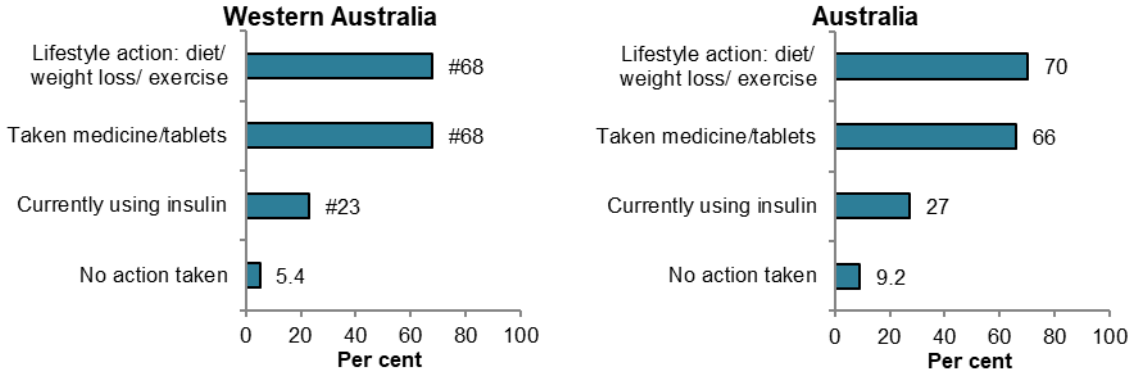
Source: Table D3.14.31.

Figure 3.05.2: People with diagnosed, current and long-term diabetes or high sugar levels who had an HbA1c test (non-remote only), blood glucose check, or foot check in the previous 12 months, by Aboriginal status, Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D3.05.13.

Figure 3.05.3: Actions taken by Aboriginal people to manage diabetes or high sugar levels in previous 2 weeks, Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D3.05.13.

3.06 Access to hospital procedures

Why it is important

This measure reports on hospitalisations with a procedure recorded for Aboriginal people. 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 2022d). Studies have shown that while Aboriginal people are more likely to be hospitalised than other Australians, they are less likely to receive a medical or surgical procedure while in hospital (ABS & 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 (AIHW 2024b). However, these factors do not fully explain the disparities between Aboriginal people and non-Aboriginal people (Cunningham 2002).

Key findings

Overall: In Western Australia between July 2021 and June 2023, 69% (61,022) of hospitalisations (excluding dialysis) for Aboriginal people had a procedure recorded (Table D3.06.1). Based on age-standardised rates, Aboriginal people in Western Australia were less likely to have a procedure recorded than non-Aboriginal people (difference of 16 percentage points) (Figure 3.06.1).

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).

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).

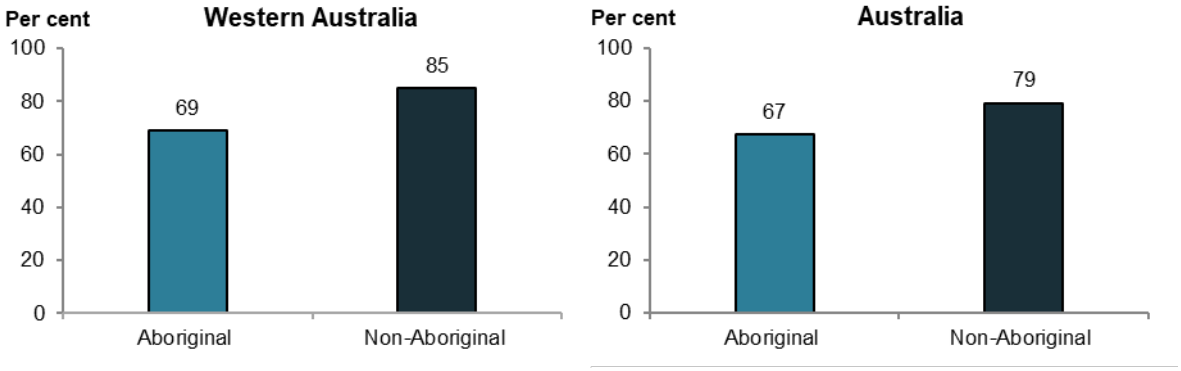
Main diagnosis: In Western Australia between July 2021 and June 2023, the proportion of hospitalisations for Aboriginal people that included at least one procedure was highest for hospitalisations with a principal diagnosis of diseases of the eye (96%), followed by cancer (neoplasms) (94%) and congenital malformations (93%) (Figure 3.06.2).

Nationally, between July 2021 and June 2023, the proportion of hospitalisations for Aboriginal people where a procedure was recorded was highest for diseases of the eye (94%), followed by cancer (neoplasms) (94%) and diseases of the blood (93%) (Figure 3.06.2).

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).

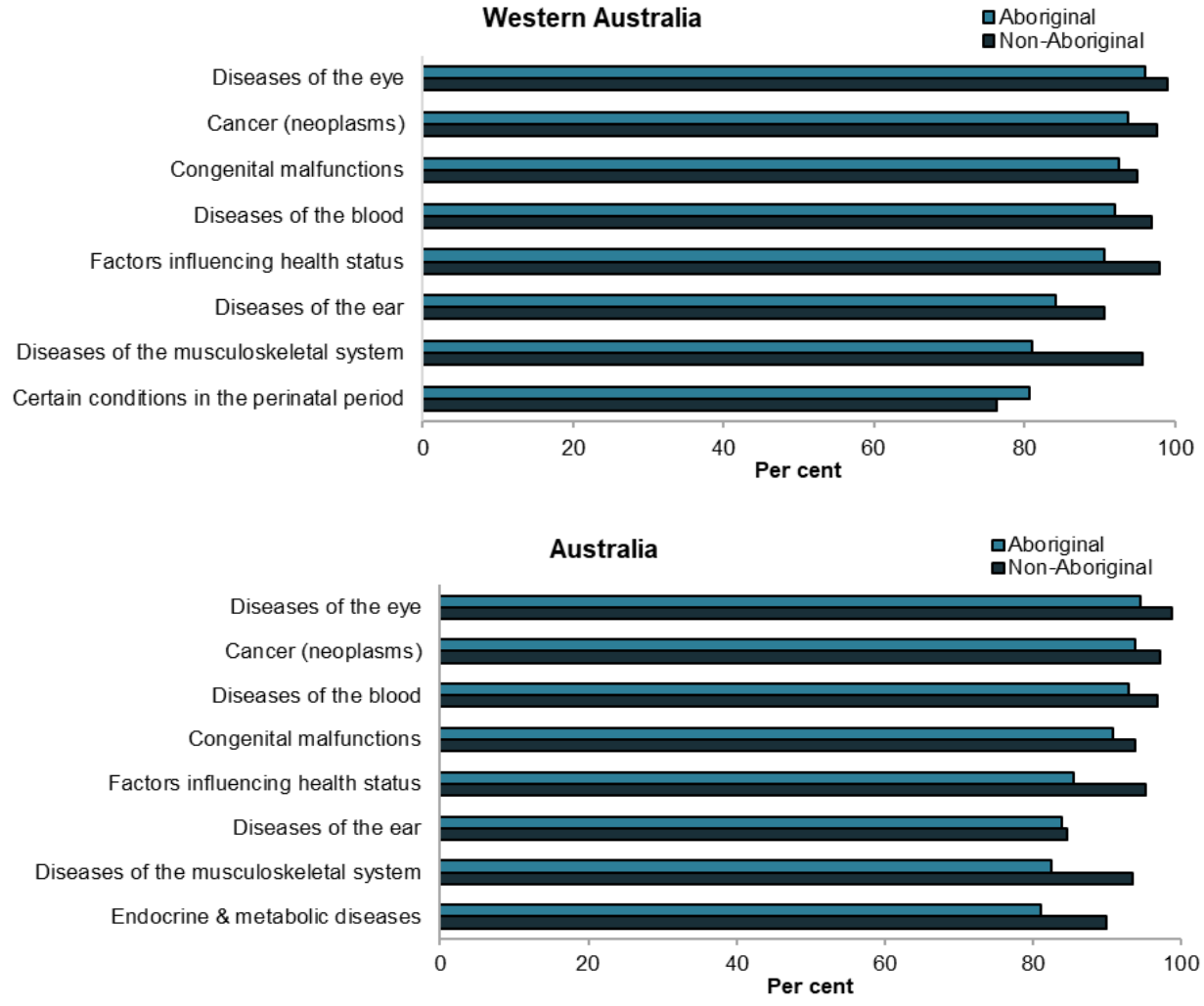
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.06.1: Age-standardised proportion of hospitalisations with a procedure recorded, by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



Source: Table D3.06.1.

Figure 3.06.2: Hospitalisations with a procedure recorded, by selected principal diagnosis and Aboriginal status, Western Australia and Australia, July 2021 to June 2023



Source: Table D3.06.2 WA.

3.07 Selected potentially preventable hospital admissions

Why it is important

This measure reports on the number of Potentially Preventable Hospitalisations (PPH) for Aboriginal people. PPH are hospitalisations for conditions that can be effectively treated in a non-hospital setting. 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 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, e.g. congestive heart failure).

Key findings

Overall: In Western Australia between July 2021 and June 2023, there were 15,108 hospitalisations for Aboriginal people that were potentially preventable. The PPH rate was higher for Aboriginal females than males (71 and 53 hospitalisations per 1,000, respectively) (Table D3.07.2). After adjusting for differences in the age structure between the two populations, Aboriginal people in Western Australia were hospitalised for potentially preventable conditions at a rate 3.9 times that for non-Aboriginal people (Table D3.07.2).

Nationally, between July 2021 and June 2023, the PPH rate was higher for Aboriginal females than 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: Between July 2021 and June 2023 for Aboriginal people in Western Australia, the PPH rate was lowest for those aged 15–24 and increased with age (Figure 3.07.1). The PPH rate was higher for Aboriginal than non-Aboriginal people across all age groups. The largest relative difference was in the 45–54 age group where the PPH rate for Aboriginal people were 8.7 times that for non-Aboriginal people.

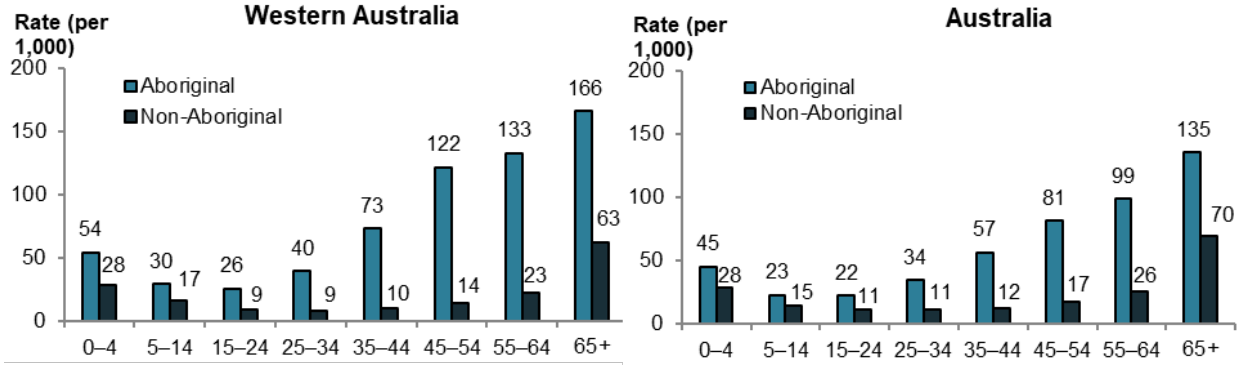
Nationally, the PPH rate was higher for Aboriginal than non-Aboriginal people across all age groups, with the largest relative difference in the 45–54 age group (Figure 3.07.1).

Leading causes of PPH: Between July 2021 and June 2023, the 5 leading causes of PPH among Aboriginal people in Western Australia were cellulitis, chronic hepatitis B, diabetes complications, COPD, and dental conditions (Figure 3.07.2). Aboriginal people had higher age-standardised PPH rates than non-Aboriginal people for all 5 causes. The largest relative difference was for chronic hepatitis B, where the hospitalisation rate for Aboriginal people was over 15 times the rate for non-Aboriginal people (Figure 3.07.3).

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 (Figure 3.07.2). 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). Nationally, chronic hepatitis B was the 8th leading cause of PPH among Aboriginal people. Aboriginal people were over 7 times as likely as non-Aboriginal people to be hospitalised for chronic hepatitis B (Table D3.07.5).

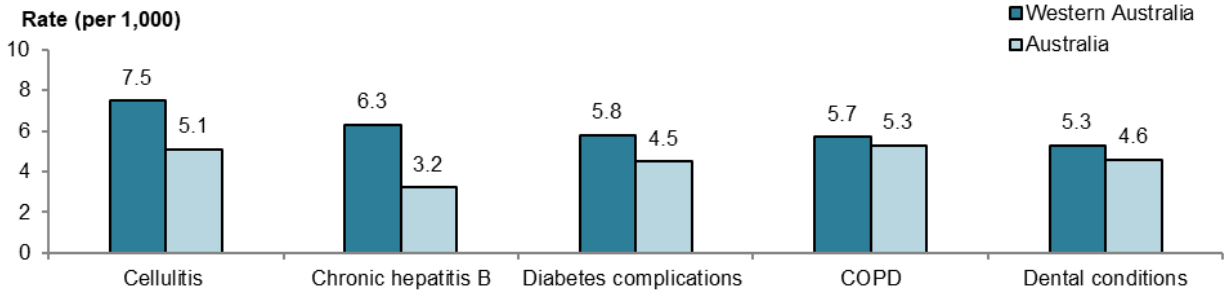
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.07.1: Age-specific hospitalisation rates for potentially preventable hospitalisations, by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



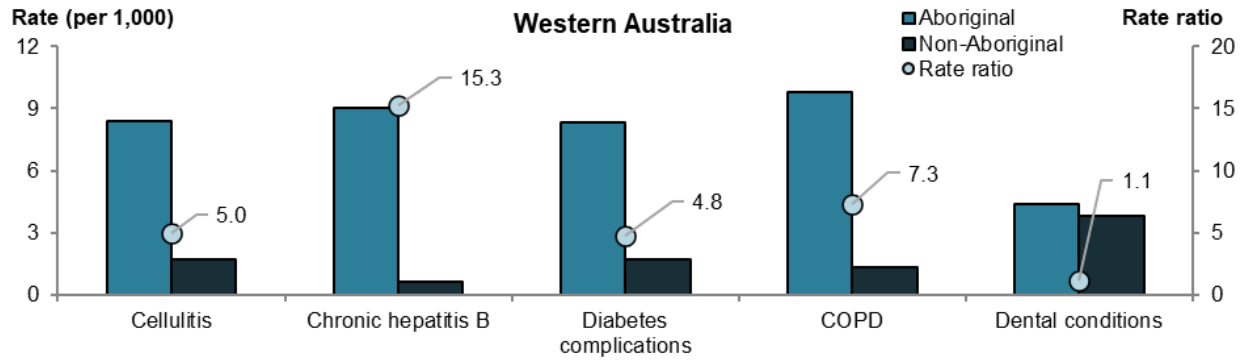
Source: Table D3.07.1 WA.

Figure 3.07.2: Crude rates for top 5 potentially preventable hospitalisations among Aboriginal people, Western Australia and Australia, July 2021 to June 2023



Source: Tables D3.07.5 WA and D3.07.5.

Figure 3.07.3: Rate ratios and age-standardised rates for top 5 potentially preventable hospitalisations among Aboriginal people in Western Australia, by Aboriginal status, July 2021 to June 2023



Source: Tables D3.07.5 WA.

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 the access to health care for Aboriginal people, increase the effectiveness of the care that is received, 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; Truong et al. 2014).

Key findings

Patient experience: The 2022–23 National Aboriginal and Torres Strait Islander Health Survey showed that an estimated 71% (40,100) of Aboriginal people aged 15 and over in Western Australia rated the health care they received in the last 12 months as 'excellent' or 'very good' (Table D3.08.7).

In 2022–23 in Western Australia, around 9 in 10 Aboriginal people aged 15 and over who had seen a doctor in the last 12 months reported that their general practitioner (GP) always/usually listened carefully to them (87%), explained things in a way that could be understood (87%), showed respect for what was said (92%), respected culture, traditions, customs and beliefs (88%) and spent enough time with them (87%). These findings were consistent with the national results for Aboriginal people aged 15 and over (Figure 3.08.1).

Did not access health care when needed to: In Western Australia in 2022–23, 31% (36,300) 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 (53%, this proportion has a high margin of error and should be used with caution) (Figure 3.08.2, Table 3.08.4, Table 3.08.5).

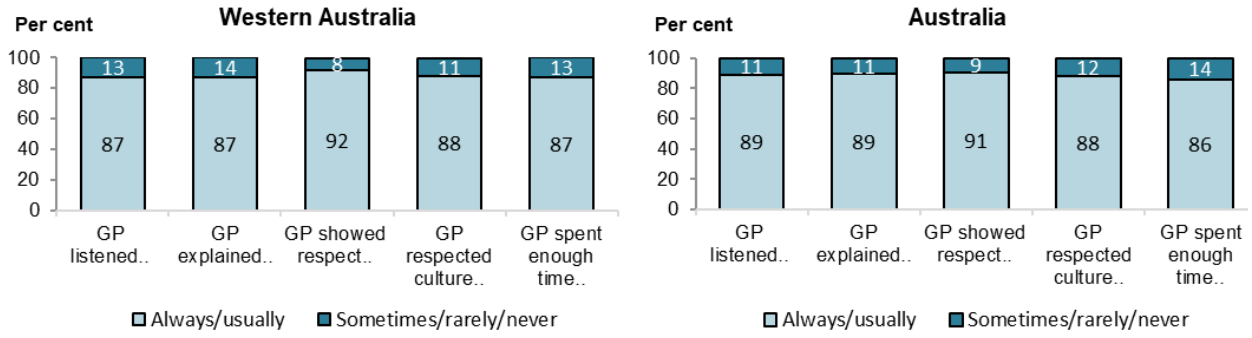
Nationally in 2022–23, 35% of Aboriginal people reported that they did not access health care when they needed to in the past 12 months. The dentist was the most common service not accessed when needed (21%), with cost being the most common reason given for not accessing the service (45%) (Figure 3.08.2, Table 3.08.4).

Cultural barriers to accessing health care: In 2022–23 in Western Australia, of the Aboriginal people who did not access health care when needed, 29% reported the reason to be related to 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 Aboriginal people in Western Australia reported were cost (45%), logistical reasons (48%) and personal reasons (42%). Reasons do not total 100% as more than one response was allowed. Note that these estimates have a high margin of error and should be used with caution.

Nationally, almost one-third (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).

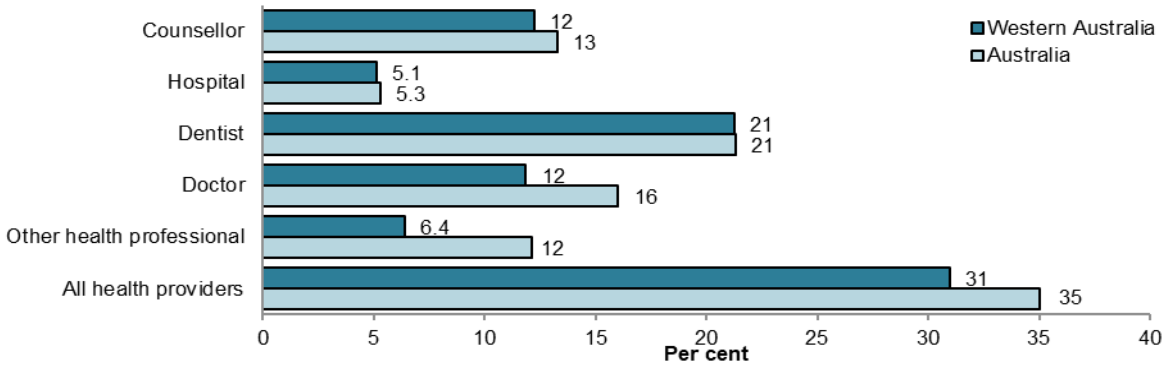
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.08.1: Patient experience in the last 12 months, Aboriginal people aged 15 and over, Western Australia and Australia, 2022–23



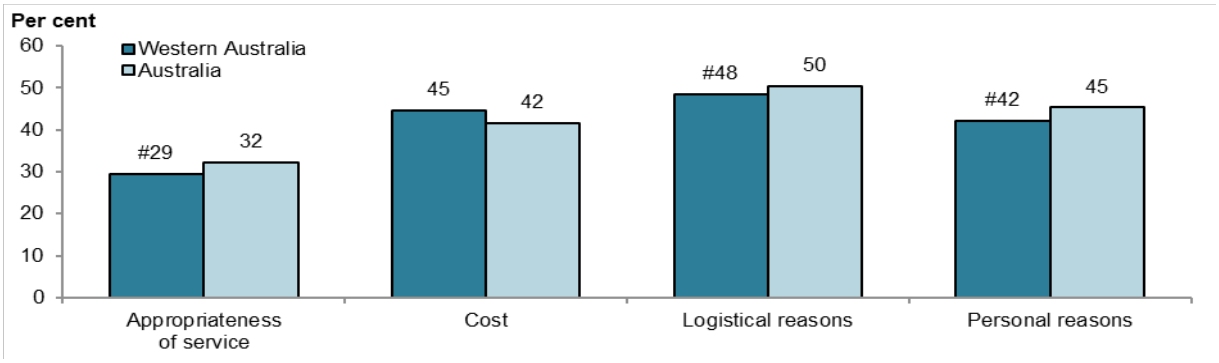
Source: Table D3.08.7.

Figure 3.08.2: Proportion of Aboriginal people not accessing a health provider when needed in the last 12 months, by health provider type, Western Australia and Australia, 2022–23



Note: Category 'Other health professionals' includes: nurse, sister, and Aboriginal (and Torres Strait Islander) Health Worker.
Source: Table D3.08.4.

Figure 3.08.3: Reasons for Aboriginal people not accessing health services when needed in the last 12 months, Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D3.08.4.

3.09 Self-discharge from hospital

Why it is important

This measure reports on the rate at which Aboriginal people self-discharge from hospital. People who leave hospital before discharge are more likely to re-present to emergency departments and have higher mortality rates (Shaw 2016). Rates of self-discharge provide an indirect measure of the responsiveness of health services to patient needs. 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 higher rates of Aboriginal people self-discharging from hospital (Askew et al. 2021).

Key findings

Hospitalisations: In Western Australia between July 2021 and June 2023, there were 3,920 hospitalisations (excluding dialysis) for Aboriginal people that ended in self-discharge from hospital. This equated to 4.4% of all hospitalisations for Aboriginal people in Western Australia. After adjusting for differences in the age, the proportion for Aboriginal people was 8.5 times that for non-Aboriginal people.

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, the proportion for Aboriginal people was 5.1 times that for non-Aboriginal people (Figure 3.09.1).

Hospitalisations by age group: In Western Australia between July 2021 and June 2023, Aboriginal people aged 35–44 had the highest proportion of hospitalisations that ended in self-discharge from hospital (7.7%). Higher proportions of Aboriginal people than non-Aboriginal people in all age groups had a hospitalisation that ended in self-discharge from hospital.

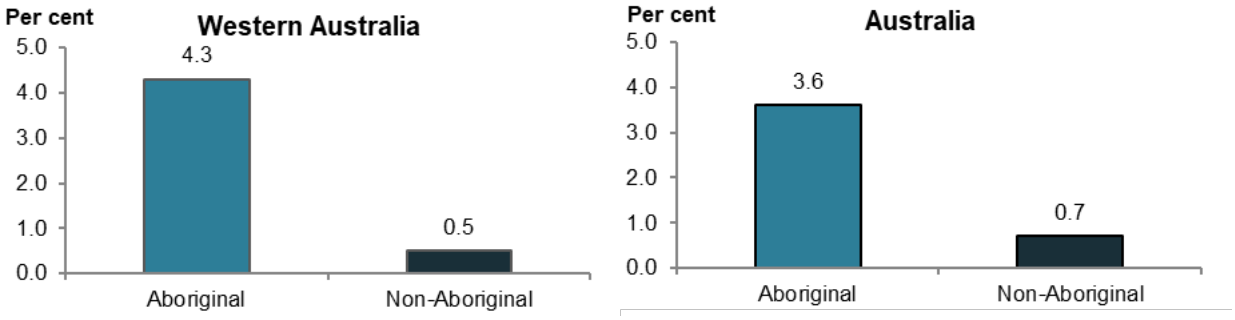
Nationally between July 2021 and June 2023, Aboriginal people aged 35–44 had the highest proportion of hospitalisations that ended in self-discharge from hospital (6.1%). Higher proportions of Aboriginal people than non-Aboriginal people in all age groups had a hospitalisation that ended in self-discharge from hospital (Figure 3.09.2).

Principal diagnosis: In Western Australia from July 2021 to June 2023, the highest proportion of hospitalisations for Aboriginal people that ended in self-discharge from hospital was for diseases of the skin and subcutaneous tissue (for example, sunburn) (7.9%), followed by injury and poisoning (for example, fracture) (6.7%).

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%) (Figure 3.09.3).

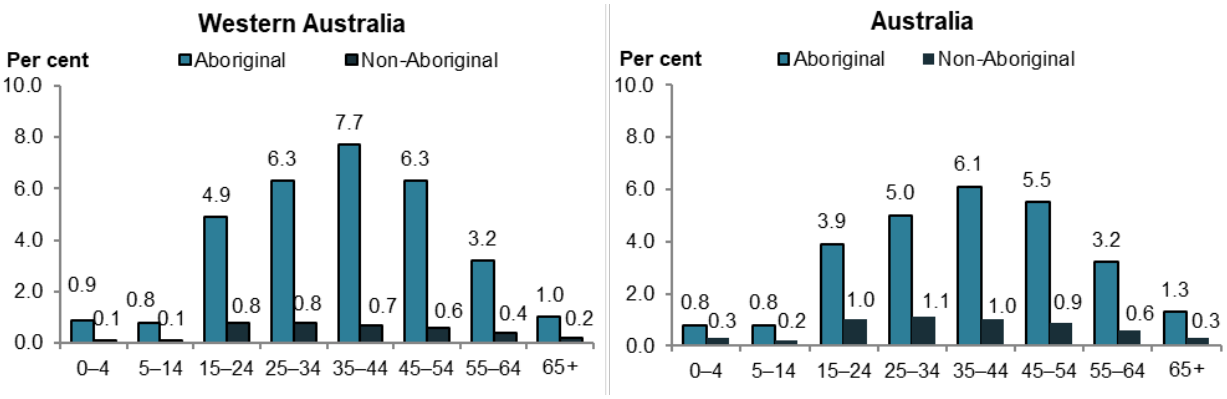
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.09.1: Age-standardised proportion of hospitalisations that ended in self-discharge, by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



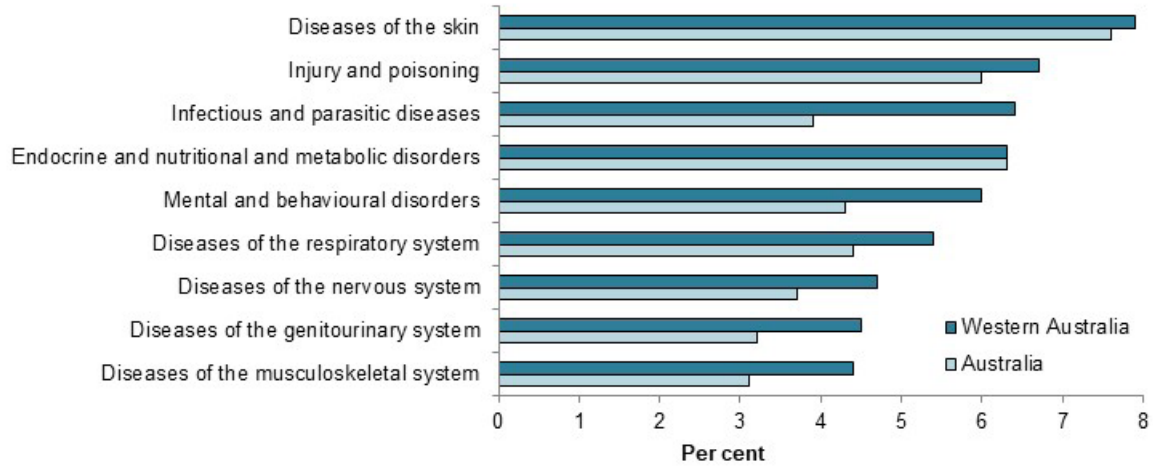
Source: Table D3.09.3.

Figure 3.09.2: Hospitalisations that ended in self-discharge, by Aboriginal status and age group, Western Australia and Australia, July 2021 to June 2023



Source: Table D3.09.1 WA.

Figure 3.09.3: Hospitalisations for Aboriginal people that ended in self-discharge, by main diagnosis, Western Australia and Australia, July 2021 to June 2023



Source: Table D3.09.7 WA.

3.10 Access to mental health services

Why it is important

This measure reports on access to psychologist and psychiatric care, and hospitalisations for mental health-related conditions for Aboriginal people. 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).

Key findings

Psychologist and psychiatric care: In 2023–24, Aboriginal people in Western Australia claimed 8,981 psychologist services and 3,775 psychiatrist services through Medicare, at rates of 71.5 and 30 per 1,000 population, respectively (Table D3.10.2). After adjusting for differences in the age structure between the two populations, non-Aboriginal people were 3 times as likely as Aboriginal people to have claimed a psychologist service, and 2.8 times as likely to have claimed a psychiatrist service (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, non-Aboriginal people were 1.6 times as likely as Aboriginal people to have claimed a psychologist service, and 1.5 times as likely to have claimed a psychiatrist service (Figure 3.10.1).

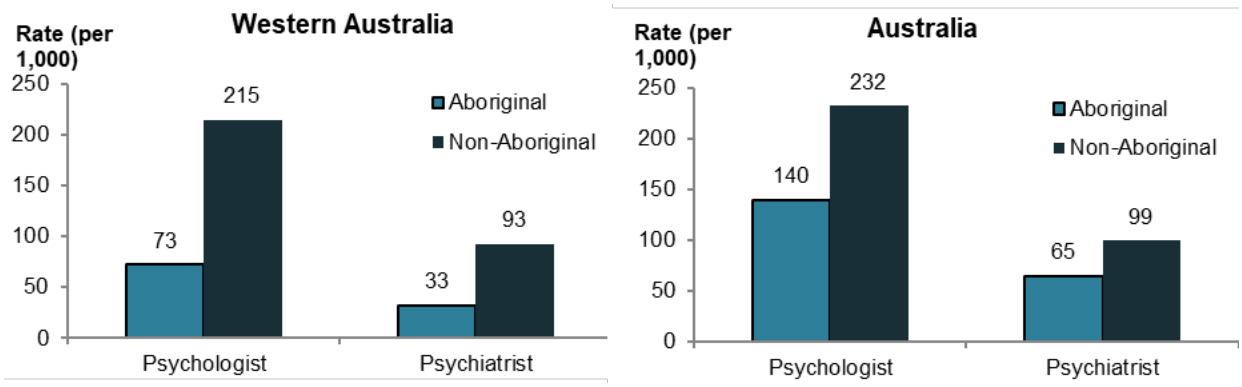
Hospitalisation for mental health-related conditions: In Western Australia, between July 2021 and June 2023, there were 5,973 hospitalisations for Aboriginal people with a principal diagnosis of mental health-related conditions, at a rate of 24 per 1,000 population (Table D1.18.15). After adjusting for differences in age, the hospitalisation rate for mental health-related conditions among Aboriginal people was 2.5 times the rate for non-Aboriginal people. 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).

Hospitalisations over time: In Western Australia from 2016–17 to 2022–23, the age-standardised hospitalisation rate for mental healthrelated conditions (as the principal diagnosis) for Aboriginal people decreased by 10%. Over the same period, for non-Aboriginal people the age-standardised hospitalisation rate decreased by 7% using linear regression analysis. Nationally from 2016–17 to 2022–23, the age-standardised hospitalisation rate for mental healthrelated conditions for Aboriginal people increased by 16%. Over the same period, for non-Aboriginal people the age-standardised hospitalisation rate decreased by 4% (Figure 3.10.3).

Use of mental health services: In 2022–23, an estimated 27% (19,300) of Aboriginal people in Western Australia had accessed health services for their own mental health in the previous 12 months, and 20% (14,000) would have liked to seek mental health support but did not (Table D3.10.12).

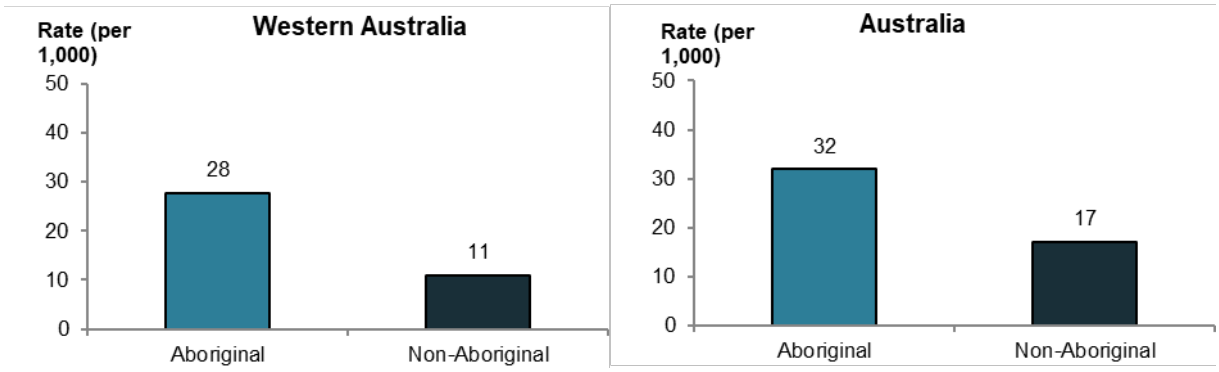
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.10.1: VII adjusted, age-standardised rate of MBS services claimed, psychologists and psychiatrists, by Aboriginal status, Western Australia and Australia, 2023–24



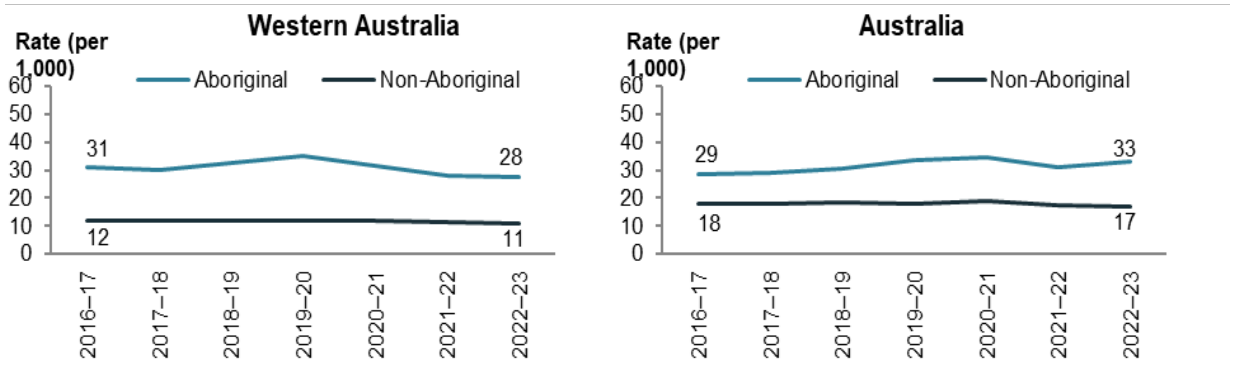
Source: Table D3.10.2.

Figure 3.10.2: Age-standardised rate of hospitalisations for mental health-related conditions (based on principal diagnosis), by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



Source: Table D1.18.15.

Figure 3.10.3: Age-standardised hospitalisation rate for mental health-related conditions, by Aboriginal status, Western Australia and Australia, 2016–17 to 2022–23



Note: Based on principal diagnosis.
Source: Table D1.18.20 WA.

3.11 Access to alcohol and drug 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). Treatment services for AOD problems are composed of multiple types: counselling, withdrawal, psycho-social therapy, residential rehabilitation and pharmacotherapy maintenance.

Key findings

AOD treatment services: In 2023–24, 125 publicly funded AOD treatment agencies in Western Australia provided 19,639 treatment episodes to 14,521 clients. In Western Australia, 21% (3,094) of all clients of AOD treatment agencies identified as Aboriginal, which is higher than the national proportion (18%) (AIHW 2025b).

Of the 4,097 treatment episodes for Aboriginal clients in Western Australia in 2023–24, over half (57%) were provided to clients aged 20–39, which is similar to the national proportion (58%) (Figure 3.11.1).

In Western Australia from 2014–15 to 2023–24, the number of treatment episodes decreased by 25% for Aboriginal clients and by 14% for non-Aboriginal clients. Nationally over the same period, treatment episodes increased by 67% for Aboriginal clients and by 41% for non-Aboriginal clients (Figure 3.11.2).

Drugs of concern: People may seek 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 seek treatment. In Western Australia in 2023–24, alcohol was the most common principal drug of concern (44%) for Aboriginal clients, followed by amphetamines (27%) and cannabis (22%) (AIHW 2025b).

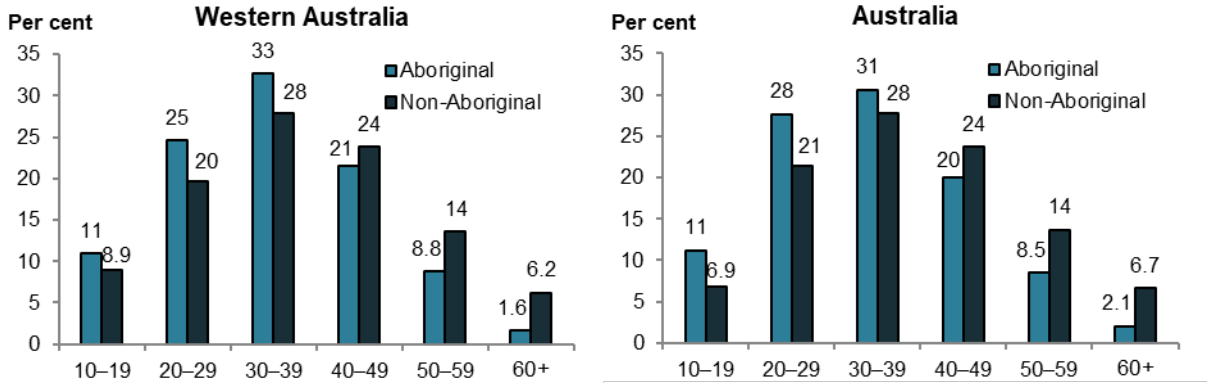
Type of AOD treatment services: In Western Australia in 2023–24, counselling was reported as the main treatment type for almost three-quarters (72%) of Aboriginal clients receiving help for their own alcohol or drug use, compared with around two-thirds (66%) of non-Aboriginal clients (Figure 3.11.3).

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 2024, 329 Aboriginal people were receiving pharmacotherapy treatment for their opioid dependence in Western Australia. The rate of Aboriginal pharmacotherapy clients in Western Australia was lower than the national rate (26 and 57 clients per 10,000 Aboriginal people, respectively) (AIHW 2025h).

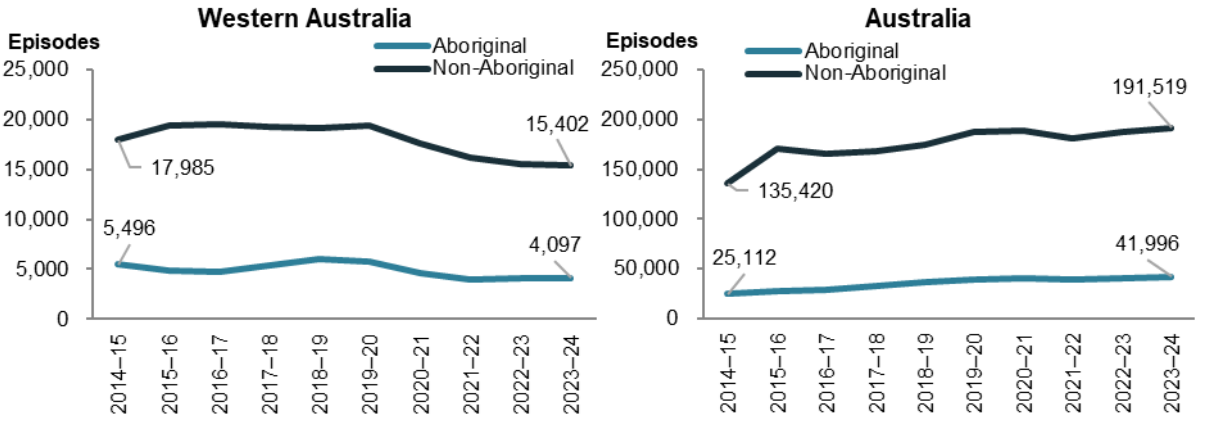
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.11.1: Closed treatment episodes for alcohol and other drug treatment, by Aboriginal status and age group, Western Australia and Australia, 2023–24



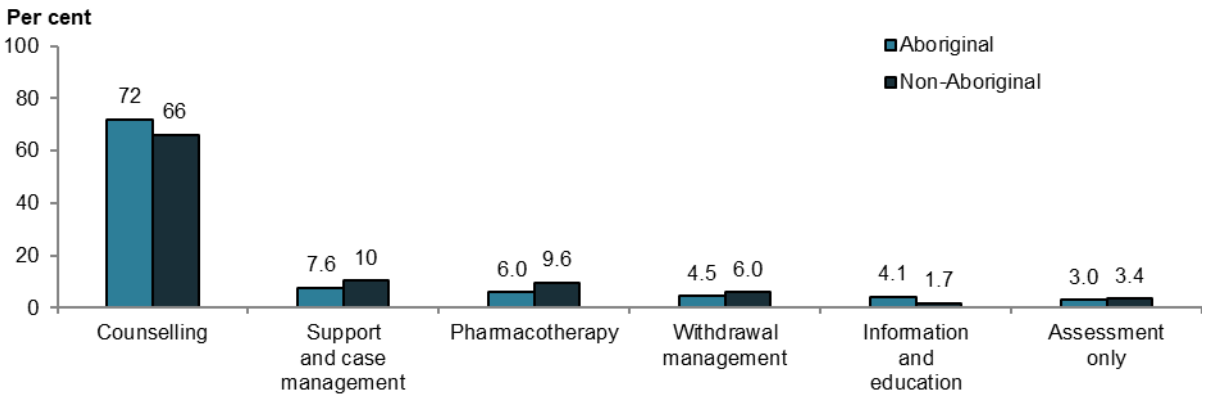
Source: Alcohol and Other Drug Treatment Services National Minimum Data Set data cubes 2023–24.

Figure 3.11.2: Number of closed treatment episodes for alcohol and other drug treatment, by Aboriginal status, Western Australia and Australia, 2014–15 to 2023–24



Source: Alcohol and Other Drug Treatment Services National Minimum Data Set data cubes 2023–24.

Figure 3.11.3: Alcohol and drug treatment clients by main treatment type for own drug use, by Aboriginal status, Western Australia, 2023–24



Source: AIHW 2025b Table SC WA.15.

3.12 Aboriginal people in the health workforce

Why it is important

This measure reports on Aboriginal people employed in the health workforce. Aboriginal people are significantly underrepresented 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 to 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). 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 self-reported data from the ABS 2021 Census, in Western Australia 2.3% (1,369) 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 Western Australia increased from 200 to 231 per 10,000 population. In 2021, non-Aboriginal people in Western Australia were employed in health-related occupations at over twice the rate for Aboriginal people (rate ratio 2.3) (Figure 3.12.1).

Nationally, between 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 in 2021 (Figure 3.12.1).

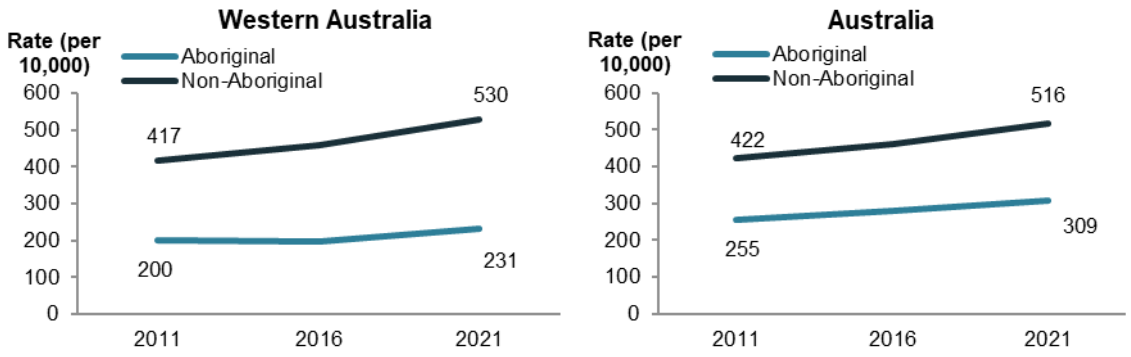
Registered health professionals: The National Health Workforce Data Set provides information on registered health professionals. It shows that in Western Australia in 2023, 1.0% (733) of registered health professionals employed in their registered profession identified as being Aboriginal. Of these 733 Aboriginal people, 58% (422) were employed as a nurse and/or midwife, 31% (228) as an allied health professional, 9.3% (68) as a medical practitioner, and 2.0% (15) as a dental practitioner (Figure 3.12.2).

In 2023, non-Aboriginal people in Western Australia were employed in registered health professions at 4.6 times the rate for Aboriginal people (Figure 3.12.3).

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).

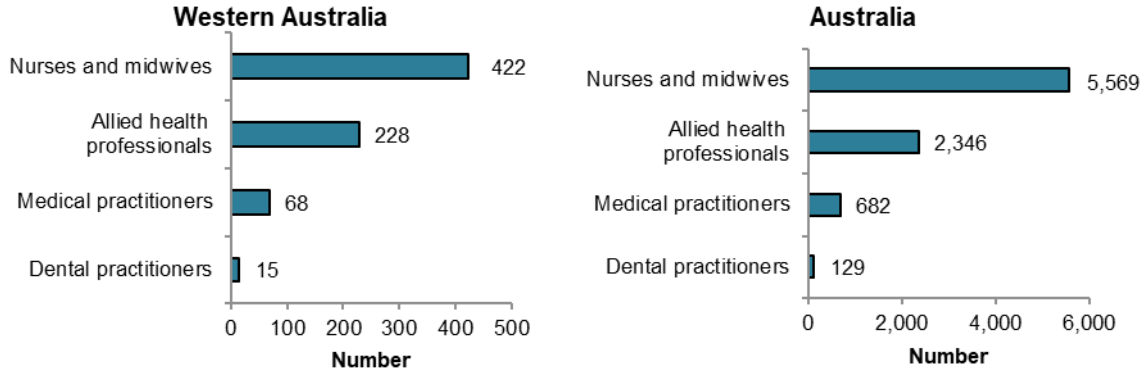
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.12.1: Rate of people aged 15 and over employed in health-related occupations, by Aboriginal status, Western Australia and Australia, 2011 to 2021



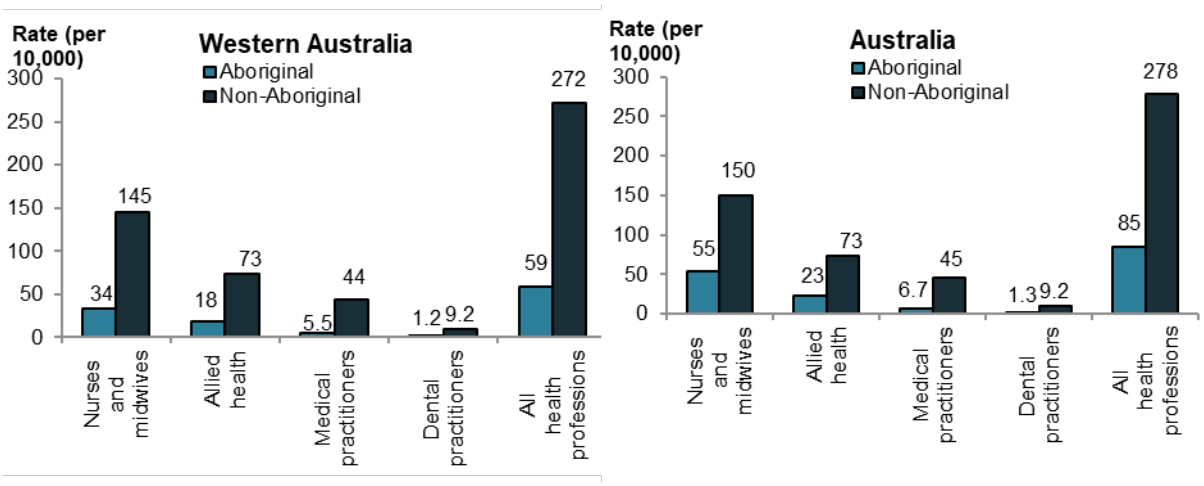
Source: Table D3.12.13.

Figure 3.12.2: Number of Aboriginal people registered and employed in selected health professions, Western Australia and Australia, 2023



Source: Table D3.12.4.

Figure 3.12.3: Rate of people registered and employed in selected health professions, by Aboriginal status, Western Australia and Australia, 2023



Source: 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.

Note that these data are no longer collected and so the information presented below cannot be updated.

Key findings

Aboriginal health-care organisations: In 2021–22 in Western Australia, all 25 Aboriginal primary health-care organisations had a governing committee/board. Of these organisations, 14 (56%) had a board who were all Aboriginal, 10 (40%) included at least one independent (skill-based) member and 9 (36%) had members who had received training related to governance issues (Figure 3.13.1).

Nationally in 2021–22, 162 of the 211 (76%) Aboriginal primary healthcare organisations reported having a governing committee/board. Of these 162 organisations, 91 (56%) had a board who were all Aboriginal people, 69 (43%) included at least one independent (skill-based) member and 79 (49%) had members who had received training related to governance issues (Figure 3.13.1).

Aboriginal substance-use services: In Western Australia in 2017–18, 11 of the 13 Aboriginal substance use services had a governing committee/board. Of these, all had met the requirement of the constitution for the frequency of meetings and had income and expenditure statements presented on at least 2 occasions. There were 7 (64%) boards who were all Aboriginal people, 5 (46%) that had members who received training related to governance issues, and 4 (36%) that included at least one independent (skill-based) member (Figure 3.13.2).

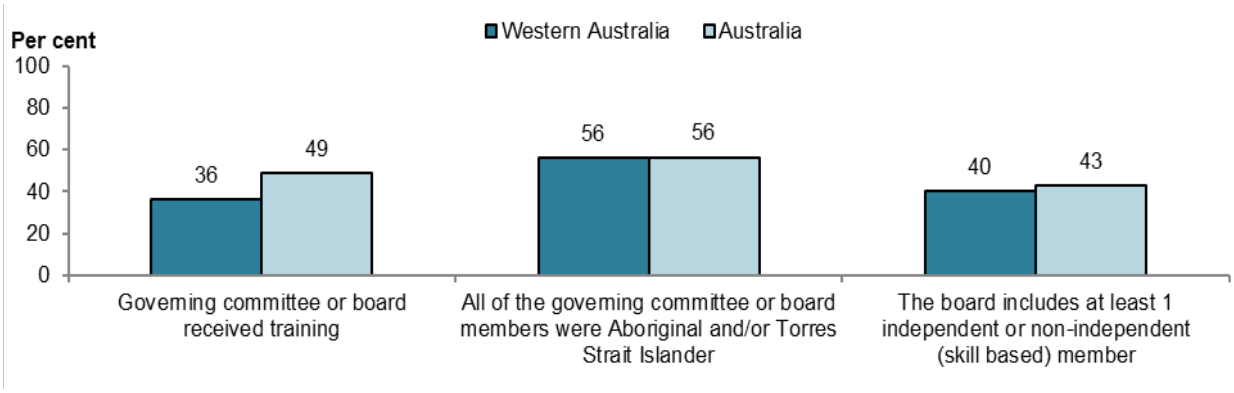
Nationally in 2017–18, 77 of the 79 (97%) Commonwealth-funded Aboriginal substanceuse services reported they had a governing committee/board. Of these, all had presented income and expenditure statements to the board on at least 2 occasions, 76 (99%) had met the requirement of the constitution for the frequency of meetings, 64 (83%) had members who had received training related to governance issues, 47 (61%) were all Aboriginal people, and 37 (48%) included at least one independent (skill-based) member (Figure 3.13.2).

Participation in planning processes: In Western Australia in 2017–18, all 26 Aboriginal health services had participated in organisational planning processes and in regional health planning processes, 22 (85%) had representatives on external boards (for example, hospitals), and 21 (81%) had participated in state/territory or national policy development (Figure 3.13.3).

Nationally in 2017–18, 193 of the 198 (97%) Aboriginal health services had participated in organisational planning processes, 164 (83%) had participated in regional health planning processes, 125 (63%) had representatives on external boards (for example, hospitals), and 121 (61%) had participated in state/territory or national policy development (Figure 3.13.3).

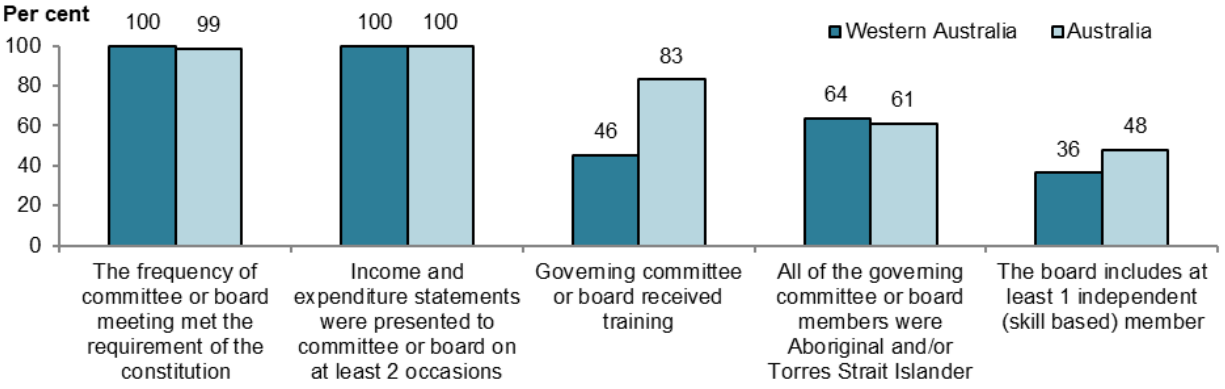
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.13.1: Governing committee or board information, Aboriginal primary health-care services, Western Australia and Australia, 2021–22



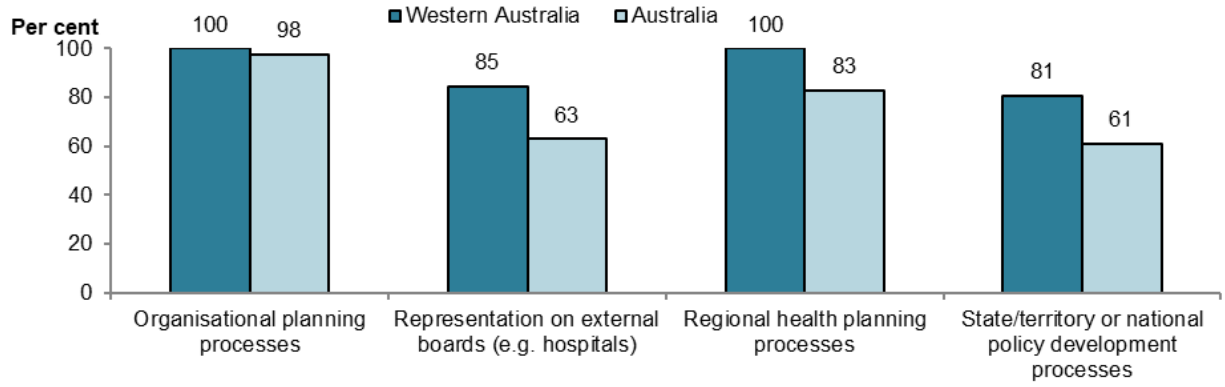
Source: Tables D3.13.3 and D3.13.3 WA.

Figure 3.13.2: Aboriginal substance-use services, governing committee or board information, Western Australia and Australia, 2017–18



Source: Tables D3.13.4 and D3.13.4 WA.

Figure 3.13.3: Aboriginal primary health-care services participating in mainstream processes, Western Australia and Australia, 2017–18



Source: Tables D3.13.5 and D3.13.5 WA.

3.14 Access to services compared with need

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) by Aboriginal people. Aboriginal people have significantly poorer health outcomes than non-Aboriginal people. Inequalities in health care access and use are considered important drivers of this difference (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 people and non-Aboriginal people. In 2018, Aboriginal people in Western Australia experienced burden of disease at 2.7 times the rate for non-Aboriginal people, a greater disparity than the national rate ratio of 2.3 times.

Key findings

Self-reported use of services: In 2022–23 in Western Australia, in the previous 12 months, an estimated 81% (95,100) of Aboriginal people had consulted a doctor or specialist, 41% (46,300 of those aged 2 and over) had seen a dentist or dental professional, and 27% (19,300 of those aged 15 and over) had accessed services for mental health. In the previous 12 months, 16% (19,400) had been admitted to hospital (ABS 2024d Table 55.1, Figure 3.14.1).

Nationally in 2022–23, 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 2024d Table 55.1, Figure 3.14.1).

Services claimed through Medicare: In 2023–24 in Western Australia, about 1.2 million Medicare claims were made for services provided to Aboriginal people, at a rate of 9,640 per 1,000 population (Table D3.14.30). The age-standardised rate of claims for Aboriginal people was 0.8 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 D3.14.23). The age-standardised rate of claims for Aboriginal people was 0.9 times the rate for non-Aboriginal people (Figure 3.14.2).

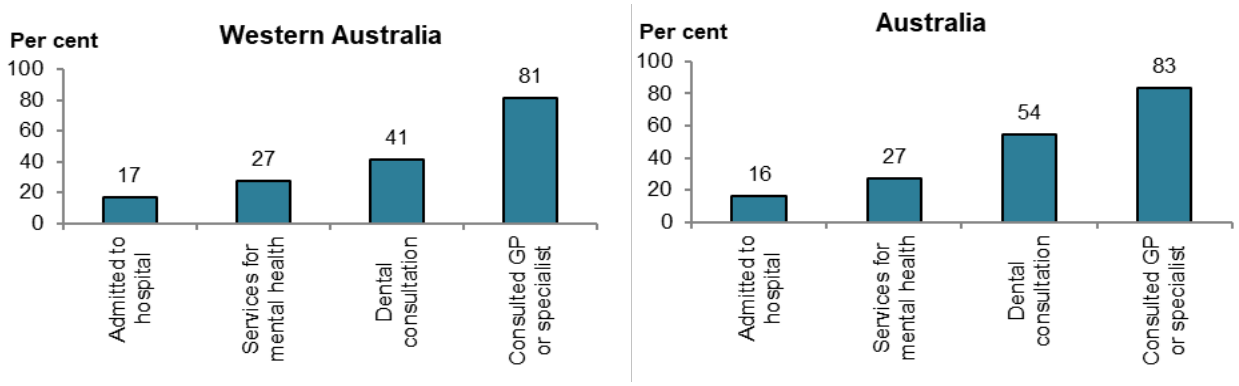
Hospitalisation for palliative care: Between July 2021 and June 2023 in Western Australia, there were 265 hospitalisations for palliative care for Aboriginal people, equivalent to 1.1 per 1,000 population (Table D3.14.48). After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised for palliative care at 1.7 times the rate for non-Aboriginal people (Figure 3.14.3).

Nationally over the same period, 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 people (Figure 3.14.3).

Elective surgery: Between July 2021 and June 2023 in Western Australia, 7.1% of Aboriginal people had a waiting time of more than 1 year for elective surgery, which was similar to non-Aboriginal Western Australia patients (6.8%). 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 patients (Table D3.14.51).

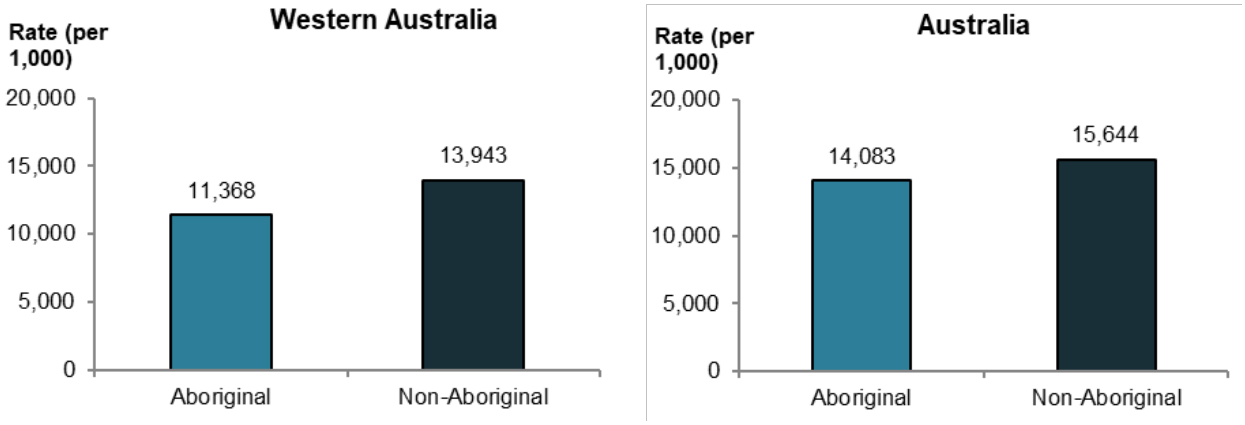
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.14.1: Aboriginal people accessing health-care services in the previous 12 months, Western Australia and Australia, 2022–23



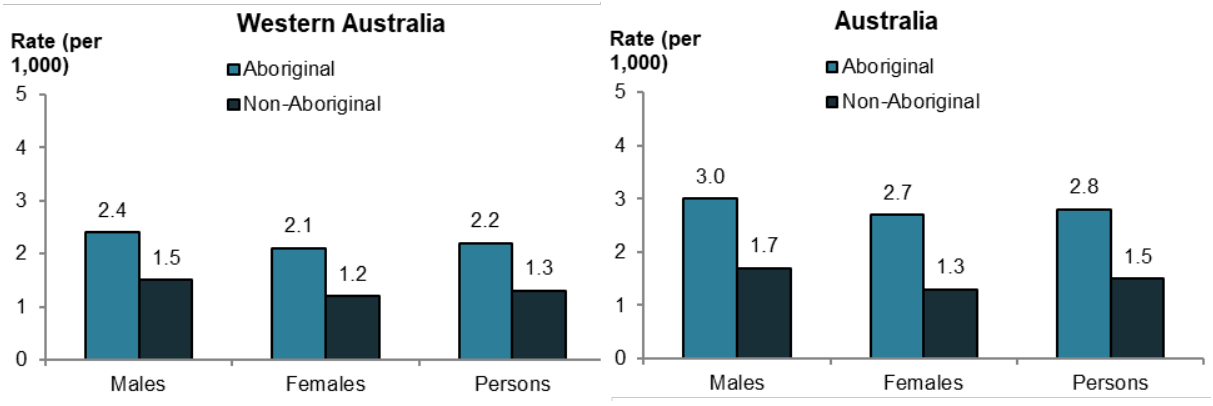
Source: ABS 2024d Table 55.3.

Figure 3.14.2: VII adjusted, age-standardised rate of total MBS services claimed, by Aboriginal status, Western Australia and Australia, 2023–24



Source: Table D3.14.31.

Figure 3.14.3: Age-standardised rate of hospitalisation for palliative care, by Aboriginal status and sex, Western Australia and Australia, July 2021 to June 2023



Source: Table D3.14.48.

3.15 Access to prescription medicines

Why it is important

This measure reports on First Nations 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 (WHO 2017). 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 Western Australia in 2022–23, an estimated 14% (7,200) 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 deciding it was not needed (42%), being too busy (38%), and cost (17%) (Figure 3.15.2). These estimates have a high margin of error and should be used with caution.

Nationally in 2022–23, 13% 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%) and deciding it was not needed (30%) (Figure 3.15.2).

Expenditure per person: Nationally in 2022–23, total expenditure (government and nongovernment) on benefit-paid pharmaceuticals for Aboriginal people was $685 million, which was an average of $677 per person. For non-Aboriginal people, the average expenditure was $758 per person (Table D3.15.1).

Australian Government expenditure: In Western Australia in 2022–23, expenditure on benefit-paid pharmaceuticals by the Australian Government was $596 per person for Aboriginal people. For non-Aboriginal people, the average expenditure on benefit-paid pharmaceuticals was $587 per person.

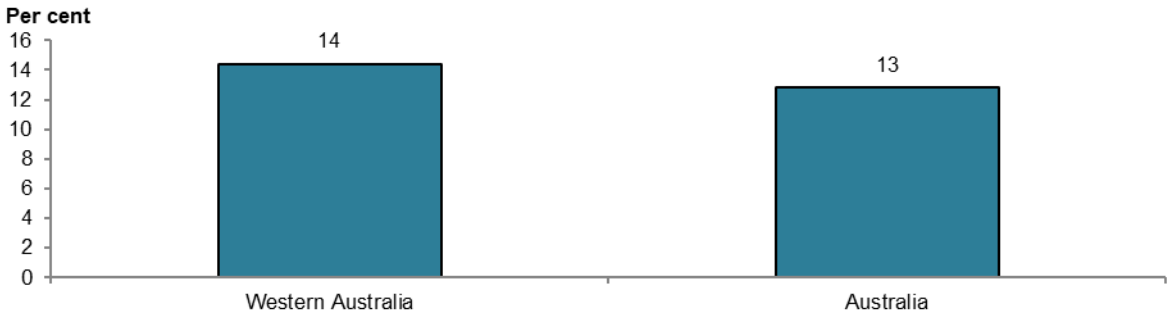
Nationally in 2022–23, expenditure on benefit-paid pharmaceuticals by the Australian Government was $636 per person for Aboriginal people. For non-Aboriginal people, the average expenditure on benefit-paid pharmaceuticals was $627 per person (Figure 3.15.3).

Individual expenditure: In Western Australia in 2022–23, expenditure on benefit-paid pharmaceuticals by individuals was $31 per person for Aboriginal people. For non-Aboriginal people, the average expenditure on benefit-paid pharmaceuticals was $129 per person.

Nationally in 2022–23, expenditure on benefit-paid pharmaceuticals by individuals was $41 per person for Aboriginal people. For non-Aboriginal people, the average expenditure on benefit-paid pharmaceuticals was $132 per person (Figure 3.15.3).

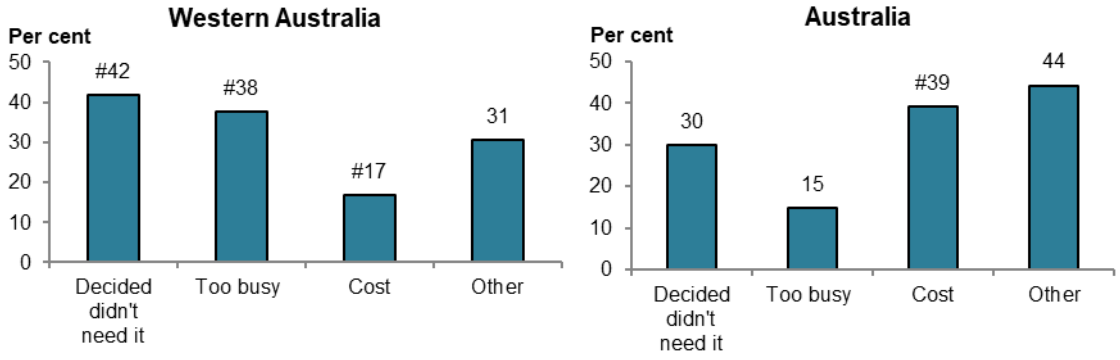
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.15.1: Aboriginal people aged 15 and over (non-remote areas) who had a prescription that did not get filled in the last 12 months, Western Australia and Australia, 2022–23



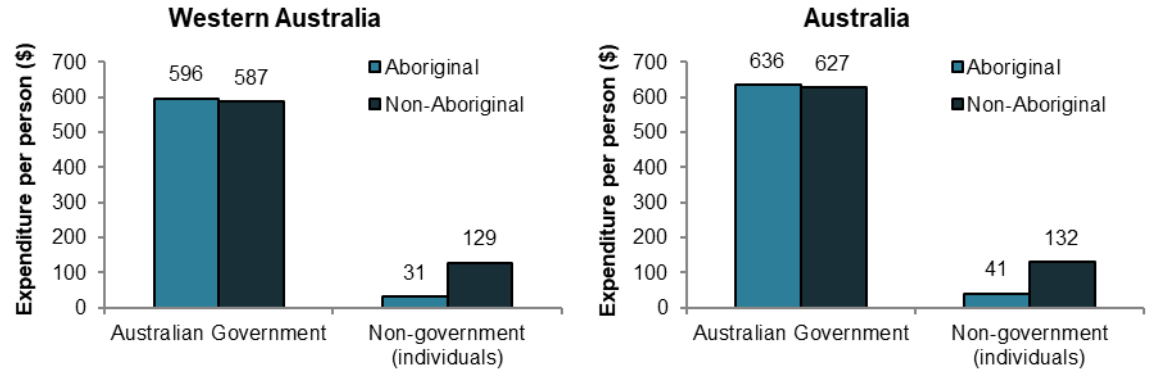
Note: This information was not collected from respondents in remote areas.
Source: Table D3.15.5.

Figure 3.15.2: Reasons for not filling prescriptions, Aboriginal people aged 15 and over (in non-remote areas), Western Australia and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.
Source: Table D3.15.5.

Figure 3.15.3: Per person expenditure on benefit-paid pharmaceuticals[(a)(b)], by source, and Aboriginal status, Western Australia 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: 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 for Aboriginal people. '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.

Key findings

After hours doctor: In 2022–23 in Western Australia, an estimated 2.6% (2,000) of Aboriginal people living in nonremote areas who saw a doctor in the previous 12 months did so outside normal business hours. Note this estimate has a high margin of error and should be used with caution.

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).

Services claimed through Medicare: In 2023–24 in Western Australia, there were 26,936 MBS claims for after-hours services provided to Aboriginal people, at a rate of 214 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 1.1 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).

Emergency department presentations, overall: In Western Australia, between July 2021 and June 2023, 49% (112,370) of emergency presentations for Aboriginal people occurred after hours. This was higher than the proportion for non-Aboriginal people (45%).

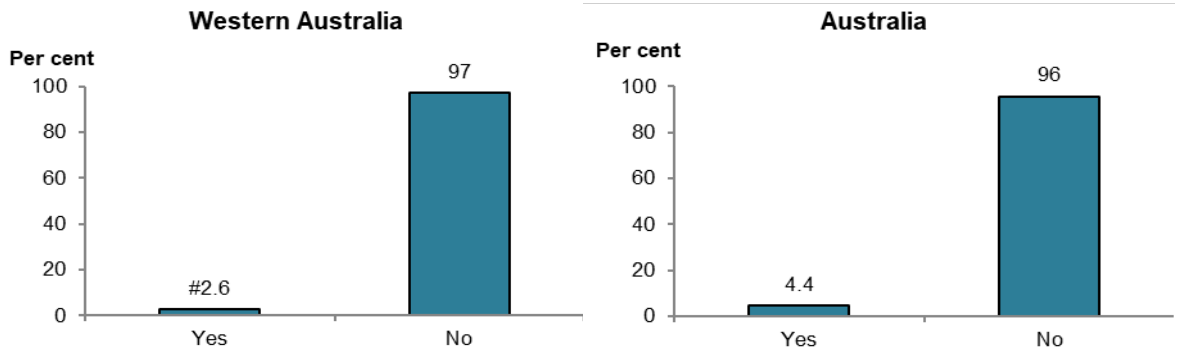
Nationally, between July 2021 and June 2023, 49% of emergency presentations for Aboriginal people occurred after hours. This was higher than the proportion for non-Aboriginal people (46%) (Figure 3.16.3).

Emergency department presentations, semi-urgent or non-urgent: In Western Australia, between July 2021 and June 2023, 46% (57,882) 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 afterhours emergency department episodes of care (43%).

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 (44%) (Table D3.16.11).

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.16.1: Proportion of Aboriginal people who saw a doctor[(a)] after hours in the last 12 months (non-remote areas), Western Australia and Australia, 2022–23

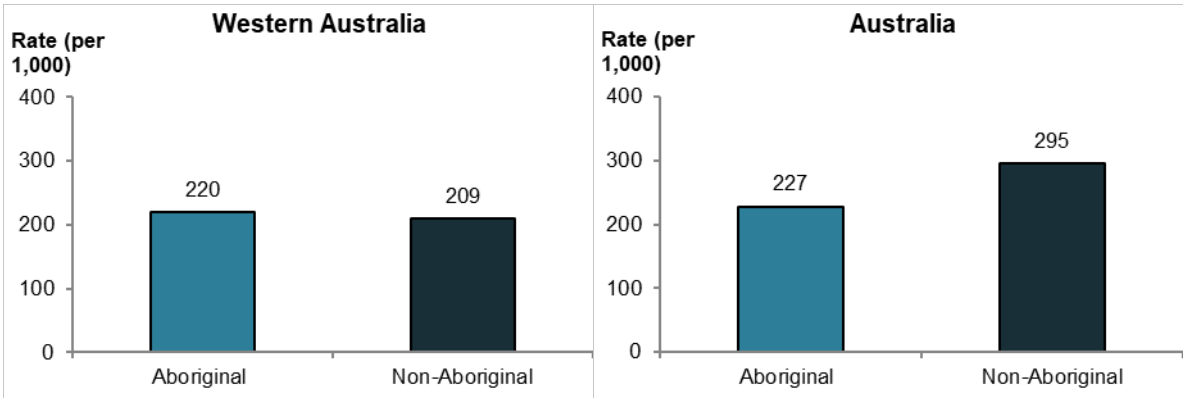


(a) Doctor includes general practitioners and specialists such as surgeons, pathologists, gynaecologists, radiologists, psychiatrists etc. This item includes all consultations with a doctor in the reference period, regardless of the type of treatment/service provided.

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

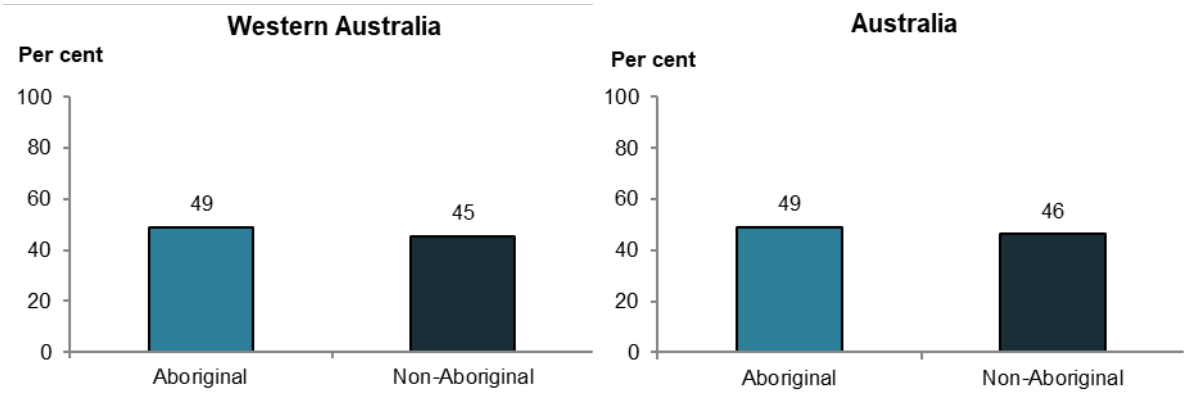
Source: Table D3.16.1.

Figure 3.16.2: VII adjusted, age-standardised rate of MBS services claims for after-hours care, by Aboriginal status, Western Australia and Australia, 2023–24



Source: Table D3.16.3.

Figure 3.16.3: Proportion of emergency department presentations that were after hours, by Aboriginal status of the patient, Western Australia and Australia, July 2021 to June 2023



Source: Table D3.16.10.

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 2025f).

Key findings

Overall: Based on self-reported data from the 2022–23 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), an estimated 92% (107,900) of Aboriginal people in Western Australia had a usual place to go for health problems and advice:

- 49% (57,800) usually went to a doctor/GP other than an Aboriginal Medical Services (AMS)
- 34% (39,700) usually went to an AMS or community clinic
- 7.3% (8,500) usually went to a hospital.

Nationally, a similar proportion (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).

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 Western Australia, Aboriginal people reported that:

- a doctor or GP was locally available (87%, 102,200)
- an AMS or community clinic was locally available (70%, 81,600)
- a hospital was locally available (76%, 89,000).

Other health care, including traditional healers, was locally available for 34% of Aboriginal people in Western Australia.

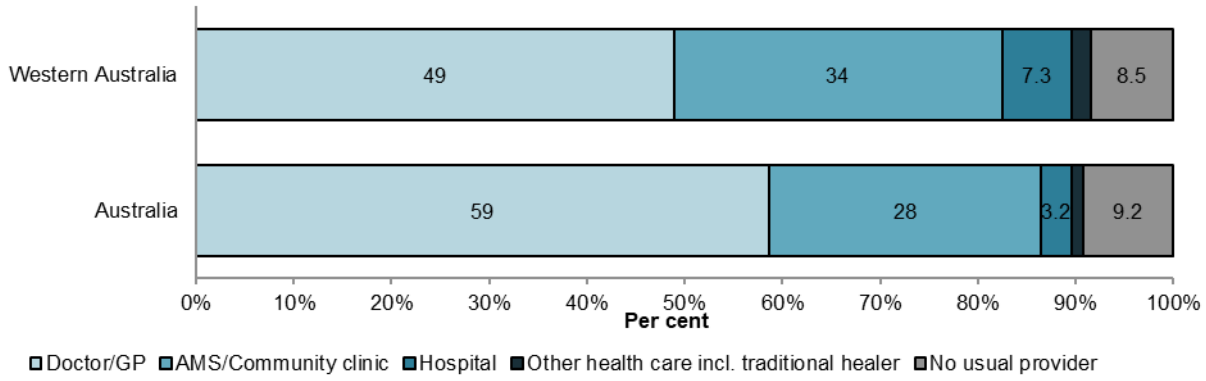
Nationally in 2022–23, around two-thirds Aboriginal people reported that an AMS or community clinic was locally available (69%) (Figure 3.17.2).

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 Western Australia, around 2 in 5 Aboriginal people reported they would prefer to go to an AMS or community clinic, or a doctor/GP (each 42%), 11% preferred a hospital, and 4.9% preferred other health care (including traditional healers).

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).

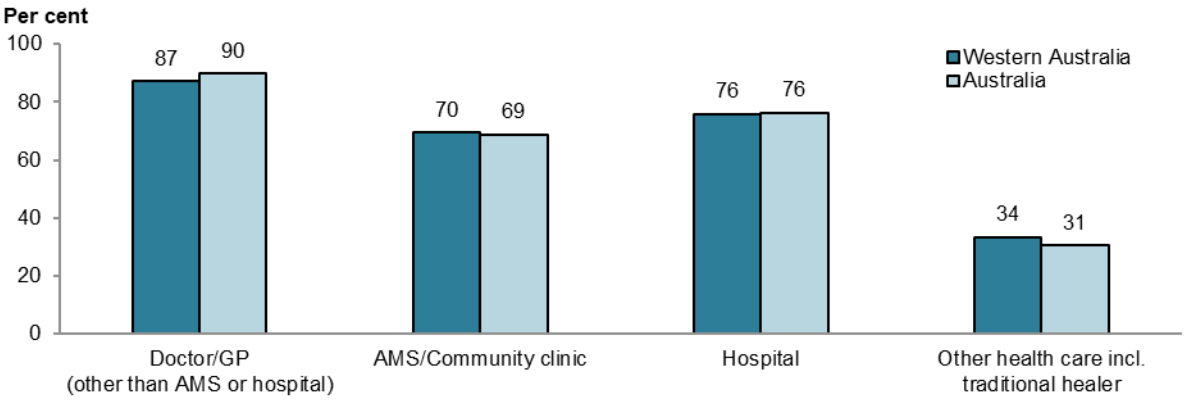
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.17.1: Usual source of health care by type, Aboriginal people, Western Australia and Australia, 2022–23



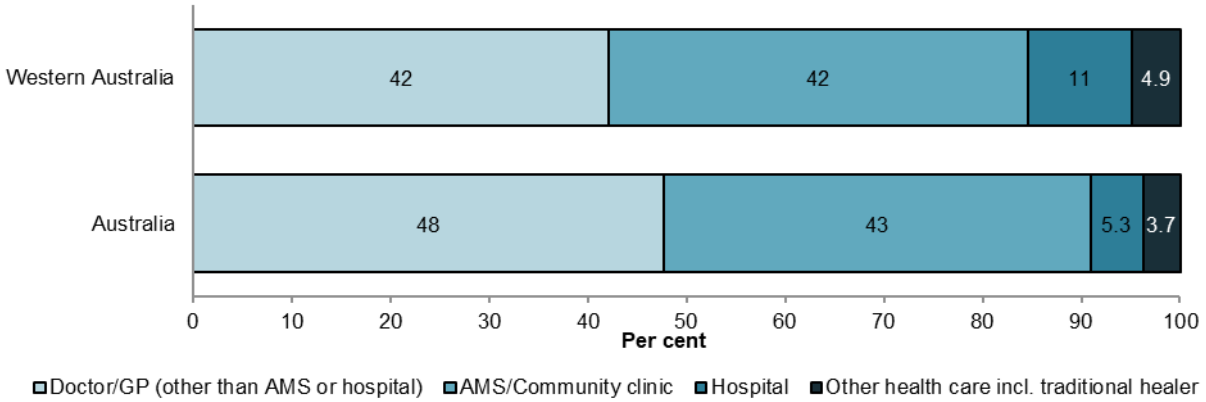
Source: Table D3.17.1.

Figure 3.17.2: Health services available in local area, Western Australia and Australia, 2022–23



Note: Estimates for 'No services available' are not presented due to data quality issues.
Source: Table D3.17.1.

Figure 3.17.3: Preferred source of health care by type, Aboriginal people, Western Australia and Australia, 2022–23



Source: 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 people is attributed to chronic diseases (AIHW 2016a). Effective management of chronic diseases can delay the progression of disease, reduce the need for highcost 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 Western Australia in 2023–24, there were 10,192 MBS claims for the preparation of GPMPs and 9,186 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 1.3 times the rate for non-Aboriginal patients in Western Australia in 2023–24 (Figure 3.18.1).

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 Western Australia, of regular (that is, has visited a particular PHC provider three or more times in the previous two years) Aboriginal patients of PHC organisations who had type 2 diabetes:

- 61% had a GPMP in the 2 years to December 2024, an increase of 5.4 percentage points from June 2023.
- 52% had a TCA in the 2 years to June 2020, a decrease of 0.4 percentage points from December 2018 (Figure 3.18.2).
- Nationally, of regular Aboriginal patients of PHC organisations who had type 2 diabetes:
- 55% had a GPMP in the 2 years to December 2024, an increase of 3.8 percentage points from June 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).

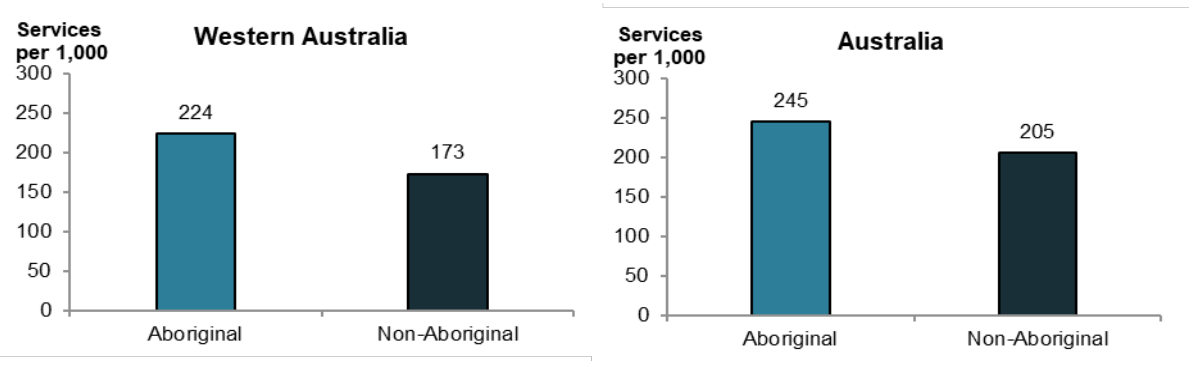
Note that the collection of this data ceased after June 2020, so these results cannot be updated.

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 Western Australia, 27% of the 11,400 Aboriginal people living with asthma had a written asthma action plan. Of the 255,800 non-Aboriginal people living with asthma, 34% had a written asthma action plan (Figure 3.18.3). Note that these estimates have a high margin of error and should be used with caution.

Nationally in non-remote areas in 2022–23, 34% of Aboriginal people and 35% of non-Aboriginal people with asthma had a written asthma action plan (Figure 3.18.3).

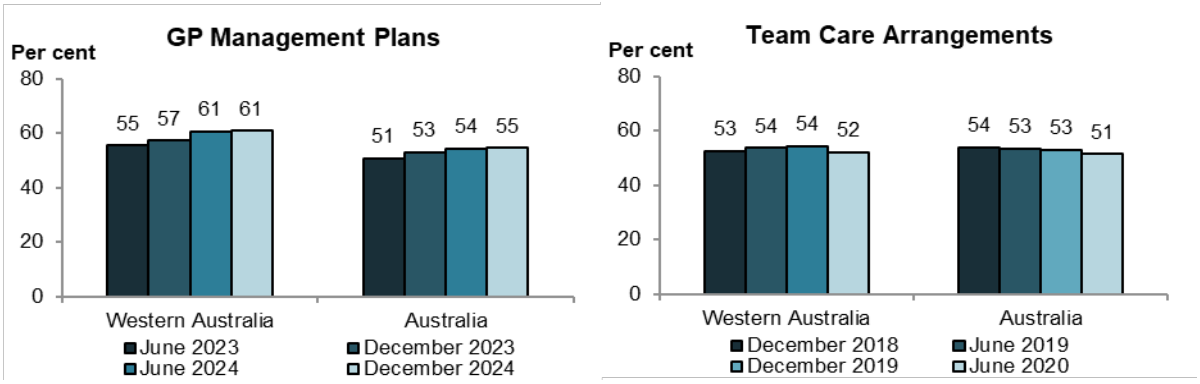
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.18.1: Age-standardised rate of GPMPs/TCAs claimed through Medicare, by Aboriginal status, Western Australia and Australia, 2023–24



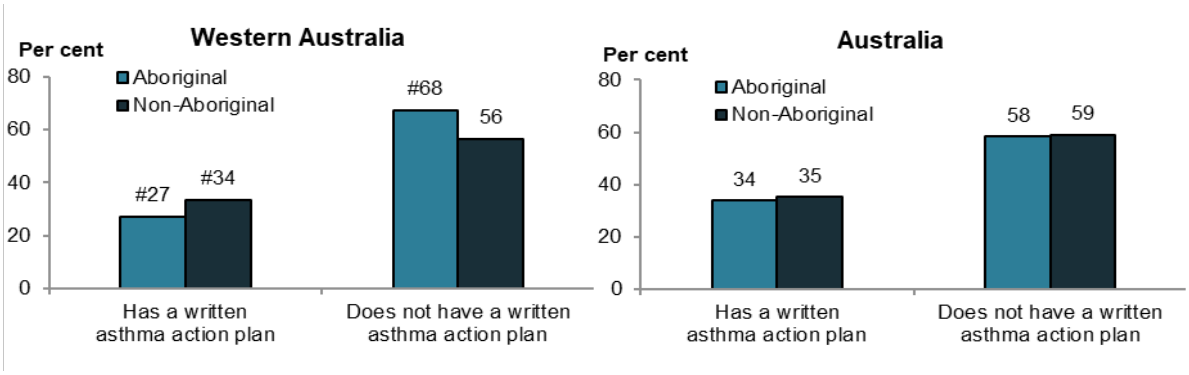
Source: Table D3.14.31.

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, Western Australia and Australia, 4 most recent periods



Note: Collection of information on Team Care Arrangements ceased after June 2020.
Source: Table D3.18.1.

Figure 3.18.3: People with asthma reporting having a written asthma action plan, by Aboriginal status, non-remote areas, Western Australia and Australia, 2022–23



Note: Estimated marked with # have a high margin of error and should be used with caution.
Source: Table D3.18.5.

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). As at 1 January 2020, there were 5 approved providers of general practice accreditation: Australian General Practice Accreditation Limited (AGPAL), Quality Practice Accreditation (QPA), the Australian Council on Health-care Standards (ACHS), Global-Mark, and the Institute for Healthy Communities Australia Certification (IHCAC) (ACSQHC 2021). General practice accreditation data for 2019 are available for 3 of these organisations; AGPAL, QPA and ACHS.

Key findings

Hospitals: In Western Australia between July 2021 and June 2023, 99.9% (136,228) of hospitalisations for Aboriginal people in public hospitals occurred in accredited hospitals, with the remaining 0.1% occurring in non-accredited hospitals (105 hospitalisations). The proportion of hospitalisations for non-Aboriginal people in accredited hospitals in Western Australia was also 99.9% (1,119,273 hospitalisations) (Figure 3.19.1).

Nationally between July 2021 and June 2023, 97.6% (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 97.2% (12,371,737 hospitalisations) (Figure 3.19.1).

General practice accreditation (overall): In Western Australia in 2019, 96% (592) of general practices registered with AGPAL, QPA or ACHS were fully accredited by the respective organisation (Figure 3.19.2).

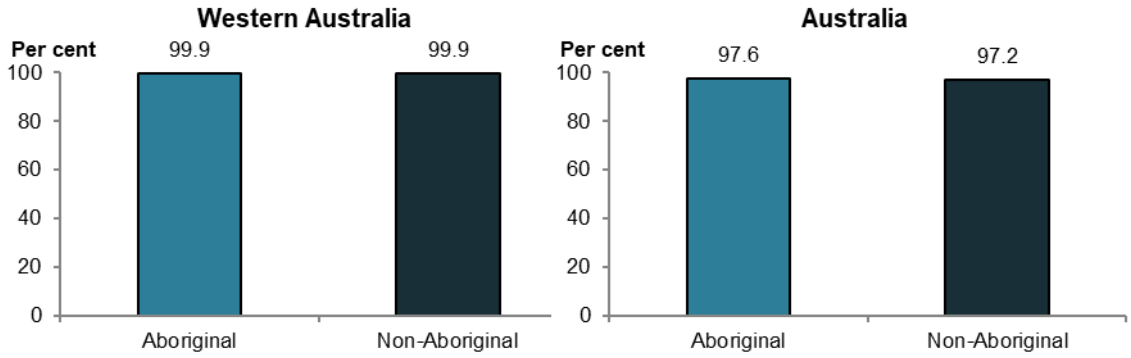
Nationally 96% (6,185) of general practices registered with AGPAL, QPA or ACHS were fully accredited by the respective organisation in 2019 (Figure 3.19.2).

General practice accreditation by Primary Health Network (PHN): In 2019, within PHNs in Western Australia, the proportion of general practices registered with AGPAL, QPA or ACHS that were fully accredited ranged from 95% in Perth South to 96% in Perth North and Country WA (Figure 3.19.2).

When the general practices in Western Australia are disaggregated into categories representing the proportion of the Aboriginal population in the PHN they service, the rate of accreditation of general practices was similar across all Aboriginal population size categories (95%-96%). Similar distribution was observed for the general practices nationally (94%-96%) (Figure 3.19.3).

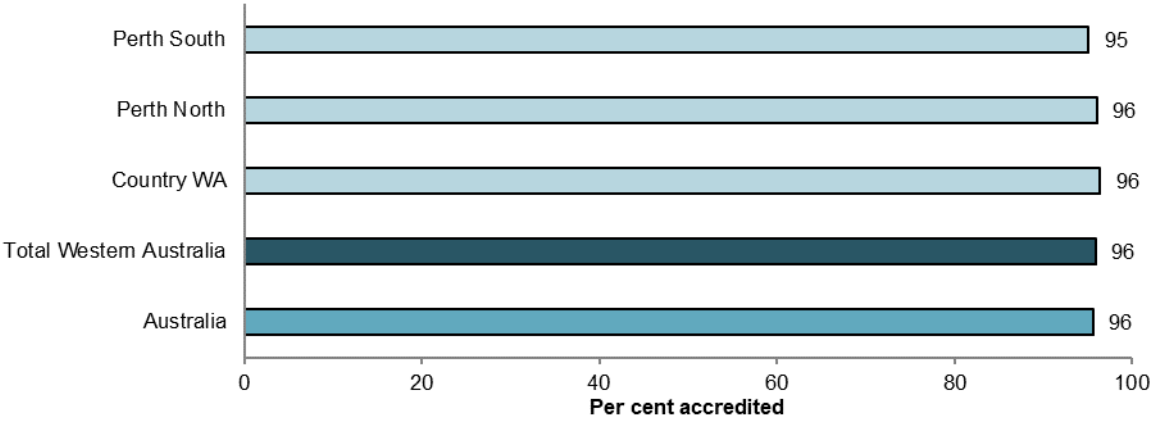
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.19.1: Public hospitalisations in accredited hospitals, by Aboriginal status, Western Australia and Australia, July 2021 to June 2023



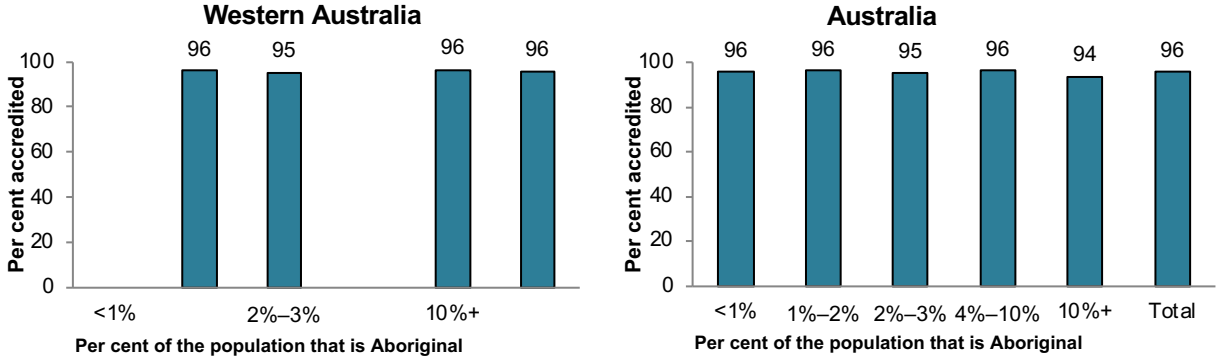
Source: Table D3.19.1.

Figure 3.19.2: General practices registered for accreditation through AGPAL, QPA or ACHS that had been accredited, by Primary Health Network area, Western Australia, 2019



Source: Tables D3.19.8, D3.19.5 WA.

Figure 3.19.3: General practices registered for accreditation through AGPAL, QPA or ACHS that had been accredited, by per cent of the population that is Aboriginal, Western Australia and Australia, 2019



Note: The <1% and 4%–10% population categories are not applicable for any PHNs in Western Australia.
Source: Tables D3.19.5 WA, D3.19.5.

3.20 Aboriginal people training for health-related disciplines

Why it is important

This measure reports on the participation of Aboriginal people in tertiary education for healthrelated 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 Western Australia in 2024, there were 477 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 55 enrolments per 10,000 population (Figure 3.20.1). In Western Australia, Aboriginal students accounted for 2.8% of total enrolments in VET health-related courses (Table D3.20.37).

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 Western Australia in 2024, Aboriginal students aged 15 and over completed 138 VET health-related courses (on a government-funded or fee-for-service basis), a rate of 16 completions per 10,000 population (Figure 3.20.1). In Western Australia, Aboriginal students accounted for 2.4% 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).

Higher education enrolments for health-related courses: In Western Australia in 2024, there were 158 commencements and 397 total enrolments for health-related higher education courses for Aboriginal undergraduate and postgraduate students aged 15 and over, rates of 18 commencements and 45 enrolments per 10,000 population, respectively. These rates were lower than those for non-Aboriginal students (Figure 3.20.2).

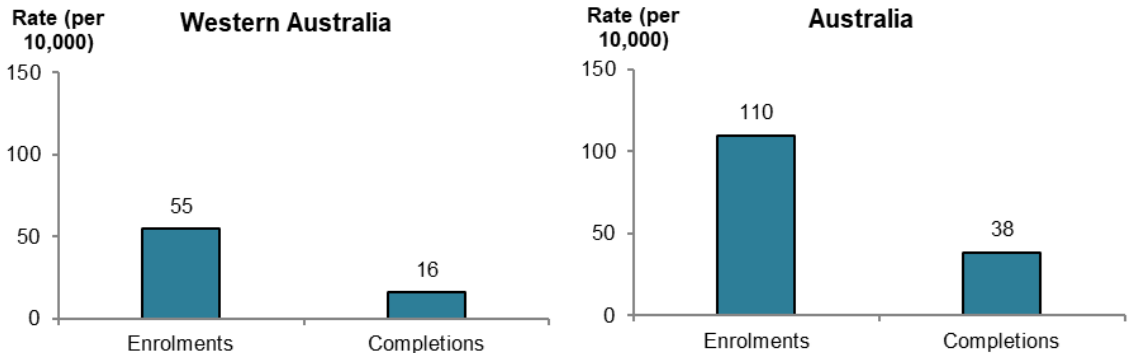
Nationally in 2024, the commencement rate for Aboriginal undergraduate and postgraduate students in health-related higher education courses was 26 per 10,000 population and the total enrolment rate was 66 per 10,000 population. These rates were lower than those for non-Aboriginal students (Figure 3.20.2).

Higher education completions for health-related courses: In Western Australia in 2024, there were 59 completions in health-related higher education courses for Aboriginal undergraduate and postgraduate students aged 15 and over, a rate of 6.8 completions per 10,000 population. This was one-third the completion rate (24 per 10,000) for non-Aboriginal students (Figure 3.20.3).

Nationally in 2024, the completion rate for Aboriginal undergraduate and postgraduate students was 15 completions per 10,000 population. This was half the completion rate (28 per 10,000) for non-Aboriginal students (Figure 3.20.3).

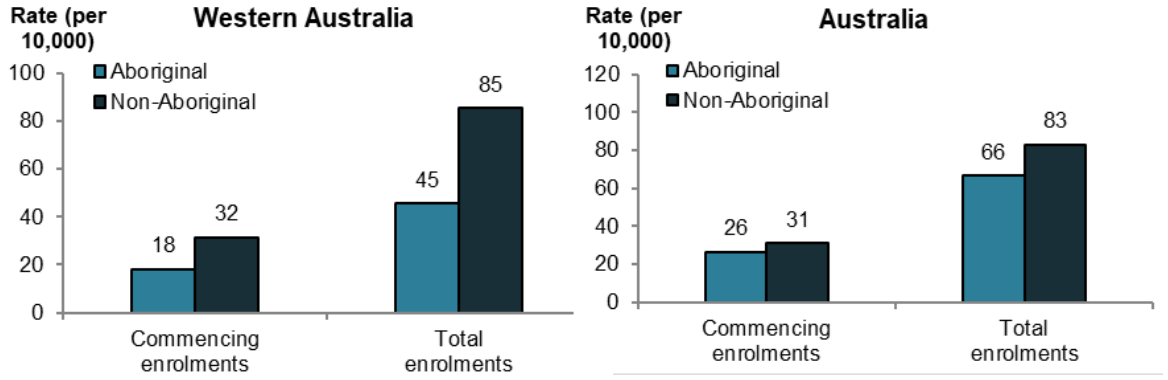
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.20.1: Vocational Education and Training (VET) health-related course enrolments and completions for Aboriginal people aged 15 and over, Western Australia and Australia, 2024



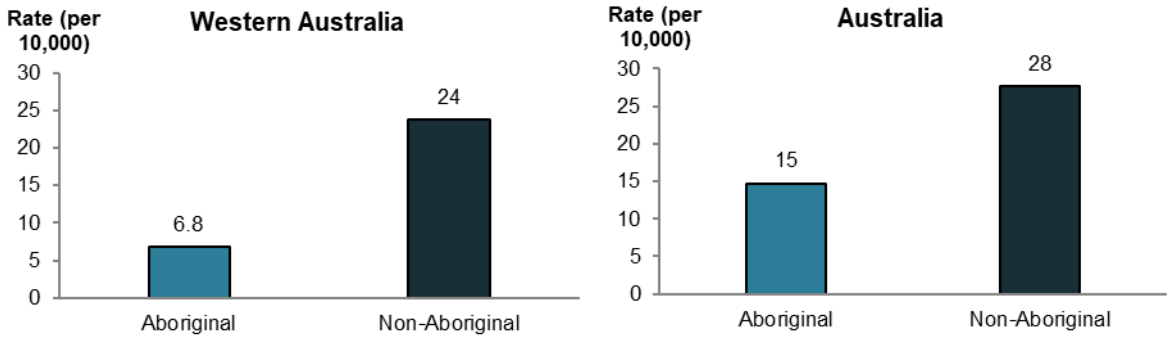
Source: Tables D3.20.37, D3.20.38.

Figure 3.20.2: Enrolments in undergraduate and postgraduate health-related courses, people aged 15 and over, by Aboriginal status, Western Australia and Australia, 2024



Source: Table D3.20.27.

Figure 3.20.3: Completions of undergraduate and postgraduate health-related courses, people aged 15 and over, by Aboriginal status, Western Australia and Australia, 2024



Source: Table D3.20.27.

3.21 Expenditure on Aboriginal health compared to need

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 2025). Data presented in this measure are recurrent expenditures and do not include capital expenditures.

Key findings

Total health expenditure: In 2022–23 in Western Australia, health expenditure for Aboriginal people was $1,559 million in total, accounting for 6.0% of the overall health expenditure in Western Australia. About two-fifths (38%) of this amount was spent on admitted patient services in public hospitals, 19% on non-admitted patient services in public hospitals, and 5% on benefit-paid pharmaceuticals. Under the Indigenous Australians' Health Programme (IAHP) 4.2% was spent on Australian Government Aboriginal-specific health programs. Health expenditure for non-Aboriginal people was $24,427 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, two fifths (38%) was spent on admitted patient services in public hospitals, 14% on non-admitted patient services in public hospitals, and 6% on Medicare services. Health expenditure for non-Aboriginal people was $225,402 million (Figure 3.21.1).

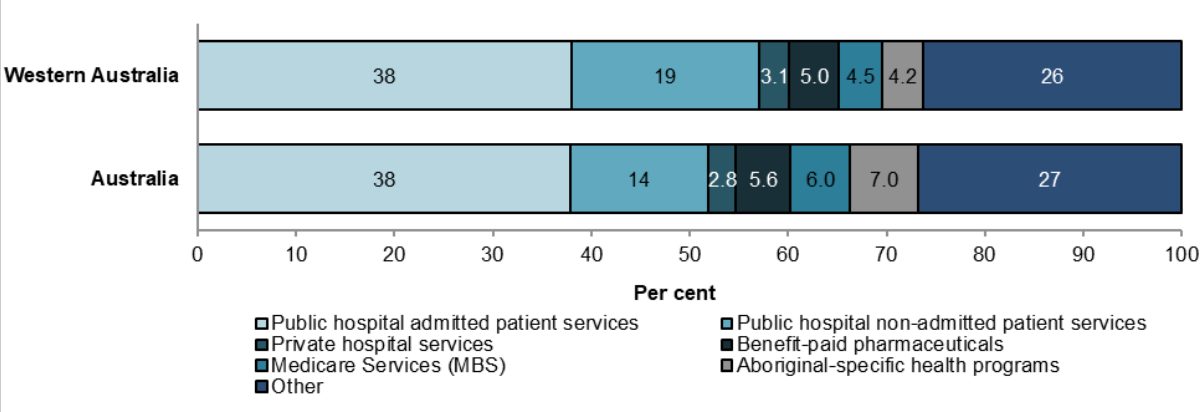
Public hospital services: In Western Australia in 2022–23, 57% ($889 million) of the health expenditure for Aboriginal people was for public hospital services (both admitted and non-admitted services). For non-Aboriginal people, expenditure on public hospital services accounted for 34% of the total ($8,277 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 Western Australia, 4.5% ($70 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 11% (2,673 million) of the total. Nationally, spending on Medicare services accounted for 6.0% (737million) of health expenditure for Aboriginal people, and 13% ($28,277) of that for non-Aboriginal people (Figure 3.21.2).

Benefit-paid pharmaceuticals: In 2022–23 in Western Australia, health expenditure on benefit-paid pharmaceuticals (including both government and individual contributions) for Aboriginal people was $77 million (5.0%) and for non-Aboriginal people $1,943 million (8.0%). 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).

Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

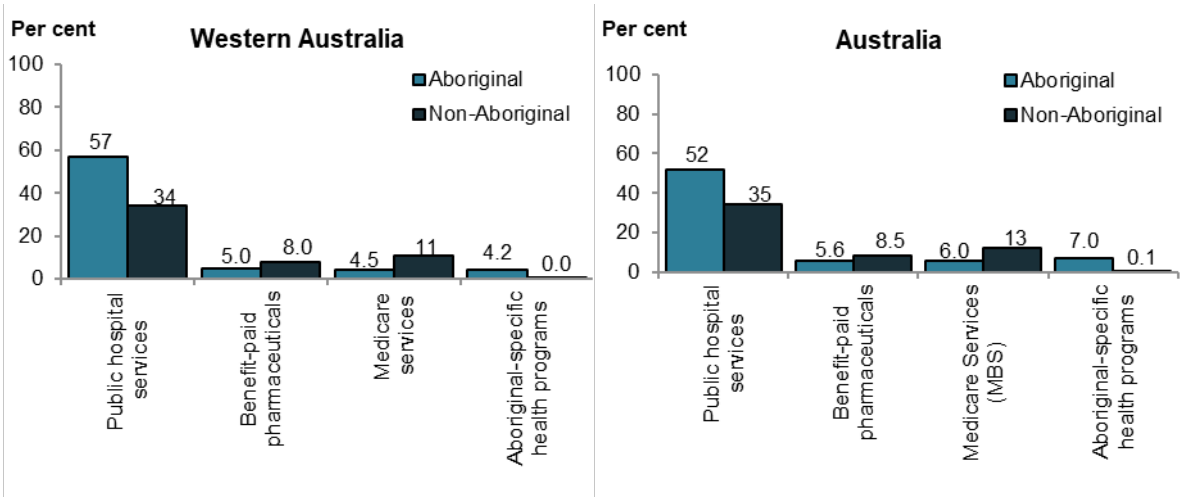
Figure 3.21.1: Health expenditure for Aboriginal people, by area of expenditure, Western Australia and Australia, 2022–23



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: Table D3.21.3.

Figure 3.21.2: Health expenditure on selected services, by Aboriginal status, Western Australia and Australia, 2022–23



IAHP Indigenous Australians' Health Programme

Note: Expenditure on Aboriginal-specific health programs can include expenditure on services also used by some non-Aboriginal people, such as ACCHOs.

Source: 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 other Australian 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 Western Australia in 2023, there were 12,777 registered medical practitioners in the medical workforce, 93% of whom were employed as clinicians. Registered medical practitioners not in the medical workforce included those who were retired (260), not currently employed (167) or overseas (188). There were 44,077 nurses and midwives in the nursing/midwifery workforce in Western Australia, 92% of whom were employed in nursing or midwifery. 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).

Aboriginal primary health-care organisations: In Western Australia, as at 30 June 2024, there were 821 full-time equivalent (FTE) health/clinical staff and 672 FTE administrative and support staff within Commonwealth-funded Aboriginal primary health-care organisations. The vacancy rate was 13% for health/clinical staff positions and 3.7% for administrative and support staff positions. Vacancies for health/clinical staff were highest for nurses (20 FTE), followed by Aboriginal health worker/practitioners (17 FTE) and doctors/general practitioners (13 FTE) (AIHW 2025a OSR table S2.2).

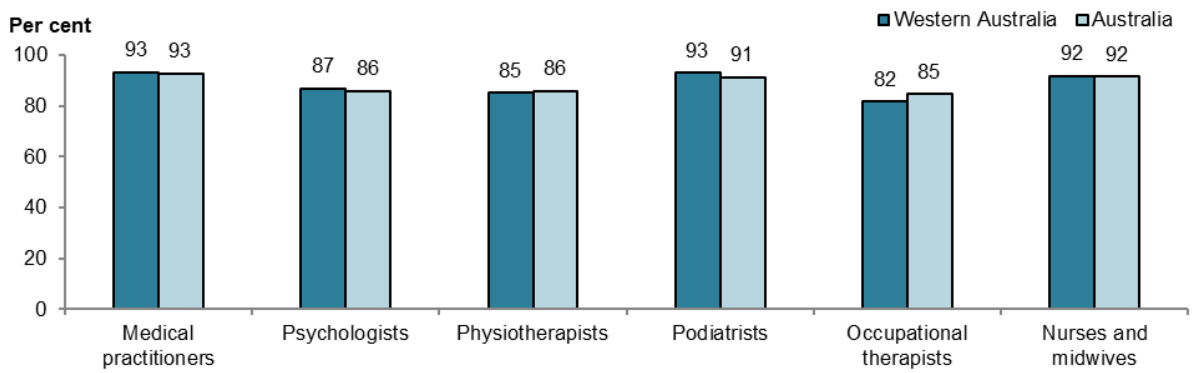
In Western Australia from 2019 to 2023, the vacancy rates increased from 7.4% to 13% for health/clinical positions and from 1.9% to 3.7% for administrative and support positions (AIHW 2025a, Figure 3.22.2). Nationally, from 2019 to 2024, the vacancy rates for health/clinical staff positions grew from 6.3% to 12%, while administrative and support position vacancies grew from 2.6% to 5.2% (Figure 3.22.2).

Vacancy rates in ACCHOs: In Western Australia, as at 30 June 2024, within Commonwealth-funded Aboriginal primary health-care organisations, the vacancy rates for health/clinical staff in Aboriginal Community Controlled Health Organisations (ACCHOs) were higher than in non-ACCHOs (14% compared with 6.9%). Vacancy rates for other staff were lower in ACCHOs than in non-ACCHOs (3.4% compared with 6.6%) (Figure 3.22.3).

Nationally, as at 30 June 2024, within Commonwealth-funded Aboriginal primary health-care organisations, the vacancy rates for health/clinical staff in Aboriginal Community Controlled Health Organisations (ACCHOs) were lower than in non-ACCHOs (11% compared with 23%). Vacancy rates for other staff were also lower in ACCHOs than in non-ACCHOs (4.6% compared with 14.3%) (Figure 3.22.3).

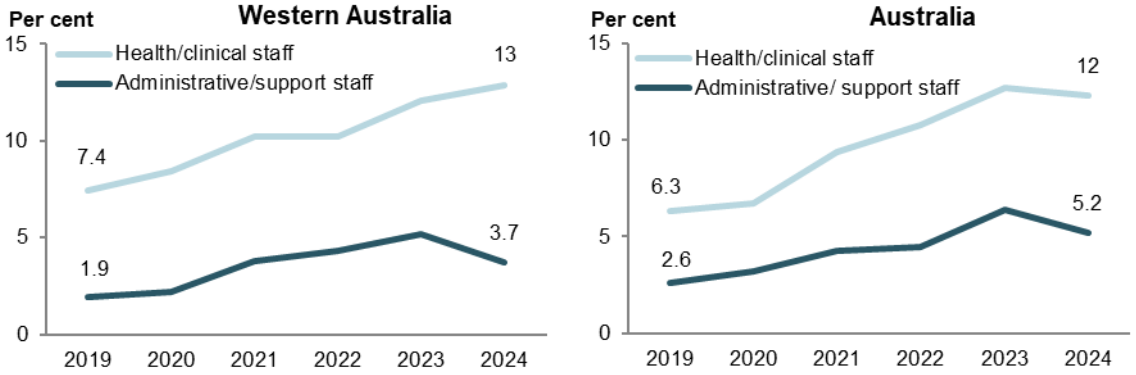
Data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

Figure 3.22.1: Health practitioners in their field's workforce employed as clinicians in their field, by type of profession, Western Australia and Australia, 2023



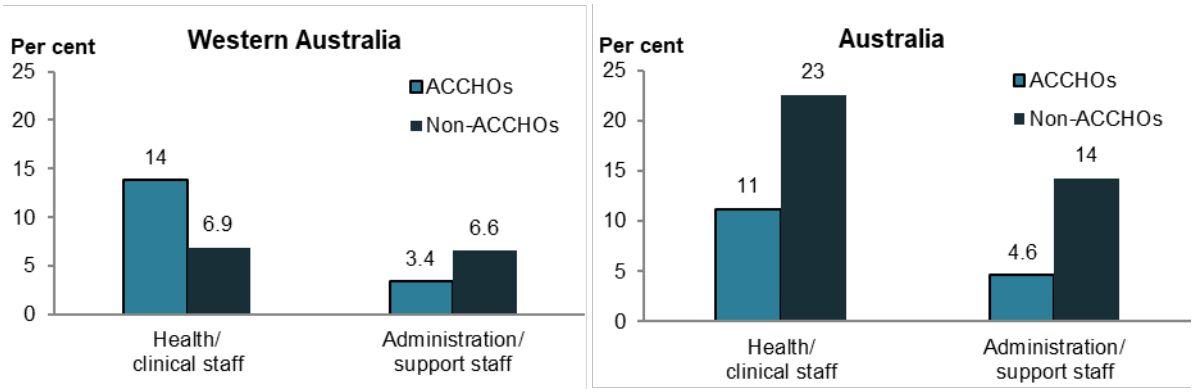
Source: Tables D3.22.1, D3.22.5, D3.22.6, D3.22.7, D3.22.9 and D3.22.10.

Figure 3.22.2: FTE vacant positions in Aboriginal primary health-care organisations, by position type, Western Australia and Australia, 30 June 2019 to 30 June 2024



Sources: AIHW 2025a Tables S2.2 and S2.16.

Figure 3.22.3: FTE vacant positions in Aboriginal primary health-care organisations, by position type and organisation type, Western Australia and Australia, at 30 June 2024



Source: AIHW 2025a Tables S2.5 and S2.19.

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.

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Thanks to staff from this agency for review and feedback on this report.

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

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

Glossary

Aboriginal and Torres Strait Islander household: Household that contains one or more people identified as being of Aboriginal and/or Torres Strait Islander origin.

Aboriginal and Torres Strait Islander people: In most data collections, a person who identified themselves, or was identified by another household member, as being of Aboriginal or Torres Strait Islander origin. For a few data collections, information on acceptance of a person as being Aboriginal and Torres Strait Islander by a First Nations community may also be required. Also referred to as **First Nations people**.

admission: An admission to hospital. Within the relevant topic summaries, the term hospitalisation is used to describe an episode of hospital care that starts with the formal admission process and ends with the formal separation process. The number of separations has been taken as the number of admissions; hence, the admission rate is the same as the separation rate.

age-specific rate: Rate for a specified age group. Both numerator and denominator refer to the same age group.

age-standardisation: Method to remove the influence of age when comparing rates between population groups with different age structures. This is used as the rate of many diseases vary strongly (usually increasing) with age, and so too can service use, for example, hospitalisations – a population group with an older age structure will likely have more hospitalisations. The age structures of different populations are converted to the same 'standard' structure, and then the relevant rates, such as hospitalisations, that would have occurred within that structure are calculated and compared.

age-standardised rates: are incidence, or prevalence rates that enable comparisons to be made between populations that have different age structures. The age structures of the different populations are converted to the same 'standard' structure, and then the rates that would have occurred with that structure are calculated and compared. Rates can be expressed in many ways, examples, per 100,000 per population years, per 100,000 population and per 1,000 population.

antenatal care: A planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. It does not include visits where the sole purpose is to confirm the pregnancy. Also known as an antenatal visit.

burden of disease (or injury): The quantified impact of a disease or injury on a population, using the disability-adjusted life years (DALYs) measure. One DALY is equivalent to one healthy year of life lost.

cardiovascular disease/condition: Any disease that affects the circulatory system, including the heart and blood vessels. Examples include coronary heart disease, heart failure, rheumatic fever and rheumatic heart disease, congenital heart disease, stroke and peripheral vascular disease.

care and protections orders: Legal orders or arrangements that give child protection departments some responsibility for a child's welfare.

child maltreatment: Child maltreatment refers to the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

chronic obstructive pulmonary disease (COPD): Serious, progressive and disabling long-term lung disease where damage to the lungs, usually because of both emphysema and chronic bronchitis, obstructs oxygen intake and causes increasing shortness of breath. By far the greatest cause is cigarette smoking.

circulatory disease: Alternative name for cardiovascular disease.

coronary heart disease: A disease due to blockages in the heart's own (coronary) arteries, expressed as angina or a heart attack. Also known as **ischaemic heart disease**.

COVID-19 (Coronavirus disease 2019): An infectious disease caused by the SARS-CoV-2 virus.

crude rate: A rate derived from the number of events recorded in a population during a specified time period, without adjustments for other factors such as age (see age-standardisation).

dialysis: An artificial method of removing waste substances from the blood and regulating levels of circulating chemicals – functions usually performed by the kidneys.

disability-adjusted life year (**DALY**): A year (1 year) of healthy life lost, either through premature death or equivalently through living with disability due to illness or injury. It is the basic unit used in burden of disease and injury estimates.

ear or hearing problems: Diseases of the ear and mastoid including deafness, otitis media, other diseases of the middle ear and mastoid, Meniere's disease, other diseases of the inner ear and other diseases of the ear.

employed: The term 'employed' includes people who have worked for at least 1 hour in the reference week.

First Nations people: see **Aboriginal and Torres Strait Islander people.**

high blood pressure/hypertension: High blood pressure is defined as when the systolic blood pressure is greater than or equal to 140 mmHg, and/or diastolic blood pressure is greater than or equal to 90 mmHg. Hypertension is a diagnosed medical condition where a person's blood pressure is consistently high, a single high measurement indicates a need for further medical follow up. Generally, if a person has a high blood pressure reading taken on at least 2 separate days by a health professional, this may indicate a diagnosis of hypertension (Health Direct n.d.; Heart Foundation n.d).

high blood triglycerides: Triglycerides make up about 95 per cent of all dietary fats. In many cases, regular overeating leading to obesity causes a person to have raised triglycerides, which are linked with an increased risk of health conditions including diabetes and heart disease. High triglyceride levels in the blood are also known as hypertriglyceridemia.

hospitalisation: An episode of hospital care that starts with the formal **admission** process and ends with the formal **separation** process (synonymous with **admission** and **separation**). An episode of care can be completed by the patient's being discharged, being transferred to another hospital or care facility, or dying, or by a portion of a hospital stay starting or ending in a change of type of care (for example, from acute to rehabilitation).

illicit drugs: Illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes.

incidence: The number of new cases (of an illness or event, and so on) in a given period. Compare with **prevalence**.

infant death: The death of a child before one year.

ischaemic heart disease: Ischaemic heart disease, or myocardial ischaemia, is a disease characterised by reduced blood supply (ischaemia) of the heart muscle, usually due to coronary artery disease. See also **coronary heart disease**.

labour force: People who are employed or unemployed (not employed but actively looking for work). Also known as the **workforce**.

life expectancy: Life expectancy measures how long a person is expected to live if the rest of their life follows the age and sex-specific mortality rates applicable to their respective year of birth. This is the expectation of the average years that a person lives at a specific age.

mastoid process: The mastoid process – a bony protrusion located behind the ear in the lower part of the skulls – contains mastoid cells (small air-filled cavities) that communicate with the middle ear. Infection of the mastoid process can lead to hearing loss and other complications.

neoplasms: An abnormal mass of tissue that results when cells divide more than they should or do not die when they should. Neoplasms may be benign (not cancer), or malignant (cancer). Also called tumour.

otitis media: Also known as middle ear infection. In severe or untreated cases, otitis media can lead to hearing loss.

overweight and obesity: Overweight and obesity are measured using height and weight to calculate Body Mass Index (BMI). BMI scores in the range 25.00 to 29.99 are classified as 'overweight' and scores 30.00 or more as 'obese'.

perinatal: Describes something that pertains to, or that occurred in, the period shortly before or after birth (usually up to 28 days after).

perinatal death: A fetal or neonatal death of at least 20 weeks gestation or at least 400 grams birthweight.

prevalence: The number or proportion (of cases, instances, and so forth) in a population at a given time. For example, in relation to cancer, refers to the number of people alive who had been diagnosed with cancer in a prescribed period (usually 1, 5, 10 or 26 years). Compare with **incidence**.

primary health care: These are services delivered in many settings, such as general practices, community health centres, Aboriginal health services and allied health practices (for example, physiotherapy, dietetic and chiropractic practices) and come under numerous funding arrangements.

principal diagnosis: The diagnosis established after study to be chiefly responsible for occasioning an episode of patient care (hospitalisation), an episode of residential care or an attendance at the health care establishment. Diagnoses are recorded using the relevant edition of the International statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM).

rheumatic heart disease (RHD): RHD may develop after illness with rheumatic fever, usually during childhood. Rheumatic fever can cause damage to various structures of the heart including the valves, lining or muscle and this damage is known as RHD (see also acute rheumatic fever).

separation: An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.

statistical significance: A statistical measure indicating how likely the observed difference or association is due to chance alone. Rate differences are deemed to be statistically significant when their confidence intervals do not overlap, since their difference is greater than what could be explained by chance.

syphilis (infectious): A sexually transmitted infection, which if untreated can cause irreversible damage. It is caused by Treponema pallidum bacteria. It is a notifiable disease.

unemployed: The term 'unemployed' refers to people who are without work, but have actively looked for work in the last four weeks and are available to start work.

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The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was developed to monitor progress towards health equity for Aboriginal and Torres Strait Islander 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 Aboriginal people in Western Australia

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Stronger evidence,
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