Australian Government
Australian Institute of Health and Welfare

AIHW

Aboriginal and Torres Strait Islander Health Performance Framework

Queensland 2025 report

The AIHW is an independent statutory Australian Government agency producing authoritative and accessible information and statistics to inform and support better policy and service delivery decisions, leading to better health and wellbeing.

A complete list of the Institute's publications is available from the Institute's website www.aihw.gov.au.

ISBN 978-1-923272-59-0 (Online)

ISBN 978-1-923272-60-6 (Print)

Suggested citation

Australian Institute of Health and Welfare (2025) *Aboriginal and Torres Strait Islander Health Performance Framework: Queensland 2025 report*, catalogue number IHPF 13, AIHW, Australian Government.

Any enquiries relating to copyright or comments on this publication should be directed to:
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Tel: (02) 6244 1000
Email: info@aihw.gov.au

Published by the Australian Institute of Health and Welfare.

Cover art by Jay Hobbs

Please note that there is the potential for minor revisions of data in this report.

Please check the online version at www.aihw.gov.au for any amendment.

Contents

Summary

The *Aboriginal and Torres Strait Islander Health Performance Framework Queensland 2025 report* finds mixed results, with some areas of improvement and other areas of concern for First Nations people living in Queensland across the three tiers. A snapshot of these findings are below.

Areas of improvement

- The age-standardised rate of cardiovascular disease deaths from 2010 to 2019 for First Nations people in Queensland decreased by 15%, from 277 to 248 per 100,000 population.
- The death rate for First Nations infants in Queensland dropped slightly from 6.2 per 1,000 live births in 2010–2012 to 5.6 per 1,000 live births in 2019–2021.
- Over the period 2011 to 2021, the proportion of First Nations people aged 20–24 in Queensland who had completed Year 12 or equivalent increased from 61% to 75%.
- The proportion of First Nations people living in overcrowded households in Queensland fell between 2004–05 and 2018–19 from 30% to 20%. The 2021 Census showed that in Queensland, 81% of First Nations people lived in appropriately sized housing.
- The rate of First Nations young people aged 10–17 in Queensland who were under youth justice supervision on an average day decreased from 198 per 10,000 in 2012–13 to 175 per 10,000 in 2021–22.
- The proportion of First Nations people aged 15 and over in Queensland who were current smokers declined over time, from 51% in 2002 to 43% in 2018–19.

Areas of concern

- Between 2012 and 2021, the incidence rate of kidney failure with replacement therapy for First Nations people in Queensland increased by 53%, from 27 to 41 per 100,000 population.
- From 2012 to 2021, incidence rates of acute rheumatic fever (ARF) among First Nations people in Queensland increased from 49 per 100,000 to 60 per 100,000. Over the same time period, the incidence rate of rheumatic heart disease (RHD) among First Nations people in Queensland increased from 43 to 56 new cases per 100,000 population.
- Over the time period 2011–12 to 2020–21, the age-standardised hospitalisation rate for injury and poisoning increased by 53% for First Nations people in Queensland, from 40 to 61 per 1,000 population.
- In Queensland, over the decade from 2010 to 2019, the age-standardised death rate due to intentional self-harm for First Nations people increased by 64%.
- Between 2012–13 and 2018–19 in Queensland, the proportion of First Nations people aged 15 years and over who were overweight or obese increased from 66% to 70%.
- The age-standardised imprisonment rate for First Nations adults in Queensland increased by 52%, from 1,330 per 100,000 in 2013 to 2,047 per 100,000 in 2022.
- the age-standardised rate of potentially avoidable deaths for First Nations people in Queensland did not change significantly from 2010 to 2019.

Introduction

The *Aboriginal and Torres Strait Islander Health Performance Framework Queensland 2025 report* provides the latest information on the health and welfare of First Nations people in Queensland, 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
- Tier 2: Determinants of health
- Tier 3: Health system performance.

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 First Nations 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 First Nations 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 (First Nations) 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.

This report uses the following terminology preferred by Queensland Health:

- 'First Nations people' when referring to Aboriginal and Torres Strait Islander people.
- 'Other Queenslanders' or 'Other Australians' (for national data) when referring to non-Indigenous Queenslanders/Australians.

Acknowledging First Nations peoples' right to self-determination, Queensland Health respects the choice of Aboriginal and Torres Strait Islander peoples to describe their own cultural identities which may include these or other terms, including particular sovereign peoples (for example Yidinji or Turrbal) or traditional place names (for example, Meanjin Brisbane) (Queensland Health 2024). The terminology used may differ to that used on the broader HPF website (indigenoushpf.gov.au).

Note that references to 'First Nations people' in this report refer to First Nations people in Australia only.

In most Australian data collections, First Nations 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 a First Nations 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 are updated on a regular basis, and may therefore have more current data than that presented in this report.

The measures also include sections on research and evaluations, and implications of findings. These provide 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.

Interpretation of results

While most results are presented for Queensland 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 First Nations people and non-Indigenous Australians 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.

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 (series B) of the First Nations population based on the 2016 Census, as published by the ABS (ABS 2019a). The base population is the Aboriginal and Torres Strait Islander estimated resident population of Australia at 30 June 2016, derived from 2016 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 more information, see https://www.indigenoushpf.gov.au/Resources.

Demographic and social context

In Queensland at 30 June 2021:

- there were an estimated 273,119 First Nations people, 5.2% of the state's total population
- First Nations people represented more than one-quarter (27.8%) of the total First Nations population in Australia.

Table D1: Estimated resident population by Indigenous status, Queensland and Australia, 30 June 2021

	First Nations		Other		Total			
	Number	%	Number	%	Number	%	% First Nations	% Other
Queensland	273,119	27.8	4,942,695	20.0	5,215,814	20.3	5.2	94.8
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.

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

- 86.5% (146,113 people) of First Nations people lived in non-remote areas: 37.7% lived in *Major cities*, 22.9% in *Inner regional* areas and 25.9% in *Outer regional* areas
- around 1 in 7 First Nations people (13.6% or 37,006 people) lived in *Remote* (5.3%) or *Very remote* areas (8.3%)
- the proportion of the total population in each area who were First Nations increased with remoteness, from 3.0% in *Major cities*, to 42.2% in *Very remote* areas (Table D2).

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

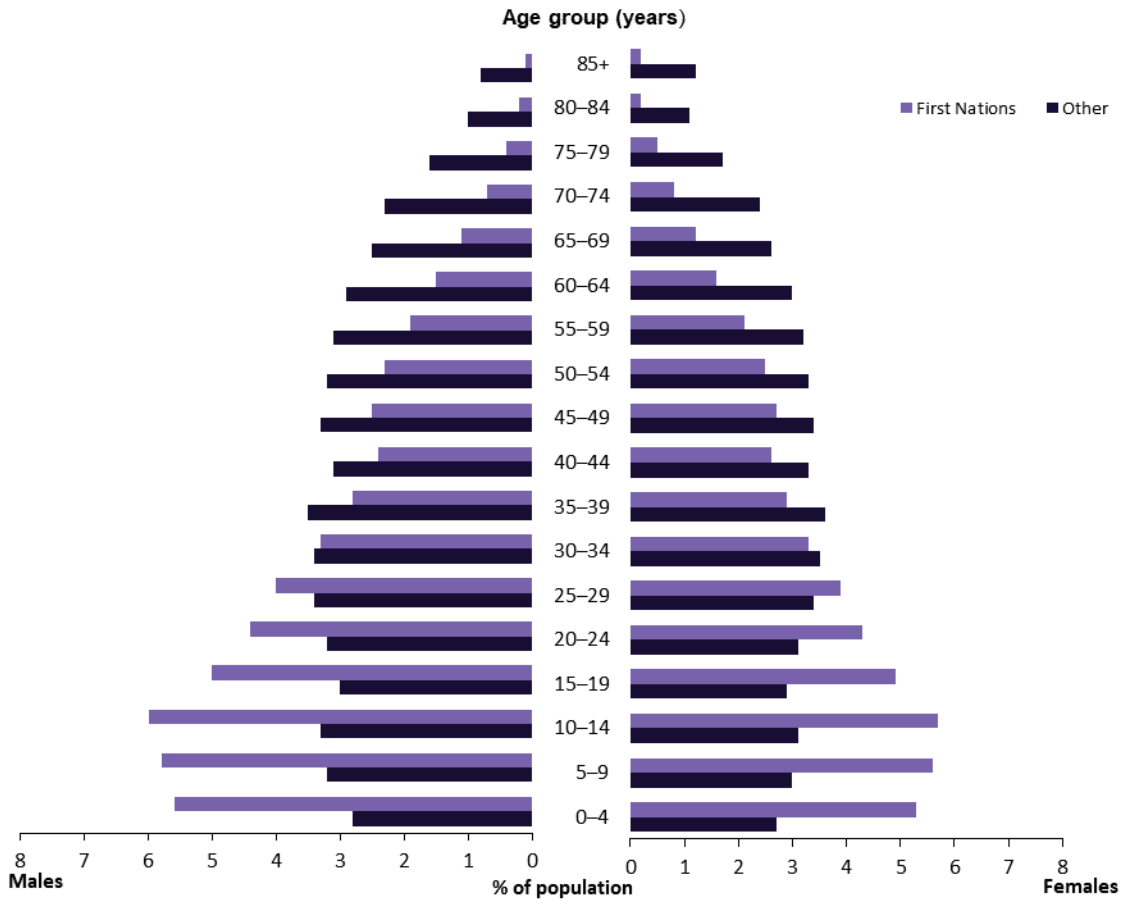
	First Nations		Other		Total			
	Number	%	Number	%	Number	%	% First Nations	% Other
					Queensland			
Major cities	102,880	37.7	3,279,991	66.4	3,382,871	64.9	3.0	97.0
Inner regional	62,547	22.9	946,976	19.2	1,009,523	19.4	6.2	93.8
Outer regional	70,686	25.9	626,609	12.7	697,295	13.4	10.1	89.9
Remote	14,430	5.3	58,148	1.2	72,578	1.4	19.9	80.1
Very remote	22,576	8.3	30971	0.6	53,547	1.0	42.2	57.8
Queensland	**273,119**	**100.0**	**4,942,695**	**100.0**	**5,215,814**	**100.0**	**5.2**	**94.8**
					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 Queensland at 30 June 2021, the First Nations population had an age structure that was significantly younger than that of other Queenslanders. For example, in Queensland:

- people aged under 15 accounted for 33% of the First Nations population compared with 18% of other Queenslanders
- people aged 65 and over comprised almost 5.4% of the First Nations population in Queensland, compared with 17% of other Australians (Figure D1).

Figure D1: Estimated resident population, by Indigenous status, age and sex, Queensland, 30 June 2021

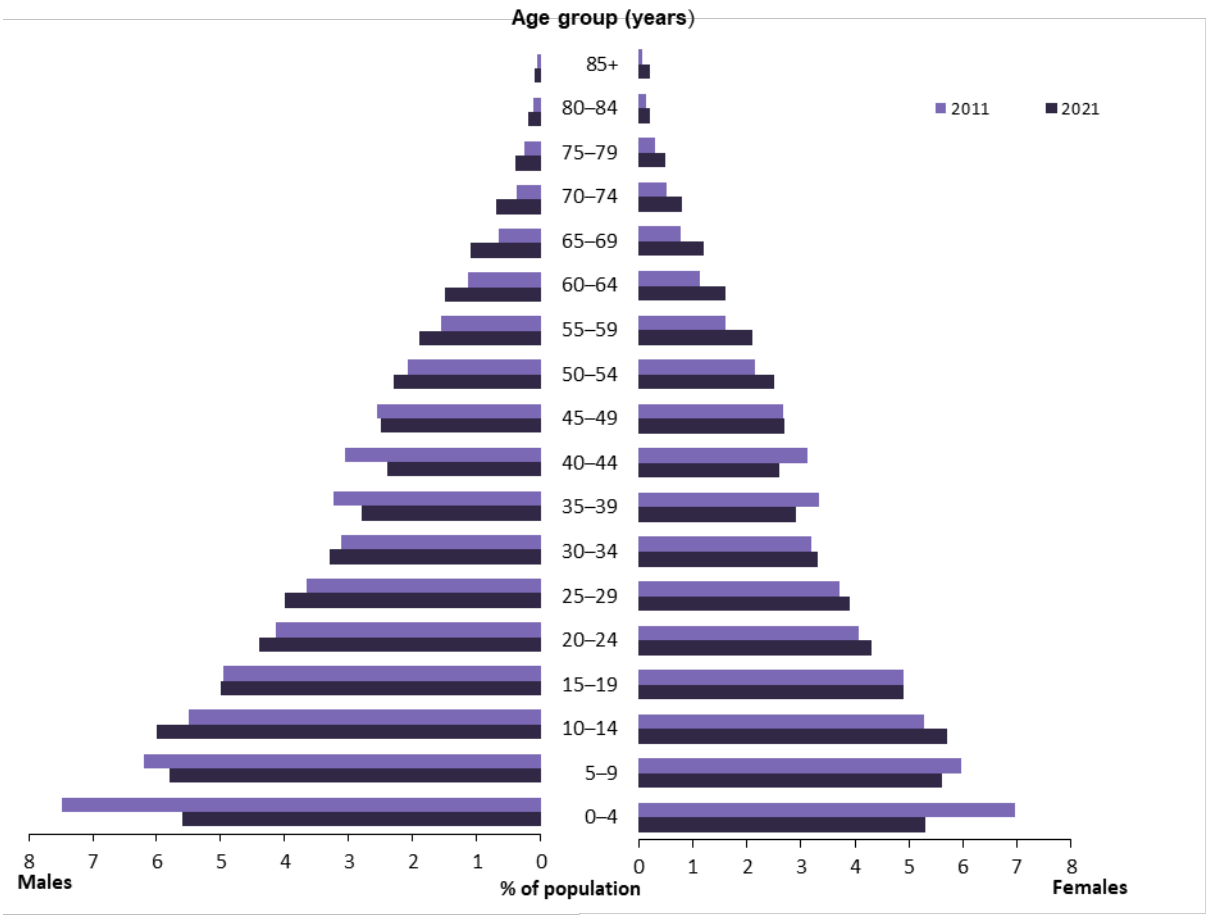


Source: AIHW analysis of ABS population estimates based on 2021 Census (Table D3.1 Qld).

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

- people aged under 15 accounted for 37% of the First Nations population compared with 34% at June 30 2021
- people aged 65 and over comprised 3.2% of the First Nations population in Queensland, compared with 5.4% at June 30 2021 (Figure D2).

Figure D2: Estimated resident population First Nations people, age and sex, Queensland, 30 June 2011 and 30 June 2021



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

Cultural and social determinants

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

The Mayi Kuwayu Study of Aboriginal and Torres Strait Islander Wellbeing aims to provide more evidence of how culture is related to First Nations 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, and practices).

Experiences of racism can have an impact on health through:

- reduced access to social resources, including employment, education, housing, health care, and other services
- psychological distress and increased likelihood of engaging in risk behaviours, such as substance use
- injury from assault (Paradies & 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 First Nations 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 First Nations people, and needs to be an integral part of First Nations-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 First Nations people must be acknowledged and addressed.
- Governments need to support long-term, coordinated, placed-based approaches that honour community priorities and embed participation (Department of Health 2017).

Health is also influenced by social determinants – the circumstances in which people grow, live, work, and age (Commission on Social Determinants of Health 2008) – and individual health risk factors. Income, employment, and education are key social determinants of health that account for a large part of the disparity in First Nations and non-Indigenous 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 First Nations health policy and research in Australia over the past 3 decades, including:

- continuing health inequalities between First Nations people and non-Indigenous Australians

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

First Nations 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 First Nations people was 1.5 times the rate of non-Indigenous people (ABS 2024).

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

In 2024, Queensland Health released the First Nations First Strategy 2032 which is the next stage of their journey to create an integrated health system in Queensland that sees more First Nations peoples across the system, listens to First Nations voices in the system, supports a more culturally capable, better integrated and coordinated system with First Nations peoples; and lays the foundation for a more equitably funded system (Queensland Health 2024).

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 and information on the health and welfare of First Nations people, to inform policy, service delivery and community debate.

Tier 1 – Health status and outcomes

1.01 Birthweight

Why it is important

This measure reports on birthweight among First Nations 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 First Nations people. The leading causes were pre-term and low birthweight complications, accounting for 28% of infant and congenital total burden (AIHW 2022a).

Key findings

Data presented for this measure are based on the Indigenous status of the baby and refer to singleton live births. A singleton birth is the birth of one baby during a pregnancy. Multiple births are associated with low birthweight (less than 2,500 grams) and as a result are generally excluded from analysis of birthweight (AIHW 2020a).

Birthweight: In Queensland, the majority of singleton First Nations babies born in 2020 had a healthy birthweight (89.4% or 4,968 babies), with almost 1 in 10 born with a low birthweight (9.3% or 517 babies). Low birthweight was twice as common among First Nations babies compared with other Queensland babies (Figure 1.01.1).

Nationally in 2020, 88.9% of singleton First Nations babies were born with a healthy birthweight (15,572 babies), and 9.6% with a low birthweight (1,680 babies). Low birthweight was about twice as common among First Nations babies compared with other babies (Figure 1.01.1).

Nationally, a small proportion of First Nations babies (1.4% or 245 babies) had a high birthweight (4,500 grams and over) (Table D1.01.14). High birthweight data was not available at a jurisdictional level.

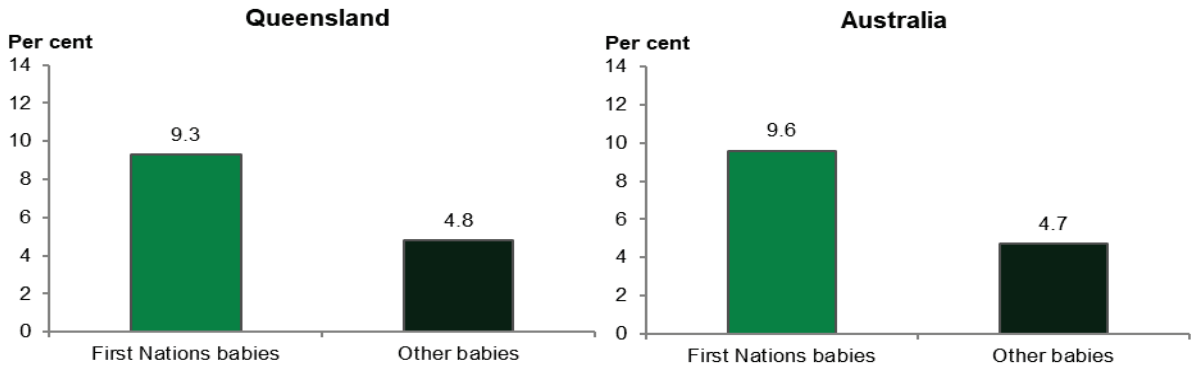
Average birthweight: Nationally in 2020, the average birthweight of singleton First Nations babies was 3,271 grams, lower than average birthweight of singleton other Australian babies (3,367 grams) (Table D1.01.5).

Low birthweight over time: Between 2013 and 2020 in Queensland, the proportion of singleton First Nations babies born with a low birthweight did not change significantly. However, the proportion of other Queensland babies born with a low birthweight increased significantly from 4.4% to 4.8% (Figure 1.01.2).

In Australia, the proportion of singleton babies born with a low birthweight did not change significantly between 2013 and 2020 for either First Nations or other Australian babies (Figure 1.01.2).

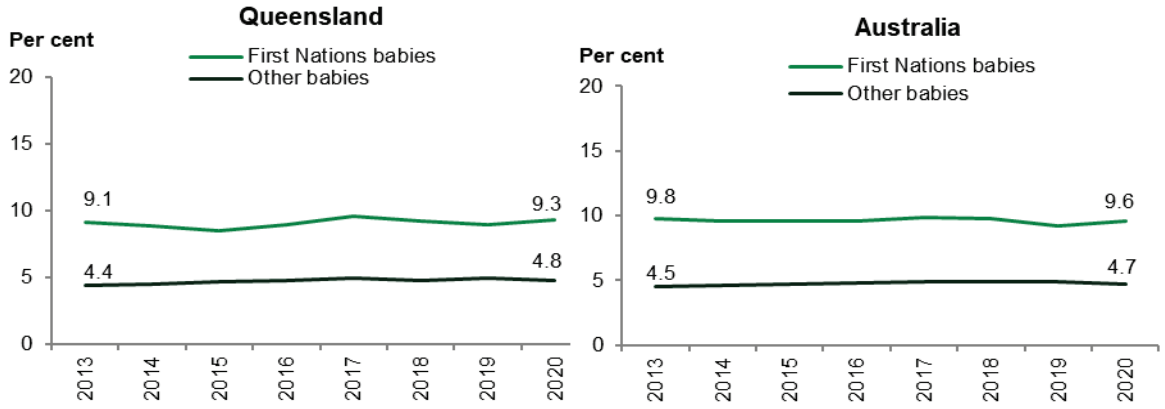
Maternal age and birthweight: Nationally in 2020, the proportion of First Nations babies born with a low birthweight was highest among mothers aged less than 20 (12.3%). For other Australian babies, the proportion born with a low birthweight was also highest among mothers aged less than 20 (7.7%), however this was substantially lower than for First Nations babies (Figure 1.01.3).

Figure 1.01.1: Low birthweight liveborn singleton babies, by Indigenous status of the baby, Queensland and Australia, 2020



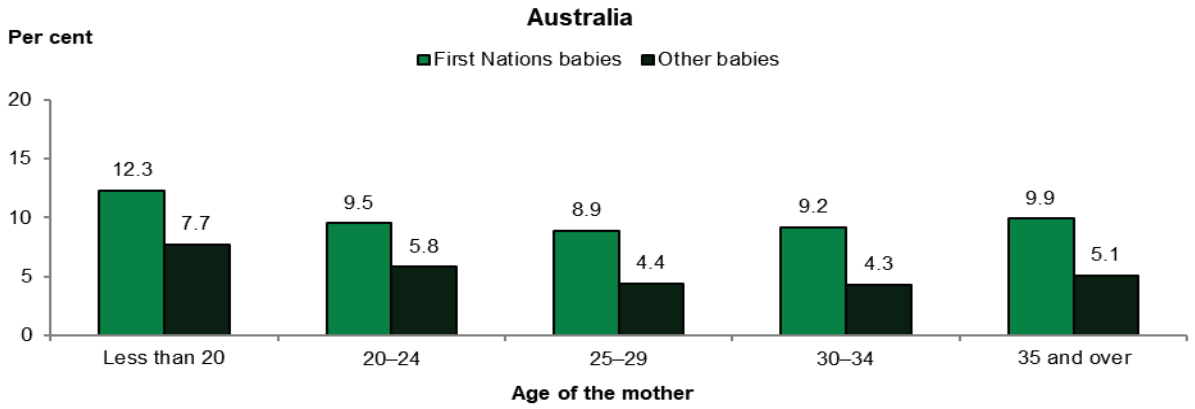
Source: Table D1.01.17.

Figure 1.01.2: Low birthweight liveborn singleton babies, by Indigenous status of the baby, Queensland and Australia, 2013 to 2020



Source: Table D1.01.20.

Figure 1.01.3: Low birthweight liveborn singleton babies, by Indigenous status of the baby and maternal age, Australia, 2020



Source: Table D1.01.22.

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

1.02 Top reasons for hospitalisation

Why it is important

This measure provides an overview of the leading causes of hospitalisations for First Nations people. Hospitalisation rates reflect the occurrence in a population of serious acute illnesses or conditions that require hospital treatment, and the access to and use of hospital treatment by people with such conditions. Hospitalisation rates for a particular disease do not directly indicate the level of occurrence of that disease in the population. Hospitalisation rates are based on the number of hospital episodes of care rather than on the number of individual people who are hospitalised.

Key findings

Overall: In Queensland, between July 2019 and June 2021, the leading cause of hospitalisation for First Nations people was care involving dialysis, which accounted for over one-third (36%) of hospitalisations. Excluding dialysis, there were 218,470 hospitalisations for First Nations people, at a rate of 452 per 1,000 population (Table D1.02.1, Table D1.02.5 Qld).

Top reasons for hospitalisation: Between July 2019 and June 2021 in Queensland, after dialysis, the causes with the highest rates of hospitalisation for First Nations people were:

- pregnancy, childbirth and the puerperium (99 hospitalisations per 1,000 First Nations females)
- symptoms, signs and abnormal findings not elsewhere classified (53 hospitalisations per 1,000 population): this includes symptoms such as abnormalities of heartbeat, abnormalities of breathing, chest pain, nausea and vomiting, headache, and convulsions that are not attributable to a specific diagnosis based on the information available at the time of the care
- injury and poisoning (51 hospitalisations per 1,000) (Figure 1.02.1): for example, fractures, wounds, burns or poisoning due to drugs.

These causes were also the 3 leading reasons for hospitalisation for First Nations people nationally (excluding dialysis) (Figure 1.02.1).

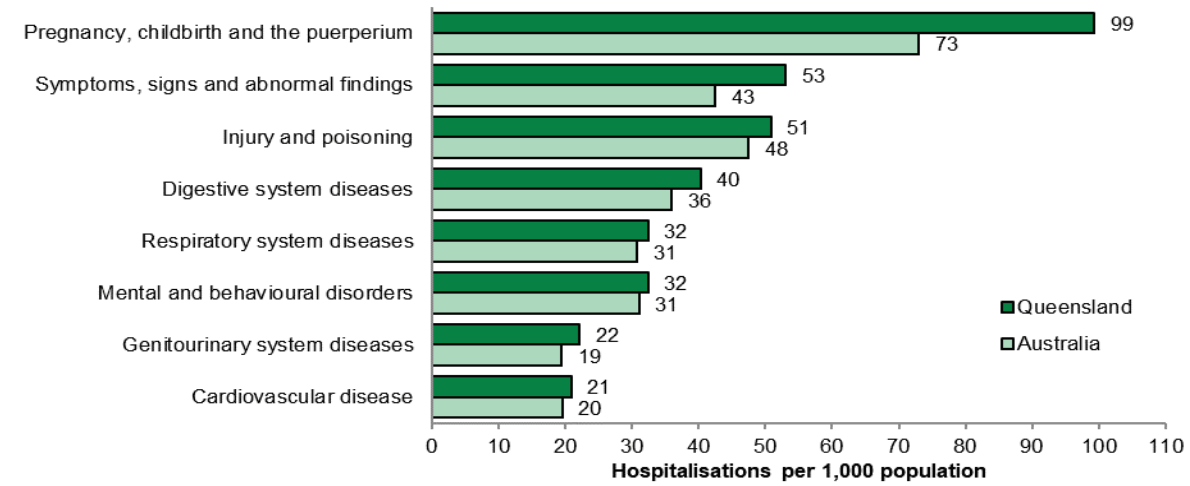
Hospitalisation by age and sex: In Queensland between July 2019 and June 2021, 58% of total hospitalisations (excluding dialysis) among First Nations people were for females (127,552 hospitalisations). First Nations females were hospitalised at 1.4 times the rate of First Nations males (524 and 379 per 1,000 population, respectively) (Table D1.02.1).

In Queensland, First Nations children aged 0–4 had a hospitalisation rate of 337 hospitalisations per 1,000 population in the 2-year period from July 2019 to June 2021. The hospitalisation rate was lowest among those aged 5–14 (120 per 1,000), then increased with age and was highest for those aged 65 and over (1,225 per 1,000) (Figure 1.02.2).

Trend over time: In Queensland, over the period 2011–12 to 2020–21, after adjusting for differences in the age structure between the two populations, the hospitalisation rate (excluding dialysis) increased by 70% for First Nations people and by 28% for other Queenslanders.

Nationally, over the same period, the hospitalisation rate (excluding dialysis) increased by 45% for First Nations people and by 6.2% for other Australians (Figure 1.02.3).

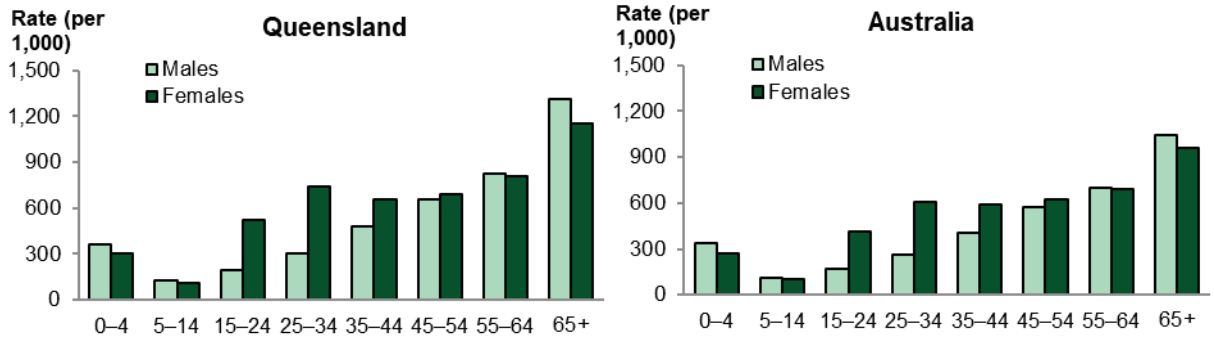
Figure 1.02.1: Leading causes of hospitalisation (excluding dialysis) for First Nations people, Queensland and Australia, July 2019 to June 2021



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

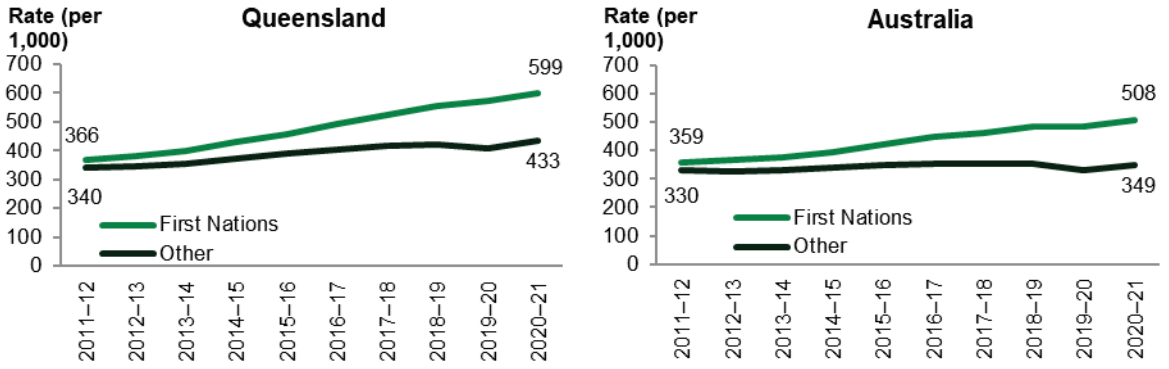
Source: Table D1.02.5 Qld.

Figure 1.02.2: Age-specific hospitalisation rates (excluding dialysis) for First Nations people, by sex and age group, Queensland and Australia, July 2019 to June 2021



Source: Table D1.02.2 Qld.

Figure 1.02.3: Age-standardised hospitalisation rates (excluding dialysis), by Indigenous status, Queensland and Australia, 2011–12 to 2020–21



Source: Table D1.02.4 Qld.

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

1.03 Injury and poisoning

Why it is important

This measure reports on death and hospitalisation among First Nations 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 First Nations people 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 2022a).

Key findings

Death due to injury and poisoning: Over the period 2015–2019, looking at broad causes of death, injury and poisoning was the third leading cause of death among First Nations people in Queensland, accounting for 14% (627) of all deaths. After adjusting for differences in the age structure between the two populations, First Nations people in Queensland died from injury and poisoning at 1.6 times the rate of other Queenslanders (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 2019 to June 2021, there were 24,579 hospitalisations due to injury and poisoning for First Nations people in Queensland – a rate of 51 per 1,000 population. Hospitalisation rates for injury and poisoning in Queensland were higher for First Nations people living in remote areas (60 per 1,000 population) than in non-remote areas (49 per 1,000) (Table D1.03.16).

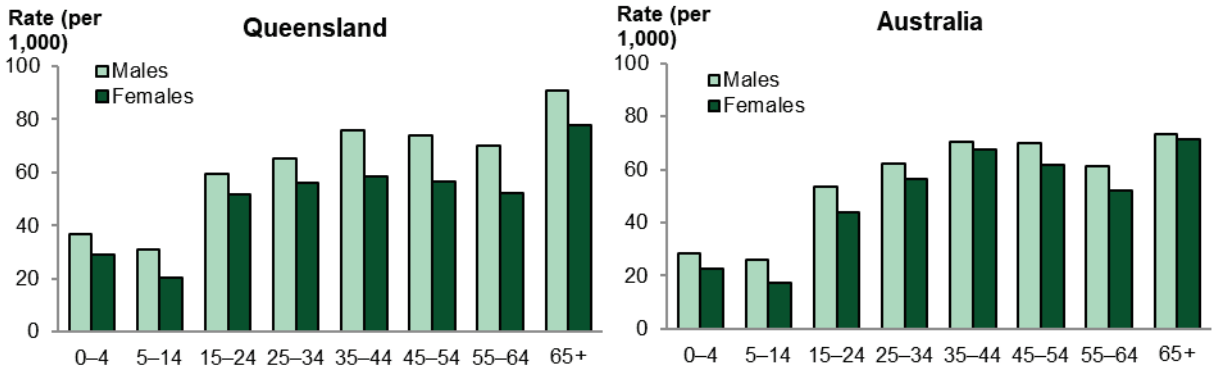
Hospitalisation by age and sex: In Queensland between July 2019 and June 2021, across all age groups, First Nations males had higher hospitalisation rates for injury and poisoning than females. For both First Nations males and females, hospitalisation rates for injury and poisoning were highest for those aged over 65 (Figure 1.03.1).

Leading causes of hospitalisation: Between July 2019 and June 2021 in Queensland, falls were the leading cause of hospitalisation due to injury and poisoning for First Nations males (22%) and females (23%). Assault was the second leading cause of hospitalisation due to injury and poisoning for First Nations females (16%) and the third leading cause for First Nations males (14%). Hospitalisations for intentional self-harm accounted for 12% of hospitalisations of First Nations females in Queensland, twice as high as for First Nations males (5.7%) (Figure 1.03.2).

Hospitalisation trend over time: In Queensland, over the period 2011–12 to 2020–21, the age-standardised hospitalisation rate for injury and poisoning increased by 53% for First Nations people and by 35% for other Queenslanders.

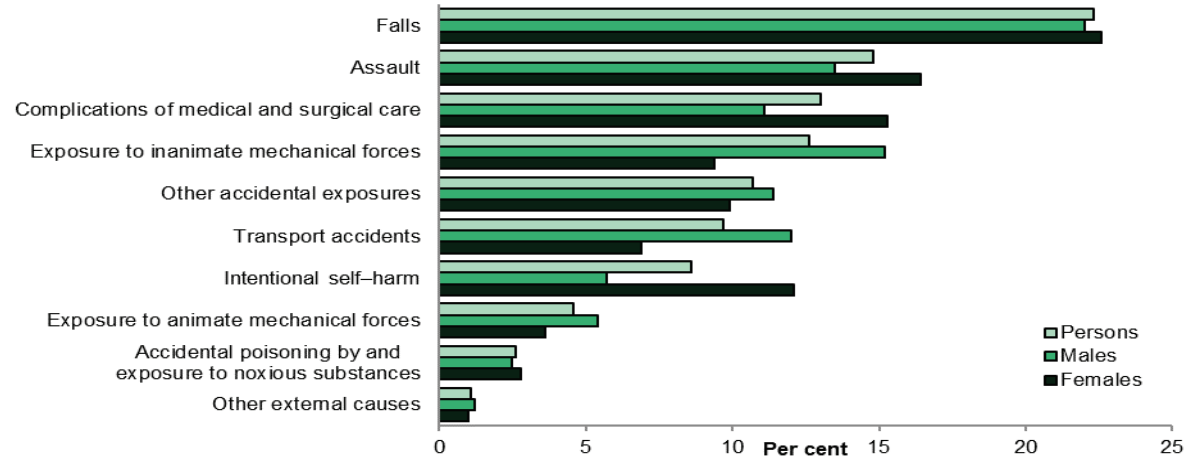
Nationally, over the same period, the age-standardised hospitalisation rate for injury and poisoning increased by 40% for First Nations people and by 19% for other Australians (Figure 1.03.3).

Figure 1.03.1: Age-specific hospitalisation rates for injury and poisoning for First Nations people, by sex and age group, Queensland and Australia, July 2019 to June 2021



Source: Table D1.03.2 Qld.

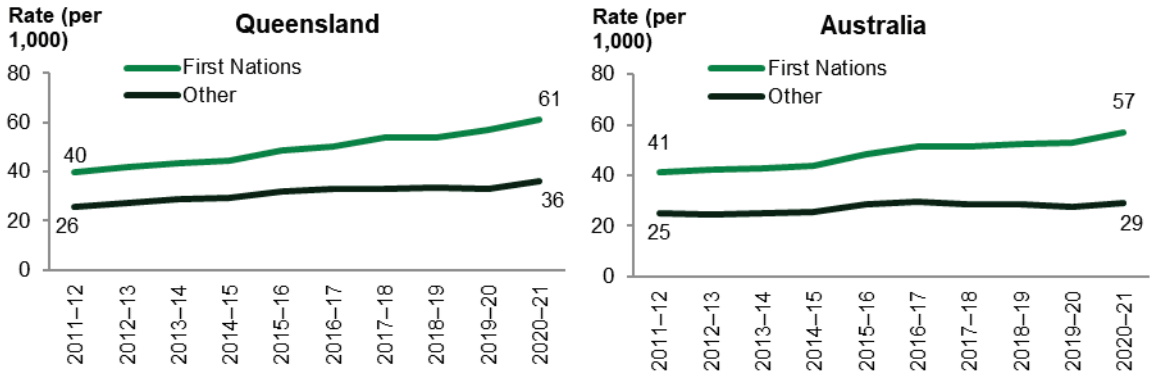
Figure 1.03.2: First reported external causes of hospitalisations for a principal diagnosis of injury and poisoning for First Nations people in Queensland, by sex, July 2019 to June 2021



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

Source: Table D1.03.7 Qld.

Figure 1.03.3: Age-standardised hospitalisation rates for a principal diagnosis of injury and poisoning, by Indigenous status, Queensland and Australia, 2011–12 to 2020–21



Source: Table D1.03.5 Qld.

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

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 First Nations people. Respiratory diseases accounted for 7.5% of the total disease burden for First Nations people in 2018 (AIHW 2022a).

Key findings

Overall prevalence (self-reported): In 2018–19 in Queensland, a quarter (25%) of First Nations people reported having a respiratory disease that lasted or was likely to last for 6 months or more. A higher proportion of First Nations people living in non-remote areas reported respiratory disease than those living in remote areas (26% and 16%, respectively).

Nationally in 2018–19, 29% of First Nations people reported having a respiratory disease that lasted or was likely to last for 6 months or more. More First Nations people living in non-remote areas of Australia reported having a respiratory disease than those living in remote areas (32% and 15%, respectively) (Figure 1.04.1).

Deaths: Respiratory diseases are among the top 5 leading causes of death for First Nations people in Queensland and in NSW, Qld, WA, SA and the NT combined. During 2015–2019 in Queensland, there were 406 deaths due to respiratory diseases for First Nations people, this was a rate of 36 per 100,000 population. The rate for First Nations people in NSW, Qld, WA, SA and the NT combined, for the same period, was 42 per 100,000 population (Table D1.23.2).

After adjusting for differences in the age structures in populations, rates of death due to respiratory diseases were higher for First Nations people (both in Queensland, and NSW, Qld, WA, SA and the NT combined) than for other Australians living in the same areas (Figure 1.04.2).

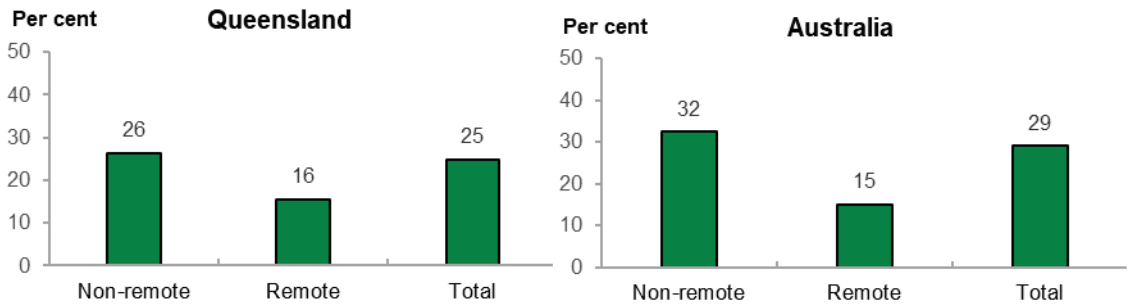
Hospitalisations for respiratory disease: From July 2019 to June 2021, there were 15,651 hospitalisations for respiratory diseases for First Nations people in Queensland (a rate of 32 per 1,000 population). Hospitalisation rates for respiratory diseases in Queensland were higher for First Nations people living in remote areas (41 per 1,000 population) than in non-remote areas (31 per 1,000 population).

Nationally over the same period, hospitalisations for respiratory diseases for all First Nations people were higher for those living in remote areas (50 per 1,000 population) than in non-remote areas (26 per 1,000 population) (Figure 1.04.3).

Hospitalisations by age and sex: In Queensland between July 2019 and June 2021, the highest rates of hospitalisations for respiratory diseases were for First Nations males and females in the 65+ age group (102 and 96 per 1,000 respectively), followed by males in the 0–4 age group (89 per 1,000) and females in the 55–64 age group (68 per 1,000). This pattern was similar for First Nations people nationally (Table D1.04.8 Qld).

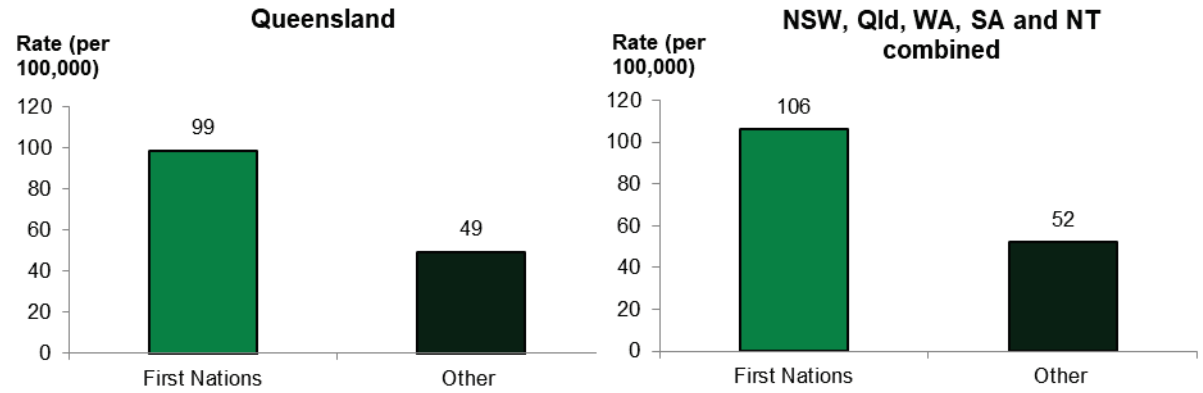
Hospitalisations trend over time: In Queensland between 2011–12 and 2020–2021, the age-standardised hospitalisation rate for First Nations people for respiratory diseases increased by 30%. This was larger than the national increase in the age-standardised hospitalisation rate for First Nations people (16%) (Table D1.04.11 Qld).

Figure 1.04.1: First Nations people reporting respiratory diseases, by remoteness, Queensland and Australia, 2018–19



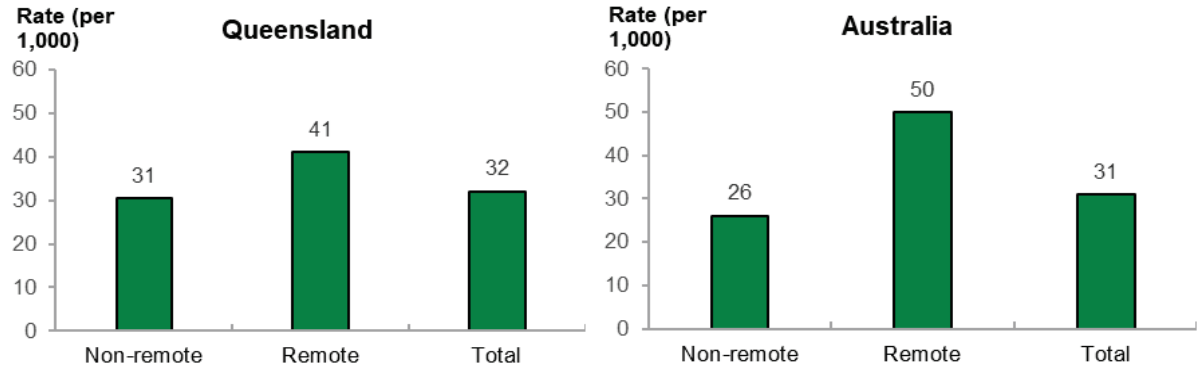
Source: Table D1.04.2.

Figure 1.04.2: Age-standardised death rate for First Nations people, by Indigenous status, Queensland, and NSW, Qld, WA, SA and the NT combined, 2015–2019



Source: Table D1.23.2.

Figure 1.04.3: Hospitalisation rate due to respiratory diseases for First Nations people, by remoteness, Queensland Australia, July 2019 to June 2021



Source: Table D1.04.17.

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

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 First Nations people. Cardiovascular disease is more common among First Nations people than other Australians, and its onset tends to occur between 10 and 20 years younger than for other Australians (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 2018–19 in Queensland, 24% of First Nations people (aged 2 and over) reported having cardiovascular disease. A higher proportion of First Nations people living in non-remote areas reported a cardiovascular disease than those living in remote areas (25% and 22%, respectively).

Nationally in 2018–19, 23% of First Nations people reported having cardiovascular disease. A slightly higher proportion who were living in remote areas of Australia reported having cardiovascular disease than those living in non-remote areas (25% and 23%, respectively) (Figure 1.05.1).

Hospitalisations for cardiovascular disease: From July 2019 to June 2021, there were 10,101 hospitalisations for cardiovascular disease for First Nations people in Queensland (a rate of 21 per 1,000 population). Hospitalisation rates for cardiovascular disease in Queensland were higher for First Nations people living in remote areas (30 per 1,000 population) than those living in non-remote areas (19 per 1,000 population).

Nationally over the same period, the rate of hospitalisations for cardiovascular disease for First Nations people was 20 per 1,000 and was higher for First Nations people living in remote areas (29 per 1,000 population) than those living in non-remote areas (17 per 1,000 population) (Figure 1.05.2).

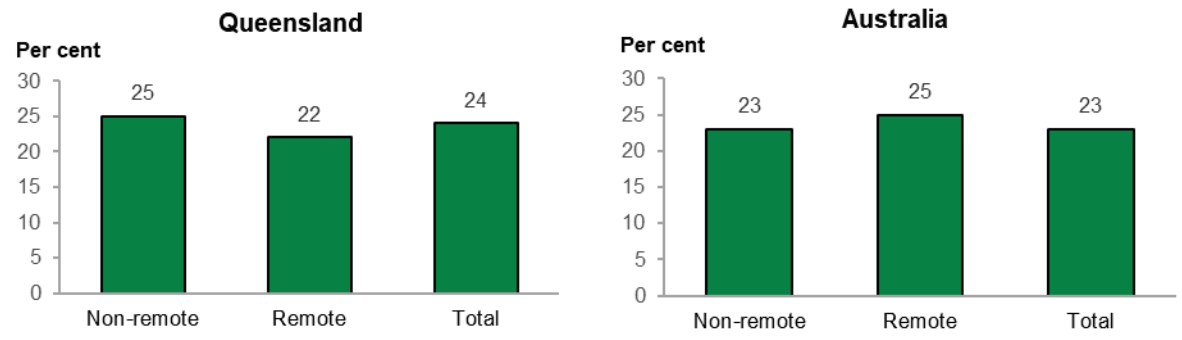
Deaths: From 2015 to 2019, cardiovascular disease was the second leading cause of death of First Nations people in Queensland (1,005 deaths or 22% of total deaths). Similarly, in NSW, Qld, WA, SA and the NT combined, cardiovascular disease was the second leading cause of death of First Nations people (3,471 deaths or 22% of total deaths) (Table D1.23.2).

The age-standardised rate of cardiovascular disease deaths from 2010 to 2019 decreased for First Nations people in Queensland by 15% (from 277 to 248 per 100,000 population) and the 5 jurisdictions combined by 18% (from 269 to 228 per 100,000 population) (Table D1.23.28).

Change in hospitalisation over time: In Queensland, between 2011–12 and 2020–21, after adjusting for differences in the age structure between the two populations, the rate of hospitalisation for cardiovascular disease increased for First Nations people and other Queenslanders (18% and 14% respectively).

Nationally, between 2011–12 and 2020–21, the age-standardised rate of hospitalisation for First Nations people for cardiovascular disease increased by 20%. For other Australians the age-standardised rate remained stable between 2011–12 and 2020–21 (Figure 1.05.3).

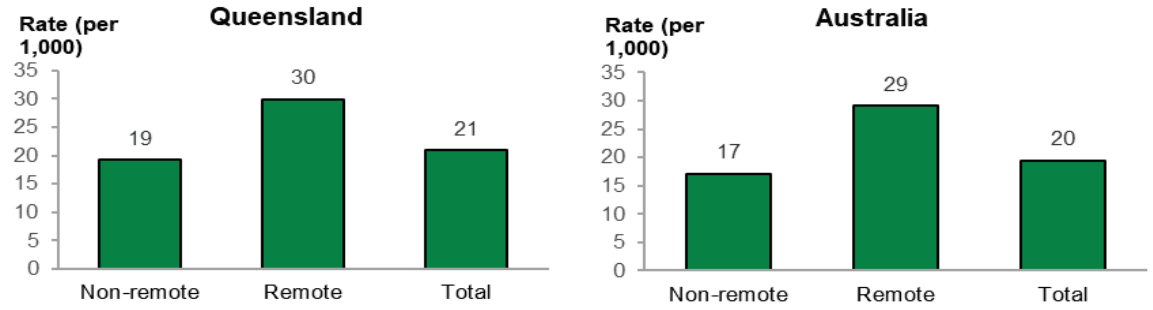
Figure 1.05.1: First Nations people (aged 2 and over) reporting cardiovascular disease, by remoteness, Queensland and Australia, 2018–19



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).

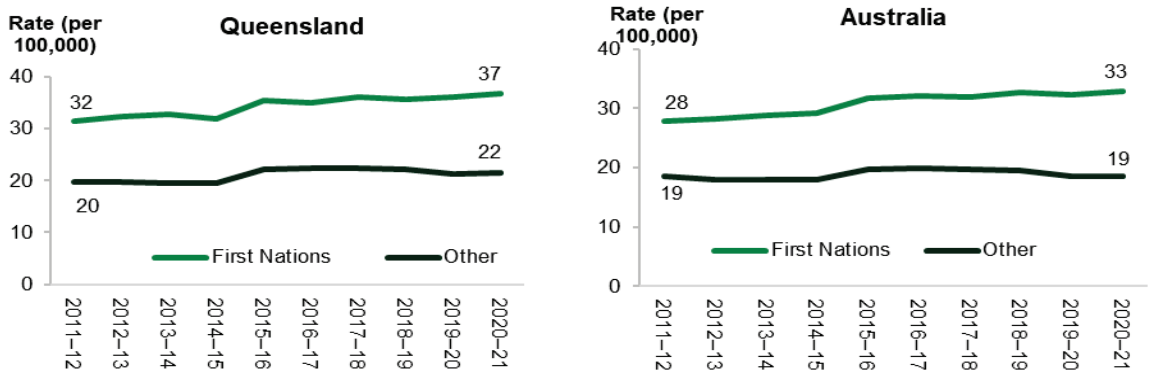
Source: Table D1.05.2.

Figure 1.05.2: Hospitalisation rate due to diseases of the cardiovascular system (based on principal diagnosis) for First Nations people, by remoteness, Queensland and Australia, July 2019 to June 2021



Source: Table D1.05.12

Figure 1.05.3: Age-standardised hospitalisation rates for cardiovascular disease (based on principal diagnosis), by Indigenous status, Queensland and Australia, 2011–12 to 2020–21



Source: Table D1.05.11 Qld.

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

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 First Nations people living in regional and remote areas of Australia (AIHW 2023). ARF symptoms can include arthritis, fever, swelling of the heart and heart valves, and rash (Ralph 2020). RHD is damage to the valves of the heart caused by one or repeated episodes of ARF (AIHW 2023). ARF and RHD are associated with social and environmental factors such as poverty, overcrowded housing and poor functioning of 'health hardware' such as facilities for washing people, clothes and bedding (Ali et al. 2018).

Key findings

Acute rheumatic fever: Over the 5-year period from 2017 to 2021, 644 cases of ARF were diagnosed among First Nations people in Queensland (Table D1.06.1). First Nations people accounted for 84% of the total number of ARF cases recorded in Queensland (excluding cases where Indigenous status was unknown). ARF occurs largely in children and young adults. Among First Nations people in Queensland in 2017–2021, 46% of cases occurred in children aged 5–14, and 28% in the 15–24 age group (Table D1.06.2).

Comparable data on ARF cases are available for 5 jurisdictions: NSW, Qld, WA, SA, and the NT. In these jurisdictions combined, 2,781 cases of ARF were diagnosed in 2017–2021, with First Nations people accounting for 92% of the cases recorded (2,570 cases) (Table D1.06.1).

Rheumatic heart disease: As at 30 December 2021, there were 1,823 First Nations people with RHD in Queensland. First Nations people were substantially over-represented among people with RHD, as a rate there were 736 RHD cases per 100,000 First Nations people, compared with 23 per 100,000 for other Queenslanders.

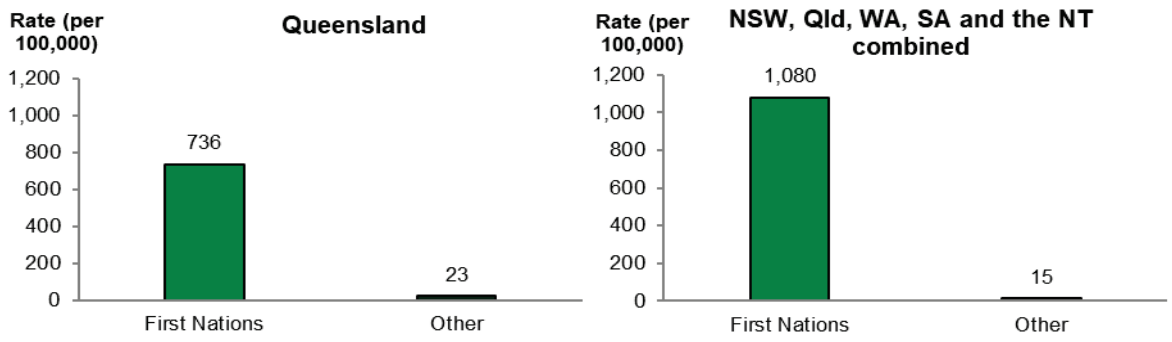
Comparable data on RHD cases are available NSW, Qld, WA, SA, and the NT. In these jurisdictions combined, as at December 2021, there were 5,221 First Nations people with RHD, equivalent to 1,080 cases per 100,000 population. The rate for other Australians was 15 per 100,000 (Figure 1.06.1).

Hospitalisations: Between July 2019 and June 2021, 282 First Nations people in Queensland were hospitalised for ARF or RHD, a rate of 58 hospitalisations per 100,000 population. Hospitalisation rates for ARF or RHD were higher among First Nations people living in remote areas (134 per 100,000) than in non-remote areas (44 per 100,000).

Nationally between July 2019 and June 2021, 1,411 First Nations people were hospitalised for ARF or RHD, a rate of 82 hospitalisations per 100,000 population. Hospitalisation rates for ARF or RHD were higher among First Nations people living in remote areas (302 per 100,000) than in non-remote areas (33 per 100,000) (Figure 1.06.2).

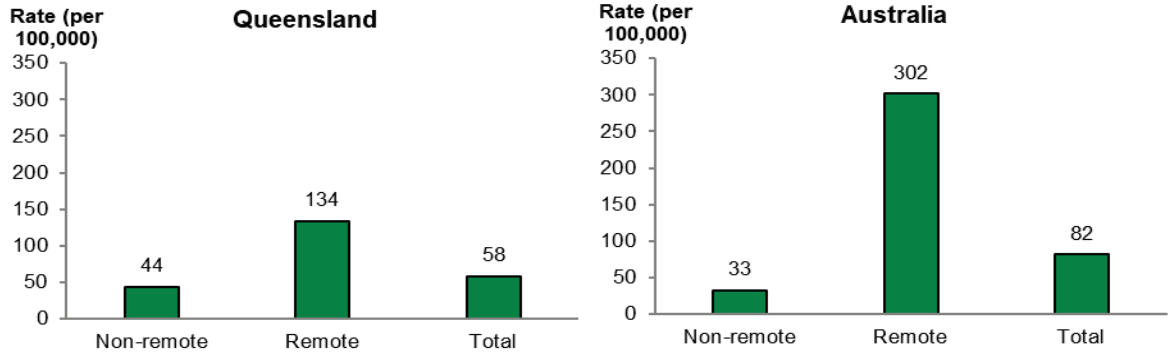
Changes over time: From 2012 to 2021, incidence rates of ARF among First Nations people in Queensland increased from 49 to 60 per 100,000. Over the same time period, the incidence rate of RHD among First Nations people in Queensland increased from 43 to 56 new cases per 100,000 population (Figure 1.06.3).

Figure 1.06.1: Rheumatic heart disease prevalence by Indigenous status, Queensland, and NSW, Qld, WA, SA, and the NT combined, as at December 2021



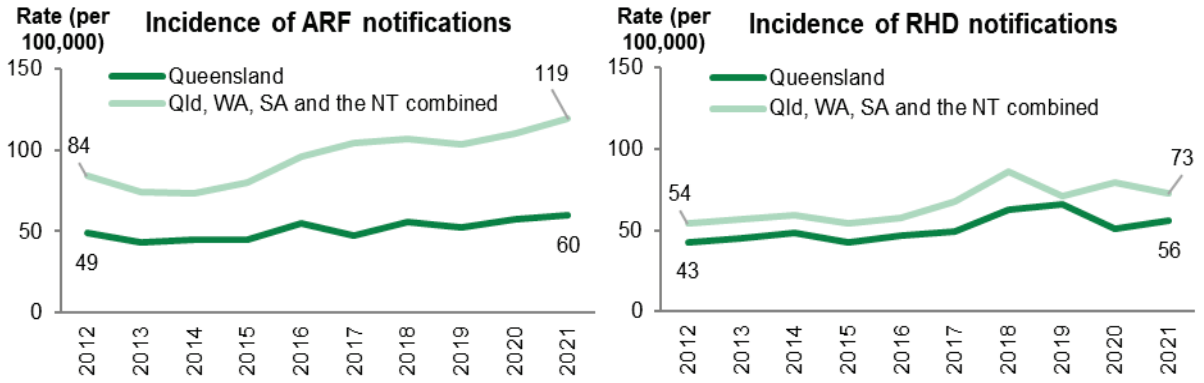
Source: Tables D1.06.9, D1.06.11.

Figure 1.06.2: Hospitalisation rate with a principal diagnosis of acute rheumatic fever or rheumatic heart disease for First Nations people, by remoteness, Queensland and Australia, July 2019 to June 2021



Source: Table D1.06.17.

Figure 1.06.3: Incidence of acute rheumatic fever and rheumatic heart disease notifications among First Nations people, Queensland, and Qld, WA, SA, and the NT combined, 2012 to 2021



Source: Tables D1.06.6 and D1.06.15.

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

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 First Nations 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 First Nations people (see measure 1.23 Leading causes of mortality).

Key findings

Adults with high blood pressure: In 2018–19, 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 2019b).

In 2018–19, based on both measured and reported data, one-third (33%, 43,300 people) of First Nations adults in Queensland were estimated to have high blood pressure (140/90 mmHg or higher) (D1.07.4). The rate of high blood pressure for First Nations adults was similar in remote areas and non-remote areas (34% and 33%, respectively) (Figure 1.07.1).

Nationally in 2018–19, based on both measured and reported data, 31% (an estimated 151,200) of First Nations adults were estimated to have high blood pressure (Table D1.07.4). The rate of high blood pressure for First Nations adults was similar in remote areas and non-remote areas (32% and 31%, respectively) (Figure 1.07.1).

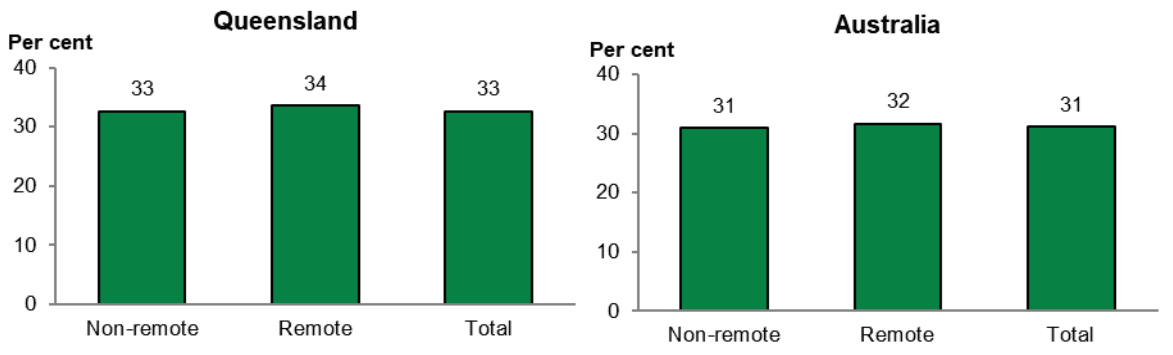
Hospitalisation for hypertensive disease: Prolonged high blood pressure could cause damage to the heart and other organs, known as hypertensive disease (AIHW 2022b). Between July 2019 and June 2021, there were 424 hospitalisations of First Nations people with a principal diagnosis of hypertensive disease in Queensland, at a rate of 88 hospitalisations per 100,000. After adjusting for differences in age structure between the two populations, the rate of hospitalisation due to hypertensive disease for First Nations people in Queensland was 1.9 times the rate for other Queenslanders (Table D1.07.10).

Hospitalisation by age and sex: In Queensland, between July 2019 and June 2021, the hospitalisation rate for hypertensive disease was higher for First Nations females than for First Nations males (108 and 67 hospitalisations per 100,000 population, respectively) (Table D1.07.9).

Hospitalisation rates for hypertensive disease increased with age. Between July 2019 and June 2021, both in Queensland and nationally, First Nations females had a higher rate of hospitalisation for hypertensive disease than First Nations males for all age groups (Figure 1.07.2).

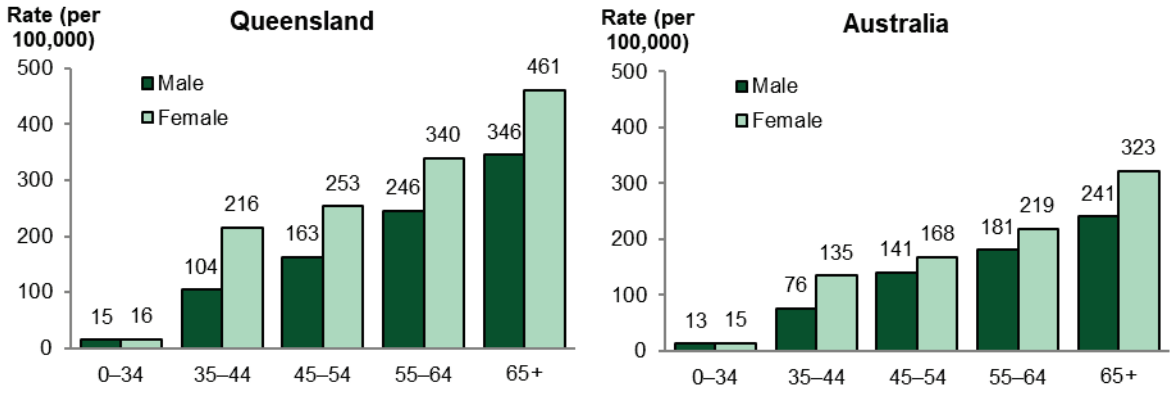
Hospitalisation by remoteness: Between July 2019 and June 2021, in Queensland, the rate of hospitalisations due to hypertensive disease for First Nations people was higher in remote than non-remote areas (149 and 76 per 100,000 population, respectively). After adjusting for differences in age structure between the two populations, First Nations people living in remote areas of Queensland were hospitalised for hypertensive disease at 3.2 times the rate for other Queenslanders (Figure 1.07.3).

Figure 1.07.1: Proportion of First Nations people aged 18 and over with high blood pressure (self-reported and measured) by remoteness, Queensland and Australia, 2018–19



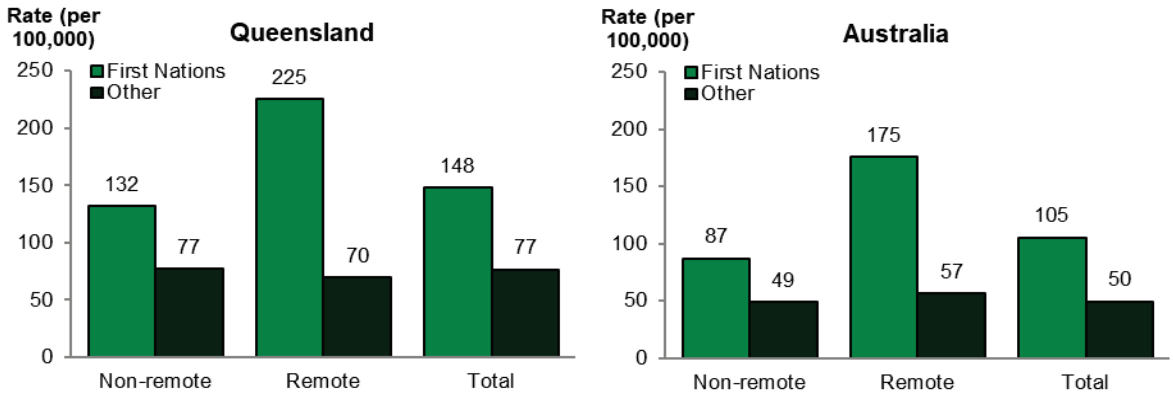
Source: Table D1.07.4.

Figure 1.07.2: Hospitalisation rates for hypertensive disease (based on principal diagnosis) for First Nations people, by age group and sex, Queensland and Australia, July 2019 to June 2021



Source: Table D1.07.9.

Figure 1.07.3: Age-standardised hospitalisation rates for hypertensive disease (based on principal diagnosis), by Indigenous status and remoteness, Queensland and Australia, July 2019 to June 2021



Source: Table D1.07.14.

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

1.08 Cancer

Why it is important

This measure reports on the number of new cases, deaths and hospitalisations for cancer among First Nations people. First Nations 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): First Nations cancer incidence data are available from 5 jurisdictions: NSW, Vic, Qld, WA and the NT.

In the 5-year period 2014–2018, there were 3,012 new cases of cancer diagnosed among First Nations people in Queensland, an incidence rate of 272 new cases per 100,000 population. In the 5 jurisdictions combined, there were 9,262 new cases of cancer diagnosed among First Nations people, an incidence rate of 257 new cases per 100,000 population in 2014–2018 (Table D1.08.3).

In both Queensland and 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 First Nations people are available from 5 jurisdictions: NSW, Vic, Qld, WA and the NT.

Over the period 2015–2019, cancer and other neoplasms was the leading cause of death among First Nations people in Queensland, accounting for about a quarter (26%, 1,187 deaths) of all deaths of First Nations people. Similarly, in the 5 jurisdictions combined, cancer and other neoplasms was the leading cause of death among First Nations people, accounting for 23% (3,612 deaths) of all deaths of First Nations people (Table D1.23.2).

Over the decade from 2010 to 2019, the age-standardised rate of deaths due to cancer and other neoplasms increased by 28% for First Nations people in Queensland and by 12% in the 5 jurisdictions combined (Table D1.23.29).

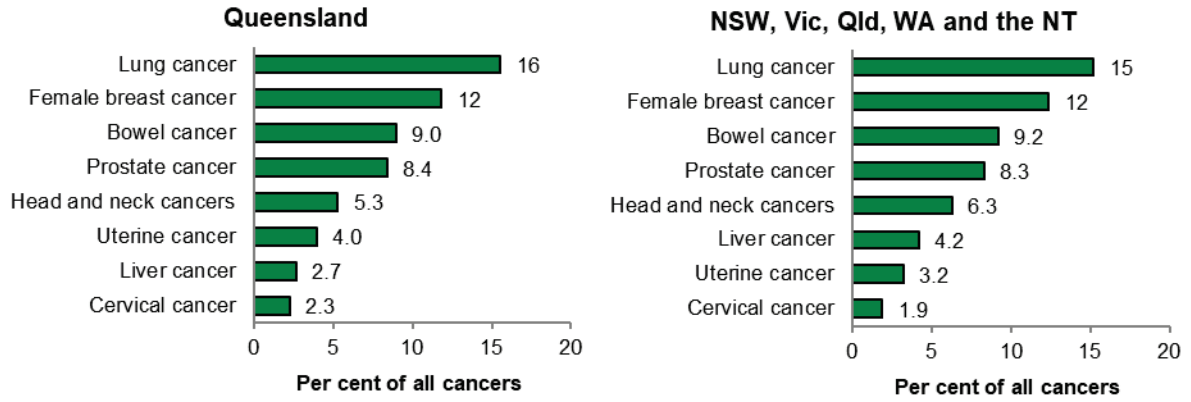
Hospitalisation due to cancer: Cancer-related hospitalisation data include hospitalisations with either a principal or additional diagnosis of cancer.

In Queensland, between July 2019 and June 2021, the cancer-related hospitalisation rate was lower among First Nations people living in remote areas compared with non-remote areas (22 and 32 hospitalisations per 1,000 population). Nationally, cancer-related hospitalisation rates among First Nations people were similar in remote and non-remote areas (20 and 22 hospitalisations per 1,000) (Figure 1.08.2).

Change in hospitalisation over time: Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change (see Statistical terms and methods).

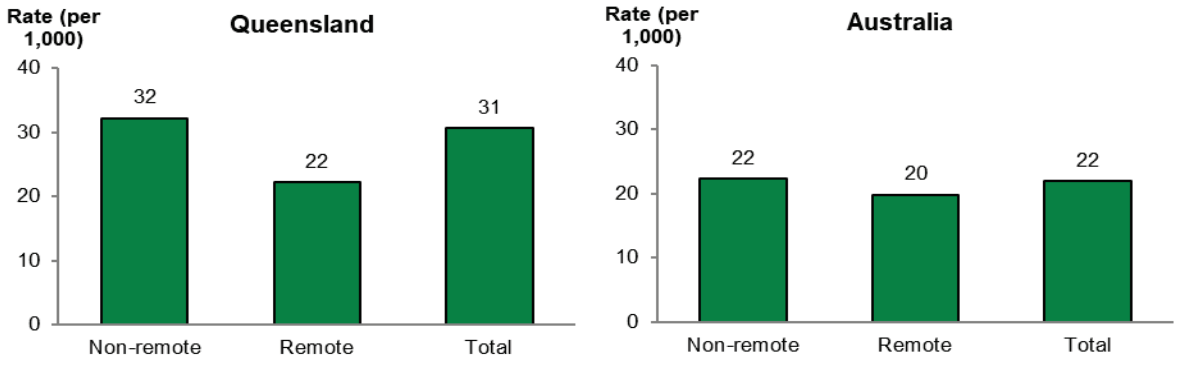
In Queensland, over the decade between 2011–12 and 2020–21, after adjusting for differences in the age structure between the two populations, cancer-related hospitalisations increased by 196% for First Nations people and by 44% for other Queenslanders. Nationally, over the same time period, cancer-related hospitalisations increased by 105% for First Nations people and by 16% for other Australians (Figure 1.08.3).

Figure 1.08.1: Selected cancers as a proportion of total new cancer cases among First Nations people, Queensland, and NSW, Qld, WA, SA and the NT combined, 2014–2018



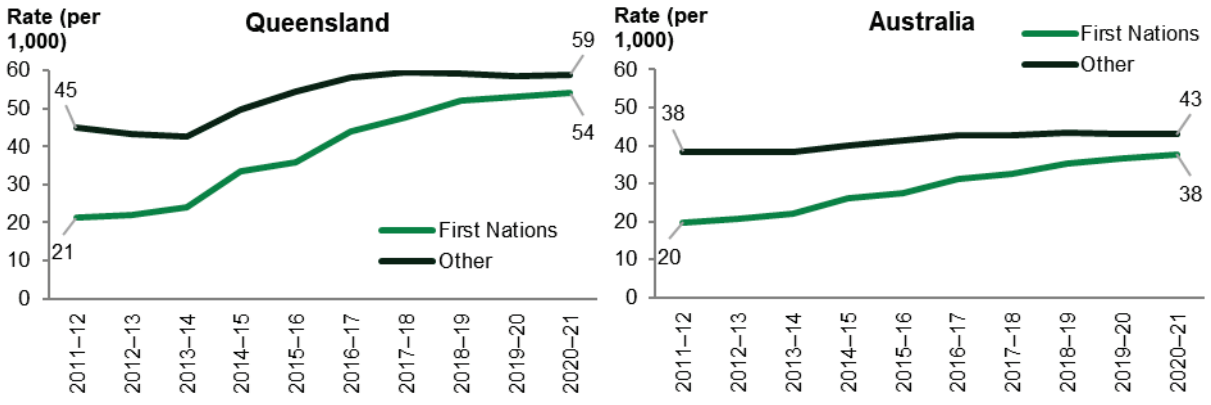
Source: Table D1.08.3.

Figure 1.08.2: Cancer-related hospitalisation rates for First Nations people, by remoteness, Queensland and Australia, July 2019 to June 2021



Source: Table D1.08.17.

Figure 1.08.3: Cancer-related age-standardised hospitalisation rates by Indigenous status, Queensland and Australia, 2011–12 to 2020–21



Source: Table D1.08.15 Qld.

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

1.09 Diabetes

Why it is important

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

Key findings

Deaths from diabetes: In Queensland, endocrine, metabolic, and nutritional disorders which include mostly diabetes are among the top 5 leading causes of death for First Nations people. In Queensland, in the 5-year period between 2015 and 2019, 7.7% (354) of total deaths of First Nations 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 First Nations people was 5.6 times the rate for other Queenslanders.

Deaths data for First Nations people are available from 5 jurisdictions: NSW, Qld, WA, SA and the NT. In these 5 jurisdictions combined, in 2015–2019, the age-standardised rate of deaths due to diabetes for First Nations people was 4.7 times the rate for other Australians (Figure 1.09.1).

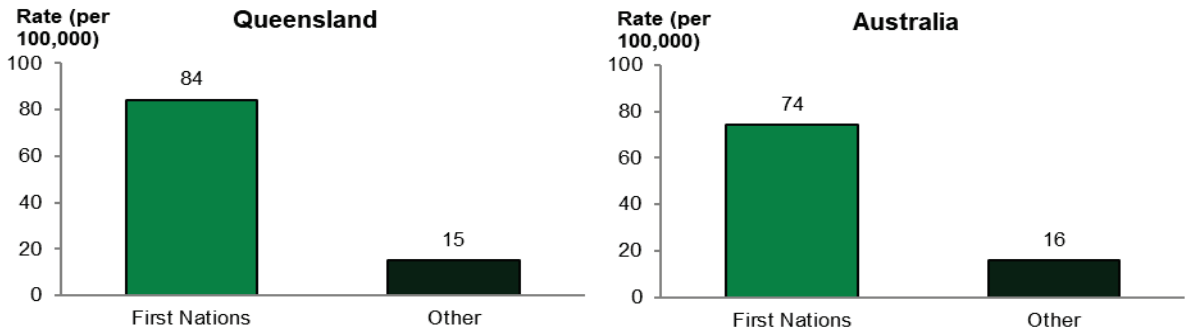
Hospitalisation for diabetes: In Queensland, between July 2019 and June 2021, there were 2,783 hospitalisations of First Nations people with a principal diagnosis of diabetes (Table D1.09.8). When hospitalisations with diabetes as an additional diagnosis are also included, there were 38,419 hospitalisations 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 First Nations people was 3.7 times the rate for other Queenslanders (Figure 1.09.2).

Nationally, between July 2019 and June 2021, the age-standardised diabetes hospitalisation rate (principal or additional diagnosis) for First Nations people was 4.4 times the rate for other Australians (Figure 1.09.2).

Hospitalisation by age: For both Queensland and Australia, between July 2019 and June 2021, hospitalisation rates for diabetes (principal or additional diagnosis) increased with age. The relative difference in rates between First Nations people and others was highest for those aged 35–44. In Queensland, for this age group, First Nations people were 7.8 times as likely as other Queenslanders to be hospitalised for diabetes. Nationally, First Nations people aged 35–44 were 11 times as likely as other Australians of the same age group to be hospitalised for diabetes (Figure 1.09.2).

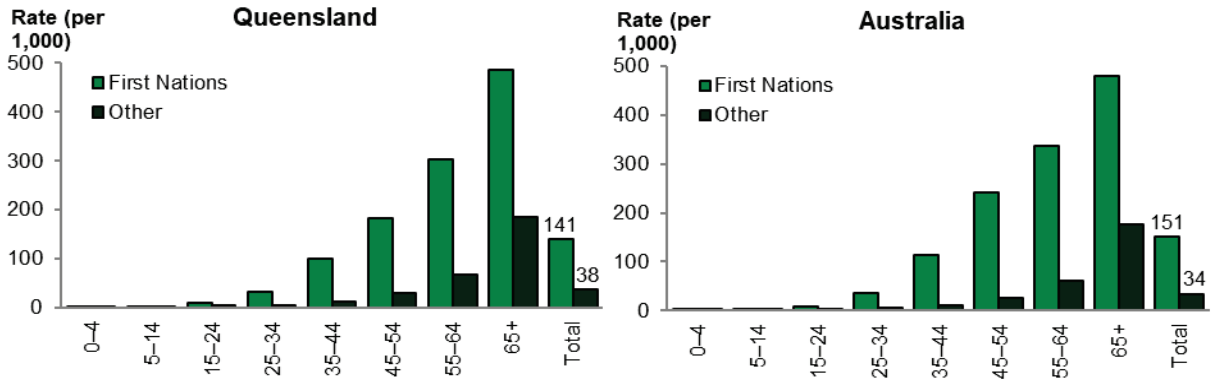
National health survey data: In 2018–19 in Queensland, 15% (20,200) of First Nations adults reported having diabetes or high blood/urine sugar levels (HSL) (Table D1.09.14). After adjusting for differences in the age structure between the two populations, First Nations adults were 3.7 times as likely to report having diabetes or HSL as other Queenslanders (Figure 1.09.3).

Figure 1.09.1: Diabetes age-standardised death rates by Indigenous status, Queensland and Australia, 2015–2019



Source: Table D1.23.2.

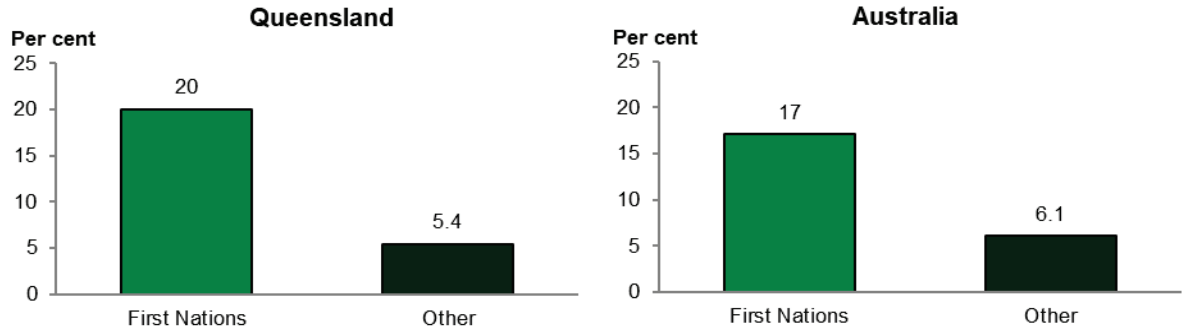
Figure 1.09.2: Hospitalisation rates for diabetes (principal or additional diagnosis), by Indigenous status, Queensland and Australia, July 2019 to June 2021



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

Source: Table D1.09.7 Qld.

Figure 1.09.3: Age-standardised proportion of persons aged 18 and over who reported having diabetes or high sugar levels, by Indigenous status, Queensland and Australia, 2018–19



Source: Table D1.09.2.

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

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 First Nations 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). First Nations 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 2018–19 National Aboriginal and Torres Strait Islander Health Survey, 2.8% of First Nations adults in Queensland have chronic kidney disease (note estimate had a relative standard error between 25% and 50% and should be used with caution). Nationally 3.4% of First Nations adults have chronic kidney disease (Table D1.10.1).

Deaths: In 2015–2019 in Queensland, there were 71 deaths of First Nations people where kidney diseases were the underlying cause of death (a rate of 6.3 per 100,000). This was lower than the national rate, for the same time period, of 7.8 per 100,000 (Table D1.23.2).

Hospitalisation: Between July 2019 and June 2021 in Queensland, there were 2,067 hospitalisations for chronic kidney disease (excluding dialysis) for First Nations people, at a rate of 4.3 per 1,000. First Nations females were hospitalised at a higher rate than First Nations males (5.6 per 1,000 compared with 2.9 per 1,000, respectively).

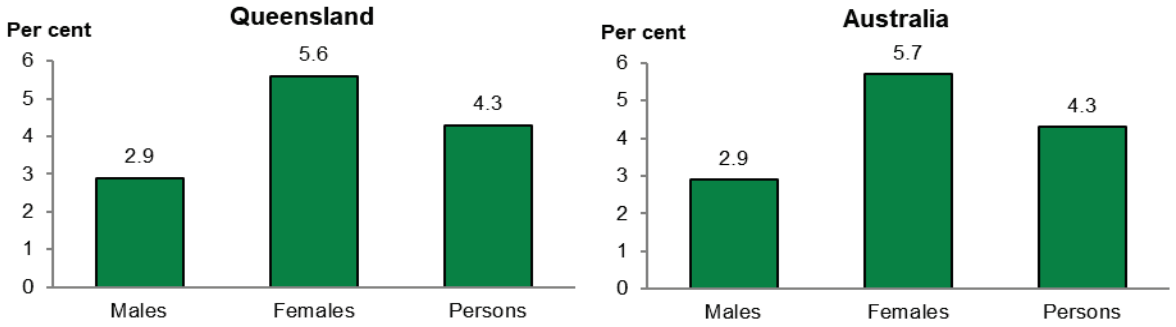
Nationally this pattern was similar for First Nations people over the same time, with females hospitalised at a rate of 5.7 per 1,000 compared with males at 2.9 per 1,000 (Figure 1.10.1).

Kidney failure with replacement therapy: During 2019–2021 in Queensland, for First Nations people the incidence rate of kidney failure with kidney replacement therapy was 42 new cases per 100,000 population. The incidence of kidney failure with replacement therapy was similar for First Nations females and males (44 per 100,000 compared with 41 per 100,000).

Nationally over the same period, the incidence of kidney failure with replacement therapy was higher for First Nations females than for First Nations males (44 per 100,000 compared with 38 per 100,000) (Figure 1.10.2).

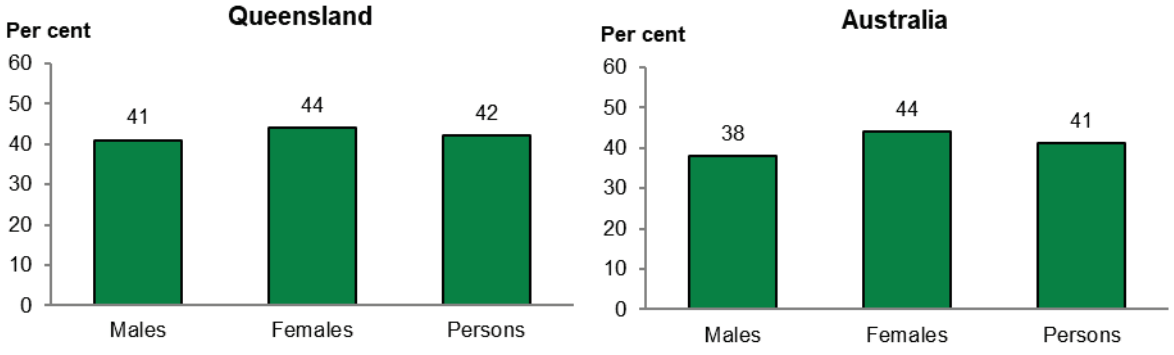
Kidney failure with replacement therapy over time: The incidence rate of kidney failure with replacement therapy for First Nations people in Queensland increased by 53% between 2012 and 2021. Nationally over the same time, the incidence rate of kidney failure with replacement therapy for First Nations people increased by 12% (Figure 1.10.3).

Figure 1.10.1: Hospitalisation rate for chronic kidney disease (excluding dialysis) (based on principal diagnosis), First Nations people, by sex, Queensland and Australia, July 2019 to June 2021



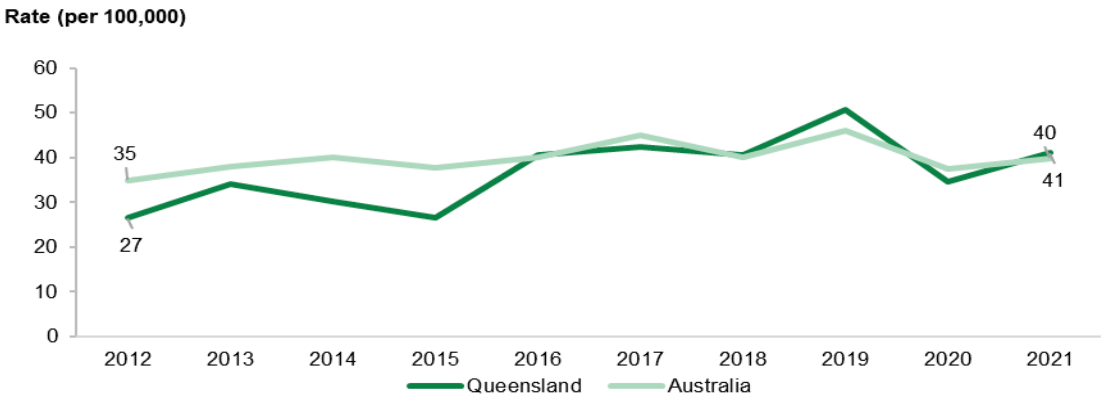
Source: Table D1.10.7.

Figure 1.10.2: Incidence (new cases) of kidney failure with replacement therapy, First Nations people, by sex, Queensland and Australia, 2012–2021



Source: Table D1.10.11.

Figure 1.10.3: Incidence (new cases) of kidney failure with replacement therapy, First Nations people, Queensland and Australia, 2012–2021



Source: Table D1.10.15.

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

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 First Nations 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

Self-reported data on oral health and dental consultations are available from the 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) (for children under 15, an adult was asked to respond on their behalf).

Seen a dentist in last 12 months: Based on data from the 2018–19 NATSIHS, in Queensland, more than 99,000 (46%) First Nations people aged 2 and over had seen a dentist in the last 12 months (ABS 2019b, tables 37.a.1 and 37.a.3).

Tooth loss: In Queensland in 2018–19, around 8,900 First Nations people aged 15 and over had complete tooth loss (6.3%). Complete tooth loss was more common for those living in non-remote areas (6.6%) compared with remote areas (5.5%) (Figure 1.11.1).

Nationally, an estimated 5.9% of First Nations people aged 15 and over had complete tooth loss in 2018–19 (Table D1.11.10).

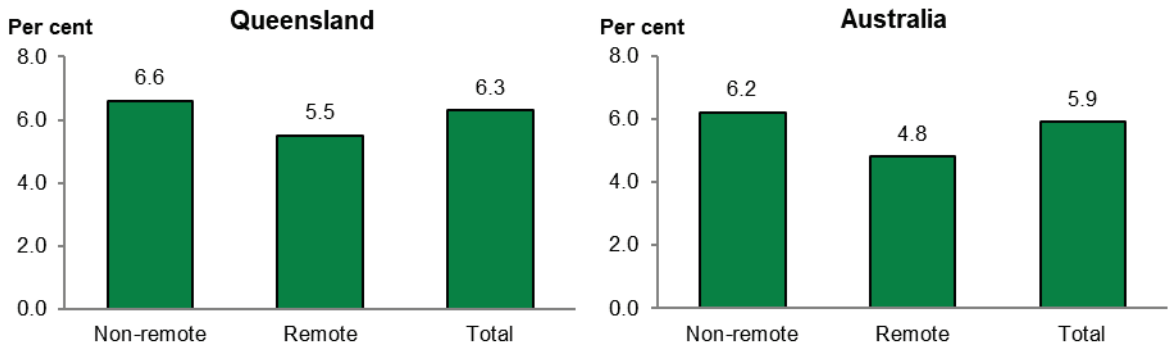
Teeth or gum problems in children: Based on data from the 2014–15 NATSISS, 26% of First Nations children aged under 15 in Queensland had teeth or gum problems, compared with 28% of First Nations children nationally (Table D1.11.1).

Hospitalisations for dental problems: In Queensland between July 2019 and June 2021, 3,373 First Nations 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 7.0 per 1,000 population (Table D1.11.33). Among First Nations people, the highest rate of hospitalisation was for those aged 5–14 (8.9 per 1,000 population). For other Queenslanders, the rate was highest for those aged 15–24 (16.8 per 1,000) (Figure 1.11.2).

Nationally, between July 2019 and June 2021, First Nations people were hospitalised for dental problems at a rate of 6.7 per 1,000 population (Table D1.11.33). Rates were highest among First Nations people for those aged 5–14 (9.6 per 1,000 population), whereas among other Australians the rate was highest for those aged 15–24 (16.2 per 1,000) (Figure 1.11.2).

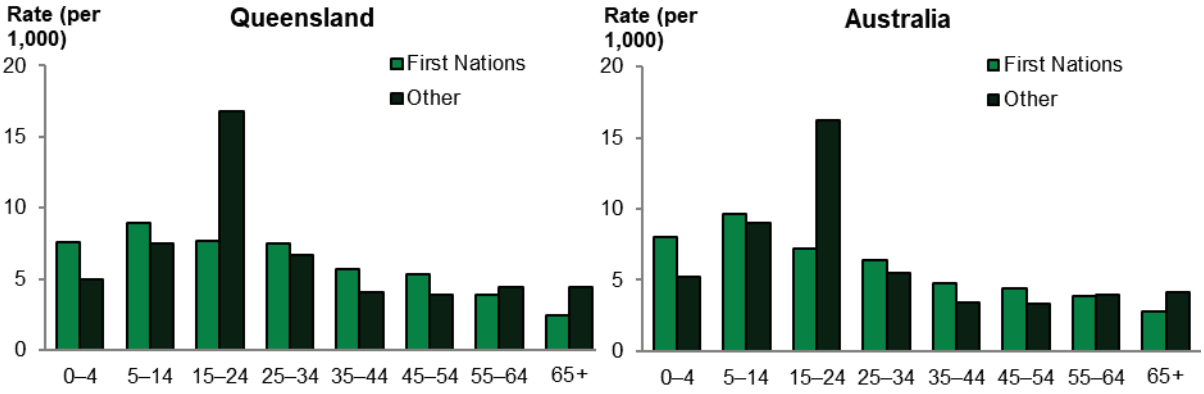
Hospitalisations under general anaesthetic: Dental care under general anaesthetic carries an additional risk and is resource intensive. In Queensland, between July 2019 and June 2021, there were 2,529 hospitalisations of First Nations people for dental procedures that involved general anaesthesia, at a rate of 5.2 per 1,000 population (Table D1.11.34). Rates of hospitalisation for dental procedures involving general anaesthesia were lower for First Nations people than for other Queenslanders (Figure 1.11.3).

Figure 1.11.1: Proportion of First Nations people aged 15 and over with complete tooth loss by remoteness, Queensland and Australia, 2018–19



Source: Table D1.11.10.

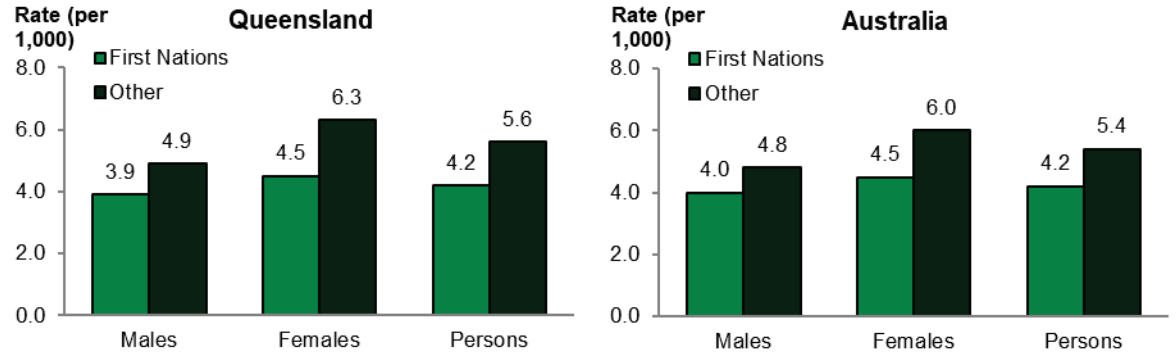
Figure 1.11.2: Age-specific hospitalisation rates for a principal diagnosis of dental problems, by Indigenous status, Queensland and Australia, July 2019 to June 2021



Source: Table D1.11.21 Qld.

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

Figure 1.11.3: Age-standardised hospitalisation rates for dental procedures involving general anaesthesia, by Indigenous status, Queensland and Australia, July 2019 to June 2021



Source: Table D1.11.34.

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

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 non-congenital 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 (World Health Organization 2024). Hepatitis causes serious illness and can also progress to cirrhosis of the liver, cancer and premature death (ASHA 2017). STIs can have serious long-term consequences such as pelvic inflammatory disease, infertility, adverse pregnancy outcomes, miscarriage, and neonatal infections. Untreated syphilis can cause heart and brain damage (Bowden et al. 2002; Guy et al. 2012).

Key findings

HIV: In the 3-year period 2019–2021, there were 389 notifications of HIV in Queensland. Of these, First Nations people accounted for 5.7% of HIV notifications. The HIV notification rate was 3.0 per 100,000 population for First Nations people (Table D1.12.8). The age-standardised notification rate for First Nations people was 1.3 times as high as the rate for other Queenslanders.

Nationally, there were 2,082 notifications of HIV in 2019–2021. Of these, First Nations people accounted for 2.8% of HIV notifications. The HIV notification rate was 2.3 per 100,000 for First Nations people (Table D1.12.8). The age-standardised notification rate for other Australians was 1.1 times as high as the rate for First Nations people (Figure 1.12.1).

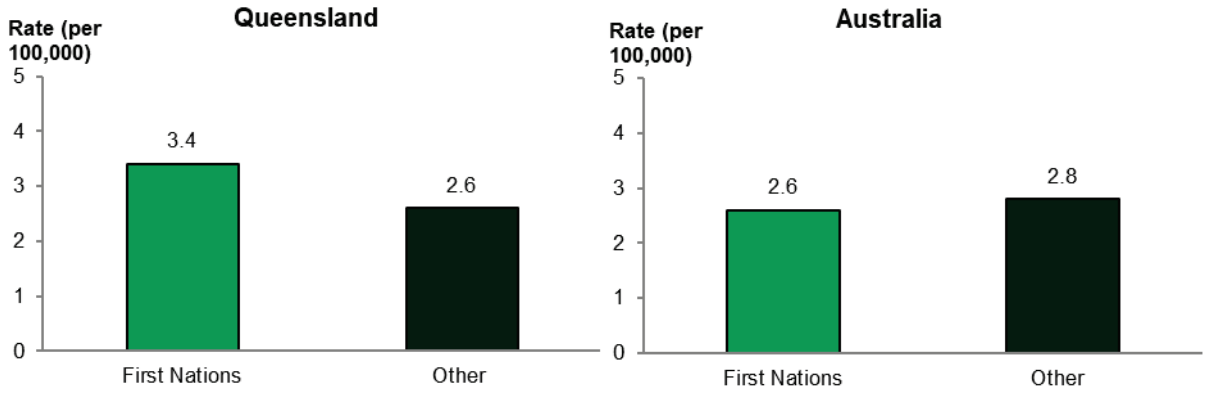
Hepatitis B and hepatitis C: In Queensland over the 3-year period 2020–2022, the notification rates of hepatitis B and hepatitis C for First Nations people were 19 and 218 per 100,000 respectively (Table D1.12.1). After adjusting for differences in the age structure between the two populations, the notification rate for First Nations people was 2.1 times as high as the notification rate for other Queenslanders for hepatitis B, and 9.2 times as high for hepatitis C (Figure 1.12.2).

In Qld, WA, SA, Tas, the ACT and the NT combined, the notification rates of hepatitis B and hepatitis C for First Nations people were 21 and 175 per 100,000 respectively (Table D1.12.1). After adjusting for differences in the age structure between the two populations, the notification rate for First Nations people was 2.0 times as high as the notification rate for other Australians for hepatitis B, and 8.6 times as high for hepatitis C (Figure 1.12.2).

Infectious syphilis: In Queensland over the 3-year period 2020–2022, there were 695 notifications for infectious syphilis among First Nations people, corresponding to 94 notifications per 100,000 population (Table D1.12.1). After adjusting for differences in the age structure between the two populations, the notification rate for First Nations people was 5.9 times as high as the rate for other Queenslanders (Figure 1.12.3).

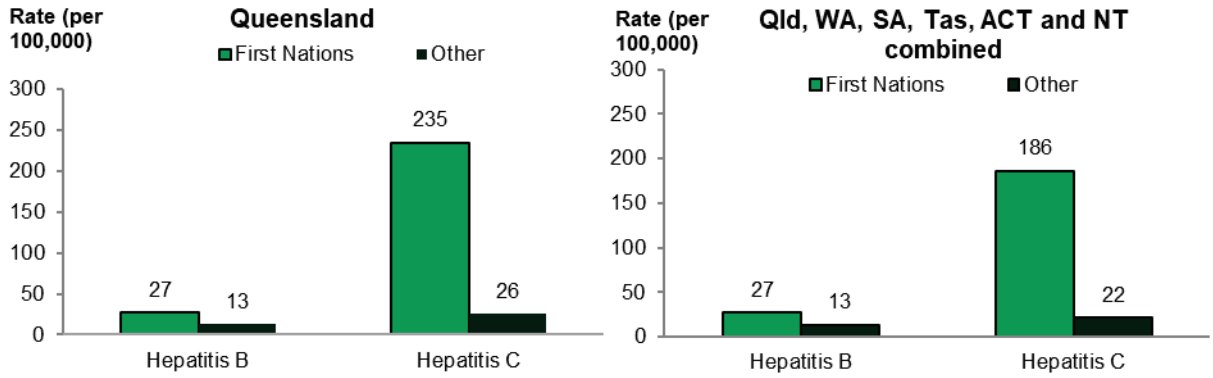
Nationally, there were 2,881 notifications for infectious syphilis among First Nations people, corresponding to 109 notifications per 100,000 population (Table D1.12.1). After adjusting for differences in the age structure between the two populations, the notification rate for First Nations people was 6.0 times as high as the rate for other Australians (Figure 1.12.3).

Figure 1.12.1: Age-standardised notification rates for HIV, by Indigenous status, Queensland and Australia, 2019–2021



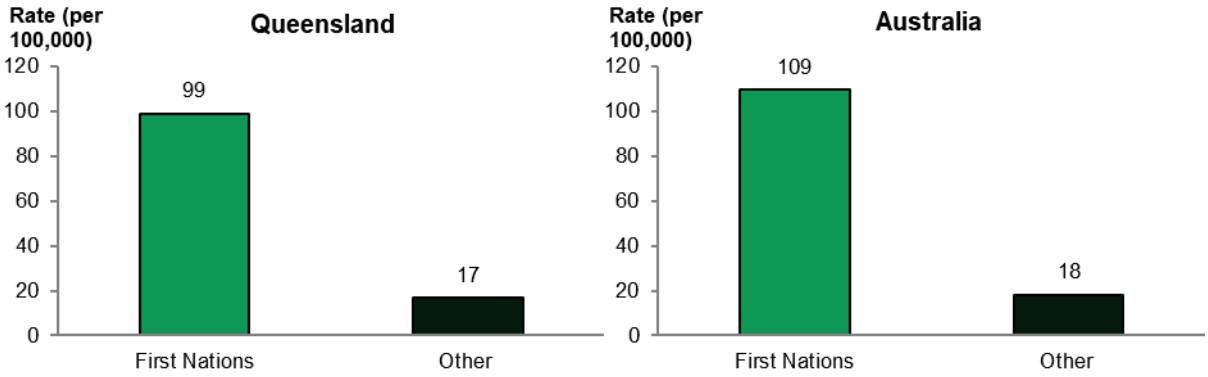
Source: Table D1.12.8.

Figure 1.12.2: Age-standardised notification rates for hepatitis B and hepatitis C, Queensland and Qld, WA, SA, Tas, the ACT and the NT combined, by Indigenous status, 2020–2022



Source: Table D1.12.1.

Figure 1.12.3: Age-standardised notification rates for infectious syphilis, by Indigenous status, Queensland and Australia, 2020–2022



Source: Table D1.12.1.

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

1.13 Community functioning

Why it is important

This measure reports on factors used to describe community functioning for First Nations Australians. 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).

Key findings

Connectedness to Country, land and history; culture and identity: In 2014–15 in Queensland, 77% of First Nations people aged 15 and over recognised their homelands; 66% identified with a clan or language group; and 61% had attended a First Nations cultural event in the last 12 months.

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

Resilience: In 2014–15 in Queensland, 99% of First Nations adults had participated in sport, social or community activities in the last 12 months and 87% of First Nations people aged 15 and over did not avoid situations due to past unfair treatment. More than a third (36%) of employed First Nations people aged 15 and over said work allowed them to fulfil cultural responsibilities.

Nationally in 2014–15, 97% of First Nations adults had participated in sport, social or community activities in the last 12 months and 86% of First Nations people aged 15 and over did not avoid situations due to past discrimination. About 2 in 5 (41%) employed First Nations 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 Queensland, 39% of First Nations Australians aged 15 and over had lived in one dwelling in the last 12 months. Nationally, 32% of First Nations Australians had lived in one dwelling in the last 12 months (Table D1.13.12).

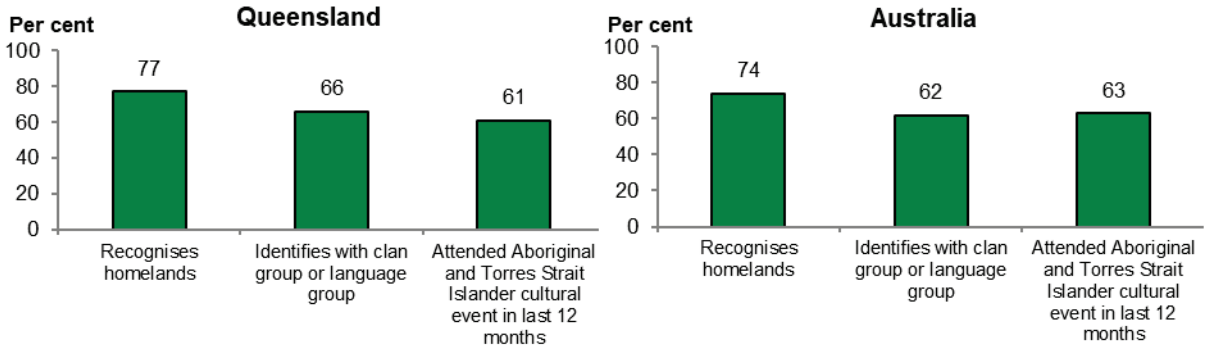
Feeling safe: In 2014–15 in Queensland, of First Nations people aged 15 and over, 78% had not experienced physical or threatened violence in the last 12 months, 86% felt safe at home alone after dark and 68% felt safe walking alone in the local area after dark.

Nationally in 2014–15, 78% of First Nations 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 Queensland, of First Nations Australians aged 15 and over, 68% had experienced low/moderate levels of psychological distress in the 4 weeks before the survey, 77% could easily get to places as needed and 82% had accessed the internet in the last 12 months.

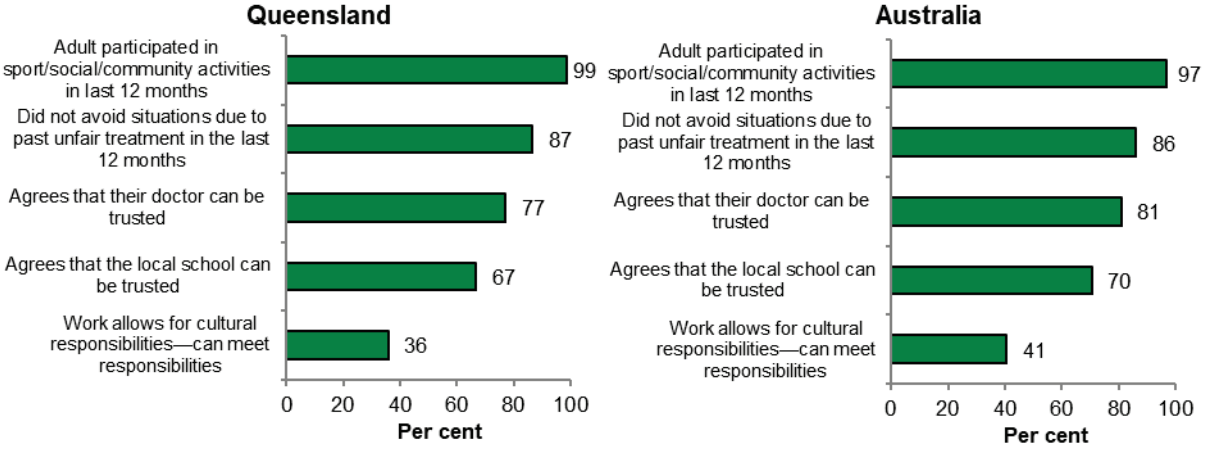
Nationally in 2014–15, of First Nations Australians aged 15 and over, 67% experienced low/moderate levels of psychological distress in the 4 weeks before the survey, 75% could easily get to places as needed and 79% had accessed the internet in the last 12 months (Table D1.13.12).

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



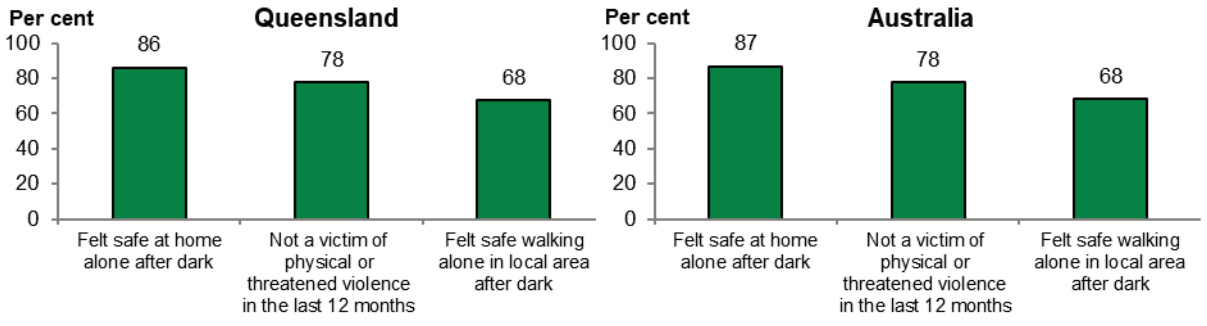
Source: Table D1.13.12.

Figure 1.13.2: Proportion of First Nations people aged 15 and over: resilience, Queensland and Australia, 2014–15



Source: Table D1.13.12.

Figure 1.13.3: Proportion of First Nations people aged 15 and over: feeling safe, Queensland and Australia, 2014–15



Source: Table D1.13.12.

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

1.14 Disability

Why it is important

This measure reports on the prevalence of disability for First Nations people, including use of disability support services. Disability may be an impairment of body structure or function, a limitation in activities or a restriction in a person's participation in specific activities. A person's functioning involves an interaction between health conditions and environmental and personal factors. First Nations 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. Along with limited access to early treatment and rehabilitation services, these factors increase a person's risk of acquiring disability.

Key findings

Overall: In 2018–19 in Queensland, 44% of First Nations people aged 15 and over reported having a disability or restrictive long-term health condition (Table D1.14.2). The age-standardised proportion of First Nations people reporting having a disability or restrictive long-term health condition was 1.4 times as high as for other Queenslanders (Figure 1.14.1).

Nationally in 2018–19, 46% of First Nations people aged 15 and over reported having a disability or restrictive long-term health condition (Table D1.14.2). The age-standardised proportion of First Nations people reporting having a disability or restrictive long-term health condition was 1.5 times as high as for other Australians (Figure 1.14.1).

Assistance with core activities: In 2021 in Queensland, 8.5% of First Nations people needed assistance with a core activity (self-care, mobility or communication) (Table D1.14.12). The age-standardised proportion of First Nations people needing assistance with core activities was 2.1 times as high as for other Queenslanders (Figure 1.14.2).

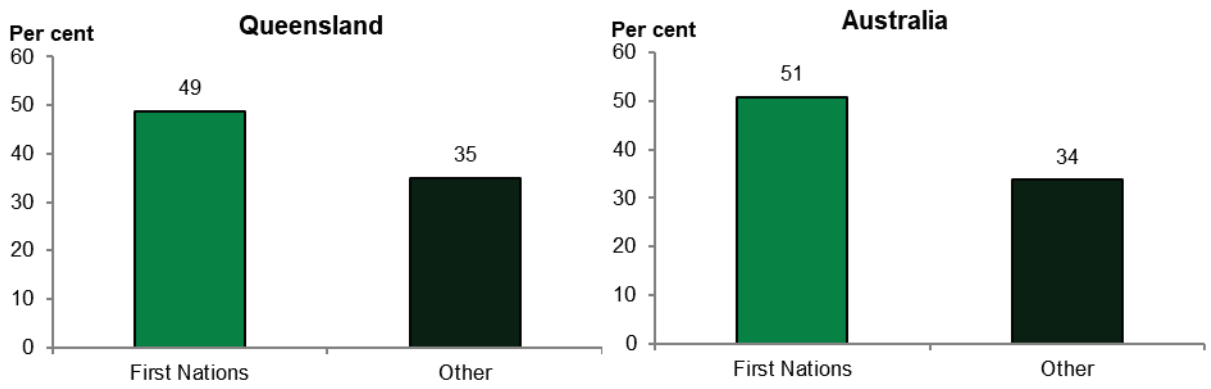
Nationally in 2021, 8.6% of First Nations people needed assistance with a core activity. The age-standardised proportion of First Nations people needing assistance was 2 times as high as for other Australians (Figure 1.14.2).

Users of disability support services: In 2017–18 in Queensland, the crude rate of First Nations people aged under 65 who had used disability support services provided under the National Disability Agreement was 17 per 1,000. The rate for First Nations males was higher than First Nations females (21 and 14 per 1,000, respectively), as was the rate for other Queenslander males compared with other Queenslander females (Table D1.14.16). First Nations people aged under 65 used disability services at 1.8 times the rate for other Queenslanders (age-standardised) (Figure 1.14.3).

Nationally in 2017–18, the crude rate of First Nations people aged under 65 who had used disability support services was 20 per 1,000. The rate for First Nations males was higher than First Nations females (24 and 16 per 1,000, respectively), as was the rate for other Australian males compared with other Australian females (Table D1.14.16). First Nations people aged under 65 used disability services at 1.9 times the rate for other Australians (age-standardised) (Figure 1.14.3).

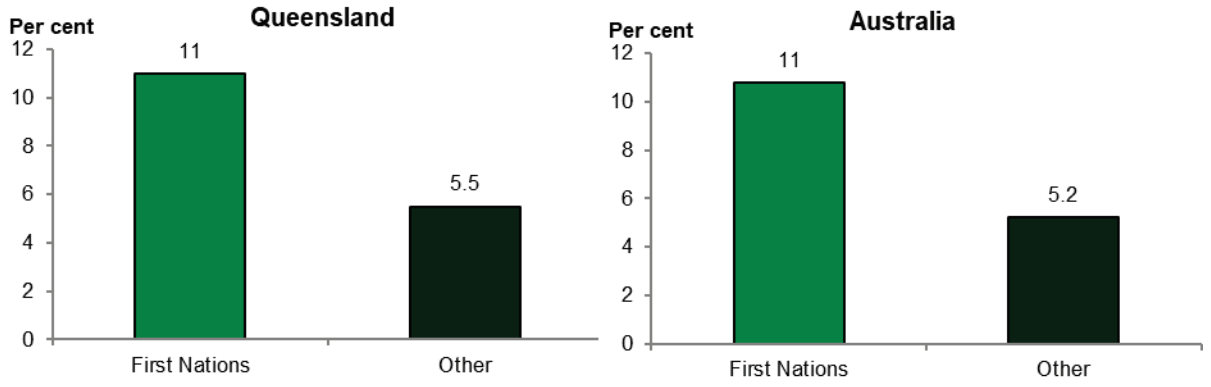
Specialist disability support services are now largely provided through the NDIS. At 31 December 2024, 15,873 First Nations people in Queensland were participating in the NDIS (11% of all NDIS participants in Queensland). Nationally, 55,675 First Nations people were participating in the NDIS (8.0% of all participants) (AIHW analysis of NDIA 2025).

Figure 1.14.1: Age-standardised proportion reporting disability or a restrictive long-term health condition, by Indigenous status, Queensland and Australia, 2017–18 and 2018–19



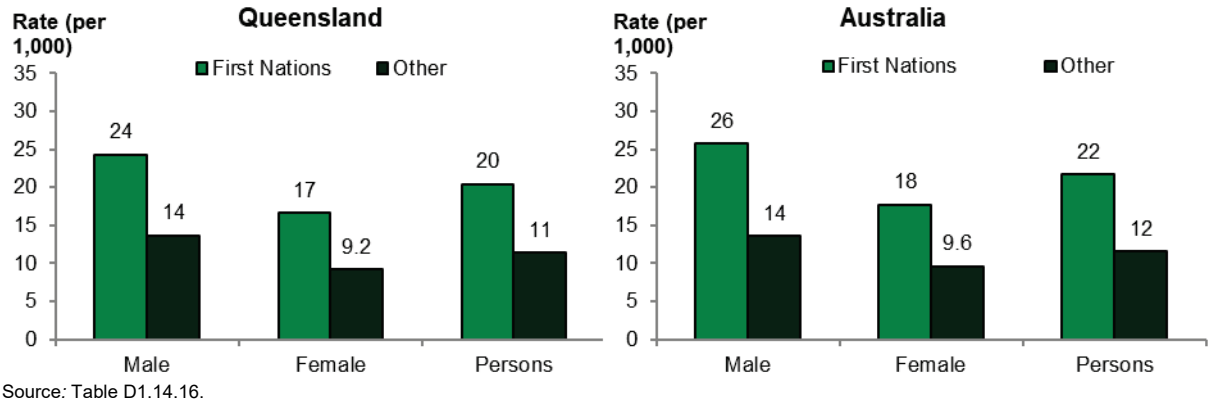
Source: Table D1.14.1.

Figure 1.14.2: Age-standardised proportion needing core-activity assistance, by Indigenous status, Queensland and Australia, 2021



Source: Table D1.14.12.

Figure 1.14.3: Age-standardised rate (aged under 65) using disability support services, by sex and Indigenous status, Queensland and Australia, 2017–18



Source: Table D1.14.16.

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

1.15 Ear health

Why it is important

This measure reports on hearing loss in First Nations 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 (NATSHIS) offered a voluntary hearing test for participants aged 7 and over. In Queensland, an estimated 86,400 (46%) First Nations 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%) First Nations 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 hearing loss for children aged 0–14: In 2018–19, 6.9% of First Nations children in Queensland were reported to have an ear or hearing problem (note this estimate has a relative standard error of 25% to 50% and should be interpreted with caution).

Nationally in 2018–19, 6.9% of First Nations children were reported to have had an ear or hearing problem (Table D1.15.9).

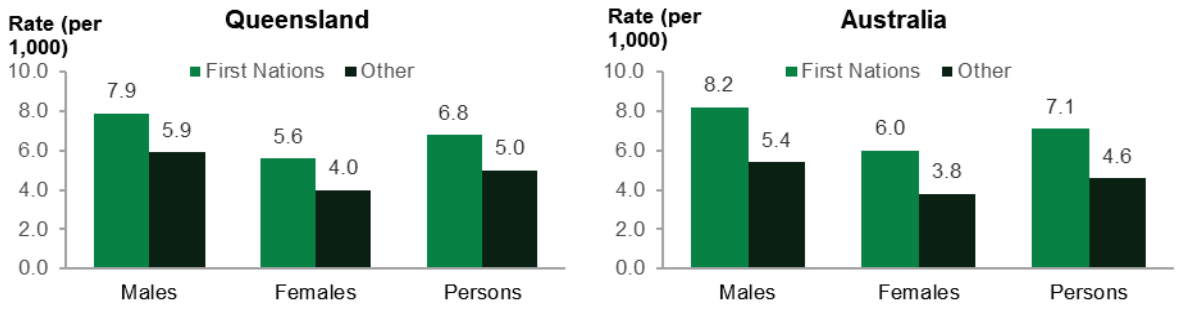
Hospitalisations for ear disease in children aged 0–14: From July 2019 to June 2021, for First Nations children aged 0–14 in Queensland, there were 1,133 hospitalisations for diseases of the ear and mastoid process (ear disease); a rate of 6.9 per 1,000 population (Table D1.15.10). After adjusting for age, the hospitalisation rate for ear disease for First Nations children was 1.4 times the rate for other children in Queensland (Figure 1.15.1).

Nationally, from July 2019 to June 2021 for First Nations children aged 0–14, there were 4,104 hospitalisations for ear disease; a rate of 7.2 per 1,000 population (Table D1.15.10). After adjusting for age, the hospitalisation rate for ear disease for First Nations children was 1.5 times the rate for other children in Australia (Figure 1.15.1).

Hospitalisations for ear disease in First Nations people: From July 2019 to June 2021, for First Nations people in Queensland, there were 2,090 hospitalisations for ear disease; a rate of 4.3 per 1,000 population (Table D1.15.12). The age-standardised hospitalisation rate of ear disease for First Nations people was 1.3 times the rate for other Queenslanders (Figure 1.15.2). From 2011–12 to 2020–21, the hospitalisation rate for ear disease among First Nations people increased by 83% (Figure 1.15.3).

Nationally from July 2019 to June 2021, for First Nations people there were 6,636 hospitalisations for ear disease; a rate of 3.8 per 1,000 population (Table D1.15.12). After adjusting for differences in the age structure between the two populations, the hospitalisation rate of ear disease for First Nations people was 1.5 times the rate for other Australians (Figure 1.15.2). From 2011–12 to 2020–21, the hospitalisation rate for ear disease among First Nations people increased by 42% (Figure 1.15.3).

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 Indigenous status and sex, Queensland and Australia, July 2019 to June 2021

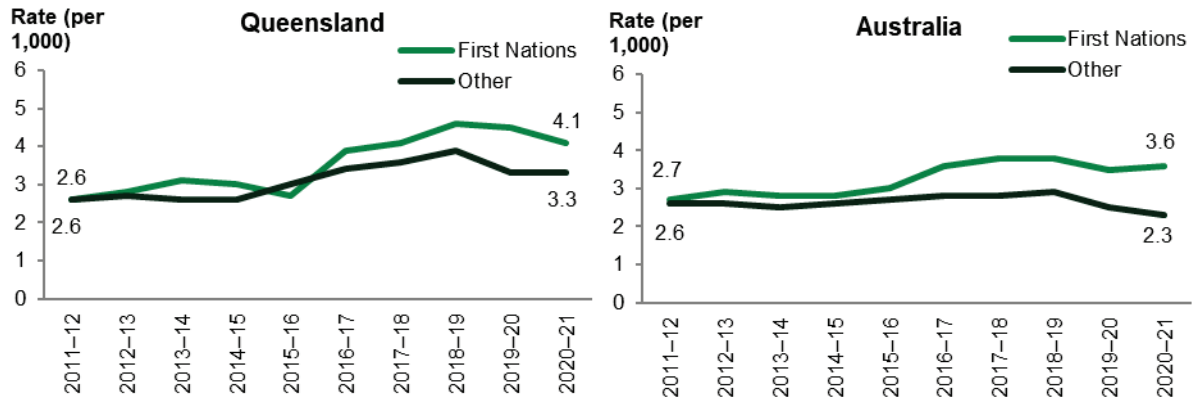


Source: Table D1.15.10.

Figure 1.15.2: Age-standardised rate for hospitalisations for diseases of the ear and mastoid process (based on principal diagnosis), by Indigenous status and sex, Queensland and Australia, July 2019 to June 2021

Source: Table D1.15.12.

Figure 1.15.3: Age-standardised rate for hospitalisation for diseases of the ear and mastoid process (based on principal diagnosis), by Indigenous status, Queensland, and Australia, 2011–12 to 2020–21



Source: Table D1.15.15 Qld.

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

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 First Nations 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 the differences in the age structure between the two populations, the burden due to hearing and vision disorders was 3.3 times as high for First Nations people as for other Australians (AIHW 2022a).

Key findings

Eye health based on self-reported data: In 2018–19, over half (51%, 75,500 people) of First Nations people aged 15 and over in Queensland reported eye or sight problems. First Nations people in non-remote areas were more likely to report eye or sight problems than those in remote areas (53% compared with 45%, respectively).

Nationally in 2018–19, 52% of First Nations people aged 15 and over reported eye or sight problems. The proportion reporting eye or sight problems in non-remote areas was higher than in remote areas (55% compared with 42%) (Figure 1.16.1).

Medicare health assessments: In Queensland in 2023, there were 10,112 Medicare health assessments (which included eye checks) undertaken for First Nations children aged 0–4 (33.2% of children in this age group); 18,309 health checks for First Nations children aged 5–14 (33.3%); 14,612 health checks for First Nations people aged 15–24 (28.5%); 25,263 health checks for First Nations people aged 25–49 (28.5%); and 21,176 health checks for First Nations people aged 50 and over (45.8%) (AIHW 2024a, Table E2).

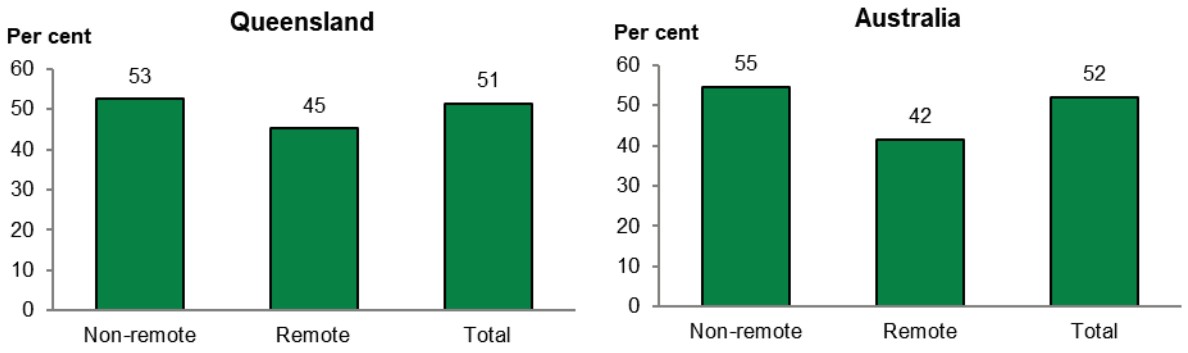
Hospitalisations: In Queensland, between July 2019 and June 2021, there were 3,519 hospitalisations of First Nations people with a principal diagnosis of diseases of the eye and adnexa (Table D1.16.14). From age 15–24 the hospitalisation rate increased with age, from 0.8 per 1,000 for those aged 15–24, to 70 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 10% lower for First Nations people than for other Queenslanders (14.8 compared with 16.2 per 1,000 population, respectively).

Nationally between July 2019 and June 2021, the hospitalisation rate for diseases of the eye and adnexa was around 10% lower for First Nations people than for other Australians (12.3 compared with 13.5 per 1,000 population, respectively) (Table D1.16.14).

Changes in hospitalisation over time: In Queensland, the age-standardised hospitalisation rate for First Nations people for diseases of the eye and adnexa doubled between 2011–12 and 2020–21 (104% increase), compared with a 30% increase for other Queenslanders. Despite the higher increase in rates over time for First Nations people compared with other Queenslanders, eye and adnexa hospitalisation rates for First Nations people remained lower than for other Queenslanders in 2020–21.

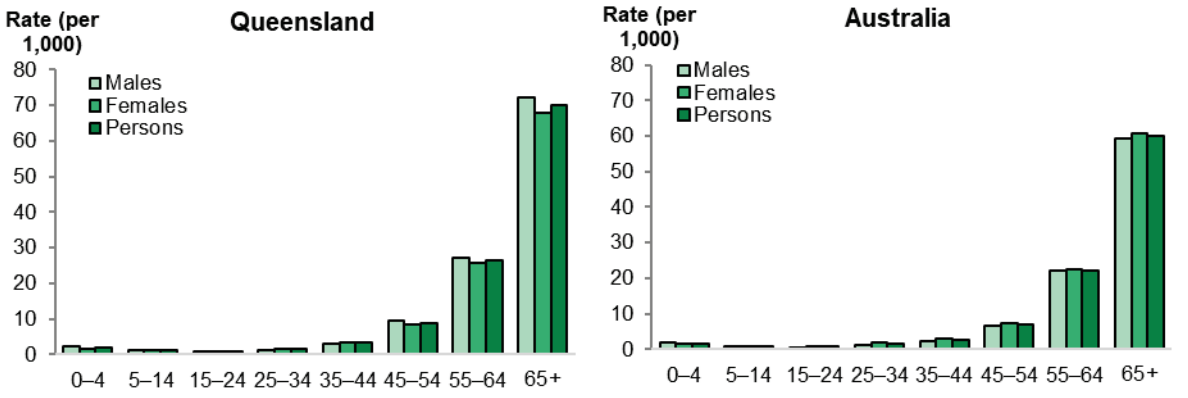
Nationally between 2011–12 and 2020–21, the hospitalisation rate for First Nations people for diseases of the eye and adnexa increased by 51%, compared with a 10% increase for other Australians (Figure 1.16.3).

Figure 1.16.1: Proportion of First Nations people aged 15 and over reporting eye or sight problems, by remoteness, Queensland and Australia, 2018–19



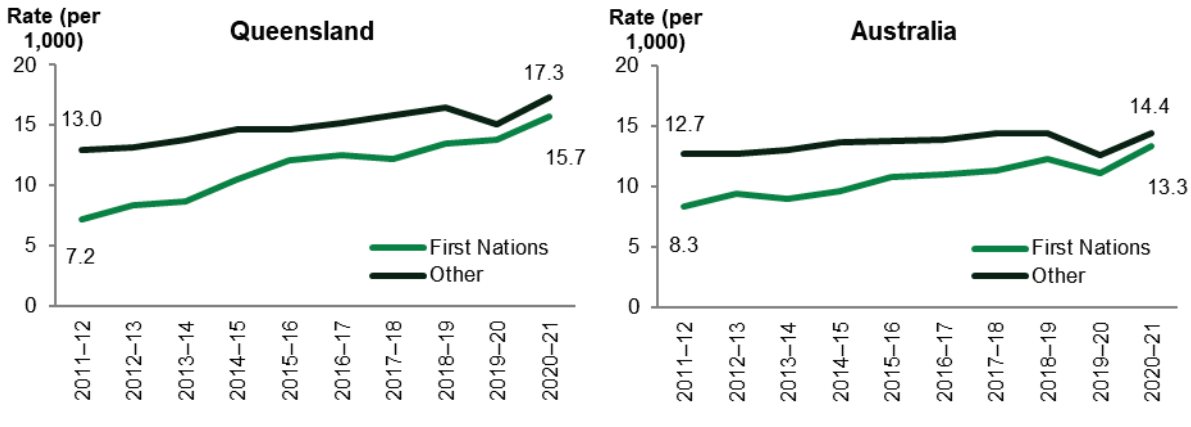
Source: Table D1.16.5.

Figure 1.16.2: Hospitalisation rates for a principal diagnosis of diseases of the eye and adnexa, First Nations people, by sex and age group, Queensland and Australia, July 2019 to June 2021



Source: Table D1.16.12 Qld.

Figure 1.16.3: Age-standardised hospitalisation rates for a principal diagnosis of diseases of the eye and adnexa, by Indigenous status, Queensland and Australia, 2011–12 to 2020–21



Source: Table D1.16.18 Qld.

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

1.17 Perceived health status

Why it is important

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

Key findings

Self-assessed health status: Based on data from the 2018–19 National Aboriginal and Torres Strait Islander Health Survey, in Queensland 43% of First Nations people aged 15 and over reported their health as excellent/very good, 34% as good, and 24% as fair/poor (Figure 1.17.1).

The age-standardised proportion of First Nations people in Queensland who reported their health as:

- excellent/very good was 0.7 times the proportion of other Queenslanders
- good was 1.2 times the proportion of other Queenslanders
- fair/poor was 1.8 times the proportion of other Queenslanders (Figure 1.17.2).

Nationally, 45% of First Nations people aged 15 and over reported their health as excellent/very good, 32% as good, and 24% as fair/poor (Figure 1.17.1).

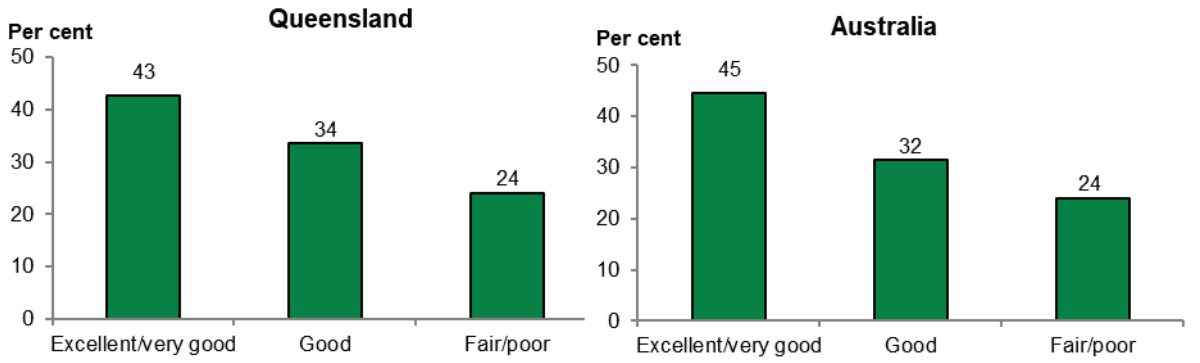
The age-standardised proportion of First Nations people nationally who reported their health as:

- excellent/very good was 0.7 times the proportion of other Australians
- good was 1.1 times the proportion of other Australians
- fair/poor was 2.0 times the proportion of other Australians (Figure 1.17.2).

Self-assessed health status over time: The proportion of First Nations people in Queensland aged 15 and over who reported their health as excellent/very good was at its highest in 2008 (44%) and its lowest in 2012–13 (37%). Meanwhile, the proportion of First Nations people in Queensland who reported their health as fair/poor was lowest in 2008 (20%) and highest in 2014–15 (27%).

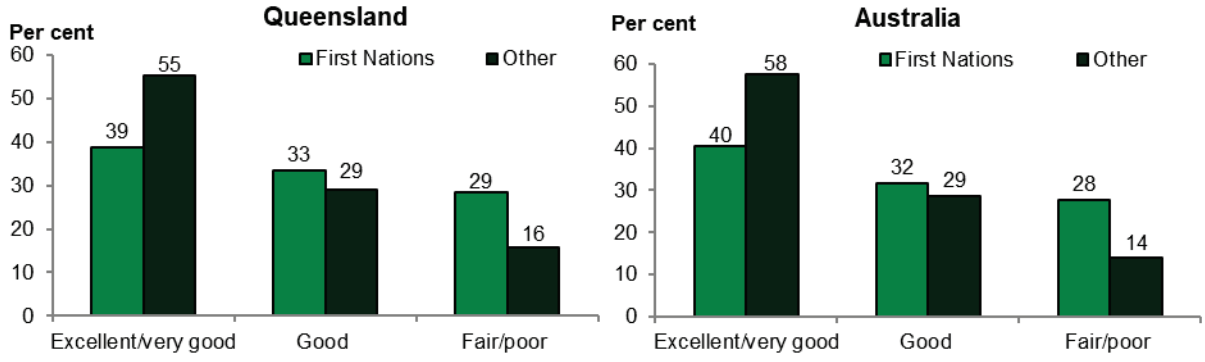
Nationally, the proportion of First Nations people who reported their health as excellent/very good was highest in 2018–19 (45%) and lowest in 2012–2013 (39%). Meanwhile, the proportion of First Nations people who reported their health as fair/poor was lowest in 2008 (22%) and highest in 2014–2015 (26%) (Figure 1.17.3).

Figure 1.17.1: Self-assessed health status, First Nations people aged 15 and over, Queensland and Australia, 2018–19



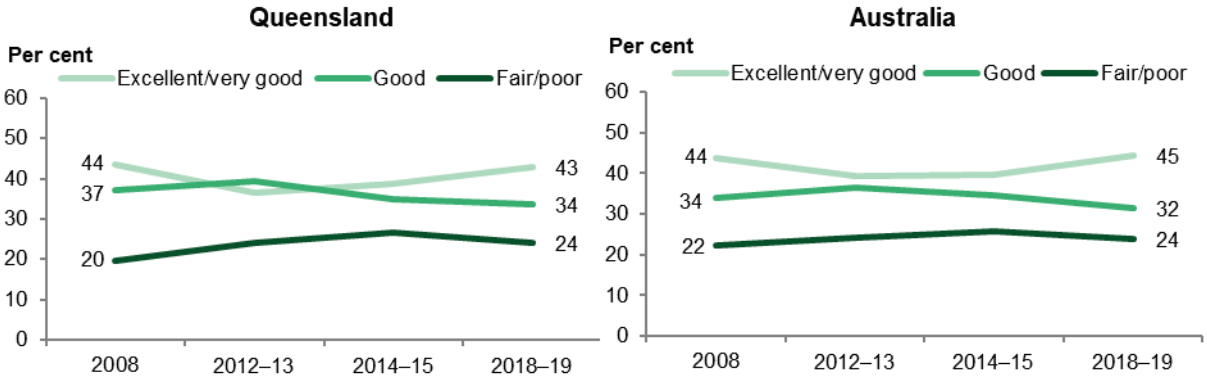
Source: Table D1.17.8.

Figure 1.17.2: Age-standardised proportion of self-assessed health status, Australians aged 15 and over, by Indigenous status, Queensland and Australia, 2018–19



Source: Table D1.17.9.

Figure 1.17.3: Self-assessed health status of First Nations people aged 15 and over, Queensland and Australia, 2008 to 2018–19



Source: Table D1.17.8.

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

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 for First Nations people, which underpins the physical and mental health of First Nations people (PM&C 2017).

Key findings

Psychological distress: The 2018–19 National Aboriginal and Torres Strait Islander Survey showed that 31% of First Nations people aged 18 and over in Queensland reported high/very high levels of psychological distress. This proportion was higher in non-remote (33%) than remote areas (26%).

Nationally, 31% of First Nations people aged 18 and over had high/very high levels of psychological distress and the proportion was higher in non-remote (32%) than remote areas (28%) (Figure 1.18.1).

Mental health-related hospitalisations: Between July 2019 to June 2021, hospitalisation rate for mental health-related conditions among First Nations people in Queensland was 33 per 1,000 population and was higher for males (45 per 1,000) than females (37 per 1,000) (Table D1.18.14 Qld). Hospitalisations for mental health-related conditions were highest at age 35–44 for males (79 per 1,000) and females (63 per 1,000) (Figure 1.18.2).

Nationally, between July 2019 to June 2021, there were 32 per 1,000 hospitalisations for mental health-related conditions among First Nations people and was similar for males and females (32 per 1,000, respectively) (Table D1.18.14 Qld). Hospitalisations for mental health-related conditions were highest at age 35–44 for males (75 per 1,000) and females (61 per 1,000) (Figure 1.18.2).

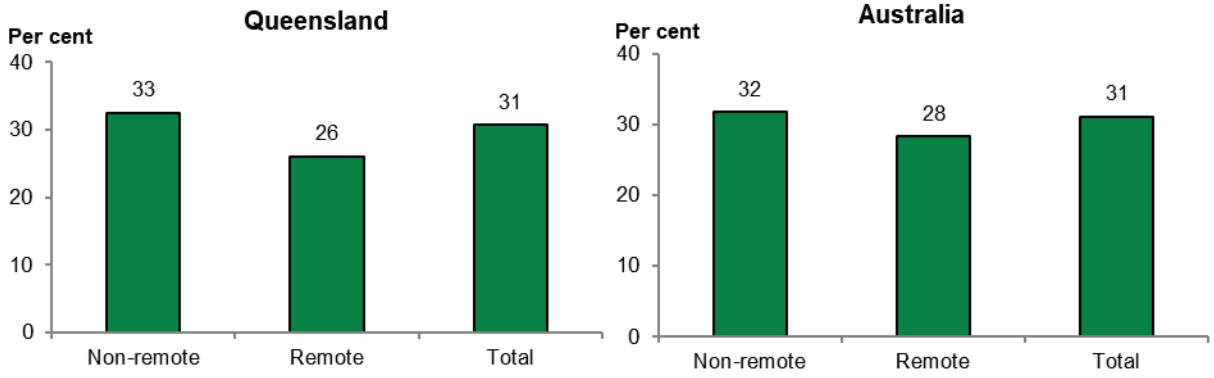
Deaths due to intentional self-harm: Between 2015–19, the intentional self-harm death rate was 26 per 100,000 among First Nations people in Queensland. This rate was higher for First Nations males than for females (39 per 100,000 compared with 13 per 100,000).

For NSW, Qld, WA, SA and the NT combined, between 2015–19, the intentional self-harm death rate was 24 per 100,000 among First Nations people (Table D1.18.30)

Deaths due to intentional self-harm over time: In Queensland, over the decade from 2010 to 2019, the age-standardised death rate due to intentional self-harm for First Nations people increased by 64% and increased for other Queenslanders by 24%.

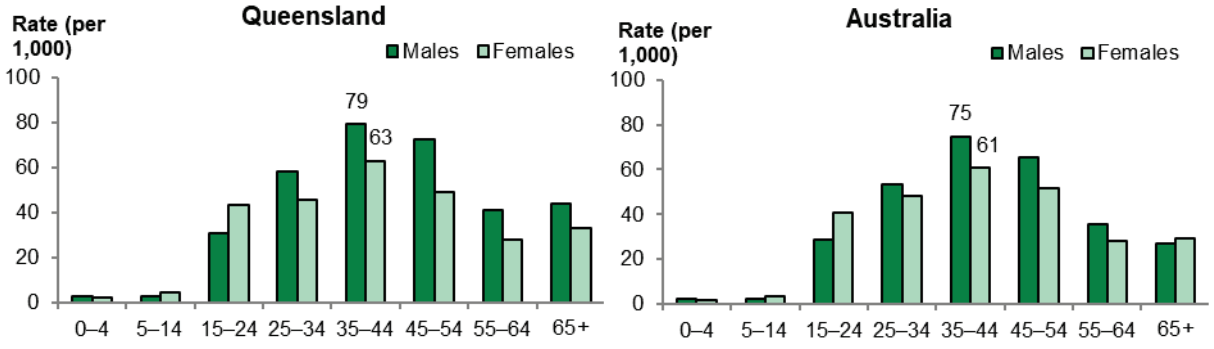
For NSW, Qld, WA, SA, and the NT combined, from 2010 to 2019, the age-standardised death rate due to intentional self-harm for First Nations people increased by 30% and increased for other Australians by 24% (Figure 1.18.3).

Figure 1.18.1: Proportion of First Nations people aged 18 and over reporting high/very high levels of psychological distress, by remoteness, Queensland and Australia, 2018–19



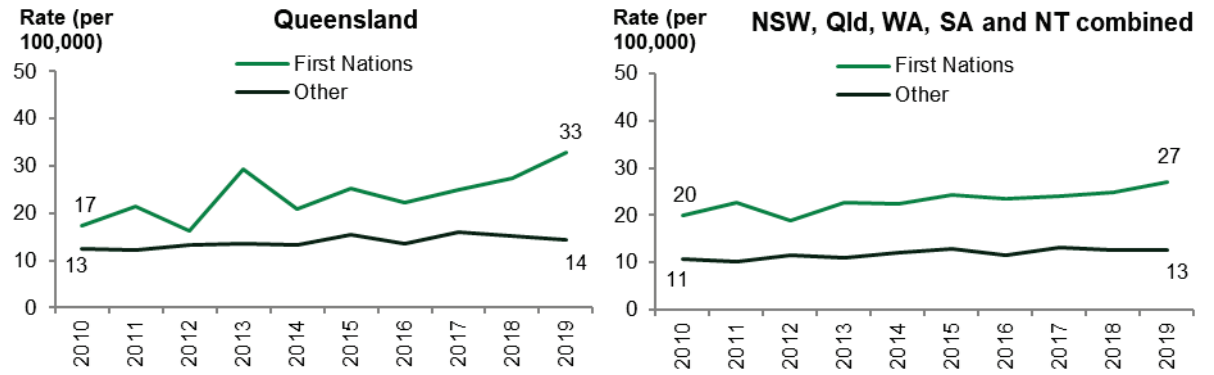
Source: Table D1.18.2

Figure 1.18.2: Hospitalisation rates for mental health-related conditions (based on principal diagnosis) for First Nations people, by sex and age group, Queensland and Australia, July 2019 to June 2021



Source: Table D1.18.14 Qld

Figure 1.18.3: Age-standardised intentional self-harm death rates, by Indigenous status, Queensland, and NSW, Qld, WA, SA and NT combined, 2010–2019



Source: Table D1.18.26.

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

1.19 Life expectancy at birth

Why it is important

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

The life expectancy gap between First Nations people and non-Indigenous Australians 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 First Nations people and non-Indigenous Australians within a generation (by 2031) (COAG 2008).

Key findings

Overall: In 2020–2022 in Queensland, life expectancy at birth for First Nations males and females was estimated to be 72.9 years and 76.6 years, respectively. These estimates were lower than for other males (80.2 years) and females in Queensland (83.5 years), representing a gap of 7.4 years for males and 7.0 years for females.

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

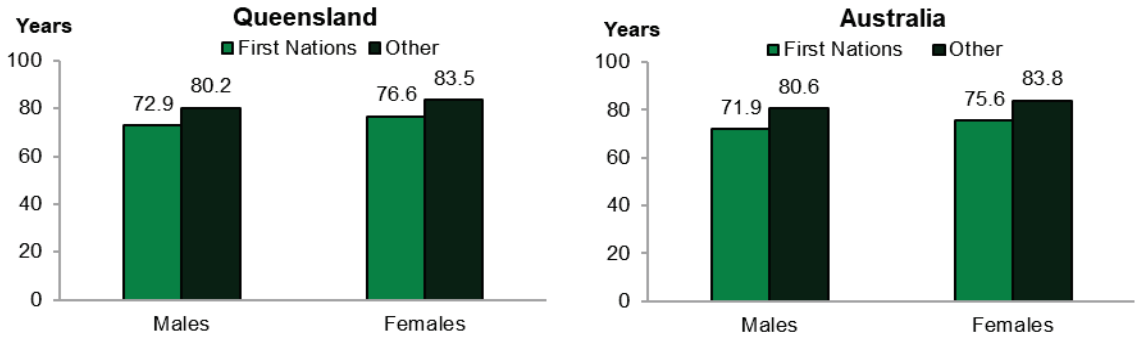
Remoteness: Life expectancy estimates that are disaggregated by remoteness are not available for individual jurisdictions.

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

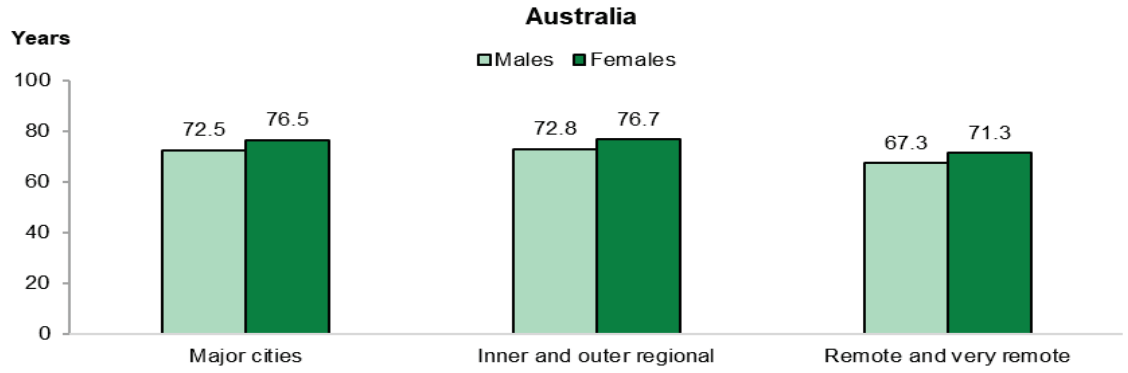
In 2020–2022, life expectancy for First Nations people living in the least socioeconomically disadvantaged areas was estimated to be 74.6 years for males and 77.0 years for females. Life expectancy decreased progressively with decreasing socioeconomic status and was estimated to be 69.5 years for First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

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



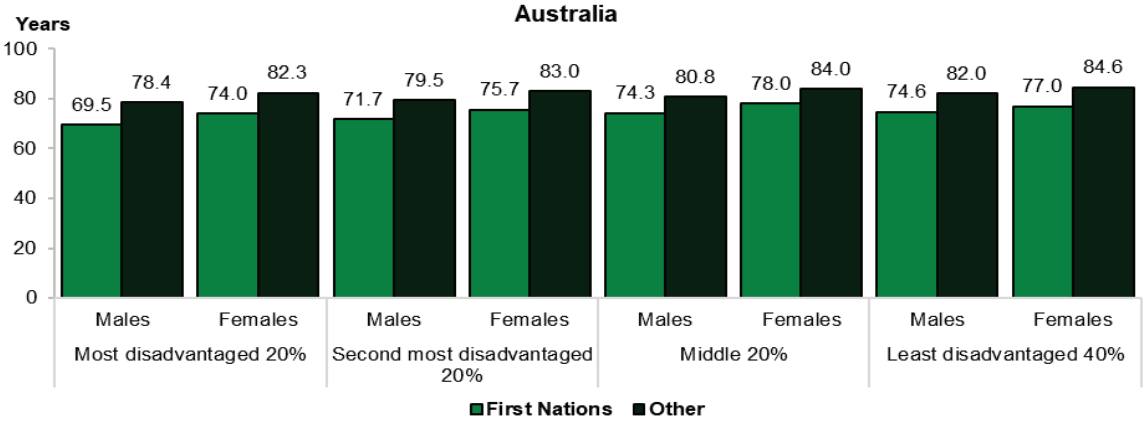
Source: Table D1.19.1.

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



Source: Table D1.19.3.

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



Source: Table D1.19.4.

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

1.20 Infant and child mortality

Content warning: This and the following measure (1.21 Perinatal mortality) contain information some readers may find distressing. If this information raises any issues for you, contact Red Nose Grief and Loss on 1300 308 307 or 13YARN on 13 92 76. Go to the AIHW support services page for a full list of support services.

Why it is important

This measure reports on the death rates of First Nations infants (less than 1 year of age) and children aged 0–4. Infant and child mortality are long-established measures of child health, as well as the overall health of the population, and its physical and social environment.

Key findings

Overall: In the period 2017–2021 in Queensland, there were 223 deaths of First Nations children aged 0–4 (85% were infant – less than 1 year of age – deaths) and 1,191 deaths of other Queensland children of the same age group (84% were infant deaths). Among this age group, the death rate for First Nations children was 1.9 times as high as the rate for other children (161 and 84 per 100,000, respectively) (Figure 1.20.1).

For NSW, Qld, WA, SA, and the NT combined, the death rate for First Nations children aged 0–4 was 2.1 times the rate for other children (145 compared with 70 per 100,000) (Figure 1.20.1).

Infant mortality: Of the 189 First Nations infant deaths in Queensland in 2017–2021, 123 deaths were in the neonatal period (aged under 28 days) which accounted for almost two-thirds (65%) of all infant deaths and just over half (55%) of all child deaths (aged 0–4). For other Queensland infants, 75% (755) of the 1,001 deaths were in the neonatal period. The death rate for First Nations infants was 1.5 times the rate for other Queensland infants (5.6 and 3.6 per 1,000 live births, respectively) (Figure 1.20.2).

For NSW, Qld, WA, SA and the NT combined, the death rate for First Nations infants was 1.8 times the rate for other infants (5.3 compared with 3.0 per 1,000 live births) (Figure 1.20.2).

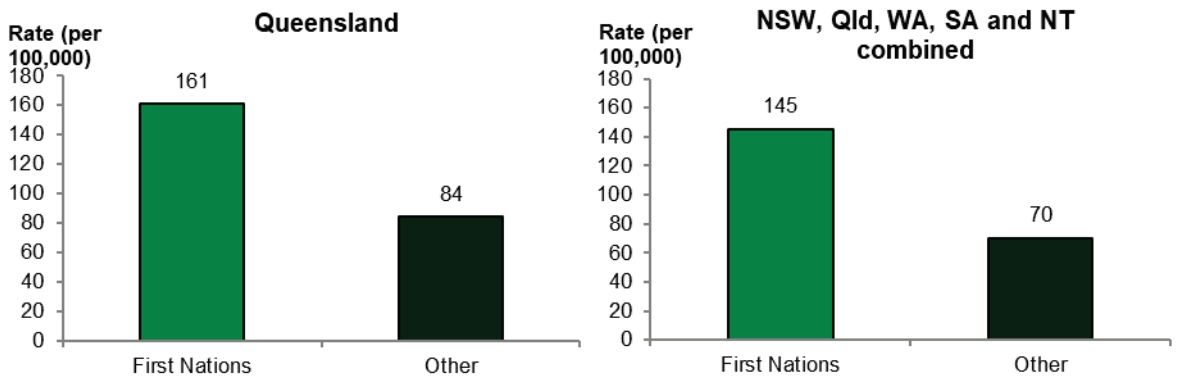
Trend over time: In Queensland, the death rate for First Nations infants dropped slightly from 6.2 per 1,000 live births in 2010–2012 to 5.6 per 1,000 live births in 2019–2021 (deaths are presented in 3-year groupings because of small numbers in each year) (Figure 1.20.3).

For NSW, Qld, WA, SA, and the NT combined, the death rate for First Nations infants decreased slightly from 5.0 per 1,000 live births in 2012 to 4.3 per 1,000 live births in 2021 (Figure 1.20.3).

In Queensland between 2012 and 2021, the death rate for First Nations children aged 0–4 increased by 11% (from 119 to 139 per 100,000), but this was not statistically significant. For other children, there was a significant decrease of 17% (from 101 to 88 per 100,000) (Table D1.20.16).

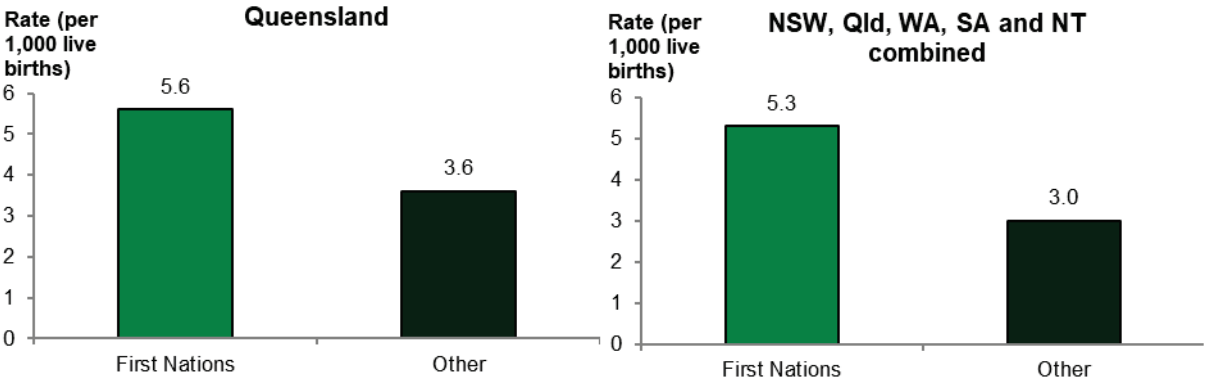
For NSW, Qld, WA, SA and the NT combined, there was a decrease of 3.5% in the death rate for First Nations children aged 0–4 (from 129 to 127 per 100,000), but this was not statistically significant. For other children, there was a significant decrease of 14% (from 79 to 73 per 100,000) (Table D1.20.3).

Figure 1.20.1: Death rate of children (aged 0–4), by Indigenous status, Queensland and NSW, Qld, WA, SA and the NT combined, 2017–2021



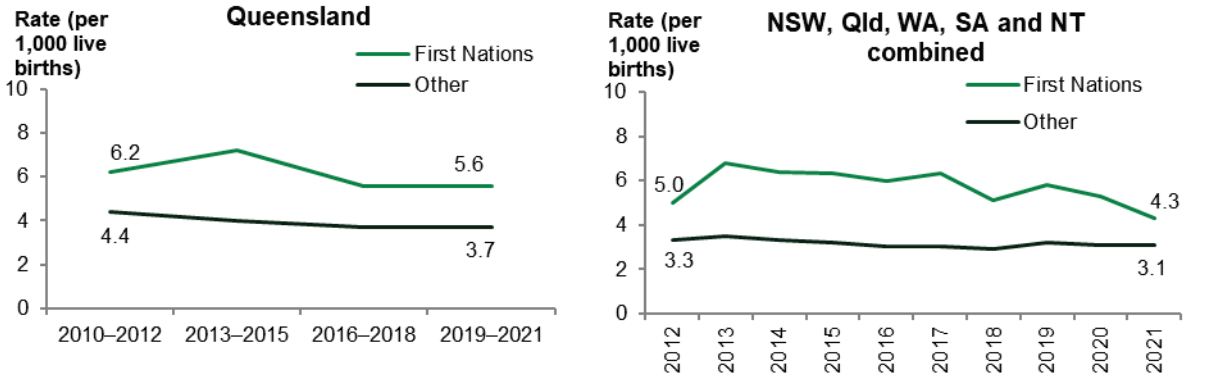
Source: Table D1.20.1.

Figure 1.20.2: Death rate of infants (aged less than 1 year), by Indigenous status, Queensland and NSW, Qld, WA, SA and the NT combined, 2017–2021



Source: Table D1.20.4.

Figure 1.20.3: Death rate of infants (aged less than 1 year), by Indigenous status, Queensland, 2010–2012 to 2019–2021, and NSW, Qld, WA, SA and the NT combined, 2012–2021



Source: Tables D1.20.8, D1.20.9.

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

1.21 Perinatal mortality

Why it is important

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

Key findings

Overall: In the 5-year period 2015–2019, there were 314 perinatal deaths among babies born to First Nations women in Queensland (Table D1.21.4). Over two thirds were stillbirths (69%), 22% occurred in the first 24 hours after birth, and the remaining 9% occurred within 28 days of birth (Table D1.21.6).

In Queensland in 2015–2019, the perinatal death rate among babies born to First Nations women was 1.6 times as high as the rate for other women (15 compared with 9.1 deaths per 1,000 births). The national perinatal death rate among babies born to First Nations women was 1.7 times the rate for other women (15 compared with 9.0 deaths per 1,000) (Figure 1.21.1).

Stillbirths (fetal deaths): In 2015–2019, the stillbirth rate among babies born to First Nations women in Queensland was 10 per 1,000 births, compared with 6.4 per 1,000 for babies born to other women.

The national stillbirth rate among babies born to First Nations women was 10 per 1,000 births, compared with 6.8 per 1,000 for babies born to other Australian women (Figure 1.21.1).

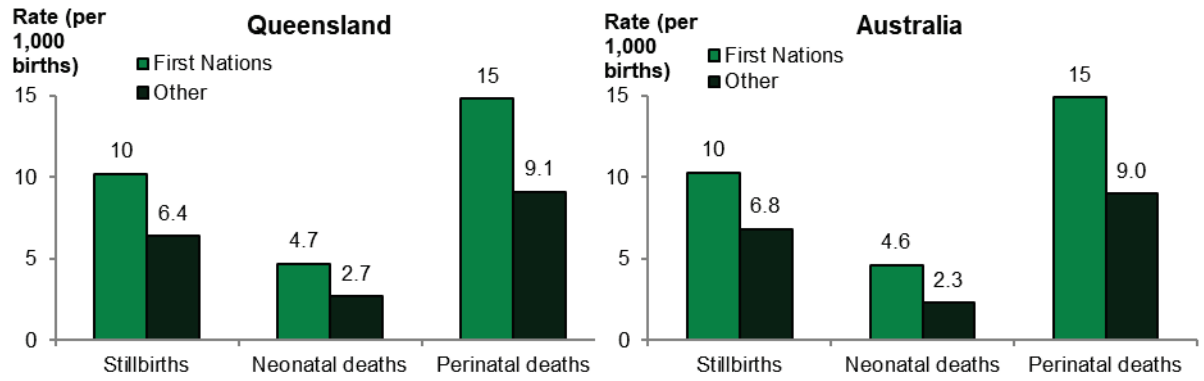
Neonatal deaths: In Queensland in 2015–2019, for neonates born to First Nations women the death rate was 4.7 per 1,000 births, 1.7 times as high as for neonates born to other Queenslander women (2.7 per 1,000).

Nationally, the death rate for neonates born to First Nations women was twice the rate for neonates born to other Australian women (4.6 compared with 2.3 per 1,000) (Figure 1.21.1).

Over time: In Queensland, the perinatal death rate among babies born to First Nations women in 2015–2019 was similar to the rate in 2010–2014 (14.8 compared with 14.5 per 1,000 births). The perinatal death rates for babies born to other Queenslander women were also similar over the two periods (9.1 and 9.6 per 1,000) (Figure 1.21.2).

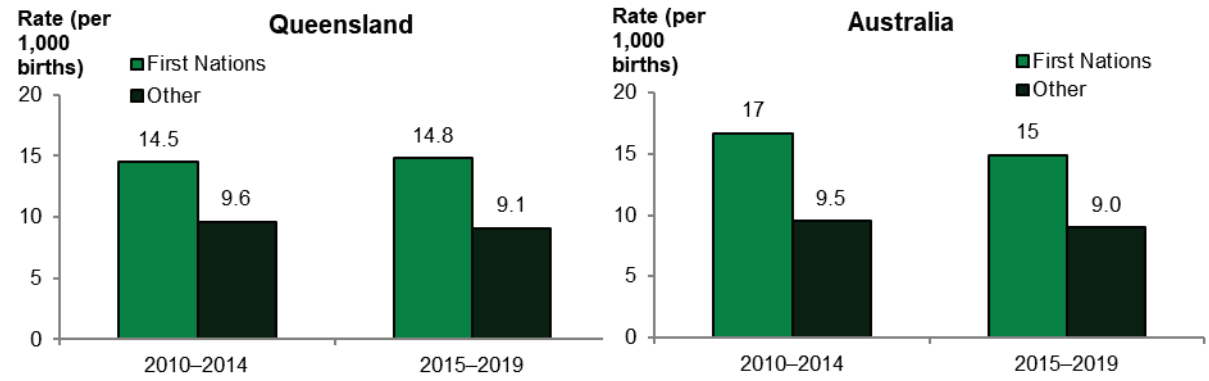
Nationally, over the longer term between 2010 and 2019, there was a decrease (of 16%) in the perinatal death rate among babies born to First Nations women (from 18 to 15 per 1,000 births). Over the same period, the neonate death rate decreased (by 29%, from 7.0 to 4.4 per 1,000), and the stillbirth rate for babies born to First Nations women decreased (by 10%, from 11 to 10 per 1,000) (Figure 1.21.3). The declines in these 3 rates were not statistically significant.

Figure 1.21.1: Stillbirth, neonatal and perinatal death rates, by Indigenous status, Queensland and Australia, 2015–2019



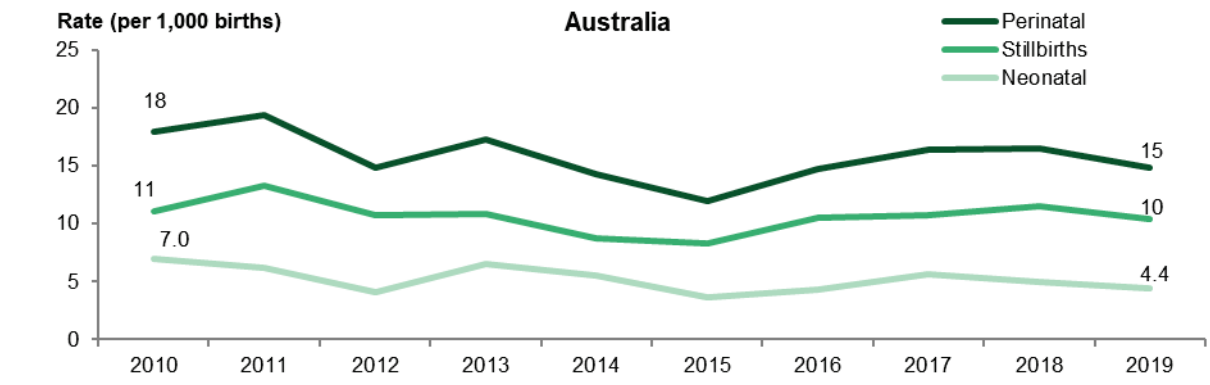
Source: Table D1.21.4.

Figure 1.21.2: Perinatal death rates, by Indigenous status, Queensland and Australia, 2010–2014 and 2015–2019



Source: Table D1.21.4.

Figure 1.21.3: Stillbirth, neonatal and perinatal death rates among babies born to First Nations women, Australia, 2010–2019



Source: Tables D1.21.2, D1.21.3.

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

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 2015–2019, the age-standardised death rate for First Nations people was 1.7 times that for other Australians, indicating that the overall health status is worse for First Nations people.

Key findings

Overall: In 2015–2019 in Queensland, there were 4,602 deaths of First Nations people, corresponding to a death rate of 407 per 100,000 population.

In 2015–2019 for NSW, Qld, WA, SA and the NT combined, there were 15,439 deaths of First Nations people, corresponding to a death rate of 430 per 100,000 population (Table D1.22.3).

Gap between First Nations and others: In 2015–2019 in Queensland, after adjusting for differences in the age structure between the two populations, the death rate for First Nations people was 1.7 times as high as the rate for other Queenslanders.

In 2015–2019 for NSW, Qld, WA, SA and the NT combined, after adjusting for differences in the age structure between the two populations, the death rate for First Nations people was 1.7 times as high as the rate for other Australians (Figure 1.22.1).

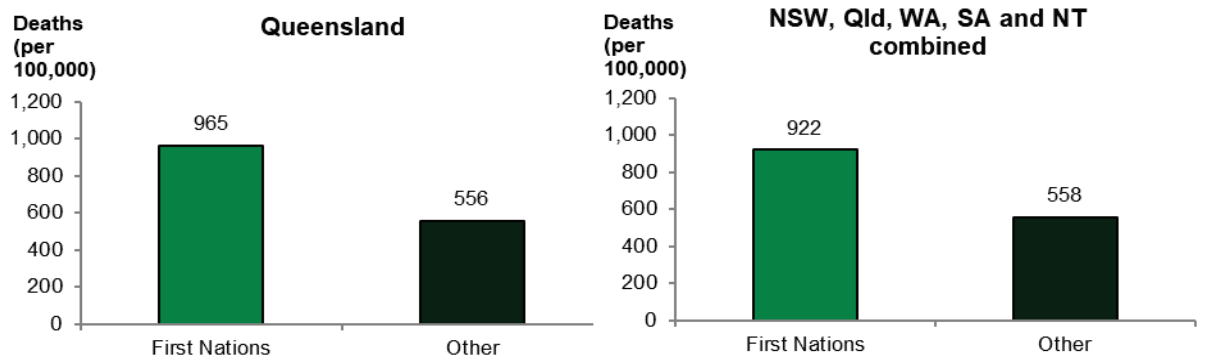
Trend over time, age-standardised death rate: From 2010 to 2019 in Queensland, the age-standardised death rate increased slightly from 945 to 974 per 100,000 for First Nations people, while it decreased from 595 to 542 per 100,000 among other Queenslanders.

From 2010 to 2019 for NSW, Qld, WA, SA and the NT combined, the age-standardised death rate for First Nations people remained relatively stable, from 926 per 100,000 in 2010 and to 937 per 100,000 in 2019. For other Australians, it decreased over the same period from 591 to 544 per 100,000 (Figure 1.22.2).

Trend over time, gap between First Nations and others: From 2010 to 2019 in Queensland, the absolute gap (rate difference) in the age-standardised death rate between First Nations people and other Queenslanders increased from 350 to 432 per 100,000. Over the same period, the relative difference (rate ratio) increased slightly from 1.6 to 1.8 times as high for First Nations people in Queensland.

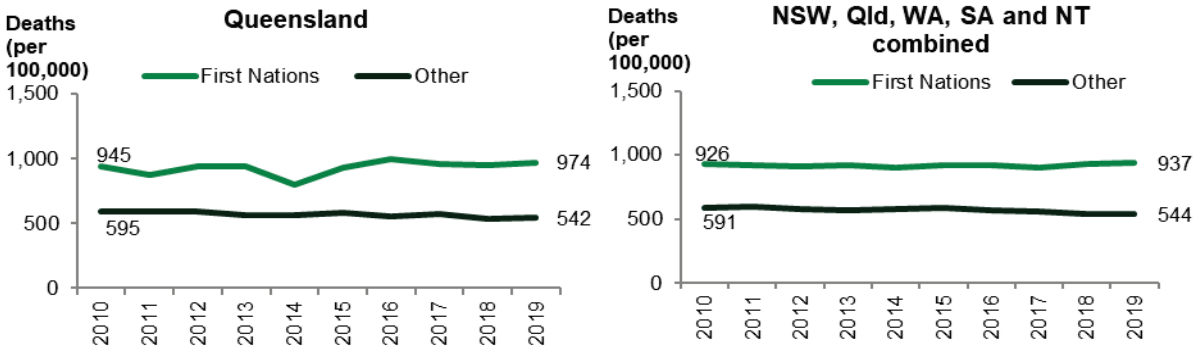
From 2010 to 2019 for NSW, Qld, WA, SA and the NT combined, the absolute difference in the age-standardised death rate between First Nations people and other Australians increased from 335 to 393 per 100,000. Over the same period, the relative difference (rate ratio) remained stable, ranging from 1.5 to 1.7 times as high for First Nations Australians (Figure 1.22.3).

Figure 1.22.1: Age-standardised death rate, by Indigenous status, Queensland, and NSW, Qld, WA, SA and the NT combined, 2015–2019



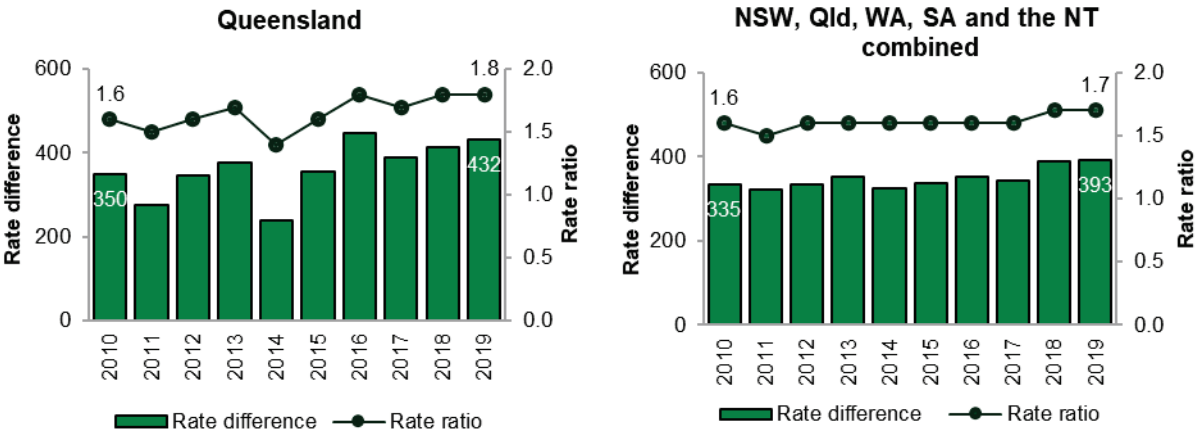
Source: Table D1.22.3.

Figure 1.22.2: Age-standardised death rate, by Indigenous status, Queensland, and NSW, Qld, WA SA and the NT combined, 2010–2019



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 Indigenous status, Queensland, and NSW, Qld, WA, SA and the NT, 2010–2019



Source: Tables D1.22.5, D1.22.6.

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

1.23 Leading causes of mortality

Why it is important

This measure reports on the main causes of death among First Nations 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 First Nations population and between First Nations Australians and other Australians 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 First Nations and other Australians are somewhat similar, although occurring at different rates.

Key findings

Overall: In the 5-year period 2015–2019, for First Nations people in Queensland, the top 5 leading causes of deaths accounted for 4,602, or 79% of all deaths (Table D1.23.2). After adjusting for differences in the age structure between the two populations, these were:

- cancer and other neoplasms (262 per 100,000)
- circulatory diseases (238 per 100,000)
- respiratory diseases (99 per 100,000)
- endocrine, metabolic, and nutritional disorders which include mostly diabetes (95 per 100,000)
- injury and poisoning (69 per 100,000).

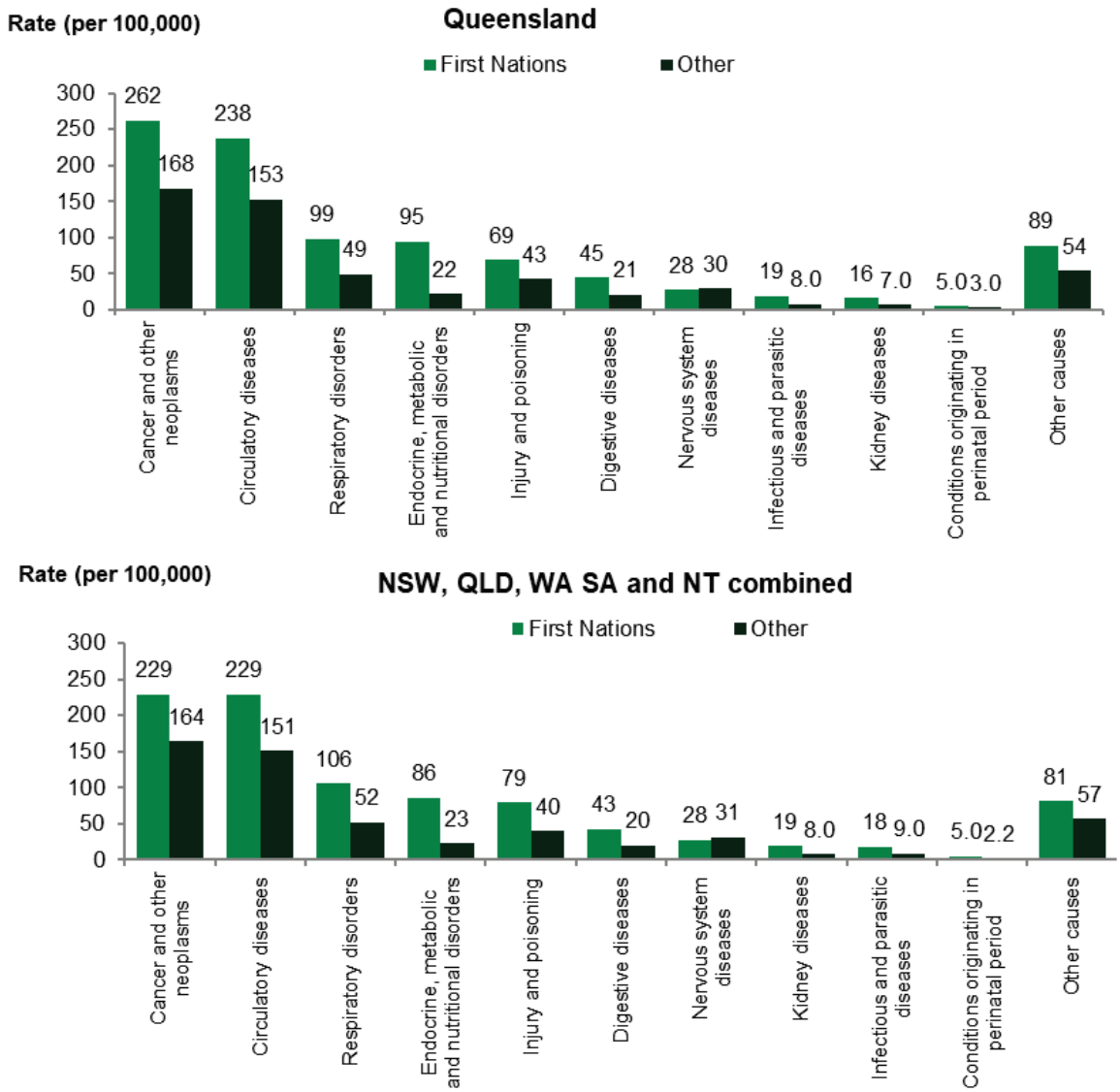
For other Queenslanders during the same period, after adjusting for differences in the age structure between the two populations, the top 5 leading causes of deaths were:

- cancer and other neoplasms (168 per 100,000)
- circulatory diseases (153 per 100,000)
- respiratory diseases (49 per 100,000)
- injury and poisoning (43 per 100,000)
- nervous system diseases (30 per 100,000) (Figure 1.23.1).

In the 5-year period 2015–2019, the top 5 leading causes of deaths for First Nations people in NSW, Qld, WA, SA and the NT combined accounted for 79% of all deaths. After adjusting for differences in the age structure between the two populations these were: cancer and other neoplasms (229 per 100,000), circulatory diseases (229 per 100,000), respiratory disorders (106 per 100,000); endocrine, metabolic and nutritional disorders which include mostly diabetes (86 per 100,000); injury and poisoning (79 per 100,000).

In NSW, Qld, WA, SA and the NT combined during the same period, the top leading 5 cause of death for other Australians after adjusting for differences in the age structure between the two populations were cancer and other neoplasms (164 per 100,000); circulatory diseases (151 per 100,000); respiratory disorders (52 per 100,000); injury and poisoning (40 per 100,000) and nervous system diseases (31 per 100,000) (Figure 1.23.1).

Figure 1.23.1: Age-standardised death rate, by cause and Indigenous status, Queensland, and NSW, Qld, WA, SA and the NT combined, 2015–2019



Source: Table D1.23.2.

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

1.24 Avoidable and preventable deaths

Why it is important

This measure reports on potentially avoidable deaths of First Nations 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 2024b). 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 the NT.

Overall: In 2015–2019 in Queensland, there were 2,137 deaths of First Nations people aged 0–74 from avoidable causes, equating to a rate of 191 deaths per 100,000 population (Table D1.24.4). After adjusting for differences in the age structure between the two populations, First Nations people died from potentially avoidable causes at 2.7 times the rate of other Queenslanders (Figure 1.24.1).

In NSW, Qld, WA, SA and the NT combined, there were 7,366 deaths of First Nations people aged 0–74 from avoidable causes, equating to a rate of 208 deaths per 100,000 population (Table D1.24.4). After adjusting for differences in the age structure between the two populations, First Nations people died from potentially avoidable causes at 3.1 times the rate of other Australians (Figure 1.24.1).

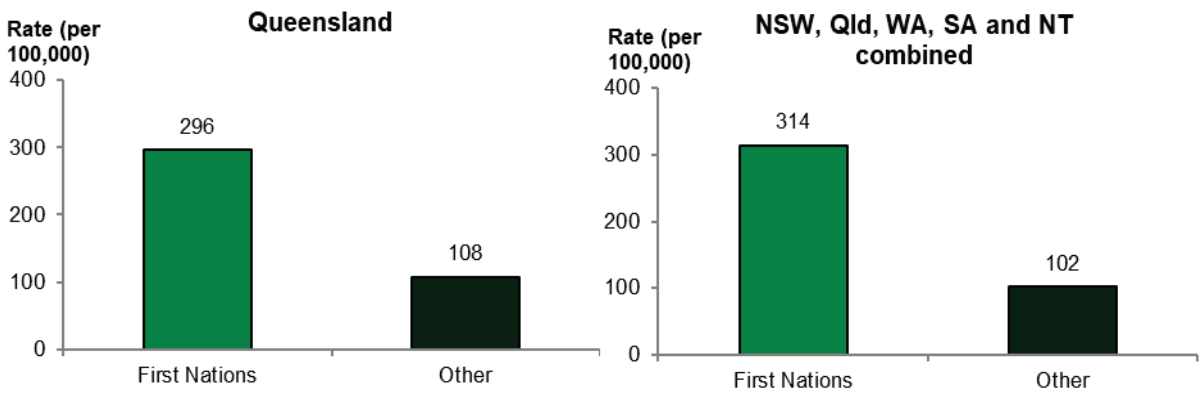
Gap between First Nations and other Australians: In 2015–2019 in Queensland, the gap in the age-standardised rate of potentially avoidable deaths between First Nations people and other Australians was 188 deaths per 100,000**.**

In NSW, Qld, WA, SA and the NT combined, the gap in the age-standardised rate of potentially avoidable deaths between First Nations people and other Australians was 211 deaths per 100,000 (Table D1.24.4).

Trend over time: In Queensland, the age-standardised rate of potentially avoidable deaths for First Nations people did not change significantly from 2010 to 2019, while for other Queenslanders it decreased by 11% from 117 per 100,000 in 2010 to 105 per 100,000 in 2019.

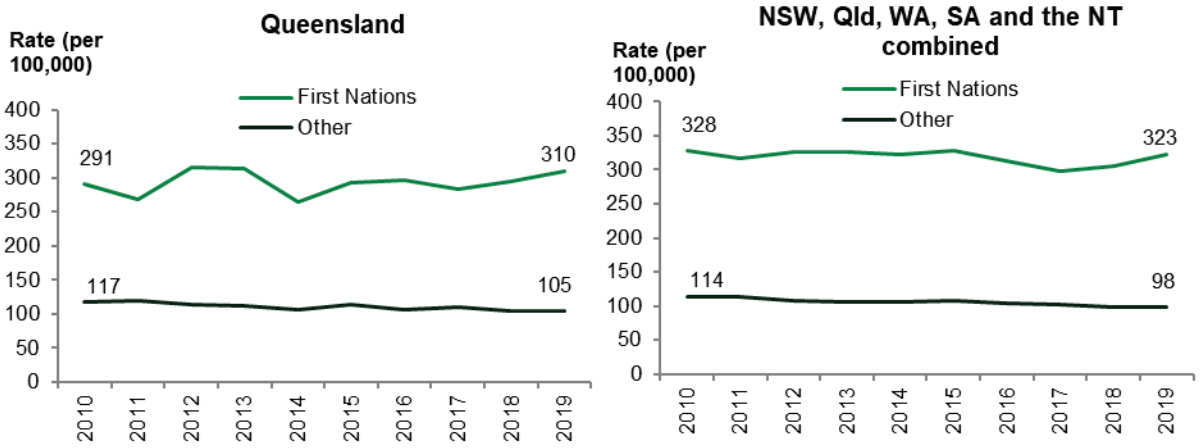
For NSW, Qld, WA, SA and the NT combined, the age-standardised rate of potentially avoidable deaths for First Nations people did not change significantly from 2010 to 2019, while for other Australians it decreased by 13% from 114 per 100,000 in 2010 to 98 per 100,000 in 2019 (Figure 1.24.2).

Figure 1.24.1: Age-standardised avoidable death rate (0–74 years), by Indigenous status, Queensland, and NSW, Qld, WA, SA and the NT combined, 2015–2019



Source: Table D1.24.4.

Figure 1.24.2: Age-standardised avoidable death rate (aged 0–74), by Indigenous status, Queensland and NSW, Qld, WA, SA and the NT combined, 2010–2019



Source: Table D1.24.8.

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

Tier 2 – Determinants of health

2.01 Housing

Why it is important

This measure reports on the housing circumstances of First Nations 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 Queensland in 2021, 26% (26,100) of First Nations households owned their home with a mortgage, 13% (12,400) owned their home outright, 60% were renting (59,200), and other tenure accounted for the remaining 1.5%.

The proportion of Queensland households that owned their own home (with or without a mortgage) in 2021 was lower for First Nations households than for other households (39% compared with 66%) (Figure 2.01.1).

Nationally, 28% (96,600) of First Nations households owned their home with a mortgage, 14% (48,500) owned their home outright, 56% were renting (192,700), 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 First Nations households than for other households (42% compared with 68%) (Figure 2.01.1).

Appropriately sized housing: In 2021 in Queensland, 81% (165,200) of First Nations people lived in appropriately sized housing – this was lower than for other Queenslanders (95%). First Nations people were 3.6 times as likely to live in an overcrowded dwelling as other Queenslanders.

Nationally, 81% of First Nations people lived in appropriately sized housing compared with 94% of other Australians. First Nations people were 2.9 times as likely to live in an overcrowded dwelling as other Australians (Figure 2.01.2).

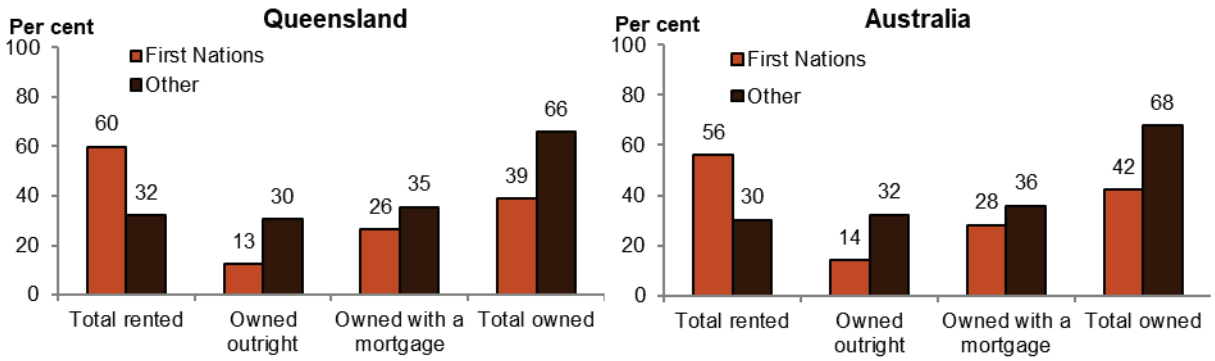
Specialist homelessness services (SHS): In 2021–22 in Queensland, there were 604 First Nations SHS clients per 10,000 population. That is, 4.7% of the First Nation population used SHS (Table D2.01.30). After adjusting for differences in the age structure between the two populations, First Nations people were about 11 times as likely to have used SHS as other Queenslanders.

Nationally in 2021–22, there were 821 First Nations SHS clients per 10,000 population. That is, 3.4% of the First Nation population used SHS (Table D2.01.30). After adjusting for differences in the age structure between the two populations, First Nations people were about 10 times as likely to have used SHS as other Australians (Figure 2.01.3).

Trends in overcrowding: In Queensland, the proportion of First Nations people living in overcrowded households fell between 2004–05 and 2018–19 from 30% to 20%.

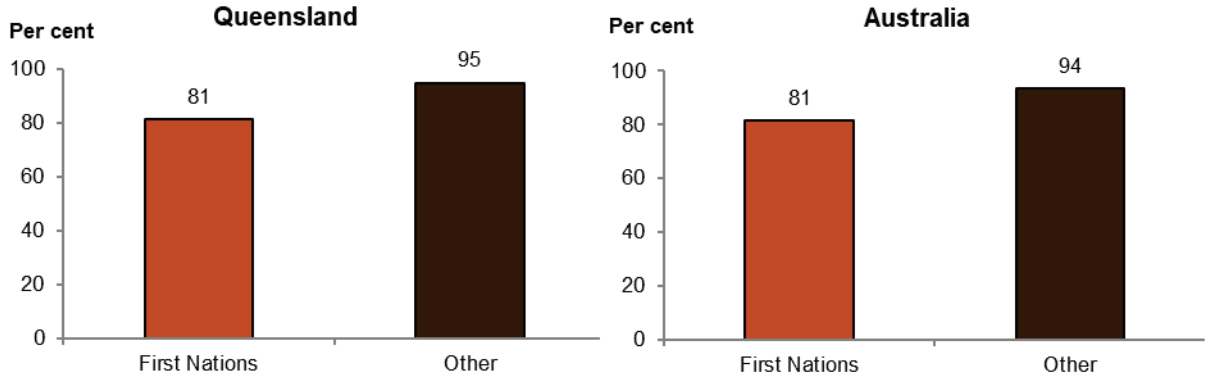
Nationally between 2004–05 and 2018–19, the proportion of First Nations people living in overcrowded households fell from 27% to 18% (Table D2.01.24).

Figure 2.01.1: Tenure type of households, by Indigenous status, Queensland and Australia, 2021



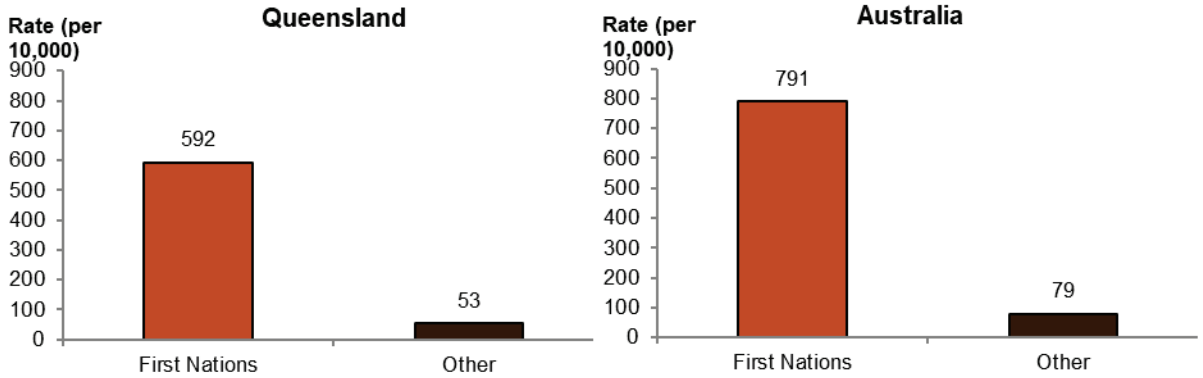
Source: Table D2.01.17.

Figure 2.01.2: People living in appropriately sized dwelling, by Indigenous status, Queensland and Australia, 2021



Source: Table D2.01.9.

Figure 2.01.3: Age-standardised rate of service use by specialist homelessness services clients, by Indigenous status, Queensland and Australia, 2021–22



Source: Table D2.01.30.

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

2.02 Access to functional housing with utilities

Why it is important

This measure reports on the functionality of First Nations' 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; FaCSIA 2007; Nganampa Health Council et al. 1987; NSW Department of Health 2019).

Key findings

Major structural problems: In 2018–19 in Queensland, an estimated 30% of First Nations 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 (11%) and walls or windows not straight (7.9%).

Nationally in 2018–19, an estimated 33% of First Nations households were living in dwellings with major structural problems. The most common structural problems were major cracks in walls/floors (12%) and walls or windows not straight (10%) (Figure 2.02.1).

Access to household facilities: In 2018–19 in Queensland, among First Nations households: 93% had access to facilities for preparing food; 97% had access to facilities for washing clothes and bedding; 98% had access to facilities for washing people; and 99% had access to working sewerage facilities.

Nationally in 2018–19, among First Nations households: 91% had access to facilities for preparing food; 96% had access to facilities for washing clothes and bedding; 97% had access to facilities for washing people; and 98% had working sewerage facilities (Figure 2.02.2).

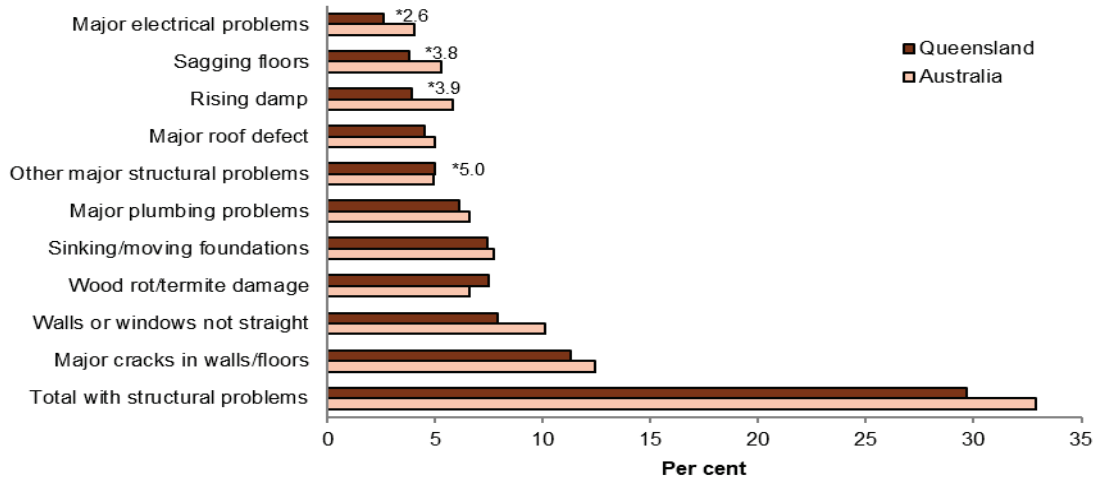
Households at an acceptable standard: In 2018–19 in Queensland, 83% of First Nations households were living in dwellings of an acceptable standard (households with 4 working facilities for washing people, clothes/bedding, storing/preparing food and sewerage and not more than 2 major structural problems).

Nationally in 2018–19, 80% of First Nations households were living in dwellings of an acceptable standard (Table D2.02.6).

Households at an acceptable standard over time: Between 2008 and 2018–19 in Queensland, the proportion of First Nations households living in dwellings of an acceptable standard varied between a low of 79% in 2012–13 and a high of 86% in 2008 and 2014–15.

Nationally, between 2008 and 2018–19, the proportion of First Nations households living in dwellings of an acceptable standard varied between 78% and 83% (Figure 2.02.3).

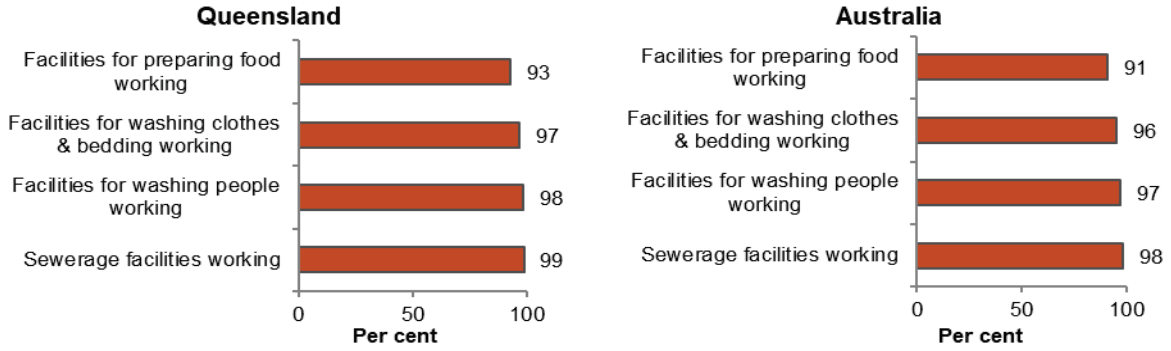
Figure 2.02.1: First Nations households with major structural problems, Queensland and Australia, 2018–19



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

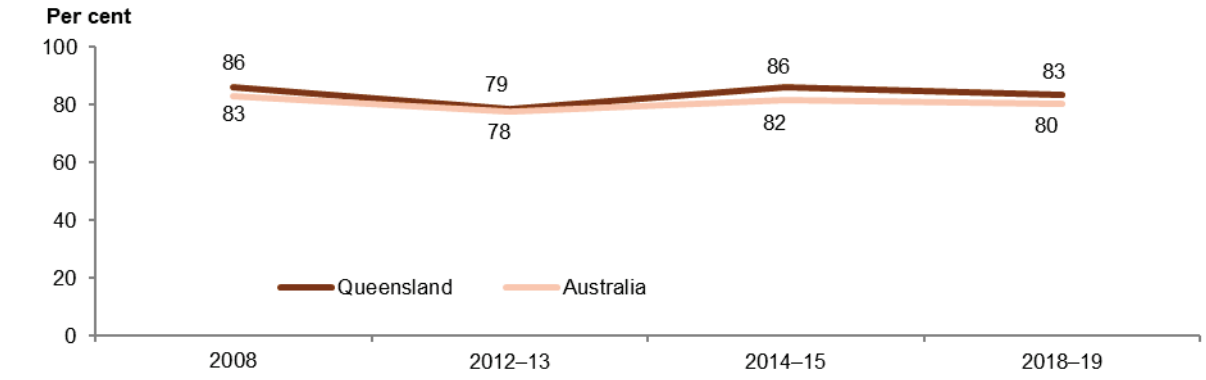
Source: Table D2.02.1

Figure 2.02.2: First Nations households with working facilities to support healthy living, Queensland and Australia, 2018–19



Source: Table D2.02.8.

Figure 2.02.3: First Nations households living in houses of an acceptable standard, Queensland and Australia, 2008, 2012–13, 2014–15 and 2018–19



Source: Table D2.02.6.

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

2.03 Environmental tobacco smoke

Why it is important

This measure reports on First Nations children aged 0–14 who live in households with daily smokers and indoor smokers. Environmental tobacco smoke (also known as second-hand smoke) is a significant cause of illness and death. There is consistent evidence that second-hand smoke causes lung cancer and ischaemic heart disease. 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 First Nations infants with bronchitis and hospitalisation of First Nations 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 2018–19, 60% of First Nations children aged 0–14 in Queensland lived in households with daily smokers. Nationally, 57% of First Nations 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 found that nationally First Nations children aged 0–14 lived in households with a daily smoker at 2.7 times the rate for other children (57% compared with 21%, respectively) (Table D2.03.7).

Nationally in 2018–19, the proportion of First Nations children aged 0–14 who lived in a household with a daily smoker was lower in non-remote areas than in remote areas (54% compared with 72%, respectively) (Table D2.03.5).

Households with indoor smoking: In 2018–19 in Queensland, 9.5% of First Nations children aged 0–14 lived in households where smoking occurred indoors. Nationally, 8.6% of First Nations children lived in households where smoking occurred indoors (Figure 2.03.2).

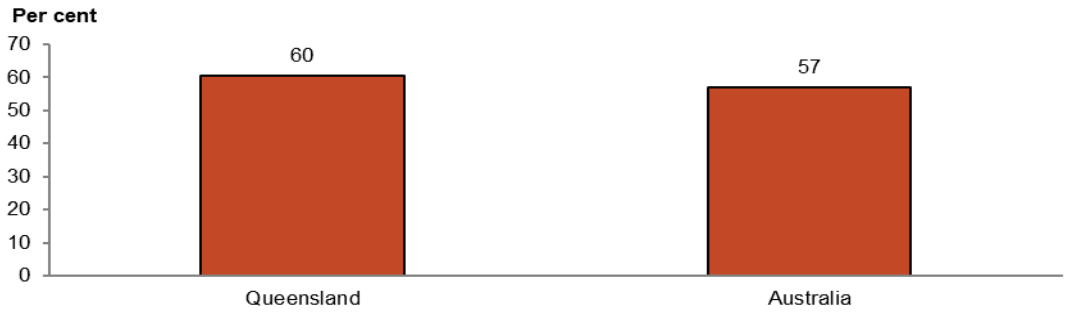
Nationally in 2018–19, the proportion of First Nations children aged 0–14, who lived in households where smoking was reported to occur indoors, was higher for those living in remote areas than for those living in non-remote areas (12% and 8%) (Table D2.03.6).

Daily smokers over time: Nationally in non-remote areas, the proportion of First Nations children who lived in households with daily smokers declined from 65% in 2004–05 to 54% in 2018–19, but in remote areas, this had reduced by only 2 percentage points from 74% in 2004–05 to 72% in 2018–19 (Figure 2.03.3).

Socioeconomic characteristics: Strong associations exist between the socioeconomic circumstances of First Nations households and whether children are exposed to second-hand smoke. In 2018–19 nationally, First Nations children aged 0–14 who lived in lower-income households were about 4 times as likely to live with a daily smoker as those who lived in households with the highest income (51% compared with 12%) (Table D2.03.8).

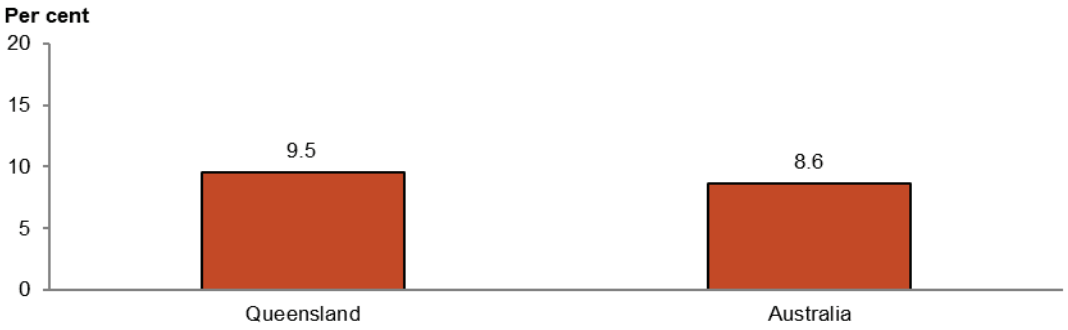
.

Figure 2.03.1: First Nations children aged 0–14 living in households with daily smokers, Queensland and Australia, 2018–19



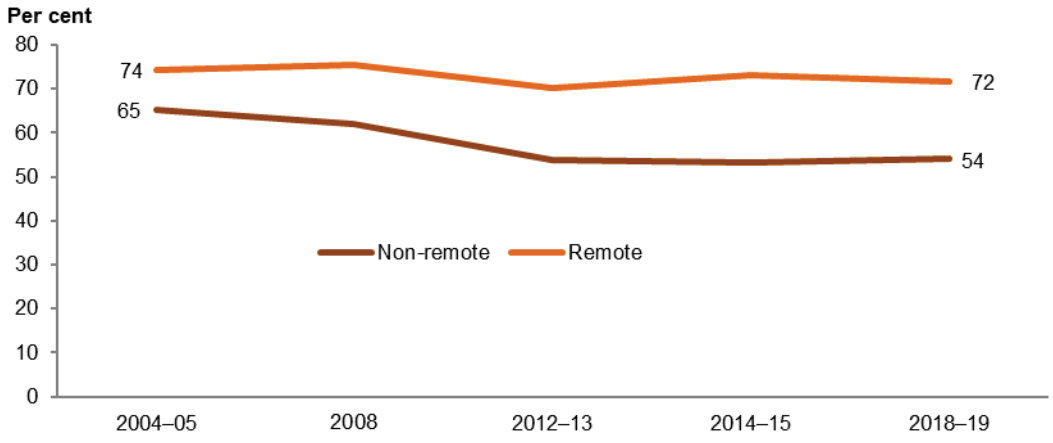
Source: Table D2.03.3

Figure 2.03.2: First Nations children aged 0–14 living in households where smoking occurs indoors, Queensland and Australia, 2018–19



Source: Table D2.03.4

Figure 2.03.3: First Nations children aged 0–14 living in households with daily smokers by remoteness, Australia, 2004–05 to 2018–19



Source: Table D2.03.7.

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

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 Queensland in 2023, based on averaging results across the five NAPLAN learning areas, around one-third of First Nations students in each year level met or exceeded proficiency expectations ('Strong' or 'Exceeding'). Another third had results in the 'Developing' category, indicating they were working towards expectations. The remaining third had results in the 'Needs additional support' category (Figure 2.04.1).

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

By learning area: In Queensland in 2023, the proportion of First Nations students assessed 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 Years 7 and 9; highest for grammar and punctuation for students in Years 5 and 7; highest for numeracy for students in Years 5 and 7.

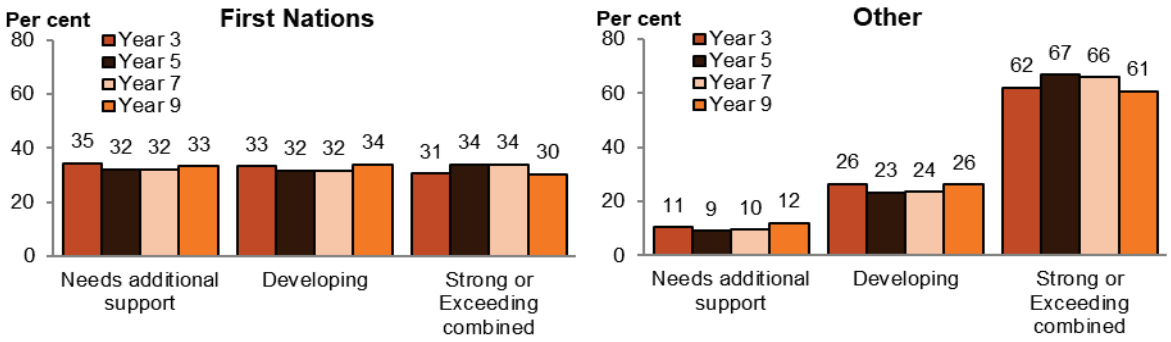
This was similar to the national pattern of results for First Nations students in 2023 (Figure 2.04.2).

By remoteness area: On average, across all five NAPLAN learning areas, the proportion of Queensland First Nations students achieving Strong or Exceeding proficiency levels was lower in more remote areas. For example, among First Nations students in Year 3, the average proportion achieving Strong or Exceeding proficiency levels across the five learning areas was 38% in *Major cities*, 33% in *Inner regional* areas, and 29% in *Outer regional* areas, compared with 15% in *Remote* areas, and 11% in *Very remote* areas.

Conversely, across the five learning areas, a lower proportion of Queensland First Nations students in *Major cities* required additional academic support, ranging from 24% to 27% across different year levels. These figures were notably lower compared with *Very remote* areas, where the range was between 59% and 67% (Figure 2.04.3).

Comparisons with other students: Averaged across the five learning areas, in Queensland in 2023, a greater proportion of First Nations students needed additional academic support compared with other students (32–35% across year levels, compared with 9–12%). Conversely, fewer First Nations students were meeting or exceeding proficiency expectations ('Strong' or 'Exceeding') compared with other students (30–34%, compared with 61–67%) (Figure 2.04.1).

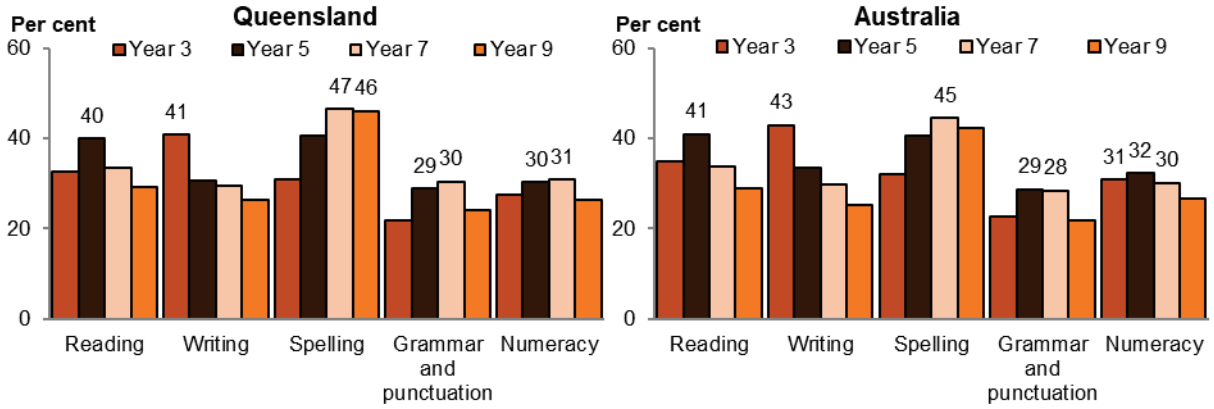
Figure 2.04.1: NAPLAN results, averaged across the five learning areas, by proficiency level, school year and Indigenous status, Queensland, 2023



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

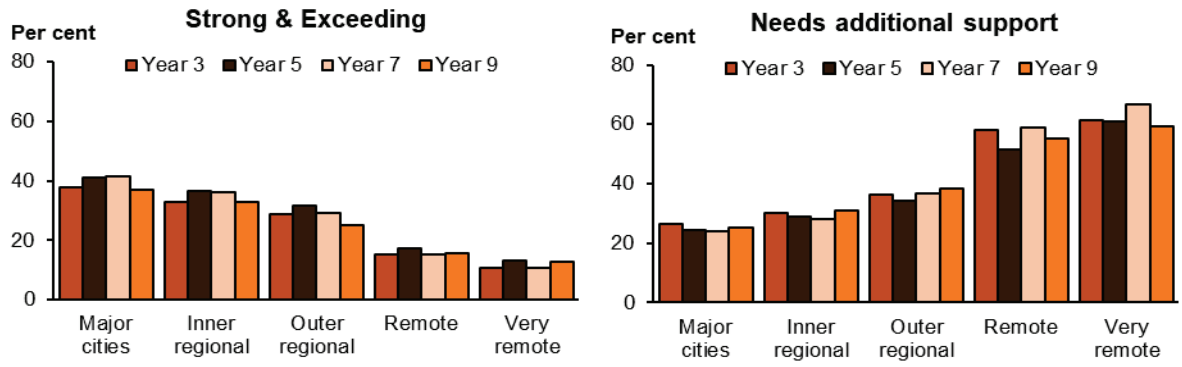
Source: Table D2.04.19.

Figure 2.04.2: Proportion of First Nations students achieving Strong or Exceeding proficiency levels, by NAPLAN learning area and school year, Queensland 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 First Nations students achieving Strong or Exceeding proficiency or needing additional support across five learning areas, by remoteness and school year, Queensland, 2023



Source: Table D2.04.11 Qld.

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

2.05 Education outcomes for young people

Why it is important

This measure reports on the proportion of First Nations 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 and Utz 2014). Research has highlighted that improving school attendance in First Nations 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 Queensland in 2021, there were 31,448 First Nations students in Years 7 to 12, making up 8.1% of total students in Queensland (Table D2.05.4, Table D2.05.5). The apparent retention rate from Year 7/8 to Year 12 in Queensland was 67% for First Nations students and 87% for other students (Figure 2.05.1).

Nationally in 2021, the apparent retention rate from Year 7/8 to Year 12 was 59% for First Nations students, and 85% for other students (Figure 2.05.1).

Year 12 or equivalent: In 2021 in Queensland, 14,926 (75%) First Nations people aged 20–24 had attained a Year 12 or equivalent qualification (Certificate III or above). The attainment rate was 1.2 times as high for other Queenslanders aged 20–24 as for First Nations people (92% compared with 75%) (Figure 2.05.2).

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

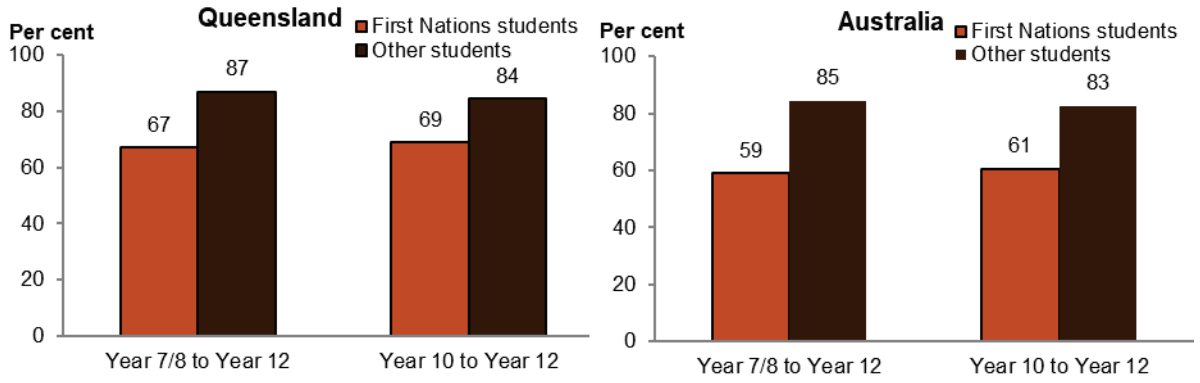
Time trends: In Queensland over the period 2011 to 2021, the proportion of First Nations people aged 20–24 who had completed Year 12 or equivalent increased from 61% to 75%. Over the same period, the proportion among other Queenslanders increased from 85% to 92%. As rates of Year 12 attainment increased more for First Nations people over the period, the gap (rate difference) decreased, from 24 to 17 percentage points (Figure 2.05.2).

Nationally, the proportion of First Nations 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 Queensland in 2014–15, 94% of First Nations children aged 4–14 were reported to usually attend school, and 28% had missed days at school, preschool, or kindergarten in the week before the survey (Figure 2.05.3).

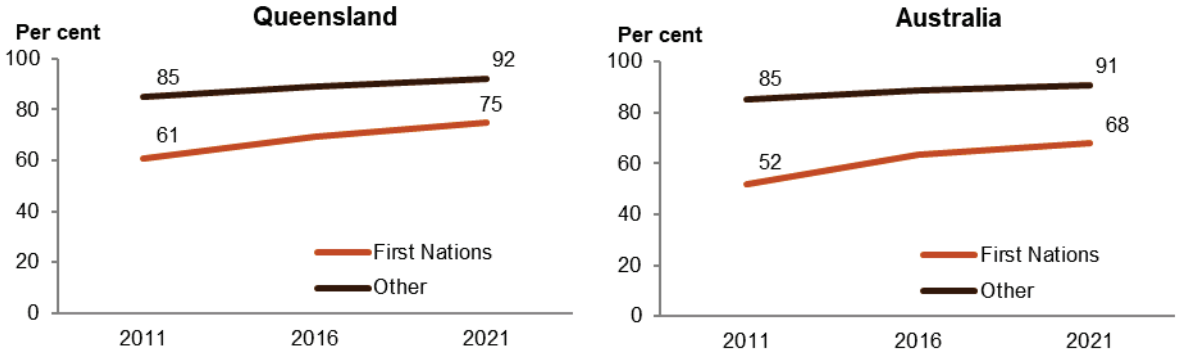
Nationally, 96% of First Nations children aged 4–14 were reported to usually attend school in 2014–15, and 28% had missed days in the week before the survey (Figure 2.05.3).

Figure 2.05.1: Apparent school retention rates, by Indigenous status, Queensland and Australia, 2021



Source: Table D2.05.2

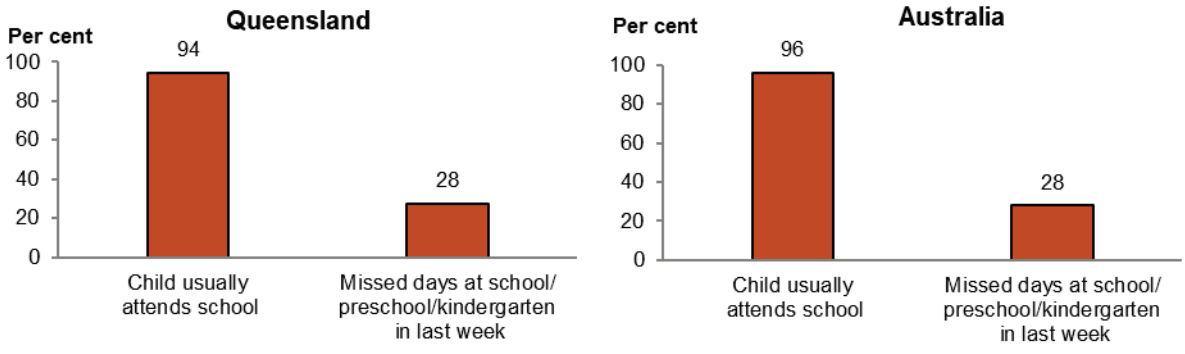
Figure 2.05.2: Completion of Year 12 or equivalent (Certificate III or above) for people aged 20–24, by Indigenous status, Queensland and Australia, 2011, 2016 and 2021



Note: Data exclude overseas visitors and persons who did not state their Indigenous status.

Source: Table D2.05.1.

Figure 2.05.3: School attendance for First Nations children (aged 4–14), Queensland and Australia, 2014–15



Source: Table D2.05.10.

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

2.06 Educational participation and attainment of adults

Why it is important

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

Key findings

Currently studying: In 2021 in Queensland, 13,048 First Nations adults (aged 18 and over) reported that they were currently studying. The proportion of First Nations adults who were currently studying was very similar to the proportion of other Queensland adults who were currently studying (9.6% and 10% respectively).

Nationally in 2021, 10% of First Nations adults reported that they were currently studying, compared with 11% of other adults (Figure 2.06.1).

Highest level of school completed: In Queensland in 2021, 46% of First Nations adults (aged 18 and over) reported Year 12 or equivalent as their highest level of school completed, compared with 62% of other adults.

Nationally in 2021, 40% of First Nations adults reported Year 12 or equivalent as their highest level of school completed, compared with 64% of other adults (Figure 2.06.1).

Non-school qualification: In Queensland in 2021, 49% of First Nations 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 69% of other Queensland adults aged 20–64. This gap was due to lower rates of attainment at Bachelor Degree and above, with 9.2% of First Nations adults aged 20–64 having a Bachelor Degree or above, compared with 30% of other Queenslanders aged 20–64.

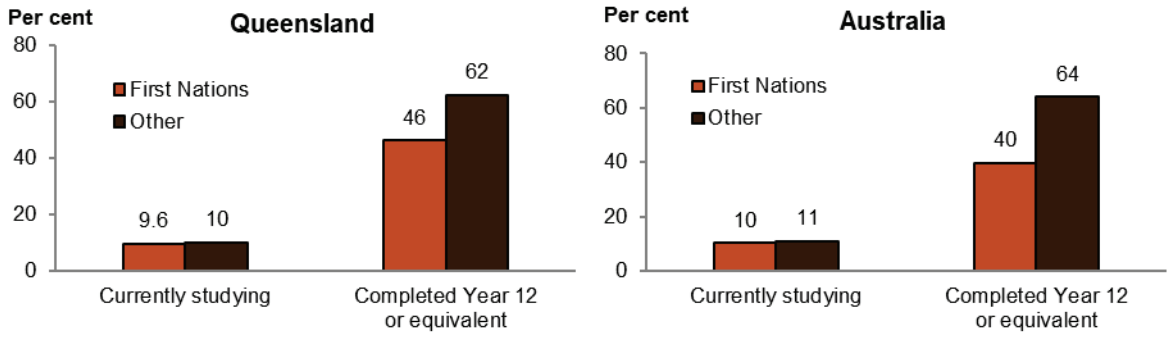
Nationally in 2021, 48% of First Nations adults aged 20–64 reported they either had a Certificate III or above, or were studying at any level, compared with 71% of other adults aged 20–64 (Figure 2.06.2).

Adults aged 25–34: The National Agreement on Closing the Gap includes an outcome (Target 6) 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 Queensland in 2021, 47% of First Nations adults aged 25–34 had completed a non-school qualification at Certificate III or above, an increase from 42% in 2016 (Table D2.06.36, Figure 2.06.3).

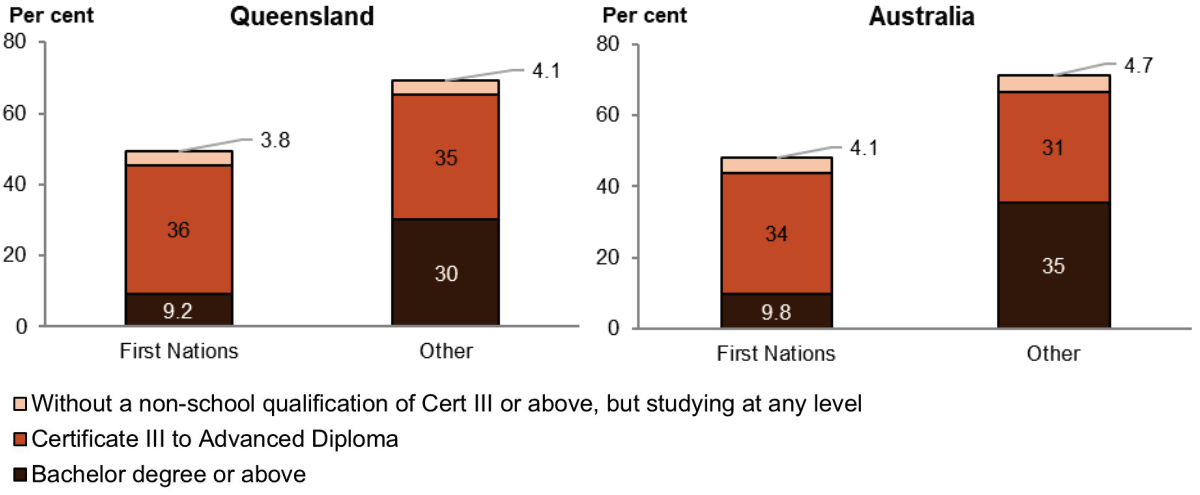
Nationally in 2021, 47% of First Nations adults aged 25–34 had completed a qualification at Certificate III or above, an increase from 42% in 2016 (Table D2.06.36, Figure 2.06.3).

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



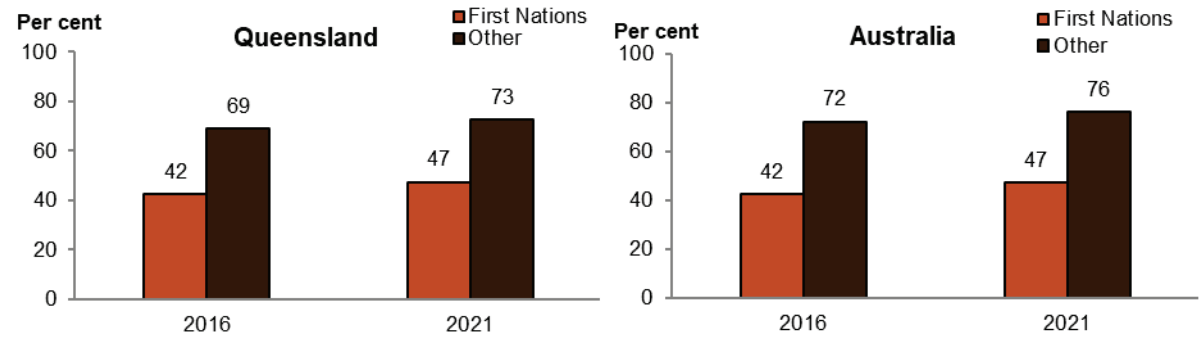
Source: Tables D2.06.3 and D2.06.7.

Figure 2.06.2: Adults aged 20–64 with non-school qualifications at Certificate III level or above and/or currently studying, by Indigenous status, Queensland 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 Indigenous status, Queensland and Australia, 2016 and 2021



Source: Table D2.06.36.

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

2.07 Employment

Why it is important

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

Key findings

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

Note that the Census was held on 10 August 2021, during which most states and territories in Australia were under restrictions due to the COVID-19 pandemic.

Labour force participation: In 2021 in Queensland, 62% of First Nations people of working age (15–64) reported they were in the labour force. Nationally, 60% of First Nations people of working age reported they were in the labour force.

In 2021 nationally, 80% of other Queenslanders of working age (15–64) compared with 79% of other Australians reported they were in the labour force (Figure 2.07.1).

Employment: In 2021 in Queensland, 54% of the First Nations working age population reported they were employed; 30% were working full time and 18% part time. Nationally, 52% of the First Nations working age population reported they were employed; 29% were working full time and 17% part time.

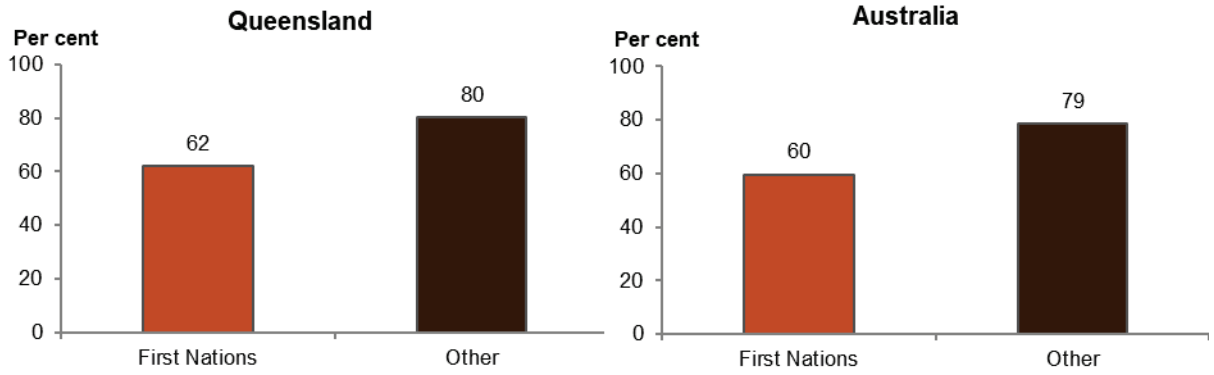
For other Queenslanders in 2021, 76% of the working age population were employed; 46% were working full time and 24% part time. For other Australians nationally, 75% of the working age population were employed; 45% were working full time and 24% part time (Table D2.07.5, Figure 2.07.2).

Unemployment: In 2021, the reported unemployment rate was 13% for First Nations people in Queensland and 12% for First Nations people nationally.

In 2021, the reported unemployment rates were both 5% for other Queenslanders and other Australians nationally (Figure 2.07.3).

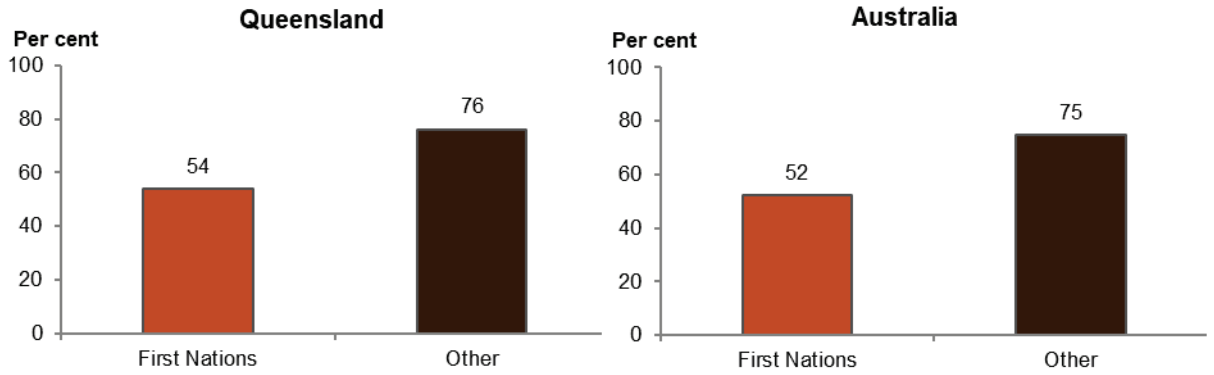
Difficulty in finding work: Nationally in 2014–15, 92% of First Nations people who were unemployed reported difficulties in finding work. The most common reasons provided were that there were no jobs in the local area or line of work (41%), and transport problems/distance (32%) (Table D2.07.11).

Figure 2.07.1: Labour force participation rate, by Indigenous status, Queensland and Australia, 2021



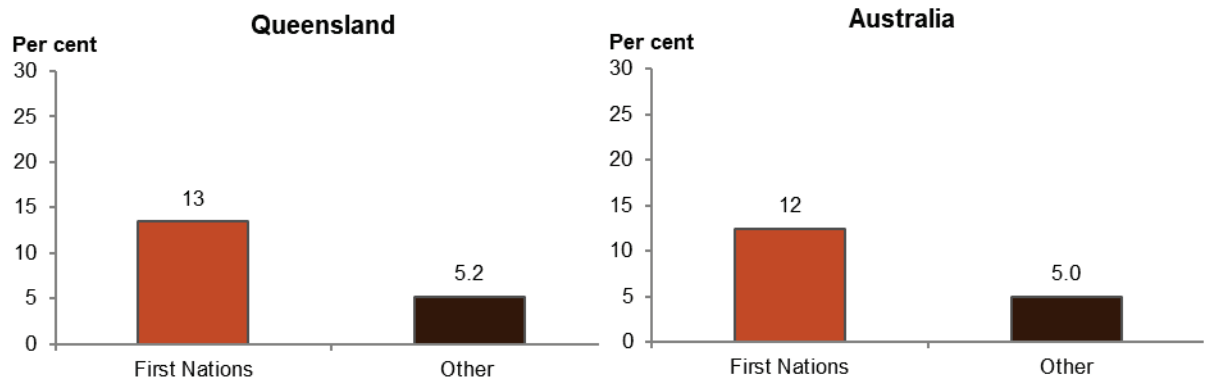
Source: Table D2.07.5.

Figure 2.07.2: Employment rate, by Indigenous status, Queensland and Australia, 2021



Source: Table D2.07.5.

Figure 2.07.3: Unemployment rate, by Indigenous status, Queensland and Australia, 2021



Source: Table D2.07.5.

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

2.08 Income

Why it is important

This measure reports on equivalised gross household and individual income of First Nations 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 and Pickett 2009). Low income can limit choices and opportunities for improving health outcomes and may influence other health-related factors, such as dietary choices and access to health care (AIHW 2015b). Disparities in income can help explain both the gaps in average health status of First Nations and other Australians, and also the wide variation observed in health outcomes within the First Nations population (AIHW 2016a).

Key findings

Equivalised gross weekly household income: In 2021, 33% of First Nations adults (aged 18 and over) in Queensland and 35% of First Nations adults nationally were living in households in the lowest equivalised weekly household income quintile (Figure 2.08.1). The proportions of First Nations adults living in households with a weekly income in the highest quintile were 9% in Queensland and 10% nationally (Table 2.08.15).

In 2021, the proportions of other Queenslanders and other Australians living in households in the lowest equivalised weekly household income quintile were the same (20%) (Figure 2.08.1). The proportions of other Queenslanders living in households with a weekly income in the highest quintile were 18% in Queensland and 20% nationally (Table 2.08.15).

Median equivalised gross weekly household income: In 2021, the median equivalised gross weekly household income for First Nations adults was reported to be $833 in Queensland compared with $825 nationally. The median equivalised gross weekly household income for other Queenslander/Australian adults was reported to be $1,114 in Queensland compared with $1,141 nationally (Table D2.08.11).

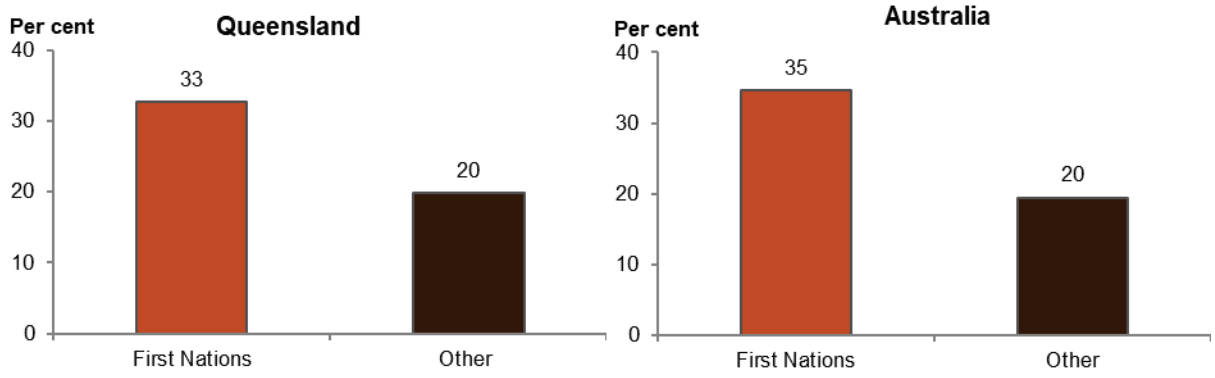
Financial stress: In 2018–19 in Queensland, an estimated 54% of First Nations people were living in households that could not raise $2,000 within a week in an emergency (indicating financial stress). The rate was higher in *Remote* areas (71%) than non-remote areas (51%).

Nationally in 2018–19, an estimated 54% of First Nations Australians were living in households that could not raise $2,000 within a week in an emergency. The rate was higher in remote areas (75%) than non-remote areas (49%) (Figure 2.08.2).

Trend over time: In Queensland, the proportion of First Nations adults aged 18 and over who were below the 50th percentile of equivalised gross weekly household income fell slightly from 70% in 2006 to 68% in 2021. The proportion below the 20th percentile stayed stable at 33% at both time points.

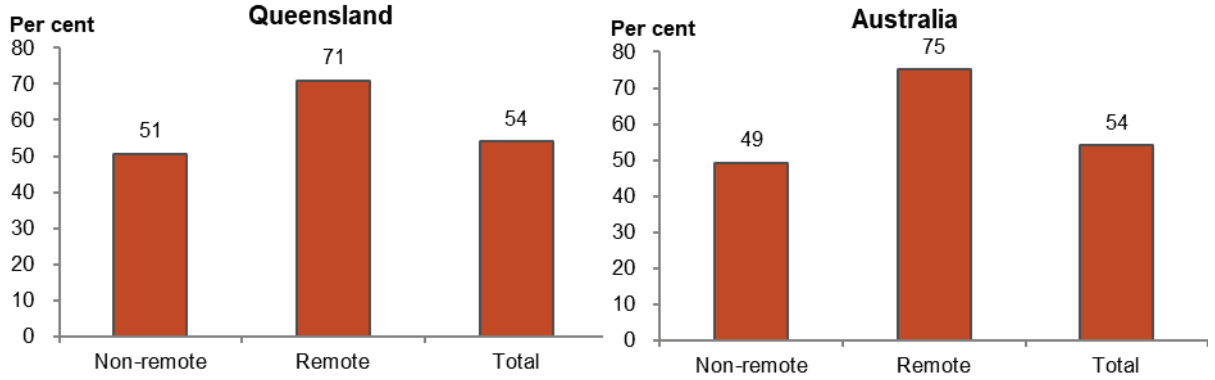
Nationally, the proportion of First Nations adults aged 18 and over who were below the 20th and 50th percentiles of equivalised gross weekly household income fell from 40% and 72% in 2006 to 35% and 67% in 2021, respectively (Figure 2.08.3).

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



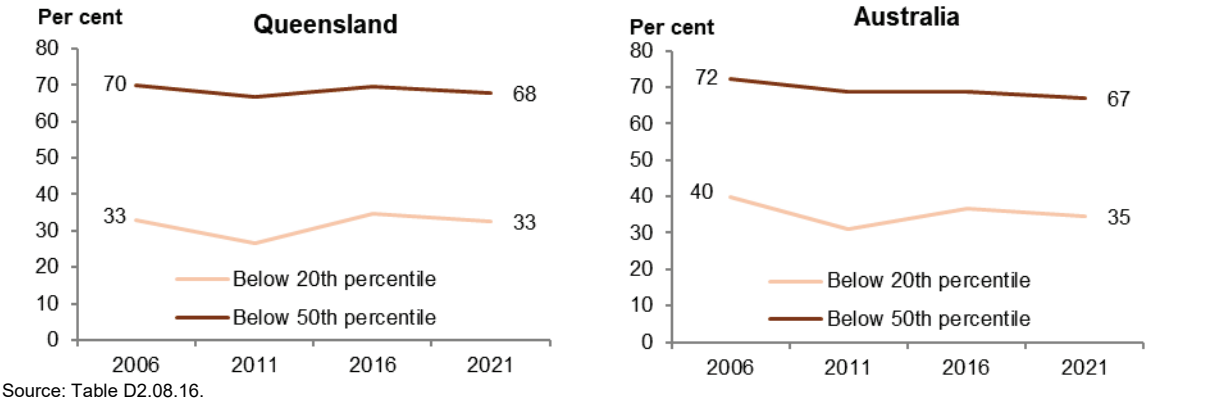
Source: Table D2.08.15.

Figure 2.08.2: First Nations Australians in households reporting they were not able to raise $2,000 in a week, by remoteness, Queensland and Australia, 2018–19



Source: Table D2.08.6.

Figure 2.08.3: First Nations 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.

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

2.09 Socioeconomic indexes

Why it is important

The association between socioeconomic disadvantage and health is a key component in understanding health disparities between First Nations people and other Australians. While improvements in economic conditions are likely to enhance health outcomes, health disparities will persist unless other factors, such as cultural, system and historical factors are addressed (Booth & Carroll 2008).

A socioeconomic index is a composite measure which takes into account a number of economic and social indicators – including income, employment, education and housing – that affect a person's level of advantage or disadvantage. Socioeconomic indexes do not tell the whole story, but they can be a useful way to measure and track progress. This measure presents data based on two area-based indexes – the Indigenous Relative Socioeconomic Outcomes (IRSEO) index and the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD).

For the analysis in this measure, relevant geographic areas have been grouped into 5 equal quintiles based on ranks for each index (Indigenous Areas for the IRSEO index; Statistical Area Level 1s for the IRSAD). Each quintile contains 20% of areas: quintile 1 contains the 20% of areas with the lowest index scores, the most disadvantaged areas; quintile 5 contains the 20% of areas with the highest index scores, the most advantaged areas.

Key findings

IRSEO index: IRSEO data relate only to the First Nations population, they do not reflect socioeconomic advantage or disadvantage for the Australian population generally, and do not provide a comparison to other Australians.

In Queensland in 2021, one-quarter (25%) of the First Nations population lived in the most advantaged Indigenous Areas ranked nationally (Quintile 5), and 7.3% lived in the most disadvantaged areas (Quintile 1) (Figure 2.09.1).

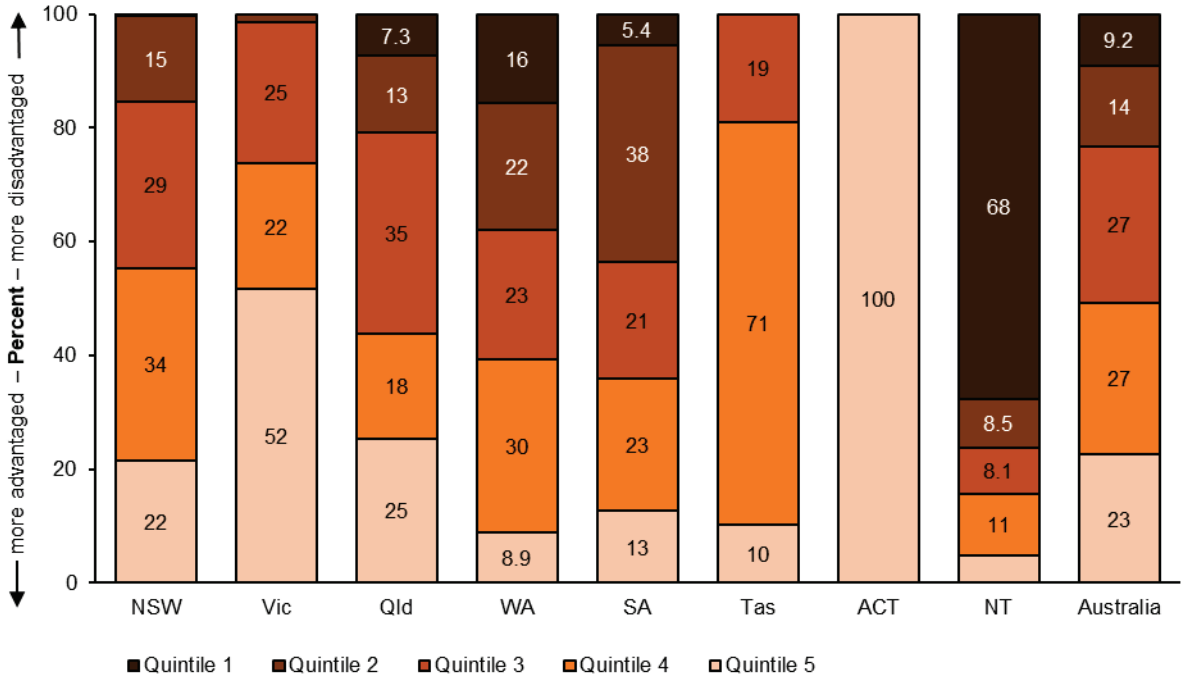
Nationally in 2021, just under one-quarter (23%) of the First Nations population lived in the most advantaged Indigenous Areas (Quintile 5), and 9.2% lived in the most disadvantaged areas (Quintile 1) (Figure 2.09.1). This reflects the fact that the more disadvantaged Indigenous Areas tend to be those with smaller populations.

IRSAD: The IRSAD is based on socioeconomic characteristics of the total population, these results should therefore be interpreted carefully. First Nations residents often represent a small proportion of an area's total population; therefore the socioeconomic status of that area as a whole will not always reflect the socioeconomic status of its First Nations residents (the 'ecological fallacy'). One study found that First Nations people consistently had a lower socioeconomic status than the socioeconomic score for their area (Kennedy and Firman 2004).

In 2021, in both Queensland and nationally, a larger proportion of First Nations people lived in areas ranked lower (more disadvantaged) on the IRSAD than in areas that ranked higher on the IRSAD (Figure 2.09.2).

In Queensland, almost half (49%) of First Nations people lived in the bottom 20% of areas while only one-fifth (21%) of other Queenslanders lived in these areas. When looking at the top 20% of areas, only 3.3% of First Nations people in Queensland lived in the most advantaged quintile compared with 14% of other Queenslanders (Figure 2.09.2).

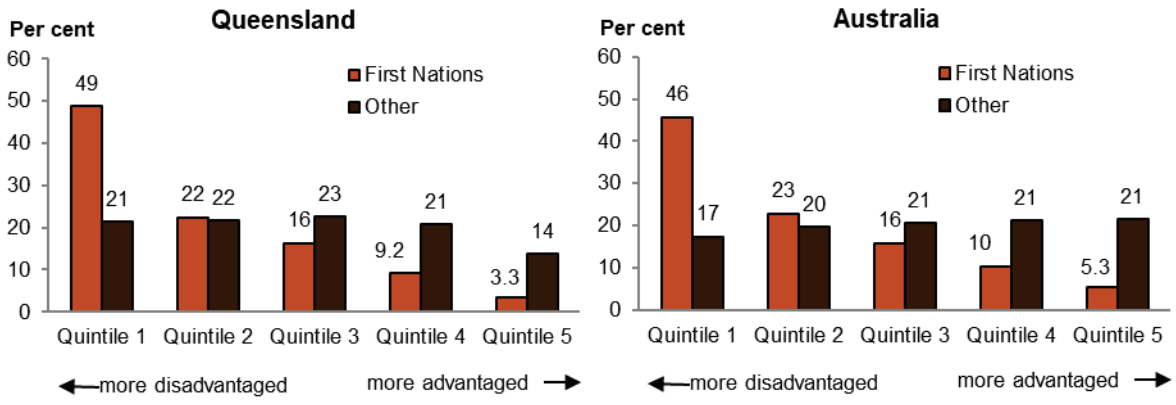
Figure 2.09.1: First Nations population distribution, by state/territory and socioeconomic area (IRSEO quintiles), 2021



Note: In 2021, all Indigenous Areas included in the analysis for the ACT scored in most advantaged quintile of Indigenous Areas nationally (top 20%), based on the IRSEO quintiles. Therefore, when looking at population distribution by socioeconomic group, 100% of the First Nations population in the ACT was living in the most advantaged quintile of Indigenous Areas nationally.

Source: Table D2.09.4.

Figure 2.09.2: Population distribution by socioeconomic area (IRSAD) and Indigenous status, Queensland and Australia, 2021



Source: Table D2.09.2.

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

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.

Why it is important

This measure reports on hospitalisations and deaths due to assault among First Nations 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). 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).

Key findings

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

In Queensland, between July 2019 and June 2021, there were 3,642 hospitalisations due to assault among First Nations people, a rate of 753 per 100,000 population (Table D2.10.5). After adjusting for differences in the age structure between the two populations, First Nations people were 8.9 times as likely to be hospitalised for assault as other Queenslanders.

Nationally, between July 2019 and June 2021, First Nations people were 15 times as likely to be hospitalised for assault as other Australians (Figure 2.10.1).

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

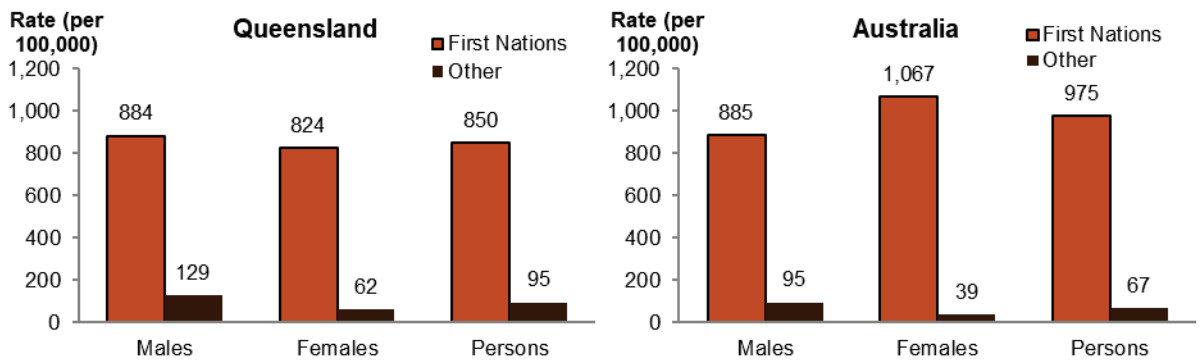
Between July 2019 and June 2021, there were 1,612 hospitalisations for family-violence related assaults among First Nations people in Queensland, a rate of 333 per 100,000 population (Table D2.10.36). After adjusting for differences in the age structure between the two populations, the rate of non-fatal hospitalisations for family violence-related assault for First Nations people was 13 times the rate for other Queenslanders (Figure 2.10.2).

Nationally, between July 2019 and June 2021, the rate of non-fatal hospitalisations for family violence-related assault for First Nations people was 29 times the rate for other Australians (Figure 2.10.2).

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

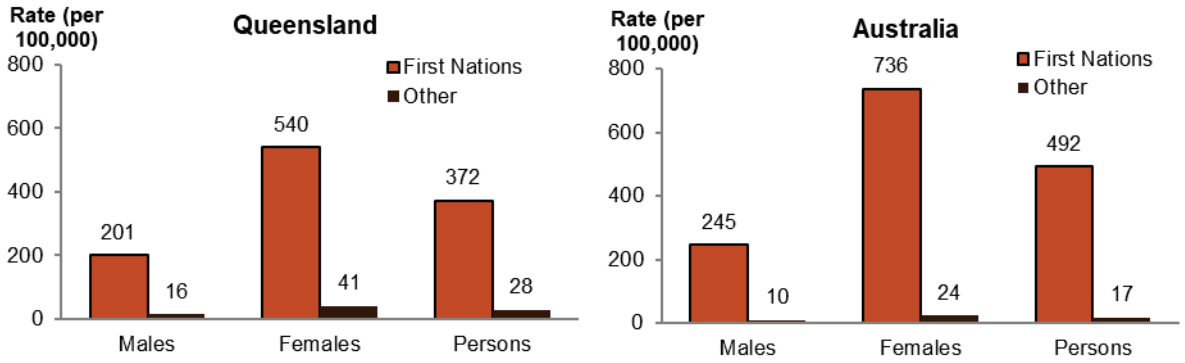
In Queensland in the 5 years from 2015–2019, there were 44 deaths of First Nations people due to homicide, a rate of 3.9 homicides per 100,000 population (Table D2.10.9). After adjusting for differences in the age structure between the two populations, deaths due to homicide were 4.7 times as high for First Nations people as for other Queenslanders. In NSW, Qld, WA, SA and the NT combined, from 2015–2019, deaths due to homicide were 6.3 times as high for First Nations people as for other Australians (Figure 2.10.3).

Figure 2.10.1: Age-standardised rates of hospitalisation due to assault, by Indigenous status and sex, Queensland and Australia, July 2019 to June 2021



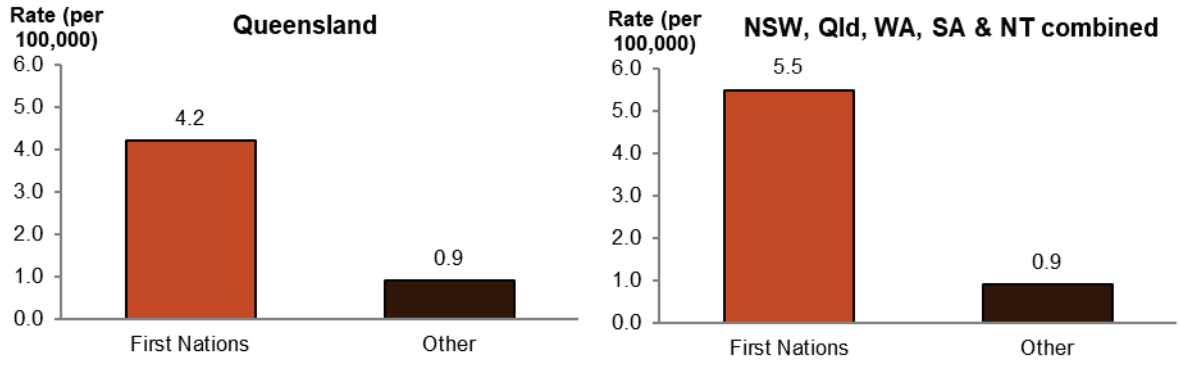
Source: Table D2.10.5.

Figure 2.10.2: Age-standardised rates of non-fatal hospitalisations for family violence-related assaults, by Indigenous status and sex, Queensland and Australia, July 2019 to June 2021



Source: Table D2.10.36.

Figure 2.10.3: Age-standardised rates of homicide deaths, by Indigenous status, Queensland, and NSW, Qld, WA, SA and the NT combined, 2015–2019



Source: Table D2.10.9.

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

2.11 Contact with the criminal justice system

Why it is important

This measure reports on First Nations young people under youth justice supervision and adults in prison custody. The majority of First Nations people have never been incarcerated. However, First Nations Australians experience contact with the criminal justice system – as both offenders and victims – at much higher rates than other Australians (AIHW 2021a, 2021b; 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 Queensland, on an average day in 2021–22, 758 First Nations people aged 10–17 were under youth justice supervision (175 per 10,000). For other Queenslanders aged 10–17, the rate was 8.2 per 10,000.

Nationally, on an average day in 2021–22, of First Nations people aged 10–17, 121 per 10,000 were under youth justice supervision. For other Australians aged 10–17, the rate was 6.5 per 10,000 (Figure 2.11.1).

Prison custody: On 30 June 2022 in Queensland, 36% of people in prison custody were First Nations (3,410, a crude rate of 2,236 per 100,000) (Table D2.11.8). The age-standardised rate of First Nations adults in prison custody was 12 times the rate for other Australians (Figure 2.11.2).

Nationally on 30 June 2022, 30% of people in prison custody were First Nations (12,902, a crude rate of 2,330 per 100,000) (Table D2.11.8). The age-standardised rate for First Nations adults in prison custody was 14 times the rate for other Australians (Figure 2.11.2).

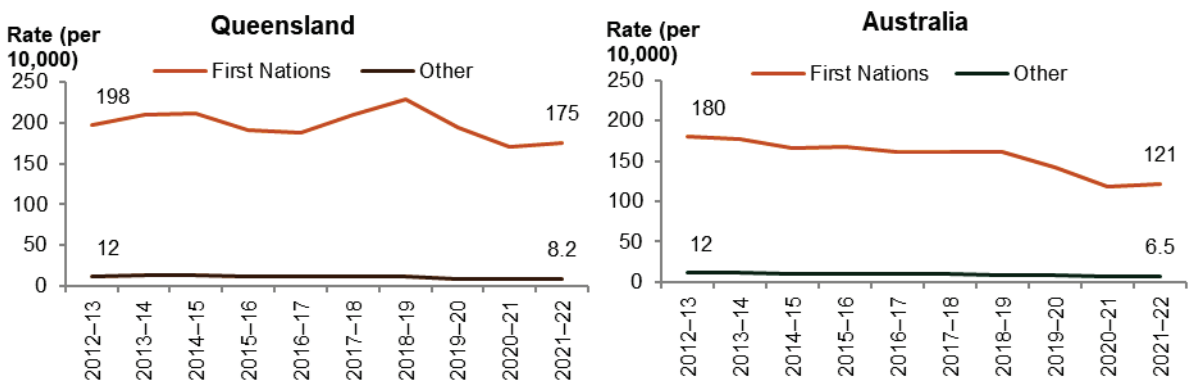
Trend over time: In Queensland, the rate of First Nations young people aged 10–17 who were under youth justice supervision on an average day decreased from 198 per 10,000 in 2012–13 to 175 per 10,000 in 2021–22. Based on linear regression, this corresponded to a decline of 12% in the rate of supervision for First Nations young people, which was not statistically significant (Figure 2.11.1).

Nationally, the rate of First Nations young people aged 10–17 under youth justice supervision on an average day decreased from 180 per 10,000 in 2012–13 to 121 per 10,000 in 2021–22. Based on linear regression, this corresponded to a decline of 32% in the rate of supervision for First Nations young people (Figure 2.11.1).

In the Queensland, the age-standardised imprisonment rate for First Nations adults increased by 52%, from 1,330 per 100,000 in 2013 to 2,047 per 100,000 in 2022. Over the same period, the imprisonment rate for other Queensland adults increased by 30%, from 126 to 167 per 100,000.

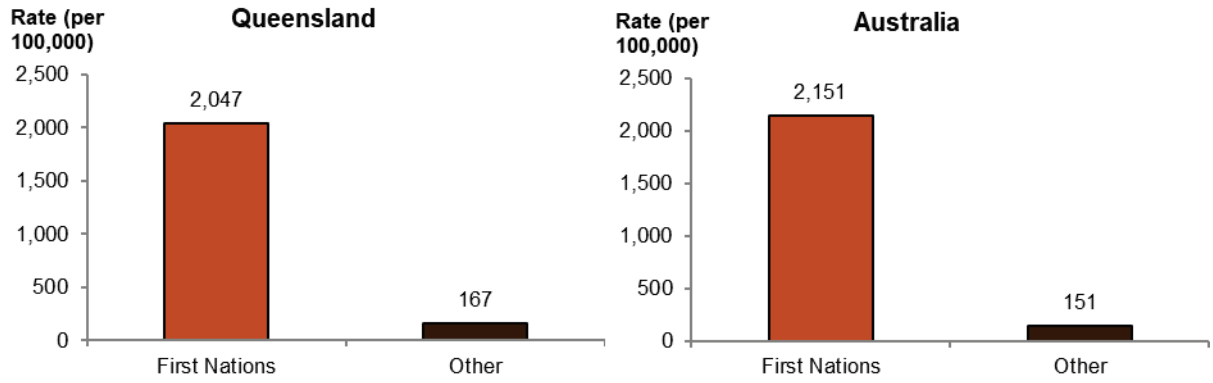
Nationally, the age-standardised imprisonment rate for First Nations adults increased by 31%, from 1,630 per 100,000 in 2013 to 2,151 per 100,000 in 2022. Over the same period, the imprisonment rate for other Australian adults increased by 13%, from 133 to 151 per 100,000 (Figure 2.11.3).

Figure 2.11.1: Young people aged 10–17 under supervision on an average day, by Indigenous status, Queensland and Australia, 2012–13 to 2021–22



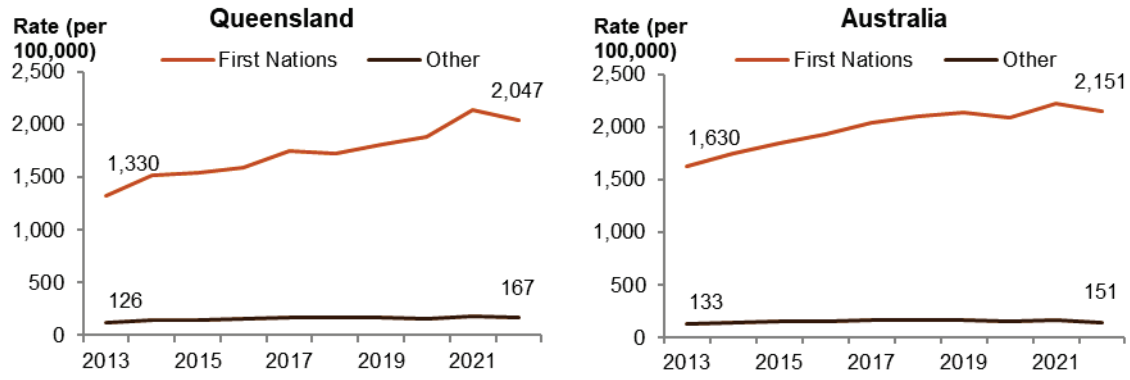
Source: Table D2.11.1.

Figure 2.11.2: Age-standardised adult imprisonment rate, by Indigenous status, Queensland and Australia, 30 June 2022



Source: Table D2.11.8.

Figure 2.11.3: Age-standardised adult imprisonment rate, by Indigenous status, Queensland and Australia, 2013–2022



Source: Table D2.11.12.

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

2.12 Child protection

Why it is important

This measure reports on First Nations children aged under 18 who came into contact with the child protection system – this includes children who were the subjects of investigations for alleged child maltreatments, were on care and protection orders and/or in out-of-home care. The child protection system aims to protect children from maltreatment in family settings. Experience of maltreatment (physical, emotional and psychological abuse, neglect, sexual abuse and witnessing family violence) during childhood has serious and long-term effects on social and emotional wellbeing and health (Emerson et al. 2015).

Key findings

Overall: In Queensland in 2022–23, 15,210 First Nations children came into contact with the child protection system – corresponding to a rate of 151 per 1,000 First Nations children receiving child protection services (AIHW 2024c).

Substantiated maltreatments: In 2022–23 in Queensland, 2,524 First Nations children were the subjects of substantiated maltreatments (25 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 maltreatments among First Nations children was 40 per 1,000 (Figure 2.12.1).

In 2022–23, the rate of substantiated maltreatments among First Nations children in Queensland was 6.8 times the rate for other Queensland children. Nationally, the rate among First Nations children was 7.1 times the rate for other Australian children (AIHW 2024c).

Substantiated maltreatments over time: Over the period 2018–19 to 2022–23, there was no clear trend in the rate of substantiated maltreatments among First Nations children in Queensland or nationally (Figure 2.12.1).

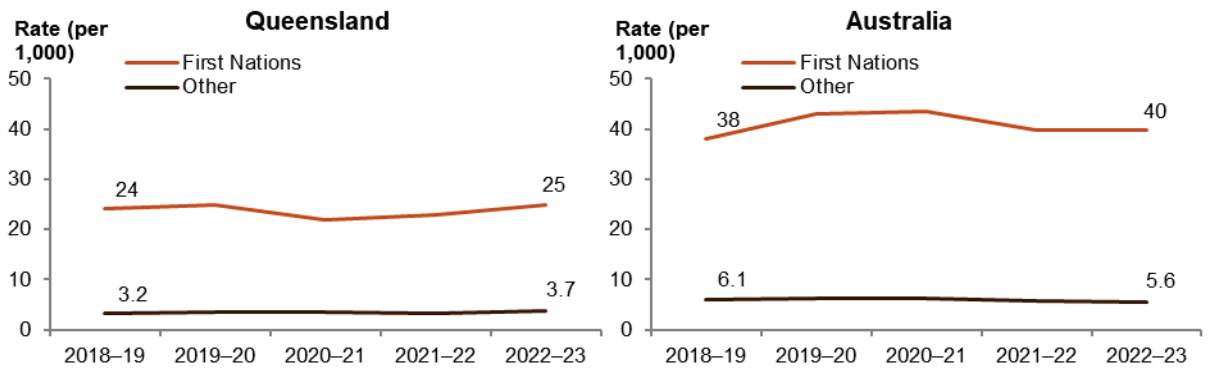
Care and protection orders: At 30 June 2022 in Queensland, there were 6,139 First Nations children on care and protection orders (61 per 1,000 children). Of these 6,139 children; 21% were aged under 5, 27% were aged 5–9, 32% were aged 10–14, and 19% were aged 15–17.

In 2022–23 the rate of First Nations children on care and protection orders in Queensland was 9.6 times the rate for other Queensland children. Nationally, the rate among First Nations children was 10.9 times the rate for other Australian children (AIHW 2024c).

Care and protection orders over time: Over the period from 30 June 2019 to 30 June 2023, the rate of First Nations children who were on care and protection orders in Queensland increased from 47 to 61 per 1,000 children. Nationally, over the same period, the rate among First Nations children increased from 66 to 72 per 1,000 children (Figure 2.12.2).

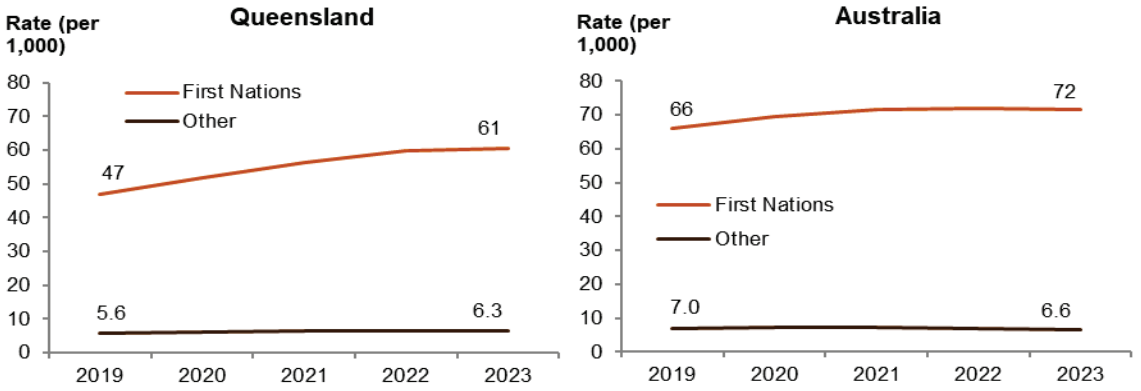
Out-of-home care: At 30 June 2023 in Queensland, there were 4,722 First Nations children in out-of-home care (47 per 1,000 children) (AIHW 2024). About half (54%) of these children were living with First Nations or non-Indigenous relatives or kin or other First Nations caregivers (Figure 2.12.3). Nationally, there were 19,731 First Nations children in out-of-home care at 30 June 2023 (57 per 1,000 children), with 63% living with First Nations or non-Indigenous relatives or kin or other First Nations caregivers (AIHW 2024, Figure 2.12.3).

Figure 2.12.1: Children aged under 18 who were the subjects of substantiated maltreatments, by Indigenous status, Queensland and Australia, 2018–19 to 2022–23



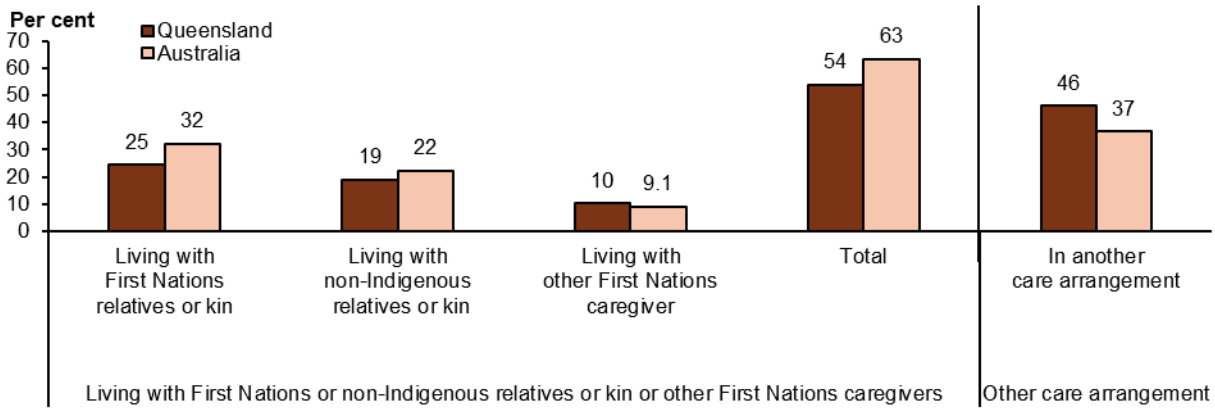
Source: AIHW 2024c.

Figure 2.12.2: Children aged under 18 on care and protection orders, by Indigenous status, Queensland and Australia, 30 June 2019 to 30 June 2023



Source: AIHW 2024c.

Figure 2.12.3: First Nations children in out-of-home care, by relationship of carer, Queensland and Australia, 30 June 2023



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

Source: AIHW 2024c.

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

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

Key findings

Access to transport: In Queensland in 2014–15, 77% of First Nations People aged 15 and over reported they could easily get to places needed; the proportion was 87% for other Queenslanders.

Nationally in 2014–15, 75% of First Nations people aged 15 and over reported they could easily get to places needed; as did 84% of other Australians (Figure 2.13.1).

Access to a motor vehicle: In the 2021 Census of Population and Housing, information was collected on the number of registered motor vehicles owned or used by household members that were garaged or parked at or near private dwellings on Census night. In these data, a First Nations household is defined as an occupied private dwelling where at least one of its usual residents identifies as being of Aboriginal and/or Torres Strait Islander origin.

In Queensland in 2021, 89% of First Nations households owned or used at least one vehicle, while 11% did not have a motor vehicle (excludes households where the number of vehicles was not reported). The proportion of First Nations households without a vehicle was higher than for other households (11% compared with 5.5%) (Figure 2.13.2).

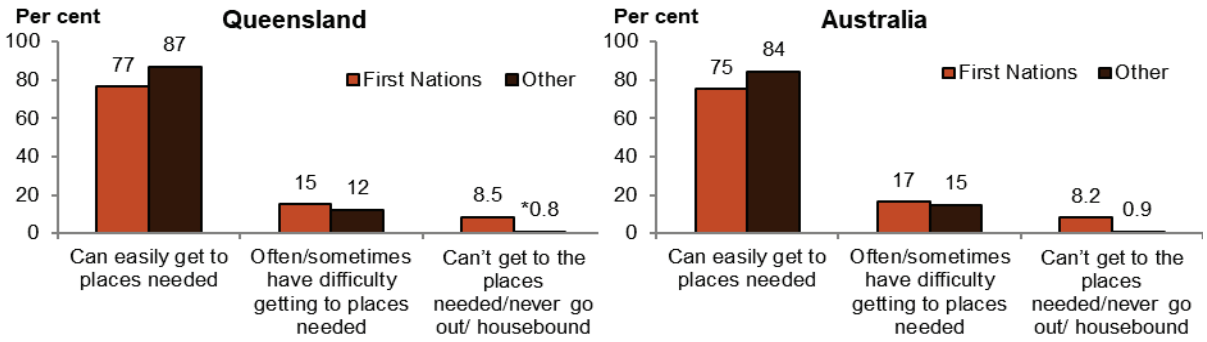
Nationally in 2021, 88% of First Nations households owned or used at least one vehicle, while 12% did not have a motor vehicle (excludes households where the number of vehicles was not reported). The proportion of First Nations households without a vehicle was higher than for other households (12% compared with 7.2%) (Figure 2.13.2).

Method of travel to work: In the 2021 Census of Population and Housing, employed people aged 15 and over were asked to record up to three methods of travel they used to get to work on the day of the Census, 10 August 2021. Caution is needed when interpreting data on how people got to work, because the 2021 Census was conducted during the COVID-19 pandemic.

In Queensland in 2021, vehicle use was the most common method of travel to work among First Nations people aged 15 and over who were employed:

- more than two-thirds (71%) of First Nations people used a vehicle such as car, truck, motorbike, or scooter to get to work, compared with 66% of other Queenslanders
- 5.1% used active transport (bicycle (0.6%) or walk (4.5%))
- 4.9% used public transport (bus (2.3%); train (1.6%); or ferry, tram, light rail, taxi, ride-share service combined (1.0%)) to get to work
- 18.6% either worked at home (7.1%) or did not go to work (11.5%) (Figure 2.13.3).

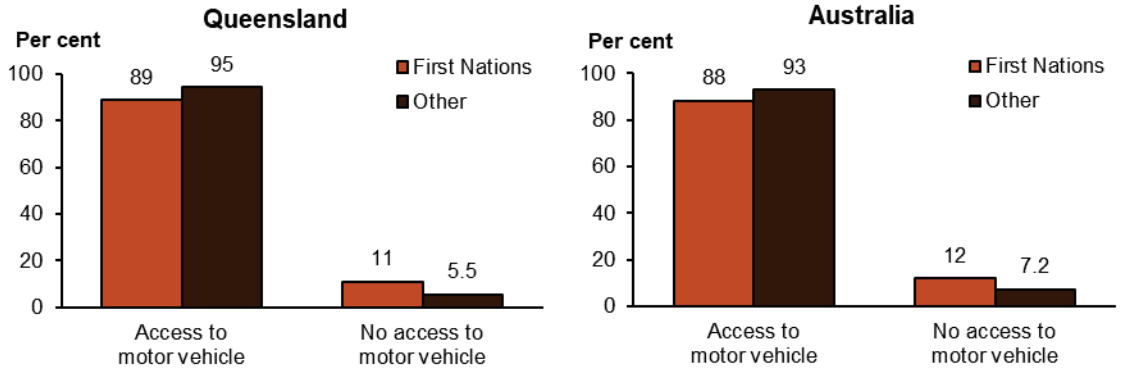
Figure 2.13.1: Perceived level of difficulty with transport for persons aged 15 and over, by Indigenous status, Queensland and Australia, 2014–15



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

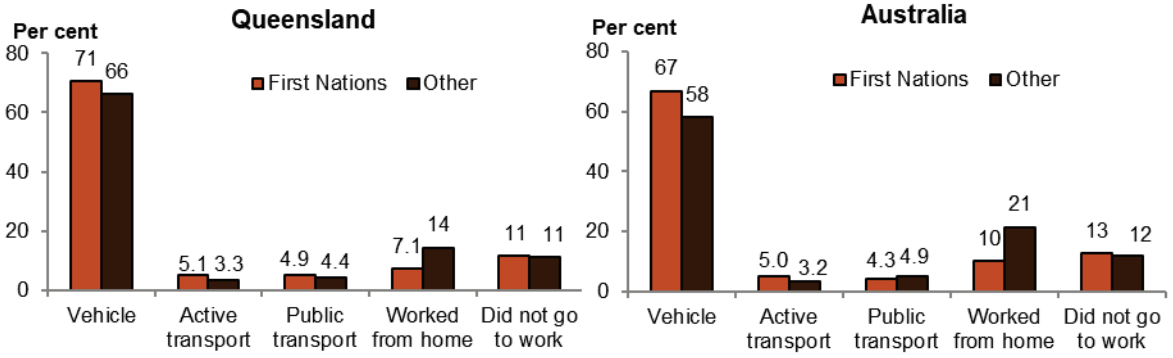
Source: Table D2.13.4.

Figure 2.13.2: First Nations households with access to a motor vehicle, by Indigenous status, Queensland and Australia, 2021



Source: AIHW analysis of ABS 2023.

Figure 2.13.3: Method of travel to work for persons aged 15 and over who were employed, by Indigenous status, Queensland and Australia, 2021



Notes:

1.Vehicle includes car, truck, motorbike or scooter; Active transport includes walk or bicycle; Public transport includes bus, train, ferry, tram/light rail, and taxi/ride-share services.

2. Caution is needed interpreting data presented in figure, as the 2021 Census was conducted during the COVID-19 pandemic.

Source: AIHW analysis of ABS 2022.

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

2.14 Indigenous people with access to their traditional lands

Why it is important

This measure reports on the proportion of First Nations 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 First Nations 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 2018–19 in Queensland, 75% of First Nations 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 2018–19, 74% of First Nations 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 First Nations people that recognised their homelands or traditional Country as an area of land with ancestral and cultural links was higher in remote than non-remote areas of Australia (90% compared with 71%) (Table D2.14.1).

Living on homelands or traditional Country: In 2018–19 in Queensland, 25% of First Nations people aged 18 and over lived on their homelands or traditional Country.

Nationally in 2018–19, 27% of First Nations people aged 18 and over lived on their homelands or traditional Country (Figure 2.14.2).

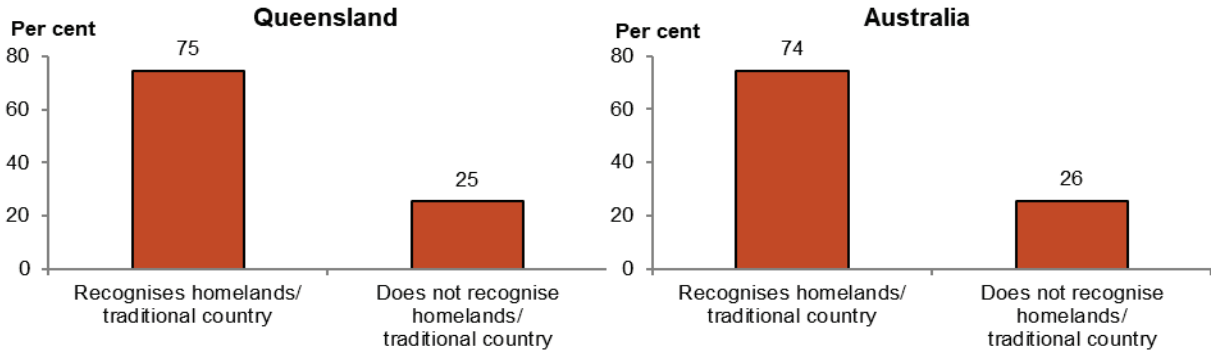
Visiting homelands or traditional Country: In 2018–19 in Queensland, 47% of First Nations people aged 18 and over were allowed to visit their homelands or traditional Country, and 0.3% reported not being not allowed to visit (this estimate has a relative standard error between 25% and 50% and should be interpreted with caution).

Nationally in 2018–19, 45% of First Nations people aged 18 and over were allowed to visit their homelands or traditional Country, and 0.4% reported not being allowed to visit (Figure 2.14.2).

Identifying with clan, tribal or language group: In 2018–19 in Queensland, nearly 2 in 3 (63%) First Nations people aged 18 and over identified with a clan, tribal or language group. The proportion that did not identify was 37%.

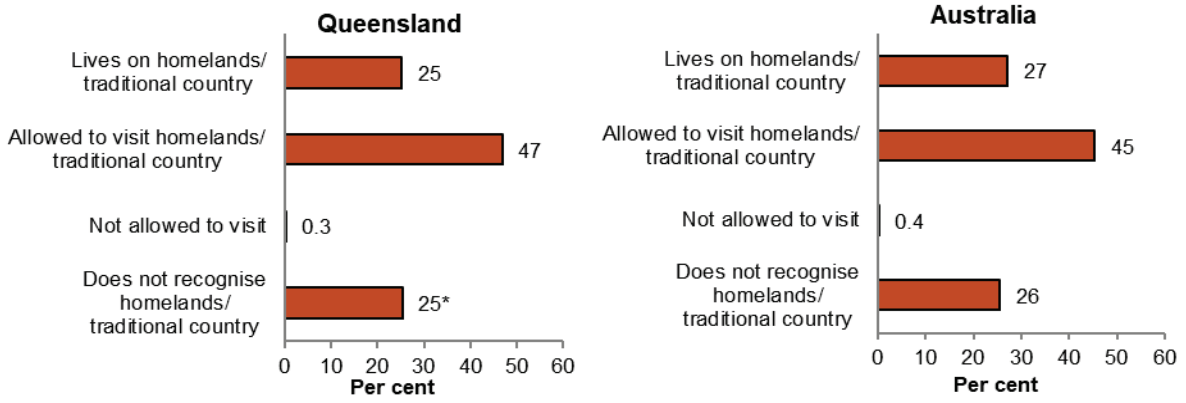
Nationally in 2018–19, about 2 in 3 (65%) First Nations people aged 18 and over identified with a clan, tribal or language group. The proportion that did not identify was 34% (Figure 2.14.3).

Figure 2.14.1: Recognition of homelands or traditional Country, First Nations people aged 18 and over, Australia, 2018–19



Source: Table D2.14.1.

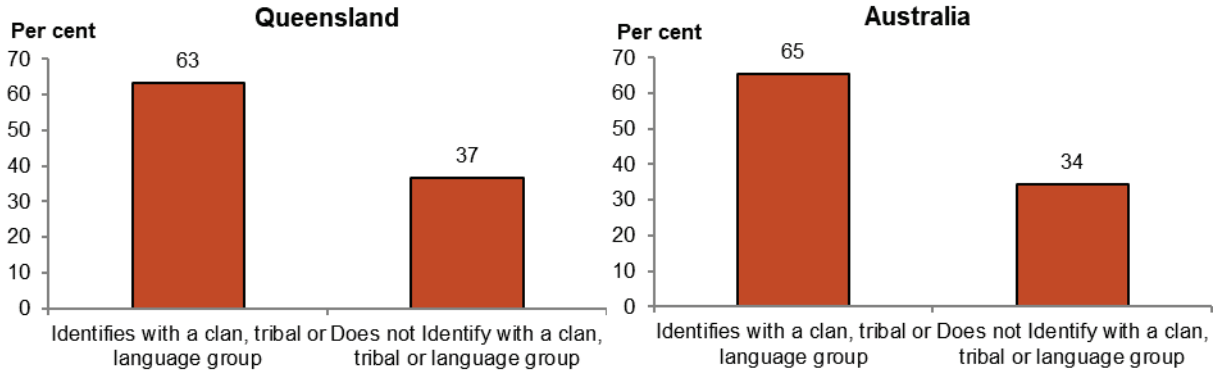
Figure 2.14.2: Access to homelands or traditional Country, First Nations people aged 18 and over, Queensland and Australia, 2018–19



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

Source: Table D2.14.6.

Figure 2.14.3: Cultural identification with a clan, tribal or language group, First Nations people aged 18 and over, Queensland and Australia, 2018–19



Source: Table D2.14.6.

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

2.15 Tobacco use

Why it is important

This measure reports on the smoking status of First Nations people. In 2018, tobacco use contributed 11.9% of the total disease burden for First Nations people, making it the leading risk factor contributing to disease burden and deaths (AIHW 2022a). 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 2021c). Smoking cessation reduces mortality, with earlier cessation resulting in greater reductions (Banks et al. 2015).

Key findings

Overall: In 2018–19 in Queensland, 43% of First Nations people aged 15 and over reported they were current smokers, 1 in 4 (25%) were ex-smokers and one third (33%) had never smoked.

Nationally in 2018–19, 41% of First Nations people reported they were current smokers, 1 in 4 (25%) were ex-smokers and one third (33%) had never smoked (Figure 2.15.1).

Current smokers: In 2018–19 in Queensland, after adjusting for differences in the age structure between the two populations, First Nations people aged 15 and over were 2.9 times as likely to be a current smoker as other Queenslanders.

Nationally in 2018–19, after adjusting for differences in the age structure between the two populations First Nations people aged 15 and over were 2.9 times as likely to be a current smoker as other Australians (Figure 2.15.1).

Remoteness: Nationally in 2018–19, after adjusting for differences in the age structure between the two populations, the proportion of First Nations people aged 15 and over who were current smokers was higher in remote areas than in non-remote areas (55% compared with 38%). For other Australians aged 15 and over, the proportion of current smokers was slightly higher in remote areas than in non-remote areas (17% compared with 14%) (Figure 2.15.2).

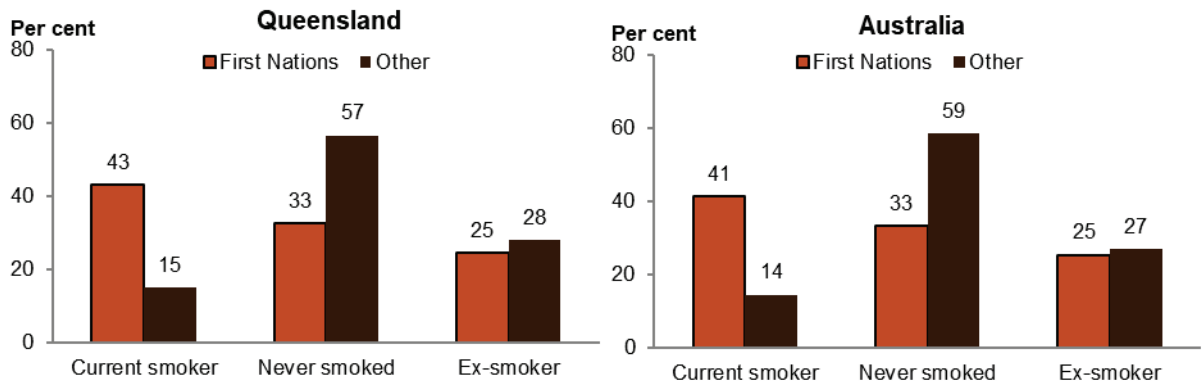
Quitting status: In 2018–19 in Queensland, 51% of First Nations people aged 15 and over who were current smokers had attempted to quit smoking in the last 12 months.

Nationally In 2018–19, 52% of First Nations people aged 15 and over who were current smokers had attempted to quit smoking in the last 12 months (Table D2.15.10).

Trend over time: The proportion of First Nations people aged 15 and over in Queensland that were current smokers declined over time, from 51% in 2002 to 43% in 2018–19.

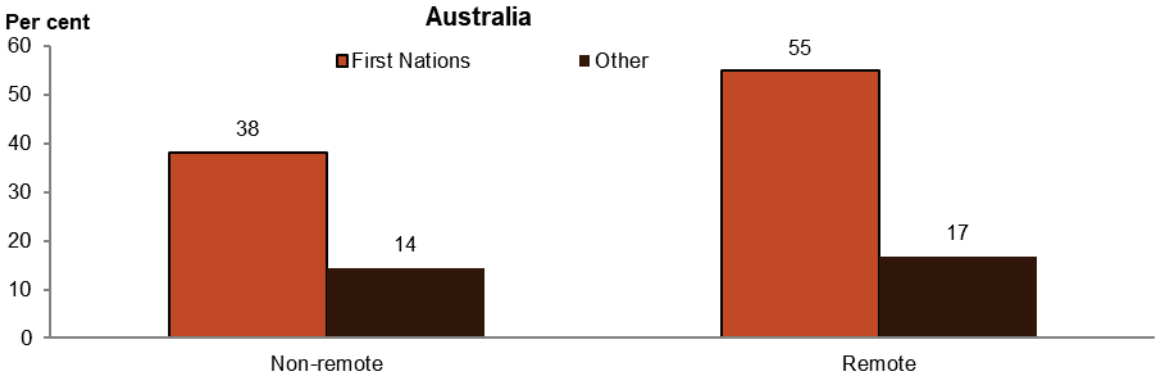
Nationally, the proportion for First Nations people aged 15 and over that were current smokers decreased from 51% in 2002 to 41% in 2018–19 (Figure 2.15.3).

Figure 2.15.1: Smoker status, First Nations people aged 15 and over, Queensland and Australia, 2018–19



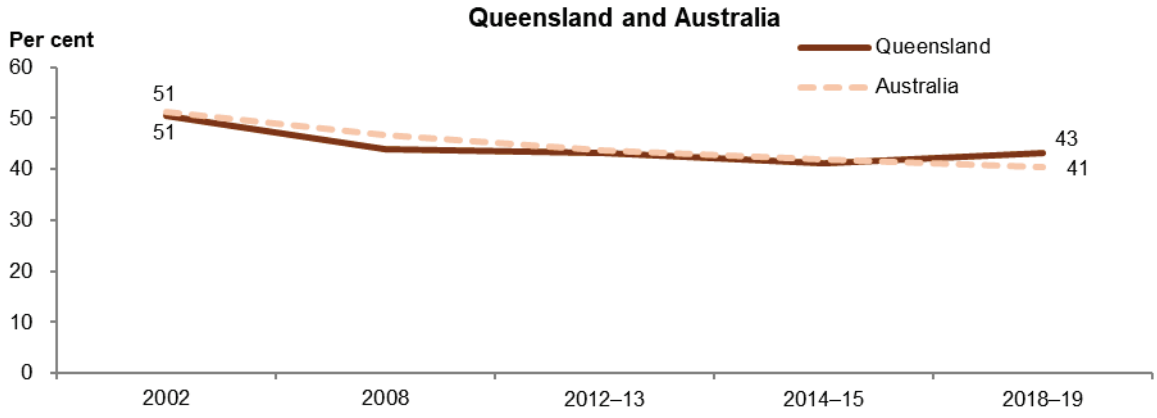
Source: Table D2.15.7.

Figure 2.15.2: Proportion of current smokers, by remoteness area and Indigenous status, aged 15 and over, Australia, 2018–19



Source: Table D2.15.8.

Figure 2.15.3: Proportion of current smokers, First Nations people aged 15 and over, Queensland and Australia, 2002 to 2018–19



Source: Table D2.15.1.

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

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 First Nations people; including abstinence, single occasion risk and lifetime risk consumption levels. In this measure risky alcohol consumption is defined according to the National Health and Medical Research Council (NHMRC) 2009 Australian Guidelines to Reduce Health Risks from Drinking Alcohol (NHMRC 2009), that applied at the time the 2018–19 National Aboriginal and Torres Strait Islander Health Survey was undertaken. The NHMRC has since updated these guidelines in 2020 (NHMRC 2020).

Key findings

Abstinence: In Queensland in 2018–19, 30% of First Nations people aged 15 and over reported abstaining from alcohol in the previous 12 months or never having consumed alcohol. Nationally, the proportion was 30% (Figure 2.16.1). The proportion of First Nations people in Queensland who abstained from alcohol was lower in non-remote areas than remote areas (29% and 36%, respectively) in 2018–19 (Figure 2.16.2).

Single occasion risk: In 2018–19 in Queensland, 50% of First Nations people aged 15 and over reported consuming alcohol in quantities that exceeded the single occasion alcohol risk guideline (more than 4 standard drinks) at least once in the 2 weeks prior to interview. Nationally, the proportion was also 50% (Figure 2.16.1).

In Queensland, the incidence of First Nations people engaging in single occasion risky alcohol consumption was lower in non-remote areas (49%) than remote areas (55%) in 2018–19 (Figure 2.16.2).

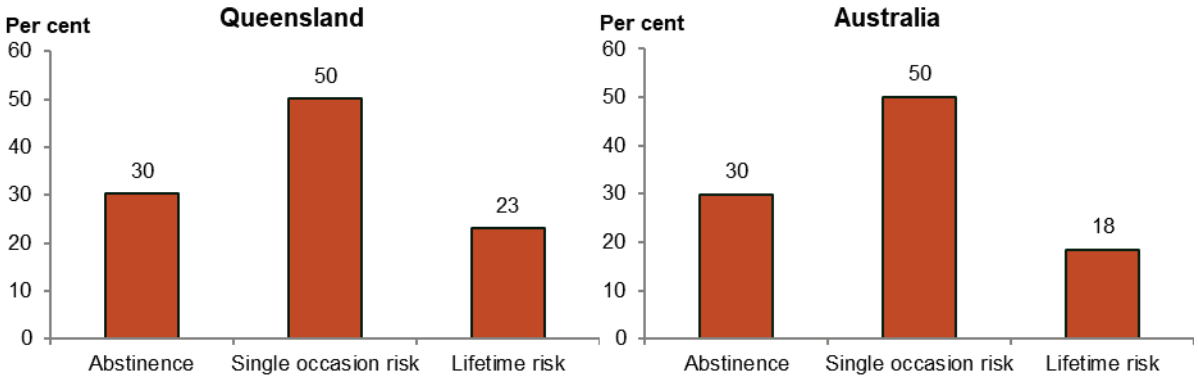
Lifetime risk: In Queensland in 2018–19, 23% of First Nations people aged 15 and over reported consuming alcohol in quantities that exceeded the lifetime risk alcohol guideline (more than two standard drinks per day on average). Nationally, the proportion was 18% (Figure 2.16.1).

In Queensland, the proportion of First Nations people exceeding the lifetime alcohol risk guidelines was higher in non-remote areas (24%) than remote areas (18%) in 2018–19 (Figure 2.16.2).

Hospitalisation: From July 2019 to June 2021 in Queensland, there were 3,679 hospitalisations of First Nations people with a principal diagnosis related to alcohol use. This corresponded to a rate of 761 hospitalisations per 100,000 population. Hospitalisation rates were higher in remote areas than in non-remote areas (1,324 and 656 per 100,000, respectively) (Table D2.16.23).

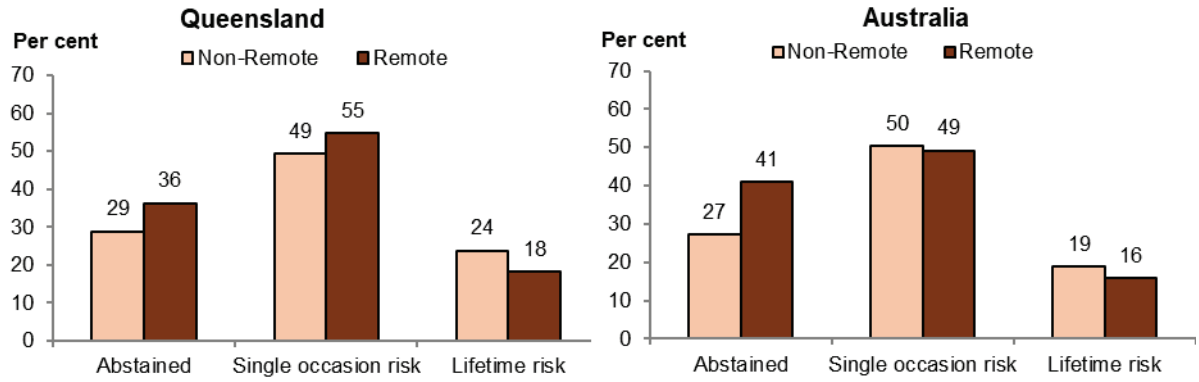
Hospitalisation changes over time: Between 2011–12 and 2020–21 in Queensland, the age-standardised rate of hospitalisations for First Nations people with alcohol use as a principal diagnosis increased by 42%, while for other Queenslanders, the rate increased by 22% (Figure 2.16.3).

Figure 2.16.1: Alcohol risk levels, First Nations people aged 15 and over, Queensland and Australia, 2018–19



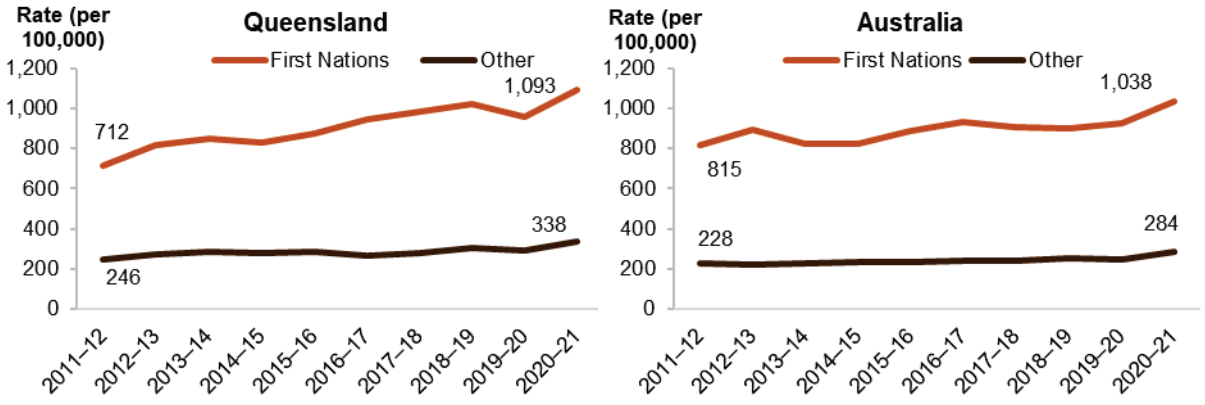
Source: Tables D2.16.18, D2.16.19 and D2.16.20.

Figure 2.16.2: Alcohol risk levels, First Nations people aged 15 and over, by remoteness, Queensland and Australia, 2018–19



Source: Tables D2.16.18, D2.16.19 and D2.16.20.

Figure 2.16.3: Age-standardised hospitalisation rates for alcohol-related hospitalisations, by Indigenous status, Queensland, and Australia, 2011–12 to 2020–21



Source: Table D2.16.13 Qld.

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

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

Key findings

Overall: In 2018–19 in Queensland, an estimated 25% of First Nations people aged 15 and over reported using substances in the last 12 months. Substance use was more prevalent for First Nations males than females (35% compared with 16%).

Nationally, an estimated 27% of First Nations people aged 15 and over reported using substances in the last 12 months. The proportion was higher for First Nations males than females (35% compared with 20%, respectively) (Figure 2.17.1).

Hospitalisations: In Queensland, from July 2019 to June 2021, there were 3,703 hospitalisations of First Nations people with a principal diagnosis related to drug use, which corresponded to a rate of 766 hospitalisations per 100,000 population. Hospitalisation rates were higher in non-remote areas (837 per 100,000) than in remote areas (387 per 100,000) (Table D2.17.8, Figure 2.17.2).

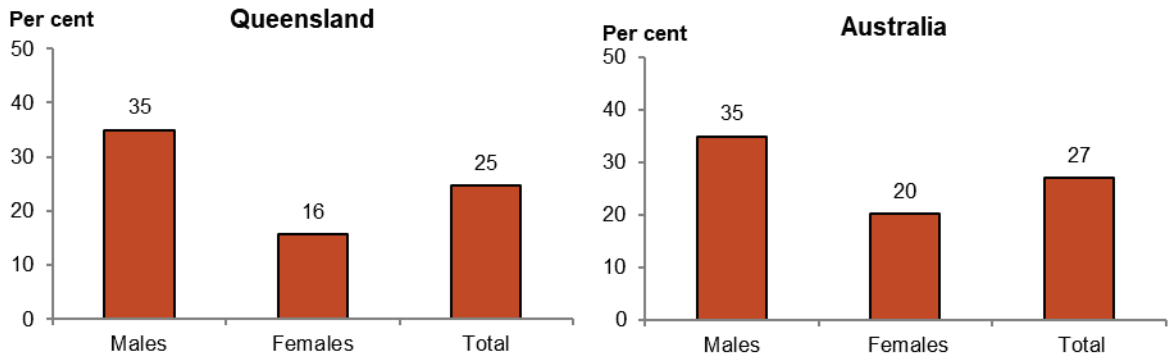
Nationally, from July 2019 to June 2021, there were 14,161 hospitalisations of First Nations people with a principal diagnosis related to drug use, which corresponded to a rate of 821 hospitalisations per 100,000 population. Hospitalisation rates were higher in non-remote areas (826 per 100,000) than in remote areas (486 per 100,000) (Table D2.17.8, Figure 2.17.2).

Police detainees: In 2017, in Queensland (Brisbane watch house), 77% of First Nations detainees (43 detainees) who provided a urine sample tested positive to a drug. The proportion for other Queensland detainees (240 detainees) was 73% (Table D2.17.10, Figure 2.13.3).

Trend over time: From 2004 to 2017, the rate for First Nations detainees in Queensland who provided urine during selected state collections, and tested positive to a drug, fluctuated between 74% and 90%. The rate for other Queensland detainees varied between 62% and 74% (Table D2.17.12, Figure 2.13.3).

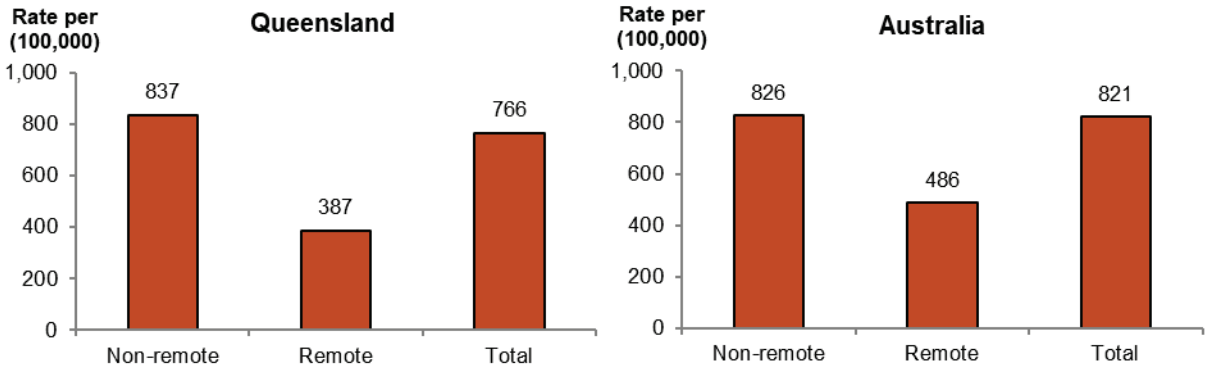
There are no national data for urinalysis test results for detainees over time as data are only collected in Sydney, Brisbane, Perth and Adelaide.

Figure 2.17.1: First Nations people aged 15 and over reporting substance use in the last 12 months, by sex, Queensland and Australia, 2018–19



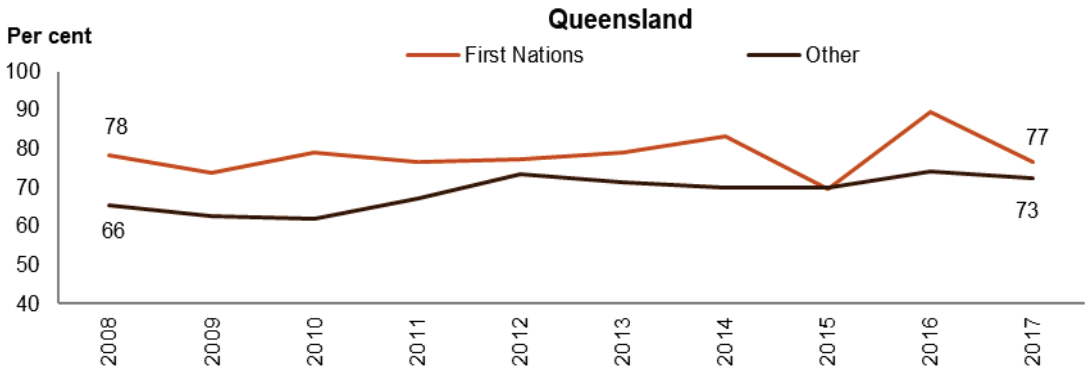
Source: Table D2.17.3.

Figure 2.17.2: Age-standardised hospitalisation rates for drug-related hospitalisations, by First Nations status, remoteness, Queensland and Australia, July 2019 to June 2021



Source: Table D2.17.8.

Figure 2.17.3: Detainees who provided urine during selected state collections who tested positive to a drug, by Indigenous status, Queensland, 2004 to 2017



Source: Table D2.17.12.

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

2.18 Physical activity

Why it is important

This measure reports on the levels of physical activity among First Nations 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 First Nations people, making it the 11th leading risk factor contributing to disease burden (AIHW 2022c).

Key findings

Level of physical activity (aged 15+): The 2018–19 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 2019b).

In Queensland in 2018–19, 10% of First Nations people aged 15 and over in non-remote areas had undertaken a sufficient level of physical activity in the week prior. Nearly 1 in 4 (23%) had undertaken no physical activity in the last week.

Nationally in 2018–19, 11% of First Nations people aged 15 and over in non-remote areas had undertaken a sufficient level of physical activity in the week prior. More than 1 in 5 (22%) had undertaken no physical activity in the last week (Figure 2.18.1).

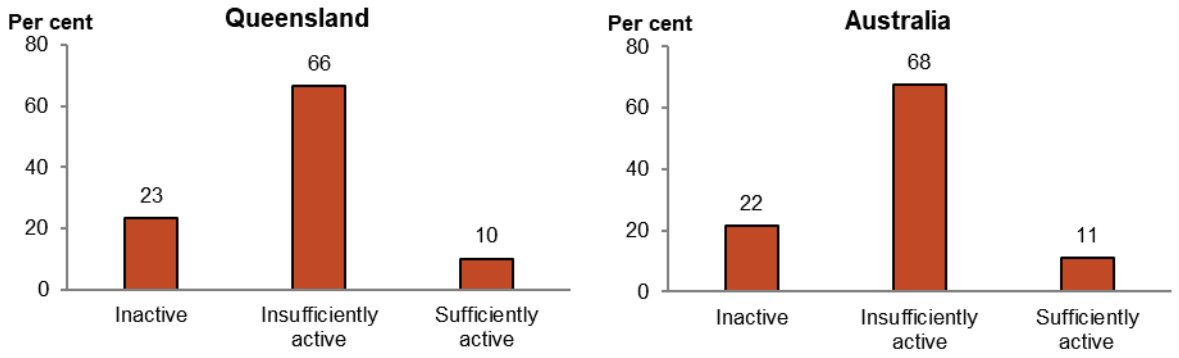
Children's daily activity: In 2014–15 in Queensland, 79% of First Nations children aged 4–14 had undertaken at least 60 minutes of physical activity every day. This is similar to the proportion in 2008 (78%).

Nationally in 2014–15, 76% of First Nations 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 Queensland, 79% of First Nations children aged 4–14 were physically active every day of the previous week, and 11% were active on 4–6 days (this estimate has a relative standard error between 25% and 50% and should be interpreted with caution).

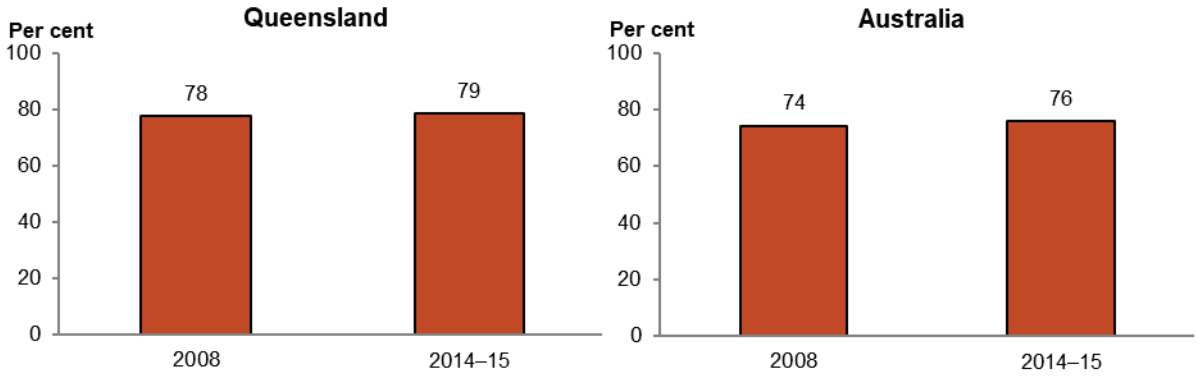
Nationally in 2014–15, 76% of First Nations children aged 4–14 were physically active every day of the previous week, and 13% were active on 4–6 days (Figure 2.18.3).

Figure 2.18.1: Proportion of First Nations people aged 15 and over reporting selected levels of physical activity, non-remote areas, Queensland and Australia, 2018–19



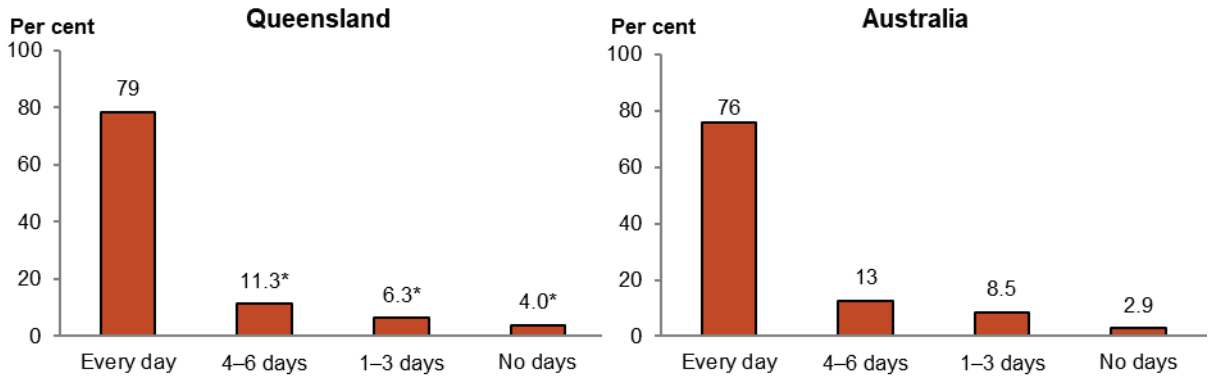
Source: ABS 2019b Table 3.3.

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



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

Source: Table D2.18.2.

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

2.19 Dietary behaviour

Why it is important

This measure reports on dietary behaviour among First Nations 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 First Nations 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).

Key findings

Consumption of fruit: In 2018–19 in Queensland, 30% of First Nations people (aged 12 and over) ate less than one serve of fruit a day. First Nations people living in non-remote areas of Queensland were more likely to eat less than one serve of fruit a day than those living in remote areas (31% compared with 23%, respectively).

Nationally in 2018–19, 29% of First Nations people (aged 12 and over) reported eating less than one serve of fruit a day. First Nations people living in non-remote areas were slightly more likely to eat less than one serve of fruit a day than those living in remote areas (29% compared with 27%, respectively) (Figure 2.19.1).

Consumption of vegetables: In 2018–19 in Queensland, 15% of First Nations people (aged 12 and over) reported eating less than one serve of vegetables a day. First Nations people living in non-remote areas of Queensland were more likely to eat less than one serve of vegetables a day than those living in remote areas (16% compared with 13%).

Nationally in 2018–19, 16% of First Nations people (aged 12 and over) reported eating less than one serve of vegetables a day. First Nations people living in non-remote areas were less likely to eat less than one serve of vegetables a day than those living in remote areas (15% compared with 19%) (Figure 2.19.2).

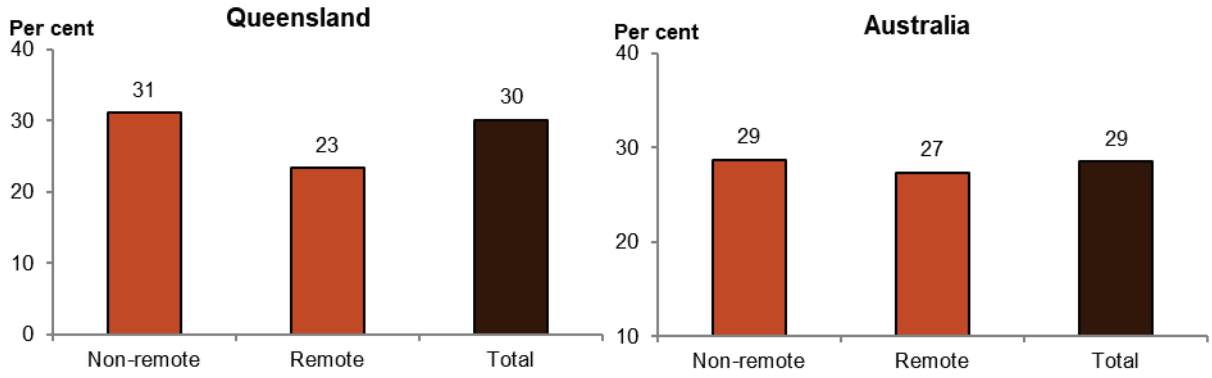
Children's consumption of fruit: In 2018–19 in Queensland, one-third (31%) of First Nations children aged 2–14 ate one serve or less of fruit a day. Almost a third (30%) ate 2 serves and 19% ate 3 serves.

Nationally in 2018–19, one-third (34%) of First Nations children aged 2–14 ate one serve or less of fruit a day. A quarter (25%) ate 2 serves and 12% ate 3 serves (Figure 2.19.3).

Children's consumption of vegetables: In 2018–19 in Queensland, 56% of First Nations children aged 2–14 ate one serve or less of vegetables a day. Almost a quarter (23%) ate 2 serves and 8.3% ate 3 serves.

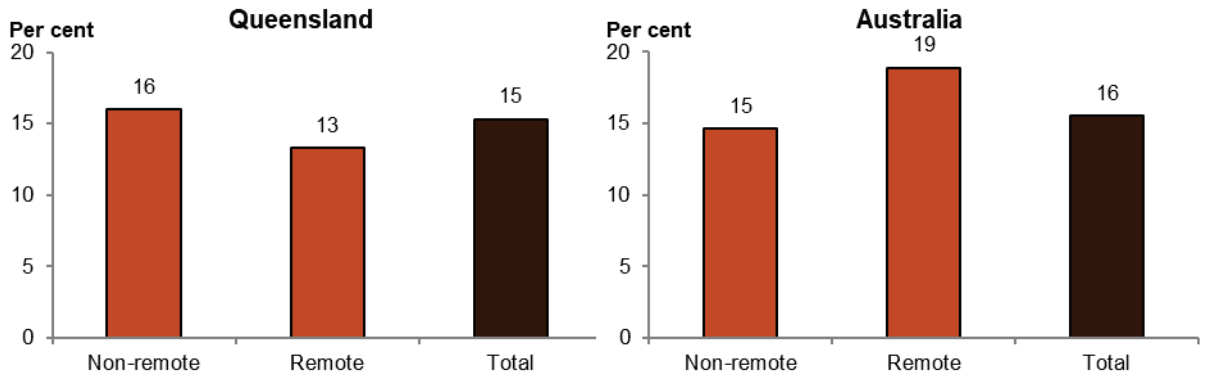
Nationally in 2018–19, 48% of First Nations children aged 2–14 were reported to eat one serve or less of vegetables a day, 25% ate 2 serves and 12% ate 3 serves (Figure 2.19.3).

Figure 2.19.1: First Nations Australians (aged 12 and over) reported to eat less than one serve of fruit per day, by remoteness, Queensland and Australia, 2018–19



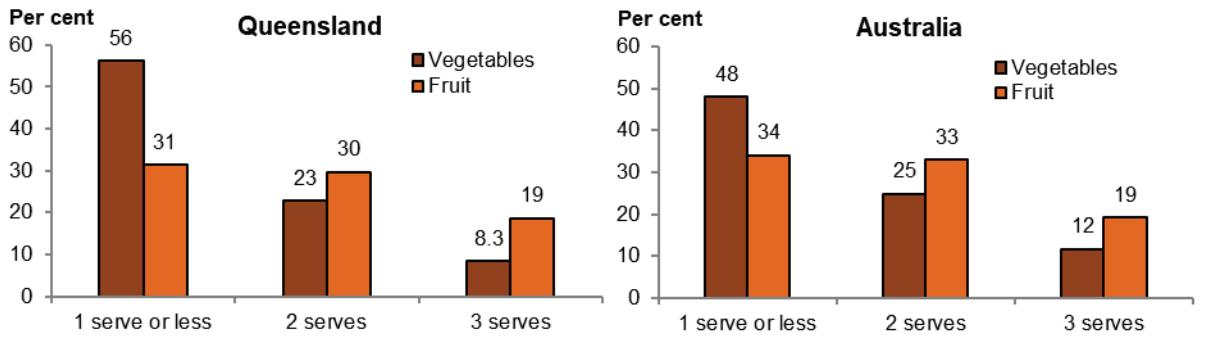
Source: Table D2.19.2.

Figure 2.19.2: First Nations Australians (aged 12 and over) reported to eat less than one serve of vegetables per day, by remoteness, Queensland and Australia, 2018–19



Source: Table D2.19.3.

Figure 2.19.3: First Nations children (aged 2–14), number of serves of fruit and vegetables consumed daily, Queensland and Australia, 2018–19



Source: Table D2.19.9.
Note: Data for 4 serves, 5 or more serves, or 'does not usually eat fruit or vegetables' are not shown due to small numbers for Queensland.

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

2.20 Breastfeeding practices

Why it is important

This measure reports on the breastfeeding status and duration of breastfeeding for First Nations 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 0–2: In 2018–19, 97% of First Nations children aged 0–2 in Queensland had been breastfed, compared with 87% nationally.

For other children aged 0–2, similar levels had been breastfed in Queensland and nationally (94% and 93% respectively) (Table D2.20.6).

Breastfeeding duration (children aged 0–2): In 2018–19 in Queensland, of First Nations children aged 0–2 who were reported to have been breastfed, the most common duration of feeding was 1 month to less than 6 months (35%). This was also the most common duration of feeding at a national level, albeit at a lower level (30%).

The proportion for other children aged 0–2 in Queensland in 2018–19 who were breastfed for a duration of 1 month to less than 6 months was 19%. This was the same at a national level (19%) (Figure 2.20.1).

Due to data quality issues, comparisons for other breastfeeding durations in the table should be done with caution.

Remoteness (children aged 0–2): Nationally in 2018–19, the proportion of First Nations children aged 0–2 who had been or were currently breastfed was highest in *Very remote* areas (92%) and lowest in *Major cities* (84%).

For other children aged 0–2, the highest proportion was in *Major cities* (95%) and the lowest was in *Inner regional* areas (84%). Due to data quality issues, data were not publishable for other children in remote areas (Table D2.20.5).

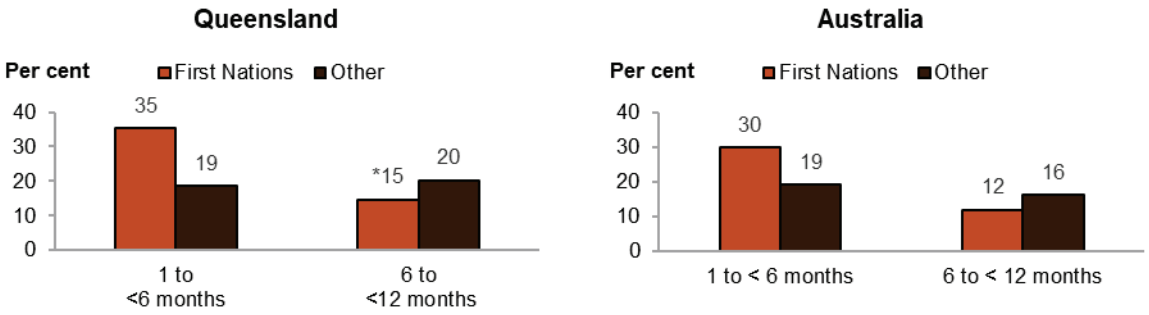
Children aged 0–3: In 2018–19 in Queensland, 95% of First Nations children aged 0–3 were reported to have been or were currently breastfed. Nationally, 85% of First Nations children aged 0–3 were reported to have been or were currently breastfed (Figure 2.20.2).

There were no comparable data for First Nations and other Australian children aged 0–3 available due to scope of the ABS National Health Survey 2017–18.

Remoteness (children aged 0–3): Nationally in 2018–19, the proportion of First Nations children aged 0–3 who were reported to have been or are currently breastfed was highest in *Remote* areas (94%), and the lowest in *Major cities* (82%) (Figure 2.20.3).

Nationally in 2018–19, the proportions of First Nations children aged 0–3 who were reported to have met the breastfeeding guidelines (for exclusive breastfeeding for at least 6 months) was higher in remote areas (33%) than in non-remote areas (13%) (Table D2.20.1).

Figure 2.20.1: Breastfeeding duration, infants aged 0–2, by Indigenous status, Queensland and Australia, 2018–19



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

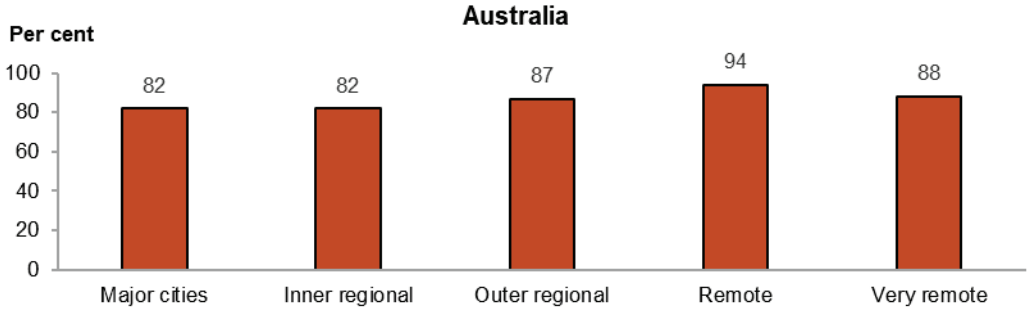
Note: Other periods of breastfeeding duration not presented due to data quality issues.

Source: Table D2.20.6.

Figure 2.20.2: Total ever breastfed (current or ceased), First Nations infants aged 0–3, by jurisdiction, 2018–19

Source: Table D2.20.2.

Figure 2.20.3: Total ever breastfed (current or ceased), First Nations infants aged 0–3, by remoteness, Australia, 2018–19



Source: Table D2.20.1.

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

2.21 Health behaviours during pregnancy

Why it is important

This measure reports on the use of tobacco, alcohol, illicit substances and other health-related behaviours of First Nations women during pregnancy. Many First Nations women have healthy pregnancies (Clarke and Boyle 2014). The health and wellbeing of women during pregnancy is vitally important to ensuring healthy outcomes for mothers and their babies (AIHW 2020b). 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 Queensland, 45% of First Nations women who gave birth in 2020 reported that they smoked during pregnancy. After adjusting for differences in the age structure between the two populations, this was about 4 times the age-standardised proportion for other Queensland women (46% compared with 12%).

Nationally, 43% of First Nations women who gave birth in 2020 reported that they smoked during pregnancy. After adjusting for differences in the age structure between the two populations, this was almost 4 times the age-standardised proportion for other Australian women (44% compared with 11%) (Figure 2.21.1).

Smoking Cessation: In Queensland, in 2020 the proportion of First Nations mothers who smoked after 20 weeks of pregnancy (39%) was lower than the proportion who smoked in the first 20 weeks (45%).

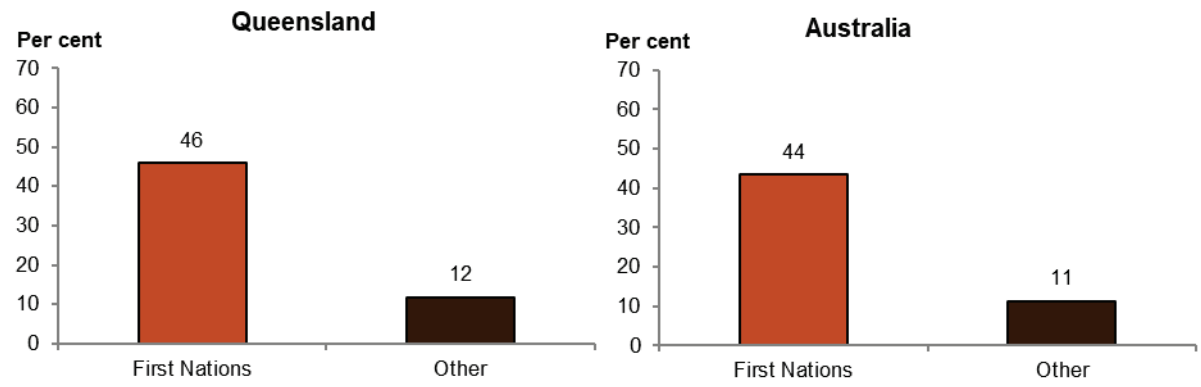
Nationally, in 2020 the proportion of First Nations mothers who smoked after 20 weeks of pregnancy (38%) was lower than the proportion who smoked in the first 20 weeks (42%) (Figure 2.21.2).

Alcohol and drug use during pregnancy: In 2018–19 in Queensland, among mothers of First Nations children aged 0–3, most did not consume alcohol (91%) and did not use illicit drugs (98%) during pregnancy.

Nationally in 2018–19, among mothers of First Nations children aged 0–3, most did not consume alcohol (90%) and did not use illicit drugs (97%) during pregnancy (Table D2.21.6).

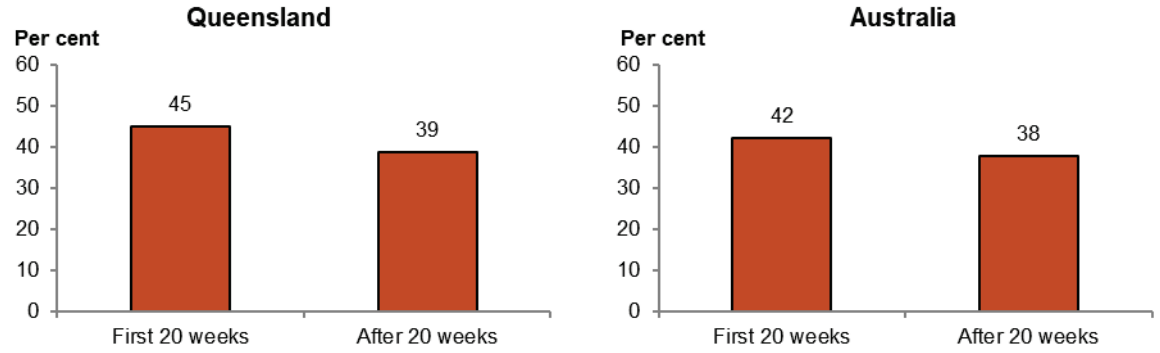
Health behaviours and remoteness: Nationally in 2018–19, mothers of First Nations children aged 0–3 who lived in remote areas reported similar proportions of alcohol consumption during their pregnancy to mothers who lived in non-remote areas (11% compared with 9.8% – estimates have a relative standard error between 25% and 50% and should be interpreted with caution). Mothers of First Nations children aged 0–3 who lived in remote areas reported higher proportions of tobacco use during pregnancy (37% compared with 31%), while similar proportions reported not using illicit drugs during pregnancy (96% and 97%, respectively) (Figure 2.21.3).

Figure 2.21.1: Age-standardised proportion of mothers who smoked during pregnancy, by Indigenous status, Queensland and Australia, 2020



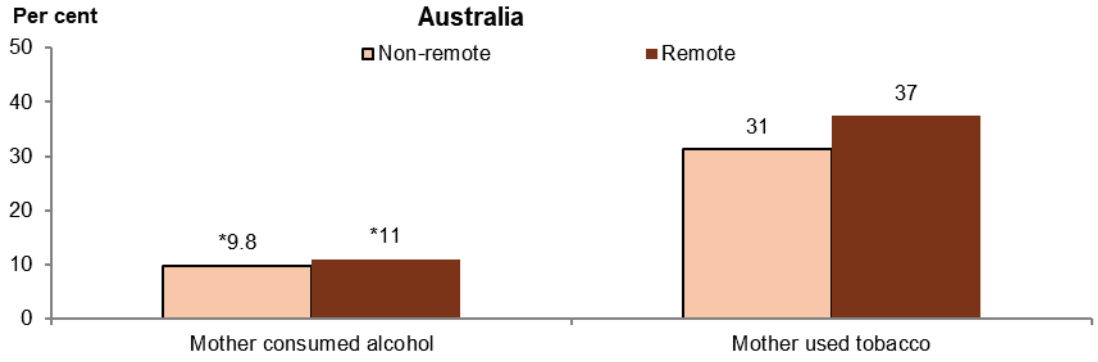
Source: Table D2.21.1.

Figure 2.21.2: First Nations mothers who smoked during the first 20 weeks of pregnancy and after, Queensland and Australia, 2020



Source: Tables D2.21.9 and D2.21.10.

Figure 2.21.3: Mother's tobacco and alcohol during pregnancy, First Nations children aged 0–3, by remoteness areas, Australia, 2018–19



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

Source: Table D2.21.7.

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

2.22 Overweight and obesity

Why it is important

This measure reports on the proportion of First Nations 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 2014; Peeters et al. 2003; Sevoyan et al. 2019). Overweight and obesity refers to abnormal or excessive fat accumulation that may impair health (WHO 2024). 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 First Nations people in 2018 (contributing 9.7% of all burden) (AIHW 2022a).

Key findings

The 2018–19 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 Queensland in 2018–19, nearly three-quarters (73%, 96,700 people) of First Nations adults had a BMI in the overweight or obese range (27% were overweight and 45% obese). First Nations females in Queensland were more likely to be overweight or obese than First Nations males in Queensland (76% compared with 70%, respectively).

Nationally in 2018–19, 74% of First Nations adults had a BMI in the overweight or obese range. First Nations females were more likely to be obese than First Nations males (48% compared with 43%, respectively), and less likely to be overweight than First Nations males (27% compared with 31%, respectively) (Figure 2.22.1)

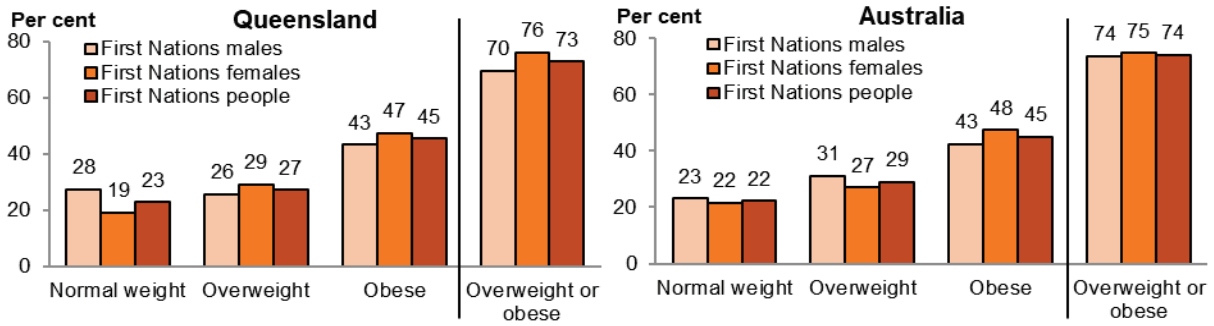
Remoteness: In Queensland in 2018–19, after adjusting for differences in the age structure between the two populations, First Nations adults were more likely than other Queenslanders to be overweight or obese across all remoteness areas. The largest differences were in *Major cities* and *Inner regional* areas, where First Nations adults were 1.2 times as likely to be overweight or obese than other Queenslander adults.

A similar patten was observed nationally, First Nations adults were 1.2 times as likely to be overweight or obese than other Australian adults in *Major cities* and *Inner regional* areas in 2018–19 (Figure 2.22.2).

Change over time: Between the two periods 2012–13 and 2018–19, in Queensland the proportion of First Nations people aged 15 and over who were overweight or obese increased from 66% to 70%.

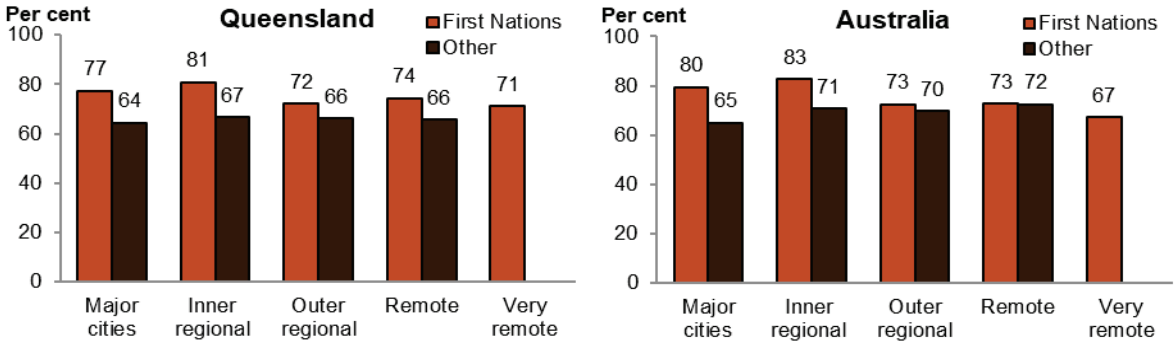
The national pattern was similar, with the proportion of First Nations people aged 15 and over who were overweight or obese increasing from 66% to 71% between 2012–13 and 2018–19 (Figure 2.22.3).

Figure 2.22.1: Proportion of First Nations people aged 18 and over by BMI category and sex, Queensland and Australia, 2018–19



Source: National Aboriginal and Torres Strait Islander Survey 2018–19 (ABS Table 37.e.3; ABS Table 18.3).

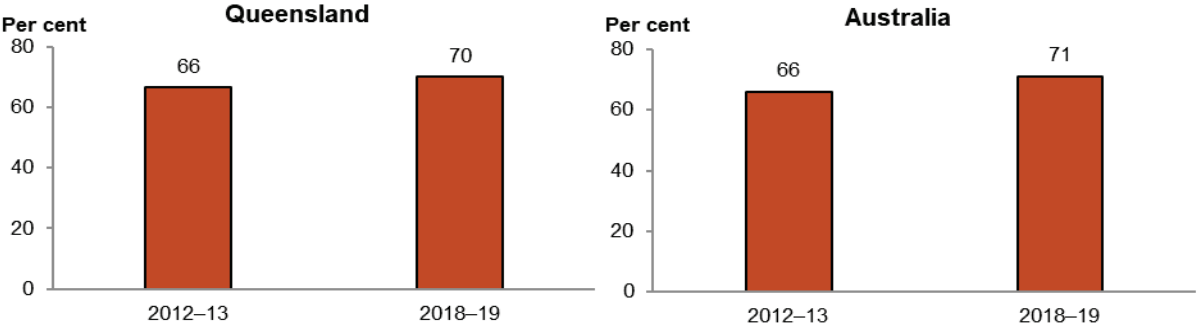
Figure 2.22.2: Age-standardised proportion of persons aged 18 and over who were overweight or obese, by remoteness and Indigenous status, Queensland and Australia, 2017–18 (other Queenslanders/other Australians) and 2018–19 (First Nations people)



Note: Data from *Very remote* areas is not available for other Queenslanders/other Australians as the National Health Survey 2017–18 excludes *Very remote* areas of Australia.

Source: Table D2.22.3.

Figure 2.22.3: Proportion of First Nations people aged 15 and over who were overweight or obese, Queensland and Australia, 2012–13 and 2018–19



Source: Australian Aboriginal and Torres Strait Islander Health Survey 2012–13 (ABS Table 3.3) and National Aboriginal and Torres Strait Islander Survey 2018–19 (ABS Table 3.3).

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

Tier 3 – Health system performance

3.01 Antenatal care

Why it is important

This measure reports the total number of antenatal visits for First Nations women, duration of pregnancy at first antenatal visit, and types of antenatal services used. Antenatal care is especially important for First Nations women because they are at higher risk of giving birth to pre-term and low birthweight babies and have greater exposure to other risk factors and complications such as anaemia, poor nutritional status, chronic illness, hypertension, diabetes, genital and urinary tract infections, smoking and high levels of psychosocial stressors (AHMAC 2012; de Costa and Wenitong 2009). Regular antenatal care 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 Queensland in 2020, among First Nations mothers who gave birth at 20 weeks or more gestation, 71% (3,104) accessed antenatal care services during the first trimester (less than 14 weeks) of their pregnancy, 14% (624) attended their first visit after the first trimester but before 20 weeks, and 15% (636) first attended after 20 weeks or did not attend (Table D3.01.10). After adjusting for differences in the age structure between the two populations, First Nations mothers were 0.8 times as likely as other Queensland mothers to have first attended antenatal care services in the first trimester of pregnancy (before 14 weeks) (Figure 3.01.1).

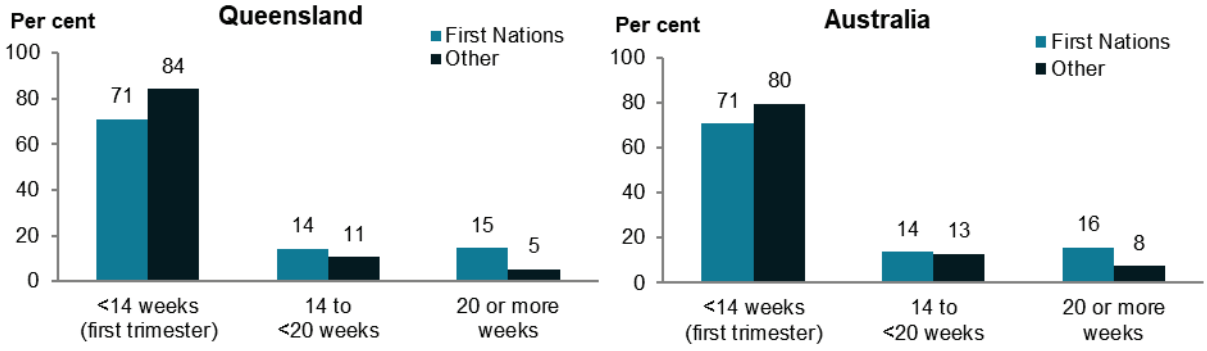
Nationally in 2020, among First Nations mothers who gave birth at 20 weeks or more gestation, 71% (10,027) accessed antenatal care services during the first trimester (less than 14 weeks) of their pregnancy, 14% (1,923) attended their first visit after the first trimester but before 20 weeks, and 16% (2,237) first attended after 20 weeks or did not attend (Table D3.01.10). After adjusting for differences in the age structure between the two populations, First Nations mothers were 0.9 times as likely as other Australian mothers to have first attended antenatal care services in the first trimester of pregnancy (before 14 weeks) (Figure 3.01.1).

Number of antenatal visits: In Queensland in 2020, among First Nations women who gave birth at 32 weeks or more, 91% (3,849) had 5 or more antenatal visits during pregnancy, 7.4% (315) attended 2 to 4 visits, 0.8% (35) attended one visit, and 1.1% (45) attended no visits (Table D3.01.1). After adjusting for differences in the age structure between the two populations, First Nations women were 0.9 times as likely as other Queensland women to have had 5 or more antenatal visits.

Nationally in 2020, among First Nations women who gave birth at 32 weeks or more, 88% had 5 or more antenatal visits during pregnancy, 9.3% attended 2 to 4 visits, 1.6% attended one visit, and 0.7% attended no visits (Table D3.01.1). After adjusting for differences in the age structure between the two populations, First Nations women were 0.9 times as likely as other Australian women to have had 5 or more antenatal visits (Figure 3.01.2).

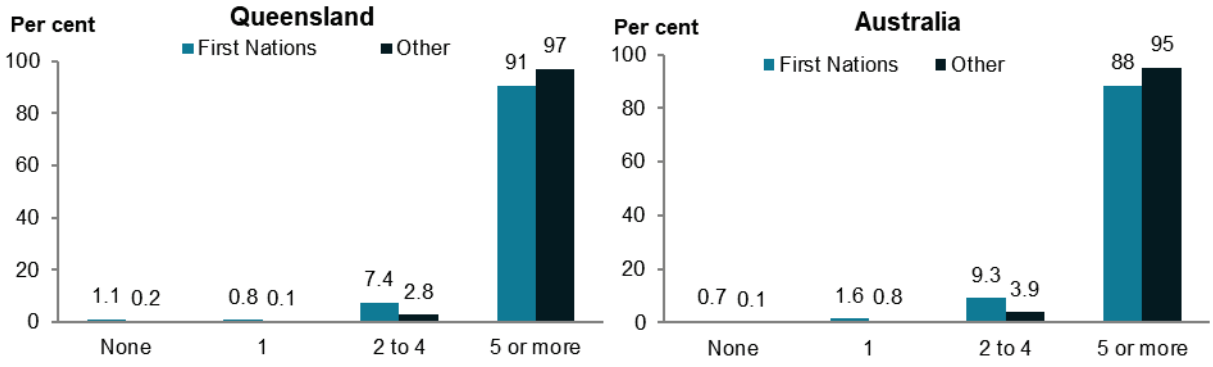
Regular care: In 2014–15 in Queensland, 94% of mothers of First Nations children aged 0–3 reported they had regular pregnancy check-ups, and 54% of mothers had sought advice or information about pregnancy or childbirth. Nationally, 94% of mothers of First Nations children reported they had regular pregnancy check-ups, and 51% of mothers had sought advice or information about pregnancy or childbirth (Figure 3.01.3).

Figure 3.01.1: Age-standardised proportion of women who gave birth at 20 weeks or more gestation, by duration of pregnancy at first antenatal visit and Indigenous status of the mother, Queensland and Australia, 2020



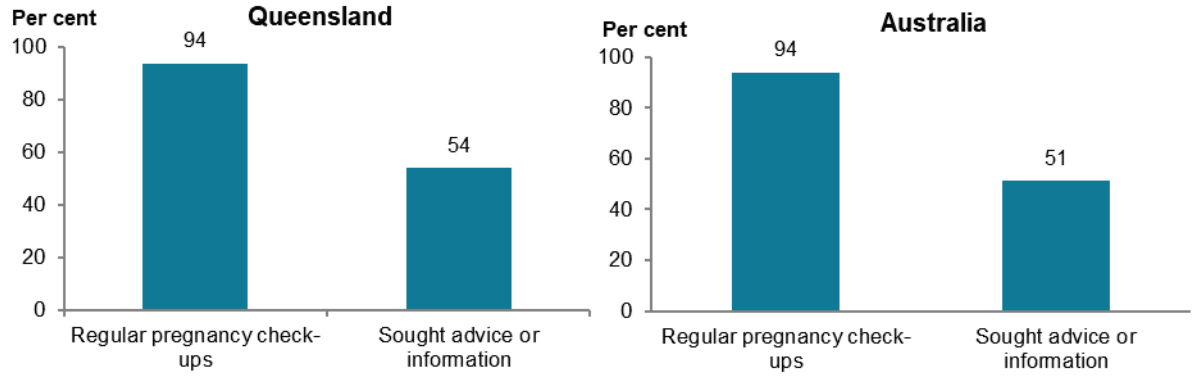
Source: Table D3.01.10

Figure 3.01.2: Age-standardised proportion of women who gave birth at 32 weeks' gestation or more, by number of antenatal visits and Indigenous status, Queensland and Australia, 2020



Source: Table D3.01.1

Figure 3.01.3: Regular care for mothers of First Nations children aged 0–3, Queensland and Australia, 2014–15



Source: Table D3.01.18

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

3.02 Immunisation

Why it is important

This measure reports on vaccination coverage rates for First Nations children aged 1, 2 and 5 years. Vaccination is highly effective in reducing illness and death caused by vaccine-preventable diseases. Vaccinations have been effective in reducing the disease disparities between First Nations and other Australians (Menzies and Singleton 2009).

Key findings

Overall: At 31 December 2022 in Queensland, 90% of First Nations children were fully immunised at age 1, 89% were fully immunised at age 2, and 96% were fully immunised at age 5. For other Queensland children, 94% were fully immunised at age 1, 92% were fully immunised at age 2, and 93% were fully immunised at age 5.

Nationally at 31 December 2022, 91% of First Nations children were fully immunised at age 1, 89% were fully immunised at age 2, and 96% were fully immunised at age 5. For other Australian children, 94% were fully immunised at age 1, 92% were fully immunised at age 2, and 94% were fully immunised at age 5 (Figure 3.02.1, Figure 3.02.2, Figure 3.02.3).

At age 1: In Queensland at 31 December 2022, for First Nations children aged 1 year, the vaccination rates for diphtheria, tetanus, pertussis (DTP), polio and *Haemophilus influenzae* type b (HIB) were all 90%, for hepatitis B it was 91%, and for pneumococcal it was 96%. For other Queensland children aged 1 year, the vaccination rates for hepatitis B, DTP, polio and HIB were all 94%, and 95% for pneumococcal.

Nationally at 31 December 2022, coverage for DTP, polio, and HIB for First Nations children aged 1 year was 91%, 92% for hepatitis B and 96% for pneumococcal. For other Australian children aged 1 year the coverage for DTP, polio, and HIB was 94%, 95% for hepatitis B and 96% for pneumococcal (Figure 3.02.1).

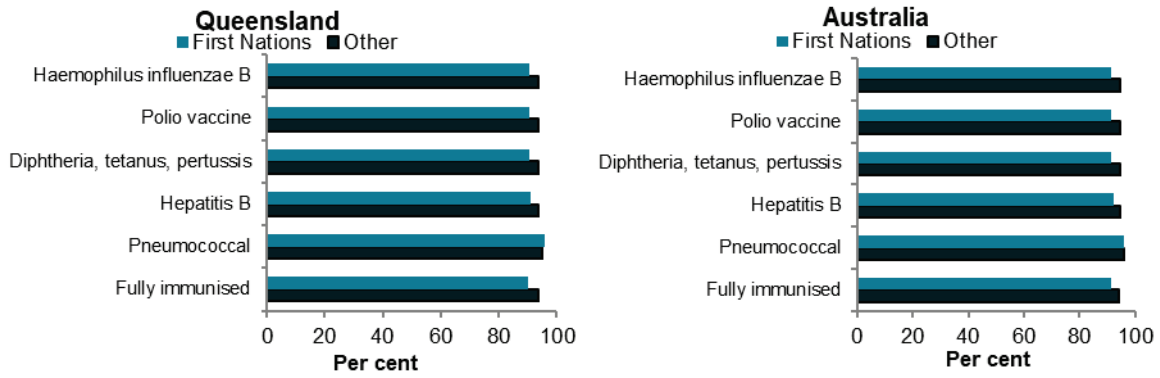
At age 2: In Queensland at 31 December 2022, for children aged 2, the vaccination rates for hepatitis B, polio and pneumococcal were higher for First Nations children (97% for hepatitis B and polio, and 96% for pneumococcal) than for other children (96% for hepatitis B and polio, and 95% for pneumococcal). For DTP, HIB, measles, mumps, and rubella (MMR) and varicella, the rates for were lower for First Nations children (91% for DTP and MMR, 92% for varicella and 93% for HIB) than for other children (94% for HIB and 93% for DTP, MMR and varicella).

Nationally at 31 December 2022, the vaccination coverage for First Nations children at age 2 for DTP was 90%, 91% for MMR and varicella, 93% for HIB, 96% for meningococcal C and pneumococcal, and 97% for hepatitis B and polio. For other Australian children at age 2 the vaccination coverage for DTP and MMR was 93%, 94% for varicella and HIB, 95% for pneumococcal, 96% for hepatitis B, meningococcal C and polio (Figure 3.02.2).

At age 5: In Queensland at 31 December 2022, for children aged 5, the vaccination rates for DTP and polio were 96% for First Nations children and 93% for other Queensland children.

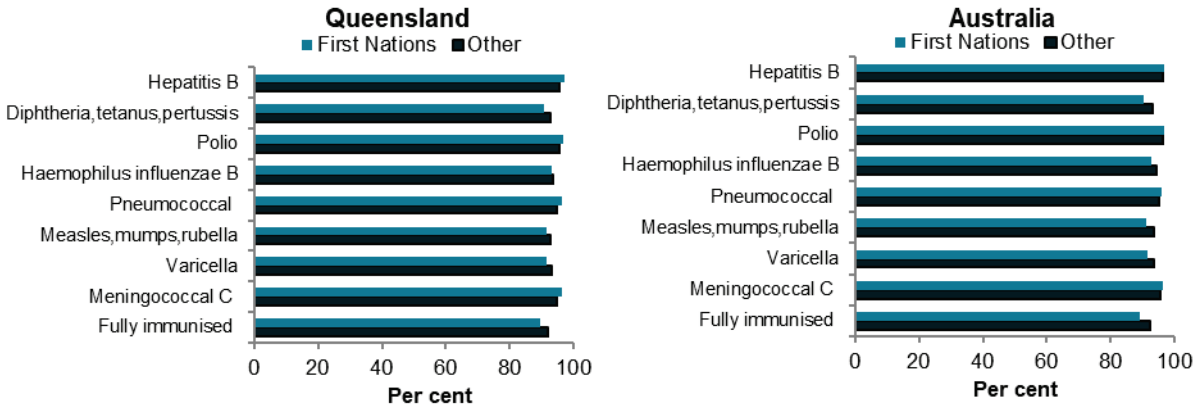
Nationally, coverage for DTP and polio was 96% for First Nations children and 94% for other Australian children (Figure 3.02.3).

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



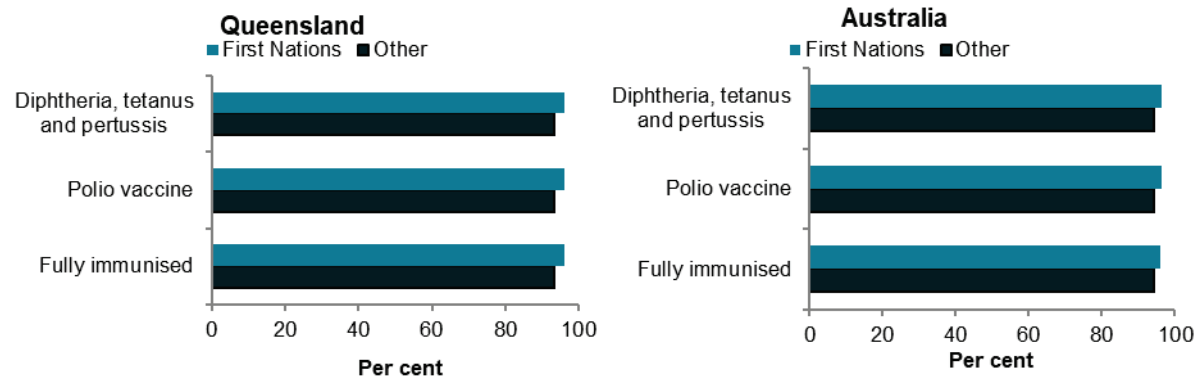
Source: Table D3.02.2.

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



Source: Table D3.02.4.

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

3.03 Health promotion

Why it is important

This measure reports on GP or specialist consultations for First Nations people, including health issues discussed and health promotion programs and activities provided by Indigenous primary health care organisations. First Nations people currently experience higher levels of illness and death from potentially avoidable conditions than other Australians (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 (for example, packaging of cigarettes, seat belt laws); information to support healthy lifestyles (for example, smoking, alcohol and drug use, physical activity and diet); social marketing (for example, sunscreen use); and mass media campaigns (for example, drink-driving, road safety) (WHO 2008).

Key findings

Consulted a GP or specialist: In Queensland in 2018–19, 88% of First Nations people aged 15 and over reported they had consulted a doctor or specialist in the previous 12 months.

Nationally in 2018–19, 86% of First Nations people aged 15 and over reported they had consulted a doctor or specialist in the previous 12 months (Figure 3.03.1).

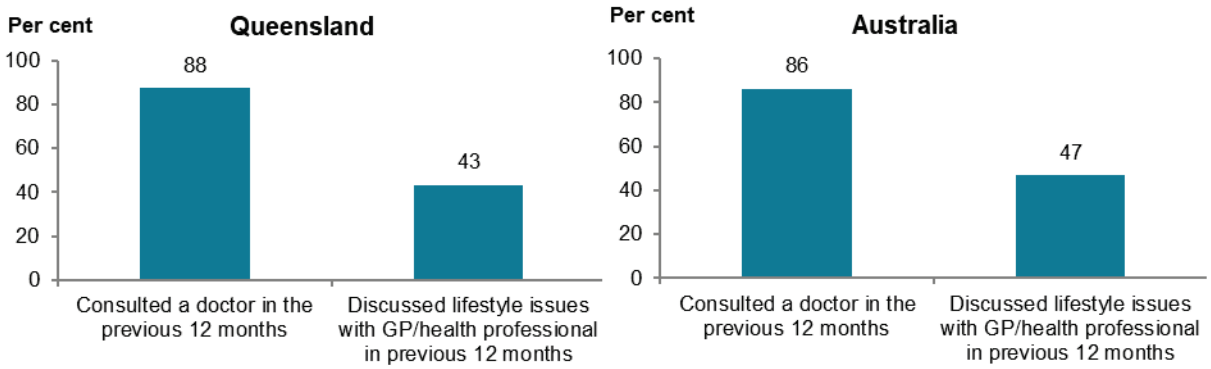
Lifestyle issues discussed: In Queensland in 2018–19, 43% of First Nations people aged 15 and over discussed lifestyle issues with a GP or health professional (Figure 3.03.1). The most common issues discussed were reaching a healthy weight (50%) and eating healthy food or improving their diet (42%). The least common issues were family planning (7.4%) and drug use (7.0%, note this estimate has a relative standard error between 25% and 50% and should be used with caution) (Figure 3.03.2).

Nationally in 2018–19, 47% of First Nations people aged 15 and over discussed lifestyle issues with a GP or health professional (Figure 3.03.1). The most common issues discussed were reaching a healthy weight (48%) and eating healthy food or improving their diet (42%) and the least common issues were family planning (8.2%) and drug use (7.6%) (Figure 3.03.2).

Health promotion programs and activities: In Queensland, between July 2017 and June 2018, the most common type of health promotion activities and programs provided by Indigenous primary health-care organisations were physical activity or healthy weight program activities (79%), women's groups (76%), men's groups (72%), and chronic disease client support groups (72%).

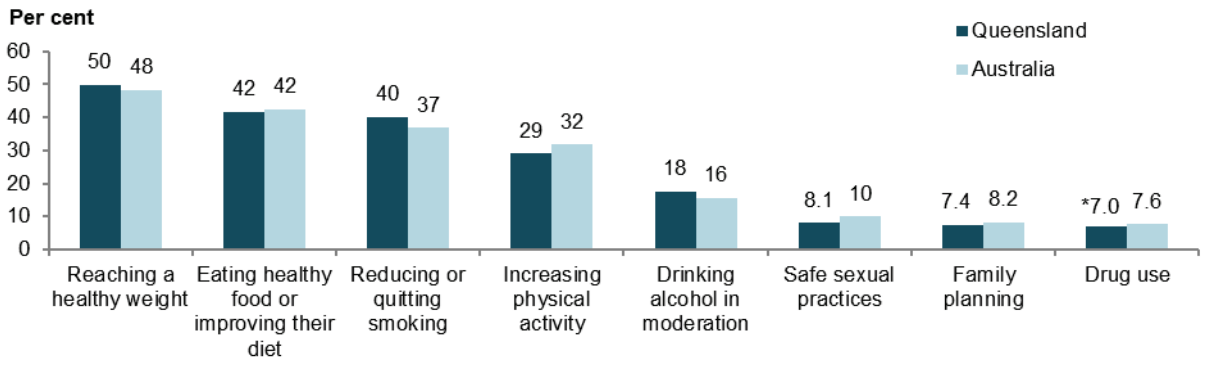
Nationally, between July 2017 and June 2018, the most common type of health promotion activities and programs provided by Indigenous primary health-care organisations were men's groups (71%), women's groups (70%), physical activity or healthy weight program activities (70%), and living skills groups, such as cooking or nutrition groups (66%) (Figure 3.03.3).

Figure 3.03.1: First Nations people aged 15 and over who consulted a doctor, and who discussed lifestyle with a GP or health professional, Queensland and Australia, 2018–19



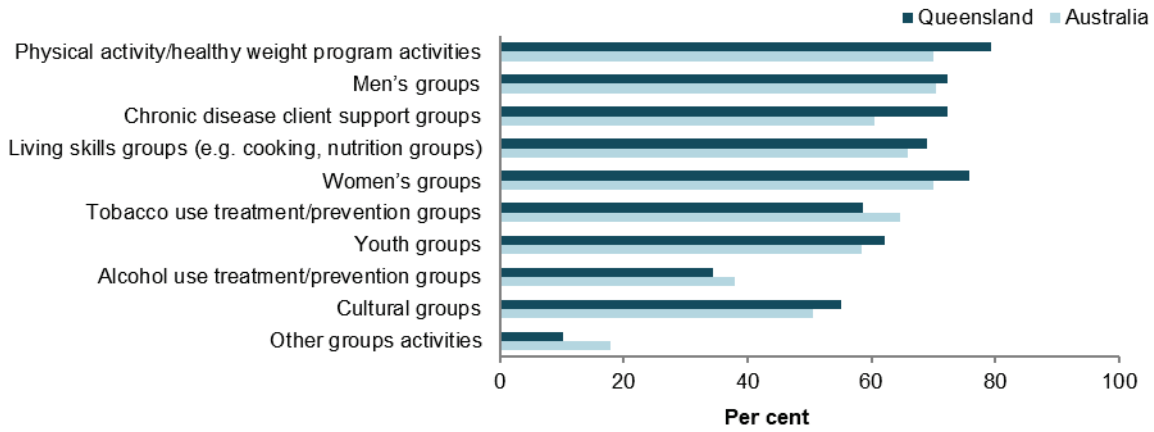
Source: Table D3.03.4.

Figure 3.03.2: Type of lifestyle issues discussed with a GP or health professional in the last 12 months (multiple responses allowed), by First Nations people aged 15 and over, Queensland and Australia, 2018–19



Source: Table D3.03.4.

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



Source: Table D3.03.10.

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

3.04 Early detection and early treatment

Why it is important

This measure reports on the early detection and early treatment of disease for First Nations 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 First Nations 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

Health checks: In 2023 in Queensland, 89,471 health checks were provided to First Nations people (an uptake of 34%). The uptake of health checks was highest among people aged 50 and over (46% received a health check) and lowest among people aged 15–24 (28%).

Nationally in 2023, 257,105 health checks were provided to First Nations people (an uptake of 28%). The uptake of health checks was highest among people aged 50 and over (39% received a health check) and lowest among people aged 15–24 (23%) (Figure 3.04.1).

Breast cancer screening: In 2019–2020 in Queensland, the age-standardised participation rate for First Nations women aged 50–74 was 44%, compared with 52% for other Queensland women.

In 2019–2020 nationally, the age-standardised participation rate for First Nations women aged 50–74 was 36%, compared with 49% for other Australian women (Figure 3.04.2).

Pap smear test: In 2018–19 in Queensland, 69% of First Nations women aged 20–69 reported they had regular pap smear tests.

Nationally in 2018–19, 68% of First Nations women aged 20–69 reported they had regular pap smear tests (Table D3.04.13).

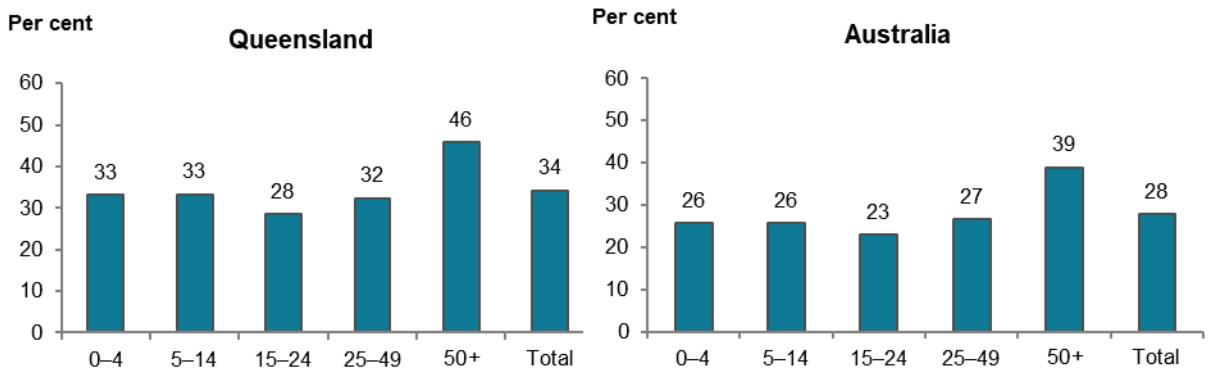
Bowel cancer screening: In 2018–19 in Queensland, 20% of First Nations males and 14% of First Nations females aged 50–74 reported they had participated in bowel cancer screening tests (note that female estimates have a relative standard error between 25% and 50% and should be interpreted with caution).

Nationally in 2018–19, 23% of First Nations males and 20% of First Nations females aged 50–74 reported they had participated in bowel cancer screening tests (Table D3.04.17).

Trend in health checks over time: In Queensland between 2014 and 2023, the uptake of First Nations-specific health checks increased from 27% to 34%. People aged 50 and over had the highest uptake of health checks in all years, with uptake in this age group increasing from 35% in 2014 to 46% in 2023.

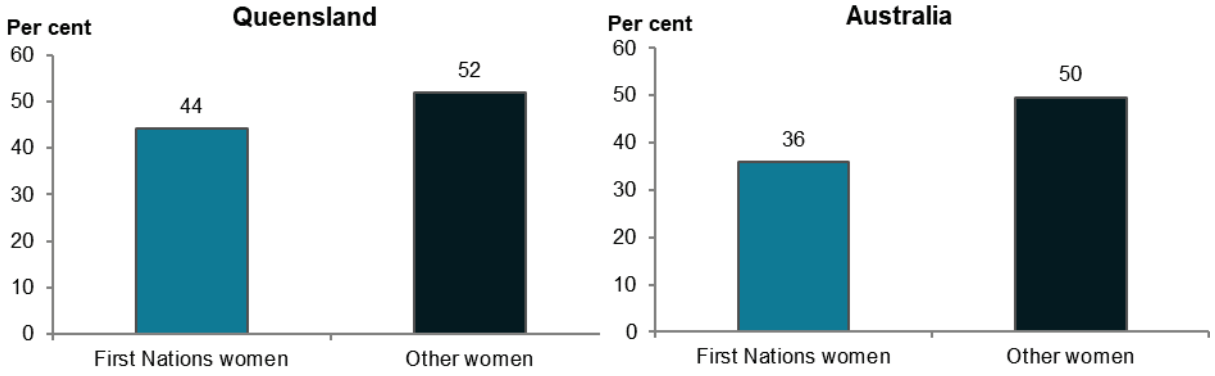
Nationally, the uptake of First Nations-specific health checks increased from 21% to 28% between 2014 and 2023 (Figure 3.04.3).

Figure 3.04.1: Health check uptake within the previous 12 months (%), First Nations people, by age group, Queensland and Australia, December 2023



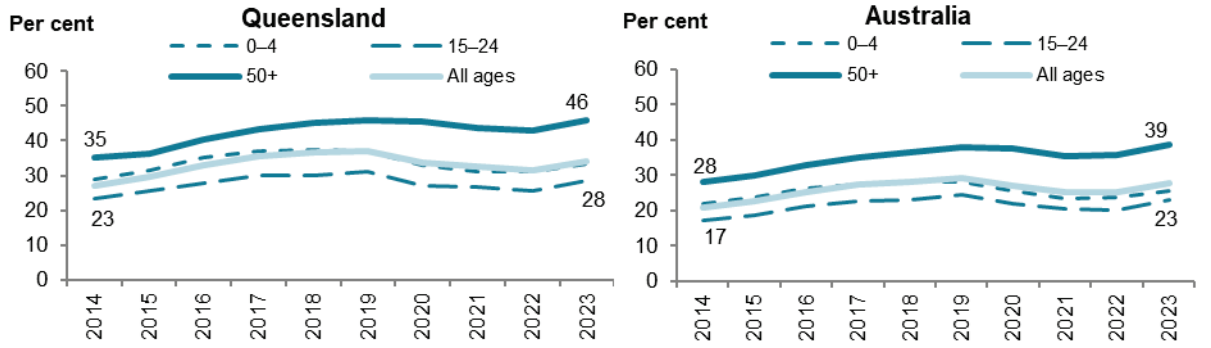
Source: AIHW 2024, Table E2.

Figure 3.04.2: Age-standardised participation rates in BreastScreen Australia programs for women aged 50 to 74, by Indigenous status, Queensland and Australia, 2019–2020



Source: Table D3.04.9.

Figure 3.04.3: Health check uptake within the previous 12 months (%), First Nations people, by selected age groups, Queensland and Australia, December 2014 to 2023



Source: AIHW 2024, Table E2.

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

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 First Nations people and are estimated to be responsible for 70% of the health gap between First Nations people and other Australians (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 (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 First Nations people and other Australians within a generation.

Key findings

Medicare Benefits Schedule (MBS): The Medicare Benefits Schedule (MBS) includes items for general practitioner management plans (GPMPs) and team care arrangements (TCAs) to support a structured approach to the management of patients with chronic or terminal conditions.

In Queensland in 2022–23, for First Nations people, there were 26,100 MBS claims for the preparation of GPMPs and 22,500 for coordination of TCAs (Table D3.05.01). In 2022–23 the age-standardised MBS claim rate for First Nations patients for GPMPs/TCAs was 1.3 times the rate for other patients in Queensland. Whereas the age-standardised claim rate for other Queensland patients accessing specialists was 2.2 times the rate for First Nations patients (Figure 3.05.1).

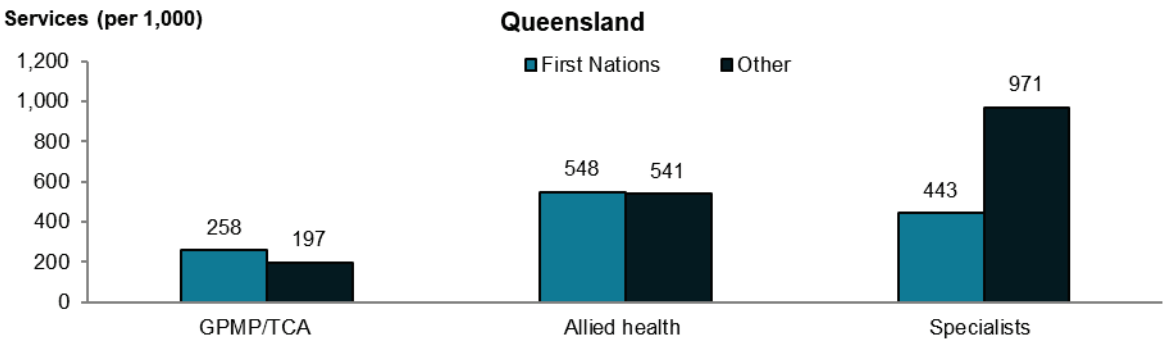
Blood tests and foot checks: In 2018–19 in non-remote areas of Queensland, of those with current and long-term diabetes or high sugar levels, 79% of First Nations adults reported having undergone HbA1c testing in the previous 12 months compared with 82% of other adults. Of those in all areas (non-remote and remote) with current and long-term diabetes or high sugar levels, blood glucose levels had been checked for 93% of First Nations adults in the previous 12 months compared with 97% for other adults; and foot checks had been completed for 80% of First Nations adults compared with 78% of other adults (Figure 3.05.2).

Nationally in non-remote areas in 2018–19, 73% of First Nations adults with current and long-term diabetes or high sugar levels reported having undergone HbA1c testing in the previous 12 months, compared with 75% of other adults. Of those in all areas (non-remote and remote*)* with current and long-term diabetes or high sugar levels*,* blood glucose levels had been checked for 93% of First Nations adults in the previous 12 months, compared with 95% for other adults; and foot checks had been completed for 77% of First Nations adults, compared with 74% of other adults (Figure 3.05.2).

Health actions taken: In Queensland in 2018–19, First Nations people reported that actions they 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 (84%); taking medicine or tablets (71%); and using insulin (26%) (Figure 3.05.3).

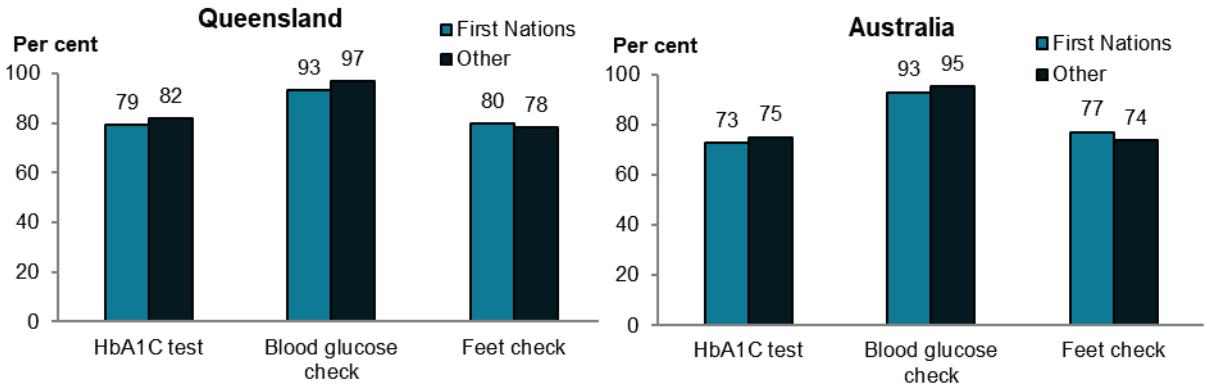
Nationally in 2018–19, First Nations people reported that actions they had taken to manage current and long-term diabetes or high sugar levels included: a lifestyle action such as diet, weight loss or exercise (75%); taking medicine or tablets (68%); and using insulin (26%) (Figure 3.05.3).

Figure 3.05.1: VII adjusted, age-standardised rate of selected MBS services claimed, by Indigenous status, Queensland, 2022–23



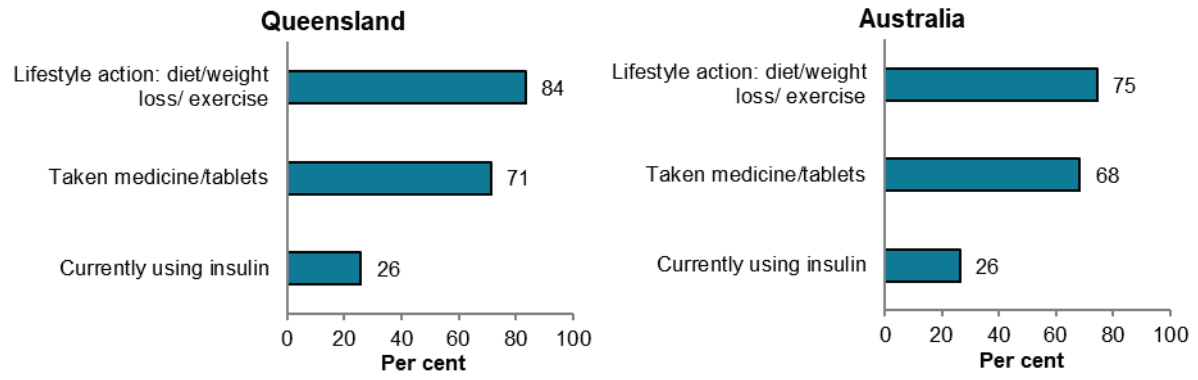
Source: Table D3.14.23.

Figure 3.05.2: People with diagnosed, current and long-term diabetes or high sugar levels who had an HbA1c test (non-remote areas only), blood glucose check, or feet check in the previous 12 months, by Indigenous status, Queensland and Australia, 2017–18 (other Queenslanders/Australians) and 2018–19 (First Nations)



Source: Table D3.05.13.

Figure 3.05.3: Actions taken by First Nations people to manage diabetes or high sugar levels in previous 2 weeks, Queensland and Australia, 2018–19



Source: Table D3.05.13.

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

3.06 Access to hospital procedures

Why it is important

This measure reports on hospitalisations with a procedure recorded for First Nations 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 2022c). Studies have shown that while First Nations 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 and AIHW 2008; Cunningham 2002). Significant factors associated with the likelihood of receiving a procedure when admitted to hospital include: whether the hospital was public or private; the principal diagnosis for which a person was admitted; the number of additional diagnoses; state/territory of usual residence; age group; remoteness of usual residence; and sex (AIHW 2024d). However, these factors do not fully explain the disparities between First Nations people and other Australians (Cunningham 2002).

Key findings

Overall: In Queensland between July 2019 and June 2021, 64% of hospitalisations (excluding dialysis) for First Nations people had a procedure recorded. Nationally, 66% of hospitalisations for First Nations people had a procedure recorded (Table D3.06.1).

Based on age-standardised proportions, First Nations people in Queensland were less likely to have a procedure recorded than other Queenslanders (difference of 11 percentage points). Nationally, First Nations people were less likely to have a procedure recorded than other Australians (difference of 12 percentage points) (Figure 3.06.1).

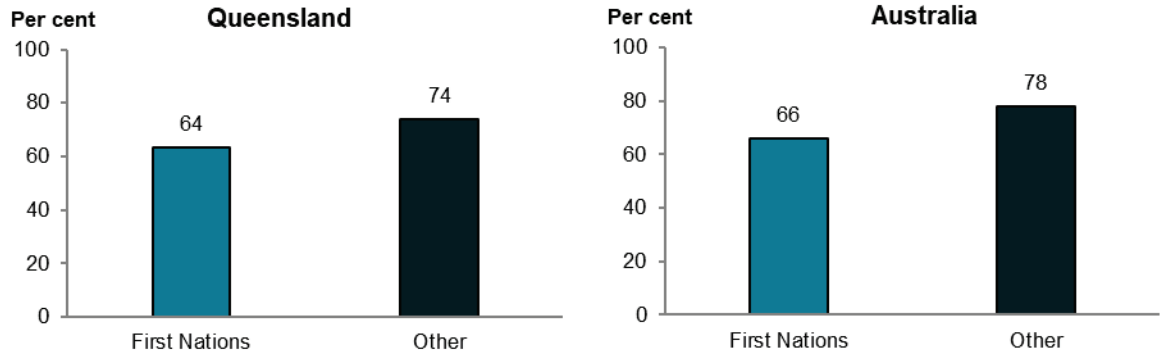
Procedures by age: Nationally between July 2019 and June 2021, the proportion of hospitalisations for First Nations people where a procedure was recorded generally increased with age – ranging from 56% for infants under 1, to 79% for those aged 65 and over. Across all age groups, hospitalisations for First Nations people were less likely to include a procedure than hospitalisations for other Australians (Table D3.06.1).

Main diagnosis: In Queensland between July 2019 and June 2021, the proportion of hospitalisations for First Nations people that included at least one procedure was highest for hospitalisations with a principal diagnosis of diseases of the blood (94%), followed by cancer (neoplasms) (93%) and diseases of the eye (93%).

Nationally, between July 2019 and June 2021, the proportion of hospitalisations for First Nations people where a procedure was recorded was highest for cancer (neoplasms) (94%) followed by diseases of the eye (93%) and diseases of the blood (92%) (Figure 3.06.2).

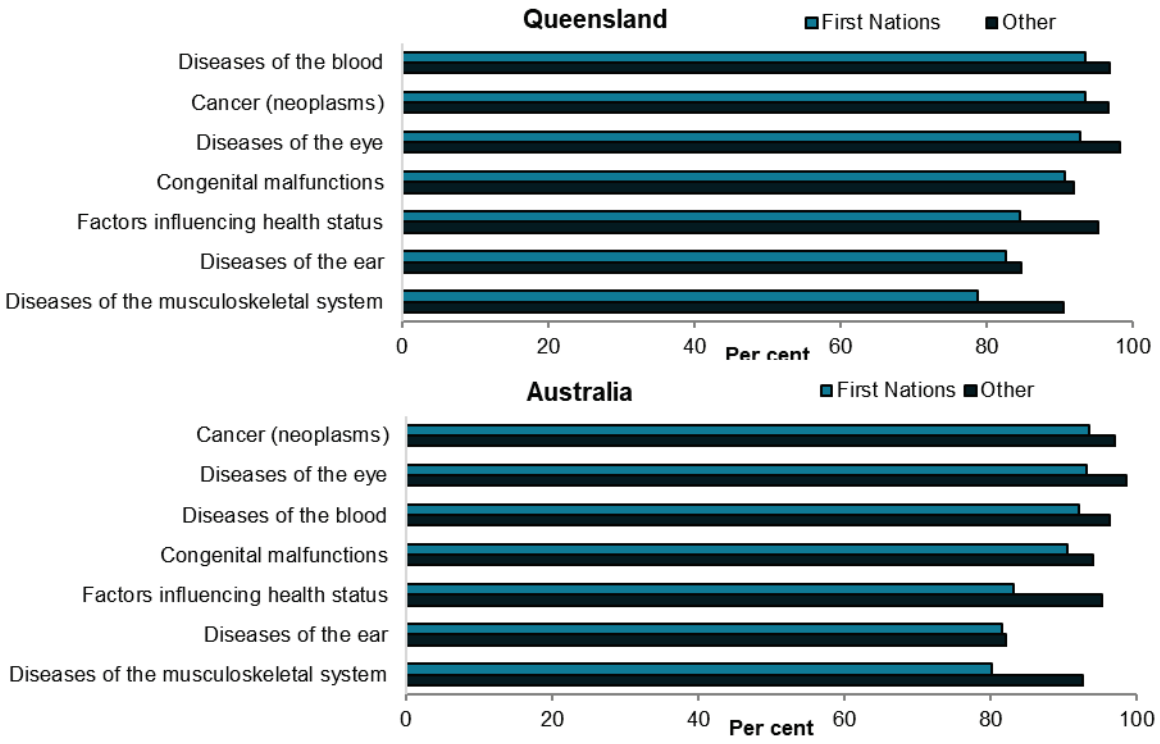
Trend over time: Nationally, between 2011–12 and 2020–21, there was a 19% increase in the age-standardised proportion of hospitalisations for First Nations people where a procedure was recorded, and a 2% increase for other Australians, resulting in a decrease in the gap between First Nations people and other Australians (Table D3.06.11).

Figure 3.06.1: Age-standardised proportion of hospitalisations with a procedure recorded, by Indigenous status, Queensland and Australia, July 2019 to June 2021



Source: Table D3.06.1.

Figure 3.06.2: Proportion of hospitalisations with a procedure recorded, by selected principal diagnosis and Indigenous status, Queensland and Australia, July 2019 to June 2021



Source: Table D3.06.2 Qld.

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

3.07 Selected potentially preventable hospital admissions

Why it is important

This measure reports on the number of Potentially Preventable Hospitalisations (PPH) for First Nations people. PPH are hospitalisations for conditions that could potentially have been prevented through provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings. This is a key measure of the performance of the health system, in particular, it serves as a proxy measure of access to timely, effective and appropriate primary and community-based care (AIHW 2020c). Systematic differences in hospitalisation rates for First Nations people and other Australians can indicate gaps in the provision of population health interventions (such as immunisation), primary care services (such as early interventions to detect and treat chronic disease), and continuing care support (such as care planning for people with chronic illnesses, for example congestive heart failure).

Key findings

Overall: In Queensland from July 2019 to June 2021, there were 27,185 hospitalisations for First Nations people that were potentially preventable. The PPH rate was higher for First Nations females than males (62 and 50 hospitalisations per 1,000, respectively) (Table D3.07.2). After adjusting for differences in the age structure between the two populations, First Nations people in Queensland were hospitalised for potentially preventable conditions at a rate 2.7 times that for other Queenslanders (Table D3.07.2).

Nationally, from July 2019 to June 2021, the PPH rate was higher for First Nations females than males (59 and 47 hospitalisations per 1,000, respectively). The PPH rate for First Nations people was 3.0 times the rate for other Australians (Table D3.07.1).

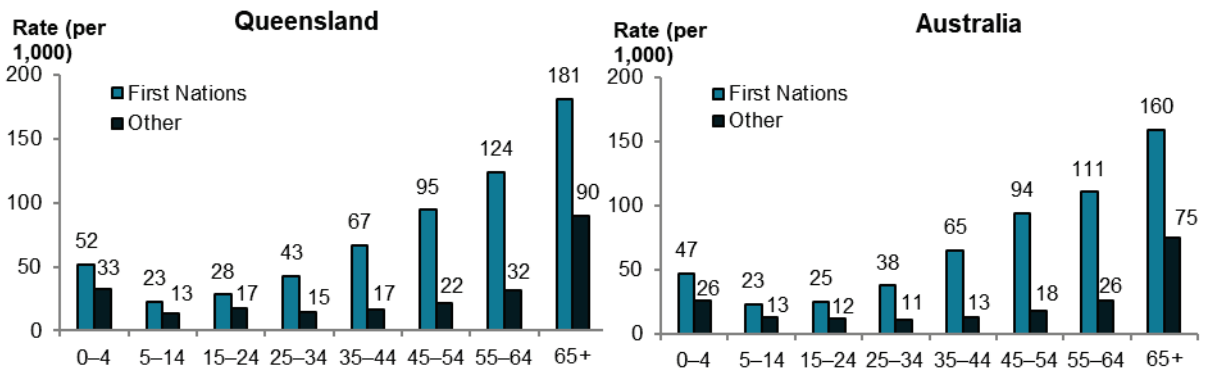
By age: For First Nations people in Queensland, the PPH rate was lowest for those aged 5–14 and increased with age (Figure 3.07.1). The PPH rate was higher for First Nations than other Queenslanders across all age groups, with the largest relative difference in the 45–54 age group (rate ratio of 4.4) (Table D3.07.1 Qld).

Nationally, the PPH rate was higher for First Nations people than for other Australians across all age groups, with the largest relative difference in the 45–54 age group (rate ratio of 5.4) (Figure 3.07.1).

Leading causes of PPH: Between July 2019 and June 2021, the 5 leading causes of PPH among First Nations people in Queensland were: cellulitis; urinary tract infections; diabetes complications; convulsions and epilepsy; and chronic obstructive pulmonary disease (COPD) (Table D3.07.5 Qld, Figure 3.07.2). First Nations people had higher age-standardised PPH rates than other Queenslanders for all 5 causes, with the greatest relative difference for COPD (rate ratio 4.5) (Figure 3.07.3).

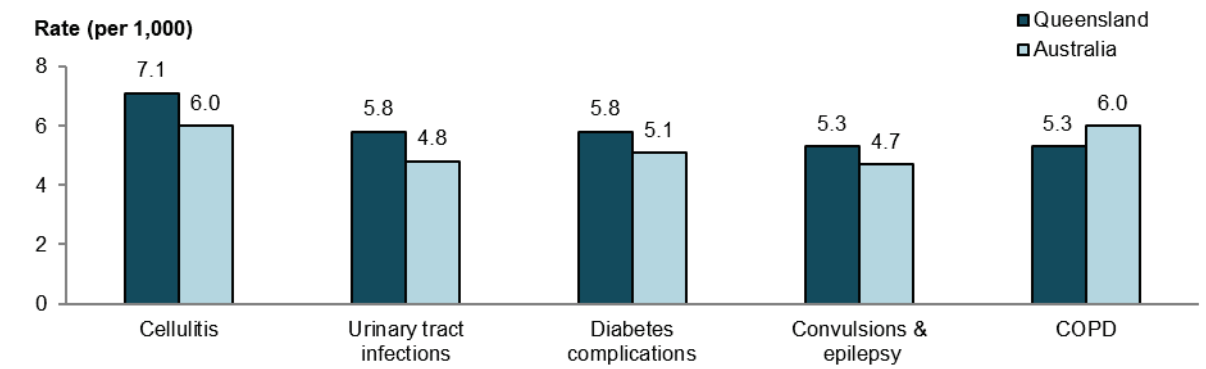
Nationally, between July 2019 and June 2021, the 5 leading causes of PPH among First Nations people were cellulitis, COPD, diabetes complications, dental conditions, and urinary tract infections. First Nations people had higher age-standardised PPH rates than other Australians for all 5 causes, with the greatest relative difference for COPD (rate ratio 6.0) (Table D3.07.5). Nationally, convulsions and epilepsy was the 6th leading cause of PPH among First Nations people. First Nations people were 3.7 times as likely as other Australians to be hospitalised for convulsions and epilepsy (Table D3.07.5).

Figure 3.07.1: Age-specific hospitalisation rates for potentially preventable hospitalisations, by Indigenous status, Queensland and Australia, July 2019 to June 2021



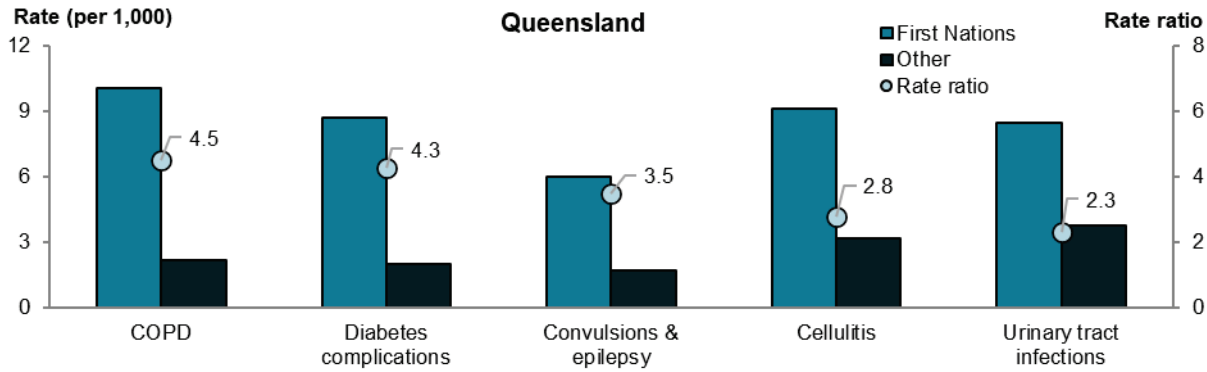
Source: Table D3.07.1 Qld.

Figure 3.07.2: Crude rates for top 5 potentially preventable hospitalisations among First Nations people, Queensland and Australia, July 2019 to June 2021



Source: Table D3.07.5 Qld and D3.07.5.

Figure 3.07.3: Rate ratios and age-standardised rates for top 5 potentially preventable hospitalisations among First Nations people in Queensland, by Indigenous status, July 2019 to June 2021



Source: Tables D3.07.5 Qld.

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

3.08 Cultural competency

Why it is important

This measure presents self-reported data from First Nations 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 First Nations people. Improving the cultural competency of health care service providers can increase the access to health care for First Nations 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 First Nations people (Clifford et al. 2015; Truong et al. 2014).

Key findings

Patient experience: The 2018–19 National Aboriginal and Torres Strait Islander Health Survey showed that 76% (73,500) of First Nations people aged 15 and over in non-remote areas of Queensland gave excellent or very good as the overall rating of the health care they received in the last 12 months (Table D3.08.7).

In 2018–19 in Queensland, around 9 in 10 First Nations people who had seen a doctor in the last 12 months reported that their general practitioner (GP) always/usually listened carefully to them (88%), explained things in a way that could be understood (87%), showed respect for what was said (91%), and spent enough time with them (90%).

These findings were consistent with the national results for First Nations people aged 15 and over in non-remote areas (Figure 3.08.1).

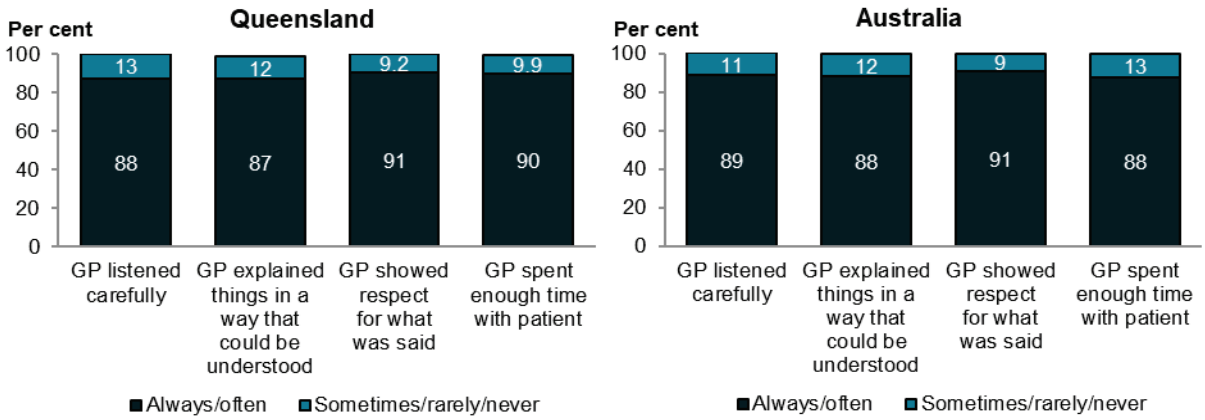
Did not access health care when needed to: In Queensland in 2018–19, 29% (65,600) of First Nations people reported that they did not access health care when they needed to in the past 12 months. The dentist was the most common service not accessed when needed (20%), with cost the most common reason given for not accessing the service (33%).

Nationally in 2018–19, 30% of First Nations 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 (19%), with cost the most common reason given for not accessing the service (42%) (Figure 3.08.2, Table 3.08.4).

Cultural barriers to accessing health care: In 2018-19 in Queensland, of the First Nations people who did not access health care when needed, 29% reported the reason related to cultural appropriateness of service (dislikes service/professional, embarrassed, afraid; felt it would be inadequate; does not trust service/provider; discrimination/not culturally appropriate/language problems). Other reasons First Nations people in Queensland reported were cost (29%), logistical reasons (32%) and personal reasons (56%). Reasons do not total 100% as more than one response was allowed.

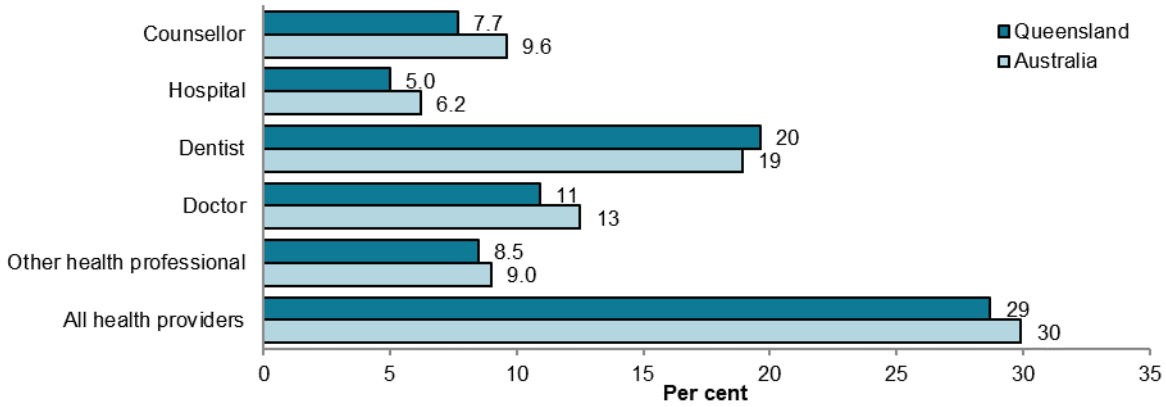
Nationally in 2018–19, almost one-third (32%) of First Nations people who did not access health care when needed reported reasons relating to the cultural appropriateness of the service (Figure 3.08.3).

Figure 3.08.1: Patient experience in the last 12 months, First Nations people aged 15 and over (non-remote areas), Queensland and Australia, 2018–19



Source: Table D3.08.7.

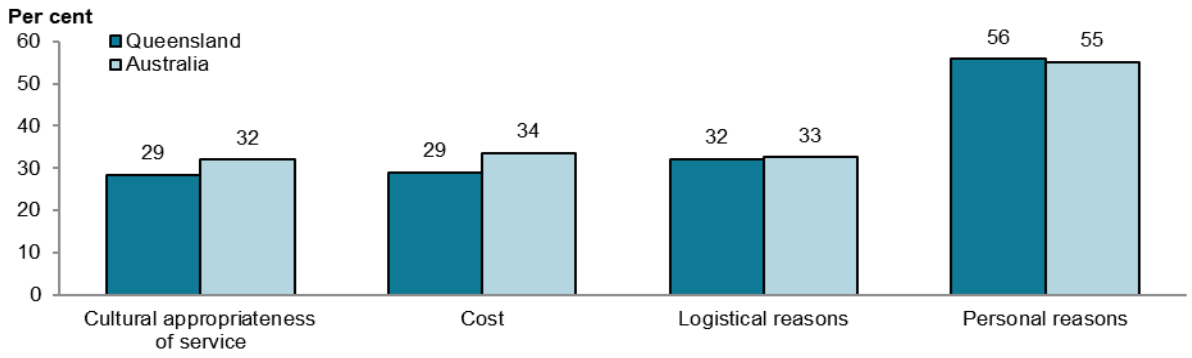
Figure 3.08.2: Proportion of First Nations people not accessing a health provider when needed, by health provider type, Queensland and Australia, 2018–19



Note: Category 'Other health professionals' include: nurse, sister, and Aboriginal (and Torres Strait Islander) Health Worker.

Source: Table D3.08.4.

Figure 3.08.3: Reasons for First Nations people not accessing health services when needed in the last 12 months, Queensland and Australia, 2018–19



Source: Table D3.08.4.

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

3.09 Self-discharge from hospital

Why it is important

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

Key findings

Hospitalisations: In Queensland between July 2019 and June 2021, there were 5,792 hospitalisations (excluding dialysis) for First Nations people that ended in self-discharge from hospital. This equated to 2.7% of all hospitalisations for First Nations people in Queensland (Table D3.09.3). After adjusting for differences in the age structure between the two populations, the age-standardised proportion for First Nations people was 3.6 times that for other Queenslanders (Figure 3.09.1).

Nationally between July 2019 and June 2021, the proportion of hospitalisations (excluding dialysis) for First Nations people that ended in self-discharge from hospital was 4.0% (Table D3.09.3). After adjusting for differences in the age structure between the two populations, the age-standardised proportion for First Nations people was 5.2 times that for other Australians (Figure 3.09.1).

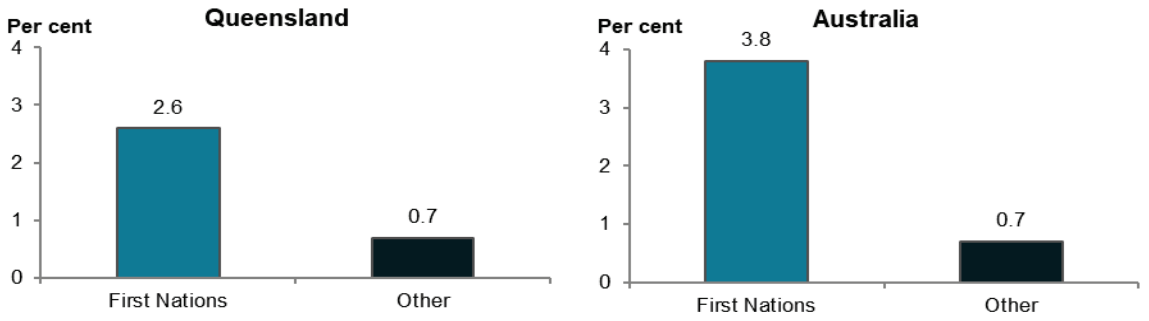
Hospitalisations by age group: In Queensland between July 2019 and June 2021, First Nations people aged 35–44 had the highest proportion of hospitalisations that ended in self-discharge from hospital (4.6%). Higher proportions of First Nations people than other Queenslanders in all age groups had a hospitalisation that ended in self-discharge from hospital.

Nationally between July 2019 and June 2021, First Nations people aged 35–44 had the highest proportion of hospitalisations that ended in self-discharge from hospital (6.8%). Higher proportions of First Nations people than other Australians in all age groups had a hospitalisation that ended in self-discharge from hospital (Figure 3.09.2).

Principal diagnosis of patients: In Queensland between July 2019 and June 2021, the highest age-standardised proportion of hospitalisations for First Nations patients that ended in discharge at own risk was for diseases of the skin and subcutaneous tissue (5.0%), injury, poisoning and certain other consequences of external causes (4.2%), and endocrine, nutritional and metabolic disorders (3.8%).

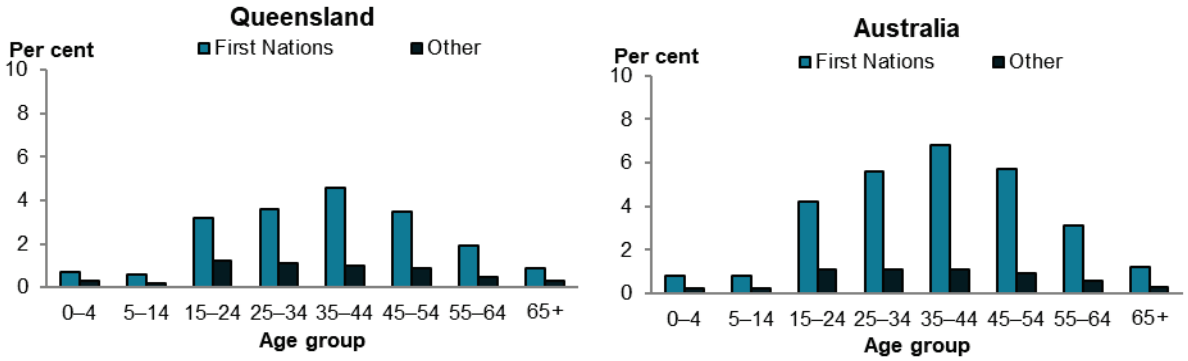
Nationally between July 2019 and June 2021, the highest age-standardised proportion of hospitalisations for First Nations patients that ended in self-discharge from hospital was for endocrine, nutritional and metabolic disorders, diseases of the skin and subcutaneous tissue (both 7.3%), and injury, poisoning and certain other consequences of external causes (6.3%) (Figure 3.09.3).

Figure 3.09.1: Age-standardised proportion of hospitalisations that ended in discharge at own risk, by Indigenous status, Queensland and Australia, July 2019 to June 2021



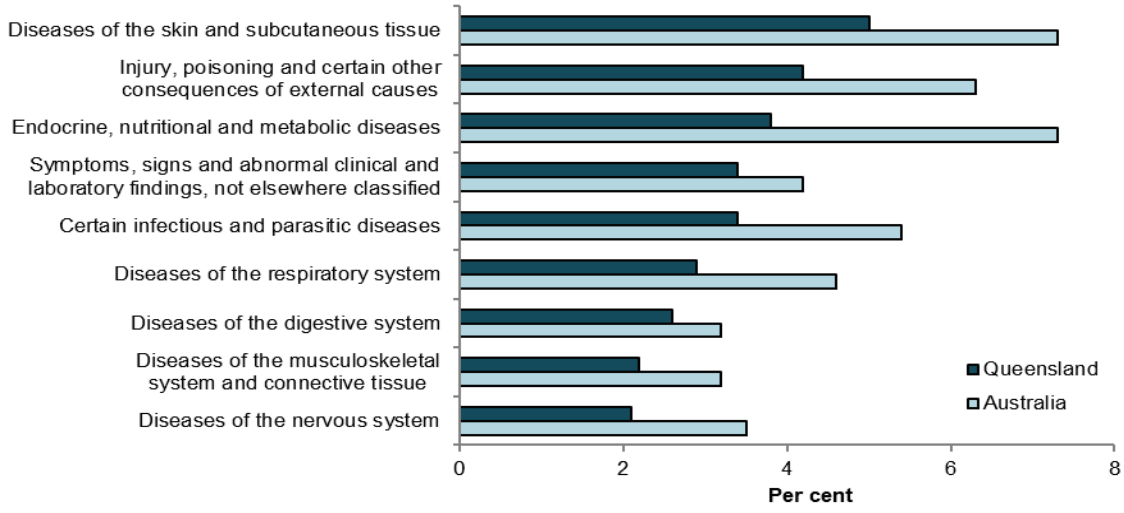
Source: Table D3.09.3.

Figure 3.09.2: Hospitalisations that ended in discharge at own risk, by age group (years) and Indigenous status, Queensland and Australia, July 2019 to June 2021



Source: Table D3.09.1 Qld.

Figure 3.09.3: Hospitalisations for First Nations people that ended in discharge at own risk, by diagnosis, Queensland and Australia, July 2019 to June 2021



Source: Table D3.09.7 Qld.

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

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 First Nations people. First Nations people experience a higher rate of mental health issues than non-Indigenous people (see measure 1.18 Social and emotional wellbeing). While First Nations people use some mental health services at higher rates than non-Indigenous people, it is difficult to assess whether this use is as high as the underlying need. Leading First Nations mental health researchers and advocates maintain that mental health care for First Nations people remains inadequate and inequitable (Dudgeon et al. 2020).

Key findings

Psychologist and psychiatric care: In 2022–23, First Nations people in Queensland claimed 34,400 psychologist services through Medicare, at a rate of 134 per 1,000 population (Table D3.10.2). After adjusting for differences in the age structure between the two populations, other Queenslanders were 1.8 times as likely as First Nations people in Queensland to have claimed a psychologist service (Figure 3.10.1).

In 2022–23, First Nations people in Queensland claimed 12,800 psychiatrist services through Medicare, at a rate of 50 per 1,000 population (Table D3.10.2). After adjusting for differences in the age structure between the two populations, other Queenslanders were 2.0 times as likely as First Nations people in Queensland to have claimed a psychiatrist service (Figure 3.10.1).

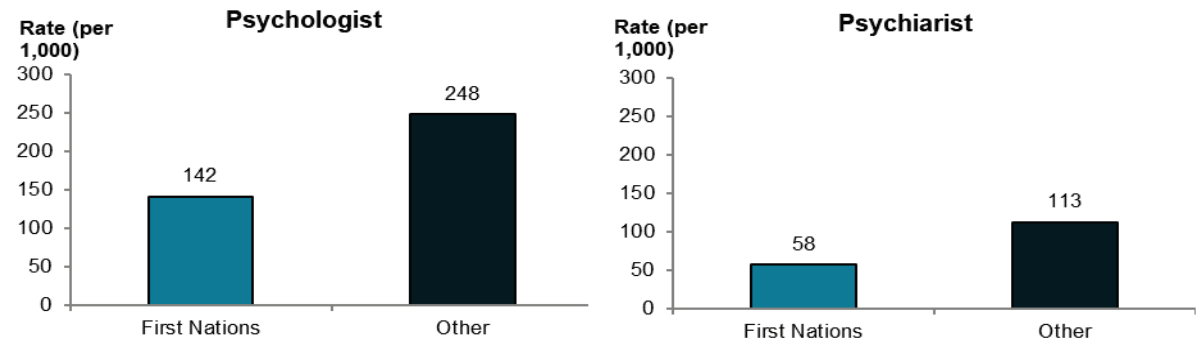
Hospitalisation for mental health-related conditions: In Queensland, from July 2019 to June 2021, there were 16,076 hospitalisations for First Nations people with a principal diagnosis of mental health-related conditions, at a rate of 33 per 1,000 population (Table D1.18.15). After adjusting for differences in the age structure between the two populations, the hospitalisation rate for mental health-related conditions among First Nations people in Queensland was 1.7 times the rate for other Queenslanders (Figure 3.10.2).

Nationally, from July 2019 to June 2021, there were 55,060 hospitalisations for First Nations people with a principal diagnosis of mental health-related conditions, at a rate of 32 per 1,000 population (Table D1.18.15). The age-standardised hospitalisation rate for mental health-related conditions among First Nations people was 2.1 times the rate for other Australians (Figure 3.10.2).

Hospitalisations over time: In Queensland between 2011–12 and 2020–21, the age-standardised hospitalisation rate for mental health-related conditions (as the principal diagnosis) for First Nations people increased by 95%. Over the same period, for other Queenslanders the age-standardised hospitalisation rate increased by 59%.

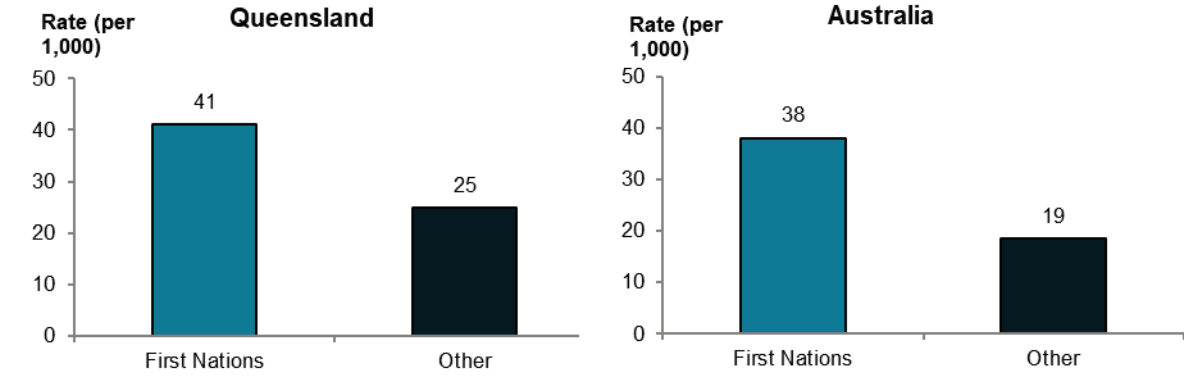
Nationally between 2011–12 and 2020–21, the age-standardised hospitalisation rate for mental health-related conditions for First Nations people increased by 57%. Over the same period, for other Australians the age-standardised hospitalisation rate increased by 32% (Figure 3.10.3).

Figure 3.10.1: VII adjusted, age-standardised rate of MBS services claimed, psychologists and psychiatrists, by Indigenous status, Queensland, 2022–23



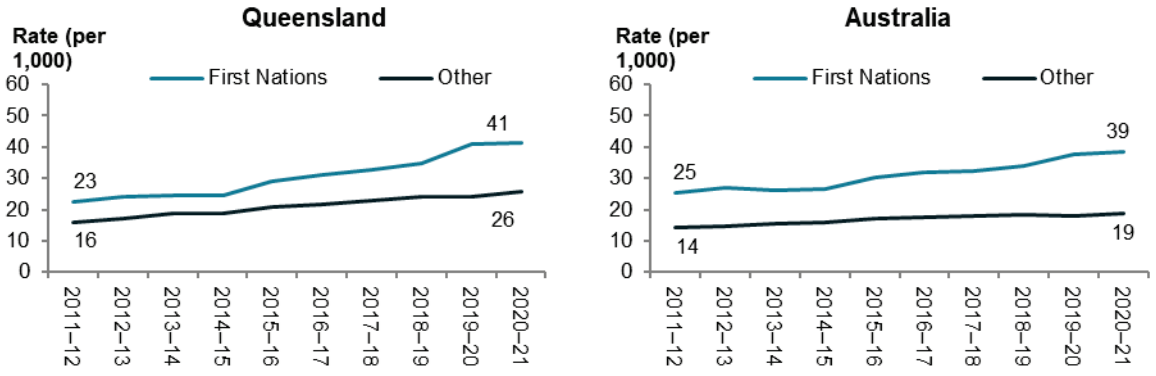
Source: Table D3.10.2.

Figure 3.10.2: Age-standardised rate of hospitalisations for mental health-related conditions (based on principal diagnosis), by Indigenous status, Queensland and Australia, July 2019 to June 2021



Source: Table D1.18.15.

Figure 3.10.3: Age-standardised hospitalisation rate for mental health-related conditions (based on principal diagnosis), by Indigenous status, Queensland and Australia, 2011–12 to 2020–21



Source: Table D1.18.20 Qld.

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

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

Alcohol and other drug (AOD) treatment services: In 2022–23, 179 publicly funded AOD treatment agencies in Queensland provided 53,280 treatment episodes to 36,331 clients. In Queensland, 19% of all clients of AOD treatment agencies identified as First Nations people, which is consistent with the national proportion (18%) (AIHW 2024e).

Of the 9,918 treatment episodes for First Nations clients in Queensland in 2022–23, over half (57%) were provided to clients aged 20–39, which was similar to the national proportion (60%) (Figure 3.11.1).

In Queensland between 2013–14 and 2022–23, the number of treatment episodes increased by 62% for First Nations clients and 51% for other clients. Nationally over the same period, treatment episodes increased by 65% for First Nations clients and by 28% for other clients (Figure 3.11.2).

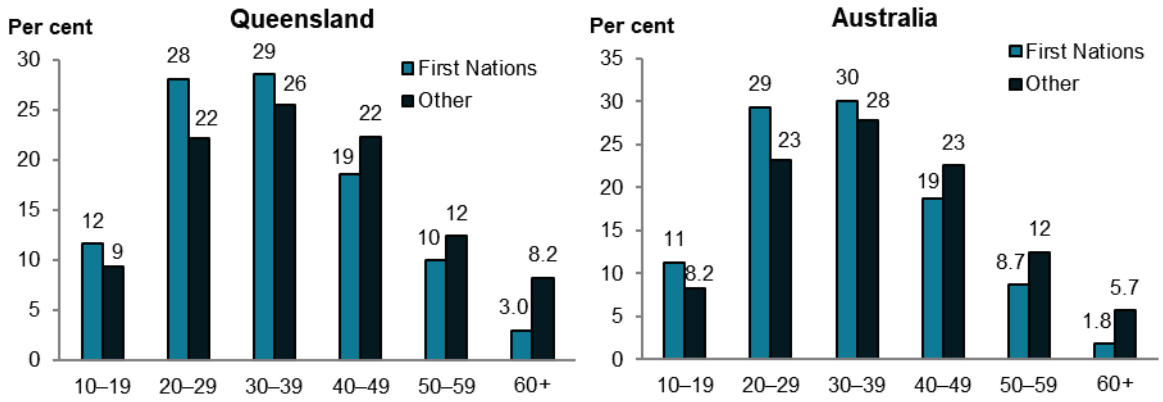
Drugs of concern: People may seek AOD treatment services for use of one or several substances (including alcohol). The principal drug of concern is the main substance that the client stated led them to seek treatment. In Queensland in 2022–23, alcohol was the most common principal drug of concern (38%) for First Nations clients, followed by cannabis (25%) and amphetamines (22%) (AIHW 2024e).

Type of AOD treatment services: In Queensland in 2022–23, counselling was reported as a main treatment type for around half of First Nations (38%) and other clients (44%) receiving help for their own alcohol or drug use. Assessment only was the second most reported type of main treatment type for both First Nations (35%) and other clients (37%) in 2022–23 (Figure 3.11.3). Although all service providers would normally include an assessment component in all treatment types, assessment only episodes are those for which only an assessment has been provided to the client. Assessment interventions aim to reduce immediate or short-term harms; engage and support people; and refer people into treatment.

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.

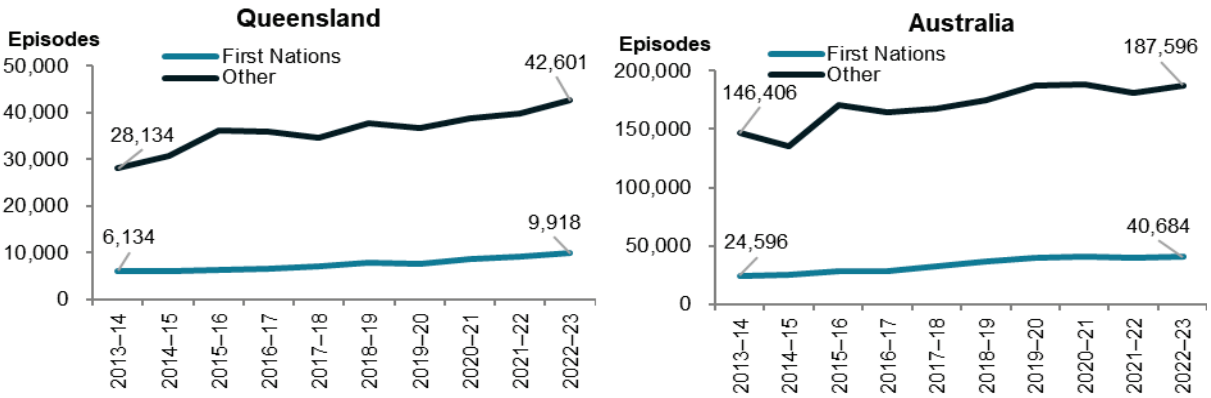
On a snapshot day in June 2023, 915 First Nations people were receiving pharmacotherapy treatment for their opioid dependence in Queensland. The rate of First Nations pharmacotherapy clients in Queensland was lower than the national rate (35 and 81 clients per 10,000 First Nations people, respectively) (AIHW 2024f).

Figure 3.11.1: Closed treatment episodes for alcohol and other drug treatment, by Indigenous status and age group, Queensland and Australia, 2022–23



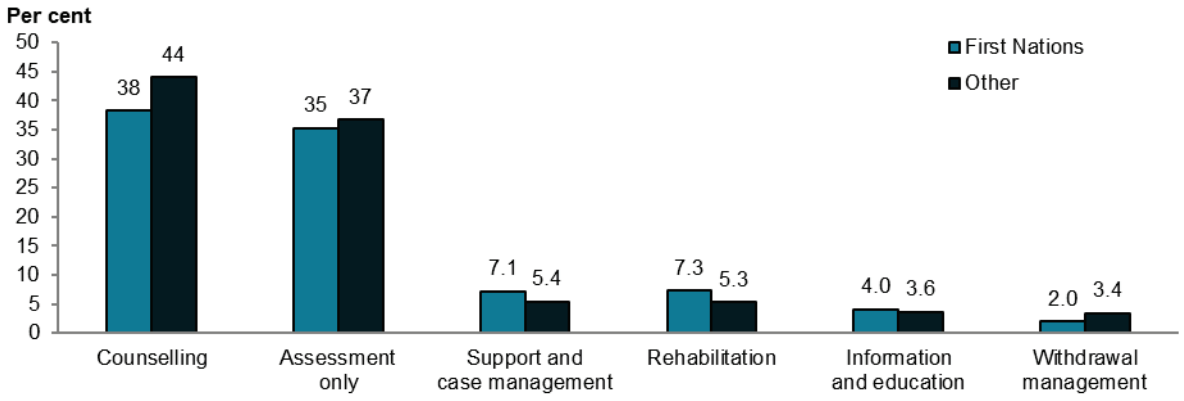
Source: Alcohol and Other Drug Treatment Services National Minimum Data Set data cubes 2013–14 to 2022–23.

Figure 3.11.2: Number of closed treatment episodes for alcohol and other drug treatment, by Indigenous status, Queensland and Australia, 2013–14 to 2022–23



Source: Alcohol and Other Drug Treatment Services National Minimum Data Set data cubes 2013–14 to 2022–23.

Figure 3.11.3: Alcohol and drug treatment clients by selected main treatment type for own drug use, by Indigenous status, Queensland, 2022–23



Source: AIHW 2024e.

Tables referenced, and data sources and quality: see Aboriginal and Torres Strait Islander Health Performance Framework (HPF).

3.12 Aboriginal and Torres Strait Islander people in the health workforce

Why it is important

This measure reports on First Nations people employed in the health workforce. First Nations people are significantly under-represented in the health workforce, which potentially contributes to reduced access to health services for the broader First Nations population. There is evidence to suggest that First Nations 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 First Nations 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 Queensland 3.2% (4,921) of First Nations people aged 15 and over were employed in health-related occupations in 2021 (Table D3.12.13).

Between 2011 and 2021, the rate of First Nations people employed in health-related occupations in Queensland increased from 266 to 318 per 10,000 population. In 2021, other Queenslanders were employed in health-related occupations at 1.7 times the rate for First Nations people.

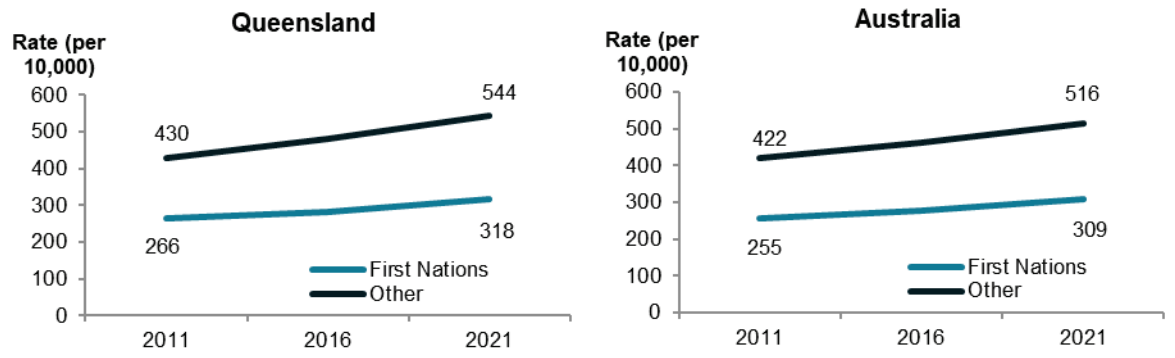
Nationally, between 2011 and 2021, the rate of First Nations people employed in health-related occupations increased from 255 to 309 per 10,000 population. In 2021, other Australians were employed in health-related occupations at 1.7 times the rate for First Nations people in 2021 (Figure 3.12.1).

Registered health professionals: The National Health Workforce Data Set provides information on registered health professionals. It shows that in Queensland in 2021, 1.5% (2,117) of registered health professionals employed in their registered profession identified as being First Nations people. Of these 2,117 First Nations people, 68% were employed as a nurse and/or midwife (1,430), 24% as an allied health professional (507), 6.6% as a medical practitioner (139), and 1.9% as a dental practitioner (41) (Figure 3.12.2).

In 2021, other Queenslanders were employed in registered health professions at over 3 times the rate (rate ratio 3.2) for First Nations people.

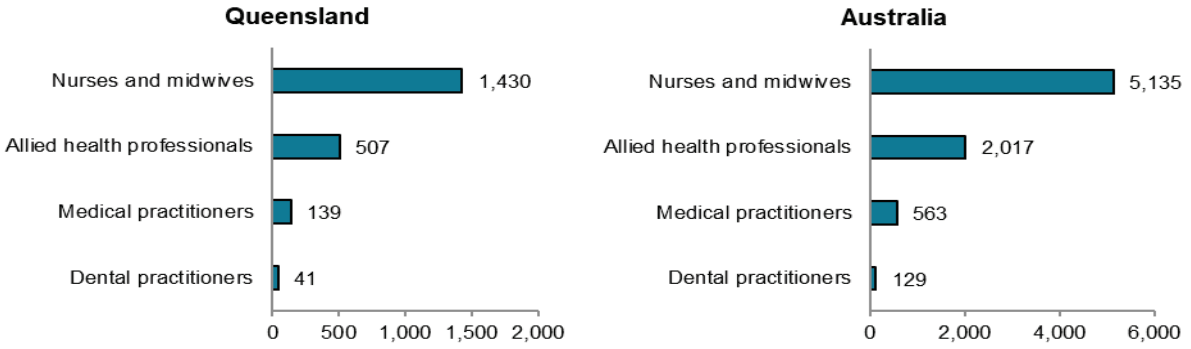
Nationally in 2021, 1.2% (7,844) of registered health professionals employed in their registered profession identified as being First Nations people. Other Australians were employed in registered health professions at 3 times the rate (rate ratio 3.0) for First Nations people (Figure 3.12.3).

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



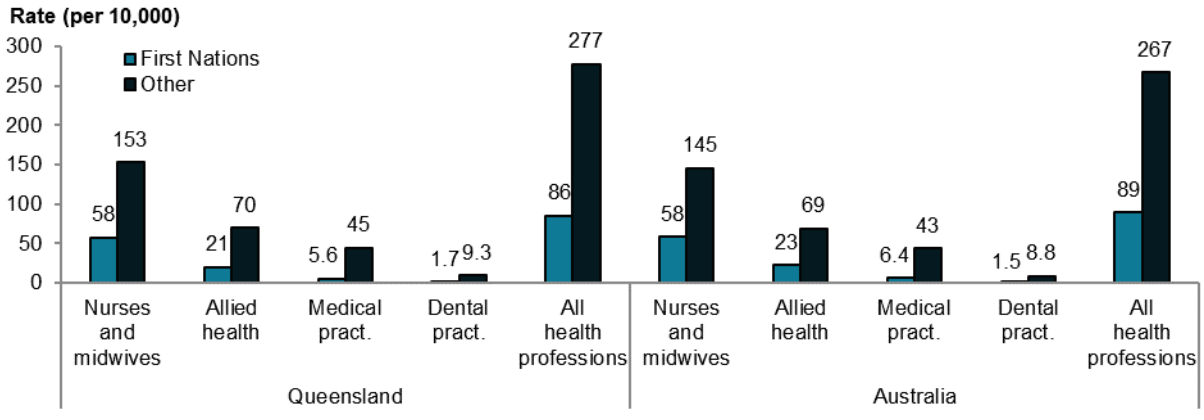
Source: Table D3.12.13.

Figure 3.12.2: Number of First Nations people aged 15 and over registered and employed in selected health professions, Queensland and Australia, 2021



Source: Table D3.12.4.

Figure 3.12.3: Rate of people aged 15 and over registered and employed in selected health professions, by Indigenous status, Queensland and Australia, 2021



Source: Table D3.12.4.

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

3.13 Competent governance

Why it is important

This measure reports on governance in First Nations-specific and mainstream health services. Governance refers to the evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve things that matter to them (Hunt et al. 2008). The manner in which governance functions are performed has a direct effect on the wellbeing of individuals and communities.

Key findings

Indigenous primary health-care organisations: In Queensland in 2021–22, there were 34 Indigenous primary health-care organisations that had a governing committee/board. Of these organisations, 20 (59%) had governing committee/board members who had received training related to governance issues, 18 (53%) had a board that included at least one independent (skill-based) member and 15 (44%) had a committee/board who were all First Nations people.

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

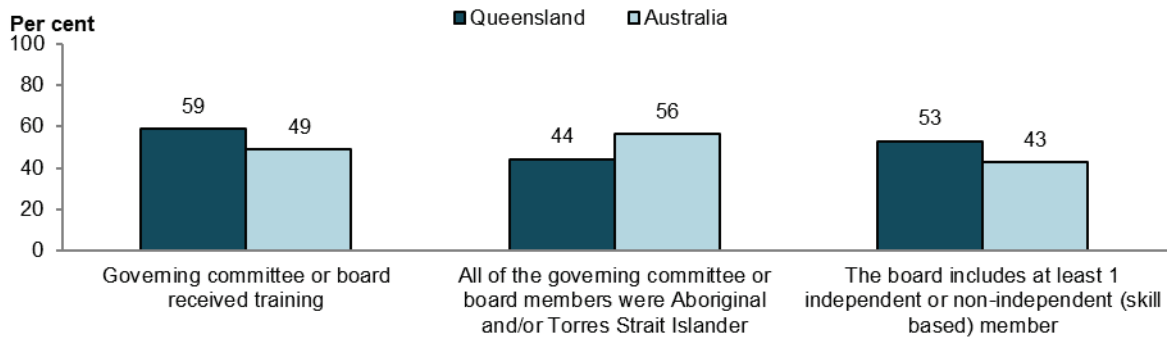
First Nations substance-use services: In Queensland in 2017–18, there were 14 First Nations substance use services that had a governing committee/board. Of these organisations, all had met the requirement of the constitution for the frequency of meetings and had income and expenditure statements presented on at least 2 occasions. There were 13 (93%) governing committees/boards that had members who received training related to governance issues, 12 (86%) had a board that included at least one independent (skill-based) member, and 2 (14%) had a committee/board who were all First Nations people.

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

Participation in planning processes: In Queensland in 2017–18, all 29 First Nations health services had participated in organisational planning processes, 25 (86%) participated in regional health planning processes, 19 (66%) had representatives on external boards (for example, hospitals), and 17 (59%) had participated in state/territory or national policy development.

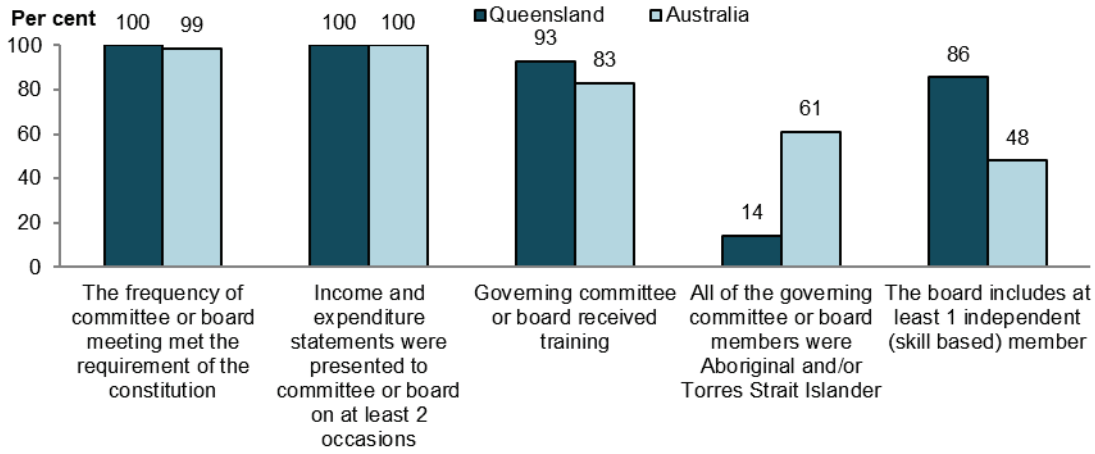
Nationally in 2017–18, 193 of the 198 (97%) First Nations health services had participated in organisational planning processes, 164 (83%) had participated in regional health planning processes, 125 (63%) had representatives on external boards (for example, hospitals), and 121 (61%) had participated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

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



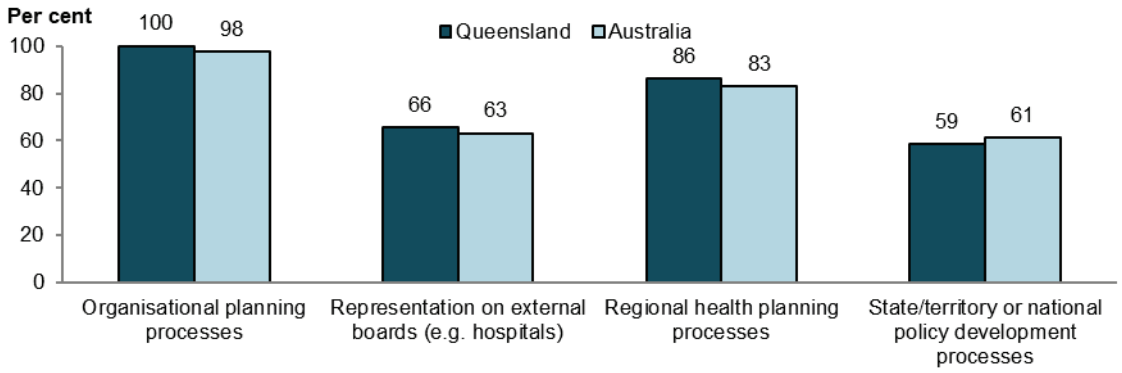
Source: Tables D3.13.3 and D3.13.3 Qld.

Figure 3.13.2: Aboriginal and Torres Strait Islander substance-use services, governing committee or board information, Queensland and Australia, 2017–18



Source: Tables D3.13.4 and D3.13.4 Qld.

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



Source: Tables D3.13.5 and D3.13.5 Qld.

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

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 First Nations people. First Nations people have significantly poorer health outcomes than non-Indigenous people. Inequalities in health care access and use are considered important drivers of this difference (OECD 2009). Therefore, access to health care commensurate with the level of need is essential to closing the gap in life expectancy between First Nations people and non-Indigenous Australians.

Key findings

Self-reported use of services: In 2018–19 in Queensland, in the previous 2 weeks, 22% of First Nations people had consulted a doctor or specialist, 8.2% had visited casualty or outpatient services and 5.7% (of those aged over 2) had seen a dentist. In the previous 12 months, 16% reported having been admitted to hospital (Figure 3.14.1).

Nationally in 2018–19, in the previous 2 weeks, 23% of First Nations people had consulted a doctor or specialist, 6.8% had visited casualty or outpatient services and 4.7% (of those aged over 2) had seen a dentist. In the previous 12 months, 17% reported having been admitted to hospital (Figure 3.14.1).

Services claimed through Medicare: In 2022–23 in Queensland, about 2.9 million Medicare claims were made for services provided to First Nations people, at a rate of 11,457 per 1,000 population (Table D3.14.23). The age-standardised rate of claims for First Nations people was 0.9 times the rate for other Queenslanders (Figure 3.14.2).

Nationally in 2022–23, the rate of claimed MBS services for First Nations people was 11,938 per 1,000 population (AIHW analysis of Medicare data). The age-standardised rate of claims for First Nations people was 0.9 times the rate for other Australians (Figure 3.14.2).

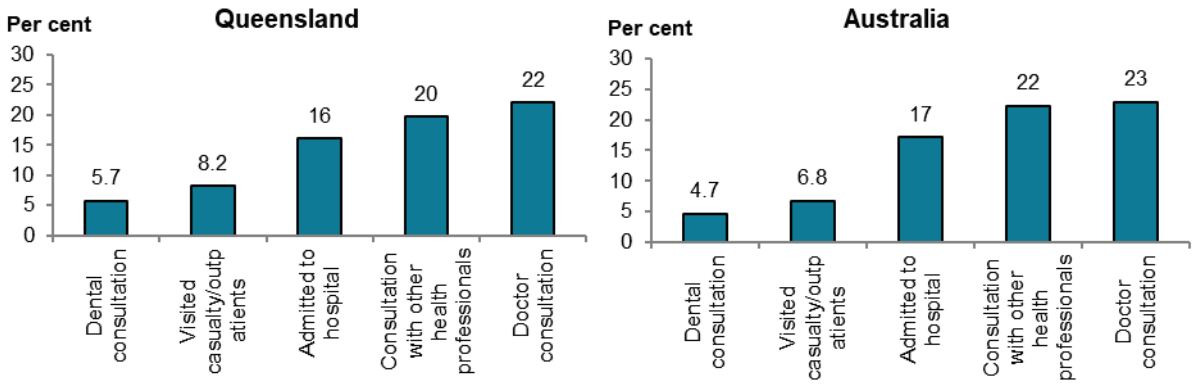
Hospitalisation for palliative care: From July 2019 to June 2021 in Queensland, there were 876 hospitalisations for palliative care for First Nations people, equivalent to 1.8 per 1,000 population (Table D3.14.48). After adjusting for differences in the age structure between the two populations, First Nations people were hospitalised for palliative care at 1.8 times the rate of other Queenslanders (Figure 3.14.3).

Nationally in July 2019 to June 2021, there were 2,620 hospitalisations for palliative care for First Nations 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, First Nations people were hospitalised for palliative care at 2.0 times the rate of other Australians (Figure 3.14.3).

Elective surgery: From July 2017 to June 2019 in Queensland, 1.3% of First Nations elective surgery patients had a waiting time of more than 1 year, which was the same for other Queensland patients.

Nationally over the same period, 2.1% of First Nations elective surgery patients had a waiting time of more than 1 year, compared with 1.9% for other Australian patients (Table D3.14.51).

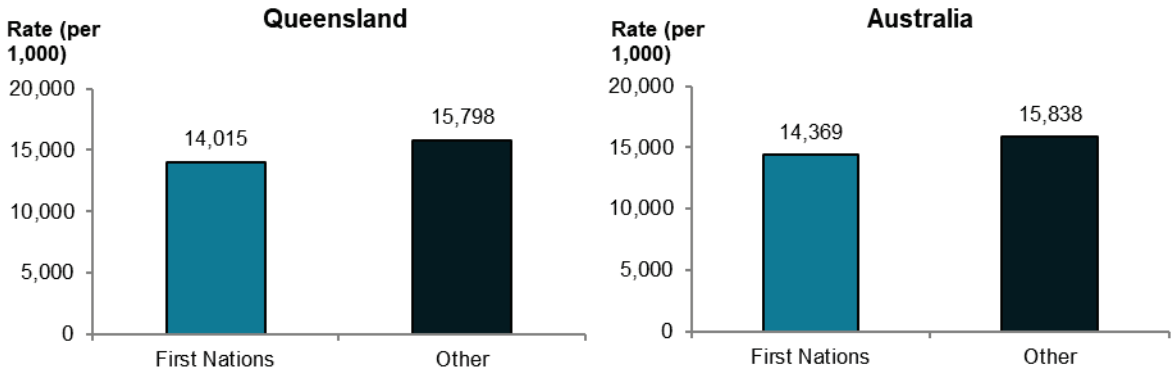
Figure 3.14.1: First Nations people accessing health-care services, Queensland and Australia, 2018–19



Note: Admitted to hospital in the last 12 months. Health care services were accessed in the last 2 weeks.

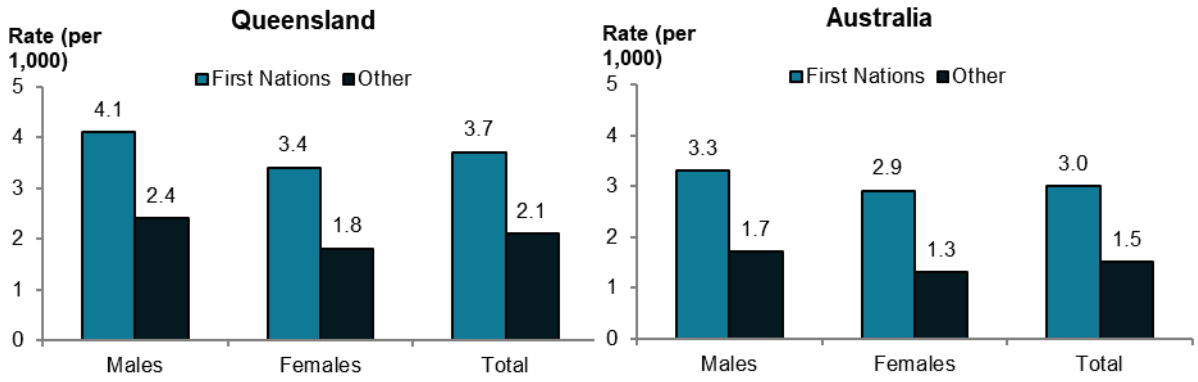
Source: Table D3.14.3.

Figure 3.14.2: VII adjusted, age-standardised rate of total MBS services claimed, by Indigenous status, Queensland and Australia, 2022–23



Source: Table D3.14.23.

Figure 3.14.3: Age-standardised rate of hospitalisation for palliative care, by Indigenous status and sex, Queensland and Australia, July 2019 to June 2021



Source: Table D3.14.48.

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

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 First Nations 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 Queensland in 2018–19, 11% of First Nations 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). The most common reason reported by First Nations Queenslanders for not having a prescription filled was cost (35%) (Figure 3.15.2).

Nationally in 2018–19, 14% of First Nations 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). The most common reason reported by First Nations people for not having a prescription filled was cost (36%) (Figure 3.15.2).

Expenditure per person: Nationally in 2022–23, total expenditure (government and non-government) on benefit-paid pharmaceuticals for First Nations people was $684 million, which was an average of $676 per person. For other Australians, the average expenditure was $758 per person (AIHW analysis of the PBS data in the Australian Government Department of Health and Aged Care's Enterprise Data Warehouse and Financial Journaling System; and ABS population estimates and projections (ABS 2024) for calculation of rates).

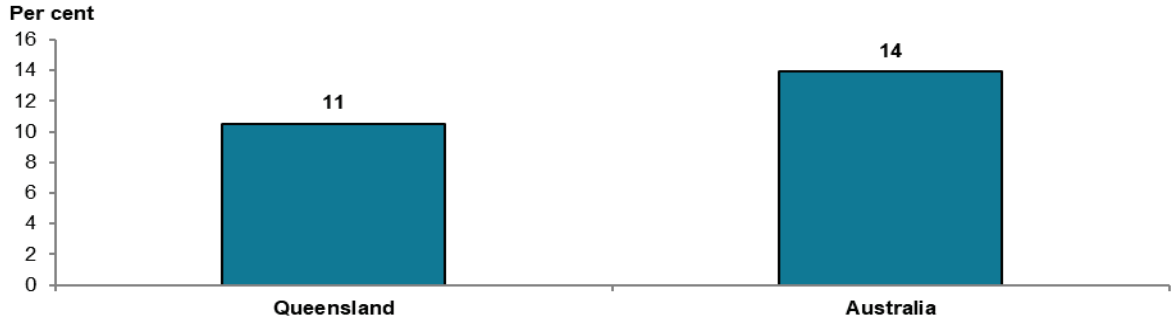
Australian Government expenditure: In Queensland in 2022–23, expenditure on benefit-paid pharmaceuticals by the Australian Government was $615 per person for First Nations people. For other Queenslanders, the average expenditure on benefit-paid pharmaceuticals was $617 per person.

Nationally in 2022–23, expenditure on benefit-paid pharmaceuticals by the Australian Government was $635 per person for First Nations people. For other Australians, the average expenditure on benefit-paid pharmaceuticals was $627 per person (Figure 3.15.3).

Individual expenditure: In Queensland in 2022–23, expenditure on benefit-paid pharmaceuticals by individuals was $38 per person for First Nations people. For other Queenslanders, the average expenditure on benefit-paid pharmaceuticals was $131 per person.

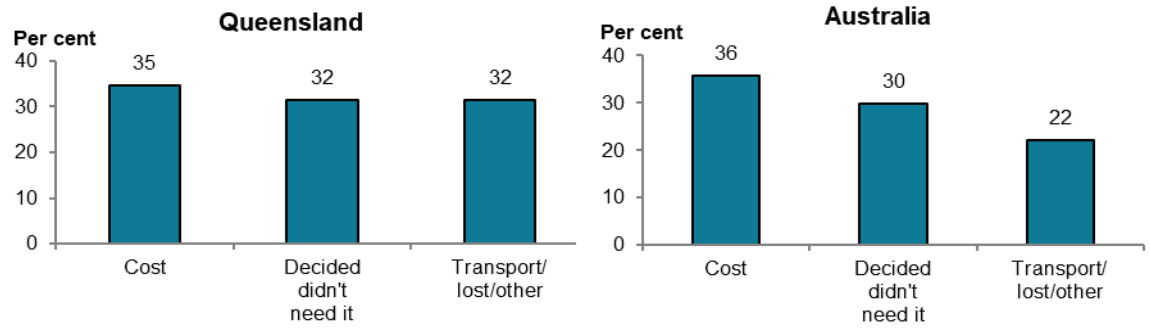
Nationally in 2022–23, expenditure on benefit-paid pharmaceuticals by individuals was $41 per person for First Nations people. For other Australians, the average expenditure on benefit-paid pharmaceuticals was $132 per person (Figure 3.15.3).

Figure 3.15.1: First Nations people aged 15 and over (in non-remote areas only) who did not have a prescription filled in the last 12 months, Queensland and Australia, 2018–19



Source: Table D3.15.5.

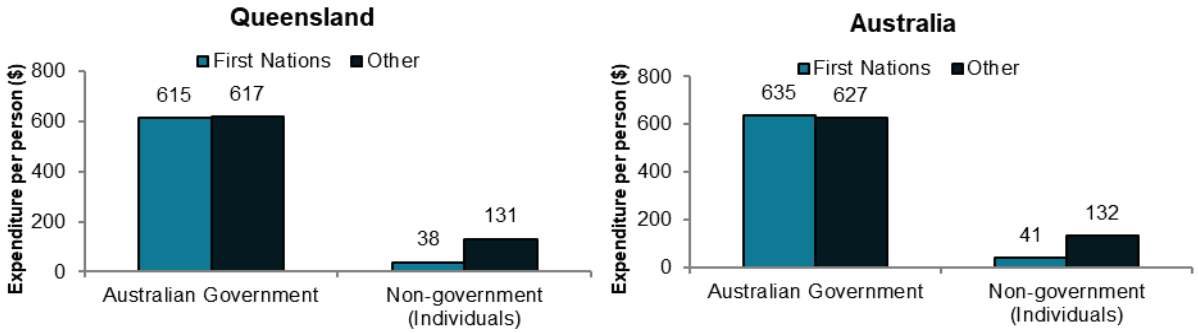
Figure 3.15.2: Reasons for not filling prescriptions, First Nations people aged 15 and over (in non-remote areas), Queensland and Australia, 2018–19



Note: Other reasons for not filling prescriptions are not presented due to data quality issues.

Source: Table D3.15.5.

Figure 3.15.3: Per person expenditure on benefit-paid pharmaceuticals[(a)(b)], by source, and Indigenous status, Queensland and Australia, 2022–23



(a) Excludes expenditure that were 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 (RAAHSP).

Source: AIHW analysis of the PBS data in the Australian Government Department of Health and Aged Care's Enterprise Data Warehouse and Financial Journaling System; and ABS population estimates and projections (ABS 2024) for calculation of rates.

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

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 First Nations people. 'After hours' refers to services provided on Sundays, before 8 am and/or after 12 pm on a Saturday, or at any time other than 8 am to 6 pm on weekdays. 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 2018–19 in Queensland, 9.6% of First Nations people living in non-remote areas accessed a doctor outside normal business hours in the previous 12 months.

Nationally in 2018–19, 8.1% of First Nations people living in non-remote areas accessed a doctor outside normal business hours in the previous 12 months (Figure 3.16.1).

Services claimed through Medicare: According to the 2022–23 Medicare data on MBS services claimed for after-hours care items, there were 62,100 after-hours services provided to First Nations people in Queensland, at a rate of 243 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 First Nations people was 0.9 times that for other Queenslanders (Figure 3.16.2).

Nationally, the rate for MBS services claimed by First Nations people for after-hours care items in 2022–23 was 222 per 1,000 (Table D3.16.3). The age-standardised rate for First Nations people was 0.7 times the rate for other Australians (Figure 3.16.2).

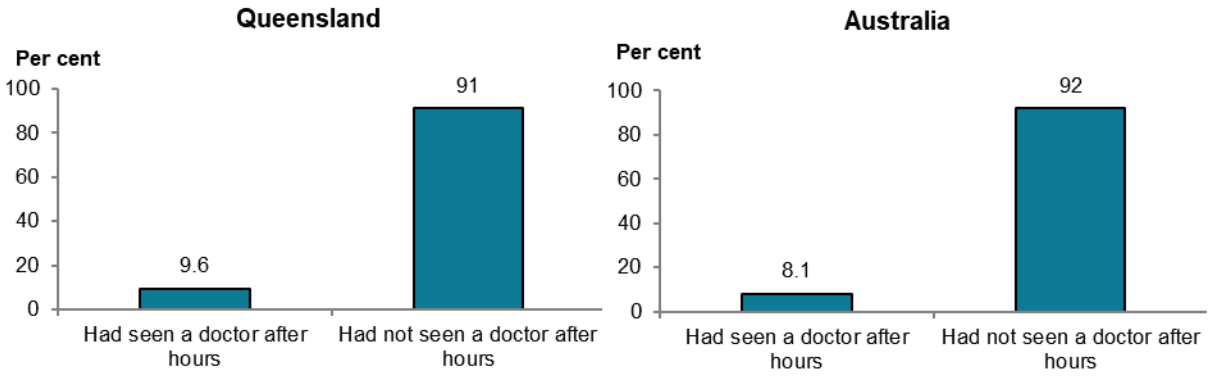
Emergency department presentations, overall: In Queensland, between July 2019 and June 2021, 57% of emergency presentations for First Nations people occurred after hours. This was higher than for other Queenslanders (53%).

Nationally, between July 2019 and June 2021, 57% of emergency presentations for First Nations people occurred after hours. This was higher than for other Australians (54%) (Figure 3.16.3).

Emergency department presentations, semi-urgent or non-urgent: In Queensland, between July 2019 and June 2021, 54% of emergency department presentations for First Nations patients that occurred after-hours were classified as semi-urgent or non-urgent (triage categories 4 and 5). This was higher than the proportion for other Queensland patients for after-hours emergency department episodes of care (49%).

Nationally, between July 2019 and June 2021, 54% of emergency department presentations for First Nations patients that occurred after hours were classified as semi-urgent or non-urgent (triage categories 4 and 5). This is higher than the proportion for First Nations patients for after-hours emergency department episodes of care (51%) (Table D3.16.11).

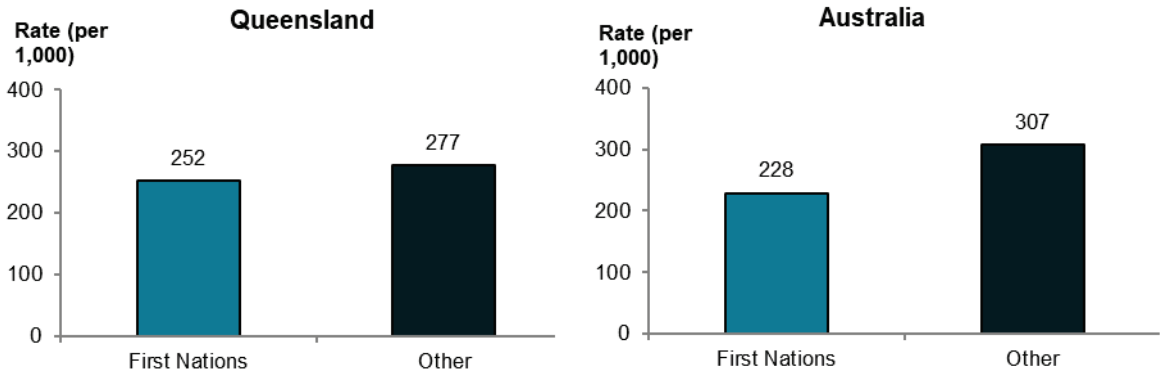
Figure 3.16.1: Proportion of First Nations people reporting access to a doctor or GP after hours in the last 12 months (non-remote areas), Queensland and Australia, 2018–19



Note: 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.

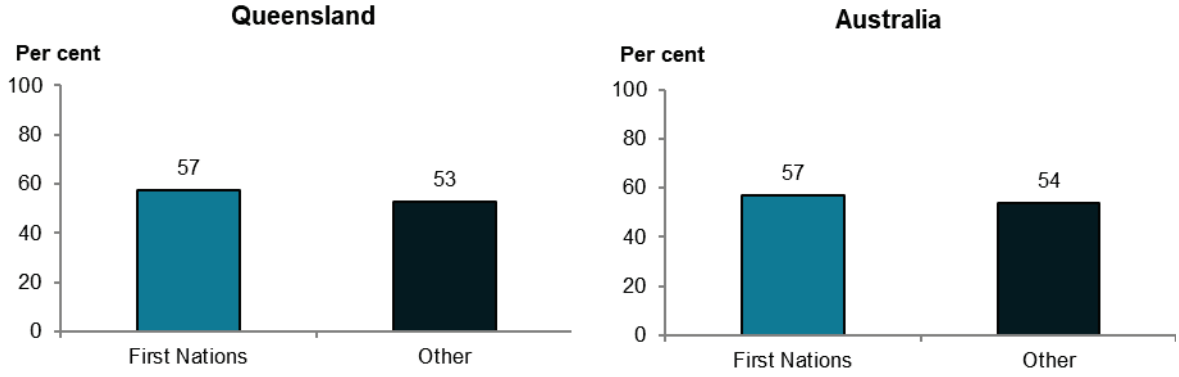
Source: Table D3.16.1.

Figure 3.16.2: VII adjusted, age-standardised rate of MBS services claims for after-hours care, by Indigenous status, Queensland and Australia, 2022–23



Source: Table D3.14.23.

Figure 3.16.3: Proportion of emergency department presentations that were after hours, by Indigenous status of the patient, Queensland and Australia, July 2019 to June 2021



Source: Table D3.16.10.

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

3.17 Regular general practitioner or health service

Why it is important

This measure reports on First Nations 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 and Torres Strait Islander health workers. In Australia, general practice is often the first point of contact in the health care system, with almost 90% of Australians seeing a GP at least once each year (AIHW 2024g).

Key findings

Overall: Based on self-reported data from the 2018–19 National Aboriginal and Torres Strait Islander Health Survey (Health Survey), 92% of First Nations people in Queensland had a usual place to go for health problems and advice:

- 46% usually went to a doctor
- 40% usually went to an Aboriginal Medical Services (AMS) or community clinic
- 6.3% usually went to a hospital.

Nationally, the same proportion (92%) of First Nations people had a usual place to go for health problems and advice, however the use of AMS and community clinics was higher in Queensland (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 2018–19 in Queensland, at least three-quarters of First Nations people reported that:

- a doctor or GP was locally available (81%)
- an AMS or community clinic was locally available (75%)
- a hospital was locally available (76%).

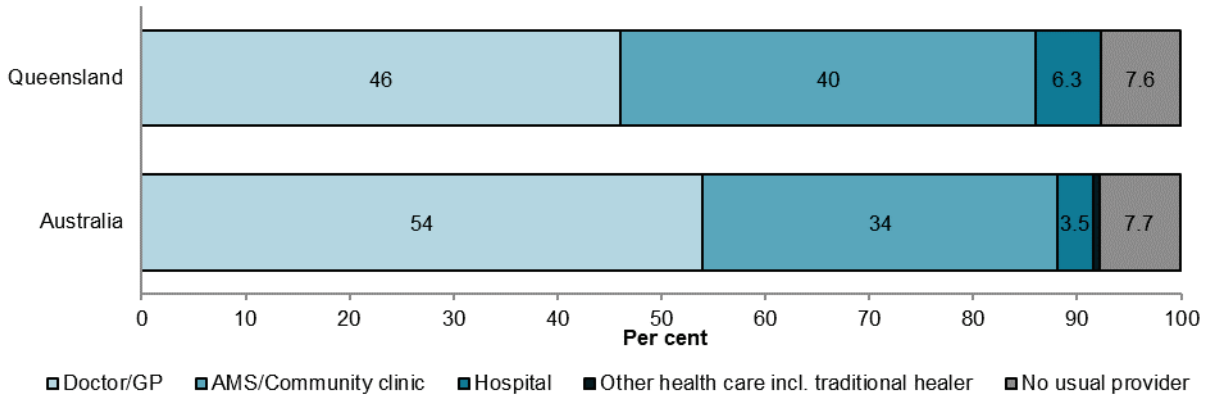
Other health care, including traditional healers, were locally available for 7.1% of First Nations people in Queensland.

Nationally in 2018–19, around two-thirds of First Nations people reported that an AMS or community clinic was locally available (67%) (Figure 3.17.2).

Preferred health care: The Health Survey asked where people would like to go if they were sick or needed advice about their health. In 2018–19 in Queensland, over half (52%) of First Nations people reported they would prefer to go to an AMS or community clinic, more than one-third (36%) preferred a doctor/GP, 8.5% preferred a hospital, and 3.2% preferred other health care (including traditional healer).

Nationally in 2018–19, 48% of First Nations people reported that they preferred to go to an AMS or community clinic, 43% preferred a doctor/GP, 6.5% preferred a hospital, and 2.6% preferred other health care (including traditional healer) (Figure 3.17.3).

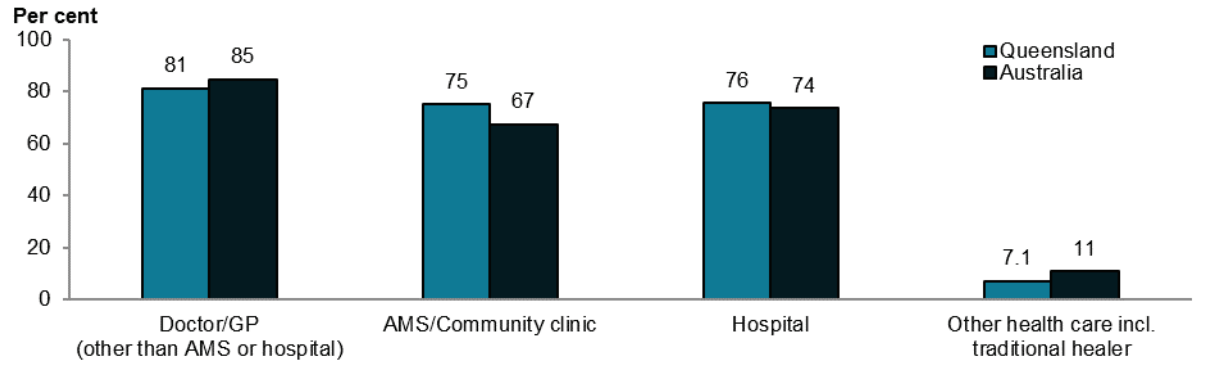
Figure 3.17.1: Usual source of health care by type, First Nations people, Queensland and Australia, 2018–19



Note: Estimate for 'Other health care including traditional healer' are not presented for Queensland due to data quality issues.

Source: Table D3.17.1.

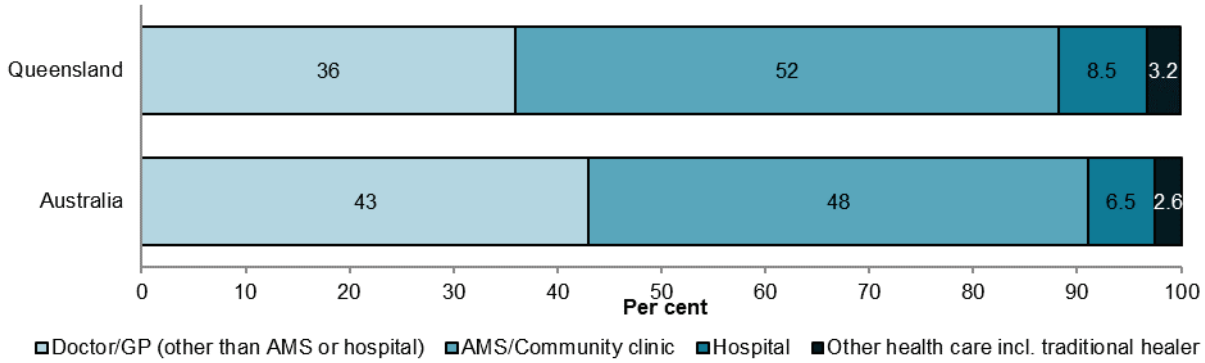
Figure 3.17.2: Health services available in local area, Queensland and Australia, 2018–19



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, First Nations people, Queensland and Australia, 2018–19



Source: Table D3.17.1.

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

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 First Nations people. An estimated 70% of the health gap between First Nations and other Australians is attributed to chronic diseases (AIHW 2016b). Effective management of chronic diseases can delay the progression of disease, reduce the need for high-cost interventions, improve quality of life and increase life expectancy. Good quality care for people with chronic diseases generally involves multiple health-care providers across multiple settings. As a result, care plans are one way the client and primary health-care 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 Queensland in 2022–23, there were 26,100 MBS claims for the preparation of GPMPs and 22,500 for the coordination of TCAs for First Nations people (Table D3.05.1). In 2022–23 the age-standardised MBS claim rate for First Nations patients for GPMPs was 1.3 times the rate for other patients in Queensland and for TCAs it was 1.3 times the rate for other patients in Queensland (Figure 3.18.1).

Primary health care (PHC) patients with diabetes with GPMPs and TCAs: Commonwealth-funded Indigenous-specific PHC organisations provide data on a range of process of care measures related to chronic disease management. As at December 2018 in Queensland, of regular First Nations patients of PHC organisations (that is, patients who had visited a particular PHC provider 3 or more times in the previous 2 years) who had type 2 diabetes:

- 65% had a GPMP in the 2 years to December 2018, an increase of 6.1 percentage points from June 2017
- 62% had a TCA in the 2 years to December 2018, an increase of 5.3 percentage points from June 2017 (Figure 3.18.2).

Nationally, of regular First Nations patients of PHC organisations who had type 2 diabetes:

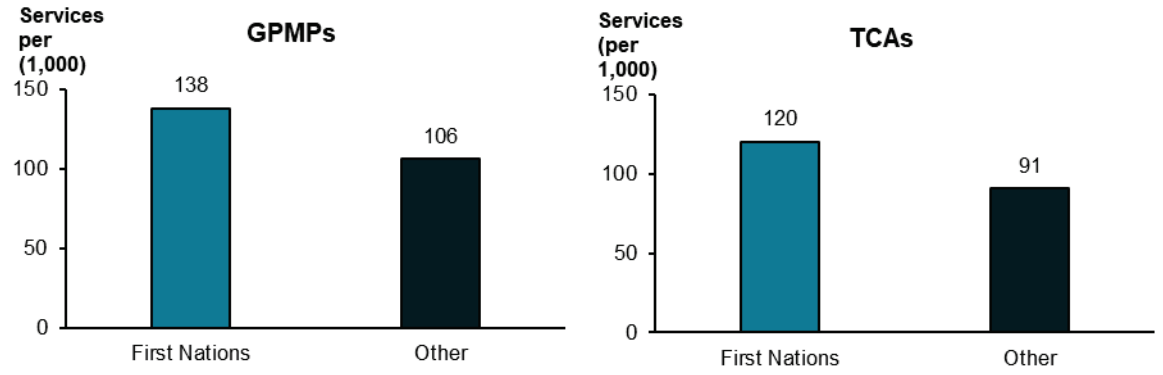
- 56% had a GPMP in the 2 years to December 2018, an increase of 2.8 percentage points from June 2017
- 54% had a TCA in the 2 years to December 2018, an increase of 2.9 percentage points from June 2017 (Figure 3.18.2).

Asthma management: Key elements of effective asthma management include a written asthma action plan and regular use of medications that control the disease and prevent exacerbations of the condition (AIHW 2011).

In 2018–19 in non-remote areas of Queensland, 27% of the 28,200 First Nations people living with asthma had a written asthma action plan, compared with 33% of other Queenslanders (Figure 3.18.3).

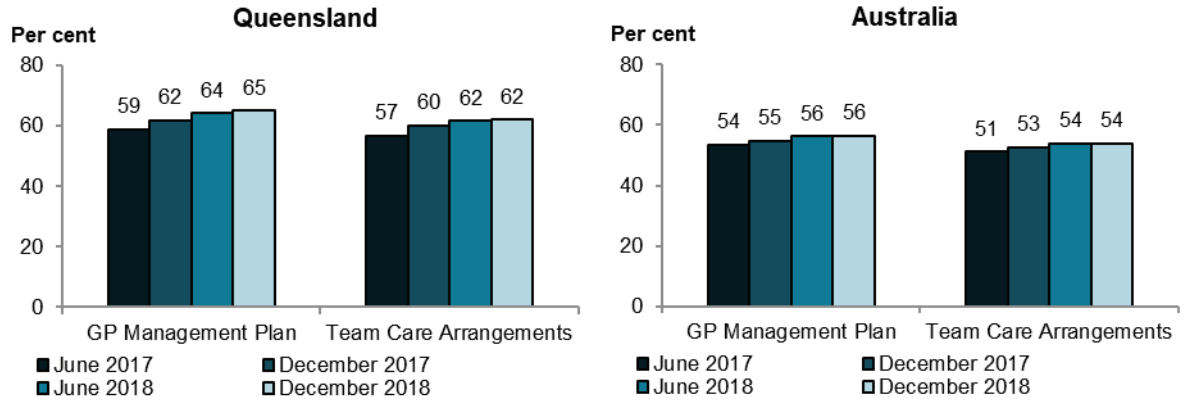
Nationally in 2018–19, 33% of First Nations people with asthma who lived in non-remote areas had a written asthma action plan, compared with 32% of other Australians (Figure 3.18.3).

Figure 3.18.1: Age-standardised rate of GPMPs and TCAs claimed through Medicare, by Indigenous status, Queensland, 2022–23



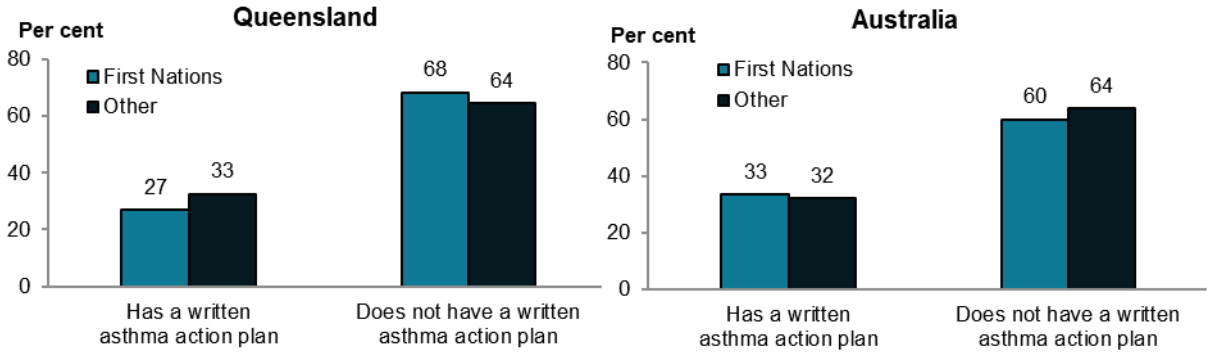
Source: Table D3.05.1.

Figure 3.18.2: First Nations regular clients with type 2 diabetes who had a GPMP and TCA in the last 2 years, Indigenous-specific primary health-care services, Queensland and Australia, June 2017 to December 2018



Source: Table D3.18.1.

Figure 3.18.3: People with asthma reporting having a written asthma action plan, by Indigenous status, non-remote areas, Queensland and Australia, 2018–19



Source: Table D3.18.5.

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

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 2023, there were 4 approved providers of general practice accreditation: Australian General Practice Accreditation Limited (AGPAL), Quality Practice Accreditation (QPA), the Australian Council on Health-care Standards (ACHS), and Global-Mark (ACSQHC 2024). General practice accreditation data for 2019 are available for 3 of these organisations; AGPAL, QPA and ACHS.

Key findings

Hospitals: In Queensland from July 2019 to June 2021, all of the 307,462 hospitalisations for First Nations people occurred in accredited hospitals. This was the same for the 2,965,766 hospitalisations for other Queenslanders (Table D3.19.1, Figure 3.19.1).

Nationally from July 2019 to June 2021, 99.8% (1,040,959) of hospitalisations for First Nations people in public hospitals occurred in accredited hospitals. The proportion of hospitalisations for other Australians in accredited hospitals was 99.3% (12,470,916 hospitalisations) (Table D3.19.1, Figure 3.19.1).

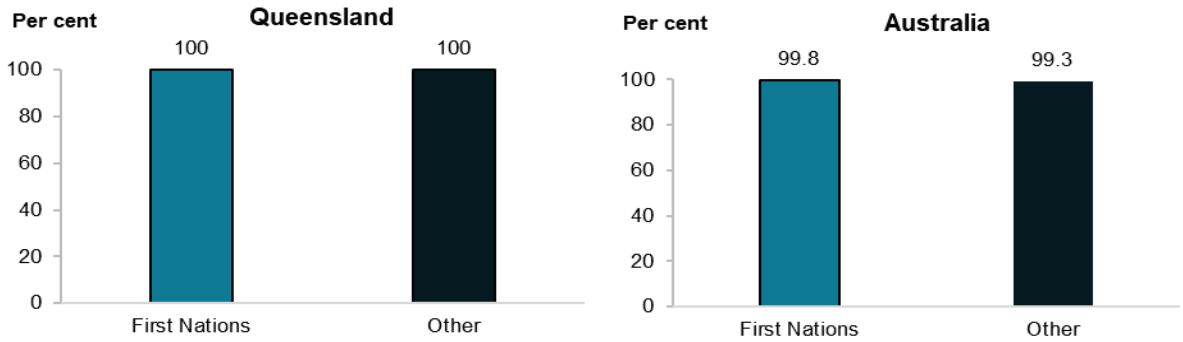
General practice accreditation (overall): In Queensland in 2019, 95% (1,310) of general practices registered with AGPAL, QPA or ACHS were fully accredited by the respective organisation (Figure 3.19.2).

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 Queensland, the proportion of general practices registered with AGPAL, QPA or ACHS that were fully accredited ranged from 94% in Brisbane North to 97% in Western Queensland and Northern Queensland (Figure 3.19.2).

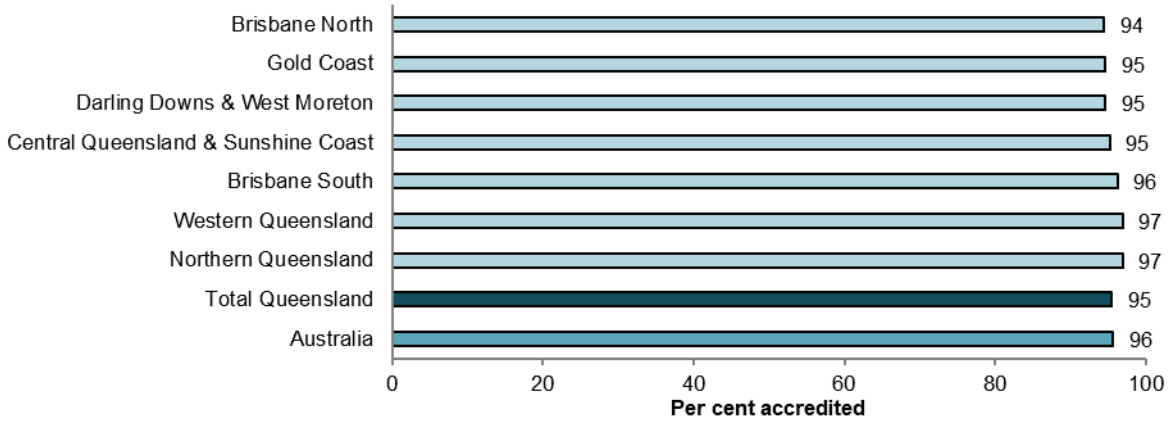
When the general practices in Queensland are disaggregated into categories representing the proportion of the population in the PHN they service that are First Nations people, the rate of accreditation was lowest in areas where First Nations people made up 2%–3% of the population (95%). However, rates of accreditation of general practices were similar in all First Nations population size categories (Figure 3.19.3).

Figure 3.19.1: Public hospitalisations in accredited hospitals, by Indigenous status, Queensland and Australia, July 2019 to June 2021



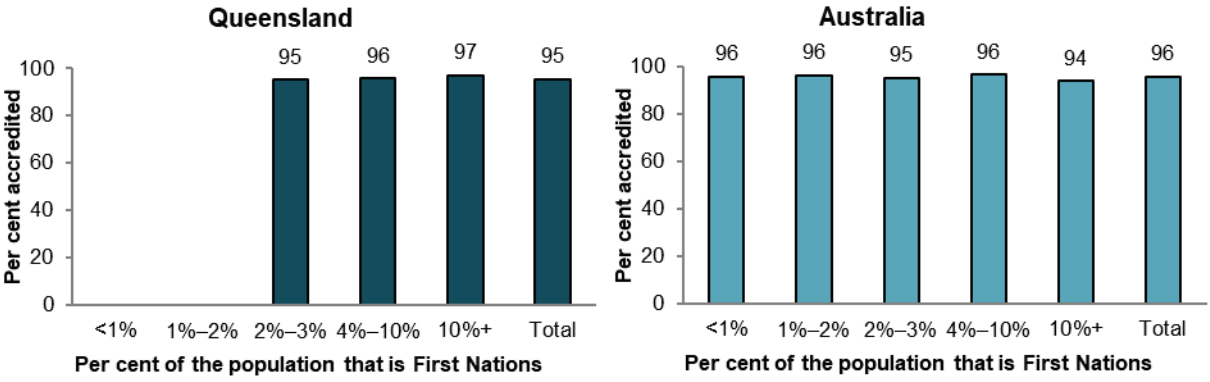
Source: Table D3.19.1.

Figure 3.19.2: Proportion of general practices registered for accreditation through AGPAL, QPA or ACHS that had been accredited, by Primary Health Network area, Queensland, 2019



Source: Tables D3.19.8, D3.19.5 Qld.

Figure 3.19.3: Proportion of general practices registered for accreditation through AGPAL, QPA or ACHS that had been accredited, by per cent of the population that is First Nations, Queensland and Australia, 2019



Note: The <1% and 1%–2% population categories are not applicable for any PHNs in Queensland.
Source: Tables D3.19.5 Qld, D3.19.5.

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

3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines

Why it is important

This measure reports on the participation of First Nations people in tertiary education for health-related disciplines. Improving and supporting the participation of First Nations people in tertiary education for health-related disciplines is crucial to increasing participation in the health workforce, in which First Nations people are significantly under-represented. Vocational Education and Training (VET) can provide essential pathways for First Nations people to enter tertiary education and the health professions (Gwynne et al. 2019).

Key findings

Vocational Education and Training (VET) enrolments: In Queensland in 2021, there were 2,427 enrolments of First Nations students aged 15 and over in VET health-related courses (on a government-funded or fee-for-service basis), a rate of 148 enrolments per 10,000 population (Table D3.20.37, Figure 3.20.1). In Queensland, First Nations students accounted for 7.3% of total enrolments in VET health-related courses.

Nationally in 2021, First Nations students accounted for 4.7% of enrolments in VET health-related courses, and the enrolment rate was 120 per 10,000 population (Table D3.20.37).

Vocational Education and Training (VET) completions: In Queensland in 2021, First Nations students aged 15 and over completed 834 VET health-related courses (on a government-funded or fee-for-service basis), a rate of 51 completions per 10,000 population (Figure 3.20.1). In Queensland, First Nations students accounted for 6.5% of course completions in VET health-related courses (Table D3.20.38).

Nationally in 2021, First Nations students accounted for 3.5% of course completions in VET health-related courses, and the completion rate was 30 per 10,000 population (Figure 3.20.1).

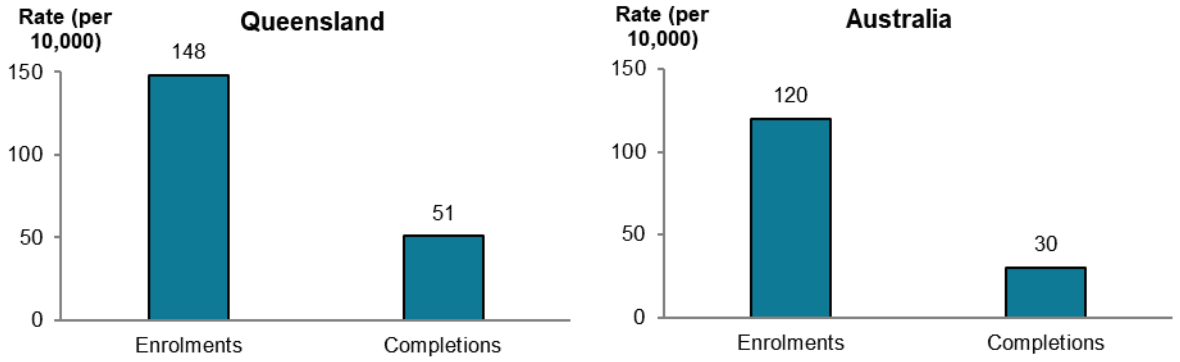
Higher education enrolments for health-related courses: In Queensland in 2018, there were 291 commencements and 800 total enrolments for health-related higher education courses for First Nations undergraduate students aged 15 and over, rates of 19 commencements and 53 enrolments per 10,000 population, respectively. These rates were slightly lower than those of other students in Queensland (Figure 3.20.2).

Nationally in 2018, the commencement rate for First Nations undergraduate students in health-related higher education courses was 18 per 10,000 population and the total enrolment rate was 49 per 10,000 population. These rates were slightly lower compared with those of other Australian students (Figure 3.20.2).

Higher education completions for health-related courses: In 2018 in Queensland, there were 120 completions in health-related higher education courses for First Nations undergraduate students aged 15 and over, a rate of 8.0 completions per 10,000 population. This was lower than the completion rate (12 per 10,000) for other students in Queensland.

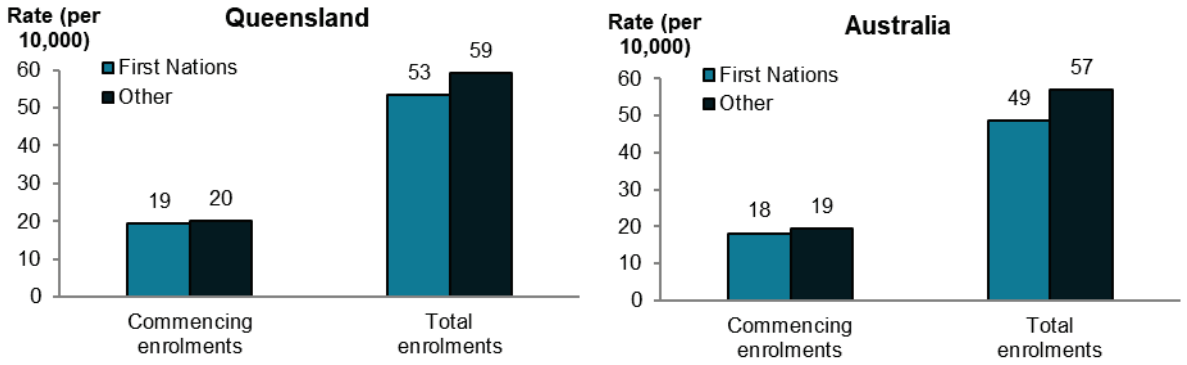
Nationally in 2018, the completion rate for First Nations undergraduate students was 7.1 completions per 10,000 population. This rate was lower than the completion rate (11 per 10,000) for other students in Australia (Figure 3.20.3).

Figure 3.20.1: Vocational Education and Training (VET) health-related course enrolments and completions for First Nations students aged 15 and over, Queensland and Australia, 2021



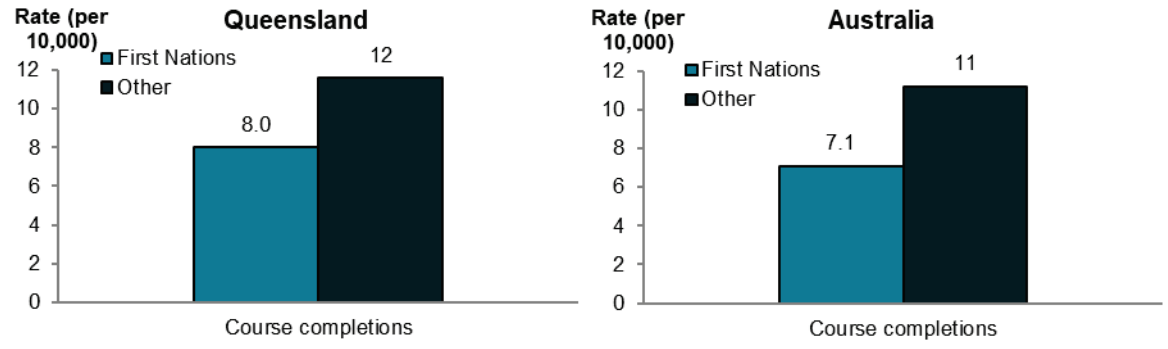
Source: Tables D3.20.37 and D3.20.38.

Figure 3.20.2: Undergraduate domestic higher education students aged 15 and over enrolled in health-related courses, by Indigenous status, Queensland and Australia, 2018



Source: Table D3.20.27.

Figure 3.20.3: Undergraduate domestic higher education students aged 15 and over completing health-related courses, by Indigenous status, Queensland and Australia, 2018



Source: Table D3.20.27.

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

3.21 Expenditure on Aboriginal and Torres Strait Islander health compared to need

Why it is important

This measure presents information on health expenditure. A basic principle of equity is that health expenditure should reflect the relative needs for health services (Braveman and Gruskin 2003; Whitehead 1991). Health expenditure for population groups with higher levels of need should be proportionately higher. In this Qld HPF report, the data presented relate to health expenditure by state and territory governments. For total health expenditure, including by the Australian government, see the national HPF report.

Key findings

Total state government health expenditure: In 2019–20 in Queensland, state government health expenditure for First Nations people was $6,164 per person. About half (51%) of this amount was spent on admitted patient services in public hospitals, 23% on non-admitted patient services in public hospitals, and 18% on community health services (Figure 3.21.1). State government health expenditure for other Queenslanders was $3,540 per person (Figure 3.21.2).

Nationally in 2019–20, state and territory government health expenditure for First Nations people was $6,048 per person. Of this amount, 49% was spent on admitted patient services in public hospitals, 22% on non-admitted patient services in public hospitals, and 15% on community health services (Figure 3.21.1). Nationally, health expenditure for other Australians was $3,273 per person (Figure 3.21.2).

Public hospital services: In Queensland in 2019–20, three-quarters (74%) of the per person state government health expenditure for First Nations people was for public hospital services (both admitted and non-admitted services). Public hospital services expenditure for First Nations people was $4,586 per person and for other Queenslanders was $2,456 per person (Figure 3.21.3).

Nationally, 69% of the per person state and territory government health expenditure for First Nations people was for public hospital services. Public hospital services expenditure for First Nations people was $4,276 per person and for other Australians was $2,542 per person (Figure 3.21.3).

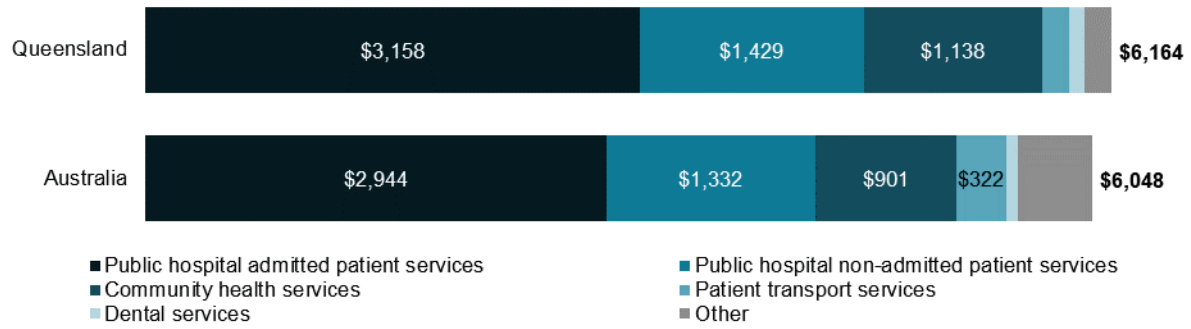
Community health services: In 2019–20 in Queensland, state government health expenditure on community health services for First Nations people was $1,138 per person and for other Queenslanders was $624 per person (Figure 3.21.3).

Nationally in 2019–20, state and territory government health expenditure on community health services for First Nations people was $901 per person and other Australians was $324 per person (Figure 3.21.3).

Patient transport services: In 2019–20 in Queensland, state government health expenditure on patient transport services for First Nations people was $178 per person and for other Queenslanders was $221 per person (Figure 3.21.3).

In 2019–20 nationally, state and territory government health expenditure on patient transport services for First Nations people was $322 per person and for other Australians was $156 per person (Figure 3.21.3).

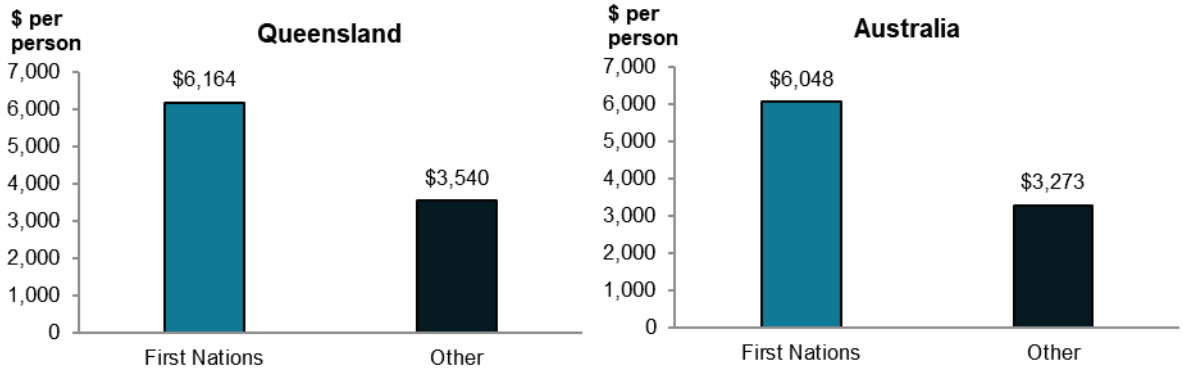
Figure 3.21.1: State and territory government health expenditure per person for First Nations people, by area of expenditure, Queensland and Australia, 2019–20



Note: 'Other' category includes public health services, health administration, private hospital services and research.

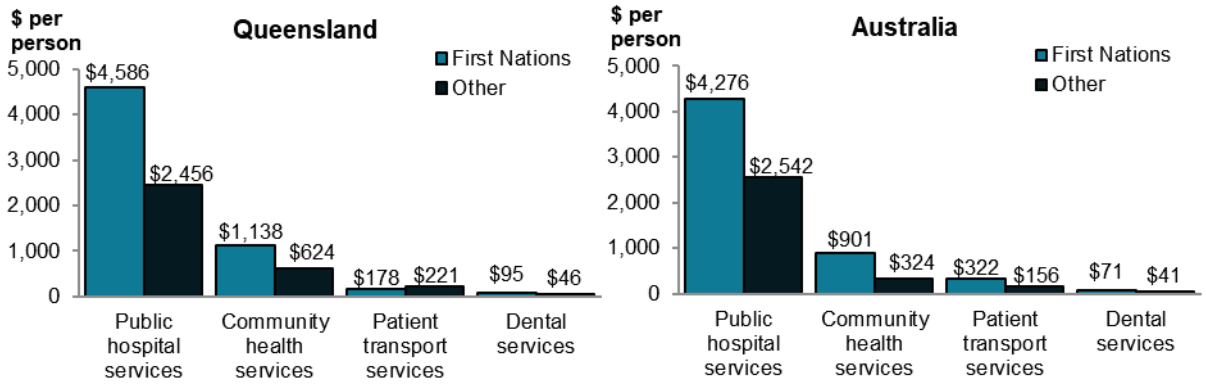
Source: Table D3.21.3.

Figure 3.21.2: State and territory government health expenditure per person, by Indigenous status, Queensland and Australia, 2019–20



Source: Table D3.21.3.

Figure 3.21.3: State and territory government health expenditure per person, by selected services and Indigenous status, Queensland and Australia, 2019–20



Source: Table D3.21.3.

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

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 Indigenous primary health care organisations. First Nations 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 First Nations people. While the First Nations 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 Queensland in 2021, there were 23,130 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 (293), not looking for work in medicine (290) or overseas (273) (Table D3.22.1). There were 84,838 nurses and midwives in the nursing/midwifery workforce in Queensland, 92% of whom were employed in nursing or midwifery (Figure 3.22.1).

Nationally in 2021, there were 111,654 registered medical practitioners in the medical workforce, 92% of whom were employed as clinicians (Figure 3.22.1).

Indigenous primary health care organisations: In Queensland, as at 30 June 2023, there were 1,320 full-time equivalent (FTE) health/clinical staff and 1,065 FTE administrative and support staff within Commonwealth-funded Indigenous primary health care organisations. The vacancy rate was 9.7% for health/clinical staff positions and 5.6% for administrative and support staff positions. Vacancies for health/clinical staff were highest for social and emotional wellbeing workers (23 FTE), followed by nurses (22 FTE) and doctors (17 FTE) (AIHW 2024g).

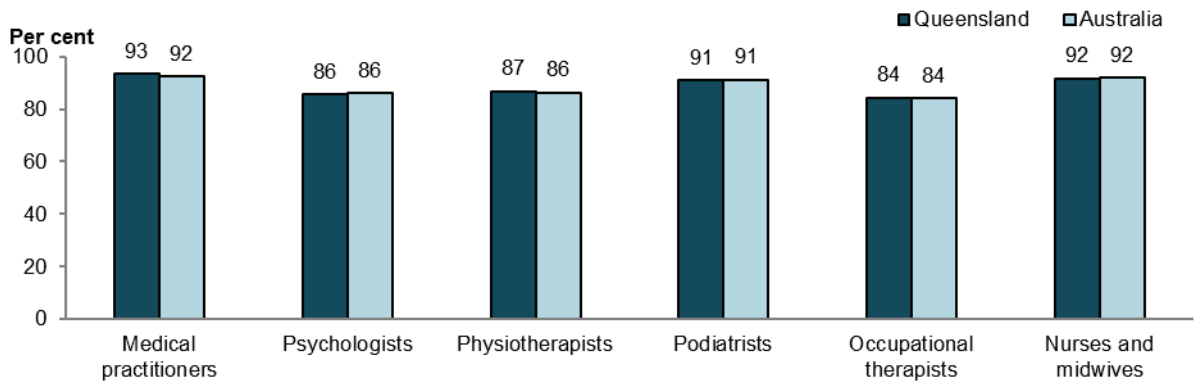
In Queensland, the vacancy rates increased between 2019 and 2023, from 4.0% to 9.7% for health/clinical positions and from 2.5% to 5.6% for administrative and support positions.

Nationally, the vacancy rates for health/clinical staff positions grew from 6.3% to 13% between 2019 and 2023, while administrative and support position vacancies grew from 2.6% to 6.4% (Figure 3.22.2).

Staffing challenges in Indigenous primary health care organisations: In Queensland in 2017–18, 62% (18 services) of Indigenous primary health care organisations reported that recruitment, training and support of First Nations staff was a major challenge. In relation to all staff, retention and turnover were reported as a challenge by 48% of services (14 services).

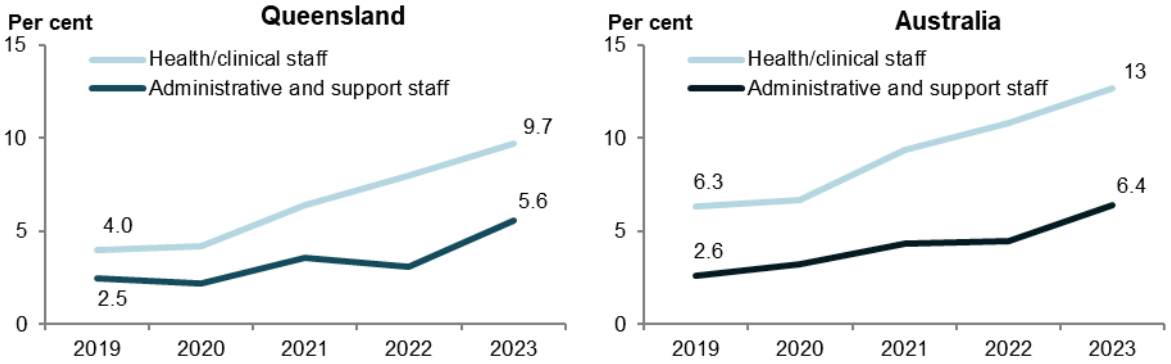
Nationally in 2017–18, 71% (141 services) of Indigenous primary health care organisations reported that recruitment, training and support of First Nations staff was a major challenge. In relation to all staff, staff retention and turnover were reported as a challenge by 54% of services (106 services) (Figure 3.22.3).

Figure 3.22.1: Medical practitioners in their field's labour force employed as clinicians in their field, by type of profession, Queensland and Australia, 2021



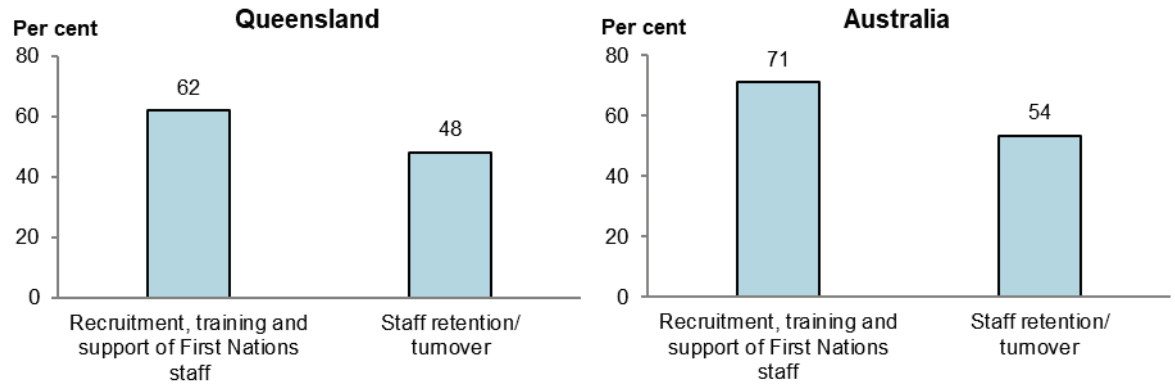
Source: Tables D3.22.1, D3.22.5, D3.22.6, D3.22.7, D3.22.9 and D3.22.10.

Figure 3.22.2: FTE vacant positions in Indigenous primary health-care organisations, by position type, Queensland and Australia, at 30 June, 2019 to 2023



Source: Tables D3.22.12, D3.22.29, AIHW 2024d.

Figure 3.22.3: Indigenous primary health care organisations experiencing selected staffing challenges, Queensland and Australia, 2017–18



Source: Table D3.22.24

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

Acknowledgements

We acknowledge the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

This report was prepared by Nancy Stace-Winkles, Ilona Brockway, Kim Xu, Ben Moy, Danni Zheng, Bina Gubhaju, Kalijah Madsen-Guarini, Tara Tolhurst and Josh Sweeney at the Australian Institute of Health and Welfare (AIHW). The authors would like to acknowledge members of the Indigenous Health Performance Framework Unit at the AIHW for the provision of data.

Thanks to Fadwa Al-Yaman, Tracy Dixon and Jessica Cargill for their advice and feedback on this report.

This report was produced for the Aboriginal and Torres Strait Islander Health Performance Framework website, with funding from Queensland Health. Thanks to staff from this agency for review and feedback on this report.

Abbreviations

ABS Australian Bureau of Statistics

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 years

DUMA Drug Use Monitoring in Australia

FTE Full-Time Equivalent

GP general practitioner

GPMP General Practitioner Management Plan

HPF Health Performance Framework

HIV Human Papilloma Virus

MBS Medicare Benefits Schedule

NATSIHS National Aboriginal and Torres Strait Islander Health Survey

NATSISS National Aboriginal and Torres Strait Islander Social Survey

NSW New South Wales

NT Northern Territory

PBS Pharmaceutical Benefits Scheme

PPH Potentially preventable hospitalisations

QPA Quality Practice Accreditation

RHD Rheumatic Heart Disease

RPBS Repatriation Schedule of Pharmaceutical Benefits

SA South Australia

SEIFA Socio-Economic Indexes for Areas

SHS Specialist Homelessness Services

STI sexually transmissible infections

Tas Tasmania

TCA Team Care Arrangement

VET Vocational education and training

Vic Victoria

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

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.

References

ABS (Australian Bureau of Statistics) and AIHW (Australian Institute of Health and Welfare) (2008) *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008*, ABS & AIHW, Australian Government, accessed 12 July 2024.

ABS (2013) *Australian Health Survey: Physical Activity*, ABS website, accessed 12 July 2023.

— — (2018) *Life Tables for Aboriginal and Torres Strait Islander Australians, 2015-2017*, ABS website, accessed 12 July 2023.

— — (2019a) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, ABS website, accessed 12 July 2023.

— — (2019b) *National Aboriginal and Torres Strait Islander Health Survey*, ABS website, accessed 12 July 2023.

— — (2022) 2021 Census - counting persons, place of usual residence [Census TableBuilder].

— — (2023) 2021 Census - counting dwellings, place of enumeration [Census TableBuilder].

— — (2024) *Deaths due to COVID-19, influenza and RSV in Australia - 2022 - November 2024*, ABS website, accessed 21 January 2025.

ACSQHC (Australian Commission on Safety and Quality in Health Care) (2024) *Approved accrediting agencies under the NGPA Scheme,* ACSQHC, Australian Government, accessed 17 January 2025.

AHMAC (Australian Health Ministers' Advisory Council) (2012) *Clinical Practice Guidelines: Antenatal Care - Module 1*, AHMAC, Australian Government, accessed 12 July 2024.

— — (2016) *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander health*, AHMRC, Australian Government, accessed 12 July 2024.

AIHW (Australian Institute of Health and Welfare) (2011) *Asthma in Australia 2011: with a focus chapter on chronic obstructive pulmonary disease*, AIHW, Australian Government, accessed 12 July 2023.

— — (2015a) *Cardiovascular disease, diabetes and chronic kidney disease - Australian facts: Aboriginal and Torres Strait Islander people 2015*, AIHW, Australian Government, accessed 12 July 2023.

— — (2015b) *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015,* AIHW, Australian Government, accessed 12 July 2023.

— — (2016a) *Australia's health 2016*, AIHW, Australian Government, accessed 12 July 2023.

— — (2016b) *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*, AIHW, Australian Government, accessed 12 July 2023.

— — (2018a) *Australia's health 2018*, AIHW, Australian Government, accessed 12 July 2023.

— — (2018b) *Family, domestic and sexual violence in Australia, 2018*, AIHW, Australian Government, accessed 12 July 2023.

— — (2019a) *Income support among working-age Indigenous Australians*, AIHW, Australian Government, accessed 12 July 2023.

— — (2019b) *Australia's welfare snapshots 2019: Indigenous community safety*, AIHW, Australian Government, accessed 12 July 2024.

— — (2020a) *Australia's mothers and babies 2018: in brief,* AIHW, Australian Government, accessed 1 May 2020.

— — (2020b) *Mothers & babies Resources for supporting psychosocial health in pregnancy*, AIHW website, accessed 7 October 2020

— — (2020c) *Disparities in potentially preventable hospitalisations across Australia: Exploring the data,* AIHW, Australian Government, accessed 1 May 2020.

— — (2021a) *Youth detention population in Australia 2020*, AIHW, Australian Government, accessed 12 July 2024.

— — (2021b) *Youth justice in Australia 2019-20*, AIHW, Australian Government, accessed 12 July 2023.

— — (2021c) *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018*, AIHW, Australian Government, accessed 12 July 2024

— — (2022a) *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018*, AIHW, Australian Government, accessed 12 July 2023.

— — (2022b) *Heart, stroke & vascular diseases*, AIHW website, accessed August 2022.

— — (2022c) *Procedures data cubes*, AIHW website, accessed 2 April 2024.

— — (2023) *Acute rheumatic fever and rheumatic heart disease in Australia, 2017-2021*, AIHW, Australian Government, accessed 12 July 2024.

— — (2024a) *Health checks and follow-ups for Aboriginal and Torres Strait Islander people*, AIHW, Australian Government, accessed 17 July 2024.

— — (2024b) *Deaths in Australia*, AIHW, Australian Government, accessed 23 July 2024

— — (2024c) Child protection Australia 2022–23, AIHW, Australian Government, accessed 14 January 2025.

— — (2024d) *Tier 3 - Health system performance 3.06 Access to hospital procedures*, Aboriginal and Torres Strait Islander Health Performance Framework website, accessed 2 April 2024.

— — (2024e) *Alcohol and other drug treatment services in Australia annual report*, AIHW, Australian Government, accessed 15 January 2025.

— — (2024f) *National Opioid Pharmacotherapy Statistics annual data collection*, AIHW website, accessed 15 January 2025

— — (2024g) *General practice, allied health and other primary care services*, AIHW website, accessed 17 January 2025

— — (2024h) *Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections*, AIHW, Australian Government, accessed 26 February 2024.

Ali SH, Foster T, and Hall NL (2018) 'The Relationship between Infectious Disease and Housing Maintenance in Indigenous Australian Households', *International Journal of Environmental Research and Public Health* 15(12):2827, doi:10.3390/ijerph15122827.

Allen J and Hector D (2005) 'Benefits of breastfeeding', *New South Wales Public Health Bulletin* 16(3-4):42-6.

Australian National University (2020). Mayi Kuwayu Study. Canberra: National Centre for Epidemiology and Population Health, Research School of Population Health. Accessed December 2022

ASHA (Australasian Sexual Health Alliance) (2017) *Australian STI Management Guidelines for Use in Primary Care* , ASHRA website, accessed 21 July 2020.
Askew DA, Foley W, Kirk C, and Williamson D (2021) "I'm Outta Here!': A Qualitative Investigation into Why Aboriginal and Non-Aboriginal People Self-Discharge from Hospital', *BMC Health Services Research* 21(1): 907, doi:10.1186/s12913-021-06880-9.

Bailie RS and Wayte KJ (2006) 'Housing and health in Indigenous communities: key issues for housing and health improvement in remote Aboriginal and Torres Strait Islander communities', *Australian Journal of Rural Health* 14(5):178-83, doi:10.1111/j.1440-1584.2006.00804.x.

Baker DP, Leon J, Smith Greenaway EG, Collins J and Movit M (2011) 'The Education Effect on Population Health: A Reassessment', *Population and Development Review* 37(2):307-32, doi:10.1111/j.1728-4457.2011.00412.x.

Banks E, Joshy G, Weber MF, Liu B, Grenfell R, Egger S, Paige E, Lopez AD, Sitas F, and Beral V (2015) 'Tobacco Smoking and All-Cause Mortality in a Large Australian Cohort Study: Findings from a Mature Epidemic with Current Low Smoking Prevalence', *BMC Medicine*13(38), doi:10.1186/s12916-015-0281-z.

Banks G (2009) 'Are we overcoming Indigenous disadvantage' [lecturer speech], *Reconciliation Australia's 'Closing the Gap Conversation' series*, Canberra, accessed 19 July 2024.

Belachew TA and Kumar A (2014) *Examining Association Between Self-Assessed Health Status and Labour Force Participation Using Pooled NHS Data*, Australian Bureau of Statistics, Australian Government, accessed 12 July 2024.

Booth AL and Carroll N (2008) 'Economic status and the Indigenous/non-Indigenous health gap', *Economics Letters* 99(3):604-6.

Bowden FJ, Tabrizi SN, Garland SM, and Fairley CK (2002) 'Infectious Diseases. 6: Sexually Transmitted Infections: New Diagnostic Approaches and Treatments', *Medical Journal of Australia* 176(11): 551-7, doi:10.5694/j.1326-5377.2002.tb04554.x.

Bradshaw PJ, Alfonso HS, Finn J, Owen J and Thompson PL (2011) 'A comparison of coronary heart disease event rates among urban Australian Aboriginal people and a matched non-Aboriginal population', *Journal of Epidemiology and Community Health* 65(4):315-9, doi: 10.1136/jech.2009.098343.

Braveman P and Gruskin S (2003) 'Defining Equity in Health', *Journal of Epidemiology and Community Health* 57(4):254-8, doi:10.1136/jech.57.4.254.

Brown A (2012) 'Addressing Cardiovascular Inequalities among Indigenous Australians', *Global Cardiology Science and Practice* 2012(1): 2, doi:10.5339/gcsp.2012.2.

Brown A and Kritharides L (2017) 'Overcoming Cardiovascular Disease in Indigenous Australians', *Medical Journal of Australia* 206(1):10-12, doi:10.5694/mja16.00693.

Brown WJ, Bauman AE, Bull F and Burton NW (2013) *Development of Evidence based Physical Activity Recommendations for Adults (18-64 years),* a report to the Australian Government Department of Health, Australian Government, accessed 12 July 2024.

Burke H, Leonardi-Bee J, Hashim A, Pine-Abata H, Chen Y, Cook DG, Britton JR, and McKeever TM (2012) 'Prenatal and Passive Smoke Exposure and Incidence of Asthma and Wheeze: Systematic Review and Meta-Analysis', *Pediatrics* 129(4):735-44, doi:10.1542/peds.2011-2196.

Burrow S, Galloway A and Weissofner N (2009) 'Review of educational and other approaches to hearing loss among Indigenous people', *Australian Indigenous Health Bulletin*, 2(1).

Burrow S and Ride K (2016) *Review of diabetes among Aboriginal and Torres Strait Islander people,* Australian Indigenous HealthInfoNet, accessed 12 July 2024.

Catto M and Thomson N (2008) 'Review of illicit drug use among Indigenous peoples', *Australian Indigenous Health Bulletin 8(4)*, accessed 12 July 2024.

Chadban S, McDonald S, Excell L, Livingstone B and Shtangey V (2005) *ANZDATA 28th Annual Report 2005*, Australia and New Zealand Dialysis and Transplant Registry, accessed 16 July 2024.

Chandola T and Jenkins A (2014) 'The scope of adult and further education for reducing health inequalities', in Newby L and Denison N (eds) *If you Could Do One Thing...*, British Academy, London.

Clark ML and Utz SW (2014) 'Social determinants of type 2 diabetes and health in the United States', *World Journal of Diabetes* 5(3):296-304, doi:10.4239/wjd.v5.i3.296

Clarke M and Boyle J (2014) 'Antenatal Care for Aboriginal and Torres Strait Islander Women', *Australian Journal for General Practitioners* 43 (1): 20-24.

Clifford A, McCalman J, Bainbridge R and Tsey K (2015) 'Interventions to Improve Cultural Competency in Health Care for Indigenous Peoples of Australia, New Zealand, Canada and the USA: A Systematic Review', *International Journal for Quality in Health Care* 27(2):89-98, doi:10.1093/intqhc/mzv010.

COAG (Council of Australian Governments) (2008) *Council of Australian Governments Meeting Perth 2 October 2008 Communiqué*, COAG, Australian Government, accessed 19 July 2024.

Coles J, Lee A, Taft A, Mazza D and Loxton D (2015) 'Childhood Sexual Abuse and Its Association with Adult Physical and Mental Health: Results from a National Cohort of Young Australian Women', *Journal of Interpersonal Violence* 30(11):1929-44, doi:10.1177/0886260514555270.

Commission on Social Determinants of Health (2008) 'Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health', World Health Organization, accessed 23 July 2024.

Cullen P, Clapham K, Hunter K, Porykali B & Ivers R 2017. Driver licensing and health: A social ecological exploration of the impact of licence participation in Australian Aboriginal communities. 6:228-36.

Cunningham J (2002) 'Diagnostic and Therapeutic Procedures among Australian Hospital Patients Identified as Indigenous', *Medical Journal of Australia* 176(2): 58-62, doi:10.5694/j.1326-5377.2002.tb04284.x.

Cunningham J, Rumbold AR, Zhang X and Condon JR (2008) 'Incidence, Aetiology, and Outcomes of Cancer in Indigenous Peoples in Australia', *Lancet Oncology* 9(6):585-95, doi:10.1016/S1470-2045(08)70150-5.

de Costa CM and Wenitong M (2009) ‘Could the Baby Bonus Be a Bonus for Babies?’, *Medical Journal of Australia* 190(5):242-3, doi:10.5694/j.1326-5377.2009.tb02383.x.

de Looper M and Lafortune G (2009) ‘Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries’, *OECD Health Working Papers*, No. 43, OECD Publishing, Paris, doi:10.1787/225748084267.

Delpierre C, Lauwers-Cances V, Datta GD, Lang T, and Berkman L (2009) ‘Using Self-Rated Health for Analysing Social Inequalities in Health: A Risk for Underestimating the Gap between Socioeconomic Groups?’ , *Journal of Epidemiology and Community Health* 63(6):426-32, doi:10.1136/jech.2008.080085.

Department of Health and Aged Care (2017) 'My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations', Department of Health and Aged Care, Australian Government, accessed 23 July 2024.

Department of Health and Aged Care (2022) Communicable Diseases Intelligence, Department of Health and Aged Care, Australian Government.

Devitt J, Cass A, Cunningham J, Preece C, Anderson K and Snelling P (2008) ‘Study Protocol-Improving Access to Kidney Transplants (Impakt): A Detailed Account of a Qualitative Study Investigating Barriers to Transplant for Australian Indigenous People with End-Stage Kidney Disease’, *BMC Health Services Research* 8:31, doi:10.1186/1472-6963-8-31.

Dudgeon P, Walker R, Scrine C, Shepherd CCJ, Calma T and Ring IT (2014) *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people,* a report to the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare and Australian Institute of Family Studies, accessed 2 July 2024.

Dudgeon P, Milroy J, Calma T, Luxford Y, Ring IT, Walker R, Cox A, Georgatos G and Hollar C (2016a) *Solutions That Work: What the evidence and our people tell us*, a resource to the Australian Government Department of the Prime Minister and Cabinet, University of Western Australia, accessed 12 July 2024.

Dudgeon P, Calma T, Brideson T and Holland C (2016b) ‘The Gayaa Dhuwi (Proud Spirit) Declaration–a call to action for Aboriginal and Torres Strait Islander leadership in the Australian mental health system’, *Advances in Mental Health* 14(2):126-39, doi:10.1080/18387357.2016.1198233

Dudgeon P, Derry K & Wright M (2020) *A National COVID-19 Pandemic Issues Paper on Mental Health and Wellbeing for Aboriginal and Torres Strait Islander Peoples,* Perth : The University of Western Australia Poche Centre for Indigenous Health, accessed 27 September 2024.

Duijts L, Ramadhani MK and Moll HA (2009) ‘Breastfeeding Protects against Infe ctious Diseases During Infancy in Industrialized Countries. A Systematic Review’, *Maternal and Child Nutrition* 5(3):199-210, doi:10.1111/j.1740-8709.2008.00176.x.

Eades S and Australia. Office for Aboriginal and Torres Strait Islander Health (2004) *Maternal and Child Health Care Services: Actions in the Primary Health Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing age, Infants and Young Children*, Department of Health and Ageing, Australian Government, accessed 17 July 2024.

Eidelman AI, Schanler RJ, Johnston M, Landers S, Noble L, Szucs K and Viehmann L (2012) 'Section on breastfeeding. Breastfeeding and the use of human milk', *Pediatrics* 129(3): e827-841, doi:10.1542/peds.2011-3552

Emerson L, Fox S and Smith C (2015) *Good Beginnings: Getting it right in the early years*, The Lowitja Institute, accessed 15 July 2024.

Evans O (2021) *Gari Yala (Speak the Truth): gendered insights*, WGEA commissioned research report in partnership with the Jumbunna Institute of Education and research and Diversity Council Australia, accessed 15 July 2024.

FaCSIA (Department of Families Housing Community Services and Indigenous Affairs) (2007) *National Indigenous housing guide: improving the living environment for safety, health and sustainability: third edition,* FaCSIA, Australian Government, accessed 19 July 2024.

Foster G, Gronda H, Mallett S & Bentley R (2011) *Precarious housing and health: research synthesis,* Australian Housing and Urban Research Institute, Hanover Welfare Services, University of Melbourne, University of Adelaide & Melbourne Citymission, accessed 15 July 2024.

Freeman T, Edwards T, Baum F, Lawless A, Jolley G, Javanparast S and Francis T (2014) 'Cultural Respect Strategies in Australian Aboriginal Primary Health Care Services: Beyond Education and Training of Practitioners', *Australian and New Zealand Journal of Public Health* 38(4):355-61, doi:10.1111/1753-6405.12231.

Gee G, Dudgeon P, Schultz C, Hart A, & Kelly K (2014) Aboriginal and Torres Strait Islander Social and Emotional Wellbeing. In P Dudgeon, H Milroy, & R Walker (eds.), Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice *(2nd ed)*, a resource to the Australian Government Department of Prime Minister and the Cabinet, Telethon Institute for Child Health Research/Kulunga Research Network, in collaboration with University of Western Australia, accessed 2 July 2024.

Giarola BF, McCallum GB, Bailey EJ, Morris PS, Maclennan C and Chang AB (2014) 'Retrospective Review of 200 Children Hospitalised with Acute Asthma. Identification of Intervention Points: A Single Centre Study', *Journal of Paediatrics and Child Health* 50(4): 286-90, doi:10.1111/jpc.12470.

Gray C, Macniven R and Thomson N (2013) 'Review of physical activity among Indigenous people*'*, *Australian Indigenous Health Bulletin 13(3),* accessed 15 July 2024.

Guy R, Ward JS, Smith KS, Su JY, Huang RL, Tangey A, Skov S, Rumbold A, Silver B, Donovan B and Kaldor JM (2012) 'The Impact of Sexually Transmissible Infection Programs in Remote Aboriginal Communities in Australia: A Systematic Review', *Sexual Health* 9(3): 205-12, doi:10.1071/SH11074.

Gwynne K, Rojas J, Hines M, Bulkeley K, Irving M, McCowen D and Lincoln M (2020) 'Customised Approaches to Vocational Education Can Dramatically Improve Completion Rates of Australian Aboriginal Students', *Australian Health Review* 44(1):7-14, doi:10.1071/AH18051.

Hancock KJ, Shepherd CCJ, Lawrence D and Zubrick SR (2013) *Student attendance and educational outcomes: Every day counts*, a report for the Department of Education, Employment and Workplace Relations, Australian Government, accessed 15 July 2024.

Hart MB, Moore MJ and Laverty M (2017) 'Improving Indigenous Health through Education', *Medical Journal of Australia* 207(1):11-12, doi:10.5694/mja17.00319.

Helps Y, Moodie D and Warman G (2010) *Aboriginal People Travelling Well: Community Report*, The Lowitja Institute, accessed 15 July 2024.

Hogan A, Shipley M, Strazdins L, Purcell A and Baker E (2011) 'Communication and Behavioural Disorders among Children with Hearing Loss Increases Risk of Mental Health Disorders', *Australian and New Zealand Journal of Public Health* 35(4):377-83, doi:10.1111/j.1753-6405.2011.00744.x.

Horta BL, Loret de Mola C and Victora CG (2015) 'Long-Term Consequences of Breastfeeding on Cholesterol, Obesity, Systolic Blood Pressure and Type 2 Diabetes: A Systematic Review and Meta-Analysis', *Acta Paediatrica* 104(467):30-7, doi:10.1111/apa.13133.

Hunt J, Smith D, Garling S and Sanders W (eds) (2008) *Contested governance: culture, power and institutions in Indigenous Australia (volume 29),* ANU Press, Canberra.

Hunter B, Dinku Y, Eva C, Markham F and Murray M (2022) *Employment and Indigenous mental health*, a report to the Indigenous Mental Health and Suicide Prevention Clearinghouse, Australian Institute of Health and Welfare, Australian Government, accessed 15 July 2024.

Isaacs AN, Enticott J, Meadows G and Inder B (2018) 'Lower Income Levels in Australia Are Strongly Associated with Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas', *Frontiers in Psychiatry* 9:536, doi:10.3389/fpsyt.2018.00536.

Ivers RQ, Hunter K, Clapham K, Helps Y, Senserrick T, Byrne J, Martiniuk A, Daniels J and Harrison JE (2016) 'Driver Licensing: Descriptive Epidemiology of a Social Determinant of Aboriginal and Torres Strait Islander Health', *Australian and New Zealand Journal of Public Health* 40(4):377-82, doi:10.1111/1753-6405.12535.

Jamieson LM, Roberts-Thomson KF and Sayers SM (2010) 'Risk Indicators for Severe Impaired Oral Health among Indigenous Australian Young Adults', *BMC Oral Health* 10: 1, doi:10.1186/1472-6831-10-1.

Jongen C, McCalman J, Campbell S and Fagan R (2019) 'Working Well: Strategies to Strengthen the Workforce of the Indigenous Primary Healthcare Sector', *BMC Health Services Research* 19(1):910, doi:10.1186/s12913-019-4750-5.

Joshipura KJ, Hung HC, Rimm EB, Willett WC and Ascherio A (2003) 'Periodontal Disease, Tooth Loss, and Incidence of Ischemic Stroke', *Stroke* 34(1):47-52, doi:10.1161/01.str.0000052974.79428.0c.

Katzenellenbogen JM, Knuiman MW, Sanfilippo FM, Hobbs MS and Thompson SC (2014) 'Prevalence of Stroke and Coexistent Conditions: Disparities between Indigenous and Nonindigenous Western Australians', *International Journal of Stroke* 9 (SA100): 61-8, doi:10.1111/ijs.12278.

Kennedy B and Firman D (2004) Indigenous SIFA- Revealing the ecological fallacy. Population and society: issues, research, policy. (ed., Australian Population Association). Canberra: APA.

Kessels R, Hoornweg A, Bui TKT, and Erreygers G (2020) 'A Distributional Regression Approach to Income-Related Inequality of Health in Australia', *International Journal for Equity in Health* 19(1):102, doi:10.1186/s12939-020-01189-1.

Khanal N, Lawton PD, Cass A and McDonald SP (2018) 'Disparity of access to kidney transplantation by Indigenous and non-Indigenous Australians', *Medical Journal of Australia* 209:261-6, doi: 10.5694/mja18.00304

Kidney Health Australia (2020) *Know your kidneys*, Kidney Health Australia website, accessed September 2020.

Kramer MS, Aboud F, Mironova E, Vanilovich I, Platt RW, Matush L, Igumnov S, Fombonne E, Bogdanovich N, Ducruet T, Collet J, Chalmers B, Hodnett E, Davidovsky S, Skugarevsky O, Trofimovich O, Kozlova L, Shapiro S and Promotion of Breastfeeding Intervention Trial Study Group (2008) 'Breastfeeding and Child Cognitive Development: New Evidence from a Large Randomized Trial', *Archives of General Psychiatry* 65(5):578-584, doi:10.1001/archpsyc.65.5.578.

Lamb S and McKenzie P (2001) *Patterns of success and failure in the transition from school to work in Australia*, Australian Council for Educational Research, accessed 15 July 2024.

Longstreet D, Heath D, Savage I, Vink R and Panaretto K (2008) 'Estimated Nutrient Intake of Urban Indigenous Participants Enrolled in a Lifestyle Intervention Program', *Nutrition and Dietetics* 65:128-133. doi:10.1111/j.1747-0080.2008.00253.x.

Lowry D and Moskos M (2007) '*Labour force participation as a determinant of Indigenous health',* [conference presentation], Social Determinants of Aboriginal Health Workshop.

Loxton D, Townsend N, Dolja-Gore X, Forder P and Coles J (2019) 'Adverse Childhood Experiences and Healthcare Costs in Adult Life', *Journal of Child Sex Abuse* 28(5):511-525, doi:10.1080/10538712.2018.1523814.

Mainous AG 3rd, Baker R, Love MM, Gray DP and Gill JM (2001) 'Continuity of Care and Trust in One's Physician: Evidence from Primary Care in the United States and the United Kingdom', *Family Medicine* 33(1):22-7.

Marmot M, Friel S, Bell R, Houweling TA, Taylor S and Health Commission on Social Determinants (2008) 'Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health', *Lancet* 372(9650):1661-9, doi:10.1016/S0140-6736(08)61690-6.

Marsh A, Gordon D, Heslop P and Pantazis C (2000) 'Housing Deprivation and Health: A Longitudinal Analysis', *Housing Studies* 15(3):411-428, doi:10.1080/02673030050009258.

McCallum GB, Chatfield MD, Morris PS and Chang AB (2016) 'Risk Factors for Adverse Outcomes of Indigenous Infants Hospitalized with Bronchiolitis', *Pediatric Pulmonology* 51(6):613-23, doi:10.1002/ppul.23342.

Menzies RI and Singleton RJ (2009) 'Vaccine Preventable Diseases and Vaccination Policy for Indigenous Populations', *Pediatric Clinics of North America* 56(6):1263-83, doi:10.1016/j.pcl.2009.09.006.

NAHSWP (National Aboriginal Health Strategy Working Party) (1989) *A national Aboriginal health strategy,* Department of Aboriginal Affairs, Australian Government, accessed 16 July 2024.

NDIA (National Disability Insurance Agency) 2025. Quarterly report to disability ministers: 2024-25, NDIA, Australian government accessed 3 March 2025.

Nganampa Health Council, South Australia Committee of Review on Environmental and Public Health within the Anangu Pitjantjatjara Lands in South Australia, South Australian Health Commission & Aboriginal Health Organisation of South Australia (1987) *Report of Uwankara Palyanyku Kanyintjaku: An Environmental and Public Health Review within the Anangu Pitjantjatjara Lands*, Adelaide.

NHMRC (National Health and Medical Research Council) 2009. *Australian guidelines to reduce health risks from drinking alcohol*, NHMRC, Australian Government, accessed 15 July 2024..

NHMRC (National Health and Medical Research Council) (2013) *Australian Dietary Guidelines*, NHMRC, Australian Government, accessed 15 July 2024.

NHMRC (National Health and Medical Research Council) (2020) *Australian guidelines to reduce health risks from drinking alcohol*, NMHRC, Australian Government, accessed 15 July 2024.

NIDAC (National Indigenous Drug and Alcohol Committee) (2014*)* Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, Australian Government, accessed 15 July 2024.

NSW Department of Health (2019), *Housing for Health*, NSW Health website, accessed 20 August 2019.

OECD (Organisation for Economic Co-operation and Development) 2014. Obesity Update. OECD Publishing.

Paradies Y and Cunningham J (2012) 'The DRUID study: racism and self-assessed health status in an indigenous population', *BMC public health* 12:131, https://doi.org/10.1186/1471-2458-12-131

Paradies Y, Truong M and Priest N (2014) 'A Systematic Review of the Extent and Measurement of Healthcare Provider Racism', *Journal of General Internal Medicine* 29(2):364-87, doi:10.1007/s11606-013-2583-1.

Paradies Y (2016) 'Colonisation, racism and indigenous health', *Journal of Population Research* 33:83–96, https://doi.org/10.1007/s12546-016-9159-y.

Parker R and Milroy H (2014) 'Aboriginal and Torres Strait Islander Mental Health: An Overview', in: Dudgeon P, Milroy H and Walker R (eds) Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, a resource to the Australian Government Department of Prime Minister and the Cabinet, Telethon Institute for Child Health Research/Kulunga Research Network, in collaboration with University of Western Australia.

Peeters A, Barendregt JJ, Willekens F, Mackenbach JP, Al Mamun A and Bonneux L (2003) 'Obesity in Adulthood and Its Consequences for Life Expectancy: A Life-Table Analysis' *Annals of Internal Medicine* 138(1): 24-32, doi:10.7326/0003-4819-138-1-200301070-00008.

Performance Indicator Reporting Committee 2002. Plan for Federal/Provincial/Territorial Reporting on 14 Indicator Areas. Canada: PIRC.

PM&C (Department of the Prime Minister and Cabinet) (2017) *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, PM&C, Australian Government, accessed 12 July 2024.

Queensland Government (2023) COVID-19 information for First Nations people, State Government of Queensland, accessed 21 January 2025.

Queensland Health (2024) First Nations First Strategy 2032, State Government of Queensland, accessed 23 July 2024.

Ralph A 2020. What is Acute Rheumatic Fever? Darwin: RHDAustralia.

Reserve Bank of Australia (2024) *Statement on Monetary Policy May 2024*, Reserve Bank of Australia, accessed 23 July 2024.

Rix EF, Barclay L, Stirling J, Tong A and Wilson S (2015) 'The Perspectives of Aboriginal Patients and Their Health Care Providers on Improving the Quality of Hemodialysis Services: A Qualitative Study', *Hemodialysis International* 19(1):80-9, doi:10.1111/hdi.12201.

Robinson G, Silburn S and Leckning B (2011) Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee, Menzies Centre for Child Development and Education, accessed 15 July 2024.

Royal Commission into Aboriginal Deaths in Custody 1991. National Report. Australian Government Publishing Service.

Schers H, van den Hoogen H, Bor H, Grol R and van den Bosch W (2005) 'Familiarity with a Gp and Patients' Evaluations of Care. A Cross-Sectional Study', *Family Practice* 22(1):15-9, doi:10.1093/fampra/cmh721.

SCRGSP (Steering Committee for the Review of Government Service Provision) (2014a) *Overcoming Indigenous Disadvantage: Key Indicators 2014* report, Productivity Commission, Australian Government, accessed 15 July 2024.

— — (2014b) *Report on Government Services 2014*, Productivity Commission, Australian Government, accessed 18th July 2024.

— — (2016) *Overcoming Indigenous Disadvantage: Key Indicators 2016*, Productivity Commission, Australian Government, accessed 18th July 2024.

— — (2020) *Overcoming Indigenous Disadvantage: Key Indicators 2020*, Productivity Commission, Australian Government, accessed 15 July 2024.

Senate Community Affairs Committee Secretariat (2010) Hear Us: Inquiry into Hearing Health in Australia, Senate Community Affairs Committee Secretariat, Australian Government, accessed 15 July 2024.

Sevoyan A, Davison B, Rumbold A, Moore V and Singh G (2019) 'Examining the Relationship between Body Mass Index and Adverse Cardio-Metabolic Profiles among Australian Indigenous and Non-Indigenous Young Adults', *Scientific Reports* 9(1):3385, doi:10.1038/s41598-019-40083-x.

Shaw C (2016) *An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients*, The Deeble Institute for Health Policy Research, Australian Healthcare and Hospitals Association, accessed 15 July 2024.

Sims J, Hill K, Hunt S, Haralambous B, Brown A, Engel L, Huang N, Kerse N and Ory M (2006), National physical activity recommendations for older Australians: Discussion document, a report to the Australian Government Department of Health and Ageing, National Ageing Research Institute, accessed 15 July 2024.

Starfield B (1998) *Primary Care: Balancing Health Needs, Services and Technology*, Oxford University Press, New York.

Starfield B and Shi L (2004) 'The Medical Home, Access to Care, and Insurance: A Review of Evidence' *Pediatrics* 113(5 Suppl):1493-8.

Stephens A, Cullen J, Massey L and Bohanna I (2014) 'Will the National Disability Insurance Scheme Improve the Lives of Those Most in Need? Effective Service Delivery for People with Acquired Brain Injury and Other Disabilities in Remote Aboriginal and Torres Strait Islander Communities', *Australian Journal of Public Administration* 73(2): 260-270, doi:10.1111/1467-8500.12073.

Taylor GW and Borgnakke WS (2008) 'Periodontal Disease: Associations with Diabetes, Glycemic Control and Complications', *Oral Diseases* 14(3):191-203, doi:10.1111/j.1601-0825.2008.01442.x.

Thomas DP and Stevens M (2014) 'Aboriginal and Torres Strait Islander Smoke-Free Homes, 2002 to 2008', *Australian and New Zealand Journal of Public Health* 38(2):147-153, doi:10.1111/1753-6405.12202.

Thomas SL, Zhao Y, Guthridge SL and Wakerman J (2014) 'The Cost-Effectiveness of Primary Care for Indigenous Australians with Diabetes Living in Remote Northern Territory Communities', *Medical Journal of Australia* 200(11):658-62, doi:10.5694/mja13.11316.
Thomson H, Thomas S, Sellstrom E and Petticrew M (2013) 'Housing Improvements for Health and Associated Socio-Economic Outcomes', *Cochrane Database of Systematic Reviews*, (2):CD008657, doi:10.1002/14651858.CD008657.pub2.

Thurber KA, Brinckley M-M, Jones R, Evans O, Nichols K, Priest N, Guo S, Williams DR, Gee GC, Joshy G, Banks E, Thandrayen J, Baffour B, Mohamed J, Calma T, and Lovett R (2022) 'Population-level contribution of interpersonal discrimination to psychological distress among Australian Aboriginal and Torres Strait Islander adults, and to Indigenous–non-Indigenous inequities: cross-sectional analysis of a community-controlled First Nations cohort study', *The Lancet* 400:2084–94, https://doi.org/10.1016/S0140-6736(22)01639-7.

Truong M, Paradies Y and Priest N (2014) 'Interventions to Improve Cultural Competency in Healthcare: A Systematic Review of Reviews', *BMC Health Services Research* 14(3): 99, doi:10.1186/1472-6963-14-99.

Wand H, Ward J, Bryant J, Delaney-Thiele D, Worth H, Pitts M and Kaldor JM (2016) 'Individual and population level impacts of illicit drug use, sexual risk behaviours on sexually transmitted infections among young Aboriginal and Torres Strait Islander people: results from the GOANNA survey', *BMC Public Health* 16:600, doi:10.1186/s12889-016-3195-6.

Wang X, Ouyang Y, Liu J, Zhu M, Zhao G, Bao W and Hu FB (2014) 'Fruit and Vegetable Consumption and Mortality from All Causes, Cardiovascular Disease, and Cancer: Systematic Review and Dose-Response Meta-Analysis of Prospective Cohort Studies', *British Medical Journal* 349:g4490, doi:10.1136/bmj.g4490.

Weir JK (2012) 'Country, Native Title and Ecology', in Weir JK (ed.) *Country, Native Title and Ecology* (volume 24), ANU Press and Aboriginal History Incorporated, Canberra.

Whitehead M (1991) 'The Concepts and Principles of Equity and Health', *Health Promotion International* 6(3):217-228, doi:10.1093/heapro/6.3.217.

WHO (World Health Organization) (2008). The Bangkok charter for health promotion in a globalized world.

— — (2017) *Towards access 2030: WHO essential medicines and health products strategic framework 2016-2030*, WHO, accessed 15 July 2024.

— — (2024a) *HIV*, WHO website, accessed 26 March 2024.

— — *Obesity and overweight*, WHO website, accessed 16 July 2024.

Wilkinson R and Pickett K (2009) 'Income Inequality and Social Dysfunction', *Annual Review of Sociology* 35:493-511, doi:10.1146/annurev-soc-070308-115926.

Williams S, Jamieson L, MacRae A and Gray C (2011) *Review of Indigenous oral health*. Australian Indigenous HealthInfoNet, accessed 15 July 2024.

Williams CJ and Jacobs AM (2009) 'The Impact of Otitis Media on Cognitive and Educational Outcomes', *Medical Journal of Australia* 191(S9):S69-72, doi:10.5694/j.1326-5377.2009.tb02931.x.

Wilmot EG, Edwardson CL, Achana FA, Davies MJ, Gorely T, Gray LJ, Khunti K, Yates T and Biddle SJ (2012) 'Sedentary Time in Adults and the Association with Diabetes, Cardiovascular Disease and Death: Systematic Review and Meta-Analysis', *Diabetologia* 55(11):2895-905, doi:10.1007/s00125-012-2677-z.

Wood D, Chan I & Coates B (2023) How high inflation is affecting different Australian households, Grattan Institute, accessed April 2023.

Xiong X, Buekens P, Fraser WD, Beck J and Offenbacher S (2006) 'Periodontal Disease and Adverse Pregnancy Outcomes: A Systematic Review', *British Journal of Obstetrics and Gynaecology* 113(2):135-43, doi:10.1111/j.1471-0528.2005.00827.x

Yiengprugsawan V, Hogan A and Strazdins L (2013) 'Longitudinal Analysis of Ear Infection and Hearing Impairment: Findings from 6-Year Prospective Cohorts of Australian Children', *BMC Pediatrics* 13(1):28, doi:10.1186/1471-2431-13-28.

Ylöstalo PV, Järvelin MR, Laitinen J and Knuuttila ML (2006) 'Gingivitis, Dental Caries and Tooth Loss: Risk Factors for Cardiovascular Diseases or Indicators of Elevated Health Risks', *Journal of Clinical Periodontology* 33(2):92-101, doi:10.1111/j.1600-051X.2005.00875.x.

Zajacova A & Lawrence EM (2018) 'The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach', *Annu Rev Public Health* 39:273-89, doi: 10.1146/annurev-publhealth-031816-044628

Zhao Y, Thomas SL, Guthridge SL and Wakerman J (2014) 'Better Health Outcomes at Lower Costs: The Benefits of Primary Care Utilisation for Chronic Disease Management in Remote Indigenous Communities in Australia's Northern Territory', *BMC Health Services Research* 14(1):463, doi:10.1186/1472-6963-14-463.

List of tables

List of figures

The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) was developed to monitor progress towards health equity for First Nations people. The HPF brings together information about health outcomes, broader determinants of health like housing and education, health protective and risk factors, and access to health services. This report presents key findings from the HPF for First Nations people in Queensland.

AIHW

Stronger evidence,
better decisions,
improved health and welfare