



Australian Government
Australian Institute of
Health and Welfare



Aboriginal and Torres Strait Islander
Health Performance Framework
2020 summary report



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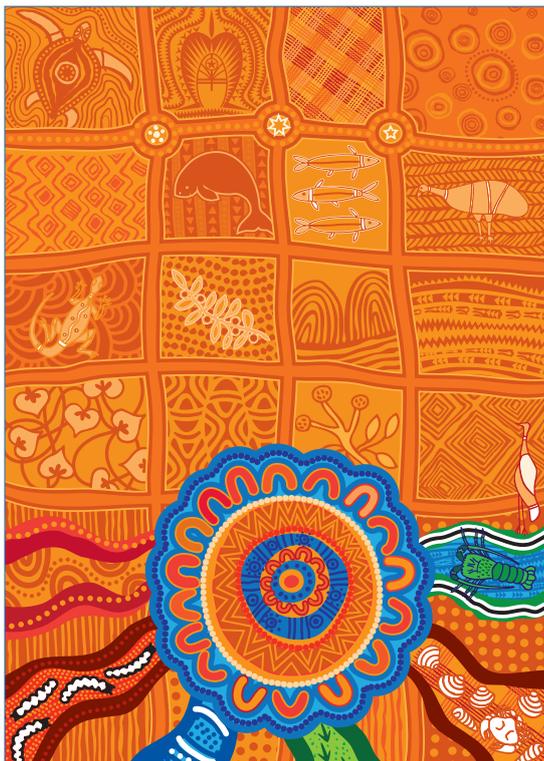
Please note that there is the potential for minor revisions of data in this report.

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

COVID-19 pandemic

This report includes data from before the COVID-19 pandemic. For data and information that relates to COVID-19, please see our COVID-19 resources <www.aihw.gov.au/covid-19>.

Artwork story



The artwork used for the report has been derived from the Aboriginal and Torres Strait Islander Health Plan artwork created by Gilimbaa. Gilimbaa is an Indigenous creative agency accredited by Supply Nation.

The original description of the artwork is as follows:

The artwork for the Department of Health and Ageing 'The Culture of Healing' brings together many people from Government to community all across Australia to address the theme of health and wellbeing for all Aboriginal and Torres Strait Islander peoples.

The 'Health Plan' is a whole of government approach, the aim of which is to initiate genuine discussion, solutions and community driven outcomes for Aboriginal and Torres Strait Islander peoples within the area of health.

The foundation of the artwork is set in a grid pattern. Each area consists of different cultural markings and motifs from the Torres Straits and across mainland Australia. These markings are the tracks left by the Rainbow Serpent, the Creation Spirit, and they represent the diversity of country. The lines that make up the grid formation are the navigational pathways and meeting places. Three stars represent these navigational pathways for Government and for Aboriginal and Torres Strait Islander peoples. The plant and animal motifs represent traditional health and wellbeing—'bush tucker'.

The central figures represent Aboriginal and Torres Strait ancestors who teach us the traditional ways so we can keep our culture strong today and into the future. The circular motif towards the bottom of the artwork represents Government and communities coming together in discussion, working together to create better health outcomes for Aboriginal and Torres Strait Islander peoples. The inner circle represents the Government from the Minister, to staff and other stakeholders and moving outwards to the Communities. The 'U' shaped motifs represent people seated in discussion, or a 'Yarning Circle'.

The pathways that lead out from these people represent the expertise and cultural knowledge and understanding that each individual brings to the table of their family, their community and their people and how the 'Health Plan' can best benefit them for a happier, healthier and brighter future together.

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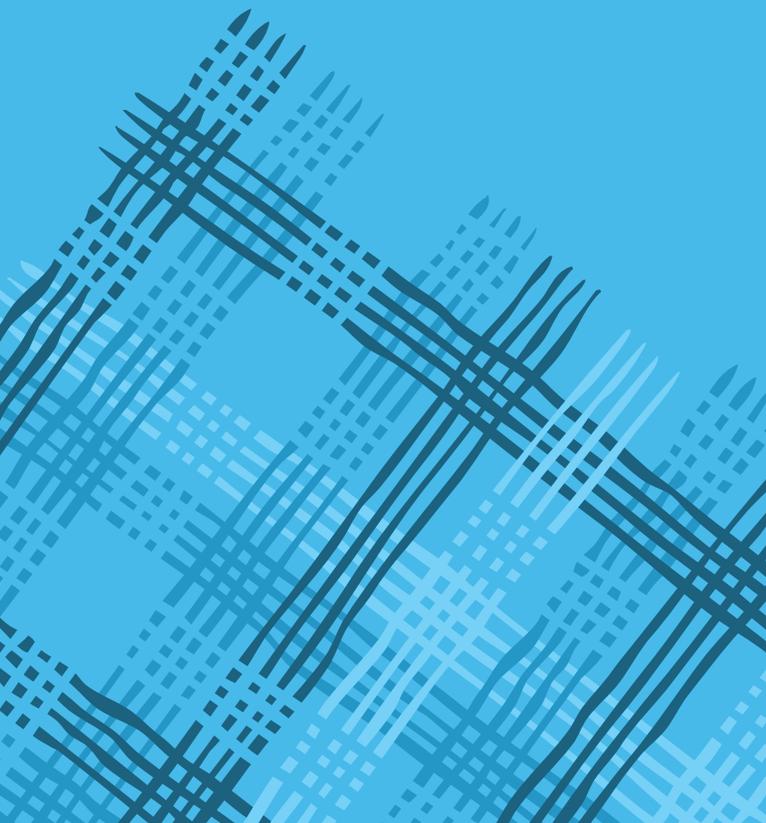
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Key findings



Indigenous Australians

Improving

Cardiovascular disease

Age-standardised rate of deaths per 100,000 population **decreased**

323 ↓ **229**
2006 2018

Education

Proportion of people aged 20–24 who had a year 12 or equivalent qualification **increased**

45% ↑ **66%**
2008 2018–19

Smoking

Those aged 15–17 reported that they had **never smoked**

72% ↑ **85%**
2008 2018–19

Health checks

The rate of Medicare health checks **increased** per 1,000 population

68 ↑ **297**
2009–10 2018–19

Not improving

Cancer

Age-standardised rate of deaths per 100,000 population **increased**

205 ↑ **235**
2006 2018

Out-of-home care

Rate of children in out-of-home care per 1,000 **increased**

35 ↑ **54**
2009 2018

Imprisonment

Rate of adults per 100,000 **increased**

1,337 ↑ **2,088**
2006 2019

Health service access

In 2018–19

3 in 10

who needed to go to a health provider **did not go**—the same proportion as in 2012–13. Barriers included cost, and health services being unavailable, far away or with long waiting times.



Introduction

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

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

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

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

When the risk of COVID-19 became apparent, Aboriginal and Torres Strait Islander leaders and communities led the response, and partnered with governments. Together, Indigenous leaders and the Australian Government co-designed a remote travel restrictions and quarantine regime to keep COVID-19 out of our most vulnerable Indigenous communities in remote Australia.

New governance mechanisms were also established—such as the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 co-chaired by the Australian Department of Health and National Aboriginal Community Controlled Health Organisation (NACCHO)—and utilised existing partnerships with Indigenous organisations and communities to target support for vulnerable populations, addressing both the health and economic impacts of COVID-19 on Indigenous communities and businesses, and delivering culturally appropriate and in-language communications with Indigenous Australians in remote communities.

To date, it appears that these measures have helped protect remote Indigenous communities (DoH 2020a). As at the writing of this report, the number of reported cases for Aboriginal and Torres Strait Islander people was less than one per cent of all reported cases in Australia.

Initial concerns, during the pandemic, that not enough attention was being paid to Indigenous Australians living in urban and regional areas are also being addressed by the Australian Department of Health through the development of national guidance for Aboriginal and Torres Strait Islander people living in urban and regional settings (Aboriginal and Torres Strait Islander Advisory Group on COVID-19 2020).

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

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

The Aboriginal and Torres Strait Islander Health Performance Framework

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

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

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

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

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

The Aboriginal and Torres Strait Islander Health Performance Framework

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

Tier 1: Health status and outcomes

Tier 2: Determinants of health

Tier 3: Health system performance

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

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

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

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

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

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

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

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

Future HPF developments

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

This year has seen important strides taken in governments working with Aboriginal and Torres Strait Islander people on issues of national significance. 'Formal partnerships and shared decision making' is one of the priority reforms in the National Agreement on Closing the Gap, paving the way for governments and Aboriginal and Torres Strait Islander representatives to work together.

The National Agreement on Closing the Gap, July 2020

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

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

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

The agreement is available at closingthegap.gov.au. Appendix 2 lists the priority reforms and targets in the agreement.

'Shared access to data and information at a regional level' is another Closing the Gap priority reform area. The Australian Institute of Health and Welfare (AIHW) Regional Insights for Indigenous Communities website will help improve access to regional data for Indigenous communities (forthcoming).

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 was developed to provide an overarching framework which builds links with other major Australian Government health activities and identifies areas of focus to guide future investment and effort to improve Indigenous health. In late 2020, the plan will undergo a refresh. The refreshed Health Plan will embed the cultural determinants and social determinants of health and provide a single, overarching policy framework for Aboriginal and Torres Strait Islander health with a vision that Aboriginal and Torres Strait Islander peoples enjoy long, healthy lives that are centred in culture, with access to services that are prevention-focused, responsive, culturally safe, and free of racism and inequity.

While the current Health Plan is not due to expire until 2023, undertaking the refresh now provides an opportunity to align the Health Plan with the National Agreement on Closing the Gap and other whole-of-population health strategies under development, such as the National Preventive Health Strategy, the 10-Year Primary Health Care Plan and the various mental health, suicide prevention and social and emotional wellbeing strategies. It will also highlight the importance of ensuring that mainstream, or whole-of-population, services and programs are responsive to the needs of Aboriginal and Torres Strait Islander peoples.

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

About this report

This *Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report* provides an overview of the key statistics, and summarises the latest information on how Indigenous Australians are faring, drawing from the HPF performance measures.

This year, for the first time, the detailed findings and data are presented together on a dedicated website, indigenoushpf.gov.au. The website includes:

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

This will enable readers to more easily explore all the HPF data.

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

Over the coming years, feature articles will be published at indigenoushpf.gov.au to further draw out insights from the data and research, exploring particular topics across HPF measures.

Terminology

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

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

Interpretation of results

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

Given the differences in the age structure between the Indigenous and non-Indigenous populations, age-standardised rates have been used in this report when comparing the two populations and change over time. Where age-standardised rates have been used, this is stated throughout the report.

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

For more information, see the technical notes in this report and indigenoushpf.gov.au.

Structure of this report

- Section 1 *Introduction* presents an overview of the broader social and policy context to the health of Indigenous Australians and the background to, and purpose of, the HPF.
- Section 2 *How Indigenous Australians are faring* presents a summary of key findings from the 2020 Aboriginal and Torres Strait Islander HPF.
- Section 3 *Social context* outlines the demographic profile of Indigenous Australians, and provides an overview of the impact of cultural and social determinants on the health of Indigenous Australians.
- Section 4 *Tier 1—Health status and outcomes* presents key findings from Tier 1 of the HPF.
- Section 5 *Tier 2—Determinants of health* presents key findings from Tier 2 of the HPF.
- Section 6 *Tier 3—Health system performance* presents key findings from Tier 3 of the HPF.
- Appendix 1 outlines Aboriginal and Torres Strait Islander Health Performance Framework measures.
- Appendix 2 outlines the National Agreement on Closing the Gap priority reform areas and targets.
- Appendix 3 provides supporting information for the map presented in Figure 6.6.





How Indigenous Australians are faring



The burden of disease among Aboriginal and Torres Strait Islander people is 2.3 times that of non-Indigenous Australians. Mental health and chronic diseases such as cancer, cardiovascular disease, respiratory diseases, diabetes and kidney disease are areas of particular concern. A large part of the disparity in health outcomes between Indigenous Australians and non-Indigenous Australians is explained by disparities in social determinants, in particular income, employment and education. In many cases, Indigenous Australians also have lower access to health services than non-Indigenous Australians, for a range of reasons including barriers such as cost and a lack of accessible or culturally appropriate health services. For Indigenous Australians to have better health outcomes, improvements in the health system and determinants beyond the health sector are required.

Overview

Measures of Indigenous Australians' health status and outcomes drawn from the 2020 Aboriginal and Torres Strait Islander HPF show mixed results over the most recent decade. While there have been some improvements, in other cases progress has stalled or outcomes have become worse. For example, perinatal, infant, and child death rates for Aboriginal and Torres Strait Islander people have declined over the past 20 years, but there has been little change in the ten years to 2018. Key health determinants such as education, income and employment and risk factors such as smoking and obesity also show mixed outcomes. Similarly, HPF measures of how well the health system is meeting the needs of Aboriginal and Torres Strait Islander people show varying results. These outcomes are discussed in more detail in this summary report.

The health of Aboriginal and Torres Strait Islander people improved on a number of measures over the most recent decade. The proportion of low birthweight babies has decreased. The rate of avoidable deaths has decreased and death rates for cardiovascular disease, diabetes and kidney disease have fallen.

There have also been improvements in some social determinants of health—levels of educational attainment have increased and the proportion of Indigenous Australians living in overcrowded housing has decreased. Among Indigenous Australians, rates of smoking—a key health risk factor—continue to decline.

There have also been some improvements in the health system, such as increases in rates of attendance at antenatal care among Indigenous women. Immunisation rates for Indigenous children have increased, with the vast majority being fully immunised at 5 years. Rates of health checks and use of general practitioner (GP) management plans for chronic diseases have also increased substantially.

Other health outcomes for Indigenous Australians have not improved or have worsened over the most recent decade. Child death rates have not changed significantly over this time, following improvements during the early 2000's.

The proportion of Indigenous Australians with diabetes has not changed significantly, and rates of death from cancer and suicide among Indigenous Australians have increased.

There has been little change in the employment rate—a key social determinant of health— among Indigenous Australians. The imprisonment rate among Indigenous adults has increased over the most recent decade. The rate of obesity among Indigenous adults has increased—this is a key health risk factor.

Some areas of health system performance that have worsened for Indigenous Australians over the most recent decade include an increase in the rate of preventable hospitalisations and in the rate of people taking their own leave from hospital before completing treatment. Indigenous Australians are less likely than non-Indigenous Australians to receive a medical or surgical procedure while in hospital, and per person expenditure on prescription medicines is lower for Indigenous Australians than non-Indigenous Australians.

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

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

However, the following examples illustrate how measures across the HPF tiers can provide insights into changing health outcomes:

- the proportion of low birthweight babies has decreased, as the rate of smoking during pregnancy has decreased and the rate of antenatal care visits early in pregnancy has increased
- deaths from cardiovascular disease have decreased along with a decreased rate of smoking and increased rates of hospital procedures related to coronary heart disease.

This national summary report presents a selection of results from the Aboriginal and Torres Strait Islander Health Performance Framework 2020. The following Key facts in detail section includes some additional results that are not covered in detail in this report but are available from the full set of measures (listed at Appendix 1) at indigenoushpf.gov.au.

Key facts in detail

The following key facts are structured into three groups: outcomes that have improved, those where there has been no recent change, and those that worsened over time. Changes over time cannot be assessed for all measures, as trend data are not available in all cases.

Outcomes have improved for a number of measures

The proportion of low birthweight babies (excluding multiple births) born to Indigenous mothers fell from 11.3% in 2007 to 10.7% in 2017. There is a strong relationship between low birthweight and smoking during pregnancy, which has also declined (see below).

Between 2006 and 2018, the age-standardised rate of avoidable deaths among Indigenous Australians fell from 374 to 303 per 100,000. Indigenous Australians died from avoidable causes at three times the rate of non-Indigenous Australians.

Cardiovascular disease (CVD) is the second leading cause of death among Aboriginal and Torres Strait Islander people. The age-standardised death rate for CVD fell from 323 per 100,000 in 2006 to 229 per 100,000 in 2018. The decline in mortality from CVD coincided with reductions in smoking rates and an increase in hospitalisations for CVD-related procedures.

Levels of educational attainment have improved over the decade. The proportion of Indigenous Australians aged 20–24 who had a Year 12 or equivalent qualification increased from 45% in 2008 to 66% in 2018–19. The rate at which Indigenous adults completed higher education courses increased from 38 to 67 per 10,000 between 2001 and 2018–19.

There has been some improvement in the rate of youth justice supervision among Indigenous youth (decreasing from 212 to 170 per 10,000 population between 2010–11 and 2017–18). However, Indigenous Australians represented nearly half (47%) of all young people in detention in 2017–18.

In 2016, 38% of Indigenous households were home owners/buyers—an increase from 32% in 2001. The proportion of Indigenous Australians who lived in overcrowded households fell from 27% in 2004–05 to 18% in 2018–19.

Household incomes of Indigenous adults increased in real terms (that is, after adjusting for inflation) from \$544 to \$802 per week between 1996 and 2016. Other Australian adults experienced a weekly increase in household income from \$801 to \$1,096 over the same period.

The proportion of Indigenous Australians aged 15 and over who smoked daily fell from 45% in 2008 to 37% in 2018–19. The proportion of Indigenous Australians aged 15–17 who smoked fell from 22% to 13% between 2008 and 2018–19 and the proportion who had never smoked increased from 72% to 85% over the same period. The proportion of Indigenous women who smoked during pregnancy fell from 54% in 2006 to 44% in 2017.

In 2017, 99.2% of Indigenous mothers accessed antenatal care services at least once during their pregnancy. From 2012 to 2017, the proportion of Indigenous mothers who attended antenatal care in the first trimester (less than 14 weeks) increased from 51% to 63%. Mothers who attend antenatal care during pregnancy are more likely to have babies in the healthy birthweight range.

The proportion of Indigenous children aged 1 who were fully immunised increased from 82% in 2001 to 92% in 2018. The immunisation rate for Indigenous 5-year-olds increased from 77% in 2008 to 97% in 2018, which was higher than the non-Indigenous rate of 95% in 2018.

The number of health assessments for Indigenous Australians increased fourfold between 2009–10 and 2018–19, from 68 to 297 per 1,000. Health check rates increased across all age groups over this period. There was also an increase in the proportion of Indigenous women aged 50–69 who were screened for breast cancer, from 31% in 1999–00 to 37% in 2017–18.

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

The number of Commonwealth-funded Indigenous-specific primary health-care organisations increased from 108 in 1999–00 to 198 in 2017–18. Episodes of care delivered by these organisations increased from 1.2 million to 3.6 million and the number of health care workers in these organisations more than tripled from 2,300 to 8,200 over the same period.

In 2018–19, 92% of Indigenous Australians reported they had a usual place to go for health problems and advice, an increase from 87% in 2012–13. Those with a usual general practitioner or medical service reported higher rates of satisfaction with their health care experience than those without one.

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

Between 2004–05 and 2016–17, the proportion of Indigenous Australians who received a hospital procedure increased from 53% to 64%. However, Indigenous hospital patients were less likely to undergo a medical or surgical procedure than non-Indigenous Australians (64% compared to 81% in the period July 2015 to June 2017).

However, there has been little or no recent change for some measures

The crude death rate for Indigenous Australians in 2014–2018 was 418 per 100,000. Between 1998 and 2018, the age-standardised death rate for Indigenous Australians decreased significantly by 32%. However, most of the decline occurred between 1998 and 2006 (a 27% decrease) and there was a slower rate of decline from 2006 to 2018 (by 10%). There was no change in rates of death from respiratory disease or injuries between 2006 and 2018.

Perinatal death rates among Indigenous Australians declined over the past 20 years, but most of this decline was for the period 1998 to 2007 and there has been little or no change in the 10-year period to 2018. In 2008, the perinatal death rate was 9.7 per 1,000 births, compared with 9.0 per 1,000 births in 2018.

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

The employment rate for Indigenous Australians remained unchanged between 2008 and 2018–19 (48% and 49%, respectively).

Some measures have worsened

Cancer is currently the leading cause of death among Indigenous Australians. Between 2006 and 2018, the age-standardised death rate from cancer among Indigenous Australians increased from 205 to 235 per 100,000. A decrease in the cancer death rate among non-Indigenous Australians occurred over the same period, leading to a widening of the gap. Indigenous Australians have lower cancer screening rates and are more likely to be diagnosed with cancer at more advanced stages resulting in lower cancer survival rates.

In 2014–2018, the suicide rate for Indigenous Australians was 24 per 100,000. There was an increase (49%) in suicide rates for Indigenous Australians between 2006 and 2018 from 18 to 24 per 100,000 with the highest rate of suicide being among those aged 35–39. From 2004–05 to 2016–17, the rate of hospitalisation due to intentional self-harm increased by 120% for Indigenous females (from 2.2 to 4.5 per 1,000) and increased by 81% for Indigenous males (from 1.6 to 3.3 per 1,000).

Between 2004–05 and 2016–17, the age-standardised rate of Indigenous Australians hospitalised after an assault increased from 4.2 to 6.9 per 1,000 population for females and from 1.6 to 2.4 per 1,000 population for males. In the period July 2015 to June 2017, the hospitalisation assault rate (age-standardised) was highest in *Remote* areas (25 per 1,000 population).

There was an increase of 61% in the imprisonment rate for Indigenous adults (from 1,337 to 2,088 per 100,000) between 2006 and 2019, compared with an increase of 36% for non-Indigenous adults (from 132 to 173 per 100,000) (age-standardised). In 2019, Aboriginal and Torres Strait Islander adults were imprisoned at twelve times the rate of non-Indigenous adults (age-standardised).

The age-standardised rate of Medicare claims for specialist care among Indigenous Australians did not change significantly between 2009–10 (252 per 1,000) and 2017–18 (236 per 1,000). Rates for Indigenous Australians were lower than those for non-Indigenous Australians across all remoteness areas, with the largest difference in *Very remote* areas (70% lower).

In the two-year period July 2015 to June 2017, 15% of all hospitalisations (excluding dialysis) of Indigenous Australians were potentially preventable. Between 2010–11 and 2016–17, the potentially preventable hospitalisation rate for chronic conditions among Indigenous Australians increased from 30 to 34 per 1,000 population (age-standardised). The age-standardised rate of potentially preventable hospitalisations for Indigenous Australians with acute conditions also increased, from 24 per 1,000 in 2010–11 to 29 per 1,000 in 2016–17.

The age-standardised rate at which Indigenous Australians took their own leave from hospital increased from 11 per 1,000 population in 2004–05 to 16 per 1,000 population in 2016–17.

More details about the selected findings presented in this report, and information about the full range of HPF measures, can be found at indigenoushpf.gov.au.

Key findings

These findings are based on analysis of change over time for the relevant time period.

Improving

Health status and outcomes		
Low birthweight (Measure 1.01)	2007	2017
Decrease in the proportion of low birthweight live born babies born to Indigenous mothers (excluding multiple births) (%) ^a	11.3	10.7
Circulatory (cardiovascular) disease (Measure 1.05)	2006	2018
Decrease in the age-standardised rate of deaths from cardiovascular disease among Indigenous Australians (per 100,000 population) ^b	323	229
Diabetes (Measure 1.09)	2006	2018
Decrease in the age-standardised rate of deaths from diabetes among Indigenous Australians (per 100,000 population) ^b	93	72
Kidney disease (Measure 1.10)	2006	2018
Decrease in the age-standardised rate of deaths from kidney disease among Indigenous Australians (per 100,000 population) ^b	45	20
Avoidable and preventable deaths (Measure 1.24)	2006	2018
Decrease in the age-standardised rate of avoidable deaths among Indigenous Australians (per 100,000 population) ^b	374	303
Determinants of health		
Housing (Measure 2.01)	2004–05	2018–19
Decrease in the proportion of Indigenous Australians living in overcrowded housing (%)	27	18
Education outcomes for young people (Measure 2.05)	2008	2018–19
Increase in the proportion of Indigenous Australians aged 20–24 who had a Year 12 or equivalent qualification (%)	45	66
Tobacco use (Measure 2.15)	2008	2018–19
Increase in the proportion of Indigenous Australians aged 15–17 who had never smoked (%)	72	85
Health system performance		
Antenatal care (Measure 3.01)	2012	2017
Increase in the age-standardised proportion of Indigenous women accessing antenatal care in first trimester of pregnancy (%)	51	63
Immunisation (Measure 3.02)	2008	2018
Increase in the proportion of Indigenous children fully immunised at age 5 (%)	77	97
Early detection and early treatment (Measure 3.04)	2009–10	2018–19
Increase in the rate of health checks for Aboriginal and Torres Strait Islander people (per 1,000 population)	68	297
Chronic disease management (Measure 3.05)	2009–10	2017–18
Increase in the age-standardised rate of claims for GP management plans for chronic disease (per 1,000 population)	69	142

a Data from New South Wales, Victoria, Queensland, Western Australia, South Australia, and the Northern Territory combined.

b Data from New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory combined.

These findings are based on analysis of change over time for the relevant time period.

Not improving

Health status and outcomes		
Cancer (Measure 1.08)	2006	2018
Increase in the age-standardised rate of deaths from cancer among Indigenous Australians (per 100,000 population) ^a	205	235
Diabetes (Measure 1.09)	2012–13	2018–19
No significant change in the prevalence of self-reported diabetes among Indigenous adults (%)	7.7	7.9
Social and emotional wellbeing (Measure 1.18)	2006	2018
Increase in the age-standardised suicide rate among Indigenous Australians (per 100,000 population) ^a	18	24
Infant and child mortality (Measure 1.20)	2008	2018
No significant change in the rate of child deaths (aged 0–4) for Indigenous Australians (per 100,000 population) ^b	160	147
Perinatal mortality (Measure 1.21)	2008	2018
No significant change in the rate of perinatal deaths (stillbirths and infant deaths within 28 days following birth) for Indigenous Australians (per 1,000 births) ^a	9.7	9.0
Determinants of health		
Employment (Measure 2.07)	2008	2018–19
No significant change in the employment-to-population rate ^c among Indigenous Australians aged 15–64 (%)	48	49
Contact with the criminal justice system (Measure 2.11)	2006	2019
Increase in the age-standardised imprisonment rate of Indigenous Australians (per 100,000 population)	1,337	2,088
Overweight and obesity (Measure 2.22)	2012–13	2018–19
Increase in the proportion of Indigenous Australians aged 15 and over who are overweight or obese (%)	66	71
Health system performance		
Selected potentially preventable hospital admissions (Measure 3.07)	2013–14	2016–17
Increase in the age-standardised rate of potentially preventable hospitalisations among Indigenous Australians (per 1,000 population)	63	70
Discharge against medical advice (Measure 3.09)	2004–05	2016–17
Increase in the age-standardised rate at which Indigenous hospital patients leave hospital without completing treatment (per 1,000 population) ^d	11	16
Access to services compared with need (Measure 3.14)	2012–13	2018–19
No change in the proportion of Indigenous Australians who needed to go to a health provider in the previous 12 months but didn't (%)	30	30

a Data from New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory combined.

b Data from New South Wales, Western Australia, South Australia, and the Northern Territory combined.

c Excludes employment through the Community Development Employment Projects Scheme.

d Data from New South Wales, Victoria, Queensland, Western Australia, South Australia, and the Northern Territory combined.

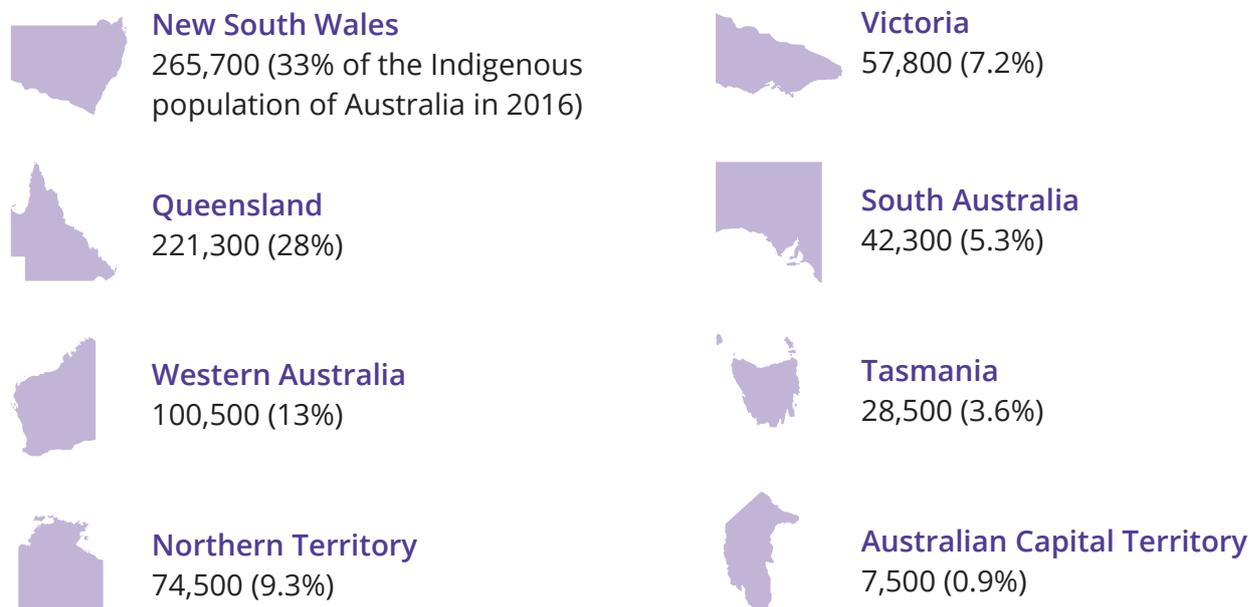


Social context



Demographic information

According to national population estimates, about 800,000 Australians identified as being Aboriginal and/or Torres Strait Islander in 2016. About 3 in 5 (61%) live in New South Wales and Queensland.



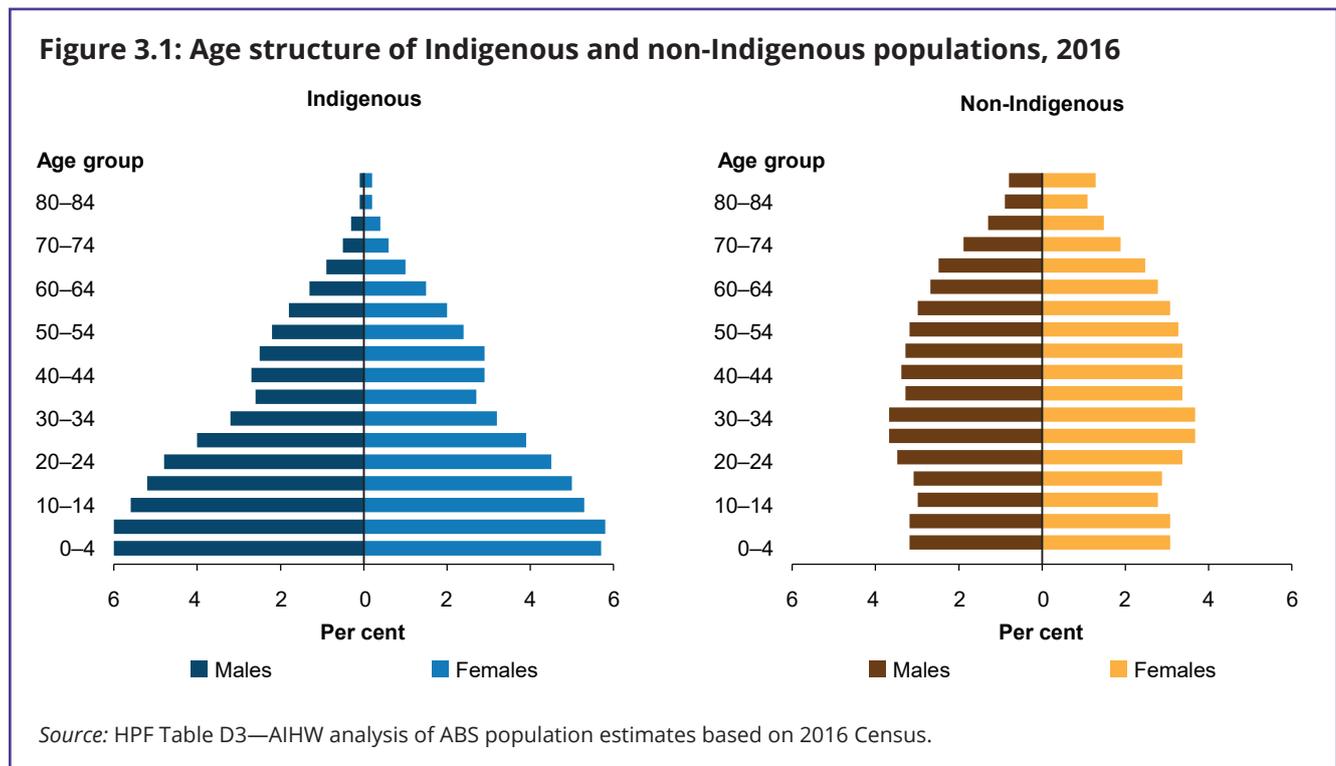
Most Aboriginal and Torres Strait Islander people (around 3 in 5) live in *Major cities* and *Inner regional* areas, 1 in 5 live in *Outer regional* areas, and nearly 1 in 5 live in *Remote* or *Very remote* areas.

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

	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Indigenous population	2%	4%	8%	18%	47%	3%
Non-Indigenous population	98%	96%	92%	82%	53%	97%
Total population	100%	100%	100%	100%	100%	100%

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

The Indigenous population is relatively young. In 2016, about 1 in 3 (34%) Indigenous Australians (274,300) were aged under 15, compared with fewer than 1 in 5 (18%) non-Indigenous Australians (Figure 3.1).



Cultural and social determinants

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

A new study—the Mayi Kuwayu Study of Aboriginal and Torres Strait Islander Wellbeing—aims to provide more evidence of how culture is related to Aboriginal and Torres Strait Islander people’s health and wellbeing (ANU 2020).

In contrast to cultural protective factors, racism or racial discrimination are associated with poorer physical and mental health (see, for example, Paradies 2006; Priest et al. 2011). Colonisation is recognised as having a fundamental impact on disadvantage and health among Indigenous peoples worldwide, through social systems that maintain disparities (see, for example, Paradies 2016; Paradies & Cunningham 2012).

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).

In 2017, the Australian Government released *My life my lead—opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: report on the national consultations*. These consultations provided an opportunity for Indigenous communities and leaders, governments, the non-government and private sectors to inform the refresh of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

Four main themes emerged from the consultations:

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

This report will guide the development and delivery of future policy and programs, including the next National Aboriginal and Torres Strait Islander Health Plan.

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



Tier 1

**Health status
and outcomes**

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

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

Life expectancy

In 2015–2017, life expectancy at birth was 71.6 years for Indigenous males and 75.6 years for Indigenous females. The gap between Indigenous and non-Indigenous Australians was 8.6 years for males and 7.8 years for females (Table 4.1). These life expectancy estimates for Australia are age-adjusted (ABS 2018b).

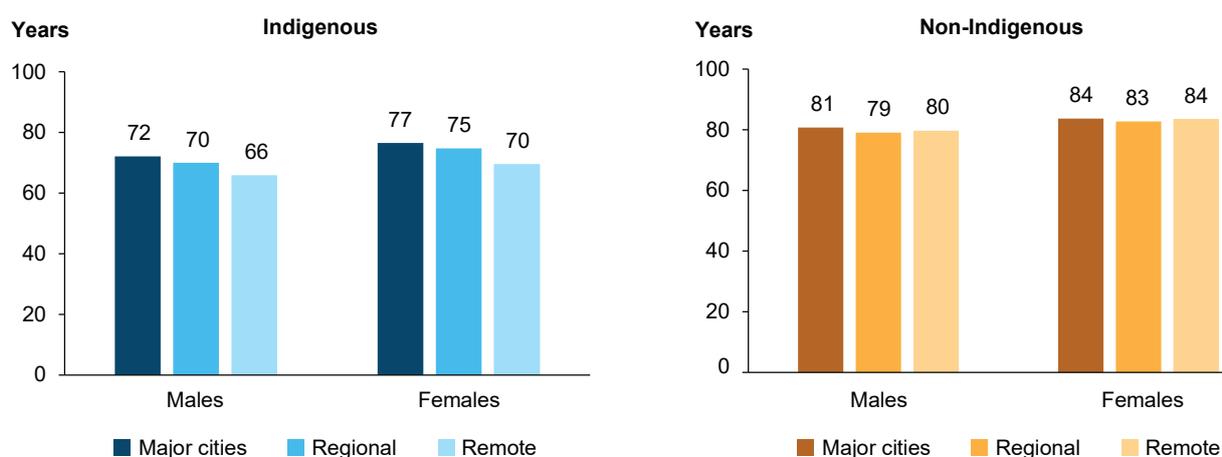
Table 4.1: Life expectancy at birth (age-adjusted), by Indigenous status and sex, 2015–2017

	Years
Indigenous males	71.6
Non-Indigenous males	80.2
<i>Difference in years</i>	8.6
Indigenous females	75.6
Non-Indigenous females	83.4
<i>Difference in years</i>	7.8

Source: HPF Table D1.19.1—ABS 2018b.

Life expectancy decreases as remoteness increases for Indigenous Australians, but not for non-Indigenous Australians. Indigenous males and females living in *Remote* or *Very remote* areas have a life expectancy 6–7 years lower than those in *Major cities* (Figure 4.1). These results could not be age-adjusted, and so cannot be compared with the estimates for Australia provided in Table 4.1.

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



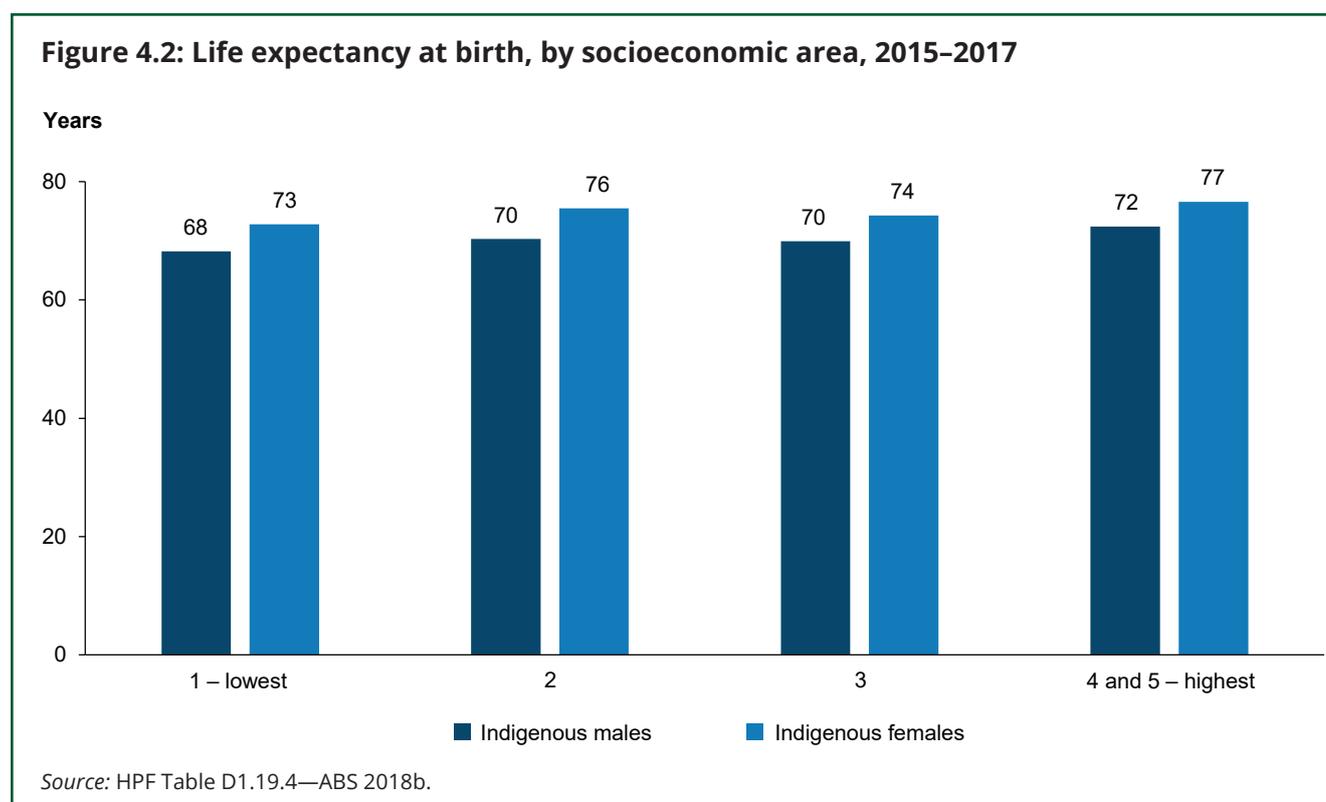
Note: 'Regional' includes *Inner regional* and *Outer regional* areas, 'Remote' includes *Remote* and *Very remote* areas.

Sources: HPF Table D1.19.3—ABS 2018b; ABS unpublished data.

Socioeconomic disadvantage

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

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



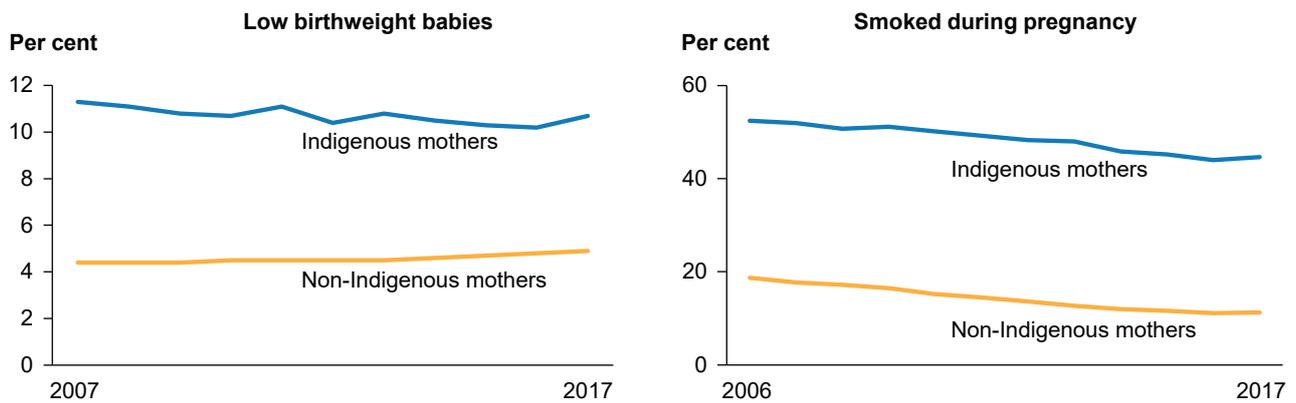
Healthy birthweight

Having a healthy weight at birth provides children with a good start in life, while low birthweight infants are prone to ill-health in childhood and to chronic disease as adults (AHMAC 2017).

Most babies born to Indigenous mothers had a healthy birthweight. There has been a small but significant decline in the low birthweight rate for babies born to Indigenous mothers (excluding multiple births)—from 11.3% in 2007 to 10.7% in 2017 (data from NSW, Vic, Qld, WA, SA and NT combined) (Figure 4.3).

Note: Since data were compiled for the Aboriginal and Torres Strait Islander HPF, AIHW has released more recent information in Australia's mothers and babies data visualisations, available at <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies-data-visualisations/contents/focus-groups/indigenous-mothers>.

Figure 4.3: Low birthweight babies (2007–2017) and smoking during pregnancy (age-standardised) (2006–2017)



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

Sources: HPF Table D1.01.2; HPF Table D2.21.11—AIHW analysis of the National Perinatal Data Collection.

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

Aboriginal and Torres Strait Islander women who had their first antenatal care visit in the first trimester of their pregnancy (before 14 weeks) were less likely to have a baby of low birthweight than women whose first antenatal visit occurred later in their pregnancy.

The age-standardised proportion of Indigenous mothers who attended antenatal care in the first trimester of their pregnancy increased from 51% in 2012 to 63% in 2017.

The proportion of low birthweight babies was higher for Indigenous mothers who smoked (15%) than for those who did not (6.7%). The age-standardised rate of smoking during pregnancy among Indigenous women who gave birth decreased from 52% in 2006 to 45% in 2017 (Figure 4.3).

Leading causes of disease burden and mortality

Burden of disease

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

- 429 years were lost to disease burden—premature death or living with disease or injury—for every 1,000 Indigenous Australians
- 185 years were lost to disease burden for every 1,000 non-Indigenous Australians.

These results come from *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011* (AIHW 2016), the latest available burden of disease information for Indigenous and non-Indigenous Australians.

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

'Burden of disease' refers to the impact of disease and injury on a population. It is measured in 'years of healthy life lost', which comprises:

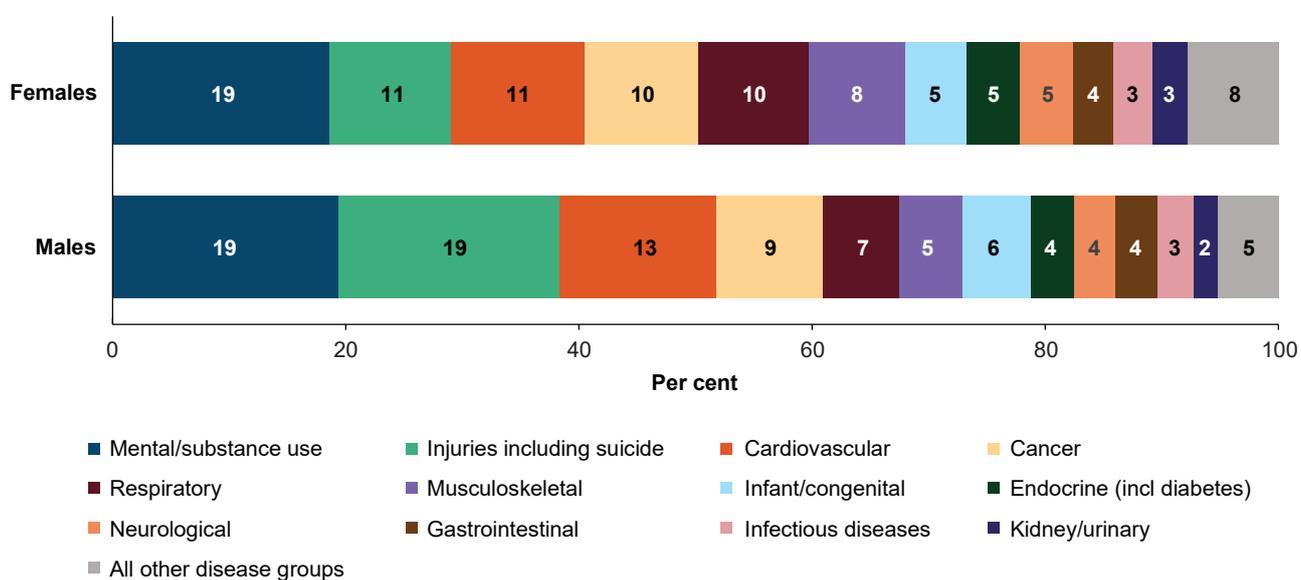
- years lost from dying prematurely, also known as fatal disease burden
- years lost due to living with disease or injury, also known as non-fatal disease burden.

Among Indigenous Australians, nearly two-thirds of disease burden is a result of the following broad disease groups:

- mental and substance use disorders
- injuries
- cardiovascular disease
- cancer
- respiratory disease (Figure 4.4).

Diabetes and kidney disease are also of concern, because of their contribution to disease burden, particularly in remote areas. There are large disparities between Indigenous and non-Indigenous Australians in the prevalence and impact of these two diseases.

Figure 4.4: Leading causes of disease burden among Indigenous Australians, by sex, 2011



Source: AIHW 2016.

Mortality rate and leading causes of death

The crude death rate for Aboriginal and Torres Strait Islander people in 2014–2018 was 418 per 100,000. Between 1998 and 2018, the age-standardised death rate for Indigenous Australians decreased significantly by 32%. However, most of the decline occurred between 1998 and 2006 (a 27% decrease) and there was a slower rate of decline from 2006 to 2018 (by 10%).

In 2014–2018, cancer (as a broad disease group) was the leading cause of death among Aboriginal and Torres Strait Islander people. The five leading specific causes of death for Indigenous Australians were:

- coronary heart disease
- diabetes
- lung cancer
- chronic obstructive pulmonary disease
- suicide.

For Indigenous Australians, the age-standardised death rate for diabetes was more than 5 times as high as for non-Indigenous Australians (78 compared with 15 deaths per 100,000 population).

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

Diabetes and suicide were not among the five leading causes of death for non-Indigenous Australians (which were coronary heart disease, dementia including Alzheimer’s disease, cerebrovascular disease, lung cancer, and chronic obstructive pulmonary disease) (AIHW 2020a).

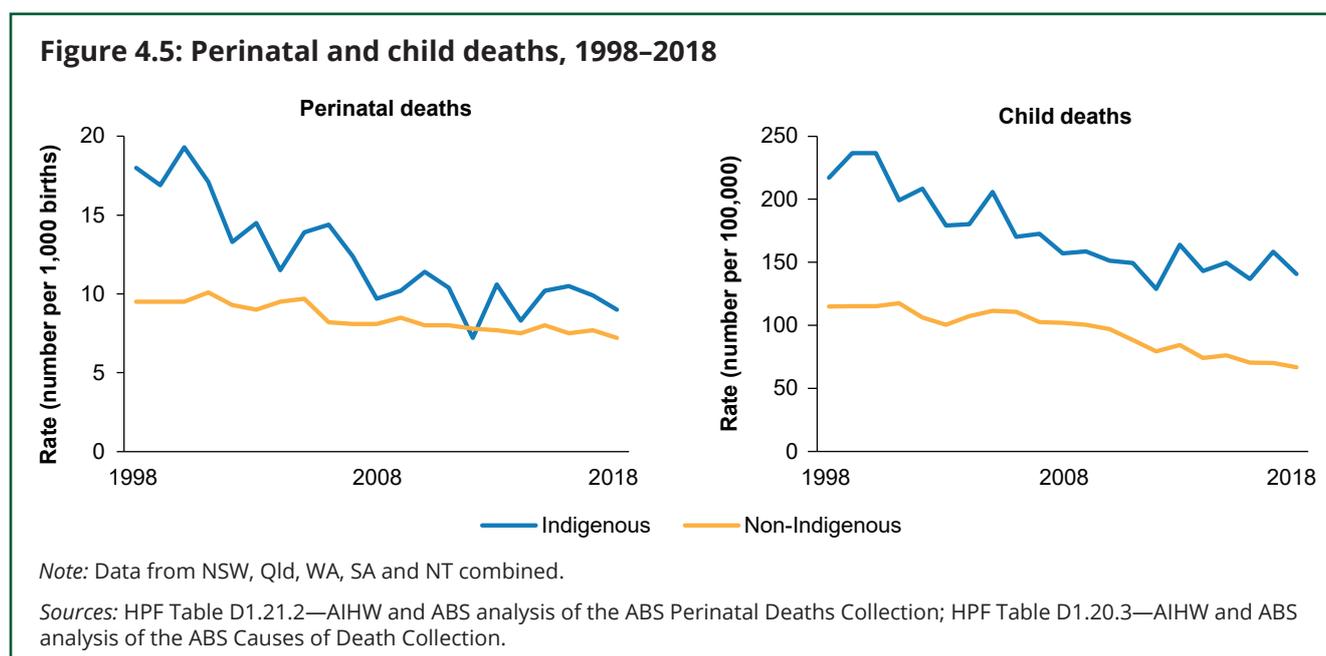
Mortality data, including data on the leading causes of death, are available for the period 2014–2018, in the five jurisdictions with data of adequate quality (NSW, Qld, WA, SA and NT).

Perinatal, infant, and child mortality

Perinatal, infant, and child death rates for Aboriginal and Torres Strait Islander people have declined over the past 20 years, but there has been little change in the ten years to 2018.

Perinatal deaths are stillbirths and infant deaths within 28 days following birth. The rate of perinatal deaths for Indigenous Australians decreased from 18 deaths per 1,000 births in 1998 to 9.7 per 1,000 in 2008, but did not change significantly over the following decade (Figure 4.5). Note that HPF information about perinatal deaths (measure 1.21) is sourced from AIHW and ABS analysis of the ABS Perinatal Deaths Collection, using data from New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. This allows for comparison of HPF data over time and should not be confused with information sourced from AIHW’s National Perinatal Data Collection which includes all jurisdictions.

Similarly, death rates of infants (aged under 1) and children (aged 0–4) decreased between 1998 and 2008, but did not change significantly over the following decade (Figure 4.5).



Avoidable deaths

Avoidable deaths

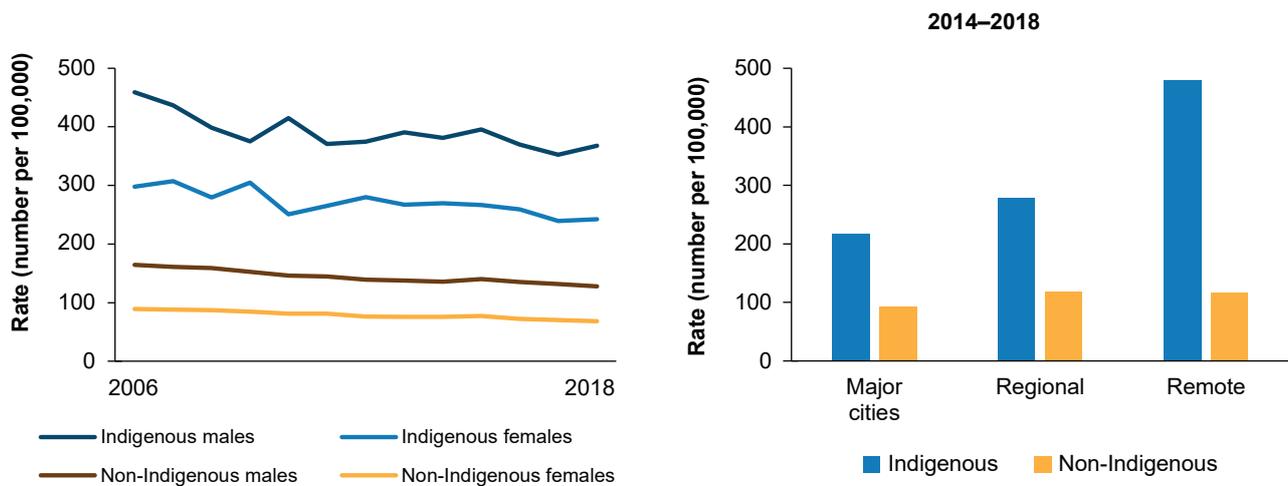
Avoidable deaths are premature deaths—among those aged under 75—from health conditions and injuries that could be avoided with disease prevention and population health initiatives or access to timely and effective health care.

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

There were 7,100 avoidable deaths among Aboriginal and Torres Strait Islander people during the period 2014–2018. This equates to an age-standardised rate of 312 per 100,000 people, compared with 103 per 100,000 among non-Indigenous Australians (data from NSW, Qld, WA, SA and NT combined).

Between 2006 and 2018, the age-standardised rate of avoidable deaths among Indigenous Australians declined from 374 per 100,000 population to 303 per 100,000. Age-standardised rates of avoidable deaths among Indigenous Australians are higher in remote areas than in non-remote areas (Figure 4.6).

Figure 4.6: Avoidable deaths by Indigenous status and sex (2006–2018), and remoteness area (2014–2018) (age-standardised)



Notes:

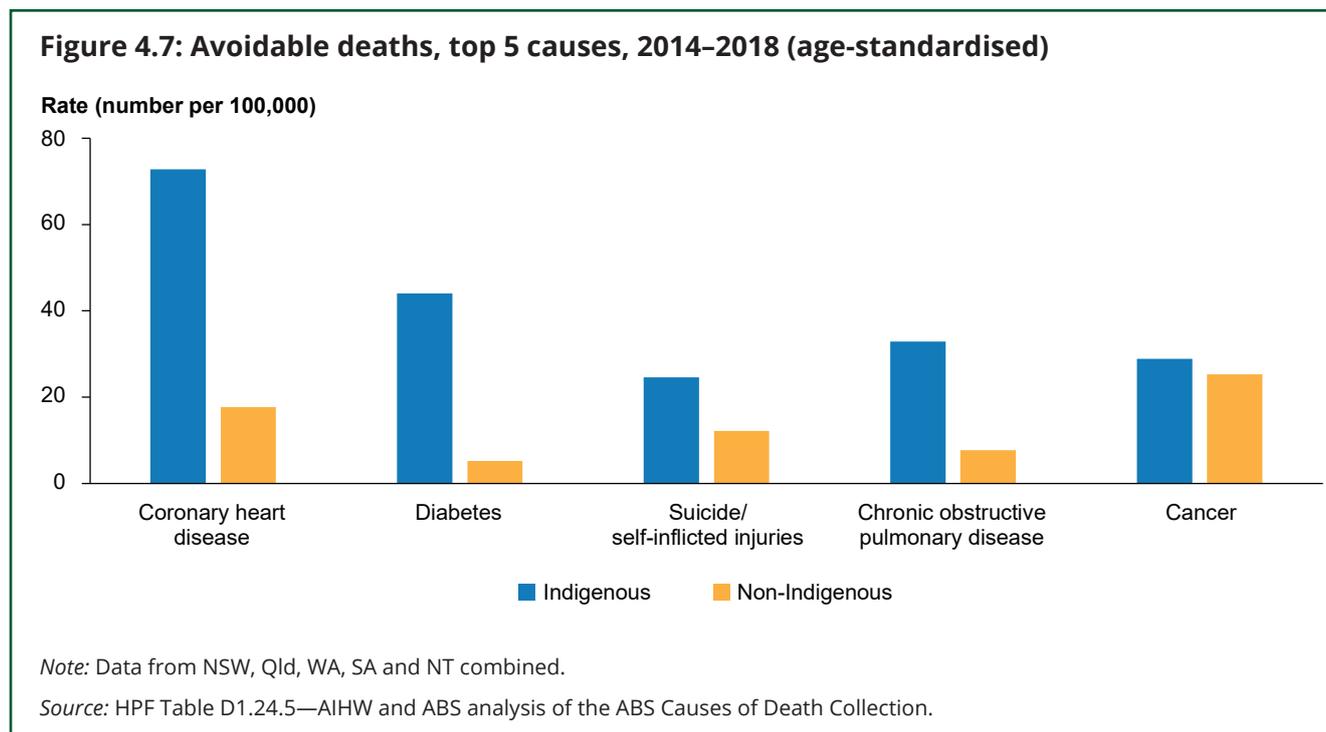
1. Data from NSW, Qld, WA, SA and NT combined.
2. 'Regional' includes *Inner regional* and *Outer regional* areas, 'Remote' includes *Remote* and *Very remote* areas.

Sources: HPF Table D1.24.2 and HPF Table D1.24.6—AIHW and ABS analysis of the ABS Causes of Death Collection.

In 2014–2018, the leading five causes of avoidable deaths among Indigenous Australians were:

- coronary heart disease (1,510 deaths)
- diabetes (840)
- suicide and self-inflicted injuries (790)
- chronic obstructive pulmonary disease (580)
- cancer (570).

Age-standardised death rates per 100,000 population for these leading causes show that there are particular disparities between Indigenous and non-Indigenous Australians for coronary heart disease and diabetes (Figure 4.7).



Mental health and social and emotional wellbeing

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

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

The National Agreement on Closing the Gap has identified the importance of Indigenous Australians enjoying high levels of social and emotional wellbeing with a specific outcome, target and indicators to direct policy attention and monitor progress in this area. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing (Commonwealth of Australia 2017b) and the Fifth National Mental Health and Suicide Prevention Plan (Commonwealth of Australia 2017a) are important components of the national response to Aboriginal and Torres Strait Islander mental health, but there is a need for data development to improve monitoring of progress.

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

Almost 1 in 3 Indigenous adults (31% or 149,400) had high to very high levels of psychological distress in 2018–19 (age-standardised), a similar proportion to 2014–15. In comparison, 13% of non-Indigenous adults had high levels of psychological distress. Those who had been removed from families or had relatives removed from families had a higher proportion with high or very high levels of psychological distress (38%) compared to those who were not removed from their families (26%).

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

About 34% of those who had experienced at least one of these events had high to very high levels of psychological distress, compared with 19% of those who had not.

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

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

Notes

1. More than one response could be given.

2. 'Non-remote' includes *Major cities, Inner regional* and *Outer regional* areas, 'Remote' includes *Remote* and *Very remote* areas.

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

Mental health care services used by Indigenous Australians

In 2015–16, Indigenous Australians used the *Access to Allied Psychological Services Programme* at an age-standardised rate of 826 per 100,000 population. This was more than 4 times that of non-Indigenous Australians (193 per 100,000).

This program is for people with common mental disorders, like anxiety and depression, who have difficulty accessing Medicare-subsidised mental health services, because of a lack of services in some areas, difficulty paying fees, or being at risk of homelessness (AIHW 2020b).

In 2018–19, the rate of contact with state and territory community and hospital-based outpatient mental health care services (age-standardised) for Indigenous Australians was 1,200 per 1,000 population, more than three times that for non-Indigenous Australians (340 per 1,000) (AIHW 2020b).

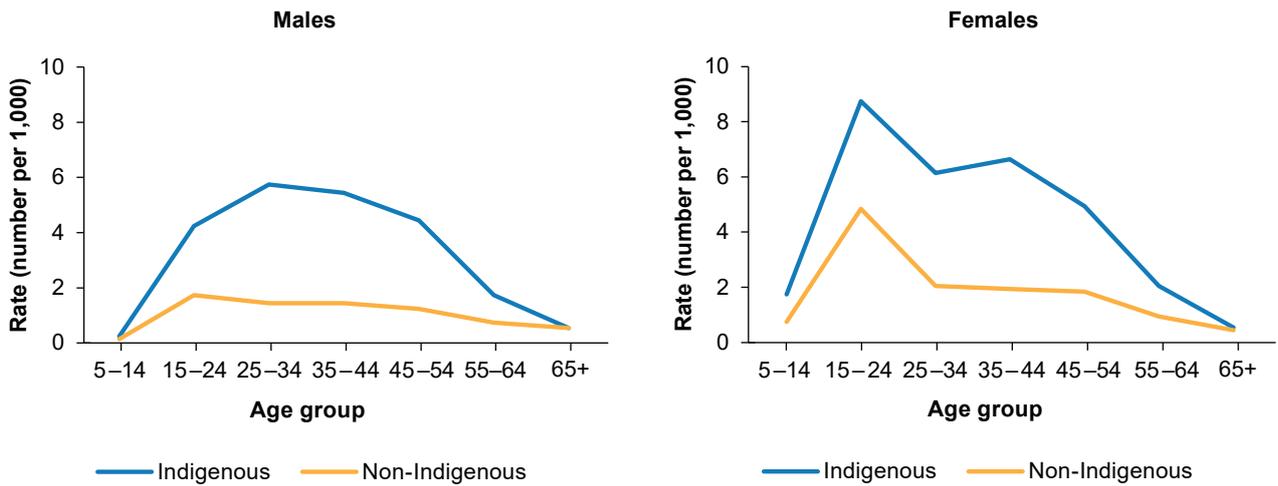
Medicare claim rates for psychologist and psychiatrist care were much lower for Indigenous Australians than for non-Indigenous Australians.

Intentional self-harm and suicide

Between July 2015 and June 2017, 5,700 Aboriginal and Torres Strait Islander people were hospitalised due to intentional self-harm.

Indigenous Australians were hospitalised for self-harm at nearly 3 times the rate of non-Indigenous Australians (age-standardised), with the greatest disparities in those aged 25–34 to 45–54 (Figure 4.8).

Figure 4.8: Hospitalisations from intentional self-harm, July 2015 to June 2017



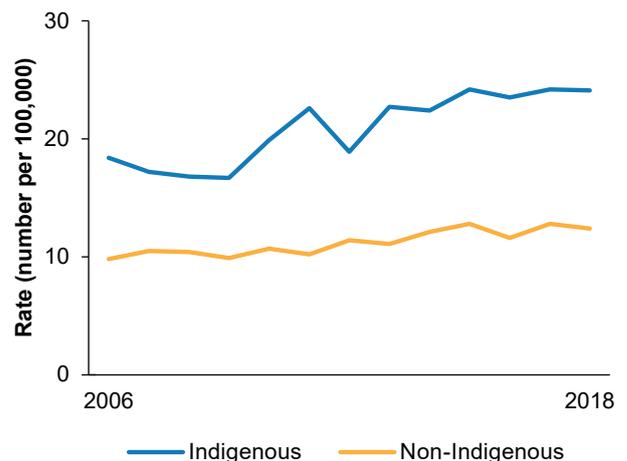
Source: HPF Table D1.18.27—AIHW analysis of National Hospital Morbidity Database.

In 2014–2018, 796 Indigenous Australians died from intentional self-harm (suicide). The age-standardised suicide rate for Indigenous Australians increased from 18 per 100,000 population in 2006 to 24 per 100,000 in 2018 (data from NSW, Qld, WA, SA and NT combined) (Figure 4.9).

In 2014–2018, the age-standardised suicide rate among Indigenous Australians was 1.9 times the rate among non-Indigenous Australians.

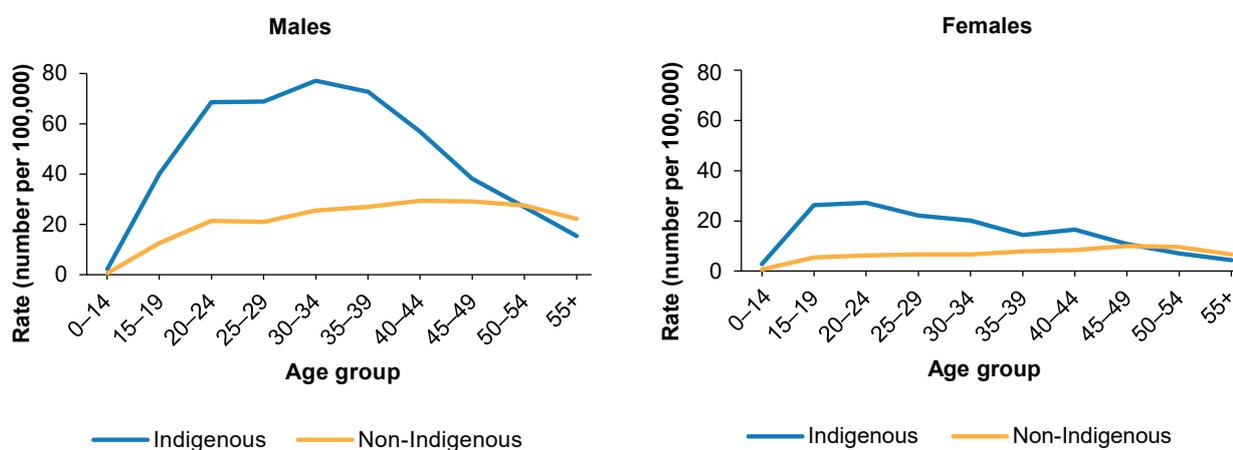
The suicide rate among Indigenous Australians was highest among those aged 35–39 (62 per 100,000) in 2014–2018 (data from NSW, Qld, WA, SA and NT combined). Among non-Indigenous Australians, the suicide rate was highest among those aged 45–49 (20 per 100,000) (Figure 4.10).

Figure 4.9: Suicide rates (age-standardised), 2006–2018



Note: Data from NSW, Qld, WA, SA and NT combined.
Source: HPF Table D1.18.24—AIHW and ABS analysis of the ABS Causes of Death Collection.

Figure 4.10: Suicide rates, by age group and sex, 2014–2018



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

Source: HPF Table D1.18.22—AIHW and ABS analysis of the ABS Causes of Death Collection.

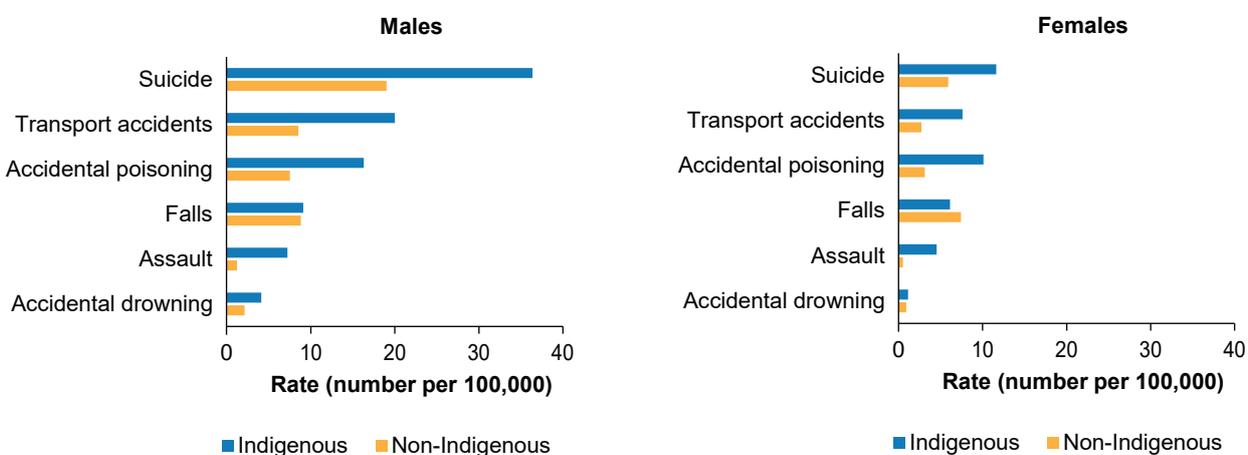
Injury and poisoning

Injury and poisoning is the second leading cause of disease burden and third leading cause of death among Aboriginal and Torres Strait Islander people. It accounted for 15% of deaths (2,200) in 2014–2018.

Among Indigenous Australians, the most common underlying causes of deaths from injury and poisoning in 2014–2018 were suicides (796 deaths), transport accidents (418 deaths), accidental poisoning (369 deaths), assault (183 deaths) and falls (95 deaths).

After adjusting for differences in the age structure of the Indigenous and non-Indigenous populations, there are large disparities between the two populations in the rates of death per 100,000 from all these causes except for falls (Figure 4.11).

Figure 4.11: Injury and poisoning causes of death, 2014–2018

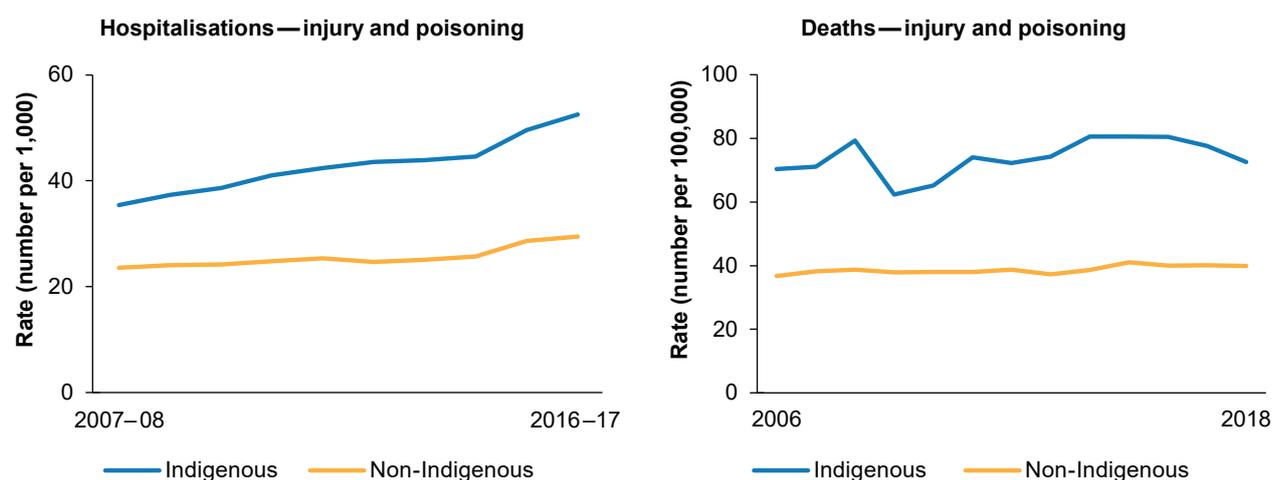


Note: Data from NSW, Qld, WA, SA and NT combined.

Source: HPF Table D1.03.1—AIHW and ABS analysis of the ABS Causes of Death Collection.

Injury and poisoning was the most common cause of hospitalisation for Indigenous Australians (excluding dialysis), and the age-standardised hospitalisation rate increased between 2007–08 and 2016–17. The age-standardised death rate due to injury and poisoning among Indigenous Australians did not change significantly between 2006 and 2018 (Figure 4.12).

Figure 4.12: Injury and poisoning hospitalisations (2007–08 to 2016–17) and deaths (2006–2018) (age-standardised)



Notes

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

Sources: HPF Table D1.03.5—AIHW analysis of National Hospital Morbidity Database; HPF Table D1.23.19—AIHW and ABS analysis of the ABS Causes of Death Collection.

Cancer

Cancer is a leading cause of disease burden, and the leading cause of death among Aboriginal and Torres Strait Islander people. Cancer accounted for 23% of deaths (3,400) in 2014–2018 (data from NSW, Qld, WA, SA and NT combined).

Lung cancer accounts for about one-quarter (26%) of deaths from cancer among Indigenous Australians.

National screening programs in Australia reduce the risk of death from several cancers. Indigenous Australians have lower rates of participation in screening programs than non-Indigenous Australians for breast cancer (age-standardised) and bowel cancer (Table 4.3).

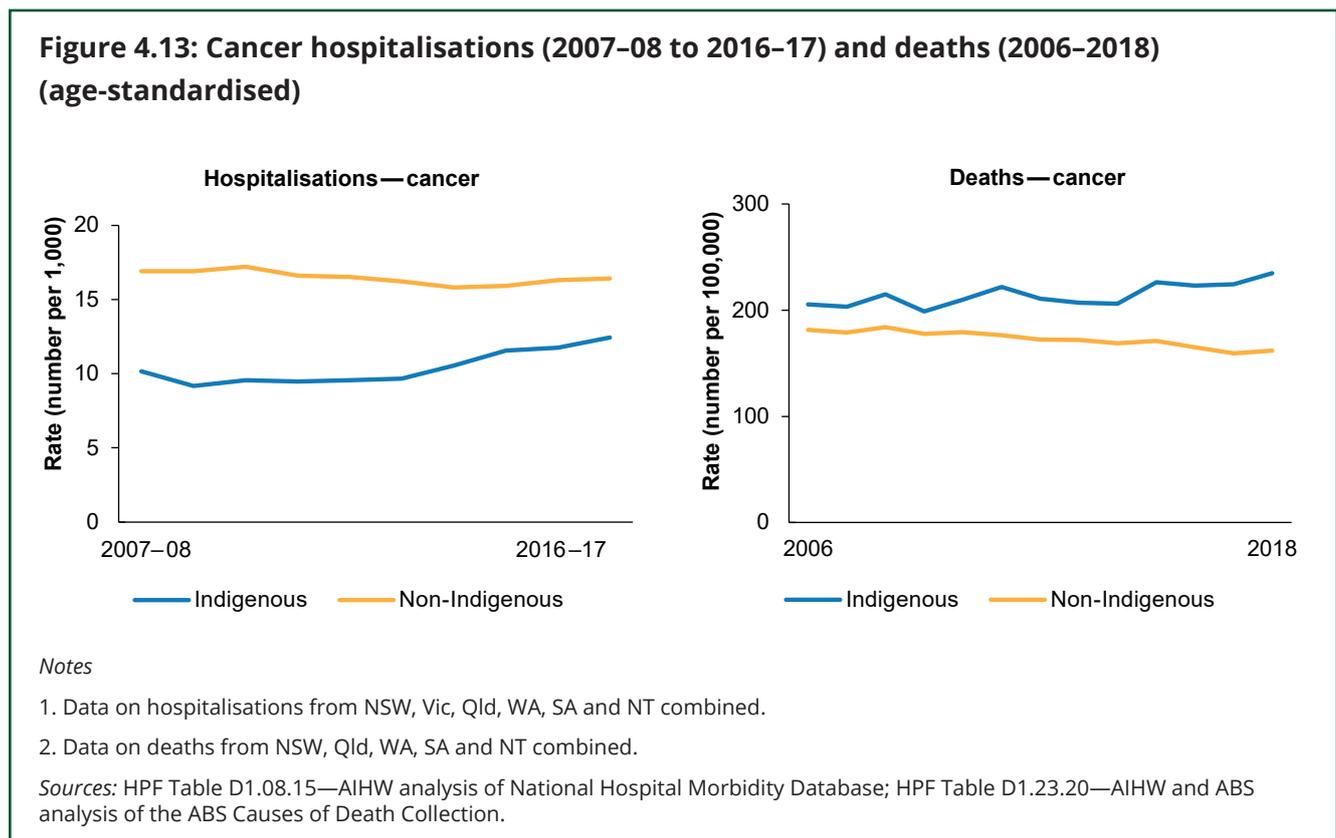
Table 4.3: Participation in cancer screening programs

	Indigenous	Non-Indigenous
	Per cent	
Women aged 50–74 screened for breast cancer— age-standardised rate, 2017–2018	38	54
People aged 50–74 participating in National Bowel Screening Program, 2017	21	43
People aged 50–74 having follow up colonoscopy, where appropriate, 2017	51	67

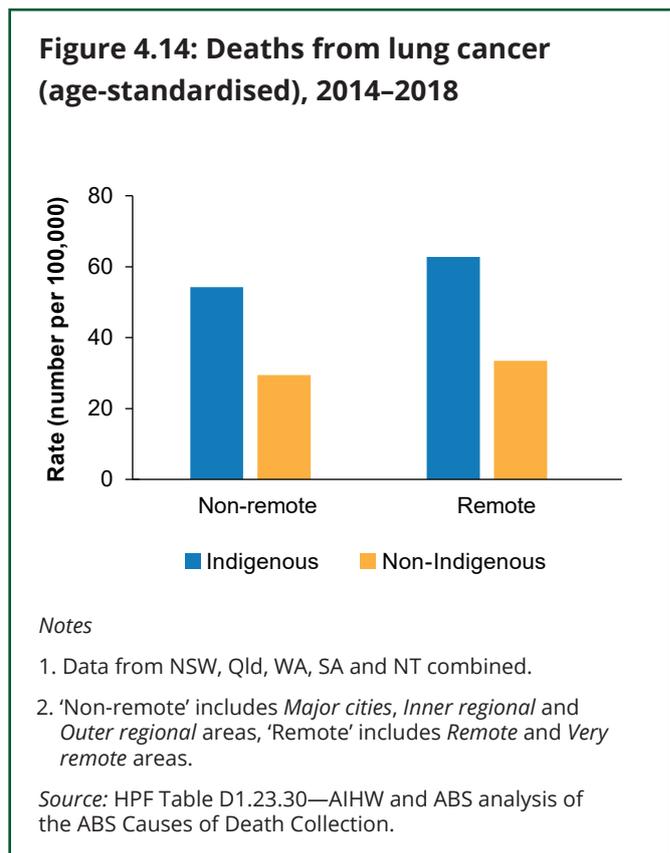
Sources: HPF Table D3.04.9—AIHW analysis of BreastScreen Australia data; AIHW 2019e.

The age-standardised hospitalisation rate for cancer among Indigenous Australians increased from 10.2 per 1,000 population in 2007–08 to 12.5 per 1,000 in 2016–17 (data from NSW, Vic, Qld, WA, SA and NT combined).

Among Indigenous Australians, age-standardised death rates from cancer increased from 205 per 100,000 population in 2006 to 235 per 100,000 in 2018 (data from NSW, Qld, WA, SA and NT combined) (Figure 4.13).



In 2014–2018, death rates from lung cancer (age-standardised) were higher among Indigenous Australians than among non-Indigenous Australians. For Indigenous Australians living in non-remote areas, the death rate from lung cancer was 54 per 100,000 population, compared with 29 per 100,000 in remote areas. For non-Indigenous Australians, death rates from lung cancer were similar in non-remote areas (29 per 100,000) and remote areas (33 per 100,000) (Figure 4.14).



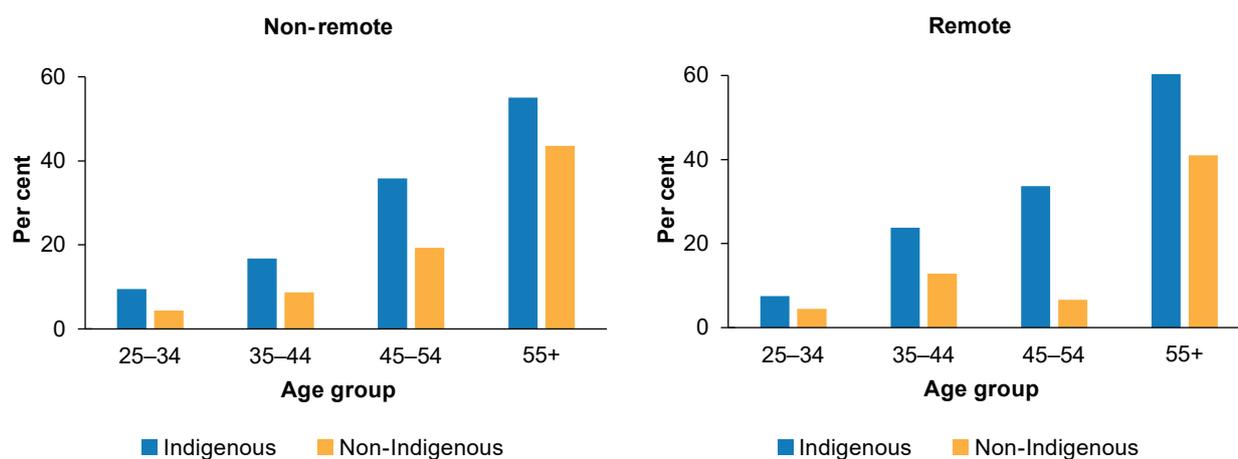
Cardiovascular disease

Cardiovascular disease, also referred to as circulatory disease, includes conditions such as coronary heart disease and stroke. It is the second leading cause of death among Aboriginal and Torres Strait Islander people, accounting for 23% of deaths (3,300) in 2014–2018 (data from NSW, Qld, WA, SA and NT combined).

In 2018–19, about 16% (122,100) of Indigenous Australians aged 2 and over had a cardiovascular condition, based on self-reported survey information.

For Indigenous adults aged 25–54, rates of self-reported cardiovascular disease are about double those of non-Indigenous adults in corresponding age groups in both non-remote and remote areas (Figure 4.15).

Figure 4.15: Cardiovascular conditions, 2018–19



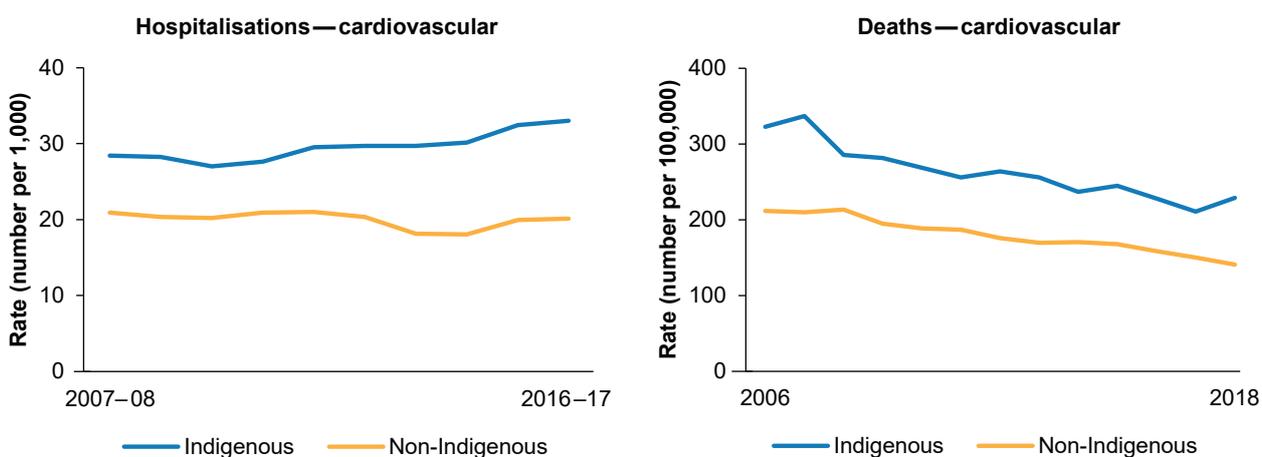
Note: 'Non-remote' includes Major cities, Inner regional and Outer regional areas, 'Remote' includes Remote and Very remote areas.

Source: HPF Table D1.05.2—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and National Health Survey 2017–18.

The age-standardised rate of hospitalisations from cardiovascular diseases among Indigenous Australians increased over the decade to 2016–17 (Figure 4.16). Between 2004–05 and 2016–17, the age-standardised proportion of hospitalisations of Indigenous Australians involving procedures for coronary heart disease increased from 32% to 58%. These were procedures such as angiography (X-ray imaging of blood vessels) and coronary revascularisation (including, for example, procedures to dilate blood vessel and heart bypass surgery).

The age-standardised death rate from cardiovascular diseases among Indigenous Australians fell from 323 in 2006 to 229 in 2018 (Figure 4.16).

Figure 4.16: Cardiovascular disease hospitalisations (2007–08 to 2016–17) and deaths (2006–2018) (age-standardised)



Notes

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

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

Sources: HPF Table D1.05.11—AIHW analysis of National Hospital Morbidity Database; HPF Table D1.23.18—AIHW and ABS analysis of the ABS Causes of Death Collection.

Respiratory diseases

Chronic respiratory diseases, such as asthma and chronic obstructive pulmonary disease, make a large contribution to disease burden among Aboriginal and Torres Strait Islander people.

In 2014–2018, 1,400 Indigenous Australians died from respiratory diseases (9% of all deaths), making this the fourth leading cause of death (data from NSW, Qld, WA, SA and NT combined). Most of these deaths were from chronic obstructive pulmonary disease (62%), pneumonia and influenza (17%), and asthma (4.6%).

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

Chronic respiratory diseases

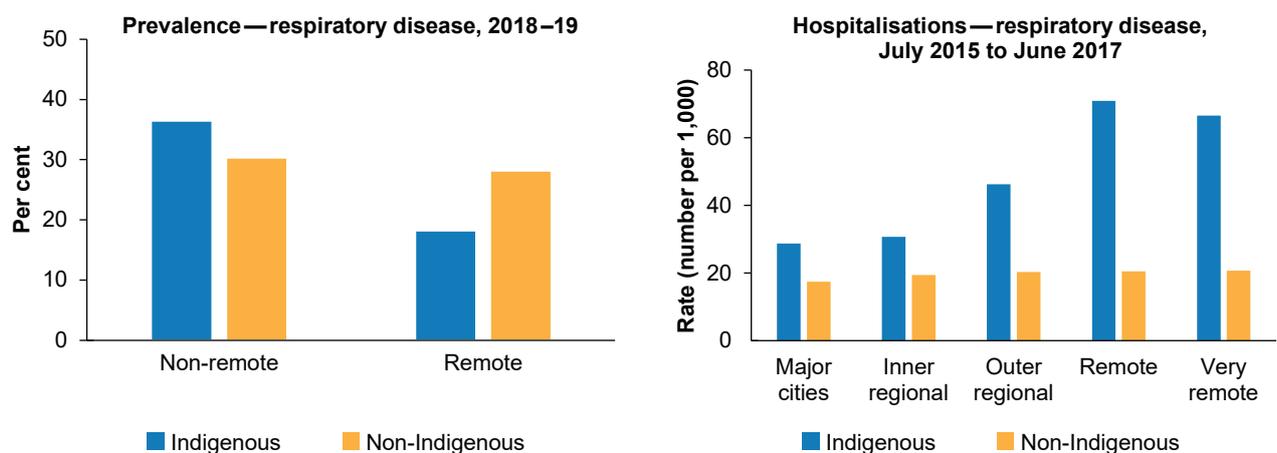
Chronic respiratory diseases are long-lasting with persistent effects.

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

Respiratory diseases are more prevalent among Indigenous Australians in non-remote areas than among those in remote areas.

But age-standardised rates of hospitalisation due to respiratory disease are higher among Indigenous Australians living in *Remote* and *Very remote* areas than among those in other areas (Figure 4.17).

Figure 4.17: Respiratory disease prevalence (2018–19) and hospitalisations (age-standardised) (July 2015 to June 2017)

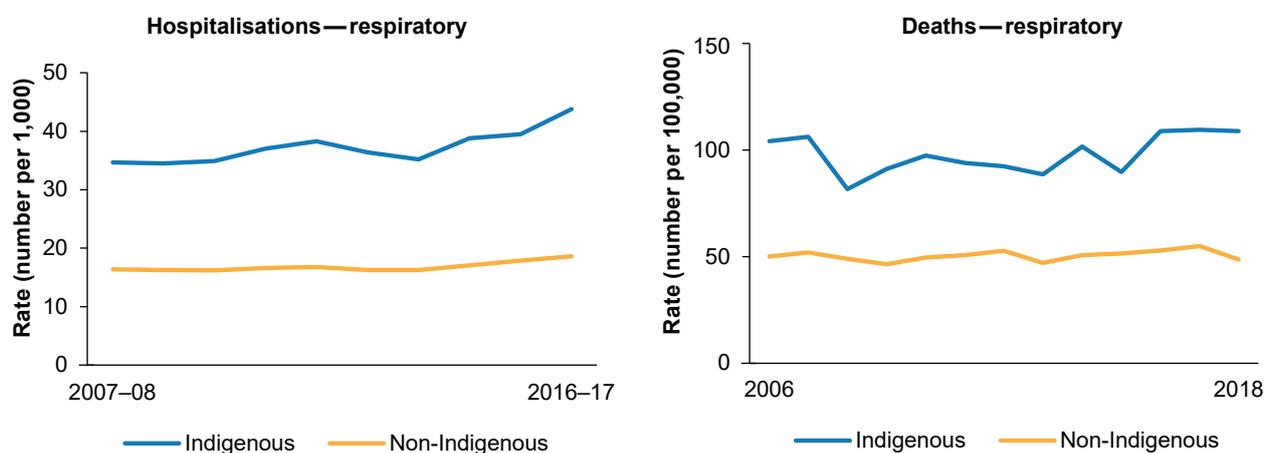


Note: 'Non-remote' includes Major cities, Inner regional and Outer regional areas, 'Remote' includes Remote and Very remote areas.

Sources: HPF Table D1.04.3—ABS and AIHW analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and National Health Survey 2017–18; HPF Table D1.04.9—AIHW analysis of National Hospital Morbidity Database.

Age-standardised rates of hospitalisation from respiratory disease among Indigenous Australians increased over the decade to 2017, but the age-standardised rate of deaths from respiratory disease changed little over a similar period (2006–2018) (Figure 4.18).

Figure 4.18: Respiratory disease hospitalisations (2007–08 to 2016–17) and deaths (2006–2018) (age-standardised)



Notes

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

Sources: HPF Table D1.04.11—AIHW analysis of National Hospital Morbidity Database; HPF Table D1.23.21—AIHW and ABS analysis of the ABS Causes of Death Collection.

Infectious respiratory diseases

Infectious respiratory diseases, such as influenza (or ‘flu’) and pneumonia, are typically caused by viruses or bacteria. Vaccinations can provide protection against these diseases.

Australians aged 65 and over are eligible for free flu and pneumococcal vaccines. These vaccines are available to Indigenous Australians at younger ages because of the greater impact of flu and pneumonia on Indigenous Australians (DoH 2020c).

In 2018–19, among Indigenous Australians aged 50 and over:

- 68% had been vaccinated against flu in the previous 12 months—a higher percentage in remote areas (73%) than in non-remote areas (67%)
- 32% had been vaccinated against pneumococcal disease in the previous 5 years—with similar proportions in remote areas (34%) and non-remote areas (32%).

Diabetes

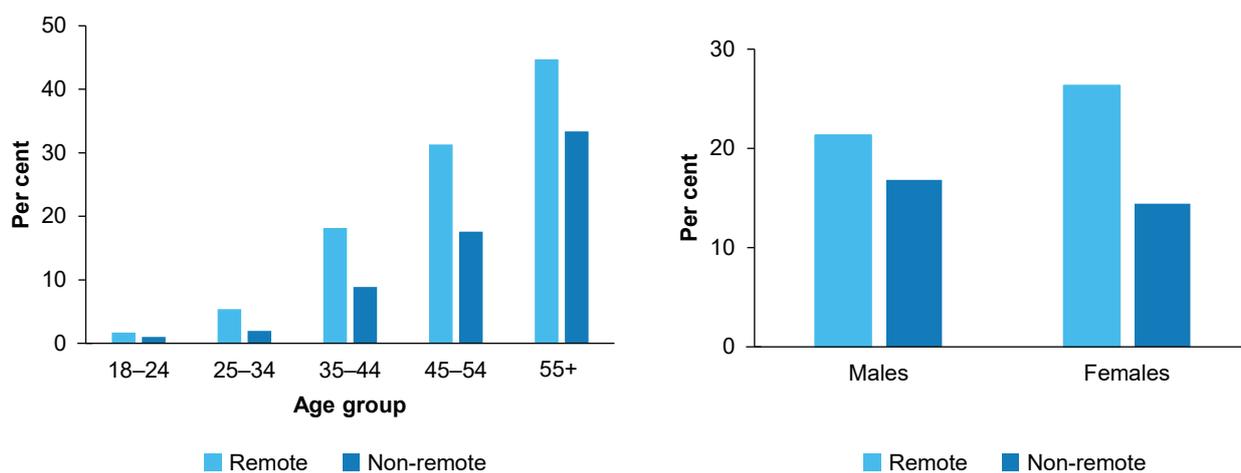
Diabetes is a chronic condition that can cause serious health complications. Some types of diabetes can be prevented through a healthy lifestyle—getting enough exercise, having a healthy diet, and not smoking. Diabetes is a risk factor for cardiovascular disease, and can lead to kidney damage. Often,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

In 2018–19, about 8% of Indigenous adults reported having diabetes, the same proportion as in 2012–13 (ABS 2019a).

In 2018–19, about 17% of Aboriginal and Torres Strait Islander adults reported having diabetes or high blood sugar levels (65,300), compared with 6.1% of non-Indigenous Australians (age-standardised).

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

Figure 4.19: Diabetes/high sugar levels among Indigenous Australians (age-standardised), 2018–19



Note: 'Non-remote' includes Major cities, Inner regional and Outer regional areas, 'Remote' includes Remote and Very remote areas.

Source: HPF Table D1.09.2—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and ABS National Health Survey 2017–18.

Between July 2015 and June 2017, Indigenous Australians were hospitalised due to diabetes at nearly 4 times the rate (age-standardised) of non-Indigenous Australians.

The age-standardised death rate from diabetes for Indigenous Australians decreased from 93 per 100,000 population in 2006 to 72 per 100,000 in 2018. But rates remain high, with Indigenous Australians dying from diabetes at about 5 times the rate (age-standardised) of non-Indigenous Australians in the period 2014–2018 (data from NSW, Qld, WA, SA and NT combined).

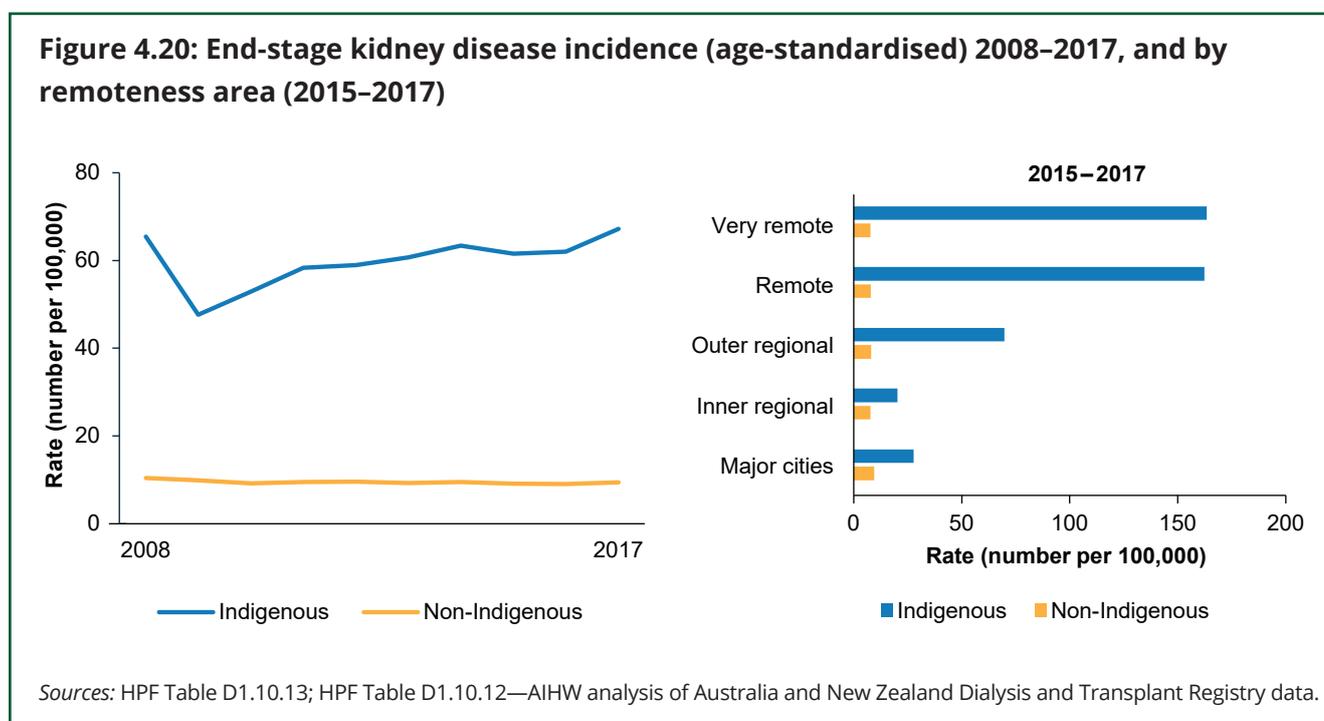
Kidney disease

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

Between July 2015 and June 2017, care involving dialysis was the leading cause of hospitalisation among Aboriginal and Torres Strait Islander people, accounting for 46% (460,900) of all hospitalisations.

Patients with end-stage kidney disease need dialysis or a kidney transplant to maintain normal kidney functions. In the three-year period 2015–2017, 950 Indigenous Australians began treatment for end-stage kidney disease, an incidence rate of 64 per 100,000 (age-standardised). In comparison, the age-standardised incidence rate for treated end-stage kidney disease for non-Indigenous Australians was 9.2 per 100,000.

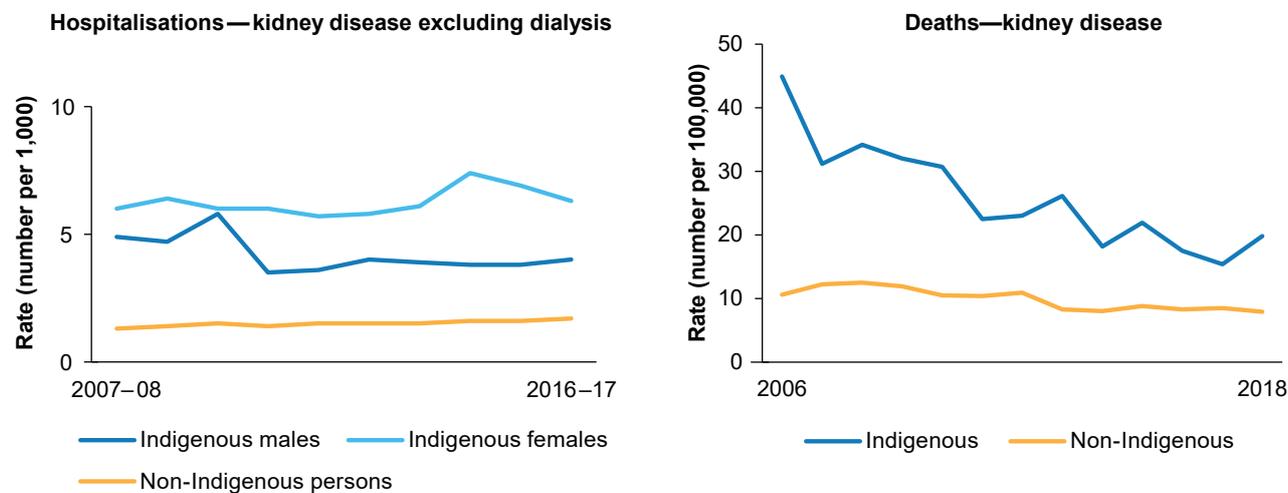
Between 2008 and 2017, the age-standardised incidence rate for treated end-stage kidney disease did not change significantly for Indigenous or non-Indigenous Australians (Figure 4.20).



At 31 December 2017, 2,160 Indigenous Australians were receiving treatment for end-stage kidney disease. Most Indigenous patients with end-stage kidney disease (87% or 1,900) received dialysis, while 13% had received a kidney transplant. In comparison, about half (51%) of non-Indigenous patients received a kidney transplant.

The age-standardised death rate from kidney disease among Indigenous Australians decreased from 45 per 100,000 in 2006 to 20 per 100,000 in 2018 (data from NSW, Qld, WA, SA and NT combined) (Figure 4.21).

Figure 4.21: Kidney disease hospitalisations (2007–08 to 2016–17) and deaths (2006–2018) (age-standardised)



Notes

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

Sources: HPF Table D1.10.20—AIHW analysis of National Hospital Morbidity Database; HPF Table D1.23.23—AIHW and ABS analysis of the ABS Causes of Death Collection.

High blood pressure

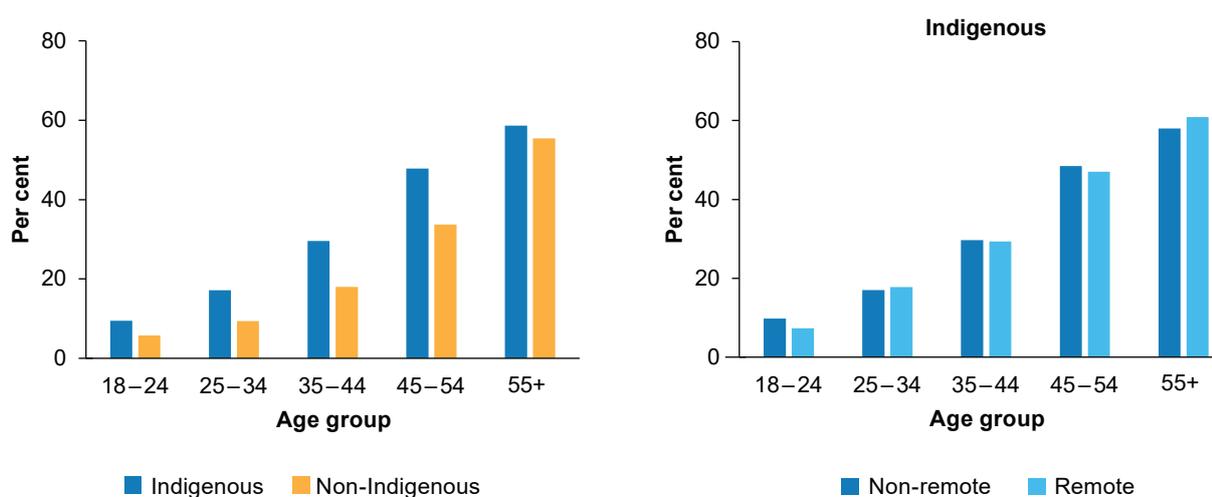
High blood pressure is a leading risk factor for cardiovascular diseases, including coronary heart disease, which is the leading cause of avoidable deaths among Aboriginal and Torres Strait Islander people (AIHW 2016).

In 2018–19, almost 1 in 3 (31%) Indigenous adults (151,200) had high blood pressure.

Younger Indigenous Australians are more likely than younger non-Indigenous Australians to have high blood pressure. About 30% of Indigenous Australians aged 35–44 had high blood pressure, compared with 18% of non-Indigenous Australians in the same age group—this was the largest difference of all age groups.

Rates of high blood pressure are similar among Indigenous Australians in non-remote and remote areas (Figure 4.22).

Figure 4.22: High blood pressure prevalence, 2017–19



Note: 'Non-remote' includes Major cities, Inner regional and Outer regional areas, 'Remote' includes Remote and Very remote areas.

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

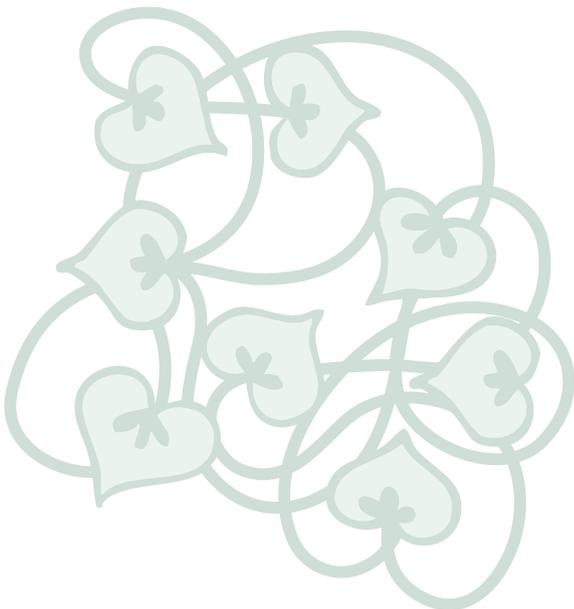
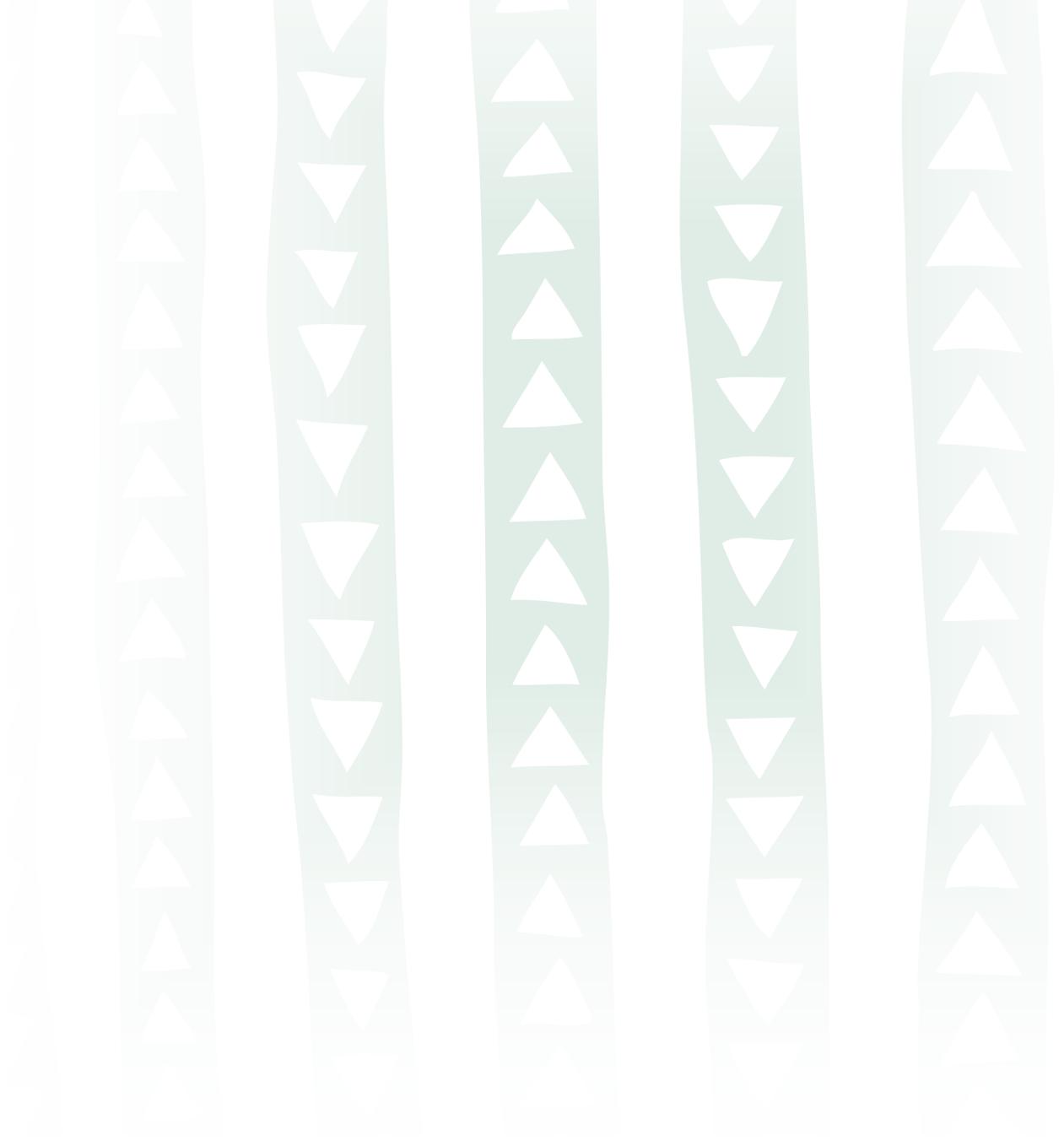
Many people with high blood pressure do not know they have the condition

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

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

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

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





5

Tier 2

**Determinants
of health**

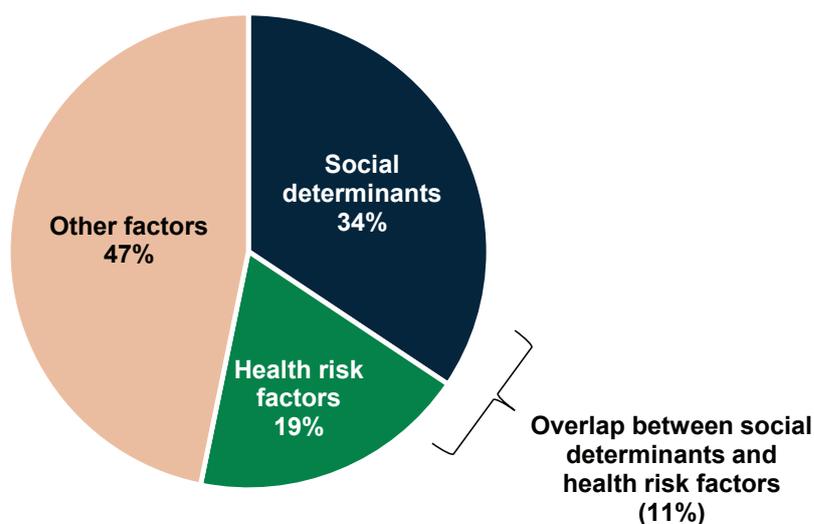
Health is influenced by social determinants—the circumstances in which people grow, live, work, and age (CSDH 2008)—and individual health risk factors.

A large part of the health gap between Indigenous and non-Indigenous Australians is explained by differences between the two populations in a few key factors (using a measure of health that combines self-assessed health, long-term health conditions, and emotional wellbeing) (AIHW 2018).

- Social determinants of health explain 34% of the total health gap between Indigenous and non-Indigenous Australians. The leading social determinants that account for the health gap are household income (explains 14% of the total health gap) and employment and hours worked (12%) (Figure 5.1).
- Health risk factors explain 19% of the total health gap between Indigenous and non-Indigenous Australians. The leading health risk factors that account for the health gap are smoking (explains 10% of the total health gap) and overweight or obesity (7.2%).

Access to health services is also an important factor, but could not be quantified from the variables in the survey used for this analysis.

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



Source: AIHW 2018.

Education

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

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

Health also influences education. Poor health through life, and health conditions like vision and hearing impairment, especially in childhood, can disrupt a person’s schooling and affect their ability to learn (Wise 2013; Department of Prime Minister and Cabinet 2020).

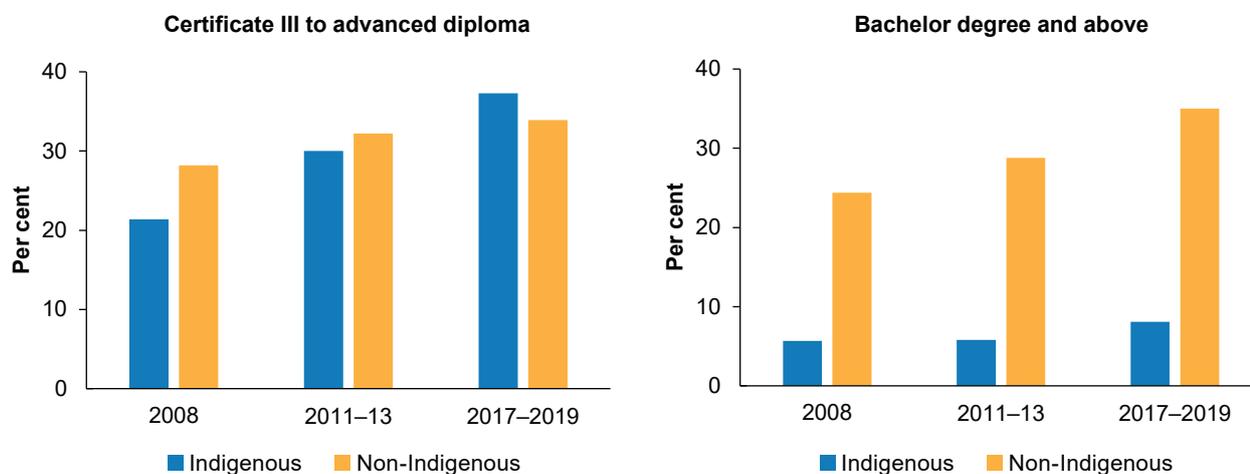
Levels of educational attainment among Aboriginal and Torres Strait Islander people have improved substantially over the past decade:

- The proportions of Indigenous school students at or above national minimum standards in reading (for Years 3 and 5) and numeracy (Years 5, 7, and 9) increased between 2008 and 2018
- The proportion of Indigenous Australians aged 20–24 who had attained at least a Year 12 or equivalent qualification increased from 45% in 2008 to 66% (73,900) in 2018–19.

The proportion of Aboriginal and Torres Strait Islander adults aged 20–64 whose highest educational qualification was a certificate III or above increased from 27% (66,600) in 2008 to 45% (183,500) in 2018–19, mainly due to increased attainment of certificate III or advanced diploma qualifications:

- The proportion whose highest educational qualification was a certificate III or advanced diploma increased from 21% in 2008 to 37% (150,900) in 2018–19
- The proportion whose highest educational qualification was a bachelor degree or above increased from 5.7% (14,100) in 2008 to 8.1% (32,800) in 2018–19 (Figure 5.2).

Figure 5.2: Attainment of post-school qualifications among Australians aged 20–64, by Indigenous status, 2008 to 2017–19



Source: HPF Table D2.06.13—AIHW and ABS analysis of 2008 National Aboriginal and Torres Strait Islander Social Survey, 2007–08 National Health Survey, 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, 2011–12 Australian Health Survey, National Health Survey 2017–18, and 2018–19 National Aboriginal and Torres Strait Islander Health Survey.

Educational attainment among Indigenous Australians was higher in *Major cities*. In 2018–19, among Indigenous Australians:

- the proportion aged 20–24 with a Year 12 or equivalent qualification was 85% in *Major cities*, compared with 38% in *Very remote* areas
- the proportion aged 20–64 with a certificate III or advanced diploma was 46% (71,200) in *Major cities*, compared with 19% (9,800) in *Very remote* areas
- the proportion aged 20–64 with a bachelor degree or above was 14% (21,100) in *Major cities*, compared with 2.9% (2,300) in *Remote* or *Very remote* areas.

Many Indigenous young people from remote areas attend boarding schools in urban areas, but boarding schools are not included in the National Aboriginal and Torres Strait Islander Health Survey.

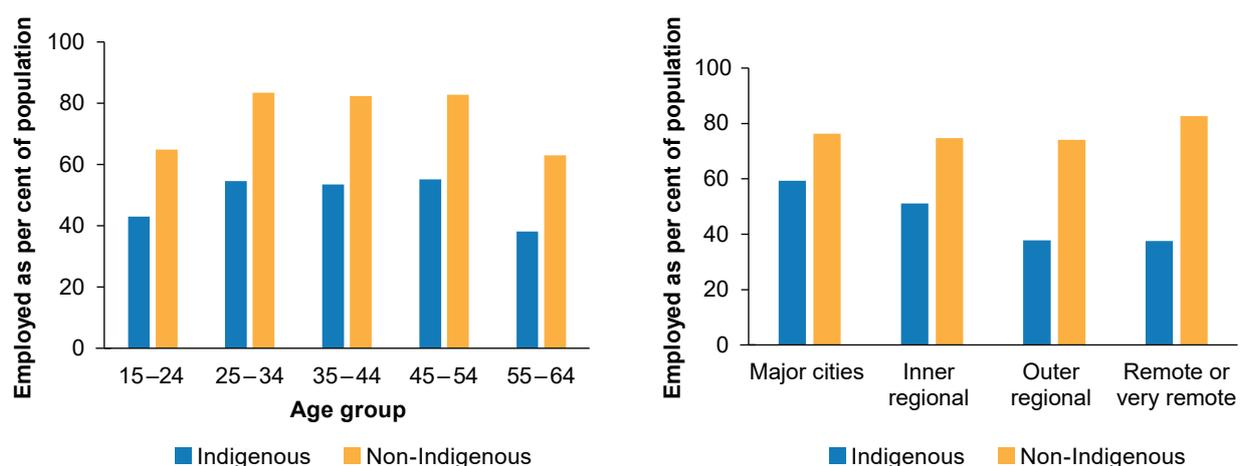
Employment

The employment rate—the number of employed people as a proportion of the working age population—remains much lower among Aboriginal and Torres Strait Islander people than non-Indigenous Australians. Increasing levels of educational attainment have not translated into higher employment rates for Indigenous Australians, partly due to large declines in employment rates in remote areas, regardless of education level (Venn & Biddle 2018).

In 2018–19, 49% (243,800) of Indigenous Australians aged 15–64 were employed, compared with 76% of non-Indigenous Australians in the same age group.

The employment rate gap is largest among those aged 25–54 and in more remote areas (Figure 5.3).

Figure 5.3: Employment (people aged 15–64), 2017–19



Sources: HPF Table D2.07.3; HPF Table D2.07.6—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and National Health Survey 2017–18.

For many Indigenous Australians, there is a conflict between family responsibilities and finding and keeping a job (Venn & Biddle 2018). A recent study found that education, disability, and having spent time in prison were the most important factors underlying labour force participation (Dinku & Hunt 2019).

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

Table 5.1: Top 5 difficulties finding work, unemployed Indigenous Australians aged 15–64, 2014–15

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

Note: 'Non-remote' includes *Major cities, Inner regional* and *Outer regional* areas, 'Remote' includes *Remote* and *Very remote* areas.

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

Income

An adequate income is fundamental to being able to live a healthy life—it gives a person greater access to nutritious food, better housing, and health and other services, as well as a greater ability for social participation (Galobardes et al. 2006).

In 2016, more than 1 in 3 (37% or 105,400) Aboriginal and Torres Strait Islander adults lived in households with incomes in the lowest 20% of incomes nationally. (This is based on equivalised gross household income, an adjusted income measure used to compare households of different types and sizes.)

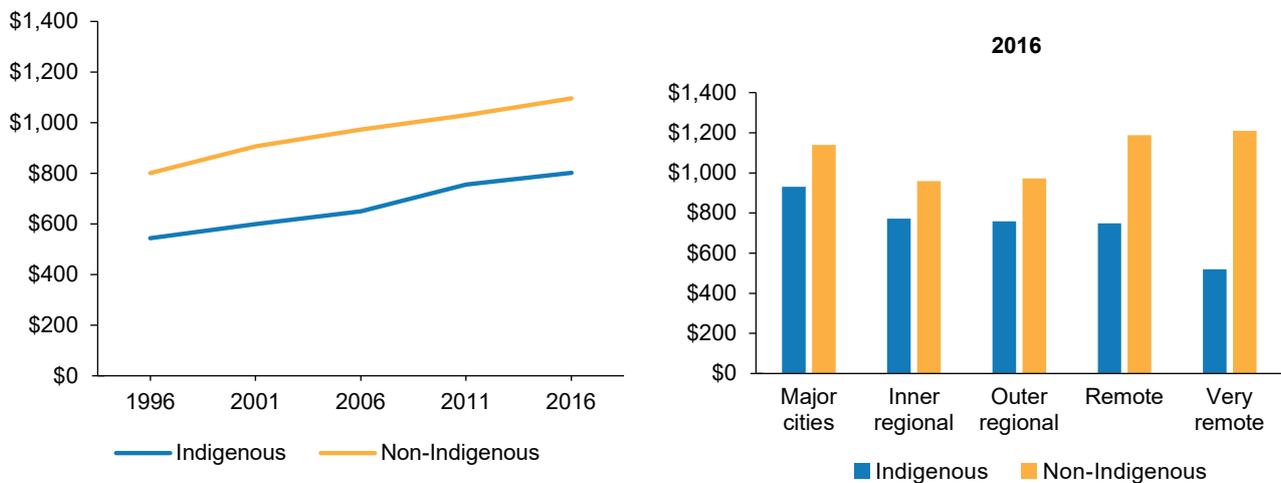
Between 1996 and 2016, average weekly equivalised household income increased:

- from \$544 to \$802 for Indigenous adults
- from \$801 to \$1,096 for non-Indigenous adults.

These were real increases, after adjusting for inflation.

Average weekly equivalised household income of Indigenous adults was highest among those living in *Major cities* (\$931), and lowest among those living in *Very remote* areas (\$520) (Figure 5.4).

Figure 5.4: Average gross weekly equivalised household income of adults 1996–2016, and by remoteness area (2016)



Sources: HPF Table D2.08.13—AIHW and ABS analysis of Censuses of Population and Housing 1996–2016; HPF Table D2.08.12—AIHW and ABS analysis of Census of Population and Housing 2016.

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

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

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

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

Housing

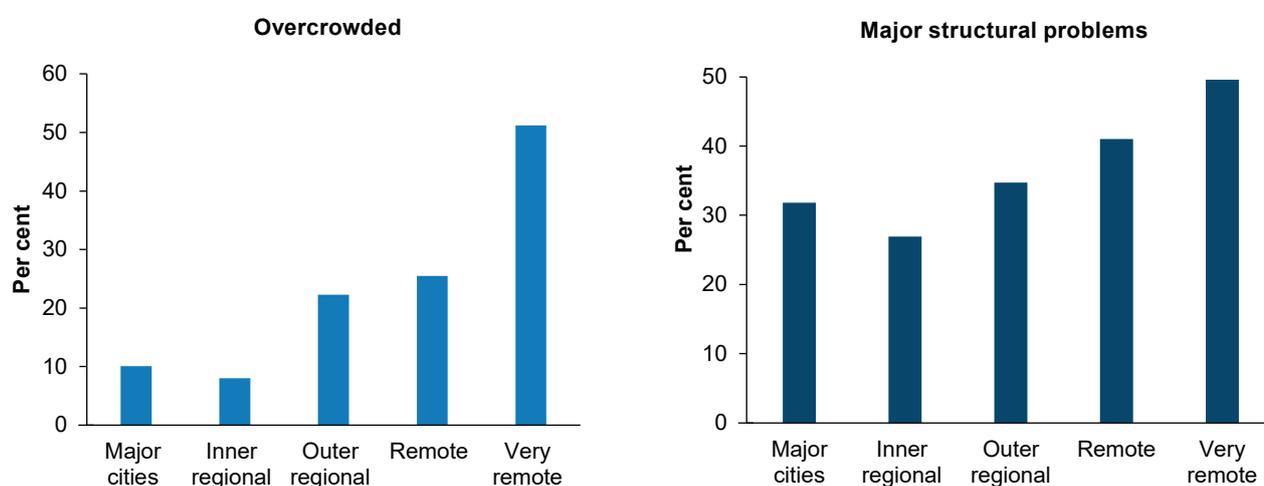
Adequate housing—that is, housing that provides space for all members of the household and is in good structural condition with adequate working facilities—is essential to good health. Housing that is overcrowded or lacks facilities for washing and cleaning increases the risk of infectious disease (Ware 2013).

In 2018–19, nearly 1 in 5 (18% or 145,300) Aboriginal and Torres Strait Islander people were living in overcrowded housing (housing that needs one or more additional bedrooms to adequately house household members). This was a lower proportion than in 2004–05 (27%).

In 2018–19, 1 in 3 (33%) Indigenous households were living in housing with one or more major structural problems, such as major cracks in walls or floors, sinking or moving foundations, or major electrical or plumbing problems. This was a similar proportion to 2012–13.

Those living in *Remote* and *Very remote* areas were most likely to live in overcrowded housing or homes with major structural problems (Figure 5.5).

Figure 5.5: Indigenous Australians living in households that were overcrowded, and dwellings with major structural problems, 2018–19



Sources: HPF Table D2.01.1; HPF Table D2.02.5—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19.

Indigenous Australians accounted for 20% of the homeless population nationally (23,400 people) in 2016, a decrease from 26% in 2011, according to Census results. People are considered homeless if their current dwelling is inadequate; or if they have no tenure or their tenure is short and not able to be extended; or if their current living arrangement does not give them control of, or access to, space for social relations.

In 2016, 70% of homeless Indigenous Australians were living in severely crowded dwellings (needing four or more extra bedrooms), 12% were living in supported accommodation for the homeless, and 9% were living in improvised tents or sleeping out. Governments across Australia fund a range of specialist services to support people who are homeless or who are at risk of homelessness (AIHW 2019f). In 2018–19, over 1 in 4 specialist homelessness services clients were Indigenous Australians (68,900 people). The rate of services use by Indigenous Australians was 9 times the rate of non-Indigenous Australians, after adjusting for differences in the age structure between the two populations.

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

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

In 2016, nearly 4 in 10 (38%) Indigenous households were home owners/buyers, compared with just over 3 in 10 (32%) in 2001. The proportion of non-Indigenous home owners/buyers fell over the same period (from 69% in 2001 to 66% in 2016). The proportion of Indigenous Australians living in social housing decreased over the 15 years (Table 5.2).

Table 5.2: Housing tenure trends, 2001–2016

	Indigenous				Non-Indigenous			
	2001	2006	2011	2016	2001	2006	2011	2016
	Per cent							
Home owners/buyers	32.0	34.2	35.9	38.1	69.3	68.9	67.8	66.3
Private renters	27.4	27.0	29.1	32.4	19.8	20.8	22.6	24.6
Social housing tenants	31.3	29.0	26.3	21.5	4.8	4.4	4.1	3.7

Source: AIHW 2019a.

Child protection

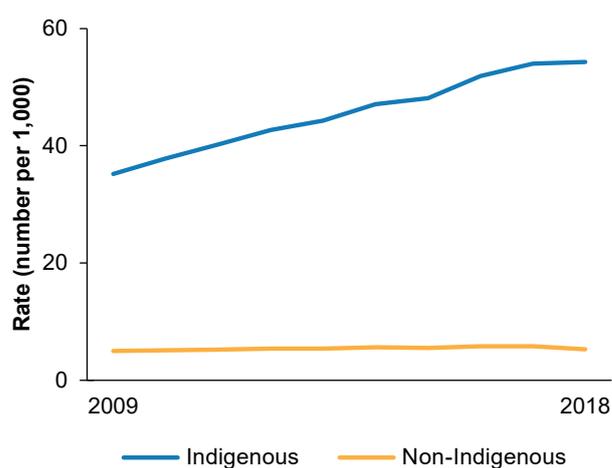
Experience of maltreatment during childhood has serious and long-term impacts on social and emotional wellbeing and health (Emerson et al. 2015). In Australia, child protection functions are the responsibility of state and territory governments. Each jurisdiction has its own legislation, policies, and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

Aboriginal and Torres Strait Islander people’s experience of child welfare policies has historically been traumatic, with the policy of forcible removal of children known as the Stolen Generations (HREOC 1997). Child protection issues continue to be very significant for Indigenous communities. This is reflected by the Closing the Gap target of reducing the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45% by 2031 (Australian Government 2020).

At 30 June 2018, of the 45,800 children in out-of-home care in Australia, 17,900 (or 39%) were Aboriginal or Torres Strait Islander. Nearly 2 in 3 (65% or 11,400) Indigenous children in out-of-home care were placed with a relative/kin, with other Indigenous carer, or in Indigenous residential care.

Between 30 June 2009 and 30 June 2018, the rate for Indigenous children who were in out-of-home care rose from 35 per 1,000 (10,500) to 54 per 1,000 (17,900). At 30 June 2018, Indigenous children were 10 times as likely as non-Indigenous children to be in out-of-home care (54 compared with 5.3 per 1,000 children, or 17,900 compared with 27,900) (Figure 5.6).

Figure 5.6: Children in out-of-home care, 30 June 2009 to 30 June 2018



Source: HPF Table D2.12.1—AIHW 2019b.

Note: Since data were compiled for the Aboriginal and Torres Strait Islander HPF, AIHW has released more recent information in *Child Protection Australia 2018–19*, available at www.aihw.gov.au/reports-data/health-welfare-services/child-protection/overview. As at June 2019, there were 18,000 Indigenous children in out-of-home care (about 54 per 1,000), compared with 26,900 non-Indigenous children (5.1 per 1,000).

Justice

Education, employment, income, and housing disparities are not only associated with a large part of the health gap between Indigenous and non-Indigenous Australians, but also with imprisonment among Indigenous Australians (PwC 2017).

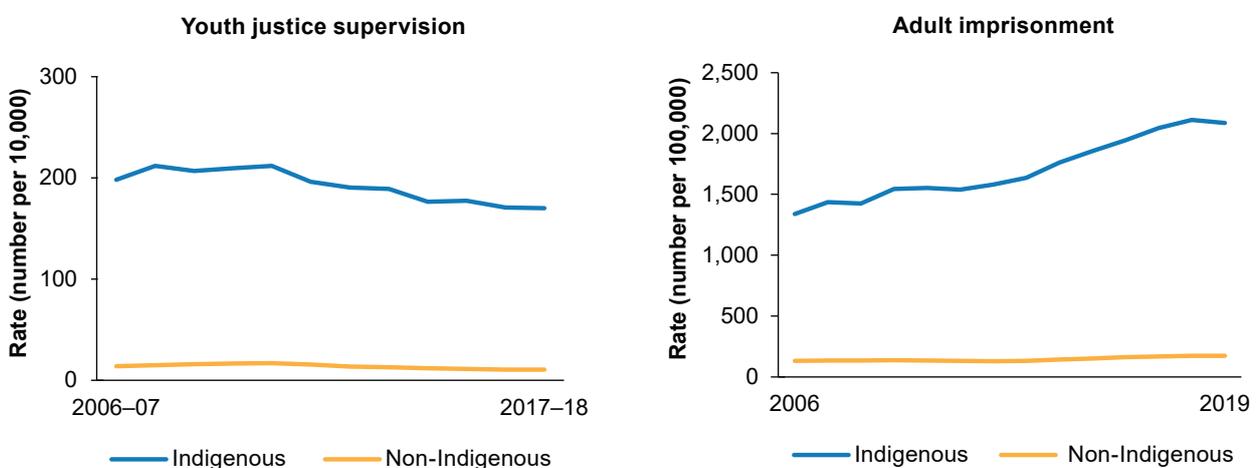
Most Aboriginal and Torres Strait Islander people have never been imprisoned (ABS 2016b). But they have contact with the criminal justice system—as both offenders and victims—at much higher rates than non-Indigenous Australians (SCRGSP 2016).

Indigenous Australians are 16 times as likely to be under youth justice supervision and 12 times as likely to be in prison (age-standardised rate) as non-Indigenous Australians.

On an average day in 2017–18, 2,600 Indigenous young people aged 10–17 were under youth justice supervision, with 81% being supervised in their community and 19% in youth detention centres. The rate of youth justice supervision (number per 10,000 population aged 10–17) has declined among both Indigenous and non-Indigenous Australians.

As at 30 June 2019, 11,900 Indigenous adults were in prison. The age-standardised imprisonment rate for the Indigenous adult population increased from 1,337 per 100,000 population in 2006 to 2,088 per 100,000 in 2019 (Figure 5.7).

Figure 5.7: Youth justice supervision rate (2006–07 to 2017–18) and age-standardised adult imprisonment rate (2006–2019)



Sources: HPF Table D2.11.1—AIHW Juvenile Justice National Minimum Data Set 2000–01 to 2017–18; HPF Table D2.11.11—ABS 2019b.

Note: Since data were compiled for the Aboriginal and Torres Strait Islander HPF, AIHW has released more recent information in *Youth Justice in Australia 2018–19*, available at www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2018-19/contents/summary. On an average day in 2018–19, 2,700 Indigenous young people aged 10–17 were under youth justice supervision.

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

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

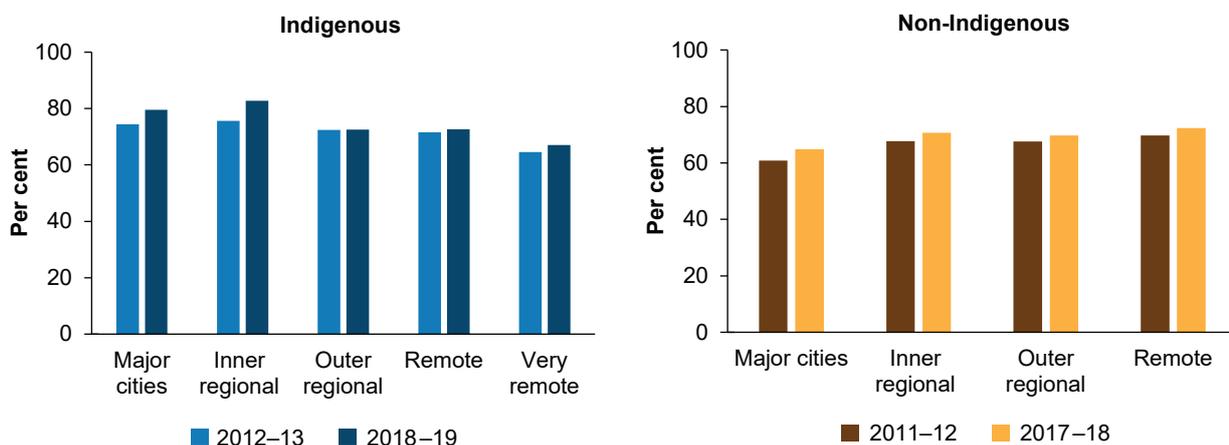
Overweight and obesity

Worldwide, rates of overweight and obesity have increased substantially over the past 4 decades, due to diets higher in saturated fats and sugar, and to people being less active (WHO 2020). Being overweight or obese is a risk factor for cardiovascular disease, diabetes, and kidney disease—health conditions that often occur together (AIHW 2015a, 2016).

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

In 2018–19, 71% (381,800) of Aboriginal and Torres Strait Islander people aged 15 and over were overweight or obese. This was higher than in 2012–13 (66%) (ABS 2019a). The rise was driven by an increase in non-remote areas (Figure 5.8).

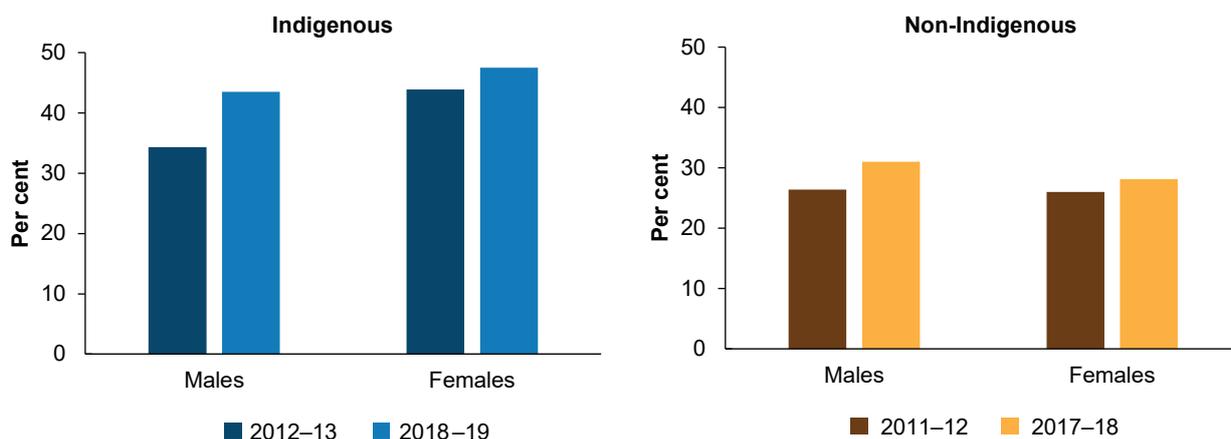
Figure 5.8: Overweight and obesity (age-standardised), people aged 15 and over, Indigenous (2012–13 and 2018–19) and non-Indigenous (2011–12 and 2017–18)



Sources: ABS 2013; ABS 2019a.

In 2018–19, 44% of Indigenous men and 48% of Indigenous women were obese (age-standardised) (Figure 5.9).

Figure 5.9: Obesity rates (age-standardised), people aged 15 and over, Indigenous (2012–13 and 2018–19) and non-Indigenous (2011–12 and 2017–18)



Sources: ABS 2013; ABS 2019a.

Tobacco use

Smoking is a major risk factor for cardiovascular disease, cancer, and respiratory disease (AIHW 2016).

The proportion of Aboriginal and Torres Strait Islander people aged 15 and over who smoke every day has fallen substantially over the past decade. In 2018–19, 37% of Indigenous Australians aged 15 and over (about 200,400) smoked every day, compared with 45% in 2008.

The largest falls in daily smoking rates have occurred among younger Indigenous Australians. In 2018–19, 85% of Indigenous Australians aged 15–17 reported that they had never smoked, compared with 72% in 2008.

The decline in daily smoking rates among Indigenous adults has occurred in non-remote areas—there has been no significant change over this period in daily smoking rates among Indigenous adults in remote areas (Figure 5.10).

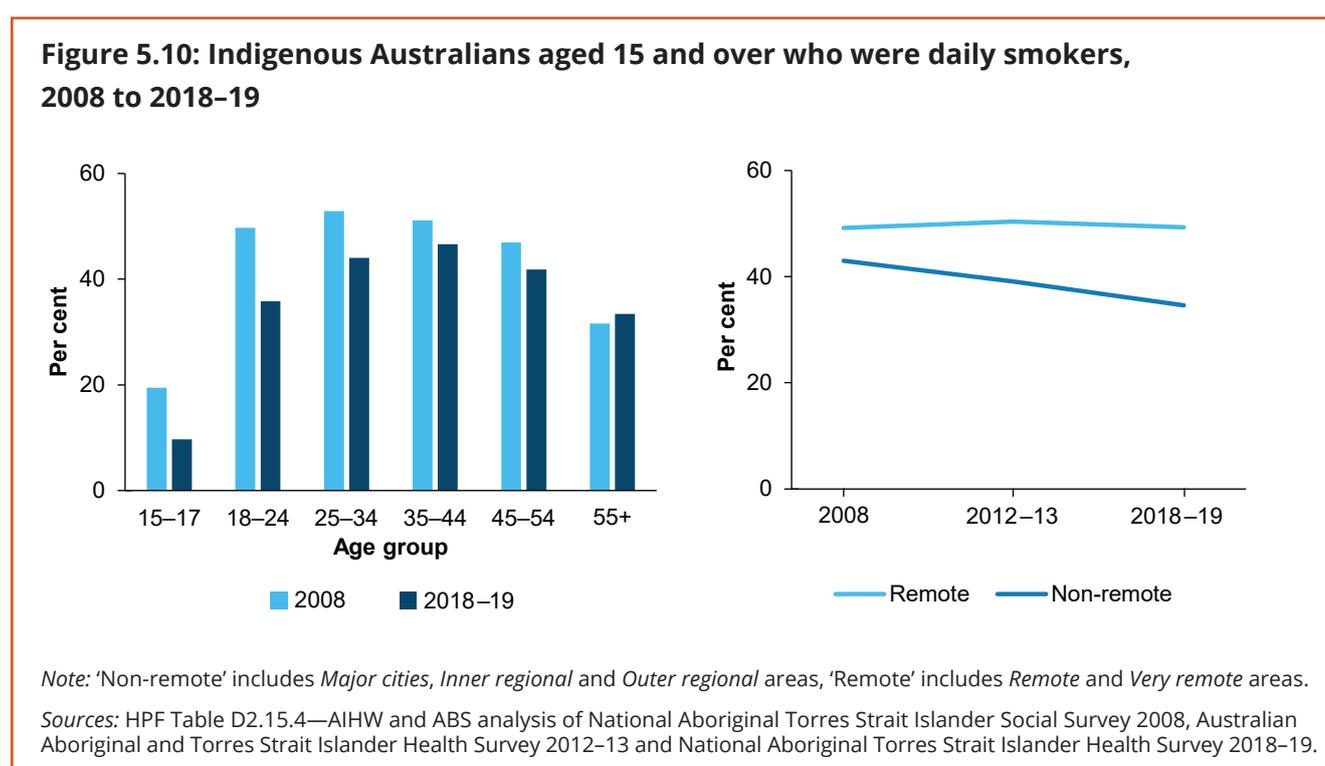


Table 5.3: Reasons Indigenous Australians tried to quit or reduce smoking, 2014–15

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

Note: More than one reason could be given.

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

Alcohol consumption

In 2018–19, just over 1 in 4 Aboriginal and Torres Strait Islander adults (26% or 211,200) had not consumed alcohol in the previous 12 months or had never consumed alcohol—23% in non-remote areas and 37% in remote areas (ABS 2019a). In comparison, about 21% of the general adult Australian population had abstained from drinking alcohol for at least 12 months (ABS 2018c).

Risky alcohol consumption

According to the 2009 National Health and Medical Research Council alcohol guidelines:

To reduce risk of ...

Alcohol-related injury from single occasion

Alcohol-related disease or injury over a lifetime

Drink no more than ...

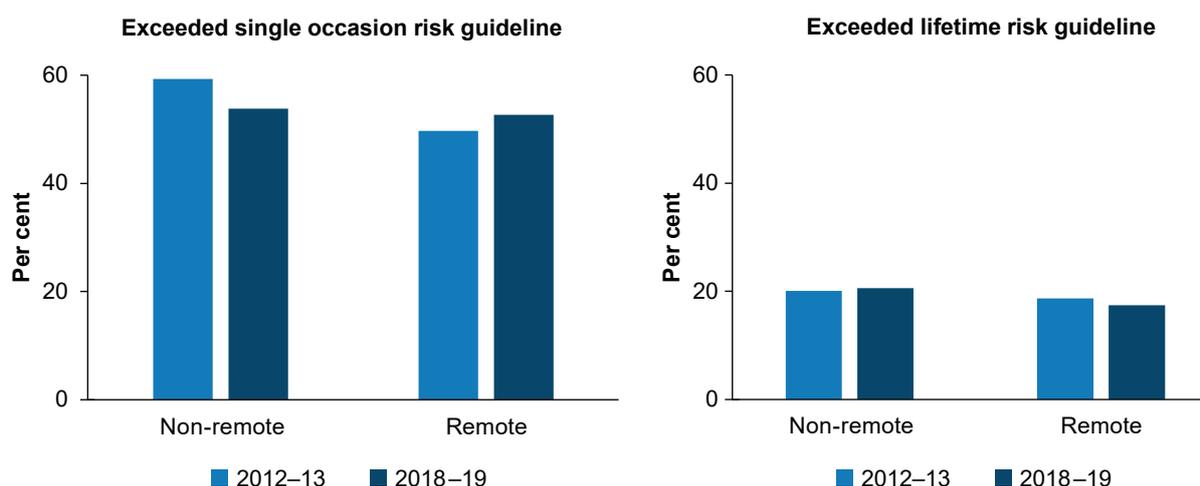
4 standard drinks on a single occasion

2 standard drinks on any day

In 2018–19, 54% (268,900) of Indigenous adults reported drinking alcohol at levels exceeding the single occasion risk guideline (more than 4 drinks) in the previous 12 months. This was a decrease from 57% in 2012–13 (ABS 2019a). The decrease in the proportion of Indigenous adults exceeding the single occasion risk guideline for alcohol consumption was driven by a decline in non-remote areas from 56% in 2012–13 to 50% in 2018–19, while the proportion in remote areas did not change significantly (Figure 5.11).

About 1 in 5 (20% or 98,700) Indigenous adults reported drinking alcohol at levels exceeding the lifetime risk guideline (more than 2 drinks per day) in the previous week. This was the same as in 2012–13 (ABS 2019a).

Figure 5.11: Risky alcohol consumption among Indigenous adults, 2012–13 and 2018–19



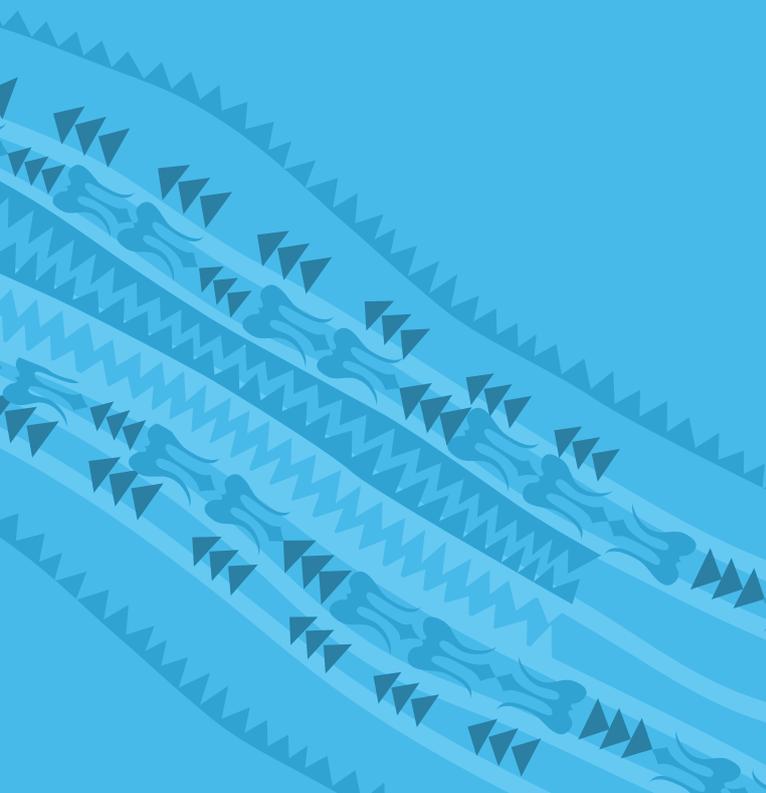
Note: 'Non-remote' includes Major cities, Inner regional and Outer regional areas, 'Remote' includes Remote and Very remote areas.

Source: ABS 2019a.

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



Tier 3
**Health system
performance**



To provide effective health care, health services must be accessible, responsive, and culturally respectful. Many Aboriginal and Torres Strait Islander people face barriers to accessing the health services they need, such as a lack of services near where they live, and being unable to afford services.

Being able to access culturally appropriate health care is also important. For Indigenous Australians to feel confident and safe in accessing health care, health services should ensure that they provide services equitably, and the level and range of accessible health care should be driven by patient needs. Cultural safety and cultural respect should be an integral part of all health services provided.

Cultural safety in the health system

Cultural safety has 3 elements:

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

Patient experience of health care—what are the experiences of Indigenous health care users? is their cultural identity respected?

Access to health care services—do Indigenous Australians have the same level of access to health services as non-Indigenous Australians (AIHW 2019c)?

Access to primary health care

Primary health care is delivered in community settings, such as general practices, community health centres, Aboriginal health services, and allied health practices like physiotherapy. It is usually people's first point of contact with the health system, and the gateway to specialised health services.

Primary health care providers play an important role in improving health through health promotion, vaccination, health checks, screening programs, diagnosis, and treatment.

Use of Indigenous-specific primary health care services

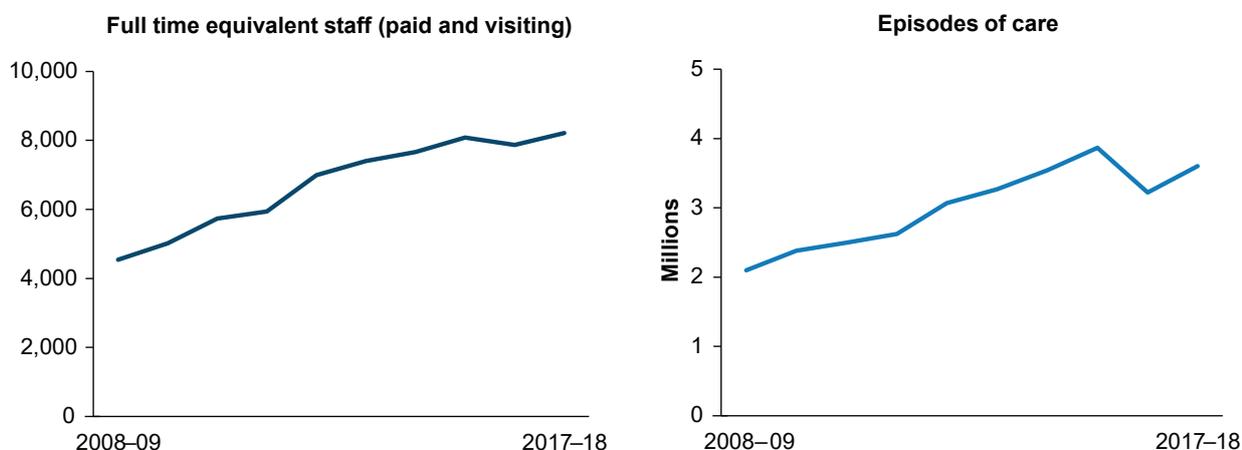
The Australian Government provides funding to organisations to provide culturally-appropriate primary health care services to Aboriginal and Torres Strait Islander people.

Indigenous-specific primary health care services are run by Aboriginal community-controlled health organisations, state/territory or local health services, or non-government organisations.

In 2017–18, most Indigenous-specific primary health care providers (95%) had a formal commitment to providing culturally safe health care, and about half (49%) of their health care workers were Indigenous. This was a similar proportion to 2013–14 (51%) (AIHW 2019d).

There were 198 Indigenous-specific primary health care services in 2017–18, compared with 211 in 2008–09. Staffing levels and episodes of care generally increased in the 10 years to 2017–18, but fell between 2015–16 and 2016–17 (Figure 6.1).

Figure 6.1: Indigenous primary health care organisations, full-time equivalent staff and episodes of care, 2008–09 to 2017–18



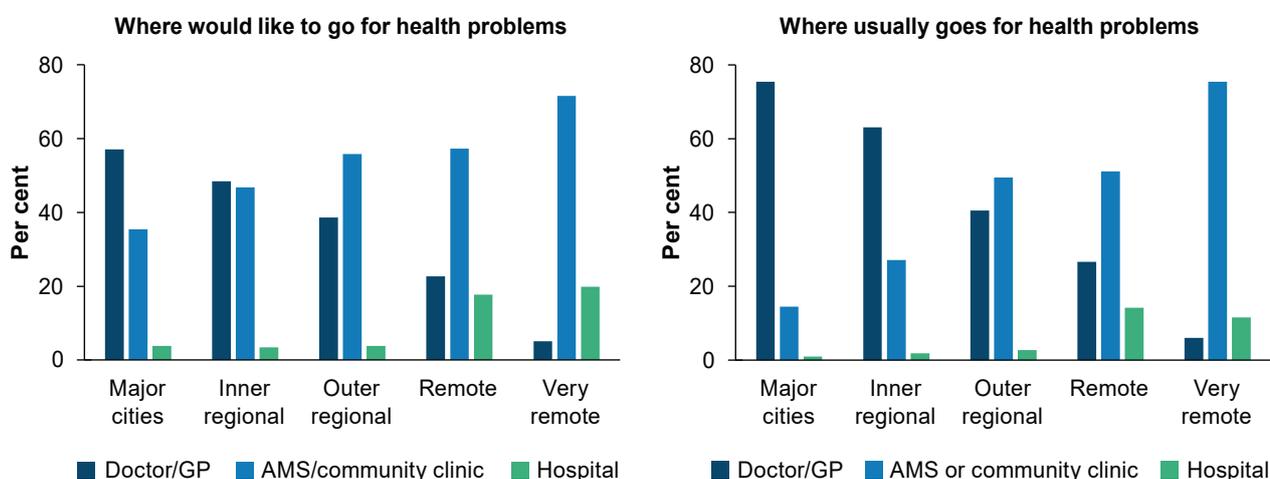
Source: HPF Table D3.14.47—AIHW analysis of Service Activity Reporting and AIHW Online Services Report data collections.

Although 4 in 5 Indigenous Australians live in *Major cities* and regional areas where mainstream health services are typically located, these services are not always accessible, for geographic, social, and cultural reasons (AIHW 2014). So, Indigenous-specific health services are important providers of comprehensive primary health services for Indigenous Australians living in various locations.

In *Very remote* areas, 3 in 4 (75%) Indigenous Australians usually went to an Aboriginal Medical Service (AMS) or community clinic (in many cases, that might be the only primary health care option available) (Figure 6.2).

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

Figure 6.2: Health service use and preferences among Indigenous Australians, 2018–19



Source: HPF Table D2.17.2—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19.

General practitioner services and health checks

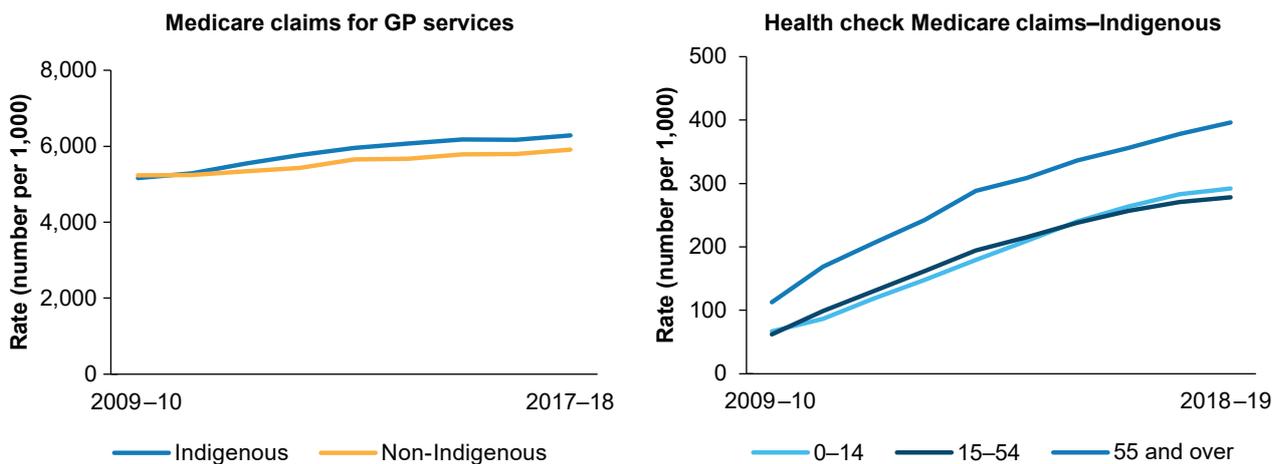
Aboriginal and Torres Strait Islander people have a slightly higher rate of GP service use than non-Indigenous Australians, measured by the number of Medicare claims for GP services.

For both Indigenous and non-Indigenous Australians, the rate of GP service use rose over the decade to 2017–18 (Figure 6.3).

The first Indigenous-specific health check, for those aged 55 and over, was introduced in 1999, and health checks for Aboriginal and Torres Strait Islander people of all ages were in place from May 2006. In May 2010, the frequency of health checks was standardised so that Aboriginal and Torres Strait Islander people of all ages were able to have a health check every year (AIHW 2017).

Between 2009–10 and 2018–19, the number of Indigenous Australians accessing these health checks increased almost fourfold, from 47,300 in 2009–10 (a rate of 68 per 1,000 population) to 248,800 in 2018–19 (a rate of 297 per 1,000). Health check rates increased across all age groups over this period (Figure 6.3).

Figure 6.3: GP service use (2009–10 to 2017–18) and Indigenous-specific health checks (2009–10 to 2018–19)



Sources: HPF Table D3.14.20—AIHW analysis of Department of Health Medicare claims data; HPF Tables D3.04.5, D3.04.6, D3.04.7—AIHW analysis of Medicare data, downloaded from the Medicare Australia Statistics website on 6 November 2018.

Child immunisation

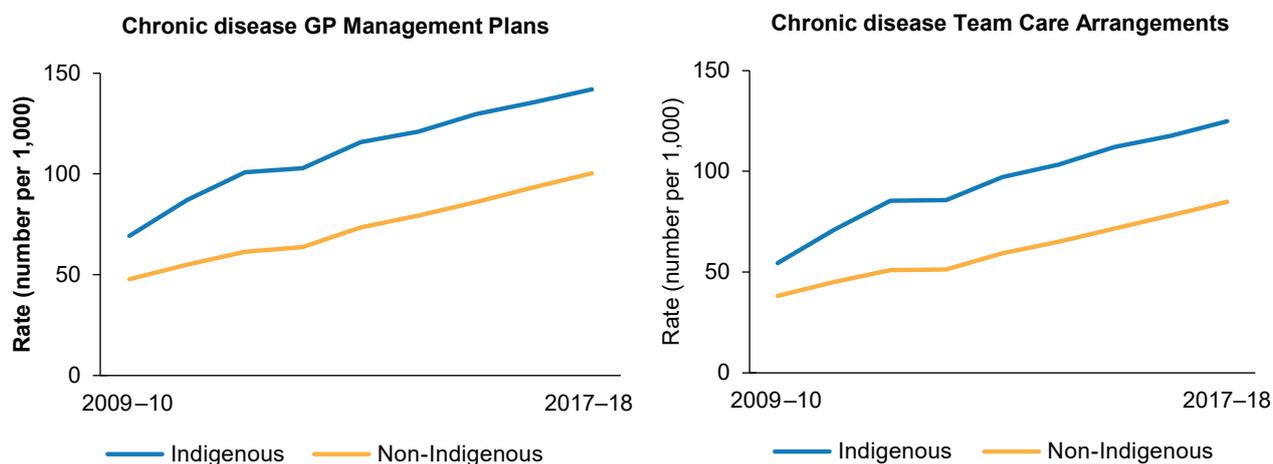
Immunisation is highly effective in reducing illness and death caused by vaccine-preventable diseases. Between 2008 and 2018, the proportion of fully immunised Aboriginal and Torres Strait Islander children aged 5 increased from 77% to 97%.

Chronic disease management

Good quality health care for people with chronic disease often involves multiple providers across multiple settings. People with chronic disease may be eligible for services as part of a GP management plan or team care arrangement.

Rates of claims for these Medicare items have increased steadily since they were introduced in 2005 (Figure 6.4). The rate of increase has been higher among Aboriginal and Torres Strait Islander people than among non-Indigenous Australians. Indigenous Australians have higher rates of chronic disease than non-Indigenous Australians.

Figure 6.4: Chronic disease GP management plans and team care arrangements, 2009–10 to 2017–18



Source: HPF Table D3.05.1—AIHW analysis of Department of Health Medicare claims data.

Access to prescription medicines

Aboriginal and Torres Strait Islander people experience high rates of acute and chronic illnesses, and must be able to access appropriate prescription medications.

In general, the Australian Government subsidises the cost of medicine for most medical conditions under the Pharmaceutical Benefits Scheme (PBS). In 2010, the Closing the Gap PBS Co-payment was established to reduce the cost of PBS medicines for eligible Indigenous Australians living with, or at risk of, chronic diseases.

In 2015–16, the total expenditure on pharmaceuticals in Australia for Indigenous Australians was \$420 million, an average of \$537 per person. For non-Indigenous Australians, the average expenditure was \$891 per person.

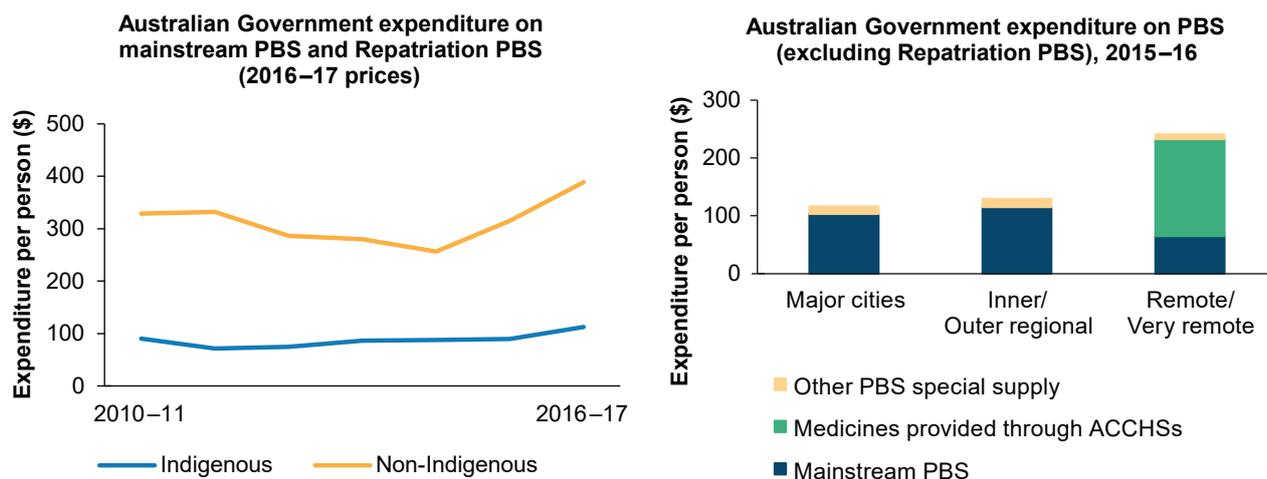
For Indigenous Australians, the main components of Australian Government PBS expenditure were:

- mainstream PBS (61%)
- medications distributed through Aboriginal and Torres Strait Islander Health Services (Section 100 expenditure) (19%).

Between 2010–11 and 2016–17, expenditure on pharmaceuticals covered by the mainstream PBS and the Repatriation PBS grew for Indigenous Australians by 3.7% per year in real terms and by 2.8% for non-Indigenous Australians. In 2016–17, average PBS expenditure per person for Indigenous Australians was estimated to be 29% of the amount spent for non-Indigenous Australians.

In 2015–16, expenditure per Indigenous person through the mainstream PBS was highest in *Remote* and *Very remote* areas (\$241) and lowest in *Major cities* (\$116) (Figure 6.5).

Figure 6.5: Expenditure on medicines 2010–11 to 2016–17, and by remoteness area (2015–16)



Sources: HPF Table D3.15.4; HPF Table D3.21.8—AIHW Health Expenditure Database.

Access to primary health services in different areas

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

- physical access (whether health services with sufficient capacity are located within a certain distance or drive time from where a person lives)
- affordability
- cultural acceptability.

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

Physical access to services was modelled with reference to:

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

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

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

In total, 29 medium-sized areas were estimated to have at least 200 Indigenous Australians with no Indigenous-specific primary health care services within one hour's drive and relatively poor access to GP services in general. These areas are highlighted in orange (300 to 900 people with poor access) and yellow (200 to 299 people) in Figure 6.6 (with other areas shown in grey). Appendix 3 shows a list of these areas. The areas are Statistical Areas Level 2 (SA2s) as described in the Australian Statistical Geography Standard (ASGS) (ABS 2016a). Table 6.1 shows the number of areas in each state/territory and remoteness classification. Identifying areas based on the number of people in them with poor access rather than on average access for the whole area is a different approach to earlier reports (AIHW 2015b) and gives somewhat different results. This approach ensures that areas that have relatively good average access but also have substantial numbers of people with poor access are not overlooked.

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

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

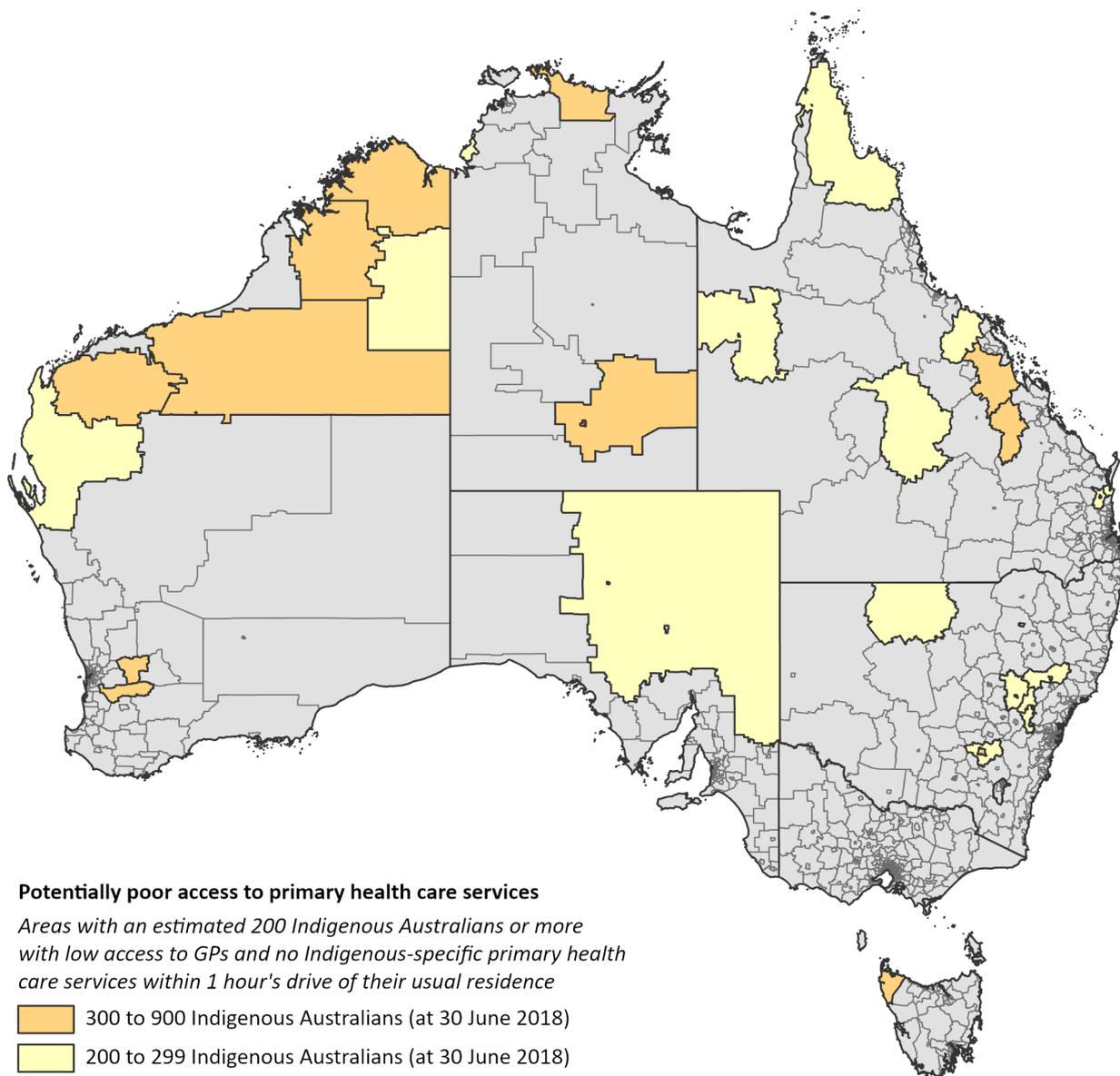
(a) Areas correspond to the Australian Bureau of Statistics' SA2 boundaries (see Appendix 3 for detailed list).

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

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

Source: AIHW analyses (forthcoming).

Figure 6.6: Areas where Indigenous Australians have potentially poor access to primary health care services, by size of population, 2018



Source: AIHW analyses (forthcoming).

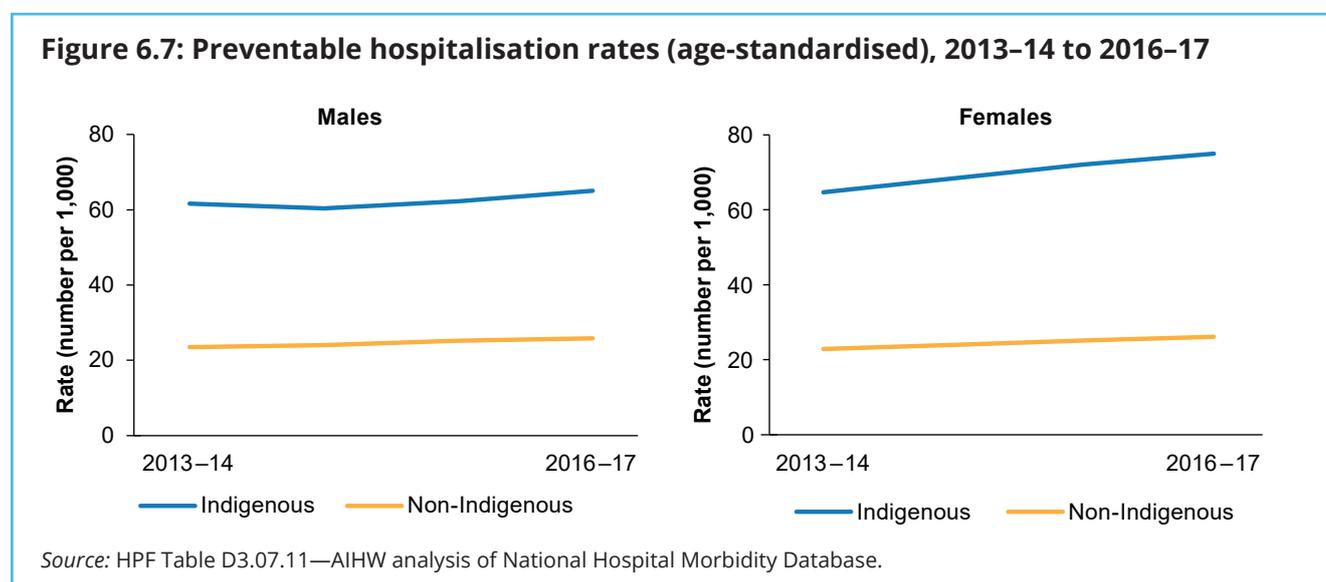
Preventable hospitalisations

Potentially preventable hospitalisations

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

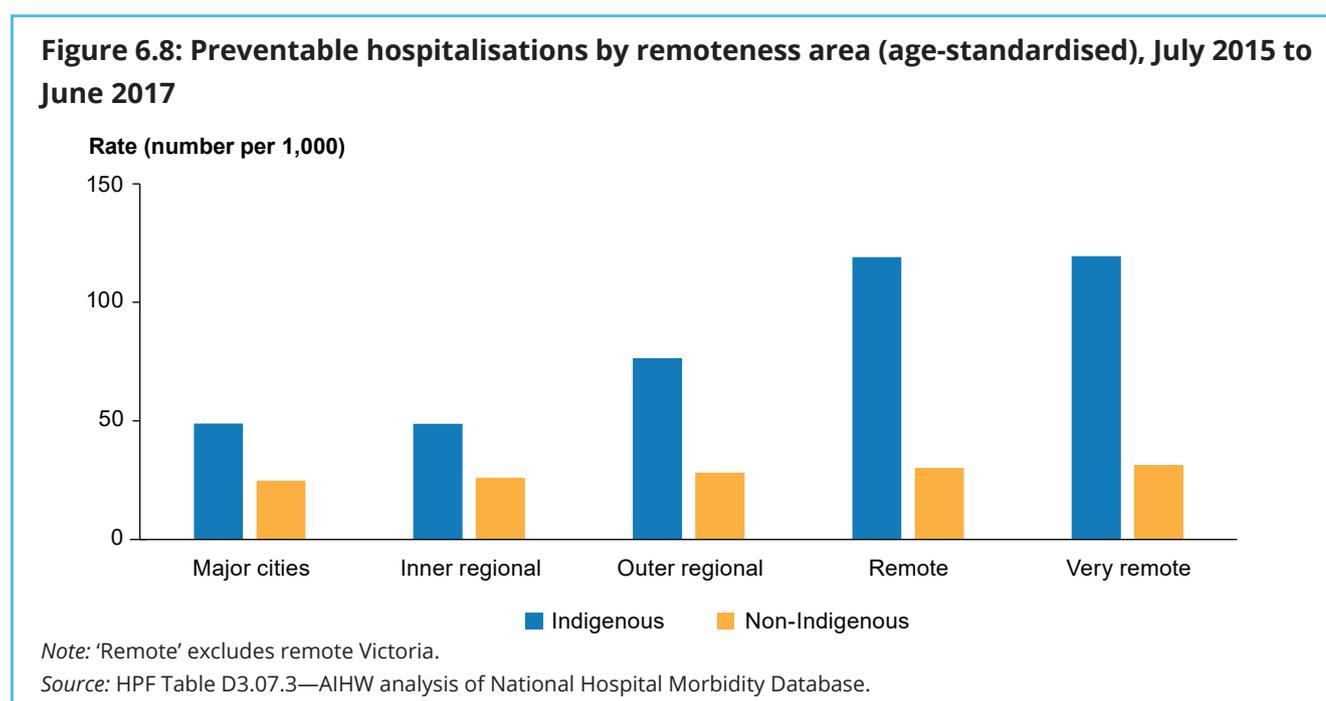
In July 2015 to June 2017, 81,100 hospitalisations of Aboriginal and Torres Strait Islander people were potentially preventable. This is an age-standardised rate of 69 preventable hospitalisations per 1,000 Indigenous Australians, compared with 26 per 1,000 among non-Indigenous Australians.

The age-standardised rate of preventable hospitalisations among Indigenous Australians has increased in recent years (a comparable time series before 2013–14 is not available) (Figure 6.7).



Note: Since data were compiled for the Aboriginal and Torres Strait Islander HPF, AIHW has released more recent information in the web report *Disparities in potentially preventable hospitalisations across Australia: Exploring the data*, available at www.aihw.gov.au/reports/primary-health-care/disparities-in-potentially-preventable-hospitalisations-exploring-the-data/contents/exploring-the-potentially-preventable-hospitalisations-data. There were 41,900 hospitalisations of Indigenous Australians that were potentially preventable in 2016–17, and 44,900 in 2017–18. In 2017–18, the age-standardised rate of preventable hospitalisations was about 80 per 1,000, compared with about 27 per 1,000 other Australians.

Age-standardised rates of preventable hospitalisations among Indigenous Australians are higher in remote areas than in non-remote areas (Figure 6.8).

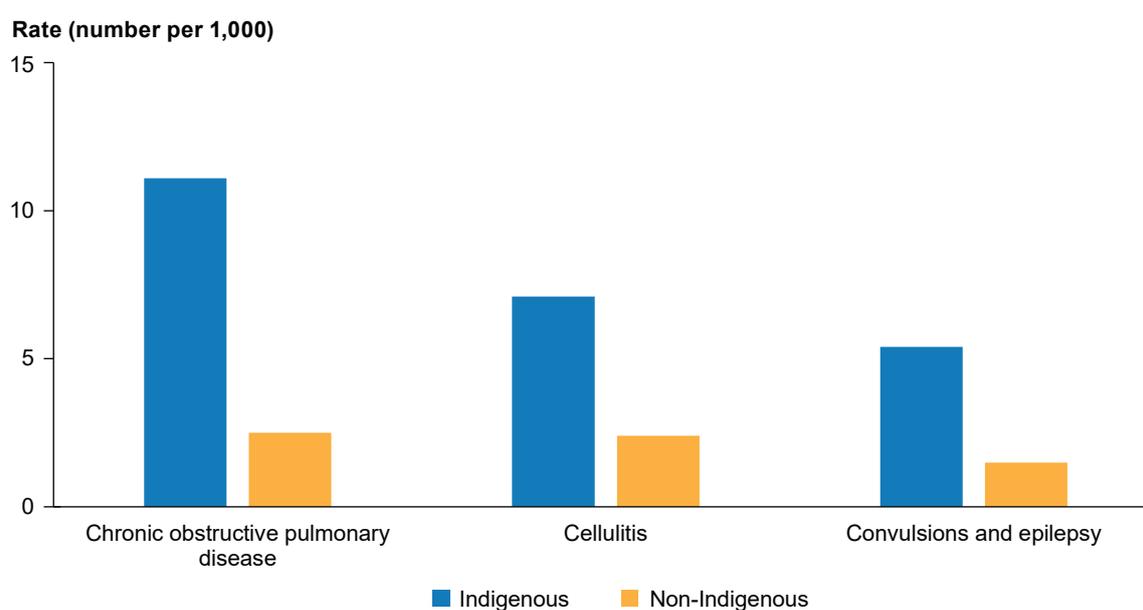


From July 2015 to June 2017, the leading three causes of preventable hospitalisations among Indigenous Australians were:

- cellulitis—a bacterial skin condition (9,500)
- chronic obstructive pulmonary disease (8,800)
- convulsions and epilepsy (7,700).

Age-standardised rates per 1,000 population for these leading causes show that there are disparities between Indigenous and non-Indigenous Australians for these causes (Figure 6.9).

Figure 6.9: Top 3 causes of preventable hospitalisations (age-standardised), July 2015 to June 2017



Source: HPF Table D3.07.12—AIHW analysis of National Hospital Morbidity Database.

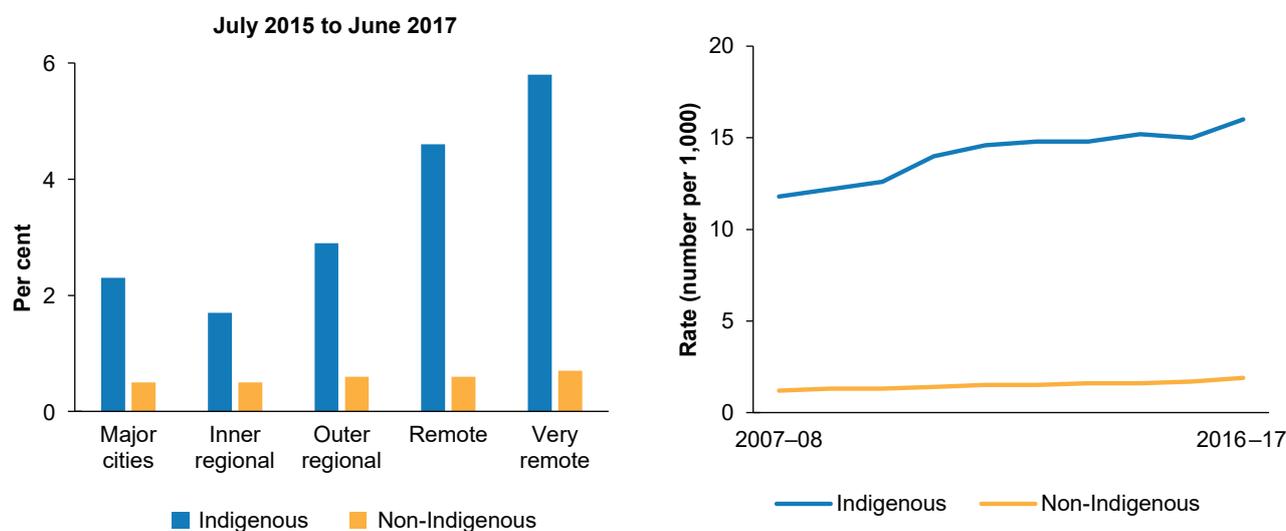
People taking their own leave from hospital

People taking their own leave from hospital after being admitted—choosing to leave before starting treatment, or leaving hospital before completing treatment—provides indirect evidence of how well hospital services are meeting patients' needs.

Nationally, 19,900 Aboriginal and Torres Strait Islander hospital patients took their own leave from hospital between July 2015 and June 2017. Indigenous hospital patients in more remote areas of Australia were the most likely to take their own leave from hospital—5.8% (5,500) in *Very remote* areas, compared with 1.7% in *Inner regional* areas (Figure 6.10).

Annual time series data shows that Indigenous hospital patients took their own leave from hospital at an age-standardised rate of 12 per 1,000 in 2007–08, increasing to 16 per 1,000 in 2016–17 (NSW, Vic, Qld, WA, SA and the NT combined).

Figure 6.10: Patients who left hospital without waiting for or completing treatment (age-standardised), by remoteness area (July 2015 to June 2017), and by Indigenous status (2007–08 to 2016–17)



Note: Graph showing trend over time (right hand side) is data from NSW, Vic, Qld, WA, SA and NT combined.

Sources: HPF Table D3.09.4; HPF Table D3.09.6—AIHW analysis of National Hospital Morbidity Database.

Access to hospital procedures

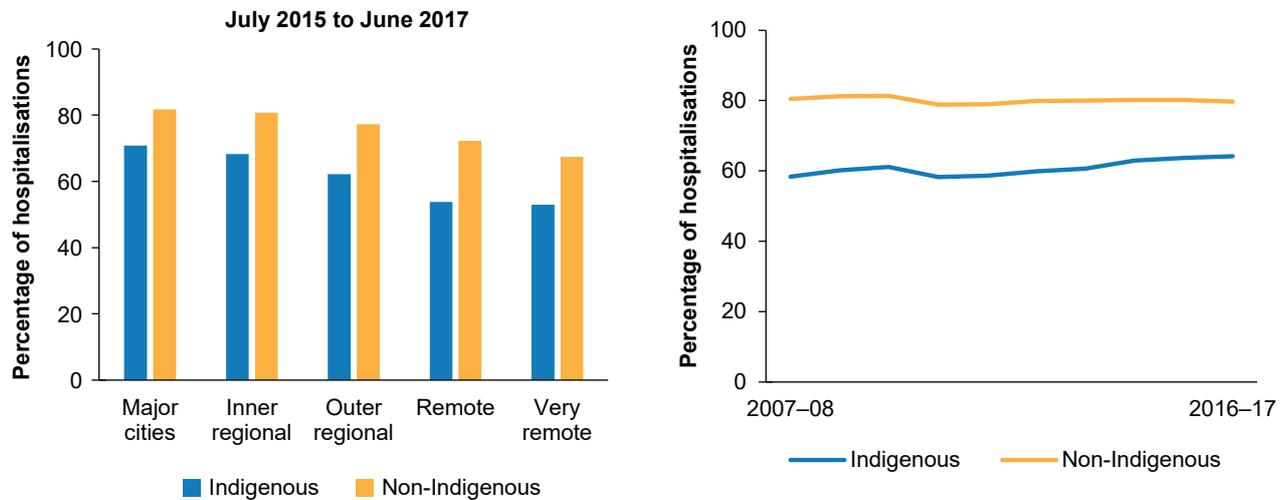
Aboriginal and Torres Strait Islander people are more likely to be hospitalised than non-Indigenous Australians, but are less likely to receive a medical or surgical procedure while in hospital.

Over the period July 2015 to June 2017, 64% (325,300) of hospitalisations (excluding dialysis) for Indigenous Australians had a medical or surgical procedure recorded, compared with 81% (14,385,300) for non-Indigenous Australians (age-standardised).

The age-standardised proportion of Indigenous Australians who received a medical or surgical procedure while in hospital was lowest in *Remote* and *Very remote* areas.

Annual time series data shows that between 2007–08 and 2016–17, the age-standardised proportion of Indigenous Australians who received a medical or surgical procedure while in hospital increased from 58% to 64% (NSW, Vic, Qld, WA, SA and the NT combined) (Figure 6.11).

Figure 6.11: Medical or surgical procedure received while in hospital (age-standardised), by remoteness area (July 2015 to June 2017), and by Indigenous status (2007–08 to 2016–17)



Note: Graph showing trend over time (right hand side) is data from NSW, Vic, Qld, WA, SA and NT combined.

Sources: HPF Table D3.06.1; HPF Table D3.06.11—AIHW analysis of National Hospital Morbidity Database.

For Indigenous Australians, most hospital procedures (93%) were performed in public hospitals, compared with 56% for non-Indigenous Australians (age-standardised).

Health expenditure

Health expenditure should reflect the relative need for health services—it should be higher for population groups with higher levels of need (Braveman & Gruskin 2003; Whitehead 1991). One way to assess this is to compare differences in health status with differences in per person health expenditure.

The burden of disease and overall death rates for Aboriginal and Torres Strait Islander people are more than twice those of non-Indigenous Australians. In 2015–16, the average amount of money per person spent on health for Indigenous Australians was \$8,949, or 1.3 times that of non-Indigenous Australians (\$6,657).

Table 6.2: Average health expenditure per person, 2015–16^a

	Indigenous	Non-Indigenous	Ratio Indigenous to non-Indigenous
Hospitals	\$4,436	\$2,718	1.6
Medicare services	\$1,157	\$1,074	1.1
Community health services	\$998	\$331	3.0
Medications	\$558	\$890	0.6
Dental services	\$414	\$416	1.0
Patient transport services	\$283	\$152	1.9
Total health expenditure^b	\$8,949	\$6,657	1.3

a Not age-standardised.

b Includes other items not listed separately here—see HPF Table D3.21.1.

Source: HPF Table D3.21.1—AIHW Health Expenditure Database.

Aboriginal and Torres Strait Islander health workers

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

In the 2016 Census, more than 11,000 Indigenous Australians were employed in health-related occupations. In 1996, about 96 of every 10,000 employed Indigenous Australians worked in health-related occupations. By 2016, this rate had increased to 173 per 10,000.

Barriers to accessing health services

In 2018–19, 30% (243,700) of Aboriginal and Torres Strait Islander people reported that they needed to, but did not see a health care provider on at least one occasion in the previous 12 months. This was the same proportion as in 2012–13. Among those who did not see a health care provider when they needed to, the following reasons were given (more than one reason could be provided):

- More than 1 in 3 (36%) said they were too busy—higher in non-remote areas at 37%, compared with 30% in remote areas.
- About 1 in 3 (34%) said cost was a factor—higher in non-remote areas at 36%, compared with 21% in remote areas.
- More than 1 in 5 (23%) said they disliked the service, or were embarrassed or afraid—higher in non-remote areas at 24%, compared with 15% in remote areas.
- About 1 in 3 (33%) said:
 - waiting times were too long or the service was not available at the time required
 - they did not have transport or the service was too far away
 - the service was not available in their area—higher in remote areas at 54%, compared with 29% in non-remote areas.

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

Reasons most commonly reported for not going to the doctor when needed were similar in non-remote and remote areas, though service availability and transport or distance were greater barriers in remote areas. They included:

- being too busy—about 1 in 3 of those in non-remote areas (33%) and remote areas (35%)
- waiting time being too long or the service not being available when needed—24% in remote areas, and 15% in non-remote areas
- lack of transport or distance—23% in remote areas, and 13% in non-remote areas.

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

Cost was the main barrier to going to the dentist for those in non-remote areas (44%). For those in remote areas who did not go to the dentist when they needed to, cost was also an important factor (29%), but service accessibility was also a factor, with large proportions reporting barriers were:

- a lack of available services in the area (26%)
- waiting time being too long or service not being available when needed (24%)
- lack of transport, or distance (22%).

For more information

This summary report presents a small selection of key findings drawn from the full set of information compiled for reporting against the HPF.

The detailed findings and data are presented together on a dedicated website, indigenoushpf.gov.au.

The website includes:

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

Appendix 1 contains a full list of HPF measures and a link to the webpage that provides detailed information for each individual measure.

Appendix 1: Aboriginal and Torres Strait Islander HPF measures (those highlighted are covered in this summary report)

1.01	Low birthweight	2.01	Housing	3.01	Antenatal care
1.02	Top reasons for hospitalisation	2.02	Access to functional housing with utilities	3.02	Immunisation
1.03	Injury and poisoning	2.03	Environmental tobacco smoke	3.03	Health promotion
1.04	Respiratory disease	2.04	Literacy and numeracy	3.04	Early detection and early treatment
1.05	Circulatory disease	2.05	Education outcomes for young people	3.05	Chronic disease management
1.06	Acute rheumatic fever and rheumatic heart disease	2.06	Educational participation and attainment of adults	3.06	Access to hospital procedures
1.07	High blood pressure	2.07	Employment	3.07	Selected potentially preventable hospital admissions
1.08	Cancer	2.08	Income	3.08	Cultural competency
1.09	Diabetes	2.09	Index of disadvantage	3.09	Discharge against medical advice
1.10	Kidney disease	2.10	Community safety	3.10	Access to mental health services
1.11	Oral health	2.11	Contact with the criminal justice system	3.11	Access to alcohol and drug services
1.12	HIV/AIDS, hepatitis and sexually transmissible infections	2.12	Child protection	3.12	Aboriginal and Torres Strait Islander people in the health workforce
1.13	Community functioning	2.13	Transport	3.13	Competent governance
1.14	Disability	2.14	Indigenous people with access to their traditional lands	3.14	Access to services compared with need
1.15	Ear health	2.15	Tobacco use	3.15	Access to prescription medicines
1.16	Eye health	2.16	Risky alcohol consumption	3.16	Access to after-hours primary health care
1.17	Perceived health status	2.17	Drug and other substance use including inhalants	3.17	Regular GP or health service
1.18	Social and emotional wellbeing	2.18	Physical activity	3.18	Care planning for chronic disease
1.19	Life expectancy at birth	2.19	Dietary factors	3.19	Accreditation
1.20	Infant and child mortality	2.20	Breastfeeding practices	3.20	Aboriginal and Torres Strait Islander peoples training for health-related disciplines
1.21	Perinatal mortality	2.21	Health behaviours during pregnancy	3.21	Expenditure on Aboriginal and Torres Strait Islander health compared to need
1.22	All causes age-standardised death rates	2.22	Overweight and obesity	3.22	Recruitment and retention of staff
1.23	Leading causes of mortality				
1.24	Avoidable and preventable deaths				

Appendix 2: National Agreement on Closing the Gap—priority reforms and targets

Priority reform 1—Formal partnerships and shared decision making

Priority reform 2—Building the community-controlled sector

Priority reform 3—Transforming government organisations

Priority reform 4— Shared access to data and information at a regional level

Outcome	Target
1. Aboriginal and Torres Strait Islander people enjoy long and healthy lives.	Close the Gap in life expectancy within a generation, by 2031.
2. Aboriginal and Torres Strait Islander children are born healthy and strong.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.
3. Aboriginal and Torres Strait Islander children are engaged in high-quality, culturally appropriate early childhood education in their early years.	By 2025, increase the proportion of Aboriginal and Torres Strait Islander children enrolled in Year Before Fulltime Schooling (YBFS) early childhood education to 95 per cent.
4. Aboriginal and Torres Strait Islander children thrive in their early years.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC) to 55 per cent.
5. Aboriginal and Torres Strait Islander students achieve their full learning potential.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander people (age 20-24) attaining year 12 or equivalent qualification to 96 per cent.
6. Aboriginal and Torres Strait Islander students reach their full potential through further education pathways.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25-34 years who have completed a tertiary qualification (Certificate III and above) to 70 per cent.
7. Aboriginal and Torres Strait Islander youth are engaged in employment or education.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander youth (15-24 years) who are in employment, education or training to 67 per cent.
8. Strong economic participation and development of Aboriginal and Torres Strait Islander people and communities.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25-64 who are employed to 62 per cent.
9. Aboriginal and Torres Strait Islander people secure appropriate, affordable housing that is aligned with their priorities and need.	By 2031, increase the proportion of Aboriginal and Torres Strait Islander people living in appropriately sized (not overcrowded) housing to 88 per cent.
10. Aboriginal and Torres Strait Islander people are not overrepresented in the criminal justice system.	By 2031, reduce the rate of Aboriginal and Torres Strait Islander adults held in incarceration by at least 15 per cent.
11. Aboriginal and Torres Strait Islander young people are not overrepresented in the criminal justice system.	By 2031, reduce the rate of Aboriginal and Torres Strait Islander young people (10-17 years) in detention by 30 per cent.

Outcome	Target
12. Aboriginal and Torres Strait Islander children are not overrepresented in the child protection system.	By 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 per cent.
13. Aboriginal and Torres Strait Islander families and households are safe.	A significant and sustained reduction in violence and abuse against Aboriginal and Torres Strait Islander women and children towards zero.
14. Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing.	Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.
15. Aboriginal and Torres Strait Islander people maintain a distinctive cultural, spiritual, physical and economic relationship with their land and waters.	<p>A. By 2030, a 15 per cent increase in Australia's landmass subject to Aboriginal and Torres Strait Islander people's legal rights or interests.</p> <p>B. By 2030, a 15 per cent increase in areas covered by Aboriginal and Torres Strait Islander people's legal rights or interests in the sea.</p>
16. Aboriginal and Torres Strait Islander cultures and languages are strong, supported and flourishing.	By 2031, there is a sustained increase in number and strength of Aboriginal and Torres Strait Islander languages being spoken.

Appendix 3: Access relative to need

Table A3.1: SA2s with potentially poor access to primary health care services, 2018

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

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

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

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

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

Sources: AIHW analyses (forthcoming); Online Services Report (2017-18).

Caveats:

- These areas have been identified based on supporting analysis, which may be subject to small changes.
- Key to identifying these areas are:
 - the AIHW's access scores, which are derived from several estimated data inputs, including GP capacities, population sizes, population distribution, per capita need, drive-times, as well as modelling parameters. Uncertainties in all of these inputs affect the quality of the results.
 - the location of Indigenous-specific primary health care services (ISPHCSs). Due to data gaps, some relevant service locations may not have been included and other service locations may have been included that do not offer clinical services.
- A small number of areas were removed from the list due to known data issues or the opening of new ISPHCS clinics.

Technical notes

More detailed information about data sources, specific data tables, and statistical methods is available from the Technical Appendix on indigenoushpf.gov.au.

Data sources

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

Data limitations

Although the statistics in this report are, as far as possible, the latest available, some data are several years old and might not reflect the current situation.

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

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

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

Age-standardisation

Age-standardisation is a way of adjusting for differences in the age structure of two populations, or change in the age structure of a population over time.

Data presented by age groups or relating to a specific age group (for example, babies, people aged 10–17, people aged 20–24) are not age-standardised.

Differences between groups or change over time

In statistical results, differences between groups or changes over time might indicate real differences, or be due to random variation. Statistical tests can indicate whether these differences are statistically significant, which means there is a high level of confidence that they reflect real differences. Percentage changes in rates over time are derived through linear regression analysis.

In general, differences and changes over time highlighted in this report are statistically significant. The confidence level used is 95%, meaning that the likelihood that the result occurred by chance is less than 1 in 20.

Numbers and percentages

Numbers are rounded to hundreds. Data come from various sources and in many cases numbers are population estimates derived from sample surveys. Percentages are rounded to the nearest whole percentage unless the percentage is under 10%, or to illustrate small but statistically significant differences or changes.

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Drawing on information compiled as part of the Aboriginal and Torres Strait Islander Health Performance Framework 2020, this summary report gives the latest information on how Aboriginal and Torres Strait Islander people are faring nationally according to various measures of health status and outcomes, determinants of health and health system performance.

Detailed findings, including comprehensive national, and state and territory reporting, supplementary data tables, and interactive data visualisations, are presented together on a dedicated website, indigenoushpf.gov.au.



Stronger evidence,
better decisions,
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