Australian Indigenous HealthInfoNet

Overview of Aboriginal and Torres Strait Islander health status 2025

Core funding is provided by the Australian Government Department of Health, Disability and Ageing

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Australian Indigenous Health*InfoNet*

The Australian Indigenous Health*InfoNet*'s (Health*InfoNet*) mandate is to contribute to improvements in Aboriginal and Torres Strait Islander health by making relevant, high-quality knowledge and information easily accessible to policy makers, health service providers, program managers, clinicians, and other health professionals (including Aboriginal and Torres Strait Islander Health Workers and Health Practitioners), and researchers. The Health*InfoNet* also provides easy-to-read summary material for students and the general community.

The Health*InfoNet* is overseen by an Advisory Board comprising representatives from Aboriginal and Torres Strait Islander peak bodies and Aboriginal and Torres Strait Islander health experts. The Health*InfoNet* achieves its mission by collating and disseminating research (and other relevant knowledge and information) about various aspects of Aboriginal and Torres Strait Islander health, mainly via the **Health*InfoNet***, **Alcohol and Other Drugs Knowledge Centre**, **Tackling Indigenous Smoking** and **WellMob** websites. The research involves analysis and synthesis of data and information obtained from academic, professional, government and other sources. The Health*InfoNet*'s work in knowledge exchange aims to facilitate the transfer of pure and applied research into policy and practice to address the needs of a wide range of users.

Recognition statement

The Health*InfoNet* recognises and acknowledges the sovereignty of Aboriginal and Torres Strait Islander people as custodians. Aboriginal and Torres Strait Islander cultures, customs and beliefs are persistent and enduring, continuing unbroken from the past to the present and will continue well into the future. Aboriginal and Torres Strait Islander people throughout Australia represent a diverse range of people, communities and groups each with unique identity, cultural practices and spiritualities. We recognise that the current health status of Aboriginal and Torres Strait Islander people has been significantly impacted by past and present practices and policies.

We acknowledge and pay our deepest respects to Elders past, present and emerging throughout the country (**https://healthinfonet.ecu.edu.au/acknowledging-country**). In particular, we pay our respects to the Whadjuk Noongar people on whose Country our offices are located.

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Cover artwork

Bibdjool *by Donna Lei Rioli*

Donna Lei Rioli, a Western Australian Indigenous artist - was commissioned by the Health*InfoNet* to create a logo incorporating a gecko, chosen as it is one of a few animals that are found across the great diversity of Australia.

Donna is a Tiwi/Noongar woman who is dedicated to the heritage and culture of the Tiwi people on her father's side, Maurice Rioli, and the Noongar people on her mother's side, Robyn Collard. Donna enjoys painting because it enables her to express her Tiwi and Noongar heritage and she combines the two in a unique way.

Donna interpreted the brief with great awareness and conveyed an integrated work that focuses symbolically on the pathway through life. This is very relevant to the work and focus of the Australian Indigenous HealthInfoNet in improving the health and wellbeing of Aboriginal and Torres Strait Islander people.

Preface

The purpose of the *Overview of Aboriginal and Torres Strait Islander health status (Overview)* is to provide a summary of the most recent indicators of health and the current health status of Aboriginal and Torres Strait Islander people. We adopt a holistic concept of health including social, cultural, political and environmental determinants. The *Overview* has been prepared by Health*InfoNet* staff as part of our contribution to supporting those who work in the Aboriginal and Torres Strait Islander health sector. The publication reflects the Health*InfoNet*'s commitment to knowledge development and exchange in Aboriginal and Torres Strait Islander health.

While the *Overview* provides a comprehensive review of key indicators across a range of health topics, it is beyond the scope of this *Overview* to provide detailed information on other aspects, such as the availability and use of services (including barriers and enablers to their use) and strategies and policies related to specific health topics. Interested readers should refer to the **topic-specific reviews** that are available on the Health*InfoNet*'s website and to the Australian Institute of Health and Welfare's (AIHW) Aboriginal and Torres Strait Islander **Health Performance Framework**. Additionally, more in-depth information about the topics summarised in this *Overview* is available in the corresponding sections of the Health*InfoNet*'s **website**.

How to read the *Overview*

The *Overview* is intended to be an easy-to-read, quick access document that provides up-to-date information on the status of Aboriginal and Torres Strait Islander peoples' health across Australia. Another aim of the *Overview* is to assist community members, service providers, and policy makers to identify emerging areas of strength, for example, where local or national statistics demonstrate positive health outcomes, as well as to identify health conditions of concern. Importantly, most of the statistics presented in the *Overview* represent population-level figures[1]. These figures can misrepresent local trends or health outcomes within specific population groups and should therefore be interpreted only as broad indicators of health status. In line with the National Closing the Gap Agreement, all Aboriginal and Torres Strait Islander health policy decisions should be made by, and in consultation with, Aboriginal and Torres Strait Islander peoples.

Feedback

The key to successful knowledge exchange and transfer is authentic partnership in the development of materials. We welcome your feedback on the *Overview*, so please let us know if you have any suggestions for improving this *Overview* or future editions. (See **https://healthinfonet.ecu.edu.au/contact-us**).

Bep Uink, Director, on behalf of the Health*InfoNet* team

1 Population level data provides a broad overview of the health status of Aboriginal and Torres Strait Islander people. Where available regional data are used. For further information at a disaggregated level refer to the Health*InfoNet* topic specific portals.

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Acknowledgements

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- members of the Health*InfoNet* Advisory Board and Health*InfoNet* consultants.
- the Department of Health, Disability and Ageing and other funding partners for their ongoing support of the work of the Health*InfoNet*.
- current and former Health*InfoNet* staff for their assistance, support and encouragement in the preparation of this *Overview* and for their contributions to earlier versions.
- users of the Health*InfoNet* resource and readers of the *Overview* for their ongoing support and feedback, including during the post-publication peer review period.

Transparency statement on the use of AI tools

The Australian Indigenous Health*InfoNet* is committed to using Artificial Intelligence (AI) in a culturally safe, ethical and responsible manner, in line with Edith Cowan University's Artificial Intelligence Framework [1]. We use AI minimally and always with human oversight to support the preparation of high-quality, evidence-based information for our audience.

In this publication, we acknowledge the use of AI for limited support to improve wording, assist with data interpretation, and clarify search terms for identifying references. All AI-generated content has been reviewed and confirmed by the authors.

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Introduction

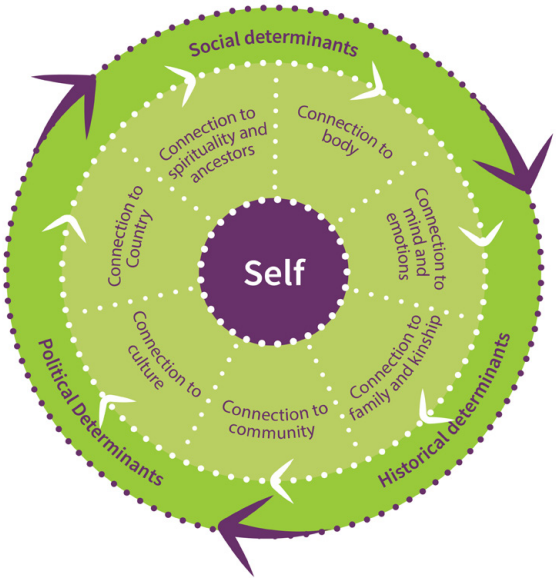
This *Overview* provides a summary of the most recent indicators of the health and wellbeing of Aboriginal and Torres Strait Islander people (of all ages, where data are available).

The topics included in the *Overview* cover chronic health conditions which are featured on the Health*InfoNet* website. Over the years as additional funding has been obtained and in consultation with Health*InfoNet* networks, more topics have been covered on the website and are now included in the *Overview*. The topics aim to reflect the status of Aboriginal and Torres Strait Islander health over this period and going forward.

What is new?

Continuing with the Health*InfoNet*'s commitment to principles of Aboriginal and Torres Strait Islander Data Sovereignty, this year's *Overview* features a broader range of indicators of social and emotional wellbeing (SEWB) alongside indicators of mental and physical health that will be familiar to readers of earlier editions of the *Overview*. This aligns the *Overview* with Aboriginal and Torres Strait Islander defined concepts of health. The indicators are based on the Aboriginal and Torres Strait Islander SEWB model (Figure 1) [2]. We provide the latest available statistics on Aboriginal and Torres Strait Islander peoples' connection to Country, Kinship and Family, Mind and Emotions, Body, Community, Culture, and Spirit and Ancestors, alongside data on social determinants of health such as racism, education and employment [3].

Figure 1: Aboriginal and Torres Strait Islander Model of Social and Emotional Wellbeing (SEWB)



Adapted from: Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K., 2014 [2]

This year's *Overview* includes updated statistics on Aboriginal and Torres Strait Islander health outcomes that became available in 2025 or were not presented in previous editions. Not all Aboriginal and Torres Strait Islander health data are updated annually. Where no new data are available, readers this year are directed to the **2024 *Overview*** for the most up-to-date information on specific health indicators, and are also provided with selected key facts from that edition.

Structure

The initial sections of the *Overview* provide information about the social, political and environmental determinants of Aboriginal and Torres Strait Islander peoples' health. Prefacing information on these determinants reflects the importance of context in interpreting Aboriginal and Torres Strait Islander health statistics.

The subsequent sections are organised according to the domains of connection outlined in the SEWB model. These are: Connection to culture, Connection to Country, Connection to spirituality and ancestors, Connection to body (physical health conditions), Connection to mind and emotions (mental health), Connection to community and Connection to family and kinship.

These sections comprise an introduction to the health indicator, alignment with relevant Closing the Gap (CTG) targets, and evidence of the status of the health indicator or risk/protective factors. Where available, information is provided for individual states and territories: New South Wales (NSW), Victoria (Vic), Queensland (Qld), Western Australia (WA), South Australia (SA), Tasmania (Tas), the Australian Capital Territory (ACT) and the Northern Territory (NT). Information is also provided, where available, by Indigenous Region, remoteness and demographic characteristics such as sex and age.

Aboriginal and Torres Strait Islander Data Sovereignty

The Health*InfoNet* continues to support the development of capacity to accurately and authentically represent data and statistics that affect Aboriginal and Torres Strait Islander people and communities. The *Overview* should be read in the context of our ongoing commitment to presenting data that empowers Aboriginal and Torres Strait Islander communities. We also acknowledge the ongoing efforts of Aboriginal and Torres Strait Islander people towards improving the quality and governance of data related to their communities.

All data presented in the *Overview* are secondary data, meaning that it has been collected by organisations outside of the Health*InfoNet*. With this in mind, we have applied the principles of the Maiam nayri Wingara Indigenous Data Sovereignty Collective in the preparation of the *Overview* [4]. This approach aligns with CTG Priority Reform 4: '*Shared access to data and information at a regional level.*'

The list below outlines how the principles of Indigenous Data Sovereignty are embedded within the *Overview*, noting that only secondary data are presented:

- The Health*InfoNet* relies on advice from its Advisory Board on the direction of the *Overview*.
- A post-publication peer review period enables readers to provide feedback.
- Where available, regional or local data are included; for example, in the P*opulation, Skin health and Ear health* sections.
- Where possible, the Health*InfoNet* has included and highlighted data that has been collected by Aboriginal and Torres Strait Islander-driven research, for example, the Mayi Kuwayu study [5].
- A number of sections include the results of analyses conducted by the Health*InfoNet* of data obtained from a variety of sources.
- Information on social determinants and the context of Aboriginal and Torres Strait Islander health is provided at the beginning of the *Overview* and, where possible, at the start of each health topic section.
- Holistic indicators of health in line with the Aboriginal and Torres Strait Islander SEWB model are included.

Additionally, Table 1 outlines how information in the *Overview* aligns with Indigenous health data needs.

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Table 1: Indigenous data needs aligned with the *Overview*, 2025

Indigenous Data Needs	*How the need is addressed in the Overview*
Lifeworld Data Data to inform a comprehensive, nuanced narrative of who we are as peoples, our culture, communities, resilience, goals and successes.	• Following previous editions of the *Overview*, less reliance is placed on comparisons between Indigenous and non-Indigenous data. • 'Target boxes' have been included to highlight where reported data aligns with a national health priority area outlined in the CTG targets. • The *Overview* incorporates a strengths-based approach where possible. This is achieved by including data on protective factors, cultural determinants, and improvements in the health status of Aboriginal and Torres Strait Islander people. • Inclusion of holistic indicators of health in line with an Aboriginal and Torres Strait Islander model of SEWB.
Disaggregated Data Data that recognise our cultural and geographical diversity and provide evidence for community-level planning and service delivery.	• Information is provided for states and territories, Indigenous Regions and remoteness, and for demographics such as sex and age where available. • Where available, information is detailed for individual states and territories: NSW, Vic, Qld, WA, SA, Tas, the ACT and the NT.
Contextualised Data Data that are inclusive of the wider social and structural context/ complexities in which Indigenous disadvantage occurs.	• Political and social concepts include a discussion of social determinants of health. • Introduction sections on disease and injury rates include the contexts that continue to contribute to these outcomes.
Indigenous Priority Data Data that measure not only our challenges but also address our priorities and agendas.	• 'Target boxes' have been included to highlight where reported data aligns with a national health priority area outlined in the CTG targets.
Available Amenable Data Data that are accessible and amenable to our requirements.	• Where available, Indigenous Data Governance mechanisms that oversee the sources of data used in the *Overview* are listed (see p11). This provides readers with an easy-to-use access point for assessing the level of governance attached to each dataset.

Source: Adapted from Walter M, Lovett R, Maher B, Williamson B, Prehn J, Bodkin-Andrews G, Lee V (2021) [6].

A note on gender-inclusive language

The *Overview* draws on a number of sources, including those reporting data on pregnancy, births and certain cancers. Some of these sources use the terms 'women' and 'men' to refer to participants. In reporting these statistics in the *Overview*, we use the terminology consistent with the data source, and we take care to identify whether the original data source refers to sex or gender. However, we acknowledge that 'women' and 'men' represent only two genders. Trans and non-binary people are often excluded from statistical data collection, and gender and sex are sometimes conflated in the reporting of some datasets. For more information on inclusive language, see the **Edith Cowan University inclusive language guide** [7].

Sources of information

The *Overview* provides the latest data on the health status of Aboriginal and Torres Strait Islander people.

Research for the *Overview* involves the collation and analysis of a wide range of relevant information. Sources include government reports, particularly those produced by the Australian Bureau of Statistics (ABS), the AIHW, the Health Chief Executives Forum [formerly the Australian Health Ministers Advisory Council (AHMAC)] and the Steering Committee for the Review of Government Service Provision (SCRGSP). Important additions to the regular ABS and AIHW publications are special reports that bring together key information about Aboriginal and Torres Strait Islander health and related areas:

- Reports in the *Aboriginal and Torres Strait Islander health performance framework series*, which provide substantial detailed analyses and were prepared by AHMAC from 2006 to 2020 and subsequently then by the AIHW and the National Indigenous Australians Agency.
- *Reports on government services*, which are produced by the SCRGSP and published annually by the Productivity Commission since 2003.

This *Overview* also draws on information from the main administrative data collections (such as the birth and death registration systems and the hospital inpatient collections), cohort studies (such as the Mayi Kuwayu study), and national surveys (such as the National Aboriginal and Torres Strait Islander Health Surveys). Information from these sources has been published mainly in government reports, particularly those from the ABS, the AIHW and the SCRGSP. The *Overview* also relies on a wide range of other sources, including registers for specific diseases and other conditions; regional and local surveys; and epidemiological and other studies examining particular diseases, conditions and health determinants. Information from these sources is disseminated mainly through journals and other periodicals, or in special reports such as the annual reports of the Kirby Institute and Australia and New Zealand Dialysis and Transplant Registry (ANZDATA).

We are pleased that many of these data sources are actively engaged in improving Aboriginal and Torres Strait Islander data sovereignty and governance:

- ANZDATA Indigenous Data Sovereignty is a key project of the ANZDATA **Aboriginal and Torres Strait Islander Health Working Group**.
- Projects undertaken at the Kirby Institute by Aboriginal and Torres Strait Islander researchers aim to integrate Indigenous methodologies, cultural governance, frameworks and principles of data sovereignty into their programs.

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Social, political and environmental determinants of health

CTG Outcome 3: Children are engaged in high quality, culturally appropriate early childhood education in their early years

CTG Outcome 5: Students achieve their full learning potential

CTG Outcome 6: Students reach their full potential through further education pathways

CTG Outcome 7: Youth are engaged in employment or education

CTG Outcome 8: Strong economic participation and development of people and their communities

CTG Outcome 9: People can secure appropriate, affordable housing that is aligned with their priorities and need

Aboriginal and Torres Strait Islander worldviews of health embrace a whole-of-life perspective that incorporates the total wellbeing of the community and not just the individual. The Aboriginal and Torres Strait Islander SEWB model [2] recognises that social and political factors can have a profound impact on the health of Aboriginal and Torres Strait Islander people [3, 8-11]. It is evident that the impacts of settler colonialism (including oppression; exploitation; marginalisation; separation from culture, land and family; intergenerational trauma; racism; and poverty) have had negative implications for health and wellbeing for many Aboriginal and Torres Strait Islander people [10, 12, 13]. Focusing less on the deficit narratives promoted by the way these indicators are framed and more on the positive, affirming impacts of cultural determinants, the narrative can shift more towards strengths-based understandings of Aboriginal and Torres Strait Islander health [3, 11]. That said, it is critical to recognise social, political and environmental factors that enhance or inhibit Aboriginal and Torres Strait Islander health.

The social determinants of racism and discrimination, level of education, employment status and income, housing, and involvement with child protection systems [14], alongside cultural determinants of family and community, Country and place, cultural identity and self-determination, can act as risk and/or protective factors for health and wellbeing [3]. These factors are further shaped by a wider set of forces and systems, including policies, political systems and social norms [15].

This section of the *Overview* contains data on racism and discrimination, education, employment, income and environmental determinants.

New since the previous release

Racism and discrimination

Racism occurs when individuals or organisations use power to harm, discriminate against or limit people's rights because of their 'race'[2] or culture. It is a system of beliefs, practices and policies that work to privilege certain groups over others and can operate at individual and systemic levels [17-19].

Aboriginal and Torres Strait Islander people experience racism in distinct ways arising from the period of European colonisation and its ongoing social, economic and cultural impacts [17, 20]. Intergenerational trauma, systematic oppression and denial of self-determination continue to have direct and profound impacts on the health and wellbeing of Aboriginal and Torres Strait Islander people [21, 22], who also continue to combat and resist racism in all forms.

2 While race has no basis in biology, it exists as a social construct and therefore has real world consequences for racialised people [16]

A key contributor to poor health outcomes is institutional racism, in which racism is structurally embedded in the laws, policies and practices within institutions and systems, which creates and maintains racial inequality and enables interpersonal racism to persist [17, 21].

This includes health systems where Aboriginal and Torres Strait Islander people are excluded from governance, control and accountability within mainstream health settings [23]. Institutional racism exists within healthcare policies, service delivery, clinical decision-making and governance arrangements [19]. These disparities are further entrenched by a lack of Aboriginal and Torres Strait Islander perspectives and limited participation in the health workforce, contributing to reduced access to health care and exacerbating poor health outcomes [19, 21].

Identifying and eliminating racism is one of the twelve key priorities outlined in the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* [21]. Priority Eight calls for the acknowledgment of institutional racism across the health, disability and aged care systems and urges governments and health bodies to acknowledge, address, measure and report institutional racism and improve cultural safety training across mainstream health services [21].

Ensuring that healthcare is culturally safe, accessible and free from racism means that Aboriginal and Torres Strait Islander people are more likely to have positive experiences within the health system and be more likely to access health services when they need care [21].

Current data on racism include:

- In 2022, the Australian Reconciliation Barometer found that 60% of Aboriginal and Torres Strait Islander people aged 18 years and over had experienced at least one form of racial prejudice in the past six months, and 20% had experienced discrimination from health care staff in the past six months [24].
- In 2018-2020, among participants aged 16 years and over in the national Mayi Kuwayu study, 2.3% reported experiencing high levels of everyday discrimination, 8.4% moderate levels, 44% low levels, and 38% reported no discrimination [9].
- The Mayi Kuwayu study found that, in 2018-2020, compared with those who experienced no discrimination, people experiencing moderate to high discrimination were 3.7 times as likely to report low happiness, 3.4 times as likely to report low life satisfaction, and 2.5 times as likely to experience high to very high psychological distress [25]. They were also 1.6 times as likely to report frequent pain and doctor-diagnosed depression and anxiety.
- Analysis of the 2018-19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) showed that of the 243,663 Aboriginal and Torres Strait Islander people who did not access health care when they needed to, 32% said this was due to cultural reasons (such as language barriers, cultural appropriateness and discrimination) [26, 27].

Access to education

The primary indicators used to assess Aboriginal and Torres Strait Islander education outcomes are enrolment, retention, and completion rates; however, these indicators do not provide a full picture of Aboriginal and Torres Strait Islander peoples' experiences within schools and education settings [28]. Access to education aligns with CTG Target 5: *Students achieve their full learning potential;* CTG Target 6: *Students reach their full potential through further education pathways;* and CTG Target 7: *Youth are engaged in employment or education.*

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New data are available on early childhood education:

- In 2024, 94.2% of Aboriginal and Torres Strait Islander children who were in the year before full-time schooling were enrolled in early childhood education [29].
- In 2024, the full-time apparent retention rates for Aboriginal and Torres Strait Islander students (the percentages of students who stayed enrolled full-time in secondary school) were:
  - 57% for Year 7/8–Year 12
  - 77% for Year 7/8–Year 11
  - 99% for Year 7/8–Year 10 [30].

The National Assessment Program – Literacy and Numeracy (NAPLAN) reports each year on primary and secondary student achievement in five domains of numeracy and literacy: reading, writing, grammar and punctuation, spelling, and numeracy [31]. For each of these areas, students are assessed as being in one of four proficiency levels: exceeding, strong, developing or needs additional support. New data are available for NAPLAN in the table below.

Table 2. Average proportion (%) of Aboriginal and Torres Strait Islander students across all NAPLAN domains, by proficiency level and year level, 2025

	Needs additional support	Developing	Strong	Exceeding
Year 3	34	30	30	2.8
Year 5	31	30	32	3.6
Year 7	32	29	31	4.5
Year 9	33	32	28	4.0

Note:

1. This table shows the average proportion of Aboriginal and Torres Strait Islander students across all domains who were assessed as being in each proficiency level in 2025. About one-third of students achieved results that were classified as strong or exceeding, combined.
2. Proportions are rounded; totals may not equal 100.

Source: Australian Curriculum Assessment and Reporting Authority, 2025 (Derived from [32])

Access to employment and income

Access to and participation in meaningful employment relate to CTG Target 7: *Youth are engaged in employment or education;* and CTG Target 8: *Strong economic participation and development of people and their communities.*

The most recent data on employment, from the NATSIHS 2022–23, show that [33]:

- 34% of Aboriginal and Torres Strait Islander people aged 15–64 years were not in the labour force
- 67% were in the labour force, and of these:
  - 57% were employed
    - 36% full-time
    - 21% part-time
  - 9.5% were unemployed.

No new data are available on household income. The 2024 *Overview* reported that the median weekly equivalised[3] household income for Aboriginal and Torres Strait Islander people was $830 [34].

3 Equivalised household income adjusts the actual incomes of households to make households of different sizes and compositions comparable.

Environmental health

Environmental health refers to the physical, chemical and biological factors that affect the health and wellbeing of people within their surroundings, primarily within their homes and communities [35-37].

Aboriginal and Torres Strait Islander people are disproportionately affected by the diseases associated with environmental health due to a number of factors, including the remoteness of some communities, inadequate housing and home health hardware[4], limited access to tradespeople and repairs, and the cost of infrastructure maintenance [36, 39-41].

The health impacts of climate change may also disproportionately affect Aboriginal and Torres Strait Islander people. However, climate adaptation strategies are increasingly drawing on Indigenous knowledges, leadership and caring for Country practices in this area [42].

There are no new data to report for major environmental health indicators for 2025. The 2024 *Overview* reported that 6.8% of Aboriginal and Torres Strait Islander people were living in overcrowded conditions in 2022-23 [85].

Unchanged since the previous release

See the **2024 *Overview*: Social indicators** and **2024 *Overview*: Environmental health** for the latest available data on these social, political, and environmental health indicators:

- Proportion of Aboriginal and Torres Strait Islander people aged 20–24 years who had completed year 12 or equivalent
- Proportion of Aboriginal and Torres Strait Islander people aged 18 years and over and 18–24 years who were studying
- Proportion of Aboriginal and Torres Strait Islander people aged 25–34 years who had completed a non-school qualification of Certificate III or above
- Top three reported occupations for employed Aboriginal and Torres Strait Islander people aged 15 years and over
- Median weekly equivalised household income and weekly personal income for Aboriginal and Torres Strait Islander people
- Percentage of Aboriginal and Torres Strait Islander people who reported living in overcrowded conditions, including by sex, age, jurisdiction and remoteness
- Percentage of Aboriginal and Torres Strait Islander households living in houses of an acceptable standard, including by jurisdiction and remoteness
- Percentage of Aboriginal and Torres Strait Islander households reporting major structural issues within their dwelling, including by type of structural issue and by jurisdiction
- Percentage of Aboriginal and Torres Strait Islander people who reported access to household facilities, including by type of facility, jurisdiction and remoteness
- Hospitalisation rates for Aboriginal and Torres Strait Islander people for selected diseases associated with poor environmental health, including by remoteness
- Death rates for Aboriginal and Torres Strait Islander people from conditions associated with poor environmental health, including by jurisdiction.

4 The kitchen, toilet, showers and laundry are recognised as home hygiene hardware [38].

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Key facts

This section provides a snapshot of key facts relating to Aboriginal and Torres Strait Islander health and wellbeing outcomes.

Social, Political and Environmental Determinants of Health

- In 2022, 60% of Aboriginal and Torres Strait Islander people aged 18 years and over reported having experienced at least one form of racial prejudice in the past six months.
- In 2022–23, 67% of Aboriginal and Torres Strait Islander people aged 15–64 years were in the labour force. Of these, 36% were employed full-time and 21% were employed part-time.
- In 2022–23, 82% of Aboriginal and Torres Strait Islander households reported living in houses of an acceptable standard.

Population

- In 2025, the estimated Aboriginal and Torres Strait Islander population was 1,059,185.
- In 2025, NSW had the largest Aboriginal and Torres Strait Islander population, with an estimated 364,450 people representing 34% of the national Aboriginal and Torres Strait Islander population.
- In 2025, the NT had the highest proportion of Aboriginal and Torres Strait Islander people, compromising 30% of its population.

Connection to Culture

- In 2021, 9.5% of Aboriginal or Torres Strait Islander people in the Census reported using or speaking an Aboriginal or Torres Strait Islander language at home.
- In 2021, there were 167 Aboriginal and Torres Strait Islander languages being actively spoken in Australia.
- In 2022–23, 66% of Aboriginal and Torres Strait Islander people identified with a tribal group, language, clan, mission or regional group.
- Based on 2018–2020 data from the national Mayi Kuwayu study, 29% of Aboriginal and Torres Strait Islander adults aged 16 years and over spend a moderate to high amount of time participating in cultural practices.

Connection to Country

- 50% of Aboriginal and Torres Strait Islander people aged 16 years and over in the Mayi Kuwayu study spent at least a little bit of time on their Country.
- 19% of Aboriginal and Torres Strait Islander people aged 16 years and over in the Mayi Kuwayu study had cultural responsibilities for their mother's Country and 14% for their father's Country.
- Indigenous Rangers are 1.3 times as likely to report very high life satisfaction than non-Rangers.
- In 2024, 56% of Australia's total land mass was subject to Aboriginal and Torres Strait Islander people's legal rights and interests.

Connection to Body

Births and pregnancy outcomes

- In 2024, there were 25,049 births registered in Australia with one or both parents identified as Aboriginal and/or Torres Strait Islander (8.6% of all births registered).
- In 2024, the median age of Aboriginal and Torres Strait Islander mothers who gave birth was 27.0 years.
- In 2024, the total fertility rate was 2.1 babies per Aboriginal and Torres Strait Islander woman.

Cardiovascular health

- In 2022-23, 14% of Aboriginal and Torres Strait Islander people reported having cardiovascular disease (CVD).
- In 2024, in NSW, Qld, WA, SA and the NT combined, there were 472 notifications of acute rheumatic fever (ARF) for Aboriginal and Torres Strait Islander people.
- In 2023-24, there were 20,169 hospital separations for CVD among Aboriginal and Torres Strait Islander people, representing 5.2% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis).
- In 2024, ischaemic heart disease (IHD) was the leading specific cause of death for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT.

Cancer

- In 2022–23, 1.1% of Aboriginal and Torres Strait Islander people reported having neoplasms (including malignant, benign, in situ and of an uncertain nature) as a long-term health condition.
- In 2023–24, there were 14,111 hospital separations with neoplasms (including all types of cancer) as the principal diagnosis, representing 3.7% of all separations (excluding dialysis) among Aboriginal and Torres Strait Islander people.
- In 2024, cancers of the trachea, bronchus and lung combined were the fourth leading cause of death for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT, being responsible for 329 deaths.
- In 2018, cancer accounted for 9.9% of the total burden of disease among Aboriginal and Torres Strait Islander people.

Diabetes

- In 2024, diabetes was the third leading specific cause of death for Aboriginal and Torres Strait Islander people in NSW, Qld, SA, WA and the NT.
- In 2022-23, 7.4% of Aboriginal and Torres Strait Islander people reported having diabetes.
- In 2021-22, there were 4,850 potentially preventable hospitalisations of Aboriginal and Torres Strait Islander people for a principal diagnosis of diabetes.

Kidney health

- In 2022-23, 1.4% of Aboriginal and Torres Strait Islander people reported kidney disease as a long-term health condition.
- In 2024, there were 2,249 prevalent dialysis patients in Australia who identified as Aboriginal and/or Torres Strait Islander people.
- In 2024, 362 Aboriginal and Torres Strait Islander people commenced dialysis.
- In 2024, 64 Aboriginal and Torres Strait Islander people received a kidney transplant.

Respiratory health

- In 2022-23, 31% of Aboriginal and Torres Strait Islander people reported having a long-term respiratory condition.
- In 2021, 13% of Aboriginal and Torres Strait Islander people reported having asthma and 2.2% chronic obstructive pulmonary disease (COPD).
- In 2023-24, 9.2% of all Aboriginal and Torres Strait Islander hospital separations (excluding those for dialysis) were for respiratory disease.
- In 2024, chronic lower respiratory disease was the second leading cause of death overall for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT.

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Eye health

- In 2022-2025, the prevalence of vision impairment in both eyes among Aboriginal and Torres Strait Islander adults aged 50 years and over was 11%.
- In 2022-23, eye and sight problems were reported by 41% of Aboriginal people and 38% of Torres Strait Islander people.
- In 2024, the estimated overall prevalence of trachoma in at-risk communities in WA, SA and the NT combined was 1.5%.
- In 2023-24, hospitalisations for diseases of the eye and adnexa accounted for 2.1% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis).

Ear health and hearing

- In 2022-2025, the prevalence of hearing impairment in both ears among Aboriginal and Torres Strait Islander adults aged 50 years and over was 49%.
- In 2022-23, 13% of Aboriginal and Torres Strait Islander people reported ear and hearing problems.
- In 2023-24, ear-related hospitalisations accounted for 1.2% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis).

Oral health

- In 2012-2014, 61% of Aboriginal and Torres Strait Islander children aged 5-10 years had experienced tooth decay in their baby teeth, and 36% of Aboriginal and Torres Strait Islander children aged 6-14 years had experienced tooth decay in their permanent teeth.
- In 2017-18, 7.1% of Aboriginal and Torres Strait Islander people aged 15 years and over had complete tooth loss.
- In 2023-24, there were 5,679 potentially preventable hospitalisations for dental conditions for Aboriginal and Torres Strait Islander people, with a crude rate of 5.6 per 1,000.

Disability

- In 2022-23, 38% of Aboriginal people and 29% of Torres Strait Islander people reported having a disability or restrictive long-term health condition.
- In 2022-23, 7.0% of Aboriginal people and 5.9% of Torres Strait Islander people reported a profound or severe disability.
- In 2022, 71% of Aboriginal and Torres Strait Islander people with disability, aged 5 years and over, reported having a schooling or employment restriction.
- In the 2021 Census, 8.2% of Aboriginal and Torres Strait Islander people reported a need for assistance with either self-care, mobility or communication.

Nutrition, physical activity and bodyweight

- In the 2022–23 NATSIHS, 35% of Aboriginal and Torres Strait Islander people aged 15 years and over met the recommended fruit intake guidelines, and 5.3% met the recommended vegetable intake guidelines.
- In the 2018–19 NATSIHS, 87% of Aboriginal and Torres Strait Islander children aged 0–2 years had been breastfed.
- In the 2022–23 NATSIHS, 17% of people aged 15 years and over in non-remote areas met the recommended guidelines for weekly physical activity.
- In the 2022–23 NATSIHS, 68% of people aged 15 years and over were overweight or obese.

Tobacco and e-cigarette use

- In 2022-23, 29% of Aboriginal and Torres Strait Islander people aged 15 years and over reported they smoked daily, a reduction from levels reported in 2018-19 (37%).
- In 2023, 38% of Aboriginal and Torres Strait Islander mothers reported smoking during pregnancy.
- In 2018, tobacco use was the leading risk factor contributing to the burden of disease among Aboriginal and Torres Strait Islander people, responsible for 12% of the total burden of disease.
- In 2022-23, 24% of Aboriginal and Torres Strait Islander people aged 15 years and over had ever used an e-cigarette and 8.3% currently used an e-cigarette.

Alcohol use

- In 2022-23, 62% of Aboriginal and Torres Strait Islander adults did not exceed the 2020 Australian adult alcohol guideline.
- In 2022-23, 36% of Aboriginal and Torres Strait Islander adults exceeded the 2020 Australian adult alcohol guideline.
- In 2023, 86% of pregnant Aboriginal and Torres Strait Islander people self-reported not consuming alcohol during the first 20 weeks of pregnancy, increasing to 90% after 20 weeks.
- In 2023-24, alcohol was the main drug of concern for 36% of Aboriginal and Torres Strait Islander people who sought treatment for their own alcohol and other drugs (AOD) use.

Illicit drug and volatile substance use

- In 2022–23, 27% of Aboriginal and Torres Strait Islander people aged 15 years and over reported they had used an illicit substance in the previous 12 months.
- In 2018, illicit drug use contributed to 6.9% of the total burden of disease among Aboriginal and Torres Strait Islander people.
- In 2023–24, 0.8% of Aboriginal and Torres Strait Islander people aged 10 years and over identified volatile solvents as the main drug they sought treatment for in publicly funded AOD services.
- In 2022–23, the majority (94%) of Aboriginal and Torres Strait Islander people aged 14 years and over reported they had never used inhalants.

Sexual health

- In 2024, there were 9,885 notified chlamydia infections among Aboriginal and Torres Strait Islander people.
- In 2024, there were 5,934 notified gonorrhoea infections among Aboriginal and Torres Strait Islander people.
- In 2024, there were 989 notified infectious syphilis for Aboriginal and Torres Strait Islander people.

Communicable disease

- In 2024, there were 23 notifications of human immunodeficiency virus (HIV) infection for Aboriginal and Torres Strait Islander people.
- In 2024, there were 1,527 notified hepatitis C virus (HCV) infections for Aboriginal and Torres Strait Islander people.
- In 2024, there were 144 notified hepatitis B virus (HBV) infections for Aboriginal and Torres Strait Islander people.
- In 2020–2024, there were 1,418 notifications for invasive pneumococcal disease (IPD) for Aboriginal and Torres Strait Islander people.

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Skin health

- In 2022-23, 4.0% of Aboriginal and Torres Strait Islander people reported having a disease of the skin or subcutaneous tissue.
- In 2023–24, 3.8% of hospital separations among Aboriginal and Torres Strait Islander people (excluding dialysis) were for diseases of the skin and subcutaneous tissue.

Immunisation

- As of 30 September 2025, 94.3% of Aboriginal and Torres Strait Islander five-year-old children were fully immunised against the recommended vaccine preventable diseases.

Connection to Mind and Emotions

- In 2022-23, 30% of Aboriginal people and 31% of Torres Strait Islander people aged 18 years and over reported high or very high levels of psychological distress.
- In 2022-23, anxiety was the most common mental or behavioural condition reported by Aboriginal and Torres Strait Islander people aged two years and over (21%), followed by depression (16%).
- In 2023-24, there were 29,289 hospital separations of Aboriginal and Torres Strait Islander people with a principal diagnosis of 'Mental and behavioural disorders'.
- In 2024, 271 Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT died from intentional self-harm.

Connection to Community

- The Mayi Kuwayu study reported that 21% of respondents felt that where they live, local Mob makes community decisions 'a lot'.
- In 2024–25, there were 146 National Aboriginal Community Controlled Health Organisation (NACCHO)-affiliated Aboriginal Community Controlled Health Organisations across Australia, operating across more than 550 sites.
- In the Mayi Kuwayu study, 48% of Aboriginal and Torres Strait Islander adults reported preferring an Aboriginal Medical Service (AMS) as a source of non-urgent care, while 33% reported using an AMS.
- In 2023–24, assault accounted for 17% of injury-related hospitalisations among Aboriginal and Torres Strait Islander people.

Connection to Family and Kinship

- In 2024, there were 19,987 Aboriginal children in out-of-home care (OOHC).
- In 2023–24, there were 4,415 Aboriginal and Torres Strait Islander children admitted to OOHC, with an admission rate of 11 per 1,000.
- In 2023–24, there were 4,433 family violence hospitalisations among Aboriginal and Torres Strait Islander people.
- In 2022–23, low or moderate distress was reported by 74% of Aboriginal and Torres Strait Islander respondents with no family removal history, compared with 60% of those with a removal history.

Mortality

- In 2024, the age-standardised death rate for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT was 9.9 per 1,000.
- For Aboriginal and Torres Strait Islander people born in 2020-2022, life expectancy was estimated to be 71.9 years for males and 75.6 years for females.
- In 2024, the leading causes of death among Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT were ischaemic heart disease (IHD), intentional self-harm (suicide), cancer of the trachea, bronchus and lung, chronic lower respiratory diseases, and diabetes.

Hospitalisation

- In 2023–24, 5.5% of all hospital separations were for Aboriginal and Torres Strait Islander people.
- In 2023–24, the age-standardised hospital separation rate for Aboriginal and Torres Strait Islander people was 900 per 1,000 population, with the highest rate in the NT of 2,166 per 1,000.
- In 2023–24, the main cause of hospitalisation for Aboriginal and Torres Strait Islander people was for 'Factors influencing health status and contact with health services' (mostly for care involving dialysis), responsible for 44% of all Aboriginal and Torres Strait Islander hospital separations.
- In 2023–24, the age-standardised rate of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people was 69 per 1,000 population.

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Population

The size and distribution of the population provide context for interpreting the prevalence of health conditions and risk factors given later in this *Overview*, including how demographic and geographic patterns influence distribution.

New since the previous release

- The ABS estimated[5] the Aboriginal and Torres Strait Islander population at 1,059,185 people in 2025 (Table 3) [43].
- In 2025, the Aboriginal and Torres Strait Islander population accounted for 3.8% of Australia's total population of 27.6 million (Derived from [43] and [44]).
- In 2025, the Aboriginal and Torres Strait Islander population was highest in NSW (364,450 people), followed by Qld (299,450), with the lowest in the ACT (10,432) (Derived from [43] and [44]).
- In 2025, the NT had the highest proportion of Aboriginal and Torres Strait Islander people among its population (30%) and Vic the lowest (1.2%) (Derived from [43] and [44]).

Table 3. Estimated Aboriginal and Torres Strait Islander (Indigenous) population, by jurisdiction, Australia, 2025

Jurisdiction	Indigenous population (number)	Proportion of Australian Indigenous population (%)	Proportion of total jurisdiction population (%)
NSW	364,450	34	4.2
Vic	85,500	8.1	1.2
Qld	299,450	28	5.3
SA	55,490	5.2	2.9
WA	129,117	12	4.2
Tas	35,712	3.4	6.2
NT	78,785	7.4	30
ACT	10,432	1.0	2.2
Australia	1,059,185	100	3.8

Note: The Australian population includes Jervis Bay Territory, the Cocos (Keeling) Islands, Christmas Island and Norfolk Island.

Source: Derived from ABS, 2025 [44], ABS, 2024 [43]

- In 2025, according to ABS estimates, just under one-third (31%) of Aboriginal and Torres Strait Islander people were aged less than 15 years and 6.3% were aged 65 years or over (Derived from [43]).
- The ABS estimated that of the population of 1,059,185 Aboriginal and Torres Strait Islander people in 2025, 44% lived in inner and outer regional areas, 41.5% in major cities and 14.5% in remote and very remote areas (Derived from [43]).
- In terms of specific geographical areas, the top five Indigenous Regions[6] where Aboriginal and Torres Strait Islander people resided in 2025 were Brisbane (127,869 residents); NSW Central and North Coast (126,378); Sydney–Wollongong (110,467); Perth (58,579) and Vic excluding Melbourne (44,312) [43].

5 Population estimates are released regularly by the ABS and provide a more accurate measure of the actual size of a population. They are assessments of what would happen to the population if components of population change (births, deaths and migration) were to hold in the future.

6 Indigenous Regions are large geographical units loosely based on the former Aboriginal and Torres Strait Islander Commission boundaries [45].

Unchanged since the previous release

No new data are available on the following population indicators since the previous release. See the **2024 *Overview*: Aboriginal and Torres Strait Islander population** for the latest available data:

- Proportion of population who identified as Aboriginal, Torres Strait Islander, and both Aboriginal and Torres Strait Islander respectively.

Key facts from the previous release

- According to estimates from the 2021 Census, 91.4% of Indigenous people were Aboriginal, 4.4% were Torres Strait Islander and 4.2% were of both Aboriginal and Torres Strait Islander descent [34].

Connection to culture

CTG Outcome 16: Cultures and languages are strong, supported and flourishing

Connection to culture is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. Being connected to culture provides continuity across generations and underpins a strong sense of identity. Evidence indicates that cultural determinants contribute to health outcomes for Aboriginal and Torres Strait Islander people peoples [3].

Protective factors that support a strong connection to culture include attending national and local cultural events; participating in cultural activities; delivering and/or receiving cultural education; expressing culture in contemporary ways; having access to cultural institutions; and speaking or learning an Aboriginal or Torres Strait Islander language [46, 47]. Risk factors for a weakened connection to culture include Aboriginal and Torres Strait Islander languages being under threat; engagement with services that are not culturally safe; and Elders passing on without full opportunities to transmit culture.

This section of the *Overview* includes measures of connection to culture for which there are current available data, including knowing who one's Mob[7] are, participating in cultural practices, using language, and the cultural safety of services. For data on community-controlled services, see *Connection to community*.

New since the previous release

Cultural identity

Knowing who one's Mob are is important for identity and is linked to better health and SEWB [9, 48, 49].

Historical policies that systematically separated people from their Country and communities have impacted the ability of some Aboriginal and Torres Strait Islander people to have knowledge of their Mob/s.

New data are available on cultural identity:

- The 2022–23 NATSIHS found that among Aboriginal and Torres Strait Islander people aged 18 years and over (an estimated 577,000 people), 66% (382,000 people) identified with a tribal group, language, clan, mission or regional group [50].
- In 2022–23, the proportion of people who identified with a tribal group, language, clan, mission or regional group was higher in remote and very remote areas (80%) than in non-remote areas (64%) [50].

7 Mob is used to refer to one's Country, Nation, Language or Aboriginal and Torres Strait Islander family group. Individuals can have connections with multiple Countries across Australia.

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- In *Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC) Early Childhood Report (2025)*, 63% of parents said their preschool-aged child identified with at least one Nation or language group [48]. This was most frequently reported for children living in remote areas (over 75%), compared with 57% in inner regional areas and 49% in major cities.
- The LSIC found that children who recognised and identified with their Nation or language group prior to starting school had higher levels of SEWB throughout middle childhood and adolescence compared with those who did not [48].
- Based on 2018–2020 data from the national Mayi Kuwayu study, 36% of Aboriginal and Torres Strait Islander adults aged 16 years and over know their totem or Dreaming (Aboriginal people: 36%; Torres Strait Islander people: 46%; people who are both Aboriginal and Torres Strait Islander: 41%) [9].
- In 2022, 83% of Aboriginal and Torres Strait Islander respondents in the Australian Reconciliation Barometer national research study reported feeling proud of First Nations cultures [24].

Participation in culture

The Aboriginal and Torres Strait Islander SEWB model highlights cultural participation and contemporary cultural expression as ways to strengthen connection to culture [46].

New data are available on cultural participation:

- Based on 2018–2020 data from the national Mayi Kuwayu study, 29% of Aboriginal and Torres Strait Islander adults aged 16 years and over spend a moderate to high amount of time participating in cultural practices (Aboriginal people: 29%; Torres Strait Islander people: 39%; people who are both Aboriginal and Torres Strait Islander: 34% (Derived from [9]) [9].

Language

Language is a key cultural determinant of health and a CTG socioeconomic outcome for Aboriginal and Torres Strait Islander people [51]. Speaking language is associated with better health, education, wellbeing, cultural continuity, community connectedness, and social and economic outcomes [52, 53].

The 2024 *Overview* reported on the prevalence of language use and its correlation with wellbeing, drawing on findings from the 2021 Census and the Mayi Kuwayu study. This 2025 edition provides additional findings from these sources:

- Based on weighted Mayi Kuwayu study data from 2018-2022 [54], 42% of Aboriginal and Torres Strait Islander adults were learning an Aboriginal or Torres Strait Islander language: 22% were learning a little bit, 7.4% were learning a fair bit, and 12.4% were learning a lot[8]. Seventeen per cent (17%) wanted to learn an Aboriginal and Torres Strait Islander language but could not, and 3.8% of Aboriginal and Torres Strait Islander adults had participated in a language program.
- The 2021 Census found that among Aboriginal and Torres Strait Islander languages spoken at home, the most common were Yumplatok (7,596 people or 9.9%), Kriol (7,403 people or 9.6%) and Djambarrpuyngu (3,839 people or 5.0%) [55].

8 Parts may not sum exactly to the total due to rounding.

Cultural safety of services

The Aboriginal and Torres Strait Islander SEWB model identifies engagement with culturally unsafe services as a risk to strong cultural connection [46].

New data are available on the cultural safety of services:

- In 2022–23, Aboriginal and Torres Strait Islander people aged 15 years and over in non-remote areas reported that their GP always/usually: explained things in a way they could understand (90%), listened to them (90%), showed respect for what they had to say (91%), and spent enough time with them (86%) [56].
- In 2022, 20% of Aboriginal and Torres Strait Islander respondents in the Australian Reconciliation Barometer national research study reported having experienced racial discrimination with doctors, nurses and/or medical staff [24].

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Cultural and social concepts** for the latest available data:

- Number of Aboriginal and Torres Strait Islander languages spoken in Australia
- Number of Aboriginal and Torres Strait Islander languages being reawakened (being used again after a time when there was no intergenerational transmission and then no speakers)
- Number of Aboriginal and Torres Strait Islander languages considered 'strong' (learnt as a first language by most children in the community)
- Proportion of the Aboriginal and Torres Strait Islander population using or speaking an Aboriginal or Torres Strait Islander language at home, including by age and jurisdiction
- Correlation between speaking or learning an Aboriginal and Torres Strait Islander language and self-reported good health, cultural connection, happiness, and/or life satisfaction
- Correlation between level of cultural knowledge and level of self-reported psychological distress.

Key facts from the previous release

- The 2021 Census reported that there were 167 Aboriginal and Torres Strait Islander languages being actively spoken in Australia [34].
- Nationally, 9.5% of Aboriginal or Torres Strait Islander people in the 2021 Census reported using or speaking an Aboriginal or Torres Strait Islander language at home [34].
- The Mayi Kuwayu study found that engaging with language was associated with a higher prevalence of self-reported 'good to excellent' general health [54].

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Connection to Country

CTG Outcome 15: Aboriginal and Torres Strait Islander people maintain a distinctive cultural, spiritual, physical and economic relationship with their land and waters

Connection to Country is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. This connection underpins identity and fosters a sense of belonging.

This section of the *Overview* includes measures of connection to Country for which there are currently available data, including access to Country, caring for Country and land rights. Information about environmental health is presented separately under *Social, political and environmental determinants of health.*

New since the previous release

Access to Country

Access to Country is essential for maintaining and nurturing connection to Country, including the practice of knowledge systems, spirituality and culture [47].

New data are available on access to Country:

- Based on 2018–2020 data from the national Mayi Kuwayu study, 30% of Aboriginal and Torres Strait Islander people aged 16 years and over lived on their Country (Aboriginal people: 31%; Torres Strait Islander people: 14%; people who are both Aboriginal and Torres Strait Islander: 25%) [9].
- The 2018–2020 Mayi Kuwayu findings indicated that 50% of people spent at least a little bit of time on their Country (Aboriginal people: 51%; Torres Strait Islander people: 45%; people who are both Aboriginal and Torres Strait Islander: 48%) [9].
- The 2022–23 NATSIHS found that among Aboriginal and Torres Strait Islander people aged 18 years and over (an estimated 577,000 people), 76% (approximately 440,000 people) recognised an area as their homeland or traditional Country. This proportion was higher in remote areas (87%) than in non-remote areas (74%) [50].
- The 2022–23 NATSIHS found that 22% (around 127,000 people) lived on their homeland or traditional Country. Living on one's homeland was more common in remote areas (43%) than in non-remote areas (18%) [50].
- Analysis of data from the 2018–19 NATSIHS by the AIHW and ABS found that Aboriginal and Torres Strait Islander people who lived on their homelands or traditional Country were more likely to rate their health as excellent, very good or good (78%) compared with those who were not allowed to visit their homelands or traditional Country (47%) [57].

Caring for Country

Caring for Country as part of cultural practice or through land management and ranger programs supports health by enhancing individual and community autonomy, providing opportunities for employment, giving recognition to Aboriginal and Torres Strait Islander peoples' skills and knowledge and increasing access to bush foods [58].

Data are available on caring for Country:

- Based on 2018–2020 data from the national Mayi Kuwayu study, 19% of Aboriginal and Torres Strait Islander people aged 16 years and over had cultural responsibilities for their mother's Country (Aboriginal people: 19%; Torres Strait Islander people: 24%; people who are both Aboriginal and Torres Strait Islander: 26%) [9]. Fourteen per cent (14%) had cultural responsibilities for their father's Country (Aboriginal people: 14%; Torres Strait Islander people: 21%; people who are both Aboriginal and Torres Strait Islander: 15%), and 2.4% had cultural responsibilities for other Country.
- As of June 2025, there were 91 Indigenous Protected Areas (areas where Traditional Owners have voluntarily declared their intention to care for Country as part of an agreement with the Australian Government) [59]. These represented 54% of all land-based Protected Areas in Australia.
- In 2025, 127 Indigenous Ranger groups from 78 Aboriginal and Torres Strait Islander land councils and corporations participated in Caring for Country activities funded by the Commonwealth [60]. A significant additional number of Ranger groups were recently funded with the aim to increase the number of women employed as Rangers [60, 61]. As well as Commonwealth-funded Ranger groups, there are jurisdictionally-funded groups in almost every state and territory [62].
- Analysis of 2018–2020 data from the national Mayi Kuwayu study found that people who were current or former Rangers were more likely to report very high life satisfaction and high family wellbeing than those who had never been Rangers [63]. In Central Australia, Rangers were 1.3 times more likely to report very high life satisfaction and 1.2 times more likely to report high family wellbeing. In non-Central Australia, Rangers were 1.3 times more likely to report very high life satisfaction and 1.4 times more likely to report high family wellbeing.

Land rights

Land rights and autonomy, which are encompassed by the Connection to Country domain [64], are linked to health and wellbeing [52, 64].

New data are available for land rights:

- In 2024, 56% of Australia's total land mass was subject to Aboriginal and Torres Strait Islander people's legal rights and interests (e.g. through native title) [29].

Connection to spirituality and ancestors

CTG Outcome 16: Cultures and languages are strong, supported and flourishing

Connection to spirituality and ancestors is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. A connection to spirituality and ancestors provides a sense of purpose and meaning. Spirituality is interconnected with Country and culture, as well as with family and community [47]. Intergenerational knowledge transfer by Elders to younger generations, participation in ceremonies, and contemporary expressions of spirituality are examples of practices that are included in this domain [46, 47].

For the latest data, refer to the interconnected topics of *Connection to culture* and *Connection to Country.*

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Connection to body

CTG Outcome 1: Everyone enjoys long and healthy lives

Connection to body is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. This domain encompasses health disorders, as well as factors which promote health such as access to nutritious foods, engaging in exercise, not smoking or vaping, and engaging in safe levels of alcohol and other drugs (AOD) use.

This section of the *Overview* includes data for a select group of health conditions and factors that are important in Aboriginal and Torres Strait Islander peoples' connection to body.

Births and pregnancy outcomes

CTG Outcome 2: Children are born healthy and strong

Evidence shows an increase in the proportion of Aboriginal and Torres Strait Islander mothers attending antenatal care in the first trimester, a decrease in the rate of mothers smoking during pregnancy, and a majority of babies being born at a healthy birthweight and normal size for their gestational age [65]. 'Birthing on Country' is an area of maternal and infant health that is gathering momentum [66]. Researchers continue to build the evidence base to show that 'Birthing on Country' models are effective in providing protective factors for mothers and babies [67].

This section of the *Overview* contains data for the number of Aboriginal and Torres Strait Islander births, age of mothers, fertility rates, participation in antenatal care and birthweight of babies.

Notes on birth registrations, age of mothers and total fertility rate

In Australia, all births are required by law to be registered with the Registrar of Births, Deaths and Marriages in the jurisdiction in which the birth occurred [68]. The true number of Aboriginal and Torres Strait Islander births may be underestimated due to variations in data collection practices, lags in birth registrations, and under-identification of Aboriginal and Torres Strait Islander status.

There are several general measures of births and fertility[9], but detailed analysis involves the use of age-specific rates. The age-specific rate is the annual number of live births per 1,000 women in five-year age-groups from 15 to 49 years (the relatively small numbers of births to women aged less than 15 years are included in the 15–19 years age-group, similarly, births to women aged 50 years and over are included in the 45–49 years age-group) [68].

The summary measure of fertility is the total fertility rate, which is the sum of age-specific fertility rates divided by 1,000. It represents the number of children a female would bear if each female experienced current age-specific fertility rates at each age of her reproductive life [68].

See Appendix 1 for a discussion of data limitations for birth statistics.

9 The study of birth information is known as fertility analysis, where 'fertility' refers to the number of babies born alive. This meaning is different to the lay use of the word, which means the capacity to bear children.

New since the previous release

Aboriginal and Torres Strait Islander births

New Aboriginal and Torres Strait Islander births data are available [68]:

- In 2024, there were 25,049 births (12,894 males and 12,155 females) registered in Australia with one or both parents identified as Aboriginal and/or Torres Strait Islander (8.6% of all births registered).
- In 2024, for births registered as Aboriginal and Torres Strait Islander, 23% recorded both parents as Aboriginal and/or Torres Strait Islander; 45% recorded only the mother as Aboriginal and/or Torres Strait Islander (including births where paternity was not acknowledged and those where the father's Indigenous status was unknown); and 30% recorded only the father as Aboriginal and/or Torres Strait Islander (including births where the mother's Indigenous status was unknown)[10].

Age of mothers

New data on the age of mothers are available [68]:

- In 2024, for births registered as Aboriginal and Torres Strait Islander, 56% were born to mothers aged 20–29 years, and 8.9% were born to mothers aged 15–19 years.
- In 2024, the median age of Aboriginal and Torres Strait Islander mothers who gave birth was 27.0 years. The highest age-specific fertility rates for Aboriginal and Torres Strait Islander women were among those aged 25–29 years (124 per 1,000) and 20–24 years (108 per 1,000). The fertility rate of teenage Aboriginal and Torres Strait Islander women, aged 15–19 years, was 32 births per 1,000 women.

Total fertility rate

- In 2024, the total fertility rate was 2.1 babies per Aboriginal and Torres Strait Islander woman [68].

Notes on antenatal care and birthweight

Antenatal care from health professionals helps people who are pregnant by monitoring their health screening and providing information and support during pregnancy [69]. It can help with the early identification of potentially preventable risk factors (especially when care is provided during the first trimester of pregnancy) that adversely affect maternal and child health outcomes [70]. Ten antenatal visits for first-time pregnancy without complications and 7 visits for subsequent uncomplicated pregnancies are recommended by current guidelines [69].

Low birthweight (LBW), defined as a birthweight of less than 2,500 grams [71], increases the risk of health problems and death in infancy [72]. Factors impacting on LBW include preterm birth, mothers smoking during pregnancy, mothers being underweight prior to pregnancy, not attending antenatal care in the first trimester, socioeconomic disadvantage, and the age of the mother [72, 73]. Smoking during pregnancy has a major impact on birthweight.

10 These represent the majority, but not all, births registered as Aboriginal and Torres Strait Islander; therefore percentages do not sum to 100.

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Antenatal care

New antenatal care data are available [74]:

- In 2023, 88% (crude proportion) of pregnant Aboriginal and Torres Strait Islander women attended five or more antenatal visits[11].
- In 2023, the proportion of women attending the first antenatal visit during the first trimester of pregnancy (less than 14 weeks) was 71%.
- In 2023, the proportion of women attending the first antenatal visit during the first trimester of pregnancy, by remoteness were: major cities/inner regional areas (both 74%), outer regional areas (71%), remote areas (56%) and very remote areas (58%).

Birthweight

New birthweight data are available [74]:

- In 2023, the average birthweight of babies born to Aboriginal and Torres Strait Islander mothers was 3,227 grams.
- In 2023, 12% of babies born to Aboriginal and Torres Strait Islander mothers were of LBW, of which 2.0% combined were very LBW (less than 1,500 grams) or extremely LBW (less than 1,000 grams).
- In 2023, 38% (age-standardised proportion) of Aboriginal and Torres Strait Islander mothers reported smoking during pregnancy.

Cardiovascular health

CTG Outcome 1: Everyone enjoys long and healthy lives

Cardiovascular disease (CVD) includes major conditions of the heart and circulatory system, such as ischaemic heart disease (IHD) and stroke [75, 76]. Most CVDs (excluding rheumatic heart disease (RHD)) share common risk factors, such as diet, high blood pressure and high cholesterol [75, 76]. CVD tends to develop earlier among Aboriginal and Torres Strait Islander people, so early risk assessments are recommended [77]. RHD is a condition in which the heart valves are permanently damaged after repeated episodes of acute rheumatic fever (ARF), a reaction to untreated strep throat or skin infections [78]. Addressing poverty, overcrowding and poor sanitation are key to reducing ARF and RHD [78, 79].

New since the previous release

Prevalence and incidence

New data on acute coronary events among Aboriginal and Torres Strait Islander people are available [76]:

- In 2023, there were 2,731 acute coronary events (heart attack and unstable angina) among Aboriginal and Torres Strait Islander people aged 25 years and over.
- In 2023, the crude rate of coronary events for those living in NSW, Qld, WA, SA and the NT combined was 5.6 per 1,000 (males: 6.3 per 1,000; females: 4.9 per 1,000).

New data on ARF from 2024 for Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT[12] are available [80]:

- There were 472 notifications of ARF for Aboriginal and Torres Strait Islander people. The crude notification rate was 52 per 100,000.

11 This excludes very preterm births.
12 The jurisdictions where there are established ARF/RHD registers.

- The ARF rate for females (61 per 100,000) was higher than for males (43 per 100,000).
- Age-specific ARF rates were high for children aged 5-14 years (111 per 100,000), young people aged 15-24 years (63 per 100,000) and adults aged 25-34 years (58 per 100,000), and comparatively low for other ages (<44 per 100,000).
- Rates of ARF were highest in the NT (117 per 100,000 population) and lowest in NSW (0.1 per 100,000), with rates in other jurisdictions ranging from 1.4 to 2.6 per 100,000.
- Rates of ARF were higher in remote areas (262 per 100,000) than in regional areas (9.4 per 100,000) and major cities (6.4 per 100,000).

New data on RHD from 2024 for Aboriginal and Torres Strait Islander people in Qld, WA, SA and the NT[13] are available [80]:

- There were 299 new diagnoses of RHD among Aboriginal and Torres Strait Islander people. The crude rate of new diagnoses was 54 per 100,000.
- The rate of new RHD diagnosis for females (68 per 100,000) was higher than for males (40 per 100,000).
- Over half of new RHD diagnoses (58%) were in people aged under 25 years (Derived from [80]).
- Rates of new RHD diagnoses were highest in the NT (180 per 100,000) followed by WA (46 per 100,000).
- As of 31 December 2023, there were 5,867 Aboriginal and Torres Strait Islander people living with RHD in Qld, WA, SA and the NT combined (crude rate 1,062 per 100,000).

New data on ARF and RHD among children aged less than 5 years in the NT are available. A retrospective audit found that between 2010 and 2020 [81]:

- The average annual incidence of ARF was 127 per 100,000.
- The average annual incidence of newly diagnosed RHD was 33 per 100,000 population.

New data on ARF and RHD among Qld residents are available. A population-level retrospective cohort study using linked administrative data found that in 2017-2021 in Qld [82]:

- The incidence of ARF was 61 per 100,000 and of RHD was 76 per 100,000 for those aged under 45 years.
- The prevalence of any history of ARF or RHD was 1,388 per 100,000 for those aged under 55 years.
- Most people with RHD in Qld (82%) lived within the north-western health services of Torres and Cape, Cairns and Hinterland, North West and Townsville.

Hospitalisation

New national data for CVD hospitalisations are available:

- In 2023-24, there were 20,169 hospital separations for CVD[14] among Aboriginal and Torres Strait Islander people [83], representing 5.2% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis) (Derived from [83]). CVD was the ninth leading cause of hospitalisation (excluding dialysis).
- In 2021-22, there were 16,986 CVD hospitalisations among Aboriginal and Torres Strait Islander people (crude rate 19 per 1,000) [76]. Rates of CVD hospitalisation for males and females were similar (20 per 1,000 and 18 per 1,000 respectively). Rates of hospitalisation for specific types of CVD were: IHD (6 per 1,000), heart failure (2.7 per 1,000), stroke (2.0 per 1,000), atrial fibrillation (1.5 per 1,000), and RHD/ARF (0.8 per 1,000).

13 NSW data not included for RHD because NSW uses different RHD notification criteria than other jurisdictions.
14 ICD-10 codes I00-I99.

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Mortality

New data for CVD deaths are available:

- Of all specific causes of death, IHD was the leading cause of Aboriginal and Torres Strait Islander deaths in NSW, Qld, WA, SA and the NT combined in 2024 (472 deaths) [84]. For males, IHD was the leading cause (309 deaths) and for females, the third-leading cause (163 deaths).
- In 2020-2024, the crude death rate for IHD among Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT combined was 53 per 100,000 (males: 68 per 100,000; females: 39 per 100,000) [84]. The rate for deaths from IHD increased with age from 10 per 100,000 in the 25-34 years age-group to 807 per 100,000 for the 75 years and over age-group.
- In 2024, cerebrovascular disease was the seventh leading specific cause of deaths of Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT combined (166 deaths) [84]. For males, it was the ninth leading cause (79 deaths) and for females, the sixth leading cause (87 deaths).
- In 2020–2022, CVD was the underlying cause of death for 2,807 Aboriginal and Torres Strait Islander people, with a crude mortality rate of 109 per 100,000 (males: 120 per 100,000; females: 99 per 100,000)[15] [76]. Crude mortality rates for specific types of CVD were: heart failure (67 per 100,000), IHD (58 per 100,000), stroke (16 per 100,000), ARF/RHD (3.7 per 100,000) and atrial fibrillation (2.2 per 100,000).

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Cardiovascular Health** for the latest available data:

- The national prevalence of self-reported CVD, 'heart, stroke and vascular disease', hypertension and high cholesterol, and the prevalence of clinically measured high blood pressure; including breakdowns by sex, age, jurisdiction and remoteness
- Breakdowns for CVD hospitalisations and mortality by age, jurisdiction and remoteness
- The national burden of disease attributable to CVD.

Key fact from the previous release

- In 2022-23, 14% of Aboriginal and Torres Strait Islander people reported having a long-term disease of the circulatory system [85].

15 Number of deaths include all states and territories of Australia. Rates are for NSW, Qld, WA, SA and the NT combined.

Cancer

CTG Outcome 1: Everyone enjoys long and healthy lives

Cancer is a disease that causes damage to healthy body cells [86]. It arises from changes to the genes that control the way cells grow and divide. Healthy cells grow and divide in a controlled way, whereas cancer causes some of the cells of the body to grow and divide in an abnormal way.

Cancer can form almost anywhere in the body, and refers to about 100 different diseases [86]. The location in the body where the cancer cells begin forming is known as the primary site, and cancer is usually classified by this, for example, lung cancer. When cancer cells travel and spread to other parts of the body, it is described as metastasis [87].

New since the previous release

Incidence

New data on cancer incidence are available:

- In 2017–2021, there were 194 cases of cervical cancer among Aboriginal and Torres Strait Islander women aged 25–74 years in NSW, Vic, Qld, WA, the ACT and the NT, with a crude incidence rate of 19 per 100,000 [88].
- In 2016–2020, the crude incidence rate of bowel cancer among Aboriginal and Torres Strait Islander people aged 50–74 years in NSW, Vic, Qld, WA, the ACT and the NT was 112 per 100,000 [89].
- In 2017–2021, there were 820 new cases of breast cancer diagnosed among Aboriginal and Torres Strait Islander women aged 50–74 years in NSW, Vic, Qld, WA, the ACT and the NT, with a crude incidence rate of 274 per 100,000 [90].

Hospitalisation

New data for cancer hospitalisations are available:

- In 2023–24, there were 14,111 hospital separations with neoplasms (including all types of cancer) as the principal diagnosis, representing 3.7% of all separations (excluding dialysis) among Aboriginal and Torres Strait Islander people (Derived from [83]).

Mortality

New data for cancer deaths are available:

- In 2024, cancers of the trachea, bronchus and lung combined were the fourth leading cause of death for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT, being responsible for 329 deaths [84]. The age-standardised rate was 67 per 100,000 (males: 83 per 100,000; females: 53 per 100,000). Age-standardised death rates for other types of cancer in 2024 include cancer of the colon (bowel), sigmoid, rectum and anus (24 per 100,000), cancers of the liver and intrahepatic bile ducts (20 per 100,000), pancreatic cancer (15 per 100,000), and cancers of the lymphoid, haematopoietic and related tissue (14 per 100,000).
- In 2021-2023, lung cancer was the fourth leading cause of death for Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT, with a crude mortality rate of 30 per 100,000 [91]. Other cancer types among the leading causes of death included colorectal cancer (9.2 per 100,000), liver cancer (8.8 per 100,000), cancer of unknown or ill-defined primary site (8.7 per 100,000), pancreatic cancer (7.7 per 100,000) and breast cancer (5.7 per 100,000).

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- In 2019-2023, the age-standardised mortality rate for cancer among Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT was 227 per 100,000 [92]. When comparing jurisdictions, the mortality rate was highest in the NT (274 per 100,000), followed by WA (232 per 100,000), Qld (231 per 100,000), NSW (216 per 100,000) and SA (199 per 100,000).
- In 2019-2023, there were 77 deaths from cervical cancer among Aboriginal and Torres Strait Islander women aged 25–74 years in Australia [88]. Of the 77 deaths nationally, 71 occurred in NSW, Qld, WA, SA and the NT, with a crude mortality rate of 6.9 per 100,000.
- In 2019–2023, there were 248 deaths from breast cancer among Aboriginal and Torres Strait Islander women living in NSW, Qld, WA, SA and the NT, with a crude mortality rate of 12 per 100,000 [90]. Of these, 160 were among women aged 50–74 years, with a crude mortality rate of 44 per 100,000.
- In 2018-2022, there were 234 deaths from bowel cancer among Aboriginal and Torres Strait Islander people aged 50–74 years [89]. Of these, 210 were registered in NSW, Qld, WA, SA and the NT, with a crude mortality rate of 36 per 100,000.

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Cancer** for the latest available data:

- Prevalence of neoplasms (including malignant, benign, in situ and of an uncertain nature) as a long-term health condition among Aboriginal and Torres Strait Islander people, by sex, age and remoteness
- Prevalence of cancer (malignant neoplasm) among Aboriginal and Torres Strait Islander people, by sex, jurisdiction and remoteness
- New cases of cancer diagnosed in Aboriginal and Torres Strait Islander people living in NSW, Vic, Qld, WA and the NT in a five-year period, by sex, cancer type, age, jurisdiction and remoteness
- Survival rates from cancer for Aboriginal and Torres Strait Islander people in NSW, Vic, Qld, WA and the NT for a 10-year period, by sex, cancer type and remoteness
- Crude rates of hospitalisations for cancer as the principal diagnosis among Aboriginal and Torres Strait Islander people, by sex, age, jurisdiction and remoteness
- Number of hospitalisations among Aboriginal and Torres Strait Islander people for selected cancer types, including cancers of unknown primary site, lung cancer, bowel cancer, breast cancer, prostate cancer, cancers of the mouth and throat, and cervical cancer
- Number of deaths among Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT for all cancers combined and selected cancers, by sex
- The contribution of cancer to the burden of disease among Aboriginal and Torres Strait Islander people.

Key facts from the previous release

- In the 2022–23 NATSIHS, 1.1% of Aboriginal and Torres Strait Islander people reported having neoplasms (including malignant, benign, in situ and of an uncertain nature) as a long-term health condition [85].
- In 2018, cancer accounted for 9.9% of the total burden of disease among Aboriginal and Torres Strait Islander people [93].

Diabetes

CTG Outcome 1: Everyone enjoys long and healthy lives

Diabetes is a chronic disease marked by high levels of glucose in the blood, caused by the pancreas not producing enough insulin, not being able to use the insulin effectively, or both [94].

There are several types of diabetes. The most frequently occurring are type 1, type 2 and gestational diabetes mellitus (GDM) [95] with type 2 being the most common of these. Aboriginal and Torres Strait Islander people with diabetes tend to have higher levels of risk factors such as smoking [94, 96, 97] and may show signs of other chronic conditions, including chronic kidney disease (CKD), CVD, liver disease and anaemia.

Diabetes can cause life-threatening complications [94]. Reducing its impact among Aboriginal and Torres Strait Islander people is one of the key goals of the *Australian national diabetes strategy 2021-2030* [98].

New since the previous release

Mortality

New data for diabetes deaths are available [84]:

- Diabetes was the third leading specific cause of death among Aboriginal and Torres Strait Islander people in NSW, Qld, SA, WA and the NT (the jurisdictions for which cause of death data are available) combined in 2024, accounting for 332 deaths (6.8% of all deaths). The crude mortality rate was 37 per 100,000.
- In 2024, crude mortality rates for diabetes among Aboriginal and Torres Strait Islander people in NSW, Qld, SA, WA and the NT were 44 per 100,000 for females and 30 per 100,000 for males.
- In 2020-2024, diabetes was a major cause of death for older Aboriginal and Torres Strait Islander people; age-specific mortality rates were 48 per 100,000 for those aged 45–54 years, 114 per 100,000 for those aged 55–64 years, 256 per 100,000 for those aged 65–74 years and 543 per 100,000 for those aged 75 years and over. In 2024, by jurisdiction age-standardised diabetes mortality rate was highest in the NT (193 per 100,000) and lowest in NSW (43 per 100,000)[16].

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Diabetes** for the latest available data:

- Prevalence of diabetes, including by sex, age, jurisdiction and remoteness
- Among people with a long-term health condition, the percentage of reported diabetes
- Children and young adults with type 1 diabetes
- Among people in Northern Australia, the percentage with youth-onset type 2 diabetes
- Among people in remote communities, the percentage of reported diabetes
- Incidence of diabetes, by diabetes type and sex
- Incidence of GDM, by age
- The national burden of disease attributable to endocrine disorders
- Hospitalisations for diabetes as a principal and/or additional diagnosis
- Hospitalisations for diabetes, by sex, age, jurisdiction and remoteness.

16 Of those four jurisdictions for which separate jurisdictional data were available (NSW, Qld, WA and the NT) [84].

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Key facts from the previous release

- In 2022-23, 7.4% of Aboriginal and Torres Strait Islander people reported having diabetes [85].
- In 2021-22, there were 4,850 potentially preventable hospitalisations of Aboriginal and Torres Strait Islander people for a principal diagnosis of diabetes [99].
- In 2018, endocrine disorders accounted for 3.3% of total disease burden among Aboriginal and Torres Strait Islander people. Of this, 87% was attributed to type 2 diabetes [93].

Kidney health

CTG Outcome 1: Everyone enjoys long and healthy lives

Kidneys clean the blood by processing excess fluid, unwanted chemicals and waste, and producing urine [100]. If the kidneys stop working properly, waste can build up in the body and lead to kidney disease (sometimes called renal disease) [101, 102]. Chronic kidney disease (CKD) refers to conditions of the kidney that cause dysfunction or kidney damage and last for three months or more [103].

The most common cause of kidney disease is diabetes, and there is a strong link between kidney disease and high blood pressure [104]. Other causes include immune diseases, congenital conditions and genetic disorders, such as polycystic kidney disease.

CKD can be prevented by a healthy lifestyle or treatment if detected early [105]. Risk factors include high blood pressure, tobacco smoking, overweight and obesity and impaired glucose regulation [106]. For Aboriginal and Torres Strait Islander people, risk factors associated with CKD also include being aged of 30 years and over, family history of CKD, history of acute kidney injury and established vascular disease [107].

New since the previous release

Hospitalisation, dialysis and transplantation

New national data for kidney disease hospitalisations, dialysis and transplantation are available:

- In 2024, there were 2,249 prevalent dialysis patients in Australia (haemodialysis (HD) and peritoneal dialysis (PD) treatments) who identified as Aboriginal and/or Torres Strait Islander people [108]]. HD accounted for the majority of treatment (78%), with 4.0% of Aboriginal and Torres Strait Islander dialysis patients receiving PD) [109].
- In 2024, 362 Aboriginal and Torres Strait Islander people commenced HD and PD (HD: 332 and PD: 30), which was a decrease from 2023 (369 people) [108].
- At the start of 2024, 72 (5.2%) of the 1,384 patients on the waiting list for a kidney transplant were Aboriginal and/or Torres Strait Islander people [108]. In the same year, there were 64 kidney transplant operations for Aboriginal and Torres Strait Islander recipients, which comprised 6.0% of all transplant operations in Australia.

Mortality

New data for kidney disease deaths are available:

- In 2024, diseases of the urinary system were reported as an underlying cause of 118 deaths (males: 47, females: 71) among Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT [84]. The age-standardised death rate for diseases of the urinary system among Aboriginal and Torres Strait Islander people was 27 per 100,000 (males: 22 per 100,000, females: 30 per 100,000).

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Kidney health** for the latest available data:

- Prevalence of kidney disease by sex, age, jurisdiction and remoteness
- Notifications and notification rates for end-stage renal disease[17] (ESRD)
- Hospitalisation rates by CKD and regular dialysis
- Number of deaths with diseases of the urinary system as the underlying cause
- Number of deaths among Aboriginal and Torres Strait Islander people receiving dialysis
- Age-standardised mortality rate for diseases of the urinary system by jurisdiction
- The national burden of disease attributable to kidney and urinary system disorders.

Key facts from the previous release

- In 2022–23, 1.4% of Aboriginal and Torres Strait Islander people (Aboriginal people: 1.4%; Torres Strait Islander people: 1.3%) reported kidney disease as a long-term health condition [85].
- In 2018–2022, the age-standardised notification rate of ESRD was 605 per 1,000,000 (Derived from [43, 111].
- In 2018–19, there were 242,274 hospitalisations of Aboriginal and Torres Strait Islander people for end-stage kidney disease [35].
- In 2018–2022, the age-standardised death rate for kidney disease (as a major cause of death) for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT was 24 per 100,000 [99].
- In 2018, CKD was the 10th leading specific cause of total disease burden among Aboriginal and Torres Strait Islander people (2.5%) [112].

Respiratory health

CTG Outcome 1: Everyone enjoys long and healthy lives

CTG Outcome 2: Children are born healthy and strong

Conditions that affect the airways and other structures of the lung, and impair the process of breathing, can have an impact on a person's respiratory health [95]. These conditions range from acute respiratory infections to chronic respiratory conditions [113]. Respiratory disease is associated with a number of risk factors, including age; genetics; inadequate nutrition and sedentary behaviour; tobacco use; environmental conditions; occupational exposures and hazards; and health conditions such as obesity [95]. Aboriginal and Torres Strait Islander children are particularly susceptible to developing respiratory diseases [114, 115], which may be due to risk factors such as premature birth, exposure to tobacco smoke; living conditions; inadequate nutrition and limited access to medical care [116, 117].

17 'Kidney failure' is the preferred, person-centred alternative to terms such as 'end-stage renal disease' [110], however, for the purposes of this *Overview*, the terms cited in the data sources are used.

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New since the previous release

Hospitalisation

New national data for respiratory hospitalisations are available [83]:

- For 2023-24, there were 35,352 hospital separations with a principal diagnosis of respiratory disease among Aboriginal and Torres Strait Islander people, representing 9.2% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis) (Derived from [83]). Respiratory disease was the fifth leading cause of hospitalisation (excluding dialysis).
- In 2023-24, Aboriginal and Torres Strait Islander people were hospitalised for respiratory disease at an age-standardised rate of 40 per 1,000 population.
- In 2023-24, there were 4,470 hospitalisations with a coronavirus disease (COVID-19) diagnosis among Aboriginal and Torres Strait Islander people.

Mortality

New data for chronic lower respiratory deaths are available [84]:

- In 2024, among Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT combined, chronic lower respiratory disease[18] was the second leading specific cause of death (369 deaths). For males, it was the fourth leading cause (182 deaths) and for females, the first (187 deaths).
- In 2020-2024, the crude death rate for chronic lower respiratory disease among Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT combined was 35 per 100,000 (males: 34 per 100,000; females: 35 per 100,000). The rate for deaths increased with age from 36 per 100,000 in the 45-54 years age-group to 620 per 100,000 for the 75 years and over age-group.

New data for acute respiratory deaths are available:

- In 2024, among Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT combined, influenza and pneumonia was the fourteenth leading cause of death (87 deaths) [84].
- In 2024, in NSW, Vic, Qld, SA, WA and the NT combined, there were 90 deaths of Aboriginal and Torres Strait Islander people associated with COVID-19, 48 with influenza, and 17 with RSV [118]. In 2025[19], there were 22 deaths associated with COVID-19, 49 with influenza, and 16 with RSV.
- In 2022-2025, deaths from or with COVID-19 occurred at similar age-standardised rates among Aboriginal and Torres Strait Islander males (30 per 100,000) and females (31 per 100,000) [118].

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Respiratory Health** for the latest available data:

- The national prevalence of self-reported respiratory disease, asthma, COPD, hay fever, allergic rhinitis, and chronic sinusitis
- Respiratory hospitalisations by disease sub-type, age and remoteness
- Number of deaths attributable to overall respiratory disease
- Historic COVID-19 incidence, hospitalisation and mortality
- The national burden of disease attributable to respiratory diseases.

Key facts from the previous release

- Long-term diseases of the respiratory system[20] were reported by 31% of Aboriginal and Torres Strait Islander people who participated in the 2022-23 NATSIHS [85].

18 Includes asthma, bronchitis, bronchiectasis, emphysema and COPD.
19 Deaths registered by 30 November 2025.
20 Includes COPD, asthma, hay fever and allergic rhinitis, chronic sinusitis and other diseases of the respiratory system [85].

Eye health

Eye health, particularly for Aboriginal and Torres Strait Islander people, can be affected by several factors that are complex and often dependent on a range of social determinants of health [119]. Factors can include previous eye problems; access to services; care coordination; medical factors; environmental and living conditions; use of alcohol and tobacco; and living in remote areas [119-121]. Eye disease and poor vision can limit opportunities in education, employment and social engagement and increase the risk of injury, which can lead to dependence on services and other people [57, 122]. Even partial loss of vision can reduce an individual's ability to live independently and increase their risk of mortality [121, 123]. The First Nations Eye Health Alliance was recently established to lead the advancements needed to improve eye health and vision care outcomes for Aboriginal and Torres Strait Islander communities.

New since the previous release

Prevalence

Vision impairment (VI) prevalence data are available from the Australian Eye and Ear Health Survey (AEEHS), conducted between August 2022 and March 2025 [124]. The survey included a comprehensive eye exam for participants. The following findings are for Aboriginal and Torres Strait Islander adults aged 50 years and over:

- The crude prevalence of bilateral VI (VI in both eyes) was 11% (moderate bilateral VI 1.9%), and the crude prevalence of bilateral blindness was 0.2%.
- There was no statistically significant difference in the prevalence of bilateral VI or blindness between males and females.
- The prevalence of bilateral VI or blindness increased with age, rising from 9.8% among those aged 50-59 years to 20% among those aged 80 years and over.
- The prevalence of bilateral VI or blindness increased with remoteness, from 4.3% for those in major cities to 7.1% in inner regional areas, 8.0% in outer regional areas, and 16% in remote and very remote areas.
- The leading causes of bilateral VI were uncorrected refractive error (38%), cataract (34%), diabetic retinopathy (15%), age-related macular degeneration (4.4%), glaucoma (4.4%), and other causes (4.4%).
- It is estimated that around 20,000 Aboriginal and Torres Strait Islander people aged 50 years and over are living with bilateral VI or blindness.

New trachoma and trichiasis screening data are available [125]:

- In 2025, SA joined NSW and Qld as being classified as free of endemic trachoma.
- Between 2010 and 2024, the number of Aboriginal and Torres Strait Islander communities considered at-risk of trachoma fell by 43% in the NT, 78% in SA and 62% in WA.
- In 2024, trachoma screening was undertaken in 86[21] at-risk Aboriginal and Torres Strait Islander communities in WA, SA and the NT. Of the 1,885 children aged 5-9 years who were screened, 3.6% (68 children) were observed to have trachoma. Prevalence was 4.9% in the NT, 4.1% in WA and 0% in SA. The estimated overall prevalence in at-risk communities in WA, SA and the NT combined was 1.5%.
- In 2024, trichiasis screening of adults aged 15 years and over was undertaken in 165 at-risk communities in WA, SA and the NT. Nine cases of trichiasis were found, all in adults aged 40 years and over [126]. Age-specific prevalence was 0.00% for Aboriginal and Torres Strait Islander people aged 15-39 years, 0.09% for those aged 40 years and over, and 0.05% for those aged 15 years and over.

21 Includes some communities not considered at-risk or not due for screening but screened for evidence collection purposes.

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Hospitalisation

New eye hospitalisation data are available:

- In 2023-24, there were 8,110 hospital separations for diseases of the eye and adnexa among Aboriginal and Torres Strait Islander people in Australia [83], accounting for 2.1% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis) (Derived from [83]).

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Eye health** for the latest available data:

- Prevalence of self-reported eye and sight problems, including breakdowns by sex, age, jurisdiction, remoteness and specific eye problem
- Hospitalisation rates, including by age, jurisdiction, remoteness, region and diagnosis (cataract)
- The burden of disease attributable to vision disorders.

Key facts from the previous release:

- Eye and sight problems[22] were reported in the 2022-23 NATSIHS by 41% of Aboriginal and Torres Strait Islander people, making these the most commonly reported long-term conditions in the survey [85].
- In 2021-23 the crude hospitalisation rate for diseases of the eye among Aboriginal and Torres Strait Islander people was 7.4 per 1,000 population [133]. Most eye hospitalisations (58%) were for cataracts[23] at a crude rate of 4.3 per 1,000.

Ear health and hearing

CTG Outcome 1: Everyone enjoys long and healthy lives

Otitis media (OM) and hearing loss are common conditions that affect Aboriginal and Torres Strait Islander people. OM refers to infection of the middle ear [127] and may be caused by viruses, bacteria, or both, often following a cold [128, 129]. The main cause of hearing loss in Aboriginal and Torres Strait Islander children is OM and its complications, including OM with effusion (glue ear) and chronic suppurative OM (CSOM) (persistent discharge through a hole in the eardrum) [127, 129, 130]. The hearing loss associated with OM can cause speech, language and psychosocial delays, and impact education and employment outcomes [127, 131-134]. Risk factors for OM include crowded housing conditions, exposure to tobacco, low socioeconomic status, hygiene, an inadequate diet, limited community involvement in the provision of services, and cultural and language differences [35, 135]. In 2023, new guidelines recommended routine ear health and hearing checks for Aboriginal and Torres Strait Islander children to support early detection of ear problems by primary care services [136].

22 Eye and sight problems include corneal disorders or defects, cataracts, glaucoma, disorders of choroid and retina, disorders of ocular muscles, binocular movement, accommodation and refraction, visual disturbances and blindness, and other diseases of the eye and adnexa [85].

23 And other lens disorders.

New since the previous release

Prevalence

New data on hearing loss among adults aged 50 years and over are available from the 2022-2025 AEEHS, which included hearing examinations for participants[24] [124]:

- Of the 461 Aboriginal and Torres Strait Islander survey participants who had examinations, 49% were found to have bilateral hearing impairment (17% moderate or worse).
- The prevalence of hearing impairment increased with age, from 32% among those aged 50-59 years to 83% among those aged 80 years and over. Moderate or worse hearing impairment ranged from 9.4% among those aged 50-59 years to 48% among those aged 80 years and over.
- Hearing loss was more common among males than females (59% compared with 40%), as was moderate or worse hearing loss (21% compared with 14%).

New data are available on the ear health and hearing status of young Aboriginal and Torres Strait Islander people in rural and remote Qld who received clinical services through the Deadly Ears program[25] [137]:

- In 2022-2024, of the 2,785 Aboriginal and Torres Strait Islander children aged 0-14 years who received at least one ear, nose and throat clinic service through the program, 7.9% had OM with effusion, 2.0% had dry perforation, 1.9% had CSOM and 1.0% had acute OM.
- Of the 2,739 children aged 0-14 years who received at least one audiology service through the program in 2022-2024, 9.7% had bilateral hearing loss and 6.6% unilateral hearing loss.

New data are available on the hearing status of Aboriginal and Torres Strait Islander children aged 0–5 years who received free ear checks through a national preventive screening program (Hearing Assessment Program – Early Ears) [137]:

- In 2023-24, of the 4,539 children assessed, 78% had no hearing loss, 19% had mild hearing loss and 2.6% had moderate or greater hearing loss.
- In 2023-24, the percentage of children who had no hearing loss was highest in NSW (86%) and Vic (85%) and lowest in WA (62%) and the NT (59%).

New data on ear and hearing problems among young people in the NT are available. These data are for young people aged under 21 years who received services through the Northern Territory Remote Aboriginal Investment (NTRAI) Hearing Health Program [138]:

- In 2023, of the 2,067 Aboriginal and Torres Strait Islander people aged under 21 years who received a service through the program, 54% were diagnosed with at least one type of ear condition at their latest visit.
- In 2023, the prevalence of ear conditions ranged from 42% among those aged 16-20 years to 65% among those aged 0-2 years.
- Among children and young people who had an ear condition in 2023, the most common diagnoses were eustachian tube dysfunction[26] (21%), OM with effusion (20%), CSOM without discharge (10%) and CSOM with discharge (7.5%).
- Of the 2,057 children who received an audiology service in 2023, 34% were found to have some hearing loss in one or both ears.

24 In the absence of population estimates, AEEHS findings are representative only of the sample selected.
25 These are clinic presentation data rather than population/prevalence data.
26 Blocking of the tubes that run between the middle ear and the upper throat.

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Hospitalisation

New data for ear hospitalisations are available for 2023-24:

- There were 4,467 ear-related hospitalisations among Aboriginal and Torres Strait Islander people in 2023-24 [83], representing 1.2% of all hospitalisations of Aboriginal and Torres Strait Islander people (excluding dialysis) (Derived from [83]).
- Aboriginal and Torres Strait Islander people were hospitalised for ear disease at an age-standardised rate of 3.7 per 1,000 population [83].

Detailed ear hospitalisation data are available for 2022-24 [137]:

- In 2022-24, there were 8,424 hospitalisations for Aboriginal and Torres Strait Islander people with a principal diagnosis related to diseases of the ear and mastoid process (crude rate 4.1 per 1,000).
- Crude hospitalisation rates were similar for males and females (4.2 per 1,000 and 4.1 per 1,000 respectively).
- Children aged 0-4 years were hospitalised at the highest rate (14 per 1,000) and young people aged 15-34 years at the lowest rate (1.3 per 1,000).
- Crude rates were highest in Qld (4.9 per 1,000) and lowest in Tas (2.2 per 1,000). Among children aged 0-14 years, rates were highest in WA (11 per 1,000) and lowest in Tas (4.5 per 1,000).
- The highest crude hospitalisation rates by Indigenous Region were in the West Kimberley (10 per 1,000), Mount Isa (8.9 per 1,000) and Kununurra (7.4 per 1,000). The lowest rates were in Tasmania (2.2 per 1,000), Port Augusta (2.4 per 1,000) and North-Eastern NSW (2.6 per 1,000).
- Rates were highest in remote and very remote areas (5.9 per 1,000 and 4.7 per 1,000 respectively) and lowest in outer regional areas (3.3 per 1,000).
- Among the hospitalisations for diseases of the ear and mastoid process, the most common diagnosis was disease of the middle ear and mastoid (crude rate 3.0 per 1,000), followed by inner ear disease/s (0.4 per 1,000), hearing loss (0.3 per 1,000) and outer ear infection (0.3 per 1,000).

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Ear Health and Hearing** for the latest available data:

- National prevalence of self-reported ear and hearing problems, including breakdowns by sex, age, jurisdiction, remoteness and disease sub-type
- Burden of disease attributable to ear/hearing problems.

Key fact from the previous release

- Ear and hearing problems were reported in the 2022-23 NATSIHS by 13% of Aboriginal and Torres Strait Islander people [85].

Oral health

Oral health is defined as the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex [139]. The two most common oral diseases are dental caries (tooth decay) and periodontal disease (gum disease) [140]. Racial discrimination has a significant impact on oral health, with those experiencing higher levels of racism facing worse oral health outcomes [141, 142]

New since the previous release

Prevalence

New data on the prevalence of dental problems among children in remote NT are available.

These data are for children aged 0-15 years who received services through the NTRAI Oral Health Program [143]:

- In 2023, among the 2,643 service recipients with complete data available, tooth decay prevalence was highest among children aged 11 years (88% of whom had decay) and lowest among children aged 1-3 years (45% of whom had decay)[27].
- In 2023, children aged 5 years had the highest average number of decayed, missing or filled primary teeth (6.2 teeth), and children aged 15 years had the highest average number of decayed, missing or filled permanent teeth (3.9 teeth).

Hospitalisation

New data for dental hospitalisations are available:

- In 2023-24, there were 5,679 potentially preventable hospitalisations for dental conditions for Aboriginal and Torres Strait Islander people (crude rate of 5.6 per 1,000) [144]. Rates were highest among children aged 5-9 years (18 per 1,000) and lowest among adults aged 65 years and over (2.2 per 1,000).
- In 2023-24, there were 6,715 hospitalisations requiring general anaesthesia for procedures related to dental conditions for Aboriginal and Torres Strait Islander people (crude rate 6.6 per 1,000). Rates were highest among children aged 5-9 years (18 per 1,000) and lowest among adults aged 65 years and over (1.5 per 1,000).
- In 2022-23, the age-standardised hospitalisation rate for acute dental conditions for Aboriginal and Torres Strait Islander people was 4.5 per 1,000 [92]. Rates were highest in the NT (5.5 per 1,000) and lowest in Tas (3.3 per 1,000).

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Oral Health** for the latest available data:

- For children nationally, the prevalence of tooth decay, gingivitis and dental plaque, and the average number of decayed, missing or filled tooth surfaces
- For adults nationally, the prevalence of complete tooth loss, inadequate dentition, denture use, filled teeth, toothache, discomfort with dental appearance, food avoidance and poor oral health, as well as the average number of decayed, missing and filled teeth
- The prevalence of recent dental visits, including by sex, age and remoteness
- Hospitalisations for periodontal disease and dental problems based on principal diagnosis, with some breakdowns by age, sex, remoteness and jurisdiction
- The burden of disease attributable to oral disorders.

27 Children who receive services through this program are not a random sample of the population and, as such, the data may not be representative of the general population of Aboriginal and Torres Strait Islander children in the NT.

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Key facts from the previous release

- The 2012-2014 National Child Oral Health Study[28] found that 61% of Aboriginal and Torres Strait Islander children aged 5-10 years had tooth decay in their primary (baby) teeth and 36% of 6-14 year olds had decay in their permanent (adult) teeth [140].

Disability

Disability can be defined as a limitation, restriction or impairment resulting from a long term health condition, which has lasted, or is likely to last, for at least six months and restricts everyday activities [147].

Aboriginal and Torres Strait Islander people tend to view disability as an accepted part of a person's lived experience [148, 149] with a focus on strengths rather than limitations. A cultural model of inclusion in family and community promotes belonging and wellbeing [150].

The burden of disability experienced by Aboriginal and Torres Strait Islander people is often associated with poorer physical and mental health, increased exposure to risk factors and higher levels of socioeconomic disadvantage [14, 57].

New since the previous release

Prevalence

New data from the 2022 Survey of Disability, Ageing and Carers (SDAC) are available [147]:

- In 2022, the total number of Aboriginal and Torres Strait Islander people who reported living with a disability[29] was 183,700 or 25% of Aboriginal and Torres Strait Islander people living in households in Australia.
- Disability prevalence was similar for males (25%) and females (26%).
- The proportion of Aboriginal and Torres Strait Islander people with a profound or severe limitation was 12%.
- The proportion of Aboriginal and Torres Strait Islander people with disability, aged 5 years and over, with a schooling or employment restriction was 71%.

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Disability** for the latest available data:

- Prevalence of disability, including by sex, jurisdiction, remoteness and severity of disability (as reported in the 2022-23 NATSIHS)
- Among people with reported disability, the distribution of disability types
- Among those with a profound or severe disability, the percentage who reported a need for assistance
- Among those with a disability, the percentage who saw a GP or specialist or were admitted to hospital in the previous 12 months.

Key facts from the previous release

- In 2022-23, 37% of Aboriginal and Torres Strait Islander people reported having a disability[30] [85].
- In 2021, 8.2% of Aboriginal and Torres Strait Islander people reported a need for assistance with either self-care, mobility or communication [34].

28 Work is underway on a 2024–26 study to update these estimates [145, 146].

29 The SDAC does not include Aboriginal and Torres Strait Islander people living in very remote areas and discrete Aboriginal and Torres Strait Islander communities [147].

30 Defined as an impairment which restricts everyday activities and has lasted or is likely to last, for at least six months.

Nutrition, physical activity and bodyweight

CTG Outcome 1: Everyone enjoys long and healthy lives

The **nutritional** intake of Aboriginal and Torres Strait Islander people has changed significantly since colonisation, with the shift from traditional diets high in protein, fibre and complex carbohydrates to diets higher in refined carbohydrates, added sugars, saturated fat, sodium and lower fibre [151]. Traditional foods remain culturally significant and strongly connected to identity and Country. Risk factors for poor diet include cultural disruption, racism and reduced food accessibility, food affordability and housing constraints, family responsibilities and individual capacity to prepare food, contributing to ongoing nutritional disadvantage [152, 153].

Sustained **breastfeeding** was practised prior to colonisation [154-157], and aligned with current World Health Organization (WHO) and UNICEF recommendations [158]. Contemporary breastfeeding practices are influenced by social and environmental conditions, including housing quality and access to culturally safe support [57, 153, 158].

Physical activity supports health and wellbeing [159], but physical inactivity is shaped by social and environmental conditions and is associated with reduced life expectancy [35]. Participation is influenced by access to safe and appropriate spaces and neighbourhood environments [159].

Bodyweight is influenced by a range of factors beyond individual behaviour, including access to nutritious food and physical activity, genetics, health inequalities related to remoteness, socioeconomic disadvantage and ethnicity, and environmental and societal factors such as food retail environments and advertising [160]. For Aboriginal and Torres Strait Islander people, additional risk factors include food insecurity, inadequate housing, limited access to health services, loss of traditional lands and the transition to Western diets due to settler colonialism [161].

Unchanged since the previous release

There have been no new national datasets released for nutrition, breastfeeding, physical activity or bodyweight among Aboriginal and Torres Strait Islander people since the publication of the 2024 *Overview*. See the **2024 *Overview*: Nutrition and breastfeeding**, **2024 *Overview*: Physical activity** and **2024 *Overview*: Bodyweight** for what is still the latest available data for:

- Prevalence of adequate fruit and vegetable consumption among people aged 15 years and over, including by sex, age and remoteness
- Prevalence of consumption of sugar sweetened and diet drinks among people aged 15 years and over, by age, sex, remoteness and frequency of consumption
- Prevalence of food security, including by remoteness
- Proportion of children aged 0–2 years who had been breastfed, including by duration, jurisdiction and remoteness
- Breastfeeding rates, including by duration
- Proportion of babies breastfed on hospital discharge in the NT, and proportion of babies breastfed on hospital discharge in NSW including by Local Health District
- Burden of disease attributable to dietary factors
- Prevalence of adequate physical activity among people aged 15 years and over in non-remote areas, including by sex, age, jurisdiction and regionality
- Burden of disease attributable to physical inactivity, including by burden type and specific health condition
- Prevalence of overweight, obesity and underweight among people aged 15 years and over, including by sex, age, jurisdiction and remoteness

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- Prevalence of overweight, obesity and underweight among young people aged 2–17 years, including by sex, age, jurisdiction and remoteness
- Prevalence of disease risk based on waist circumference among adults aged 18 years and over, including by sex and age
- Burden of disease attributable to overweight and obesity, including by burden type and specific health condition.

Key facts from the previous release

- In the 2022–23 NATSIHS, 35% of Aboriginal and Torres Strait Islander people aged 15 years and over met the recommended fruit intake guidelines, and 5.3% met the recommended vegetable intake guidelines [85].
- In the 2018–19 NATSIHS, 87% of Aboriginal and Torres Strait Islander children aged 0–2 years had been breastfed [57].
- In the 2022–23 NATSIHS, 17% of people aged 15 years and over in non-remote areas met the recommended guidelines for weekly physical activity [85].
- In the 2022–23 NATSIHS, 68% of people aged 15 years and over were overweight or obese [85].

Tobacco and e-cigarette use

CTG Outcome 1: Everyone enjoys long and healthy lives

CTG Outcome 2: Children are born healthy and strong

Tobacco use has a number of health impacts, including increasing the risk of chronic disease, such as CVD, many forms of cancer, and lung diseases, as well as a variety of other health conditions [57]. Tobacco use is also a risk factor for complications during pregnancy and is associated with preterm birth, LBW and perinatal death. Environmental tobacco smoke (second-hand smoke or passive smoking) and third-hand smoke (the residue left from second-hand smoke on surfaces and in indoor dust) is of concern to health, with children especially susceptible to resultant problems [162].

E-cigarette use (also known as vaping) is an emerging global issue in tobacco control [163]. E-cigarettes have been associated with a range of health impacts including lung cancer, oral cancer, injuries (poisoning, burns and seizures), lung injury, nicotine addiction, dual use with tobacco smoking and increased uptake of tobacco smoking among people who do not smoke [163, 164]. There are also impacts on the environment such as indoor air pollution and waste.

New since the previous release

Prevalence

New data on the prevalence of smoking among pregnant Aboriginal and Torres Strait Islander mothers are available.

- In 2023, 38% of Aboriginal and Torres Strait Islander mothers reported smoking during pregnancy [165].

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Tobacco and e-cigarette use** for the latest available data:

- The prevalence of tobacco use among Aboriginal and Torres Strait Islander people aged 15 years and over, including by sex, age, jurisdiction, Indigenous Region and remoteness
- The prevalence of tobacco use among Aboriginal and Torres Strait Islander students aged 12-17 years
- The proportion of children living in a household where someone smoked indoors
- The differences in smoking-related attitudes and behaviours among people residing in Tackling Indigenous Smoking (TIS)-funded areas of Australia compared with those in non-TIS funded area
- The number of deaths attributable to tobacco use among Aboriginal and Torres Strait Islander people
- The burden of disease caused by tobacco use among Aboriginal and Torres Strait Islander people
- The prevalence of e-cigarette use among Aboriginal and Torres Strait Islander people aged 15 years and over, including by sex, age, jurisdiction and remoteness
- The prevalence of e-cigarette use among Aboriginal and Torres Strait Islander students aged 12-17 years.

Key facts from the previous release

- In 2022-2023, 29% of Aboriginal and Torres Strait Islander people aged 15 years and over reported that they smoked daily [85].
- In 2022-23, 24% of people aged 15 years and over self-reported having ever used e-cigarettes and 8.3% reported that they were currently using e-cigarettes [85].
- Similar proportions of males (9.5%) and females (7.5%) aged 15 years and over reported currently using an e-cigarette in 2022-23 [85].

Alcohol use

CTG Outcome 1: Everyone enjoys long and healthy lives

Drinking too much alcohol, both on single drinking occasions (binge drinking) and over a person's lifetime can lead to harms including chronic diseases, injury and transport accidents, mental health disorders, intergenerational trauma and violence [166, 167]. Many factors influence why people may drink too much alcohol, for example, socioeconomic disadvantage, stress and negative early life experiences [168, 169]. With regard to Aboriginal and Torres Strait Islander people, as noted elsewhere in the *Overview*, it is important to understand the historical and social contexts of colonisation, the ongoing effects of dispossession of land and culture, economic exclusion and how these factors influence alcohol use [166, 170].

New since the previous release

Alcohol and pregnancy

- In 2023, 86% of pregnant Aboriginal and Torres Strait Islander women self-reported not consuming alcohol during the first 20 weeks of pregnancy (excluding NSW and the ACT) [165]. After 20 weeks of pregnancy, this increased to 90% of women.

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Treatment

New data on alcohol treatment are available [171]:

- In 2023-24, 19% of people aged 10 years and over who accessed publicly funded AOD treatment services for their own substance use identified as being Aboriginal and/or Torres Strait Islander.
- In 2023-24, alcohol was the main drug of concern for 36% of Aboriginal and Torres Strait Islander people who sought treatment for their own AOD use.

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Alcohol use** for the latest available data:

- Prevalence of abstinence or no consumption of alcohol in the last 12 months, by sex, age, jurisdiction and remoteness
- Prevalence of not exceeding the 2020 Australian adult alcohol guideline[31], by sex, age and remoteness
- Prevalence of exceeding the 2020 Australian adult alcohol guideline, by sex, jurisdiction and remoteness
- The proportion of Aboriginal and Torres Strait Islander participants in 2019 SA-based study aged 16 years and over who were likely dependent on alcohol
- The crude rate of alcohol-related hospitalisation by disorder type, age, sex, jurisdiction and remoteness
- The number of deaths and the crude rate of deaths attributable to alcohol use, including by sex
- The proportion of total burden of disease and non-fatal burden of disease attributable to alcohol use and alcohol-related disorders, by sex and age.

Key facts from the previous release

- In 2022-23, 62% of Aboriginal and Torres Strait Islander adults did not exceed the 2020 Australian adult alcohol guideline [85].
- In 2018, alcohol use was the second leading risk factor contributing to the total burden of disease among Aboriginal and Torres Strait Islander people, accounting for 11% of the burden of disease [93].

31 To reduce the risk from alcohol-related disease or injury, men and women should drink no more than 10 standard drinks a week and no more than four standard drinks on any one day [172].

Illicit drug and volatile substance use

CTG Outcome 1: Everyone enjoys long and healthy lives

Illicit drug use describes the use of drugs that are illegal to possess (e.g., cannabis, heroin, cocaine and methamphetamine) and the non-medical use of prescribed drugs such as painkillers [167]. Illicit drug use is associated with an increased risk of mental illness, poisoning, self-harm, infection with blood-borne viruses from unsafe injection practices, chronic disease and death [93, 173, 174].

Volatile substance use (VSU) involves sniffing substances that give off fumes at room temperature such as petrol, paint, glue or deodorants [175]. Short-term effects include slurred speech, lack of coordination, dizziness and euphoria [175, 176]. Sniffing volatile substances, particularly butane, propane and aerosols, can cause sudden death [177]. Ongoing VSU is associated with damage to the peripheral nervous system, respiratory system, digestive tract, kidneys and anaemia [178]. Excessive VSU can also lead to permanent acquired brain injury [179-181].

New since the previous release

Extent of illicit drug use

- A 2025 report on the Needle Syringe Program (NSP) found that of the people attending NSPs in 2025, 25% (excluding occasions where Indigenous status was not reported) identified as Aboriginal and/or Torres Strait Islander [182]. Stimulants and hallucinogens (mainly methamphetamine) were the most commonly injected drugs reported by attendees of NSPs.

Treatment

New data for illicit drug use and VSU treatment are available for 2023–24 [171]:

- Nineteen per cent (19%) of people who accessed treatment for their own AOD use from publicly funded AOD treatment services were Aboriginal and Torres Strait Islander people aged 10 years and over.
- Of the Aboriginal and Torres Strait Islander people who accessed treatment, there was a greater proportion of males (58%) than females (38%)[32].
- After alcohol, the most common principal drugs of concern that Aboriginal and Torres Strait Islander people sought treatment for were amphetamines (27% of people), cannabis (20%) and heroin (5.1%).
- The greatest proportion of Aboriginal and Torres Strait Islander people who accessed treatment were in the 30–39 years age-group (30%), followed by the 20–29 years age-group (27%), 40-49 years age-group (20%), 10–19 years age-group (12%), 50–59 years age-group (8.7%) and 60 years and over age-group (2.3%).
- By jurisdiction, the highest proportion of Aboriginal and Torres Strait Islander people who accessed treatment for their own AOD use in 2023–24 were in the NT (74% of people), followed by WA (22%), Qld (21%), NSW (20%), SA (17%), Tas (16%), the ACT (14%) and Vic (11%).
- Among Aboriginal and Torres Strait Islander people aged 10 years and over, 0.8% identified volatile solvents as the main drug they sought treatment for in publicly funded AOD services.
- The jurisdiction with the highest proportion of Aboriginal and Torres Strait Islander people aged 10 years and over who identified volatile solvents as the main drug they sought treatment for was the NT (5.73%), followed by Qld (0.50%), Tas (0.25%), the ACT (0.21%), Vic (0.17%), WA (0.13%), SA (0.07%) and NSW (0.02%).

32 0.4% of people reported their sex as a term other than 'male' or 'female' and 2.8% did not state their sex [171].

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Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Illicit drug use and Volatile substance use** for the latest data for these indicators:

- Prevalence of not having used illicit drugs in the last 12 months among Aboriginal and Torres Strait Islander people aged 15 years and over, and the prevalence of never having used illicit drug among those aged 14 years and over
- Prevalence of never having used inhalants among Aboriginal and Torres Strait Islander people aged 14 years and over
- Prevalence of having used illicit drugs in the last 12 months among people aged 15 years and over, and the types of illicit drugs that were most commonly used, by sex, jurisdiction and remoteness
- Prevalence of using petrol and other inhalants in the last 12 months among Aboriginal and Torres Strait Islander people aged 15 years and over
- The number of people in select Aboriginal communities using volatile substances as reported by two studies
- Crude hospitalisation rates for drug-related conditions among Aboriginal and Torres Strait Islander people, by jurisdiction and remoteness
- The leading drugs of concern that Aboriginal and Torres Strait Islander people were hospitalised for based on their principal diagnosis
- Crude hospitalisation rates for Aboriginal and Torres Strait Islander people due to volatile solvent use and volatile solvent-related disorders
- The number of deaths among Aboriginal and Torres Strait Islander people attributed to illicit drug use
- The leading drug types involved in unintentional drug induced deaths among Aboriginal and Torres Strait Islander people
- The age-standardised rates of drug-induced deaths among Aboriginal and Torres Strait Islander people, by sex and jurisdiction
- The proportion of total burden of disease, fatal burden of disease and non-fatal burden of disease attributable to illicit drug use, by sex and age
- The proportion of burden of disease attributable to different illicit drug types
- The different disease groups for which illicit drug use contributed to the total burden of disease.

Key facts from the previous release

- In 2022–23, the majority (72%) of Aboriginal and Torres Strait Islander people aged 15 years and over reported they had not used illicit substances in the last 12 months [85].
- In 2018, illicit drug use contributed to 6.9% of the total burden of disease among Aboriginal and Torres Strait Islander people [93].
- In 2022–23, the majority (94%) of Aboriginal and Torres Strait Islander people aged 14 years and over reported they had never used inhalants [85].

Communicable diseases

Communicable diseases (caused by infectious agents including bacteria, viruses, parasites, fungi, or their toxic products) can be transmitted from one person or an animal to another [183]. Disease transmission may occur directly (e.g. via contact with blood or bodily fluids), indirectly (e.g. by sharing a drinking glass), or through vectors (e.g. mosquitoes). While illnesses caused by communicable disease are often mild and brief (e.g. a common cold) and do not require medical care, risk factors may vary according to the type of disease.

The **human immunodeficiency virus (HIV)** affects a person's immune system and over time prevents their body's ability to overcome infections and illnesses [184]. HIV can be transmitted through certain body fluids such as blood, vaginal fluid, semen and breast milk. It can also be transmitted during pregnancy or birth from mother to child. If untreated, HIV can progress to acquired immune deficiency syndrome [185]. The risk factors associated with contracting HIV include engaging in unprotected sex (anal, oral or vaginal), having a sexually transmissible infection (STI), sharing injecting equipment, using unsterile piercing and tattooing equipment or accidental needle stick injuries [184, 186]. HIV symptoms often vary and develop over time, meaning it is common for people who are infected to be unaware they are HIV positive until the later stages of infection [184]. However, the most infectious time period is the first few months after infection.

Hepatitis is an inflammation of the liver which can be caused by viruses, alcohol, drugs and other toxins [187]. Transmission of **hepatitis C virus (HCV)** occurs via blood to blood contact; in Australia, mainly by the use of unsterile drug injecting equipment [188]. Treatment for HCV using direct-acting antiviral (DAA) therapies has been found to be highly effective. There is no vaccine to protect people against HCV, but due to the efforts to increase access to DAAs over recent years, Australia is predicted to eliminate HCV as a public health threat by 2030. Historically, transmission of **hepatitis B virus (HBV)** among Aboriginal and Torres Strait Islander people was from mother to child at birth, or between children and family members [189]. Now, more common forms of transmission are using unsterile drug injecting equipment or sexual contact without the use of condoms and lubrication. Australia is predicted to eliminate HBV as a public health threat by 2030.

Pneumococcal disease results from infection by the bacterium *Streptococcus pneumoniae*, which may cause severe invasive disease including meningitis, pneumonia, bacteraemia and non-invasive disease, including otitis media [190]. Pneumococcal disease is most common in very young children and the elderly [191]. Nationally-funded vaccination for pneumococcal disease is available for Aboriginal and Torres Strait Islander infants and children, and adults aged 50 years and over [192]. Funded under the National Immunisation Program (NIP), all Aboriginal and Torres Strait Islander children receive a single dose at ages 2 months, 4 months and 12 months, and children living in Qld, WA, SA and the NT receive an additional dose at 6 months of age [192, 193].

Meningococcal disease is caused by the bacterium *Neisseria meningitidis* (also known as meningococcus) [190]. The most common clinical presentations of invasive meningococcal disease (IMD) are septicaemia and/or meningitis. Meningococcal disease is more common in infants, adolescents and adults aged over 45 years [194]. The most common serogroups[33] of meningococcus found in Australia are B, Y and W [194]. The MenACWY vaccination is now funded under the NIP as a single dose for all children aged 12 months and for adolescents aged 14 to 16 years via school-based immunisation and/or primary care providers [192]. This funding covers specific populations, including Aboriginal and Torres Strait Islander people. A vaccine for serogroup B[34] (also funded under the NIP) is available Australia-wide for Aboriginal and Torres Strait Islander infants aged from 6 weeks; a catch-up vaccine is also available for children aged up to 23 months [192, 195].

Tuberculosis (TB) is primarily a lung infection caused by *Mycobacterium tuberculosis* bacteria [196]. With high incidence rates in the NT, Qld and northern SA among Aboriginal and Torres Strait Islander people, the National Tuberculosis Advisory Committee recommends neonates in these communities receive the Bacille Calmette-Guérin (BCG) vaccine.

33 A serogroup is a group of bacteria containing a common antigen.
34 SA provides free vaccination for eligible children and young people.

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***Haemophilus influenzae type b* (Hib)** is a bacterium that can cause a number of conditions including meningitis, pneumonia, epiglottitis, septic arthritis and cellulitis [190]. Children are particularly susceptible to Hib, which is serious in its invasive form [197]. Vaccination has substantially reduced notifications of invasive Hib disease in Australia, with a reduction of more than 99% across both the Aboriginal and Torres Strait Islander and non-Indigenous populations compared with the pre-immunisation era. As of the end of December 2023, 91% of Aboriginal and Torres Strait Islander children were vaccinated against Hib at one year of age [198].

New since the previous release

Human immunodeficiency virus (HIV)

New data are available for HIV notifications [174]:

- In 2024, there were 23 notifications[35] of HIV infection in Australia among Aboriginal and Torres Strait Islander people. The median age of diagnosis was 36 years. The age-standardised rate of HIV notification for Aboriginal and Torres Strait Islander people was 2.8 per 100,000 population.
- In 2024, the age-standardised HIV notification rate for Aboriginal and Torres Strait Islander males (4.7 per 100,000) was higher than for females (0.8 per 100,000).
- In 2024, the age-standardised HIV notification rate was higher among Aboriginal and Torres Strait Islander people aged 35 years and over (4.5 per 100,000) compared with those aged under 35 years (1.0 per 100,000).
- In 2024, Qld had the highest number of HIV notifications (8 cases) followed by Vic (6 cases), NSW (5 cases), WA (3 cases) and the NT (1 case). The HIV notification rate was 2.8 per 100,000 among Aboriginal and Torres Strait Islander people living in major cities and regional areas, and 2.4 per 100,000 in remote areas.

Hepatitis C

New data are available for HCV notifications in 2024 [174]:

- In 2024, 1,527 (21%) of the 7,281[36] notified HCV infections[37] were among people of Aboriginal and Torres Strait Islander origin. The age-standardised rate for notified HCV was 165 per 100,000 population[38].
- The rate for males was 3.2 times higher than for females (264 per 100,000 and 81 per 100,000 respectively).
- Across all age-groups, the highest number of notifications was among those aged 25–34 (36% of notifications) (Derived from [174]).
- For the reported jurisdictions, rates were highest in WA (270 per 100,000), followed by Qld (189 per 100,000), SA (75 per 100,000), Tas (42 per 100,000) with the lowest rate in the NT (37 per 100,000).
- Rates were similar in major cities (214 per 100,000) and regional areas (213 per 100,000), and lower in remote areas (41 per 100,000).

35 HIV notifications are based on small numbers so should be interpreted with caution.
36 1811 (25%) of the 7,281 notifications had Aboriginal and Torres Strait Islander status 'not reported'.
37 Notifications include individuals who were previously undiagnosed and have since tested positive for hepatitis C, or for those who were previously cured, but have been identified as reinfected through subsequent testing.
38 Notification rates by Aboriginal and Torres Strait Islander status are only included for jurisdictions where Aboriginal and Torres Strait Islander status was reported for ≥50% of diagnoses for each of the reported years. This included Qld, WA, SA, Tas and the NT for notified HCV.

Hepatitis B

New data are available for HBV notifications in 2024 [174]:

- In 2024, 144 (2.6%) of the 5,594[39] notified HBV infections[40, 41] were among people of Aboriginal and Torres Strait Islander origin. The age-standardised rate for newly notified HBV was 24 per 100,000 population[42].
- The rate for males was 2.4 times higher than that for females (34 per 100,000 and 14 per 100,000 respectively) (Derived from [174]).
- Across all age-groups, the highest rates were among those aged 40–49 years (39 per 100,000).
- For the reported jurisdictions, rates were highest in WA (34 per 100,000), followed by the NT (31 per 100,000), with the lowest rates in SA (5.0 per 100,000) and the ACT (0.0 per 100,000).
- Rates increased by remoteness from 15 per 100,000 in major cities to 24 per 100,000 in regional areas and 33 per 100,000 in remote areas.

Pneumococcal disease

New data are available for invasive pneumococcal disease (IPD) notifications in 2020–2024 [199]:

- There were 1,418 notifications for IPD for Aboriginal and Torres Strait Islander people, representing 16% of the 8,821 notifications in Australia.
- There were 748 cases among males and 670 among females.
- By clinical presentation, the highest numbers of cases were pneumonia (717 cases) and bacteraemia (262 cases).

Meningococcal disease

New data are available for IMD notifications in 2020-2024 [200]:

- Of the 563 notified cases of IMD, 96 (17%) were identified as Aboriginal and Torres Strait Islander people.
- Of these cases, 51 were among males and 45 were among females.
- Forty-four per cent (44%) of the cases were among children aged 0–4 years.
- The highest recorded number was for serogroup B with 69 cases.

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Communicable Diseases** for the latest available data:

- TB notification rates, including by age and jurisdiction
- TB hospitalisation rates, including by age
- Number of cases of notified Hib including number for children aged 0–4 years.

39 2007 (36%) of the 5,594 notifications had Aboriginal and Torres Strait Islander status 'not reported'.
40 Notified cases of HBV include people previously not know to have HBV who now has been tested and found to have HBV.
41 Caution should be taken due to low number of notifications.
42 HBV notification rates by Aboriginal and Torres Strait Islander status only included for jurisdictions where Aboriginal and Torres Strait Islander status was reported for at least 50% of diagnoses for each of the reported years. This included Qld, WA, SA, the ACT and the NT for notified infections.

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Key facts from the previous release

- Between 2015 and 2020, there was a 38% reduction in cases of TB among Aboriginal and Torres Strait Islander people [201].
- In 2018, the notification rate for TB among Aboriginal and Torres Strait Islander people was 3.6 per 100,000 [202].
- For 2016–2019, 22 (30%) of the 73 cases of invasive Hib disease notified in all jurisdictions were among Aboriginal and/or Torres Strait Islander people [203].

Sexual health

Sexually transmissible infections (STIs) include bacterial, viral and parasitic infections that are primarily transmitted through sexual contact [204, 205]. Young people aged 15–29 are particularly vulnerable to STIs [174, 185] and the use of condoms is regarded as fundamental in preventing STI transmission. Most bacterial STIs are treatable by antibiotics, and early detection and treatment is important in their management. However, this has been impacted by the emergence of antimicrobial resistance [204].

There are four nationally notifiable STIs including gonorrhoea, chlamydia, syphilis and donovanosis, and a range of non-notifiable STIs, including HTLV-1 (Human T-lymphotropic virus type 1; notifiable in the NT), human papillomavirus (HPV), Mycoplasma genitalium and trichomoniasis [204]. Only notifiable STIs are reported in this *Overview*.

New since the previous release

Chlamydia

Chlamydia is an infection caused by the bacterium *Chlamydia trachomatis* [174], and symptoms mainly consist of an inflamed urethra (the tube through which urine passes out of the body), leading to some pain and penile discharge for males and pain during urination and intermenstrual bleeding for females [185, 206]. However, chlamydia is asymptomatic (showing no symptoms) in about 80% of cases. As a result, chlamydia can also lead to serious complications and reproductive issues for females such as infertility, pelvic inflammatory disease and ectopic pregnancies. Chlamydia is easily curable by antibiotics [206].

New chlamydia notification data are available[43] [174]:

- Chlamydia is the most frequently diagnosed STI in Australia. In 2024, a total of 101,742 chlamydia infections were notified in Australia, of which 9,885 (9.7%) were among Aboriginal and Torres Strait Islander peoples, 48,751 (48%) were among non-Indigenous people, and 43,106 (42%) of notifications occurred in people whose Aboriginal and Torres Strait Islander status was not reported. Incomplete information on Aboriginal and Torres Strait Islander identification has the potential to misrepresent the true extent of STIs among Aboriginal and Torres Strait Islander peoples.
- The age-standardised notification rate for chlamydia in 2024 among Aboriginal and Torres Strait Islander people was 951 per 100,000 population, up from 820 per 100,000 population in 2023.
- In 2024, the rate among females (1,208 per 100,000 population) was higher than for males (704 per 100,000 population).
- In 2024, the highest number and proportion of chlamydia notifications were among Aboriginal and Torres Strait Islander peoples aged 15–19 years (3,430: 35%), followed by 20–24 year olds (2,693: 27%) (Derived from [174]).

43 Chlamydia notification rates among Aboriginal and Torres Strait Islander peoples were based on data from five jurisdictions (NSW, Qld, SA, WA and the NT) where Aboriginal and Torres Strait Islander status was at least 50% complete for all chlamydia notifications for each of the five years from 2020 to 2024 [174]. Caution is advised when interpreting these data as being fully representative of national epidemiology among Aboriginal and Torres Strait Islander peoples, because the 50% reporting threshold is low.

- In 2024, for the jurisdictions that met the required threshold of reporting of Aboriginal and Torres Strait Islander status[44], age-standardised notification rates for chlamydia were highest in the NT (2,095 per 100,000 population), followed by WA (1,313 per 100,000 population), Qld (1,138 per 100,000 population), SA (720 per 100,000 population) and NSW (431 per 100,000 population).
- The age-standardised notification rate for chlamydia increased with remoteness from 675 per 100,000 population in major cities to 797 per 100,000 population in regional areas to 2,077 per 100,000 population in remote areas.

Gonorrhoea

Gonorrhoea is an STI caused by the bacterium *Neisseria gonorrhoeae* [185]. Gonorrhoea is largely asymptomatic, with no symptoms displayed in about 80% of women and 50% of men. Symptoms are similar to those of chlamydia and so are the complications, which can lead to reproductive issues if left untreated [185, 206, 207]. Most men with urethral gonorrhoea will eventually develop symptoms but throat and anal infections do not usually cause symptoms. Gonorrhoea can be cured with antibiotics [206]. However increased resistance to most antibiotics has been reported worldwide [208].

New gonorrhoea notification data are available[45] [174]:

- In 2024, there were 5,934 gonorrhoea notifications for Aboriginal and Torres Strait Islander people. Nineteen per cent (19%) of total gonorrhoea notifications in Australia were for people for whom Aboriginal and Torres Strait Islander status was not reported.
- In 2024, the age-standardised notification rate for Aboriginal and Torres Strait Islander people was 577 per 100,000 population.
- Between 2020 and 2024 the gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples increased by 11% (519 per 100,000 compared with 577 per 100,000). The increase in gonorrhoea rates each year from 2021 was in the context of overall declines in other blood borne viruses (BBVs) and STIs during the COVID-19 pandemic.
- In 2024, the notification rate for gonorrhoea among females (611 per 100,000 population) was higher than for males (546 per 100,000 population). Gonorrhoea notification rates among Aboriginal and Torres Strait Islander males and females increased between 2020 and 2024 by 9% and 13%, respectively.
- In 2024, the greatest proportion of gonorrhoea notifications among Aboriginal and Torres Strait Islander peoples occurred among those aged 15–19 years (1,468: 25%), followed by those aged 20–24 years (1,372: 23%) and 30–39 years (1,389: 23%) (Derived from [174]). The gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples aged 15–19 years was relatively unchanged between 2020 and 2024 and was 1,160 per 100,000 population in 2024. However, among Aboriginal and Torres Strait Islander peoples aged 20–29 years, the gonorrhoea notification rate increased by 17% from 1,390 per 100,000 population in 2020 to 1,537 per 100,000 population in 2024.
- In 2024, age-standardised gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples were highest in the NT (2,138 per 100,000 population), followed by WA (1,012 per 100,000 population), and SA (760 per 100,000 population). The remaining jurisdictions reported on, had notification rates ranging from 81 per 100,000 population in Tas, 172 per 100,000 population in NSW, 230 per 100,000 population in the ACT, to 360 per 100,000 population in Qld.
- In 2024, gonorrhoea notification rates differed by remoteness, with rates of 417 per 100,000 population in major cities (up from 271 per 100,000 population in 2023), 303 per 100,000 population in regional areas (compared to 292 per 100,000 population in 2023), and 1,680 per 100,000 population in remote areas (down from 1,819 per 100,000 population in 2023).

44 Chlamydia notification data for Aboriginal and Torres Strait Islander peoples was not available in 2024 for the ACT, Vic or Tas because their reporting of Aboriginal and Torres Strait Islander status did not meet at least 50% completion for the previous 5 years [174].

45 Age-standardised notification rates for Aboriginal and Torres Strait Islander peoples were only included for jurisdictions where Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each of the previous 5 years (2020 – 2024) [174]. For gonorrhoea this included all jurisdictions except Vic.

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Syphilis

Syphilis is an infection caused by the bacterium *Treponema pallidum* which results in substantial morbidity and mortality. It can be transmitted through sexual or direct physical contact with infectious lesions, blood-to-blood contact and vertically (trans-placentally) from mother to child to the unborn foetus during pregnancy or at birth, causing congenital syphilis. If untreated, this can result in intrauterine foetal death, stillbirth, neonatal death, or a premature baby [174, 185, 208, 209].

Untreated infectious syphilis lasts many years and progresses through several different stages. Early syphilis consists of primary syphilis, secondary syphilis and early latent syphilis, while late syphilis consists of late latent syphilis and tertiary syphilis [185]. Infectious syphilis is fully curable with a single injection of long-acting penicillin [185].

New syphilis notification data are available [174]:

- Infectious syphilis data are available for the 10-year period 2015 to 2024, because at least 80% of notifications in all Australian jurisdictions had Aboriginal and Torres Strait Islander status complete for each year from 2015 to 2024. In 2024, there were 989 infectious syphilis notifications for Aboriginal and Torres Strait Islander peoples, a decrease of 71 notifications from 2023 (Derived from [174]).
- The age-standardised notification rate of infectious syphilis for Aboriginal and Torres Strait Islander people was 101 per 100,000 population in 2024.
- In 2024, the notification rate for infectious syphilis among males (115 per 100,000 population) was higher than for females (88 per 100,000 population). The male to female ratio of infectious syphilis notifications in Aboriginal and Torres Strait Islander peoples in 2024 was 1.3:1.
- Between 2019 and 2024, the age-standardised infectious syphilis notification rate declined from 124 to 101 per 100,000 population. These trends over time were seen among both Aboriginal and Torres Strait Islander males and females.
- In 2024, the highest proportion of infectious syphilis notifications were among Aboriginal and Torres Strait Islander peoples aged 40 years or over (236: 24%), followed by 20–24 years (170: 17%) (Derived from [174]).

- In 2024, notification rates for infectious syphilis were highest in the NT (281 per 100,000 population), followed by WA (162 per 100,000 population), and Qld (119 per 100,000 population). Between 2015 and 2021, infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples increased in every state and territory apart from the ACT and Qld. Aboriginal and Torres Strait Islander peoples residing in the NT had the highest notification rates during 2015 to 2020, but WA had the highest rates from 2021–2023, and in 2024 the NT reported the highest notification rates again.
- In 2024, the infectious syphilis notification rate among Aboriginal and Torres Strait Islander peoples was highest in remote areas (231 per 100,000 population), followed by major cities (89 per 100,000 population), and was the lowest in regional areas (68 per 100,000 population) of Australia.
- These data show that infectious syphilis notifications among Aboriginal and Torres Strait Islander peoples more than doubled between 2015 and 2024, increasing from 468 notifications in 2015 to 989 notifications in 2024.
- Infectious syphilis notification rates among Aboriginal and Torres Strait Islander women of reproductive age (18–44 years) increased from 106 per 100,000 in 2015 to a peak of 246 per 100,000 in 2019. Despite the notification rate decreasing to 166 per 100,000 in 2024, it remains higher than the rate reported in 2015.
- The high rates of infectious syphilis notifications among Aboriginal and Torres Strait Islander women of reproductive age were reported alongside 13 congenital syphilis notifications among Aboriginal and Torres Strait Islander infants in 2023, half of which resulted in death. The number of congenital syphilis notifications decreased to three among Aboriginal and Torres Strait Islander infants in 2024.

Skin health

Common skin infections affecting Aboriginal and Torres Strait Islander children in remote northern Australia include scabies and impetigo [210]. Scabies, caused by the mite *Sarcoptes scabiei var*. hominis, can produce skin inflammation and itching [211]. Skin breaks from scratching can result in impetigo[46], a bacterial infection of the skin [210, 211, 213]. Untreated impetigo can lead to complications such as sepsis, ARF and/or kidney disease [210].

Other common skin conditions include atopic dermatitis (eczema) and tinea (ringworm) [214-216]. Atopic dermatitis is a non-contagious, chronic skin disorder characterised by redness, dryness, itching and increased susceptibility to infection [216]. Tinea is a contagious fungal infection of the skin that typically affects warm, moist areas such as between the toes, but can occur on the head or other parts of the body [214, 215]. It commonly presents with itching, redness and a ring-shaped rash [215]. Tinea is often more prevalent in resource-poor tropical settings [215].

Risk factors for skin infections include perinatal risk factors such as male sex and LBW [217], low family income, overcrowding, unmet water and housing needs, limited access to affordable healthy food, poor hygiene, non-adherence to antibiotic treatments [218, 219], underserved environments [220, 221] and the normalisation of infections in communities [218, 222, 223].

Aboriginal and Torres Strait Islander children living in high-rainfall, humid areas of northern Australia are vulnerable to other fungal and bacterial infections [224].

New since the previous release

Prevalence

New data are available on the skin health of Aboriginal and Torres Strait Islander children and young people aged 0–18 years in an urban-based, cross-sectional study conducted in Perth and Bunbury, WA in 2022 [225]:

- Data were collected over 2 weeks from 149 urban-living children and young people with a median age of 6 years. The study found the prevalence of impetigo was 6.8% and scabies 2.7%. The study also reported a prevalence of 18% for atopic dermatitis and 12% for tinea.

New data are available on the incidence of scabies in Far North Qld (FNQ) in a retrospective study that examined all skin scraping results collected within FNQ's public health system between 2000 and 2023 [226]:

- Of the 2,706 skin scraping episodes collected from individuals who identified as Aboriginal and Torres Strait Islander, 110 (4.1%) were microbiologically confirmed cases of scabies.

Hospitalisation

New data are available on hospitalisations for skin disease:

- There were 14,646 hospital separations with a principal diagnosis of 'diseases of the skin and subcutaneous tissue[47] among Aboriginal and Torres Strait Islander people in 2023–24, representing 3.8% of all Aboriginal and Torres Strait Islander hospital separations (excluding dialysis) [83]. The age-standardised hospitalisation rate was 17 per 1,000 [227].
- In 2023–24, cellulitis (a bacterial infection of deeper layers of the skin than impetigo) had the highest hospitalisation rate among acute conditions for Aboriginal and Torres Strait Islander people [228]. The age-standardised hospitalisation rate was 7.3 per 1,000 population. The highest age-standardised rates were in the NT (13 per 1,000) and the lowest in Tas (2.7 per 1,000), with the remaining jurisdictions ranging from 3.9 per 1,000 population and 12 per 1,000 population.

46 Impetigo is also referred to as skin sores, or the broader term, pyoderma, and these terms are commonly used interchangeably [212].

47 Includes hospitalisations for diagnoses including but not limited to abscess, cellulitis, scabies, impetigo, dermatitis and eczema, psoriasis and sunburn.

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Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Skin Health** for the latest available data:

- Childhood population prevalence of impetigo and scabies in Northern Australia
- Prevalence of impetigo and scabies among children aged 5-9 years in the Kimberley region of WA
- National prevalence of self-reported diseases of the skin and subcutaneous tissue, including by age and remoteness
- The national burden of disease attributable to skin disorders.

Key fact from the previous release

- The median prevalence of impetigo among remote-living Aboriginal and Torres Strait Islander children in northern Australia was 45% [229, 230].

Immunisation

CTG Outcome 1: Everyone enjoys long and healthy lives

Immunisation is the process of becoming immune to a disease because of a vaccine [231]. Vaccines work by producing an immune response in the body without causing illness. In recent decades, immunisation has been very successful in contributing to improvements in Aboriginal and Torres Strait Islander health and child survival [232].

The vaccines recommended for Aboriginal and Torres Strait Islander people at different stages of life are set out by the NIP Schedule [233]. Vaccines on the NIP Schedule are funded by the Australian Government and are free to Aboriginal and Torres Strait Islander people.

Vaccines given to people of all ages in Australia from birth to death are recorded on the Australian Immunisation Register (AIR) [234]. AIR data are used to calculate vaccination coverage for children and, as the register grows, for adolescents and adults.

New since the previous release

Childhood vaccination

Australia's national childhood immunisation target is 95% immunisation coverage for children aged 1, 2 and 5 years [235, 236]. Vaccinations set out in the NIP Schedule for Aboriginal and Torres Strait Islander children include HBV, diphtheria, tetanus, pertussis (whooping cough), polio, Hib, rotavirus[48], pneumococcal disease, meningococcal B[49], meningococcal ACWY, measles, mumps and rubella (MMR), varicella (chickenpox) and hepatitis A[50] [233]. New data on childhood immunisation coverage are available [238]:

- As of 30 September 2025, the proportion of Aboriginal and Torres Strait Islander children who were fully immunised did not exceed the national target at ages 1, 2 or 5 years (Table 4).

48 Not included in definition of 'fully immunised' for purposes of calculating childhood immunisation coverage [237].
49 Not included in definition of 'fully immunised' for purposes of calculating childhood immunisation coverage [237].
50 For children in Qld, WA, SA and the NT [233]; not included in definition of 'fully immunised' for purposes of calculating childhood immunisation coverage [237].

- The percentage[51] of Aboriginal and Torres Strait Islander children who were fully immunised at 30 September 2025 varied by state:
  - from 85.5% in WA to 94.4% in Tas for those aged 1 year
  - from 81.3% in WA to 93.5% in Tas for those aged 2 years
  - from 92.3% in WA to 96% in SA for those aged 5 years.

Table 4. Percentage (%) of Aboriginal and Torres Strait Islander children assessed as fully immunised, by age, as of 30 September 2025

Age (years)	1	2	5
Percentage assessed as fully immunised	89.8%	87.4%	94.3%

Note: Proportion expressed as percentages rounded to one decimal point.

Source: Australian Government Department of Health, 2025 [238]

Adolescent vaccination

Vaccinations set out in the NIP Schedule and provided through school programs for Aboriginal and Torres Strait Islander adolescents include those for HPV, diphtheria, tetanus, pertussis and meningococcal ACWY [233]. New data on adolescent vaccination coverage are available [239]:

- In 2024, coverage for the adolescent booster dose of the diphtheria-tetanus-acellular pertussis vaccine for Aboriginal and Torres Strait Islander young people turning 15 years was 73% for males and 79% for females.
- In 2024, coverage for the meningococcal ACWY vaccine by 17 years of age was 61%.
- In 2024, coverage for at least one dose of HPV vaccine by 15 years of age was 69% for males and 77% for females.

Adult vaccination

Vaccinations set out in the NIP Schedule for Aboriginal and Torres Strait Islander adults include pneumococcal and shingles [233]. A maternal RSV vaccination was added to the NIP Schedule in February 2025. New data on adult vaccination coverage are available:

- In 2024, zoster (shingles) vaccine coverage in Aboriginal and Torres Strait Islander adults aged ≥65 years was 42% [239].
- Pneumococcal vaccine coverage in those aged ≥70 years was 48% [239].
- Between 1 February and 31 October 2025, 5,950 Aboriginal and Torres Strait Islander females aged 15-54 years received a maternal RSV vaccination [240].

Seasonal and COVID-19 vaccination

All Australians aged 18 years and over and some children with risk factors are recommended a primary course of COVID-19 vaccination [232]. Some Australian children and adults (such as those aged 65 years and over) are recommended regular booster doses. New data on COVID-19 vaccination are available:

- As of 31 December 2025, 8,400 Aboriginal and Torres Strait Islander people aged 18 years and over who are registered in the AIR had received a COVID-19 vaccination in the last 6 months, and 28,900 had received one in the last 12 months [241].

Seasonal influenza vaccination is recommended annually for Aboriginal and Torres Strait Islander people aged six months or older [233]. New data on influenza vaccination coverage are available:

- Influenza vaccination coverage for Aboriginal and Torres Strait Islander people aged six months or older during the 2025 influenza season was highest among those aged 65 years and over (60%) as of 31 August 2025 (Table 5) [242].

51 Proportion expressed as percentages rounded to one decimal point.

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Table 5. Influenza vaccination coverage percentage (%) for Aboriginal and Torres Strait Islander people, by age, as of 31 August 2025

Age (years)	Australia (%)
6 months - <5	18
5 - <15	12
15 - <50	18
50 - <65	37
≥65	60

Notes:

1. Proportion expressed as percentages rounded to one decimal point.
2. Coverage calculated using doses given 1 March–31 Aug 2025 using AIR data as of 7 September 2025.

Source: National Centre for Immunisation Research and Surveillance, 2025 [242]

Connection to mind and emotions

CTG Outcome 14: People enjoy high levels of social and emotional wellbeing

Connection to mind and emotions is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. This domain relates to mental health, including the ability to manage one's thoughts and emotions.

Protective factors that support a healthy connection to mind and emotions include agency (assertiveness, confidence and control over life), strong identity, education (including learning from Elders), being on Country, and access to culturally safe SEWB programs [46, 47]. Identified risk factors include unemployment, trauma (including childhood trauma), racism, mental illness and developmental or cognitive impairments and disability.

The continuation and revival of Aboriginal and Torres Strait Islander culture and Indigenous knowledge systems, together with the capacity for self-determination, are increasingly recognised as fundamental to healing and supporting SEWB [243].

This section of the *Overview* includes measures of connection to mind and emotions for Aboriginal and Torres Strait Islander people.

Hospitalisations

New data on hospitalisations are available [83]:

- In 2023–2024, there were 29,289 hospital separations of Aboriginal and Torres Strait Islander people with a principal diagnosis of 'Mental and behavioural disorders' [227]. These separations accounted for 7.6% of all hospital separations (excluding dialysis) for Aboriginal and Torres Strait Islander people.
- 'Intentional self-harm' categorised as a principal diagnosis[52] was responsible for 2,805 (0.4%) of all hospital separations for Aboriginal and Torres Strait Islander people in 2023–2024, and 0.7% of separations when dialysis was excluded.

52 Intentional self-harm as a principal diagnosis for external causes of injury or poisoning for Aboriginal and Torres Strait Islander people.

Mortality

New data on mortality are available [84]:

- In 2024, 271 Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT died from intentional self-harm (suicide)[53]. It was the fifth leading cause of death overall (second for males and tenth for females). The crude death rate for suicide was 34 per 100,000. The rate for males (55 per 100,000) was 4.2 times higher than that for females (13 per 100,000). In 2023, the median age at death from intentional self-harm (suicide) among Aboriginal and Torres Strait Islander people in NSW, Vic, Qld, WA, SA and the NT was 34.3 years (males: 34.9 years; females: 31.5 years).
- For 2020–2024, in NSW, Vic, Qld, WA, SA and the NT, 76% of the deaths from intentional self-harm (suicide) among Aboriginal and Torres Strait Islander people were aged 15–44 years. Age groups with the highest age-specific rates were 35–44 years for males (82 per 100,000) and 15–24 years for females (21 per 100,000).
- In 2020–2024, age-standardised death rates from intentional self-harm (suicide) for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT[54] ranged from 25 per 100,000 in NSW to 40 per 100,000 in WA.
- Suicide was the leading cause of death for Aboriginal and Torres Strait Islander children aged 5–17 years living in NSW, Vic, Qld, SA, WA and the NT in 2020-2024 with an age-specific rate of 5.2 per 100,000. In the same period, 21% of deaths among children were due to suicide. Just over 75% of children who died from suicide were aged 15–17 years. Over half (56%) of Aboriginal and Torres Strait Islander children who died by suicide were female.

Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Social and emotional wellbeing** for the latest available data:

- Proportion of people reporting a mental and/or behavioural condition (nationally), by sex, age, jurisdiction and remoteness
  - Proportion of people reporting anxiety (nationally), by sex, age and remoteness
  - Proportion of people reporting depression (nationally), by sex, age and remoteness
- Proportion of people reporting recent high/very high levels of psychological distress (nationally), by sex, age, jurisdiction and remoteness
- Proportion of people reporting life satisfaction, control over own life, family wellbeing, involvement in local decision-making, experience of the Stolen Generations, and experience of everyday discrimination, by reported level (e.g. high, medium or low)
- Correlation between psychological distress, anxiety, depression, low life satisfaction and/or low happiness with experiences of discrimination
- The burden of disease attributable to ‘mental and substance use disorders’ and the burden attributable to anxiety.

Key facts from the previous release

- In the 2022-23 NATSIHS, 30% of Aboriginal people and 22% of Torres Strait Islander people, aged two years and over, reported having a mental and/or behavioural condition [85].
- In the 2022–23 NATSIHS, anxiety was the most commonly reported mental or behavioural condition among Aboriginal and Torres Strait Islander people aged two years and over (21%), followed by depression (16%) [85].

53 Care needs to be taken in interpreting figures relating to intentional self-harm due to a revision process for coroner certified deaths and coding, together with enhancements to the methods in deriving Indigenous status [244].

54 Data is reported by usual residence for NSW, QLD, WA, SA and NT only. Data for VIC, TAS and the ACT is excluded in line with national reporting guidelines.

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Connection to community

CTG Outcome 1: Everyone enjoys long and healthy lives

CTG Outcome 13: Families and households are safe

CTG Outcome 14: People enjoy high levels of social and emotional wellbeing

Connection to community is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. Connection to community encompasses coming together through a shared connection to Country; being supported by strong community leadership, governance and Elders; participating in family and community activities; maintaining shared spiritual connections to place; and engaging in reciprocal relationships ([8] cited in [47]).

Protective factors that support strong connection to community include support networks, community controlled services and self-governance [46]. Identified risk factors include disengagement, limited employment opportunities within community settings, lack of local services, isolation, lateral violence and family feuding.

This section of the *Overview* includes indicators of community connection for which there are current available data, including community-controlled services, governance and leadership, and injury (as a measure of community safety). For data on employment, see *Social, political and environmental determinants of health.* For data on knowing one's Mob, see the related domain *Connection to culture*.

New since the previous release

Community controlled services

Aboriginal community controlled organisations (ACCOs) and Aboriginal Medical Services (AMSs) are central in providing spaces for community connection [2, 47].

Data are available on ACCOs and AMSs:

- Based on 2018–2020 data from the national Mayi Kuwayu Study, 48% of Aboriginal and Torres Strait Islander adults preferred an AMS as a source[55] of non-urgent care, while 33% reported using one [9].
- The 2022–23 NATSIHS reported that 43% of Aboriginal and Torres Strait Islander people preferred an AMS or Community Clinic as their main source of primary health care [56]. Of those people who said their preferred source of primary health care was an AMS or Community Clinic, 58% said they had one as their usual source of care.
- In 2024–25, the number of NACCHO-affiliated Aboriginal Community Controlled Health Organisations (ACCHOs) across Australia was 146 [245]. The number of service delivery sites was more than 550.
- The National Agreement on Closing the Gap includes a Priority Reform target to increase the amount of government funding going through Aboriginal and Torres Strait Islander community-controlled organisations [29]. However, as of June 2025, there was no agreed framework or data in place to assess progress towards this target.

55 Participants could select multiple response options.

Governance and leadership

Community self-determination is associated with improved health and wellbeing [246].

New data are available on governance and leadership:

- As of 30 June 2025, there were 3,284 Aboriginal and Torres Strait Islander corporations registered under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act) [61].
- At July 2025, Aboriginal and Torres Strait Islander people comprised 4.0% of all federal parliamentarians [247].
- In 2025, 93% of Aboriginal and Torres Strait Islander people who were eligible to vote were enrolled to vote. Enrolment was highest in Tas (98%) and lowest in the NT (88%) [248].
- The National Agreement on Closing the Gap includes Priority Reforms to share decision-making between Aboriginal and Torres Strait Islander people and governments [29]. However, as of June 2025, there was no agreed framework or data in place to assess progress towards these targets.
- Australia's first statewide Treaty was signed in November 2025 by the First Peoples' Assembly of Victoria and the Victorian Government [249].

Injury and community safety

Injury includes physical or mental harm to a person that results from either intentional or unintentional contact with an object, substance or another person [250]. Injury, including assault and intentional self-harm, is closely linked to community-level protective and risk factors. Community safety, social cohesion and freedom from violence are central to strong connection to community. Higher rates of injury may reflect disruptions to these protective community structures.

New injury hospitalisation data are available:

- There were 46,233 hospital separations for injuries for Aboriginal and Torres Strait Islander people in 2023–24 [83], representing 12% of all Aboriginal and Torres Strait Islander hospitalisations (excluding dialysis) (Derived from [83]. Injury was the leading cause of hospitalisation (excluding dialysis). The age-standardised rate of hospitalisation was 52 per 1,000.
- In 2023–24, the leading external causes of injury-related hospitalisation were falls (10,062 separations: 22%), exposure to mechanical forces (8,369 separations: 18%), assault (7,641 separations: 17%), complications of medical and surgical care (6,699 separations: 14%) and transport accidents (4,299 separations: 9.3%) [83].
- In 2023–24, the crude rate of injury hospitalisations was 35 per 1,000 [251]. The rate was higher for males (38 per 1,000) than females (32 per 1,000). Rates were highest for those aged 25–44 years (48 per 1,000), followed by 65 years and over (43 per 1,000), 45–64 years (39 per 1,000), 15–24 years (38 per 1,000), 0–4 years (19 per 1,000) and 5-14 years (18 per 1,000).

New injury mortality data are available:

- In 2024, the leading causes of death by injury among Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT were [84]:
  - intentional self-harm (271 deaths, 5.5% of all Aboriginal and Torres Strait Islander deaths[56])
  - accidental poisoning (150 deaths, 3.1% of all Aboriginal and Torres Strait Islander deaths)
  - land transport accidents (128 deaths, 2.6% of all Aboriginal and Torres Strait Islander deaths).
- In 2022–23, there were 646 Aboriginal and Torres Strait Islander deaths from injury in NSW, Qld, WA, SA and the NT combined (males: 446; females: 200) [251]. The crude rate of injury mortality was 71 per 100,000 (males: 99 per 100,000; females: 44 per 100,000).

56 Total of 4,664 deaths among Aboriginal and Torres Strait Islander people for NSW, Qld, WA, SA and the NT.

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Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Injury** and **2024 *Overview*: Social and emotional wellbeing** for the latest available data:

- Proportion of Mayi Kuwayu study participants who reported feeling:
  - that where they live, local Mob makes community decisions 'a lot'
  - that where they live, the government has 'a lot' or 'a fair bit' of the final say.
- The national prevalence of self-reported experiences of violence and of serious accidents, including by remoteness
- Crude rates of hospitalised injury by jurisdiction and remoteness
- Injury mortality ('All external causes') by age, jurisdiction and remoteness, and leading specific causes of injury-related death as a percentage of total injury deaths
- The burden of disease attributable to injury, suicide and self-afflicted injury.

Key facts from the previous release

- In the 2022–23 NATSIHS, 8.9% of Aboriginal and Torres Strait Islander people (6.7% of males and 11% of females) aged 15 years and over had experienced violence in the last 12 months[57] [85].
- The Mayi Kuwayu study reported that 21% of respondents felt that where they live, local Mob makes community decisions 'a lot' [9].

Connection to family and kinship

CTG Outcome 13: Families and households are safe

CTG Outcome 16: Cultures and languages are strong, supported and flourishing

Connection to family and kinship is one of the seven overlapping domains in the Aboriginal and Torres Strait Islander SEWB model [46]. Family and kinship structures underpin Aboriginal and Torres Strait Islander cultures and play a central role in shaping health and wellbeing [3, 47, 252].

Protective factors that support strong connection to family and kinship include loving, stable, accepting and supportive family, adequate income, and culturally appropriate family-focused programs and services [46]. Identified risk factors include absence of family members, family violence, child neglect and abuse, and children in out-of-home care (OOHC).

This section of the *Overview* includes measures of family and kinship connection for which there are current available data, including family functioning, child removal and family violence. For data on household income, refer to *Social, political and environmental determinants of health.*

New since the previous release

Family functioning

Family functioning includes the ability to get along together and cope in hard times; talking with each other about things that matter; the ability to manage money well; having good support from Mob; and having knowledge and traditions that are passed onto children [253].

57 Includes witness to violence, abuse or violent crime.

New data are available on family functioning [253]:

- In 2018–2021, the Mayi Kuwayu study found that 57.9% of Aboriginal and Torres Strait Islander adults in Central Australia reported high/very high family functioning.
- Family functioning was greater with:
  - high community cohesion
  - high individual agency in community
  - Aboriginal language as a first language
  - frequent use of Aboriginal language high exposure to cultural practice and knowledge
  - multigenerational or extended family households.

Child removals

Child removal acts as a social determinant of health for Aboriginal and Torres Strait Islander people by impacting social, economic, cultural and environmental conditions [254].

For Aboriginal and Torres Strait Islander children in OOHC, the maintenance of strong relationships with family, community and Country is essential for SEWB [255].

New data are available on children in OOHC care:

- In 2024, there were 19,987 Aboriginal children in OOHC[58] [256]
- In 2023–24, there were 4,415 Aboriginal and Torres Strait Islander children admitted to OOHC, with an admission rate of 11 per 1,000 [255]
- In 2023–24 the rate of admissions of Aboriginal and Torres Strait Islander children to OOHC was highest in Vic (30 per 1,000) with the lowest rates reported in NSW and Tas (5.4 per 1,000 and 5.9 per 1,000 respectively) [255].

Family violence

The Aboriginal and Torres Strait Islander SEWB model identifies family violence as a risk factor for a strong connection to family and kinship [46].

New family assault data are available [257]:

- In 2023, police-recorded victimisation rates for Aboriginal and Torres Strait Islander people for assault by a family member ranged from 1,900 per 100,000 in NSW to 8,500 per 100,000 in the NT, across jurisdictions with available data (NSW, Qld, SA and the NT).

New family violence hospitalisation data are available [257]:

- In 2023–24, there were 4,433 family violence hospitalisations among Aboriginal and Torres Strait Islander people.
- Among these hospitalisations, the perpetrator was most frequently recorded as being a spouse or domestic partner (43%), other family member (25%), or parent (4.4%).
- In 2023–24, the rate of family violence hospitalisations among females (668 per 100,000) was 3.5 times the rate among males (193 per 100,000).
- In 2023–24, rates of family violence hospitalisations varied by remoteness and sex. For females, rates ranged from about 2,500 per 100,000 in remote areas to 350 per 100,000 in regional areas and 275 per 100,000 in major cities. For males, rates ranged from about 780 per 100,000 in remote areas to 94 per 100,000 in regional areas and 67 per 100,000 in major cities.

58 Does not include combined relatives or kin, combined Aboriginal and Torres Strait Islander relatives or kin, or other Aboriginal and Torres Strait Islander carers.

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Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Cultural identification**, **2024 *Overview*: Injury** and **2024 *Overview*: Social and emotional wellbeing** for the latest available data:

- Prevalence of psychological distress among those with a history of family removal
- Prevalence of self-reported family wellbeing
- Prevalence of Stolen Generations status
- Hospitalisations for family violence-related assaults by age and jurisdiction.

Key fact from the previous release

- In the 2022–23 NATSIHS, low or moderate distress was reported by 74% of Aboriginal and Torres Strait Islander respondents with no family removal history, compared with 60% of those with a removal history [85].

Mortality

CTG Outcome 1: Everyone enjoys long and healthy lives

In July 2020, the National Agreement on Closing the Gap refresh was created in consultation with Aboriginal and Torres Strait Islander people. The initiative aims to close the gap in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous Australians by 2031 [51]. Specific outcomes, targets and indicators aimed at policy direction and monitoring progress for mortality include life expectancy, all-cause mortality, leading causes of death and potentially avoidable mortality [57].

This section of the *Overview* contains data for rates of death, median age at death, causes of death, avoidable deaths, and infant, child and maternal mortality.

New since the previous release

Number and rate of deaths

New data on the number and rate of deaths are available [258]:

- There were 5,603 deaths in Australia in 2024 where the deceased person was identified as Aboriginal and/or Torres Strait Islander.
- In 2024, the age-standardised death rate for Aboriginal and Torres Strait Islander people was 9.9 per 1,000 population (males: 11 per 1,000; females: 8.8 per 1,000).
- In 2024, the age-standardised death rates for Aboriginal and Torres Strait Islander people varied by jurisdiction, with the highest rate occurring in the NT (14 per 1,000) and the lowest in Qld (8.8 per 1,000) (Table 6).
- In 2024, the crude death rate in NSW, Qld, WA, SA and the NT for Aboriginal and Torres Strait Islander people was 5.3 per 1,000. The rate for males was higher than that for females (5.8 per 1,000 and 4.8 per 1,000 respectively).

Notes on death rates, maternal deaths and avoidable deaths

Crude and age-standardised death rates, median age at death, age specific death rates and infant/child mortality rates (see the Glossary for further information) for Aboriginal and Torres Strait Islander people are only available for NSW, Qld, WA, SA and the NT as they are the jurisdictions with adequate levels of identification and sufficient numbers of deaths for mortality analysis to be undertaken [258]. The Aboriginal and Torres Strait Islander data for these measures are based on three-year averages, calculated for each calendar year, and then averaged. The reported rate for 2024 is based on the three-year averages for the 2022-2024 period.

Maternal deaths refer to deaths of women during pregnancy or up to 42 days after delivery [259]. Direct maternal deaths refer to those resulting from obstetric complications (including in pregnancy, labour, and in the first six weeks after delivery) from interventions, omissions, and incorrect treatment. Indirect maternal deaths refer to those resulting from a previously existing disease, or a disease that developed during pregnancy, that were not a direct result of obstetrics but aggravated by pregnancy. Coincidental deaths refer to deaths from unrelated causes (accidental and/or incidental) that occur during the pregnancy or up until six weeks after delivery.

Maternal mortality ratios (MMRs) are calculated by dividing the number of maternal deaths (direct and indirect) by the number of women who gave birth to babies weighing at least 400 grams or who reached at least 20 weeks gestation; this result is then multiplied by 100,000 [259].

Potentially avoidable deaths refer to deaths that could have been prevented with timely and effective health care, including early detection and effective treatment [260]. They are calculated using the population data for Australians less than 75 years of age. For Aboriginal and Torres Strait Islander people, chronic disease and injury caused the highest proportion of avoidable deaths [57].

See Appendix 1 for a discussion of data limitations for mortality statistics.

Table 6. Number of deaths and age-standardised death rates, Aboriginal and Torres Strait Islander people, NSW, Qld, WA, SA and the NT, 2024

Jurisdiction	Numbers	Aboriginal and Torres Strait Islander people
NSW	1,904	9.3
Qld	1,466	8.8
WA	704	11
SA	310	11
NT	529	14
Total for the selected jurisdictions	4,913	9.9

Notes:

1. Rates are per 1,000 population.
2. Rates are based on three-year averages; for Aboriginal and Torres Strait Islander data, rates are calculated for each calendar year and then averaged to reduce variability in annual rates.

Source: ABS, 2024 (Derived from [258])

Median age at death

New data on median age at death are available [258]:

- In 2024, the median age at death[59] for Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and the NT was 63.2 years (males: 60.8 years; females: 66.0 years).
- The median age at death varied across the selected jurisdictions, with NSW recording the highest value for both males and females (63.5 years and 69.0 years respectively) (Table 7). The lowest median age at death for males was reported in WA (56.6 years) and for females in the NT (61.2 years).

59 The median age at death is the age below which 50% of people die.

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Table 7. Median age at death (in years), Aboriginal and Torres Strait Islander people, by sex, NSW, Qld, WA, SA and the NT, 2024

	Aboriginal and Torres Strait Islander people		
Jurisdiction	Males	Females	Persons
NSW	63.5	69.0	65.7
Qld	60.9	66.6	63.7
WA	56.6	63.6	60.0
SA	60.2	64.1	61.8
NT	56.8	61.2	58.7
Total for the selected jurisdictions	60.8	66.0	63.2

Notes:

1. Information is not available for the other jurisdictions because of the relatively small numbers of deaths recorded.
2. Median age at death is the age below which 50% of deaths occur.

Source: ABS, 2024 [258]

Age-specific death rates

New data on age-specific death rates are available [258]:

- In 2024, in NSW, Qld, WA, SA and the NT, the death rate for Aboriginal and Torres Strait Islander people for all ages was 528 per 100,000.
- The age-specific death rates increased with age from 5–14 years, with the highest rate reported for those 75 years and over (7,917 per 100,000), followed by 65–74 years (2,727 per 100,000) and 55–64 years (1,414 per 100,000). The lowest rate was for those aged 5–14 years (18 per 100,000).

Infant mortality

- The infant mortality rate (IMR) is the number of deaths of children aged less than one year in a calendar year per 1,000 live births in the same calendar year [258].
- In NSW, Qld, WA, SA and the NT in 2024, the Aboriginal and Torres Strait Islander IMR was 6.2 per 1,000 live births, with rates higher for males (6.8 per 1,000) compared with females (5.6 per 1,000) [258].
- The highest IMR was in the NT (13 per 1,000), followed by WA (7.5 per 1,000), Qld (7.2 per 1,000) and SA (5.5 per 1,000). The lowest rate was in NSW (3.9 per 1,000) [258].
- In the five-year period 2019–2023, in NSW, Qld, WA, SA and the NT, 565 infant deaths represented 83% of all deaths among 0-4 year old Aboriginal and Torres Strait Islander children (677 deaths) (Derived from [92]).
- For the selected jurisdictions combined, the IMR for Aboriginal and Torres Strait Islander infants was 5.4 per 1,000, with the highest rate in the NT (14 per 1,000), followed by Qld (5.7 per 1,000), WA (5.5 per 1,000), NSW (3.9 per 1,000) and SA (3.8 per 1,000) [92].

Child mortality

- For 2019–2023, in NSW, Qld, WA, SA and the NT there were 112 deaths among Aboriginal and Torres Strait Islander children aged 1-4 years (Derived from [92, 99]).
- The child mortality rate for Aboriginal and Torres Strait Islander children aged 0–4 years was 144 per 100,000 [92]. For the selected jurisdictions, the NT had the highest child mortality rate (324 per 100,000), followed by Qld (163 per 100,000), WA (150 per 100,000), SA (101 per 100,000) and NSW (100 per 100,000).

Causes of death

New data on causes of death are available [84]:

- Ischaemic heart disease (IHD) was the leading specific cause of death for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT in 2024. IHD accounted for 472 deaths, representing 9.6% of all deaths for Aboriginal and Torres Strait Islander people (total 4,913 for selected jurisdictions).
- In 2024, the other leading specific causes of death were chronic lower respiratory diseases: 369 deaths (7.5%), diabetes: 332 deaths (6.8%), cancer of trachea, bronchus and lung: 329 deaths (6.7%) and intentional self-harm (suicide) 271 deaths (5.5%).
- In 2024, for Aboriginal and Torres Strait Islander males living in NSW, Qld, WA, SA and the NT, the leading causes of death were IHD: 309 deaths, intentional self-harm: 217 deaths, cancer of trachea, bronchus and lung: 186 deaths, chronic lower respiratory diseases: 182 deaths and diabetes: 159 deaths. For females, the leading causes of death were chronic lower respiratory diseases: 187 deaths, diabetes: 173 deaths, IHD: 163 deaths, cancer of trachea, bronchus and lung: 143 deaths, and dementia (including Alzheimer's disease): 111 deaths.
- In 2020–2024, the age-standardised death rate for Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT was 936 per 100,000. The age-standardised death rate for the leading cause of death was IHD (105 per 100,000). The next leading causes of death were chronic lower respiratory diseases (73 per 100,000) and diabetes (70 per 100,000).
- In 2020–2024, age-specific rates, from 15 years of age and above, for underlying causes of death among Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT, indicated that intentional self-harm[60] was the leading cause of death for those aged 15–24 years (35 per 100,000), 25–34 years (52 per 100,000) and 35–44 years (50 per 100,000). The leading cause of death for the 45–54 years, 55-64 years and 65-74 years age-groups was IHD at rates of 105 per 100,000; 167 per 100,000 and 291 per 100,000 respectively. For Aboriginal and Torres Strait Islander people aged 75 years and over, dementia (including Alzheimer's disease) was the leading cause of death at 865 per 100,000 population.

Maternal mortality

New data on maternal mortality are available [74]:

- In Australia, for 2014–2023, 27 of the 197 maternal deaths reported were of Aboriginal and Torres Strait Islander women (Indigenous status was not reported in 13 of the total deaths). Of these 27 Aboriginal and Torres Strait Islander maternal deaths, 12 were direct and 15 were indirect.
- In 2014–2023, the MMR for Aboriginal and Torres Strait Islander women was 19 per 100,000 women who gave birth.

Avoidable deaths

New data on avoidable deaths are available [92]:

- In 2019–2023, there were 8,972 deaths from avoidable causes among Aboriginal and Torres Strait Islander people living in NSW, Qld, WA, SA and the NT at an age-standardised rate of 301 per 100,000.
- For 2019–2023, the highest rate was in the NT (534 per 100,000) followed by WA (405 per 100,000), SA (331 per 100,000), Qld (270 per 100,000) and NSW (233 per 100,000).

60 Care needs to be taken in interpreting figures relating to intentional self-harm due to a revision process for coroner certified deaths and coding.

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Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Mortality** for the latest available data:

- Number of registered deaths of Aboriginal and Torres Strait Islander people by jurisdiction
- Proportion of total population deaths that were registered as deaths of Aboriginal and Torres Strait Islander people, by jurisdiction
- Number of registered deaths for which no Indigenous status was reported
- Life expectancy, including by Indigenous status, sex, age group, jurisdiction and remoteness
- Number of maternal deaths, by cause
- Proportion of Aboriginal and Torres Strait Islander deaths that were classified as avoidable (5-year period)
- Rates of death from avoidable causes by sex, age, jurisdiction and contributing health condition (5-year period).

Key fact from the previous release

- Life expectancy for Aboriginal and Torres Strait Islander people born in Australia in 2020–2022 was 71.9 years (males) and 75.6 years (females) [261].

Hospitalisations

Statistics on hospitalisation provide some indication of the burden of disease in the population [262]. They are, however, a poor reflection of the extent and patterns of treatable illness in the community because they only represent the most serious illnesses, which require hospitalisation [57]. Hospitalisations are also influenced, to some extent, by the geographic accessibility of hospitals and variations in admission policies and practices for illnesses [263, 264]. As is the case with other major health-related data collections (such as births and deaths), the identification of Indigenous status in hospital data collections is incomplete (see Appendix 1) [264].

Another limitation of the available hospital statistics as an indicator of the health of the population is that they relate to episodes of hospitalisation rather than to individual patients [263, 265]. Also, it is difficult to analyse patterns of care for patients hospitalised multiple times (for example for kidney dialysis) from the current national hospitalisation data [83, 263].

New since the previous release

Hospital separation rates

New hospital separation rate data are available for 2023–24 [83]:

- Of the 12.6 million hospital separations in Australia, 690,953 (5.5%) were identified as being for Aboriginal and/or Torres Strait Islander people (Table 8).
- Of these identified hospital separations, 91% were for Aboriginal people, 3.9% were for Torres Strait Islander people and 5.1% were for people who identified as being both Aboriginal and Torres Strait Islander.
- The overall age-standardised hospital separation rate for Aboriginal and Torres Strait Islander people was 900 per 1,000 population.
- Forty-two per cent (42%) of Aboriginal and Torres Strait Islander separations were for males and 58% were for females.

- The largest proportion of separations was for those aged 65+ years (19% of separations), followed by ages 55-59 years (11%), 50-54 years (11%) and 60-64 years (10%), and the smallest was for those aged 10-14 years (1.6%).
- The highest age-standardised hospital separation rate was for Aboriginal and Torres Strait Islander people living in the NT (2,166 per 1,000) and the lowest in Tas (401 per 1,000) (Table 8).

Table 8. Numbers of hospital separations and age-standardised hospital separation rates for Aboriginal and Torres Strait Islander people, by jurisdiction, 2023-24

Jurisdiction	Number	Rate
NSW	136,893	502
Vic	47,539	762
Qld	200,777	943
WA	117,979	1,344
SA	40,055	1,017
Tas	n.p.	401
ACT	n.p.	726
NT	n.p.	2,166
Australia	690,953	900

Notes:

1. Age-standardised rates per 1,000 population.
2. Rates for Tas, the ACT and the NT are for public hospitals only; data for private hospitals in Tas, the ACT and the NT are included in the Australia row.

Source: AIHW, 2025 [83]

Causes of hospitalisation

New data are available for causes of hospitalisation [83]:

- In 2023–24, the most common principal diagnosis (International Classification of Diseases (ICD)) for the hospitalisation of Aboriginal and Torres Strait Islander people in Australia was 'Factors influencing health status and contact with health services', responsible for 44% of Aboriginal and Torres Strait Islander hospital separations (305,127 of 690,953 separations). Many of these separations relate to dialysis and involve repeat admissions for the same people.
- The next leading principal diagnoses (ICD) for hospitalisation among Aboriginal and Torres Strait Islander people were 'Injury, poisoning and certain other consequences of external causes' (including motor vehicle accidents, assaults, self-inflicted harm and falls), responsible for 46,233 hospital separations (6.7% of all separations) and 'Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified', responsible for 42,715 hospital separations (6.2% of all separations) (Table 9).

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Table 9. Numbers, proportions (%), and age-standardised hospitalisation rates for leading causes of hospital separations among Aboriginal and Torres Strait Islander people, Australia, 2023–24

Principal diagnosis (ICD)	Number of separations	Proportion of separations (%)	Age-standardised separation rate (per 1,000 population
Injury, poisoning and certain other consequences of external causes	46,233	6.7	52
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	42,715	6.2	52
Diseases of the digestive system	38,944	5.6	47
Pregnancy, childbirth and the puerperium	36,201	5.2	33
Diseases of the respiratory system	35,352	5.1	40
Mental and behavioural disorders	29,289	4.2	34
Diseases of the genitourinary system	20,714	3.0	26
Diseases of the musculoskeletal system and connective tissue	20,695	3.0	29
Diseases of the circulatory system	20,169	2.9	30
Endocrine, nutritional and metabolic diseases	14,694	2.1	19
Diseases of the skin and subcutaneous tissue	14,646	2.1	17
Neoplasms	14,111	2.0	21
Diseases of the nervous system	11,696	1.7	14
Certain infectious and parasitic diseases	11,514	1.7	13
Factors influencing health status and contact with health services	305,127	44	448
All causes	690,953	100	907

Notes:

1. Age-standardised rates per 1,000 population.
2. Some principal diagnoses have been excluded.

Source: AIHW, 2025 [83]

Potentially preventable hospitalisations

Potentially preventable hospitalisations are admissions that might have been avoided if people had received timely and appropriate preventive care and early treatment, typically provided through primary care and community-based health services [266]. Rates for potentially preventable hospitalisations, including those for chronic conditions, acute conditions and vaccine preventable conditions, may be used as an indirect measure of access to effective primary care [267].

New data for potentially preventable hospitalisations are available for 2023–24 [83]:

- The overall age-standardised rate of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people was 69 per 1,000.
- The rate for chronic conditions was 31 per 1,000 (including 6.9 per 1,000 for diabetes complications).
- Information by jurisdiction (Table 10) reveals that the NT had the highest rate for potentially preventable hospitalisations at 144 per 1,000, followed by WA at 88 per 1,000.
- The overall rate of potentially preventable hospitalisations was highest in remote areas (126 per 1,000) (Table 11).
- When comparing types of preventable hospitalisation by remoteness, vaccine-preventable conditions showed the largest disparity: the rate in remote areas (32 per 1,000) was approximately 5.3 times that in major cities (6.1 per 1,000) and 4.5 times that in regional areas (7.1 per 1,000).

Table 10. Age-standardised hospital separation rates for selected potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people, by condition type, by jurisdiction, all hospitals, 2023–24

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Vaccine preventable conditions	5.1	6.7	8.2	15	12	1.9	7.0	47	11
Acute conditions	19	24	33	38	28	14	27	51	29
Chronic conditions	21	33	34	38	35	16	29	54	31
Total	44	62	73	88	72	31	63	144	69

Note: Rates are age-standardised and per 1,000 population.

Source: AIHW, 2025 [83]

Table 11. Age-standardised hospital separation rates for potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people, by condition type, by remoteness, 2023–24

	Vaccine preventable conditions	Acute conditions	Chronic conditions	Total
Major cities	6.1	24	24	53
Regional	7.1	25	29	60
Remote	32	50	50	126
Total	11	29	31	69

Notes: Age-standardised rates are per 1,000 population.

Source: AIHW, 2025 [83]

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Unchanged since the previous release

No new data are available on the following indicators since the previous release. See the **2024 *Overview*: Hospitalisation** for the latest available data:

- Crude rate of hospital separations (excluding dialysis)
- Age-specific hospitalisation rates (excluding dialysis), including by sex.

Key fact from the previous release

- In 2017-19, the crude rate of hospital separations for Aboriginal and Torres Strait Islander people was 369 per 1,000 (excluding dialysis) [57].

Appendix 1: Limitations of source information

The following section outlines some of the current limitations of the sources of population, prevalence, hospitalisation, mortality and other data used in this *Overview*.

Population

The ABS produces estimates of the resident Aboriginal and Torres Strait Islander population following each census [268]. These estimates are commonly used as the denominator for the calculation of rates of disease and mortality among Aboriginal and Torres Strait Islander people.

The ABS has made considerable efforts to achieve accurate counts of the Aboriginal and Torres Strait Islander population in the five-yearly Australian censuses [34]. Despite these efforts, there are impacts on data quality such as non-responses for identification.

The number of people who identified as Aboriginal and/or Torres Strait Islander increased by 25% between the 2016 and 2021 Censuses [269]. Less than half this increase is explained by demographic factors such as births between censuses; the rest is explained by non-demographic factors including changes in the way that people identify. Because estimates of the life expectancy of Aboriginal and Torres Strait Islander people are based on data from the census, there is a risk that improvements in life expectancy over time may be attributed to improvements in health rather than to changes in identification [270, 271].

As of 30 June 2021, 88% of Aboriginal and Torres Strait Islander Australians were reported to be living in NSW, Qld, WA, SA and the NT (Derived from [268]) and the data from these jurisdictions are considered of sufficient quality for reporting on many health conditions such as cancer, and vital events such as deaths [258, 272].

Health data and vital statistics

A key concern about the various collections of health and vital statistics is that Aboriginal and Torres Strait Islander people are not always correctly identified. There is currently no national approach on how to determine Aboriginal and/or Torres Strait Islander status where classification is inconsistent or missing across multiple data sets, which may lead to different methodologies being applied and difficulties in the interpretability and comparability of data [13, 273].

Limitations of some of the specific data collections used in the *Overview* are outlined below.

Births

Variations in data collection practices and in the propensity of parents to self-identify as Aboriginal and Torres Strait Islander mean that Aboriginal and Torres Strait Islander births may be under-reported [274]. The accuracy of measures of Aboriginal and Torres Strait Islander fertility may also be affected by lags in birth registrations.

The ABS estimated that the proportion of Indigenous births identified correctly was 96% in 2002-2006, a significant improvement over the level for previous years [275]. Completeness of identification varied across the country, with only Vic, Qld, WA, SA and the NT having levels above 90%. All jurisdictions are working towards improving the quality of Indigenous identification in perinatal data collections [57].

An increase in Aboriginal and Torres Strait Islander births recorded in 2024 was largely attributable to a change in how the ABS derived a child's Indigenous status [68]. Before 2024, a child was recorded as Aboriginal and/or Torres Strait Islander if either parent identified as such on the birth registration form. From 2024, the ABS also incorporated a new item on the form that directly records whether the child is identified as Aboriginal and/or Torres Strait Islander. This additional information was used for births registered in 2024 in NSW, WA, Tas and the NT.

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Hospitalisations

The level of identification in hospital admissions is variable, but it was estimated that 88% of Aboriginal and Torres Strait Islander patients were correctly identified in Australian public hospital admission records in 2011-12 [276]. The accuracy of the identification of Indigenous people varied between states and territories, from 98% in the NT to 58% in the ACT. The accuracy of identification also varied with remoteness level, from 99% in very remote areas to 77% in major cities. It has been suggested that a more accurate number of admissions is approximately 9% higher than recorded [227]. It is unknown to what extent Indigenous people are under-identified in private hospital admissions data.

All hospitalisation data for Tas, the ACT and the NT include only public hospitals [227].

Deaths

A key concern with mortality data is that not all Aboriginal and Torres Strait Islander deaths are correctly identified in death registrations [258, 273]. The level of Aboriginal and Torres Strait Islander mortality is therefore likely to be underestimated.

While most Aboriginal and Torres Strait Islander deaths are registered, and while Indigenous identification data are provided for most registered deaths (99.8% in 2024) (Derived from [258]), some of these identification data are known to be inaccurate [258]. Estimating the proportions of deaths identified correctly is not simple, so it is difficult to calculate the actual number of Indigenous deaths occurring and the corresponding rates. Mortality analysis is usually restricted to the five jurisdictions where identification levels and numbers of deaths are considered sufficient to support analysis: NSW, Qld, WA, SA and the NT [272]. The ABS uses estimates of the proportions of registered deaths correctly identified as Indigenous in preparing its life tables, the source of life expectancy figures [261, 277].

In recent years, the ABS has enhanced its methods for deriving Indigenous status in death registration data [258]. These improvements have resulted in increases in the number of deaths both identified as Aboriginal and Torres Strait Islander and as non-Indigenous, and a corresponding reduction in cases where Indigenous status is recorded as unknown or not stated. Accordingly, caution is warranted when interpreting time series data.

Due to concerns about the mortality rates of Aboriginal and Torres Strait Islander people relative to the total population, there has been ongoing data integration to investigate the quality of the data using health and death records by the ABS and state and territory government departments [273].

Burden of disease

As burden of disease analysis makes use of Aboriginal and Torres Strait Islander population, mortality and disease/risk factor prevalence data, it is subject to the limitations that characterise these types of data [93]. For example, the reliability of estimates of fatal burden are affected by the potential under-identification of Indigenous status in death registrations.

The accuracy of estimates of burden are also affected by gaps in national Aboriginal and Torres Strait Islander data collection [93]. For example, estimates of the burden attributable to COPD are currently based on a small study from WA because national data do not exist.

Other limitations affecting burden of disease analysis for Aboriginal and Torres Strait Islander people include small numbers in the data, the lack of suitable adjustment factors to correct for under-identification in all data sources, the inability of the current method of estimating fatal burden to account for multiple causes of death, and unknown levels of Indigenous under-identification in key data collections (such as cancer incidence) [93].

National surveys

This *Overview* refers extensively to the results of the 2022-23 NATSIHS [85], as well as to other surveys.

Most data collected by major surveys are self-reported. Self-reported survey data are open to interpretation; they do provide insight into an individual's view of their health, but the conditions reported may not have been diagnosed by a health professional [85]. Self-reported data can underestimate conditions about which respondents may not be aware (such as high blood pressure) or be reluctant to disclose (such as drug use).

Changes in aspects like survey methodology can cause difficulties in the analysis and synthesis of information for periods of time (i.e. trend analysis). Survey results are also subject to sampling errors. Major national surveys are generally conducted at long intervals (such as every six years), which means that relevant information is often dated.

Other data collections

Other data collections on which this *Overview* draws include those related to notifiable diseases (surveillance data), SEWB, AOD, community services, primary health care, potentially preventable hospitalisations, screening programs, health registries and pathology.

The levels of Aboriginal and Torres Strait Islander people's identification in many of these collections vary in their degree of completeness, which questions the quality and accuracy of the various estimates of health status [13].

The ABS, the AIHW and state and territory authorities have worked together to improve the accuracy of Indigenous status identification in various collections, including:

- pathology forms
- primary health care data
- AOD treatment services
- mental health services
- community services data collection [278] (cited in [273]).

COVID-19 testing highlighted the poor level of identification on pathology forms used for testing [279-281], and work is now being undertaken to improve Indigenous identification on pathology forms used by both public and private laboratories.

STI and BBV surveillance data must be interpreted with care, as notifications and trends may be influenced by community and targeted testing levels, data capture and access to health services [204]. In 2024, all jurisdictions reported Aboriginal and Torres Strait Islander status for at least 50% of HIV and infectious syphilis notifications [174]. However, caution is advised when interpreting these data as being fully representative of national epidemiology among Aboriginal and Torres Strait Islander peoples, because the 50% reporting threshold is low.

National agencies are working to overcome data gaps to better understand health conditions among Aboriginal and Torres Strait Islander people. For example, in 2025, the AIHW began a project which explores Indigenous identification among people with dementia in linked data [282], with the aim to support analysis of service use and health outcomes for Aboriginal and Torres Strait Islander people living with dementia.

Eliminating discrimination and racism within healthcare is a critical component in creating an environment where people feel safe and respected to disclose their Aboriginal and Torres Strait Islander identity [174].

Data gaps

There are significant gaps in the national data for important areas of Aboriginal and Torres Strait Islander health, meaning that accurate prevalence estimates for certain conditions are unable to be calculated. Examples include early childhood hearing loss and OM [283] and intergenerational trauma [284].

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Limitations of aggregated data

The majority of data referred to in this *Overview* are aggregated at national or state/territory levels. Data about Aboriginal and Torres Strait Islander people which are aggregated at these levels does not align with the boundaries or structures of Indigenous communities [285]. The lack of data disaggregation at the community level can prevent informed decision-making in areas like health, wellbeing, and policy development. It is argued that a more effective approach would involve breaking down data by specific Aboriginal and Torres Strait Islander groups or regions, enabling Indigenous communities to make informed, data-driven decisions about their own needs and priorities [21, 285]. To facilitate this outcome, partnerships need to be established between Aboriginal and Torres Strait Islander people and government agencies to improve collection, access, management and use of data, including communities having ownership and control over their data.

Other limitations

For certain conditions or outcomes, numbers must be presented over multiple years because the numbers are small when disaggregated by sex, age and geographic area.

Time periods for which detailed information is available tend to vary substantially; this means that documents like this *Overview* need to draw on information from various time periods in attempting to compile a comprehensive picture.

Glossary

Aboriginal and Torres Strait Islander
people who identify themselves as being of Aboriginal and/or Torres Strait Islander origin. See also **Indigenous**

age-specific fertility rate
the number of live births to women in a specified age-group in one year per 1,000 women in the same age-group

age-specific rate
an estimate of the number of people experiencing a particular event in a specified age-group relative to the total number of people 'at risk' of that event in that age-group

age-specific death rate
the number of deaths of persons of a specific age-group in a calendar year per 1,000 persons of the same age-group. For the purposes of this report, the age-specific death rate is calculated per 100,000 persons of the same age-group so the rate can be expressed as a whole number

age-standardisation
a method of removing the influence of age when comparing populations with different age structures. This is necessary because the rates of many diseases increase with age. The age structures of the different populations are converted to the same 'standard' structure; then the disease rates that would have occurred with that structure are calculated and compared. This method is used when making comparisons for different periods of time, different geographic areas and/or different population sub-groups (e.g. between one year and the next, and states and territories). They have been included for users to make comparisons that may not be available in this report

avoidable mortality (deaths)
a death that, theoretically, could have been avoided given an understanding of causation, the adoption of available disease prevention initiatives and the use of available health care

burden of disease
the quantified impact of a disease or injury on a population using the **disability-adjusted life year** measure

cause of death
as entered on the medical certificate of cause of death - refers to all diseases, morbid conditions or injuries that either resulted in or contributed to death

child mortality rate
the number of deaths in a given period among children aged 0–14 years per 100,000 children of the same age. Can also be presented for specific age-groups within this age range, such as for children aged 0–4 years

crude rate
the number of new cases (crude incidence rate) or deaths (crude death rate) due to a disease in the total population that could be affected, without considering age or other factors

disability-adjusted life year
a year of healthy life lost, either through premature death or living with a disability due to illness or injury

fatal burden
the burden of dying prematurely from a disease or injury as measured by **years of life lost**. It offers a way to compare the impact of different diseases, conditions or injuries on a population. See **non-fatal burden**

fertility rate
see **age-specific fertility rate** and **total fertility rate**

hospital separation
an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care

hospital separation rate
the total number of episodes of care for admitted patients divided by the total number of persons in the population under study. Often presented as a rate per 1,000 or 100,000 members of a population. Rates may be crude or standardised

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hospital separations
the total number of episodes of care (also hospitalisations) for admitted patients, which can be total hospital stays (from admission to discharge, transfer or death) or portions of hospital stays beginning or ending in a change of type of care (for example, from acute to rehabilitation) that cease during a reference period

hospitalisation
an episode of admitted patient care, which can be either a patient's total stay in hospital (from admission to discharge, transfer or death), or part of a patient's stay in hospital that results in a change to the type of care (for example, from acute care to rehabilitation)

incidence
the number of instances of illness commencing, or of persons falling ill, during a given period in a specified population

incidence rate
the number of instances of illness commencing, or of persons falling ill, during a given period in a specified population divided by the population at risk

Indigenous
term used to refer collectively to the two Indigenous sub-populations within Australia – Australian Aboriginal and Torres Strait Islander people

Indigenous data sovereignty
Aboriginal and Torres Strait Islander peoples governing the creation, collection, ownership and application of their data, including health data

infant mortality
the death of a live-born child who dies before reaching his/her first birthday

infant mortality rate
the number of deaths of children under one year of age in a specified period per 1,000 live births in the same period

International Classification of Diseases
WHO's internationally accepted classification of death and disease

life expectancy
predicted number of years of life remaining to a person if the present pattern of mortality does not change. It is a statistical abstraction based on current age-specific death rates

maternal mortality
pregnancy-related deaths occurring to women during pregnancy or up to 42 days after delivery

maternal mortality ratio
number of maternal deaths divided by the number of confinements (expressed in 100,000s)

median age at death
the age above and below which 50% of deaths occurred

morbidity
state of being diseased or otherwise unwell

mortality
number of deaths in a population during a given time period

non-fatal burden
the burden from living with ill health, as measured by **years lived with disability**

non-Indigenous
a person who does not identify as Aboriginal and/or Torres Strait Islander

potentially preventable hospitalisations
hospital separations from a specified range of conditions where hospitalisation is considered to be largely preventable if timely and adequate care had been provided through population health services, primary care and outpatient services

prevalence
the number of instances of a given disease or other condition in a given population at a designated time

protective factors
health determinants that can influence health risks and/or outcomes in positive ways

rate
one number (the numerator) divided by another number (the denominator). The numerator is commonly the number of events in a specified time. The denominator is the population at risk of the event. Rates (crude, age-specific and age-standardised) are generally multiplied by a number such as 100,000 to create whole numbers

risk factor
an attribute or exposure that is associated with an increased probability of a specified outcome, such as the occurrence of a disease. A risk factor is not necessarily a causal factor

self-reported data
data based on how an individual perceives their own health. It relies on survey participants being aware, and accurately reporting, their health status and health conditions, which is not as accurate as data based on clinical records or measured data

standardised rate
the number of new cases (standardised incidence rate) or deaths (standardised death rate) due to a disease for a particular population after adjustment has been made for differences in the age structures of this population and a reference population. See **age-standardisation**

total fertility rate
the number of live births a woman would have if, throughout her reproductive years, she had children at the rates prevailing in the reference calendar year. It is the sum of the **age-specific fertility** rates for that calendar year

years lived with disability
measures the years of what could have been a healthy life that were instead spent in states of less than full health. Years lived with disability represent **non-fatal burden**

years of life lost measures years of life lost due to premature death, defined as dying before the ideal lifespan (based on the lowest observed death rates from multiple countries). Years of life lost represent **fatal burden**

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Abbreviations/acronyms

ABS - Australian Bureau of Statistics

ACCO - Aboriginal community controlled organisation

ACT - Australian Capital Territory

AEEHS - Australian Eye and Ear Health Survey

AHMAC - Australian Health Ministers Advisory Council

AI – Artificial intelligence

AIHW - Australian Institute of Health and Welfare

AIR - Australian Immunisation Register

AMS - Aboriginal medical services

ANZDATA - Australia and New Zealand Dialysis and Transplant Registry

AOD - Alcohol and other drugs

ARF - Acute rheumatic fever

CKD - Chronic kidney disease

COPD - Chronic obstructive pulmonary disease

COVID-19 - Coronavirus disease

CSOM - Chronic suppurative otitis media

CTG - Closing the Gap

CVD - Cardiovascular disease

DAA - Direct-acting antiviral

ESRD - End-stage renal disease

FNQ – Far North Queensland

GDM - Gestational diabetes mellitus

GP - General practitioner

HBV - Hepatitis B virus

HCV - Hepatitis C virus

HD - Haemodialysis

Hib - *Haemophilus influenzae* type b

HIV - Human immunodeficiency virus

HPV - Human papillomavirus

ICD - International Classification of Diseases

IHD - Ischaemic heart disease

IMD - Invasive meningococcal disease

IMR - Infant mortality rate

IPD - Invasive pneumococcal disease

LBW - Low birthweight

LSIC - Longitudinal Study of Indigenous Children

MMR - Maternal mortality ratio

MMR - Measles, mumps and rubella

NACCHO - National Aboriginal Community Controlled Health Organisation

NAPLAN - National Assessment Program – Literacy and Numeracy

NATSIHS - National Aboriginal and Torres Strait Islander Health Survey

NIP - National Immunisation Program

NSP - Needle Syringe Program

NSW - New South Wales

NT - Northern Territory

NTRAI - Northern Territory Remote Aboriginal Investment

OM - Otitis media

OOHC – Out-of-home care

PD - Peritoneal dialysis

Qld - Queensland

RHD - Rheumatic heart disease

SA - South Australia

SCRGSP - Steering Committee for the Review of Government Service Provision

SDAC - Survey of Disability, Ageing and Carers

SEWB - Social and emotional wellbeing

STI - Sexually transmissible infection

Tas - Tasmania

TB - Tuberculosis

TIS - Tackling Indigenous Smoking

VI - Vision impairment

Vic - Victoria

VSU - Volatile substance use

WA - Western Australia

WHO - World Health Organization

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