# 8 Healthy lives

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| Strategic areas for action |
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Aboriginal and Torres Strait Islander people’s understanding of health is holistic and encompasses physical, mental, cultural and spiritual health. Good health and wellbeing depends on the network of individuals, family, kin, and community, and it recognises an individual’s connection to land (which is central to wellbeing), culture, spirituality and ancestors. If the harmony of these interrelations is disrupted, it can lead to Aboriginal and Torres Strait Islander ill health.

Health outcomes directly affect the quality of people’s lives, including their ability to socialise with family and friends, to participate in the community and to work and earn an income. Physical health outcomes reflect such things as a healthy living environment and access to and use of health and community services. Mental health outcomes are related to a complex range of medical issues, historical and lifestyle factors, and the stressors associated with entrenched disadvantage and drug and substance misuse.

Culture is central to Aboriginal and Torres Strait Islander people’s health and wellbeing; their health outcomes are inextricably linked to their history and the impacts of trauma across generations (see chapter 1 *About this report* and chapter 4 *COAG targets and headline indicators*, section 4.1 *Life expectancy*). Barriers to health service access due to remoteness or cultural safety, and racism within health and other service systems, can also affect health and wellbeing. Place-based approaches that are community led and designed and delivered by Aboriginal and Torres Strait Islander people could provide better outcomes in the long run (Commonwealth of Australia 2017).

The following indicators are included in the ‘Healthy lives’ strategic area:

* access to primary health care (section 8.1) — the first point of contact with the health system enables prevention, early intervention, case management and ongoing care. It can also help to address health risk behaviours
* potentially preventable hospitalisations (section 8.2) — many hospital admissions could be prevented if more effective non‑hospital care were available, either at an earlier stage in disease progression or as an alternative to hospital care
* potentially avoidable deaths (section 8.3) — access to, and use of, quality health care can make a substantial contribution to reducing potentially avoidable deaths
* tobacco consumption and harm(section 8.4) — despite progress, smoking is still the single biggest contributor to the burden of preventable ill health and death
* obesity and nutrition (section 8.5) — maintaining a healthy body weight protects against infection, and reduces the risk of chronic disease and premature death
* oral health (section 8.5) — oral health is an important part of a person’s overall health and wellbeing and reflects diet, dental hygiene and access to dental services
* mental health (section 8.7) — mental health plays an important role in social and emotional wellbeing; it includes mental illness and the overall mental wellbeing of an individual, with the latter influenced by a range of factors including domestic violence, substance misuse, imprisonment and family breakdown
* suicide and self‑harm (section 8.8) — suicide and self‑harm cause great grief, with mental illness the largest risk factor for suicide.

Several COAG targets and headline indicators reflect the importance of healthy lives:

* life expectancy (section 4.1)
* young child mortality (section 4.2)
* disability and chronic disease (section 4.9).

Other headline indicators can be directly influenced by health outcomes:

* employment (section 4.7)
* household and individual income (section 4.10).

Outcomes in the healthy lives area can be affected by outcomes in all other strategic areas, and can influence outcomes in other areas.

Attachment tables for this chapter are identified in references throughout this chapter by an ‘A’ suffix (for example, ‘table 8A.1.1’). These tables can be found on the web page (www.pc.gov.au/oid2020).

### References

Commonwealth of Australia 2017, *My Life My Lead – Opportunities for Strengthening Approaches to the Social Determinants and Cultural Determinants of Indigenous Health: Report on the National Consultations*, Department of Health, Canberra.

## 8.1 Access to primary health care[[1]](#footnote-1)

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| Box 8.1.1 Key messages |
| * Primary health care is generally the first contact a person has with Australia’s health system, when health care is needed. * Primary health care access and use can help to improve and maintain people’s health through health promotion, prevention and early intervention services as well as the treatment of illness, and the management of chronic conditions. * The proportion of Aboriginal and Torres Strait Islander people reporting their health as excellent or very good in 2018-19 (45 per cent) is largely unchanged from 2002 (44 per cent) following a decrease in 2012-13 (39 per cent). While there is no clinical benchmark on the ideal level, the proportion for Aboriginal and Torres Strait Islander people is lower than for non‑Indigenous people. * What is more, while there were no substantial differences across Indigenous regions for those reporting their health status as excellent or very good, this was not the case for the proportions reporting their health status as fair or poor, which ranged from 13 to 31 per cent in 2018­19. * Aboriginal and Torres Strait Islander people’s health status is affected by a range of factors — including access to and uptake of health checks, vaccinations, and other primary health services. * Over time, immunisation rates and health checks for Aboriginal and Torres Strait Islander people have increased, but there is scope for further improvement. * In 2018-19, most (87 per cent) Aboriginal and Torres Strait Islander adults visited a primary health care professional such as a general practitioner (GP), specialist, nurse, sister and/or Aboriginal and Torres Strait Islander health worker at least once in the previous 12 months. Fewer (about one in four) went to a dentist in the previous six months. * However, several known barriers limit Aboriginal and Torres Strait Islander people from accessing these services when needed. In 2018-19, about one in five Aboriginal and Torres Strait Islander adults had not visited a GP/clinic doctor and about one in four had not visited a dentist on at least one occasion when needed in the previous 12 months. Half of those who needed to go to a GP/clinic doctor or dentist but didn’t, reported not going for personal reasons, including being too busy, discrimination and culturally unsafe services. Logistics (geography and time) were another important reason for not going to the GP/clinic doctor (29 per cent) and cost was a factor for not going to the dentist (42 per cent). * Removing barriers to access and providing culturally safe primary healthcare services is key to improving the health of Aboriginal and Torres Strait Islander people. Research suggests that Aboriginal Community Controlled Health Services (ACCHS) may improve both uptake of, and continued engagement with, health care services for Aboriginal and Torres Strait Islander people. |
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| Box 8.1.2 Measures of access to primary health care |
| Access to healthcare is a complex concept, involving both sufficient supply of services, and the ability to utilise available services (which may be influenced by affordability, physical accessibility and acceptability of the services, and need). There is no single measure of access that encompasses all these aspects. Five proxy measures are reported.   * *Self-assessed health status* is defined as the proportion of the population aged 15 years or over reporting their health status as very good or excellent (all jurisdictions; age; sex; remoteness; selected characteristics). Data for self-assessed health status are sourced from the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)/National Aboriginal and Torres Strait Islander Social Survey (NATSISS), with the most recent data available for 2018-19. Data for the non‑Indigenous population are sourced from the ABS  2017-18 National Health Survey (NHS). * *Aboriginal and Torres Strait Islander people’s use of primary health care services* is defined as the proportion of the population not visiting a GP/doctor at a clinic, or a dentist when they needed (national; remoteness). These are reported for people aged 18 years or over. Data for use of primary health care services are sourced from the NATSIHS with the most recent available data for 2018-19 (data for the non-Indigenous population are sourced from the NHS with the most recent available data for 2017-18). Additional data on children are reported from the 2008 and 2014-15 NATSISS. * *Health checks* funded through Medicare, which Aboriginal and Torres Strait Islander people are eligible to receive on an annual basis and whose purpose is to detect and treat early common conditions that cause ill health and early death. Data are sourced from the Department of Health, Medicare Benefits Schedule (MBS) data collection. * *Immunisation* rates are defined as vaccination coverage rates for selected diseases for children (reported at one, two and five years of age) and adult immunisation rates for those aged 50 years or over. Data for children are derived from the Australian Childhood Immunisation Register (ACIR), with the most recent data for 2018 (all jurisdictions; age). Data for Aboriginal and Torres Strait Islander adults are available from the 2018-19 NATSIHS (national; age). Data are not available for non-Indigenous adults. * *Aboriginal and Torres Strait Islander health workforce* is defined as the share of health-related professionals aged 15 years and older who are Aboriginal and Torres Strait Islander. Data for this report are sourced from the ABS Census of Population and Housing (the Census), with the most recent data for 2016 (national; remoteness). * *Expenditure on health care services* is defined as total recurrent health expenditure and per‑person expenditure on primary and secondary/tertiary health care. ‘Expenditure’ refers to funding from multiple government and non-government sources, including private health insurance. Supplementary data for 2015-16 about total direct per capita expenditure on health services from government and non-government sources (including insurance) are available from the Indigenous Expenditure Report (IER) 2017 and included in table 8A.1.32. |
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Aboriginal and Torres Strait Islander people’s understanding of health is holistic: to be healthy is to be well physically, spiritually and emotionally and to be connected with family, community, culture, language, and Country (AIHW 2018; Butler et al. 2019; Gee et al. 2014). While it includes the physical and mental wellbeing of the individual, it is also about the social, emotional and cultural wellbeing of the whole community. Given this holistic understanding, access to primary health care (along with other health services), can meet some, but not all of Aboriginal and Torres Strait Islander people’s health needs.

Primary health care is generally the first contact a person has with Australia’s health system. It aims to improve health and can reduce the need for specialised services, which involve a referral within the health system or a hospital admission. It is often the gatekeeper or referral point for specialist services.

| Box 8.1.3 Primary health care services |
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| What is the scope of primary health care services?  Primary health care services are varied and provided by a range of practitioners in a range of settings. The services include health promotion, prevention and early intervention, the treatment of illness, and the management of chronic conditions (AIHW 2016).  Who are the people who provide these services?  They are provided by local general practitioners (GP), nurses (such as general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal and Torres Strait Islander health workers.  In what settings are primary health care services provided?  Primary health care is provided in many different settings including at home (most recently via telehealth services)[[2]](#footnote-2), in general practices and at community health services (such as the local maternal health service).  What primary health care services are provided to Aboriginal and Torres Strait Islander people?  Primary health care services for Aboriginal and Torres Strait Islander people are provided by people in a range of professions and in a range of settings. These services are often designed for all people, but there are services specifically designed for Aboriginal and Torres Strait Islander people. These services are referred to as Indigenous specific primary health care services (ISPHCSs) and while funded by governments, they can be provided, administered and run by the following different organisations:   * Aboriginal community-controlled health organisations (ACCHOs) * State, territory and local governments * Non-government organisations (AIHW 2020)**.** |
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As the focus of this section is on access to primary health care services, it should be considered in conjunction with other sections that focus on health outcomes, including disability and chronic health conditions (section 4.9 *Disability and chronic disease*), potentially avoidable deaths (section 8.3 *Potentially avoidable deaths*), child mortality (section 4.2 *Young child mortality*) and life expectancy (section 4.1 *Life expectancy*).

### For over 15 years, the proportion of Aboriginal and Torres Strait Islander people reporting their health as excellent or very good has remained about 45 per cent …

Better self-assessed health status is associated with many other positive outcomes. For example, in 2018-19 the proportion of Aboriginal or Torres Strait Islander adults rating their health status as excellent or very good was higher for those:

* with Year 12 as their highest year of schooling, compared with those for whom it was Year 9
* who were employed, compared with those who were unemployed or out of the labour force
* in the higher household income quintile, compared with those in the lowest
* who mainly spoke a language other than English at home, compared with those who mainly spoke English (table 8A.1.7).

The proportion of Aboriginal and Torres Strait Islander people reporting their health as excellent or very good has not changed significantly since almost two decades ago   
(figure 8.1.1). Having remained at 44 per cent between 2002 and 2008, the proportion decreased in 2012‑13 and 2014-15, before increasing to 45 per cent in 2018-19 (table 8A.1.1). And while greater proportions of Aboriginal and Torres Strait Islander people in younger age groups than in older age groups report their health as excellent or very good, this gap is starting to narrow (table 8A.1.5).

While maximising the proportion of people reporting their health status as excellent/very good is optimal, a smaller proportion of people reporting their health as poor or fair (which could mean ‘moving to good’) is a sign of progress. However, as above, there has been no significant change in these proportions nationally over time (figure 8.1.1).

However, results can vary considerably at the regional level. In 2018-19, while there were no substantial differences across Indigenous regions in the proportions of Aboriginal and Torres Strait Islander people reporting their health status as excellent or very good, this was not the case for the proportions reporting their health status as fair or poor—which ranged from 13 to 31 per cent (figure 8.1.2).

| Figure 8.1.1 Health status of Aboriginal or Torres Strait Islander people (crude rates), 2002 to 2018-19**a** |
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| | Figure 8.1.1 Health status of Aboriginal or Torres Strait Islander people (crude rates), 2002 to 2018-19  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.1.1 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) National Aboriginal and Torres Strait Islander Health Survey (various years); ABS (unpublished) National Aboriginal and Torres Strait Islander Social Survey (various years); table 8A.1.1. |
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| Figure 8.1.2 Proportion of Aboriginal and Torres Strait Islander people reporting their health status as fair or poor, 2018-19**a** |
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| a Small area estimates for Tasmania and the ACT are not available for publication. |
| *Source*: ABS (2020) *National Aboriginal and Torres Strait Islander Health Survey: Small Area Estimates, Australia 2018­19*. Cat. no. 4715.0, table 43.1. |
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### ... and remains lower than for non-Indigenous people

The proportion of Aboriginal and Torres Strait Islander people reporting their health status as excellent or very good is lower than for non-Indigenous people. In 2018-19, after adjusting for differences in population age structures, the gap was about 17 percentage points — similar to the previous smallest gap of 19 percentage points in 2008 (table 8A.1.5).

The gap in reported health outcomes varied by age group (figure 8.1.3). While the proportion of people reporting their health status as excellent or very good decreased with age for both Aboriginal and Torres Strait Islander people and non-Indigenous people — and the proportion reporting their health status as poor or very poor increased with age for both — the gap was largest for people aged 55 years or over.

| Figure 8.1.3 Proportion of people rating their health as very good or excellent, by Indigenous status and age group, 2017–19**a,b** |
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| Figure 8.1.3 Proportion of people rating their health as very good or excellent, by Indigenous status and age group, 2017–19  More details can be found within the text surrounding this image. |
| a See table 8A.1.5 for detailed definitions, footnotes and caveats. b A-S rate is the age-standardised rate. |
| *Source*: ABS (unpublished) National Aboriginal and Torres Strait Islander Health Survey 2018-19; ABS (unpublished) National Health Survey 2017-18; table 8A.1.5. |
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### Aboriginal and Torres Strait Islander people’s health status is affected by a range of factors, one of which is access to and use of primary health care services

The ongoing effects of colonisation — including intergenerational trauma, sociocultural and economic impacts — as well as the removal of Aboriginal and Torres Strait Islander children from their families, and the persisting and institutional racism, continue to affect Aboriginal and Torres Strait Islander people (Canuto et al. 2018; Department of Health 2016; Paradies 2016) who ascribe their health to macrosocial factors, including traditional lands, kinship, languages and cultures (Shepherd, Li and Zubrick 2012). As a result, Aboriginal and Torres Strait Islander people often have higher rates of the risk factors that lead to poorer health than non-Indigenous people (such as increased substance use and smoking rates, see section 11.1 *Alcohol consumption and harm*) and their need for health care services is therefore also higher.

Access to, and use of, culturally safe and affordable primary health care services is one of the keys to improving Aboriginal and Torres Strait Islander people’s health status (AIHW 2019a). But the health system in isolation cannot address all the complex and intersecting risk factors associated with health outcomes; this requires collaboration with many sectors, including education, child protection, justice and employment (Department of Health 2016).

### Preventive services like health checks and vaccinations can maintain and improve health, and rates have been increasing for Aboriginal and Torres Strait Islander people

Across all age groups, more Aboriginal and Torres Strait Islander people are having MBS health checks than a decade ago[[3]](#footnote-3) (figure 8.1.4). In 2018-19, just over 25 per cent of people aged 0–54 years and 37 per cent of people aged 55 years and older had health checks, up from about one in ten in 2009-10 (table 8A.1.18).

Although more Aboriginal and Torres Strait Islander people are getting a health check, the proportion remains relatively low. This may be due to low uptake of the MBS health check item by practitioners who have concerns with content and are uncertain about the process of the check, as found in one urban ACCHS (Jennings, Spurling and Askew 2014). That said, the low proportion may be an underestimate, due to both a lack of awareness of the specific MBS item number for recording Indigenous-specific health checks (Schütze, Pulver and Harris 2016), and the fact that some people may receive a health check outside Medicare. As such, greater clarity within the health sector and greater promotion by primary health care service practitioners and others may increase further the uptake of the health care check.

To improve health outcomes, primary health care services need to follow-up on any issues identified in health checks (Bailie et al. 2014; Dutton, Stevens and Newman 2016). The proportion of Indigenous health check patients who had an Indigenous-specific follow-up service within 12 months of their check increased from 12 per cent to 40 per cent between 2010–11 and 2016–17 (AIHW 2019b).

| Figure 8.1.4 Proportion of Aboriginal and Torres Strait Islander people who received a MBS health check, by age group 2009-10 to 2018-19**a** |
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| Figure 8.1.4 Proportion of Aboriginal and Torres Strait Islander people who received a MBS health check, by age group 2009-10 to 2018-19  More details can be found within the text surrounding this image. |
| a See table 8A.1.18 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health unpublished, MBS data collection; ABS various years, Australian Demographic Statistics, Cat. no. 3201.0; ABS (2019) Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031, Cat. No. 3238.0; table 8A.1.18. |
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Immunisation rates[[4]](#footnote-4) for Aboriginal and Torres Strait Islander children have increased over the past decade, and in 2018 ranged from 89 to 97 per cent (table 8A.1.19). The largest increase occurred for five-year-olds, with the rate in 2018 surpassing that for other children (table 8A.1.19). Rates for one- and two-year-olds were within three percentage points of the rates for other children (table 8A.1.19).

Data on vaccinations for older Aboriginal and Torres Strait Islander people are currently only available from population surveys, and indicate that rates are below those for children. For influenza, around two-thirds of Aboriginal and Torres Strait Islander people aged 50 years and older reported that they had had a vaccination in 2018-19, an increase of ten percentage points from 2012-13 (when this proportion was 57 per cent). By age, the proportion was higher for those aged 65 years or over (84 per cent) than for those aged   
50–64 years (62 per cent) (table 8A.1.27).

### And while most Aboriginal and Torres Strait Islander adults visit providers for medical and support services, fewer visit the dentist

The majority of Aboriginal and Torres Strait Islander adults visit primary health care services. In 2018-19, 87 per cent of Aboriginal and Torres Strait Islander adults had visited a primary health care professional for medical and support services in the previous 12 months — an increase from 76 per cent in 2001.[[5]](#footnote-5) Much of this increase appears to have occurred in remote areas (table 8A.1.8), which may suggest increased access to primary health care professionals in these areas and/or increased need.

The health services most usually visited are doctors or Aboriginal Medical Services and community clinics (table 8A.1.14). For these service types, patterns of use have varied by location. In non-remote areas, doctors were more commonly visited, with 63 per cent of Aboriginal and Torres Strait Islander adults and children using their services (tables 8A.1.14 and 8A.1.17); however, in remote areas, Aboriginal Medical Services and other community clinics were more commonly visited (with about 65 per cent visiting) (tables 8A.1.14 and 8A.1.17).

Visits to the dentist are far less common. In 2018-19, just over one in four Aboriginal and Torres Strait Islander people had been to the dentist in the previous six months, with 34 per cent reporting having visited a dentist in the previous six months to two years, and a further 12 per cent reporting never having visited a dentist (table 8A.1.11). The proportion of people going to a dentist on a timely basis has remained relatively unchanged in recent times (table 8A.1.11). See section 8.6 *Oral health* for further information on oral health.

### One in five Aboriginal and Torres Strait Islander adults did not see a doctor when needed, rising to one in four for the dentist — and the reasons for not doing so are varied

About one in five Aboriginal and Torres Strait Islander adults did not go to the doctor and about one in four had not gone to the dentist when needed; this proportion remained unchanged between 2012–13 and 2018–19. In 2018‑19, 19 per cent of Aboriginal and Torres Strait Islander adults had not visited a GP or clinic doctor (table 8A.1.9) and 28 per cent had not visited a dentist (table 8A.1.12) on at least one occasion when they had a health or dental problem in the previous 12 months. These proportions were lower in remote areas (tables 8A.1.9 and 8A.1.12).

The reasons for not visiting a GP/clinic doctor or dentist when needed are multifaceted and differ by service type and location. The most commonly reported reasons in 2018-19:

* for not visiting GPs/clinic doctors, were personal reasons (53 per cent) — including being too busy, discrimination, and services not being culturally safe or adequate — and logistical reasons (29 per cent, and  43 per cent in remote areas), including geographical and timely access to services (table 8A.1.10). However, 30 per cent ultimately decided not to seek care (there is no information available on why they decided not to).
* for not visiting dentists, in non-remote areas were personal reasons (49 per cent) and cost (44 per cent), while in remote areas they were logistical reasons (52 per cent) (table 8A.1.13).

### A key step towards improving Aboriginal and Torres Strait Islander health is better access to primary health care, which involves overcoming barriers to access and providing culturally safe services

Overcoming barriers to access and providing culturally safe primary healthcare services is key to improving the health of Aboriginal and Torres Strait Islander people. Primary health care services are accessible and appropriate if they are not only affordable, timely, and situated within easy reach, , but also support the social and cultural norms of the communities they serve, ultimately leading people to engage and stay connected with these services (Davy et al. 2016).

Increasing access to ACCHSs may improve both uptake of, and continued engagement with, health services for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people report that relative to other health services, ACCHSs influence their health more positively (Campbell et al. 2018) as they are:

* accessible, with welcoming social spaces and additional services
* appropriate, as care is responsive to holistic needs
* culturally safe (Gomersall et al. 2017) — that is, they are services that patients feel safe attending (AIHW 2019a).[[6]](#footnote-6)

The role of culture is the greatest distinction between other models of care and Aboriginal and Torres Strait Islander health care service delivery models, including ACCHSs. In Aboriginal and Torres Strait Islander service models, culture underpins all aspects of care in that it ensures community participation, ownership and control, a flexible approach to care and a culturally appropriate and skilled workforce (Harfield et al. 2018). Another particular strength of the community controlled model is that services can respond to the local situation, and incorporate local community and cultural knowledge into service delivery (Holland 2016) Services provided by ACCHS are valued by their clients for these reasons (Mackey, Boxall and Partel 2014).

Supporting health professionals to develop cultural competence though skills, knowledge and attitudes is another way to increase acceptance and uptake of, and engagement with, primary health services (Bainbridge et al. 2015). For some Aboriginal and Torres Strait Islander people, culturally competent health professionals are those who engage in ‘good talk’ — which is to say that they demonstrate respect and care, and communicate effectively with the client (Jennings, Bond and Hill 2018). Establishing trust can be difficult owing to historical experience of the practices of Australian health services, incorrect assumptions and racism (Conway, Tsourtos and Lawn 2017; Dwyer et al. 2015). Hiring and retaining an Aboriginal and Torres Strait Islander local workforce aided by training and development opportunities for all staff are key to increasing cultural competence of health professionals (Harfield et al. 2018), and establishing trust, maintaining confidentiality and minimising shame for Aboriginal and Torres Strait Islander people (Warwick et al. 2019).

Despite the importance of increasing the Aboriginal and Torres Strait Islander workforce as a contributor to the provision of culturally competent services, Aboriginal and Torres Strait Islander people are underrepresented in the health workforce. According to the most recent population-level data, Aboriginal and Torres Strait Islander people comprised two per cent of people working in health-related occupations in 2016 (table 8A.1.28), although they made up three per cent of the adult Australian population (derived from (ABS 2018)). In 2016, Aboriginal and Torres Strait Islander people comprised 19 per cent of the health professionals working in remote areas and two per cent of those working in non-remote areas (table 8A.1.29). Additional data on employment in health-related occupations are reported in tables 8A.1.30–8A.1.31.

More accessible culturally safe primary care services are needed for Aboriginal and Torres Strait Islander people living in remote areas. While nearly all Aboriginal and Torres Strait Islander people in major cities live close to an ISPHCS, only 47 per cent of Aboriginal and Torres Strait Islander people in very remote areas live within an hour’s drive of their nearest ISPHCS (AIHW 2015). And in 2018-19, approximately 65 per cent of ISPHCS were ACCHSs (AIHW 2020).

### Future directions in data

Better data on influenza vaccination coverage are needed. At present, data are only available from population level surveys for children and older people. The Australian Immunisation Register (AIR) collects administrative data on notification of influenza vaccinations people have received. However, there is significant underreporting in the AIR data, particularly for the older population, as a large proportion of vaccinations provided to individuals are not notified to the AIR.

National data on the health status of Aboriginal and Torres Strait Islander people aged   
0–14 years has historically been collected in the NATSIHS, but was not collected in 2018‑19. Data from this survey on the timely use of primary health care services were also unavailable for this age group. These are critical information gaps at the population level for Aboriginal and Torres Strait Islander children.

The data collection in the NATSIHS on reasons for not using health care services when needed could be of greater use if the underlying reasons for the ‘did not seek care’ response are pinpointed.

Reporting on the uptake of Indigenous-specific health checks by Indigenous-specific health service provider (ACCHS and non-ACCHS) would support analysis of potential barriers to specific health services providers and associated outcomes.

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## 8.2 Potentially preventable hospitalisations[[7]](#footnote-7)

| Box 8.2.1 Key messages |
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| * Potentially preventable hospitalisations are hospital admissions for conditions that may have been prevented or addressed earlier in primary or community health care. They are a proxy measure for the effectiveness of health system prevention activities and primary or community health care services, particularly for chronic, acute and vaccine-preventable conditions. * For Aboriginal and Torres Strait Islander people, rates of hospitalisation for chronic, acute and vaccine-preventable conditions have increased over time and are higher than for non‑Indigenous people. * For potentially preventable chronic and acute conditions, about three-quarters of the gap to non-Indigenous people is explained by six conditions: chronic obstructive pulmonary disease (COPD), cellulitis, diabetes complications, convulsions/epilepsy, urinary tract infections and congestive cardiac failure. * While rates for rheumatic heart disease (RHD) and bronchiectasis are relatively low, the disparity for Aboriginal and Torres Strait Islander people is very large. In remote areas, for example, both conditions have hospitalisation rates that are 17 times that of non-Indigenous people. * Other hospitalisations for Aboriginal and Torres Strait Islander people that could potentially have been prevented relate to injury, poisoning or other external causes and sexually transmitted infections, and have all increased over time. * Decreasing the rates of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people will involve improving the availability and appropriateness of primary health care services, providing culturally safe support to those delaying seeking health care due to caring responsibilities and designing systems that empower Aboriginal and Torres Strait Islander people with the self-efficacy to manage their own health affairs. * Appropriate and ongoing management of chronic illness can improve a person’s ability to participate in cultural life and kinship, particularly when flexible treatment options enable them to remain on Country. |
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| Box 8.2.2 Measures of potentially preventable hospitalisations |
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| Potentially preventable hospitalisations are those admissions that may have been prevented through appropriate preventive health interventions and early disease management, usually delivered in primary care and community-based care settings.  There are three main measures for this indicator, relating to the rate of hospitalisation per 100 000 population for:   * potentially preventable chronic conditions — diseases that typically persist for at least six months (including specific tables on type 2 diabetes mellitus) * potentially preventable acute conditions — diseases that cause serious short-term illness that could possibly be prevented, or their severity minimised * vaccine-preventable conditions — including influenza and pneumonia.   Data for all measures are sourced from the AIHW National Hospital Morbidity Database, with the most recent data available for 2018-19 (national) and 2016–2018 (by remoteness). Additional data are reported on the rate of hospitalisation for injury, poisoning and other external causes and sexually transmitted conditions that could potentially have been prevented (nationally by remoteness). |
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Potentially preventable hospitalisations are hospital admissions for conditions that may have been prevented if addressed earlier in primary or community health care (AIHW 2020b).

* Preventative measures, such as health care checks, vaccinations and addressing health risk factors can reduce the development of these conditions. The following health risk factors are discussed elsewhere in this report: tobacco use (section 8.4 *Tobacco consumption and harm*), obesity (section 8.5 *Obesity and nutrition*), alcohol use (section 11.1 *Alcohol consumption and harm*) and drug consumption (section 11.2 *Drug and other substance use and harm*).
* Early intervention and coordination of care in primary or community health settings are also key factors in reducing the rate of potentially preventable hospitalisations (AIHW 2018).

Therefore, potentially preventable hospitalisations for selected conditions are a proxy measure for the effectiveness of health system prevention activities and primary or community health care services (AIHW 2020b).

The conditions most relevant in this context are:

* chronic conditions, such as diabetes, chronic obstructive pulmonary disease (COPD) and rheumatic heart disease
* acute conditions, such as cellulitis, urinary tract infections and ear nose and throat infections
* vaccine-preventable conditions, such as influenza and pneumonia.

While these hospitalisations are a proxy measure for whether services were accessible when conditions were easier to manage, increasing hospitalisations for these conditions may also represent better access to hospital services, which is a key to reducing deaths from these conditions (see section 8.3 *Potentially avoidable deaths*).

### Hospitalisation rates for Aboriginal and Torres Strait Islander people for chronic, acute and vaccine-preventable conditions have increased over time

Hospitalisation rates have increased for Aboriginal and Torres Strait Islander people for chronic, acute and vaccine-preventable conditions. From 2010–2012 to 2016–2018, after adjusting for changes in the age distribution, the largest proportional increase in the hospitalisation rate was for vaccine-preventable conditions, which doubled (figure  8.2.1). Although potentially preventable hospitalisation rates for chronic and acute conditions are still higher.

Rates of potentially preventable hospitalisation for chronic, acute and vaccine-preventable conditions are highest in remote and very remote areas (figure 8.2.1). However, over time the rate of hospitalisation in non-remote areas has increased more steeply than in remote areas (from 2010–2012 to 2016–2018), and this has resulted in a narrowing in the gap between remote and non-remote areas for these conditions (table 8A.2.1).

| Figure 8.2.1 Potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people (age-standardised rates), by condition type, over time and by remoteness**a** |
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| | Figure 8.2.1 Potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people (age-standardised rates), by condition type, over time and by remoteness  More details can be found within the text surrounding this image. | Figure 8.2.1 Potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people (age-standardised rates), by condition type, over time and by remoteness  More details can be found within the text surrounding this image. | | --- | --- | |
| a See table 8A.2.1 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 8A.2.1. |
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### Hospitalisation rates for Aboriginal and Torres Strait Islander people for these conditions are higher than for non-Indigenous people

Potentially preventable hospitalisation rates for Aboriginal and Torres Strait Islander people are higher than for non-Indigenous people for chronic, acute and vaccine-preventable conditions, with the proportional disparity highest for vaccine-preventable conditions. In 2018-19, after adjusting for differences in population age structures, the hospitalisation rate for Aboriginal and Torres Strait Islander people for:

* chronic conditions was 3.1 times the rate for non-Indigenous people (table 8A.2.4)
* acute conditions[[8]](#footnote-8) was 2.4 times the rate for non-Indigenous people (table 8A.2.8)
* vaccine-preventable conditions was 3.5 times the rate for non‑Indigenous people (table 8A.2.10).

The proportional disparity in outcomes for vaccine-preventable conditions is particularly large in remote Australia, where Aboriginal and Torres Strait Islander people are around 12 times as likely to be hospitalised for vaccine-preventable pneumonia and around five times as likely to be hospitalised for other vaccine-preventable conditions (table 8A.2.11). Further information on vaccinations can be found in section 8.1 *Access to primary health care.*

### For potentially preventable chronic and acute conditions, about three‑quarters of the gap is explained by six conditions

For potentially preventable hospitalisations for chronic and acute conditions, about three‑quarters of the gap to non-Indigenous people is explained by six conditions (figure 8.2.2). These conditions also represent 65 per cent of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people for chronic and acute conditions (tables 8A.2.5 and 8A.2.9).

Chronic obstructive pulmonary disease (COPD)[[9]](#footnote-9) is the most common cause of potentially preventable hospitalisations for chronic conditions for both Aboriginal and Torres Strait Islander people and non-Indigenous people (table 8A.2.5). However, the rate for Aboriginal and Torres Strait Islander people is over four and a half times the rate for   
non-Indigenous people (table 8A.2.5). The prevalence of COPD amongst Aboriginal and Torres Strait Islander people is concerning because it is associated with comorbidities such as arthritis, asthma and behavioural conditions (AIHW 2019), and increases susceptibility to coronaviruses (Lippi and Henry 2020).

| Figure 8.2.2 Potentially preventable hospitalisations for six key chronic and acute conditions (age-standardised rates and rate ratio),  2016–2018**a** |
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| | Figure 8.2.2 Potentially preventable hospitalisations for six key chronic and acute conditions (age-standardised rates and rate ratio),  2016–2018   More details can be found within the text surrounding this image. | | --- | |
| COPD = Chronic obstructive pulmonary disease |
| a See tables 8A.2.5 and 8A.2.9 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; tables 8A.2.5 and 8A.2.9. |
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Cellulitis[[10]](#footnote-10) is the most common cause of potentially preventable hospitalisation for an acute condition for Aboriginal and Torres Strait Islander people (table 8A.2.9) (AIHW 2020a). Cellulitis is of particular concern in remote and very remote regions, where it represents about 30 per cent of hospitalisations for acute conditions for Aboriginal and Torres Strait Islander people, and the rate is three and a half times that for non-Indigenous people in remote and very remote areas (table 8A.2.9).

### While rates of rheumatic heart disease and bronchiectasis are relatively low, the disparity for Aboriginal and Torres Strait Islander people is large, particularly in remote areas

There are two additional chronic conditions for which hospitalisation rates are relatively low, but the disparity between Aboriginal and Torres Strait Islander people and non‑Indigenous people is large, particularly in remote areas. These are:

* rheumatic heart disease (RHD) — caused by an untreated bacterial infection of the throat and skin, and can result in permanent damage to the heart. Aboriginal and Torres Strait Islander people are hospitalised at about six times the rate of non-Indigenous people, increasing to 17 times the rate in remote areas (table 8A.2.5). Aboriginal and Torres Strait Islander people have among the highest rates of RHD in the world (AHMAC 2017).
* bronchiectasis — the abnormal widening of the airways in the lungs, and is usually caused by damage to the airway walls and often from a lung infection. Aboriginal and Torres Strait Islander people are hospitalised at more than three times the rate of non‑Indigenous people, rising to more than 17 times the rate in remote areas (table 8A.2.5).

### Other hospitalisations that could potentially have been prevented relate to external causes and sexually transmitted infections — these have also increased over time though more so for Aboriginal and Torres Strait Islander people

From 2010-11 to 2018-19, the age-standardised rate of hospitalisations of Aboriginal and Torres Strait Islander people for infections with a predominately sexual mode of transmission increased by 19 per cent, compared to 3 per cent for non-Indigenous people (table 8A.2.12). However, most of this increase occurred between 2010-11 and 2011-12. The increase is likely attributable to a syphilis epidemic affecting Aboriginal and Torres Strait Islander young people living in remote areas (Department of Health 2020).

The age-standardised rate of hospitalisations of Aboriginal and Torres Strait Islander people for external causes (including injury and poisoning)[[11]](#footnote-11) increased by 31 per cent from 2010-11 to 2018-19, with an increase of 17 per cent for non-Indigenous people (table 8A.2.14). The biggest contributor to the increased rate of hospitalisations (for both Aboriginal and Torres Strait Islander and non-Indigenous people) appears to be an increase in hospitalisations from falls, particularly in major cities (table 8A.2.15). The greatest proportional disparity in rates was for assaults, with Aboriginal and Torres Strait Islander people hospitalised at about 14 times the rate for non-Indigenous people in 2016–2018 (table 8A.2.15).

### How can potentially preventable hospitalisation rates be decreased for Aboriginal and Torres Strait Islander people?

The increasing rates of potentially preventable hospitalisations of Aboriginal and Torres Strait Islander people for chronic, acute and vaccines-preventable conditions may be a key to the declining death rates for these conditions (see section 8.3 *Potentially avoidable deaths*). However, preventing these conditions from developing to the point that people need hospitalisation should also be a key focus. Appropriate and ongoing management of chronic illness can improve a person’s ability to participate in cultural life and kinship, particularly when flexible treatment options enable them to remain on Country (Conway et al. 2018).

Strategies to decrease potentially preventable hospitalisation rates for chronic, acute and vaccine-preventable conditions should focus on improving the effectiveness of health system prevention and primary health care services for Aboriginal and Torres Strait Islander people. Approaches to achieve this are covered elsewhere in this report, but include:

* eliminating barriers to accessing primary health care services and preventative health checks (see section 8.1 *Access to primary health care* and section 8.3 *Potentially avoidable deaths*)
* ensuring the cultural safety of primary health care services, so when they are accessible they are also appropriate to the needs of Aboriginal and Torres Strait Islander people. This includes increasing and supporting the Aboriginal and Torres Strait Islander health workforce, which plays an important role in providing culturally safe primary and tertiary care. Health services that provide a culturally unsafe experience are less likely to be used as they can alienate a patient and result in a person disengaging from the health system altogether (Laverty, McDermott and Calma 2017)
* designing treatment plans that are realistic and achievable within the circumstances of each patient, and in doing so, empowering patients with the knowledge that they can influence their health outcomes through their own positive actions (Seear et al. 2019).

Increasing access to Aboriginal Community Controlled Health Services (ACCHSs) may address these challenges, but improving access to other health services and ensuring their cultural safety is also likely to be required to address the needs of Aboriginal and Torres Strait Islander people (see section 8.1 *Access to primary health care*).

Delays in seeking primary health care can lead to deteriorating health and hospitalisation. Aboriginal and Torres Strait Islander people have good reasons to delay contact with primary health care professionals, such as the accessibility and appropriateness of services. However, a person’s responsibilities around caring for others may be another key explanation for this delay. The decision to prioritise one’s own health in the context of caring responsibilities and significant other challenges (discussed elsewhere in this report) is difficult. And ultimately, caring responsibilities can affect the ability of the carer to maintain their health and manage their own chronic conditions (Ristevski et al. 2020; Eades et al. 2020).

Aboriginal and Torres Strait Islander people, and women in particular, bear more caring responsibilities for children and people with disability than their non-Indigenous counterparts (ABS 2016). Some medical practitioners have reported that caring for others may explain the late presentation of Aboriginal and Torres Strait Islander women seeking care for themselves (Marcusson-Rababi et al. 2019).

To address this issue, it is important that culturally safe carer support and respite care programs are accessible in both metropolitan and remote Australia. For example, as Aboriginal and Torres Strait Islander people often consider ‘caring’ responsibilities as a wider part of ‘family’ responsibilities, it would not be unusual to expect that an entire family would require respite services they could access together (Department of Health & Human Services 2020).

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## 8.3 Potentially avoidable deaths[[12]](#footnote-12)

| Box 8.3.1 Key messages |
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| * Reducing potentially avoidable deaths contributes significantly to increasing life expectancy. * The rate of potentially avoidable deaths has decreased over time for Aboriginal and Torres Strait Islander people. Between 1998 and 2018, it fell 40 per cent and contributed to about half the overall reduction in deaths. * However, Aboriginal and Torres Islander people remain about three times as likely to die of potentially avoidable deaths than non-Indigenous people. * In the five year period 2014–2018, the rate of potentially avoidable deaths for Aboriginal and Torres Strait Islander people represented 60 per cent of overall mortality, was higher for males than females, and increased rapidly from the age of 15 years, particularly for males. * In this same period, ischaemic heart disease caused just over one in five potentially avoidable deaths of Aboriginal and Torres Strait Islander people. This, along with diabetes, and intentional self-harm combined, equated to 44 per cent of these deaths. * Access to, and use of, health care can make a substantial contribution to reducing potentially avoidable deaths. While it is improving for Aboriginal and Torres Strait Islander people it remains below that of non-Indigenous people. * Research suggests that access to and use of health care may be improved through increased access to Aboriginal Community Controlled Health Services (ACCHSs), more Aboriginal and Torres Strait Islander health workers and building the cultural competence of the health workforce. * Reductions in potentially avoidable deaths could also be achieved by providing holistic approaches to support people to reduce personal risk factors, such as obesity, and tobacco, alcohol and drug consumption. |
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| Box 8.3.2 Measures of potentially avoidable deaths |
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| There is one main measure for this indicator.   * *Potentially avoidable deaths* is defined as the number and rate of deaths from potentially preventable and treatable conditions for people aged less than 75 years (data is available for NSW, Queensland, WA, SA and the NT and by age and sex). As of 2019, deaths were classified as potentially avoidable based on their International Statistical Classification of Diseases and Related Health Problems (ICD-10 code).[[13]](#footnote-13)   Data for this measure are sourced from the ABS Causes of Death collection, with the most recent available data for 2018. People aged 75 years or over are excluded due to difficultly in assigning a cause of death that can be clearly defined as avoidable or unavoidable. |
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Reducing potentially avoidable deaths contributes to increasing life expectancy (section 4.1 *Life expectancy*). Potentially avoidable deaths are those that occur due to conditions that are preventable or treatable such as diabetes, heart failure, asthma, transport accidents and assault (see table 8A.3.6 for the full list). These conditions can often be treated through access to and use of primary health care (section 8.1 *Access to primary health care*), mental health services (section 8.7 *Mental health*) and hospital care (section 8.2 *Potentially preventable hospitalisations*). Some of these conditions can be prevented through health prevention activities such as health care checks and reductions in personal risk factors, such as obesity (section 8.5 *Obesity and nutrition*) and tobacco (section 8.4 *Tobacco consumption and harm*), alcohol (section 11.1 *Alcohol consumption and harm*) and drug consumption (section 11.2 *Drug and other substance use and harm*).

### The rate of potential avoidable deaths for Aboriginal and Torres Strait Islander people has fallen over the past 20 years, contributing substantially to the lives being saved…

The potentially avoidable deaths rate in NSW, Queensland, WA, SA and the NT for Aboriginal and Torres Strait Islander people fell by 40 per cent between 1998 and 2018 (figure 8.3.1).[[14]](#footnote-14) This 20-year decline contributed almost 50 per cent to the reduction in Aboriginal and Torres Strait Islander people’s overall mortality rate (section 4.1*Life expectancy*). The initial rate of decline in potentially avoidable deaths was rapid for the first decade but slowed to a cumulative decline of 10 per cent over the ten years since 2008 (which corresponds to around 30 fewer deaths per 100 000 population) (table 8A.3.4).

### …but more needs to be done to reduce the gap…

Even though the rate of potentially avoidable deaths for Aboriginal and Torres Strait Islander people has fallen, in 2018 it remained 3.1 times the rate for non-Indigenous people (table 8A.3.4). This rate ratio is slightly higher than that in 1998, due to a larger percentage decline in the rate for non-Indigenous people over this period (45 per cent decrease, compared to a 40 per cent decrease for Aboriginal and Torres Strait Islander people) (table 8A.3.4).

### …and over half of Aboriginal and Torres Strait Islander deaths continue to be potentially avoidable

In 2014–2018, the deaths of 7072 Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and NT were potentially avoidable (table 8A.3.1). Those deaths represented 60 per cent of the number of Aboriginal and Torres Strait Islander who died (table 8A.3.5). In that five-year period, the avoidable mortality rate (age‑standardised) for Aboriginal and Torres Strait Islander people in NSW, Qld, WA, SA and NT was around three times the rate for non-Indigenous people (table 8A.3.1). Data reported by selected states and territories are available in table 8A.3.1.

| Figure 8.3.1 Avoidable mortality for Aboriginal and Torres Strait Islander people, NSW, Queensland, WA, SA, and the NT combined, by sex, 1998 to 2018 (age-standardised)**a** |
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| | Figure 8.3.1 Avoidable mortality for Aboriginal and Torres Strait Islander people, NSW, Queensland, WA, SA, and the NT combined, by sex, 1998 to 2018 (age-standardised)  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.3.4 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) Causes of Death, Cat no. 3303.0; ABS (unpublished) Estimated Resident Population, cat. no 3101.0; ABS (2019) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, 2006–2031, Cat. no. 3238.0; table 8A.3.4. |
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As with overall mortality, potentially avoidable mortality for Aboriginal and Torres Strait Islander people is relatively high for children aged under one year of age, falling to the lowest rate for children aged 1–4 years and 5–14 years, but from 15 years of age increases rapidly — with rates higher for males compared to females (figure 8.3.2). This pattern is consistent with that for non-Indigenous people, but the rates of avoidable mortality are significantly lower across all age groups and the increase from 15 years of age is much slower, particularly for women (table 8A.3.2).

In 2014–2018, the top three causes of potentially avoidable deaths for Aboriginal and Torres Strait Islander people were ischaemic heart disease (21 per cent), diabetes (12 per cent), and intentional self-harm (11 per cent). These three causes combined were responsible for 44 per cent of all potentially avoidable deaths — similar to a decade earlier (table 8A.3.3). However, there were differences across disease categories over this period, with age‑standardised mortality rates from ischaemic heart disease decreasing, mortality associated with diabetes remaining unchanged, and mortality from intentional self-harm increasing (see section 8.8 *Suicide and self-harm*).

For non-Indigenous people, ischaemic heart disease and intentional self-harm were also major causes of potentially avoidable deaths — these, along with cancer which is the top cause, led to over one in two potentially avoidable deaths for non-Indigenous people (table  8A.3.3).[[15]](#footnote-15) However, the age-standardised mortality rates associated with all causes of potentially avoidable deaths (other than cancer) were significantly higher for Aboriginal and Torres Strait Islander people than non-Indigenous people.

| Figure 8.3.2 Avoidable mortality for Aboriginal and Torres Strait Islander people, by sex, by age group, NSW, Queensland, WA, SA and the NT combined, 2014–2018**a** |
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| | Figure 8.3.2 Avoidable mortality for Aboriginal and Torres Strait Islander people, by sex, by age group, NSW, Queensland, WA, SA and the NT combined, 2014–2018  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.3.2 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) Causes of Death, Cat no. 3303.0; ABS (unpublished) Estimated Resident Population, Cat. no 3101.0; ABS (2019) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, *2006–2031*, Cat. no. 3238.0; table 8A.3.2. |
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### Strategies to further reduce potentially avoidable deaths of Aboriginal and Torres Strait Islander people need to consider the many social, economic and cultural factors contributing to health outcomes

Strategies to reduce potentially avoidable deaths need to take into account the social, economic and cultural reasons for health-related behaviours and outcomes (Cockburn, Gartner and Ford 2018; Lovett, Thurber and Raglan 2017). Colonisation impacted on connection to Aboriginal and Torres Strait Islander people’s culture and led to sociocultural‑dislocation, economic dispossession and intergenerational trauma (Reading and Wien 2009). The ongoing effects of colonisation, the continual removal of Aboriginal and Torres Strait Islander children from their families, and the persistent personal and institutional racism, continue to affect Aboriginal and Torres Strait Islander people (Canuto et al. 2018; Department of Health 2016; Paradies 2016). As a result, Aboriginal and Torres Strait Islander people often have high rates of the personal risk factors that lead to poorer health and the greater need for health care (AIHW 2016).

Increased levels of health care access and use can make a substantial contribution to reducing avoidable deaths for Aboriginal and Torres Strait Islander people (AIHW 2019; Korda et al. 2007). This includes primary health care (section 8.1 *Access to primary health care*), mental health service (section 8.7 *Mental health*) and hospital care (section 8.2 *Potentially preventable hospitalisations*). For example, increased levels of primary care utilisation by Aboriginal and Torres Strait Islander people in remote communities in the NT led to a   
60–75 per cent reduction in deaths from common chronic diseases such as renal disease, chronic obstructive pulmonary disease, diabetes and ischaemic heart disease (Zhao et al. 2014).

However, there are a significant number of Aboriginal and Torres Strait Islander people who are not able to access or do not use health care services when needed. For example, in 2018‑19, 19 per cent of Aboriginal and Torres Strait Islander people aged 18 years or over reported that they did not see a GP/doctor at a clinic when needed on at least one occasion in the last 12 months (21 per cent in non-remote areas and 11 per cent in remote areas) with the main reason being personal which includes being too busy, discrimination, and services that are not culturally safe or adequate (section 8.1 *Access to primary health care,* tables 8A.1.9-10).

Further improvements are required to eliminate barriers to accessing health care services and to the experience of patients once in the service. Research suggests that the uptake of, and continued engagement with, health care services for Aboriginal and Torres Strait Islander people may be improved with increased access to ACCHSs (Campbell et al. 2018), more Aboriginal and Torres Strait Islander health workers and building the cultural competence of the overall health workforce as a step to ensure cultural safety in health services (see sections 8.1 *Access to primary health care* and 8.7 *Mental health*).

Reductions in personal risk factors are also important to reduce potentially avoidable deaths and can be achieved with holistic approaches that support Aboriginal and Torres Strait Islander people. These approaches may include, but are not limited to:

* improving socioeconomic conditions (AHMAC 2015; AIHW 2015; Cairney et al. 2017)
* health promotion strategies (AHMAC 2017), including empowering individuals with knowledge and skills to improve their health
* other instruments such as taxes and subsidies that provide monetary incentives to support healthy lifestyles (Greenhalgh, Scollo and Winstanley 2020).

These approaches are more likely to deliver better outcomes if they are culturally safe and are designed and implemented by Aboriginal and Torres Strait Islander people. For more information on this and other approaches to reduce personal risk factors, such as obesity, and tobacco, alcohol and drug consumption see sections 8.4 *Tobacco consumption and harm*, 8.5 *Obesity and nutrition* and 11.1 *Alcohol consumption and harm*.

### Future directions in data

Currently, data about potentially avoidable mortality are only able to be reported at the jurisdictional level for NSW, Queensland, WA, SA and the NT. Further work is required to enable reporting separately for all states and territories (subject to limitations imposed by the small number of Aboriginal and Torres Strait Islander deaths in some jurisdictions). Reporting of potentially avoidable mortality by remoteness and Indigenous status would support analysis of potential barriers to health services and associated outcomes.

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## 8.4 Tobacco consumption and harm[[16]](#footnote-16)

| Box 8.4.1 Key messages |
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| * Despite considerable progress in reducing smoking rates, tobacco consumption remains the biggest contributor to the burden of preventable ill health and death for Australian adults. * Over the past 20 years, the proportion of Aboriginal and Torres Strait Islander adults who do not smoke has increased. Between 2001 and 2018-19, the daily smoking rate declined so about 60 per cent of Aboriginal and Torres Strait Islander adults did not smoke in 2018-19. This means 50 000 fewer smokers in 2018-19 than would have been the case if smoking had remained at the 2001 level. * Smoking rates have also decreased for non-Indigenous adults. However, as they have decreased from a lower base, the ‘gap’ ratio has increased. In 2001, the smoking rate for Aboriginal and Torres Strait Islander adults was just over twice that for non-Indigenous adults, but by 2017–19 the rate was three times that for non-Indigenous adults. * Most of the decline in smoking rates for Aboriginal and Torres Strait Islander adults has occurred in non-remote areas, where health regulations to reduce tobacco consumption are likely to have had the largest impact. * The biggest reduction has been for young Aboriginal and Torres Strait Islander adults in non‑remote areas. For adults aged 25–34 years in non‑remote areas, smoking rates fell by 23 percentage points between 1995 and 2018-19. This is likely to lead to reductions in tobacco-related deaths over time, although it may take decades. * In remote areas, where Aboriginal and Torres Strait Islander adults’ smoking rates are highest, research indicates that local solutions to reduce smoking rates could be beneficial. However, more evidence is needed on the impacts of smoking cessation programs for Aboriginal and Torres Strait Islander people in different contexts. |
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| Box 8.4.2 Measures of tobacco consumption and harm |
| There is one main measure for this indicator (aligned with the associated National Indigenous Reform Agreement (NIRA) indicator) — rates of current daily smokers[[17]](#footnote-17), measured by the proportion of people aged 18 years or over who are current daily smokers (all jurisdictions; remoteness; age; sex).  Smoking rate data are available from the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) or National Aboriginal and Torres Strait Islander Social Survey (NATSISS), with the most recent data available from the 2018-19 NATSIHS. Data for the non‑Indigenous population are sourced from the ABS National Health Survey (NHS), with the most recent data available from the 2017-18 NHS. |
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Public health measures to decrease tobacco consumption have played a role in reducing smoking prevalence among Australian adults (Wakefield et al. 2014). These measures include smoke‑free laws, tobacco taxes, plain packaging of products, graphic health warnings on packets, support for smokers to quit and greater exposure to mass media campaigns (Wakefield et al. 2014). The Tackling Indigenous Smoking Program has also contributed to reduced smoking rates among Aboriginal and Torres Strait Islander people through a regional grants program driving growth in partnerships and community engagement, multi-level and locally relevant health promotion, and increased access to culturally appropriate quitting support (Mitchell, Bandara and Smith 2018).

Despite these efforts, smoking is still the single biggest contributor to the burden of preventable ill health and death in Australia (section 4.1 *Life Expectancy* has further information on cancer-related deaths), leading to over 20 000 premature deaths in 2015 (AIHW 2019). Smoking affects health in many ways — including by increasing the risk of many cancers, most notably lung cancer, and other chronic diseases such as heart disease, stroke, diabetes and oral health problems (Greenhalgh 2015; Wilson et al. 2017). Smoking in pregnancy (section 6.2 *Health behaviours during pregnancy* has further information on health behaviours during pregnancy) can lead to miscarriage, stillbirth or premature birth — and second-hand smoke can cause disease in non‑smoking adults and children, including sudden infant death syndrome (Colonna et al. 2020; Graham et al. 2007; Greenhalgh 2015).

### Over time, the proportion of Aboriginal and Torres Strait Islander adults who do not smoke has increased, and particularly for younger adults…

Over time, the rates of Aboriginal and Torres Strait Islander adults who are not smoking have increased. Between 2001 and 2018-19, the crude daily smoking rate for Aboriginal and Torres Strait Islander adults declined from 51 to 40 per cent (table 8A.4.1). About 60 per cent of Aboriginal and Torres Strait Islander adults now do not smoke, which means 50 000 fewer smokers than would have been the case if the proportion had remained at the 2001 level.

The majority of the increase in those who do not smoke was in non-remote areas, where people are likely to have benefited more from the smoking regulations that banned smoking from office workplaces and hospitality venues (Williams and Allan 2019). Crude daily smoking rates in remote and very remote areas remained relatively stable, and higher than in major cities and inner regional areas (figure 8.4.1).

In particular, the rates of younger Aboriginal and Torres Strait Islander adults in non-remote areas who are not smoking have increased. Between 1995 and 2018-19, the greatest reduction in smoking rates was in non-remote areas for adults aged 25–34 years (dropping 23 percentage points) (table 8A.4.14). In future, this is likely to lead to reductions in tobacco‑related deaths, but it may take decades (see section 4.1 *Life Expectancy*).

| Figure 8.4.1 Current daily smoking, Aboriginal and Torres Strait Islander adults, by remoteness area, 2001 to 2018-19 (crude rates)**a,b** |
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| | Figure 8.4.1 Current daily smoking, Aboriginal and Torres Strait Islander adults, by remoteness area, 2001 to 2018-19 (crude rates)  More details can be found within the text surrounding this image. | | --- | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b See tables 8A.4.2–7 for detailed definitions, footnotes and caveats. |
| *Source*: National Aboriginal Torres Strait Islander Health Survey (various years); ABS (unpublished) National Aboriginal Torres Strait Islander Social Survey (various years); tables 8A.4.2–7. |
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### …but smoking rates remain higher than for non-Indigenous adults…

Smoking rates for non-Indigenous adults have decreased by a similar percentage point amount. However, as they have decreased from a lower base, the ratio for Aboriginal and Torres Strait Islander adults and non-Indigenous adults has increased. In 2001, the smoking rate for Aboriginal and Torres Strait Islander adults was just over twice the rate for non‑Indigenous adults, but by 2017–19 the rate was three times that for non-Indigenous adults (table 8A.4.8).

### … with the higher rates influenced by a range of factors

Smoking rates are influenced by ease of access to tobacco, economic and socio-cultural factors. People from lower socio-economic groups are more likely to start smoking earlier, and to continue smoking (Greenhalgh 2015). Areas with a high concentration of people experiencing disadvantage are also more likely to have higher tobacco outlet densities, which is positively associated with smoking (Barnes et al. 2016; Marashi-Pour 2015). Smoking rates are also likely to be related to social stress and economic hardship that arise from the experiences of disadvantage. Not being able to find employment, could constitute a substantial social stressor that promotes smoking as a coping strategy (Carroll et al. 2019).

Social networks can expose people to smoking and sharing cigarettes which can make it difficult to quit, although these networks can also provide support when quitting (Thomas et al. 2019a; Wright 2018). In some communities, smoking is a socio-cultural norm, and women in a small number of communities still chew pituri and other native tobacco as a cultural practice (Cockburn, Gartner and Ford 2018; Greenhalgh 2015; Lovett, Thurber and Raglan 2017). There are little data on the use of electronic cigarettes, but preliminary research indicates that fewer Aboriginal and Torres Strait Islander people, compared to all Australians, have tried e‑cigarettes (Thomas et al. 2019b).

Aboriginal and Torres Strait Islander people who smoke are aware of the health impacts. However, in addition to the above factors Aboriginal and Torres Strait Islander people face, other structural barriers to reducing tobacco consumption include not being able to access or, in some cases, not being aware of quit programs (Nicholson et al. 2015; Robertson et al. 2013; Wright 2018).

### Evidence on approaches that reduce Aboriginal and Torres Strait Islander people’s smoking rates is scant, but programs that use local solutions are promising

The evidence on how to design effective services for reducing smoking by Aboriginal and Torres Strait Islander people is scant (Williams and Allan 2019). More evaluation of smoking cessation initiatives and their impact on Aboriginal and Torres Strait Islander people in different contexts is needed.

However, the results in this section and identified research suggest that Aboriginal and Torres Strait Islander adults in remote communities could benefit from more localised solutions to prevent the uptake of smoking and support people to quit (Carroll et al. 2019). Available research indicates that community-based programs that use local approaches to support Aboriginal and Torres Strait Islander people to quit smoking should involve Aboriginal and Torres Strait Islander people, their leaders and communities in developing, implementing and evaluating multi-faceted interventions and support services that take account of cultural practices, traditions and language (Carroll et al. 2019; Williams and Allan 2019; World Health Organization 2005). As an example, the Tackling Indigenous Smoking (TIS) program, through its flexible design, facilitates local solutions. Under the program there has been a growth in partnerships and community engagement, the delivery of local health promotion for tobacco control, increased access to culturally relevant quitting support, and an increase in the use of evidence to inform program design and improvement (Mitchell, Bandara and Smith 2018)[[18]](#footnote-18). While not an evaluation of the outcomes of the TIS, research conducted by the ABS has found that, although there has been some decline in smoking rates since the commencement of targeted measures, it takes about 10 years for smoking reduction programs to have an effect (ABS 2017).

### Future directions in data

There is little information comparing the direct effects of community-controlled and non‑community controlled responses on smoking cessation. While some research suggests that community-controlled smoking cessation programs are more effective in reducing smoking rates — as Williams and Allan (2019) concluded from their history of anti-smoking initiatives in Australia — there is no available quantitative assessment of the effectiveness of community‑controlled approaches relative to other approaches. One way to facilitate outcome evaluations, as suggested in the evaluation of the TIS program, is for Quitline to collaborate and share data with recipients of TIS regional grants and for the Department to create a baseline for further evaluation (Mitchell, Bandara and Smith 2018).

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## 8.5 Obesity and nutrition[[19]](#footnote-19)

| Box 8.5.1 Key messages |
| --- |
| * A healthy weight reduces the risk of heart disease, some cancers and other health conditions, whereas obesity leads to poor health and reduces average life expectancy. * Obesity and overweight rates are increasing for both Aboriginal and Torres Strait Islander adults and non-Indigenous adults. The rates increased at a similar pace from 2011–13 to 2017–19, but remain higher for Aboriginal and Torres Strait Islander adults (74 per cent, and around 1.2 times the rate for non-Indigenous adults after adjustments for differences in population age structures). * The higher overweight and obesity rates for Aboriginal and Torres Strait Islander adults are due to higher rates for females at all ages, and for younger males. A higher proportion of Aboriginal and Torres Strait Islander adults under the age of 45 are overweight and obese, than non-Indigenous adults in this age range. But, by the age of 45, the proportion of non‑Indigenous males who are overweight and obese is similar to the proportions for Aboriginal and Torres Strait Islander males and females in this age range. * Rates of obesity and overweight may be influenced through structural measures to improve nutrition or increase physical activity or by reducing vulnerability to personal risk factors: * Structural measures to improve nutrition or increase physical activity include improving the supply of affordable healthy food options relative to unhealthy ones, and increasing options for fresh food preparation and storage, particularly in remote areas. However, evidence on the effectiveness of structural measures to reduce obesity rates is limited. * Reducing personal risk factors related to poor nutritional choices and sedentary lifestyles, can reduce obesity in adults. Programs that address these risk factors, such as providing education and advice, are most successful if there has been Aboriginal and Torres Strait Islander community involvement in the design and delivery. * A small proportion of Aboriginal and Torres Strait Islander children and non‑Indigenous children (around 6 per cent for both) have an adequate daily intake of vegetables. The average adequate daily intake of fruit is much higher than vegetables for both Aboriginal and Torres Strait Islander children (69 per cent) and non‑Indigenous children (76 per cent). * As with obesity and overweight in adults, nutrition issues for children can be addressed through multifaceted approaches to improve individual knowledge and skills, as well as strategies to improve access to healthy food options. |
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| Box 8.5.2 Measures of obesity and nutrition |
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| There is one main measure for this indicator (aligned with the associated NIRA indicator). Overweight and obese is defined as the number of people aged 18 years or over with a Body Mass Index (BMI) in the range 25.0–29.9 (overweight) or 30 or higher (obese) as a proportion of the total population (table 8A.5.1)[[20]](#footnote-20). Additional data are also reported for people with a BMI of 18.5–24.9 (normal weight) and with a BMI of less than 18.5 (underweight) (all jurisdictions; remoteness; sex; age).  Data are also provided for two supplementary measures:   * the proportion of Aboriginal and Torres Strait Islander people (aged 18 years or over) at increased risk of developing chronic disease because their waist measurement is greater than 94 cm for men and 80 cm for women * the proportion of children aged 2–14 years meeting the recommended average daily fruit and vegetable consumption guidelines (national; remoteness; age).   The data source for these measures is the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) with the most recent data for 2018-19. Data for the non-Indigenous population are sourced from the National Health Survey (NHS) with the most recent data for 2017‑18. BMI data for 2018-19 and 2012-13 are not directly comparable with earlier data for 2004‑05. |
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Maintaining a healthy body weight can protect against infection, and reduce the risk of chronic disease and premature deaths. Whereas obesity leads to poor health, increasing the risk of an individual developing, among other things, cardiovascular disease, Type 2 diabetes, some musculoskeletal conditions and some cancers (including oesophageal, stomach, colon and rectum cancers) (AIHW 2019; Wilson et al. 2018), which reduce average life expectancy (Zhao et al. 2013).

Good nutrition and physical activity assist in maintaining a healthy body weight, whereas poor nutrition and a sedentary lifestyle can lead to obesity. However, the underlying causes of obesity are complex and not necessarily lifestyle related; for example, obesity is linked to other factors such as low income, low education levels, disability and complex health needs — although the evidence on the link with low income is mixed, with low income and related food insecurity also associated with lower BMI (NHMRC 2013; OECD 2017; Ride and Burns 2020; Thurber and Bell 2019). Racial discrimination in childhood is associated with increased BMI and waist circumference (Priest et al. 2020), and obesity in childhood is associated with an increased risk of obesity in adulthood (Salmon et al. 2019).

Population data on overweight/obesity are commonly based on measurements of BMI, as is the case with the national survey data used in this section. However, it is important to note that abdominal obesity or elevated waist circumference has been identified as having a potentially stronger association with cardiovascular disease, diabetes and all-cause mortality, than BMI, particularly for Aboriginal and Torres Strait Islander people who have a different body fat distribution and fat mass for their given body weight (Adegbija et al. 2017; Avery, Taylor and Dal Grande 2015; Bambrick 2005; Piers et al. 2003; Wang et al. 2007). In 2018‑19, about 9 percent of Aboriginal and Torres Strait Islander people with an elevated waist circumference were not overweight or obese (table 8A.5.17).

### Obesity is increasing across the Australian population, for both non‑Indigenous adults and Aboriginal and Torres Strait Islander adults

Obesity is increasing across the Australian population. The crude rate of Aboriginal and Torres Strait Islander adults who were overweight or obese increased from 69 per cent in 2012-13 to 74 per cent in 2018-19 (table 8A.5.15). After adjusting for differences in population age structures, the rate of overweight/obesity increased at a similar pace for both Aboriginal and Torres Strait Islander adults and non‑Indigenous adults from 2011–13 to 2017–19, with the rate for Aboriginal and Torres Strait Islander adults around 1.2 times the rate for non-Indigenous adults (tables 8A.5.2-3).

Higher overweight and obesity rates for Aboriginal and Torres Strait Islander adults compared to non-Indigenous adults are due to higher rates for females at all ages, and for younger males. A higher proportion of Aboriginal and Torres Strait Islander adults under the age of 45 years are overweight and obese than non-Indigenous adults in this age range (for both males and females). But, by the age of 45, the proportion of non-Indigenous males who are overweight and obese is similar to the proportions for Aboriginal and Torres Strait Islander males and females in this age range (figure 8.5.1).

In 2018-19, a higher proportion of Aboriginal and Torres Strait Islander people were overweight and obese in major cities (80 per cent) and inner regional areas (83 per cent) than in very remote areas (67 per cent) (table 8A.5.5). Data for rates of overweight and obesity by State and Territory and by remoteness area are available in tables 8A.5.2–10 (age‑standardised) and 8A.5.14–16 (crude rates).

| Figure 8.5.1 Overweight and obese adults, by Indigenous status, by age, by sex, 2017–19**a** |
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| | Figure 8.5.1 Overweight and obese adults, by Indigenous status, by age, by sex, 2017–19  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.5.11 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) National Aboriginal Torres Strait Islander Health Survey 2018-19, ABS (unpublished) National Health Survey 2017-18; table 8A.5.11. |
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### Rates of obesity and overweight may be influenced through structural measures to improve nutrition or increase physical activity or reducing personal risk factors

Overweight and obesity rates may be influenced through structural measures to facilitate changes to nutrition and/or physical activity.

* Measures to facilitate improvement in nutrition might include improving or maintaining the supply of affordable healthy food options relative to unhealthy ones, and increasing options for fresh food preparation and storage, particularly in remote areas.
* Increasing the supply of affordable healthy options in remote communities could be facilitated by subsidising the cost of healthy foods (Crowle and Turner 2010) through community stores (which in some communities provide the only food source) (Lee et al. 2016) or, encouraging the development of community gardens (Fawcett 2013; Ride and Burns 2020). Furthermore, in remote areas where healthy food options include those sourced from local resources, such as fishing in the Torres Strait Islands (section 12.1 *Outcomes for Torres Strait Islander people*), the sustainability or maintenance of these resources through environmental protection may be required.
* Improving the standard of housing could in turn improve the facilities to store and prepare nutritious food (Ride and Burns 2020, section 10.2 R*ates of disease associated with poor environmental health* and section 10.3 *Access to clean water and functional sewerage and electricity services*).
* Measures to increase physical activity might include improving access to exercise programs and facilities (Crowle and Turner 2010) that are culturally safe (Macniven and Esgin 2020).

However, evidence on whether these structural measures facilitate improved nutrition and increased physical activity is limited (Crowle and Turner 2010). One study in the Anangu Pitjantjatjara Yankunytjatjara (APY) lands found that while healthy food options have become more available and affordable over time, there continues to be high intake of unhealthy food items as they are still cheaper than healthy food and some houses have inadequate cooking facilities to make healthier alternatives (Lee et al. 2016).

Reducing personal risk factors related to poor nutritional choices and sedentary lifestyles, for example through education programs to improve knowledge and skills, can also play a role in reducing overweight and obesity. Programs designed with strong community involvement have been shown to be the most successful in reducing BMI (Browne et al. 2017; Schembri et al. 2016). Culturally safe programs led by Aboriginal and Torres Strait Islander facilitators and health workers may have more success than mainstream programs in effectively addressing the personal risk factors that can lead to obesity for Aboriginal and Torres Strait Islander people, as they recognise:

* the importance of relationships, connection to lands, environment, family and community, a sense of identity, self-determination and culture (Salmon et al. 2019).
* obesity as multi-factorial, influenced by physiological, behavioural, psychological and environmental drivers and the impact of colonisation (Bell et al. 2017).

### For all children, adequate daily consumption of fruit and vegetables by children remains below the recommended guidelines

Consumption of unhealthy foods, such as sugar-sweetened beverages and high fat foods (including takeaway and convenience foods) contribute to childhood obesity. The NHMRC Australian dietary guidelines are designed for the general population and recommend eating a wide variety of nutritious food (vegetables, legumes, fruits, cereals, lean meat, fish, poultry, and reduced fat dairy products), drinking plenty of water and limiting consumption of saturated fat, salt, alcohol and sugars. Data reported for 2018-19 are based on the 2013 NHMRC daily food consumption guidelines (NHMRC 2013). However, they do not necessarily reflect the particular dietary needs of people with illnesses such as diabetes or regional dietary preferences (Ward and Best 2020).

In 2018-19, 69 per cent of Aboriginal and Torres Strait Islander children aged 2–14 years across all areas met the guidelines for adequate daily fruit consumption; lower than the rate for non-Indigenous children (76 per cent) (table 8A.5.18). The proportions meeting the guidelines for adequate daily vegetable intake were much lower for all children — around 6 per cent for Aboriginal and Torres Strait Islander children and non‑Indigenous children (table 8A.5.18). Between 2011–13 and 2017–19, the only significant change in usual fruit and vegetable intake was an increase in usual fruit intake for non‑Indigenous children (tables 8A.5.18–20).

As with obesity and overweight in adults, nutrition issues for children can be addressed through multifaceted approaches addressing improving individual knowledge and skills, as well as strategies that improve access to healthy food options. Programs to improve nutritional choices, are most successful among Aboriginal and Torres Strait Islander people where they have strong community involvement in their design and delivery (Browne et al. 2017; Schembri et al. 2016). The consistent inclusion of culturally safe nutrition education and advice into maternal and child healthcare services may also improve Aboriginal and Torres Strait Islander children’s nutrition (Browne et al. 2017).

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## 8.6 Oral health[[21]](#footnote-21)

| Box 8.6.1 Key messages |
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| * Good oral health has many benefits including the ability to chew, swallow smile and speak with confidence, which are important for people’s overall health and wellbeing. Good oral health also prevents the most common chronic oral diseases that cause discomfort, including tooth decay and tooth loss. * Data available for 2012–14 show that Aboriginal and Torres Strait Islander children had twice as many decayed, missing or filled tooth surfaces, on average, as non-Indigenous children. But non-Indigenous adults had more decayed, missing or filled teeth than Aboriginal and Torres Strait Islander adults (in 2017-18), due in part to their older age profile. * Poor oral health outcomes are associated with lower incomes. Aboriginal and Torres Strait Islander children’s overrepresentation in lower income families may therefore be a key factor in why the oral health of Aboriginal and Torres Strait Islander children is poorer than that of non-Indigenous children. There may also be other structural factors, such as the lack of fluoridated water in some rural and remote areas. * Aboriginal and Torres Strait Islander peoples’ higher rates of preventable oral health disease are likely to lead to higher rates of potentially preventable hospitalisations for dental conditions. * Oral disease may negatively affect productivity through time lost that would otherwise be spent working or studying. Many dental conditions could be prevented through regular care and early intervention — but, because of delays to treatment, end up imposing greater costs. |
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| Box 8.6.2 Measures of oral health |
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| There are two main measures for this indicator:   * *Child dental health* is defined as the proportion of children with no decayed, missing or filled teeth surfaces (dmfs/DMFS)[[22]](#footnote-22) for children aged 5–10 years (infant teeth) and 6–15 years (permanent teeth). The most recent data for children aged 5–10 years (infant teeth) and  6–14 years (permanent teeth) are sourced from *Oral Health of Australian Children: the National Child Oral Health Study 2012-14* (Do and Spencer 2016). Until 2010, data were sourced from the AIHW Child Dental Health Survey and were for decayed, missing and filled teeth (DMFT/dmft). * *Adult dental health* is defined as the number of decayed, missing and filled teeth (DMFT) for people aged 15 years or over. The most recent data are sourced from the *National Survey of Adult Oral Health, 2017–2018*.   (continued next page) |
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| Box 8.6.2 (continued) |
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| Supplementary data for the main measures are reported from the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)/National Aboriginal and Torres Strait Islander Social Survey (NATSISS), with the most recent data for 2018-19 for people aged 15 years or over (data are based on self-report). Non-Indigenous comparator data are not available.  A supplementary measure is reported on the hospitalisation rate for dental health conditions per 100 000 population (by age and by remoteness)[[23]](#footnote-23). |
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Good oral health has many benefits including the ability to smile, speak, chew and swallow with confidence, which are important for people’s overall health and wellbeing (Glick et al. 2016). Oral health refers to the condition of a person’s teeth and gums, as well as the health the muscles and bones in the mouth (AHMAC 2017).

Dental hygiene (or regular tooth brushing and flossing), good nutrition and regular dental visits (every six months) all support oral health. Tooth brushing and flossing are important, and can be encouraged through education and modelling by adults in the home environment and/or education outside the home (Jamieson, Armfield and Roberts-Thomson 2007). Reducing how often sugar is consumed (more so than the quantity) is also a factor, as sugar consumption increases the risk of dental caries; children who fall asleep with bottles of milk or juice in their mouth are at a greater risk of permanent tooth decay (Yacoub and Karmally 2017). Regular dental visits to manage issues and for routine check-ups are vital for good oral health, and can result in lower prevalence of dental decay (Australian Indigenous HealthInfoNet 2020).

The public health policy of fluoridation also supports good oral health. Fluoride in the water supply is one of the most effective ways to prevent dental caries for children and adults (Spencer, Do and Ha 2018; Yacoub and Karmally 2017), and has been shown to reduce tooth decay by 26–44 per cent (NHMRC 2017). However, the proportion of the population with access to fluoridated water varies across states and territories (table 8.6.1).

Good oral health also prevents the most common chronic oral diseases that cause discomfort (Yacoub and Karmally 2017). These diseases include dental caries (tooth decay), periodontal disease, tooth loss, and cancers of the lips and oral cavity (AHMRC 2016; Peres et al. 2019). If left untreated, they can have significant consequences, including:

* pain and sepsis leading to poorer quality of life, lost school days, disruption to family life, and decreased work productivity (Peres et al. 2019)
* reduced nutritional intake arising from tooth loss, especially in older populations (Yacoub and Karmally 2017)
* when occurring during pregnancy, low and very low birth weight babies, preeclampsia, and gestational diabetes. Bacteria associated with dental caries can also be transmitted to the child, increasing the risk of childhood caries (Cobb et al. 2017; Hartnett et al. 2016).

| Table 8.6.1 Population with access to fluoridated water (February 2017)**a** |
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| | State or Territory | Proportion of population with access to fluoridated water | | --- | --- | | NSW | 93 per cent | | Victoria | 90 per cent | | Queensland | 76 per cent | | WA | 92 per cent | | SA | 92 per cent | | ACT | 100 per cent | | Tasmania | 90 per cent | | NT | 78 per cent | |
| a In some jurisdictions, the proportion of the population with access to fluoridated water is higher than the number given. This is because some Australian drinking water supplies, particularly those relying on bore water, contain naturally occurring fluoride at a concentration of around 0.5 mg/L. |
| *Source*: NHMRC (2017) *Water Fluoridation and Human Health in Australia*, Canberra. |
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Good oral health may also contribute to preventing other chronic diseases, although the relationship is complex. There is evidence of the link between poor oral health and chronic diseases, such as cardiovascular disease and diabetes; people with diabetes are three times more likely to get periodontitis (Seitz et al. 2019; Yacoub and Karmally 2017). However, periodontal disease is also associated with smoking, alcohol intake, and obesity (Yacoub and Karmally 2017), all of which are in turn related to chronic diseases.

### Data from 2012–14 show that Aboriginal and Torres Strait Islander children had more oral health issues than non-Indigenous children, but this pattern changes in adulthood

Data from 2012–14 show that Aboriginal and Torres Strait Islander children had twice as many decayed, missing or filled tooth surfaces (dmfs/DMFS), on average, as non-Indigenous children. The average number of dmfs/DMFS:

* in the infant teeth of Aboriginal and Torres Strait Islander children aged 5–10 years was 6, compared with 3 surfaces for non-Indigenous children (table 8A.6.1)
* in the permanent teeth of Aboriginal and Torres Strait Islander children aged 6–14 years was 1.3, compared with 0.7 surfaces for non-Indigenous children (table 8A.6.2).

But the pattern of oral health issues changes in adulthood, with the average number of DMFT for Aboriginal and Torres Strait Islander adults (aged 15 years or over) lower than for non‑Indigenous adults. In 2017-18, the average number of DMFT in the teeth of Aboriginal and Torres Strait Islander dentate[[24]](#footnote-24) adults was 7.5 compared with 11.3 for non‑Indigenous dentate people (table 8A.6.8). However, because these data have not been adjusted for differences in population age structures, the difference may be because a greater proportion of non‑Indigenous people were in the older age bracket of 75 years or over (predisposing them to have a larger average number of DMFT).

### Lower incomes may be a key reason why the oral health of Aboriginal and Torres Strait Islander people is poorer than that of non‑Indigenous people, but other structural factors may also have a role

The association between good oral health and higher income levels is well known. Oral diseases, like many non-communicable diseases, are more likely in children living in poverty and socially marginalised groups. This pattern points to the role of social factors as determinants of dental caries and the population’s use of dental services (Do and Spencer 2016; Peres et al. 2019). For example, the average number of dmfs/DMFS in   
2012–14 was lowest both among children aged 5–10 years (with infant teeth) and children aged 6–14 years (with permanent teeth) for those in families on high incomes, and highest for those in families on low incomes (tables 8A.6.1-2).

This association also exists within Aboriginal and Torres Strait Islander communities, with the extent of dental issues for children and adults varying according to household income level. In 2012–14, the proportion of Aboriginal and Torres Strait Islander children aged   
5–8 years who had dmfs>0 was 29 per cent in high income households, increasing to 64 per cent in low income households (tables 8A.6.3); for children aged 9–14 years, the DMFS proportions were 41 per cent for high income households and 51 per cent for low income households (table 8A.6.4). Similarly, the majority of Aboriginal and Torres Strait Islander adults in 2018-19 who experienced complete tooth loss came from the most disadvantaged quintile — and Aboriginal and Torres Strait Islander people who were employed, had completed year 12 or equivalent, were non‑smokers, or had no heart disease or diabetes were more likely to have no tooth loss (table 8A.6.12).

People at all income levels are more likely to skip the dentist than other types of health care, but the cost of care mostly affects people on low incomes (Duckett, Cowgill and Swerrison 2019). The cost of dental health combined with lower average income levels may mean that preventative dental care is not accessed as regularly as needed by Aboriginal and Torres Strait Islander people, but instead is delayed until a problem develops. In 2014-15, among Aboriginal and Torres Strait Islander children aged 0–14 years with teeth or gum problems, only 71 per cent had had a dental check-up within the previous year (table 8A.6.6), — and cost was the major reason why many members of this age group had not seen the dentist (28 per cent) (table 8A.6.7).

Although the cost of dental care may be a key factor, the association between low average incomes for Aboriginal and Torres Strait Islander people and poor oral health is complex. Preventative oral health behaviours such as tooth brushing and flossing are developed mainly through education and modelling by adults in the home environment, and dental hygiene practices such as brushing teeth twice a day (as recommended) are more common among children in households where parents have higher levels of education or income (Do and Spencer 2016). In 2018-19, 40 per cent of Aboriginal and Torres Strait Islander children aged 2–14 years brushed their teeth twice a day or more, and another 43 per cent brushed their teeth at least once a day (table 8A.6.13). Comparable data for non-Indigenous children are not available. However, in 2012–14, just over two-thirds of children reported brushing their teeth twice or more per day; for Aboriginal and Torres Strait Islander children, the figure was then 54 per cent (Do and Spencer 2016).

There are also other structural factors that prevent Aboriginal and Torres Strait Islander people (children and adults) obtaining good oral health, such as:

* A higher proportion of Aboriginal and Torres Strait Islander people live in areas where the water remains non-fluoridated, or they are more likely to drink non-fluoridated bottled water (AHMRC 2016; AMA 2019; Do and Spencer 2016). However, the number of dental caries in Aboriginal and Torres Strait Islander people compared with non‑Indigenous people is not necessarily always explained by lower access to water fluoridation (Lalloo et al. 2015).
* Aboriginal and Torres Strait Islander people may have limited or no access to culturally safe dental services (Durey et al. 2016). Health outcomes for Aboriginal and Torres Strait Islander patients have been found to be better when they are treated by Aboriginal and Torres Strait Islander health professionals, but Aboriginal and Torres Strait Islander people are under-represented in the oral health workforce (AMA 2019).
* A specific lack of culturally safe dental services in rural and remote areas (AMA 2019). In 2017-18, people in capital cities were more likely (61 per cent) to usually visit a dental professional than those in other places (51 per cent) (table 8A.6.9), and this disparity disproportionately affects Aboriginal and Torres Strait Islander people (AHMRC 2016; AMA 2019).
* Access to transport, the level of priority that oral health is given by the community (relative to other priorities), and competing family responsibilities may all prevent Aboriginal and Torres Strait Islander people from accessing dental services (Tynan et al. 2020).

Addressing these structural issues may go some way towards improving Aboriginal and Torres Strait Islander people’s oral health. Associated data on dental health issues are available in section 8.1 *Access to primary health care*, tables 8A.1–12.

### Aboriginal and Torres Strait Islander people’s higher rates of preventable oral health disease are likely to lead to higher rates of potentially preventable hospitalisations for dental conditions

Many dental conditions could be prevented through regular care and early intervention. However, because of the cost of private dental care and the way in which public dental waiting lists are managed, oral health can deteriorate through delay — resulting in potentially avoidable conditions and in greater hospital and GP costs (Duckett, Cowgill and Swerrison 2019; PC 2017).

Aboriginal and Torres Strait Islander peoples’ hospitalisation rates for potentially preventable oral health diseases have increased over time, while the rates for non-Indigenous people have remained similar. In 2018-19, after adjusting for differences in population age structures, hospitalisations for dental conditions were around 382 per 100 000 population for Aboriginal and Torres Strait Islander people — up from 308 per 100 000 population in   
2010-11, and 1.4 times the rate for non-Indigenous people (compared with 1.1 times the rate in 2010-11) (table 8A.6.14).

However, the results differ for Aboriginal and Torres Strait Islander children across age groups and remoteness areas. Children aged less than 10 years had higher rates of hospitalisation for dental health conditions than non-Indigenous children in the same age group, but for older Aboriginal and Torres Strait Islander children aged 10–14 years the reverse is reported (table 8A.6.17). For those aged less than 10 years, the gap in rates widened as remoteness increased (table 8A.6.19).

### Future directions in data

For data on child oral health, the AIHW last conducted its Child Dental Health Survey in 2010 and the University of Adelaide conducted its National Child Oral Health Study between 2012 and 2014. Neither the AIHW nor the University of Adelaide have current plans to conduct further national surveys. Ongoing and more regular data collection nationally on dental health for Aboriginal and Torres Strait Islander children is needed. Amongst other things, data collections (and linkage) should explore the complex association between levels of income and oral health.

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## 8.7 Mental health[[25]](#footnote-25)

| Box 8.7.1 Key messages |
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| * For Aboriginal and Torres Strait Islander people, social and emotional wellbeing is the foundation for both physical and mental health. It is a holistic concept reflecting the interconnectedness of individuals, family, kin and community, and it recognises an individual’s connection to land (central to wellbeing), culture, spirituality and ancestors. When the harmony of these interrelations is disrupted, ill health persists. * Aboriginal and Torres Strait Islander people are resilient. Despite experiencing significant challenges, in 2018-19 over two-thirds of adults reported low or medium levels of psychological distress. * Factors that protect Aboriginal and Torres Strait Islander people and enable them to feel strong and resilient include being socially connected and having a sense of belonging, connection to land and culture, living on their traditional lands, self-determination, and strong community governance. * However, one in three Aboriginal and Torres Strait Islander adults reported high/very high levels of psychological distress, and this is more than double the rate for non-Indigenous adults. There are likely to be many reasons why, but having to deal with racism can be a key source of stress and affects the mental health of Aboriginal and Torres Strait Islander people and families. * The rates at which Aboriginal and Torres Strait Islander people receive clinical mental health services are not commensurate with their rates of high/very high distress. Aboriginal and Torres Strait Islander people are overrepresented in hospitalisations and deaths from mental health and behavioural conditions. * Few programs to support Aboriginal and Torres Strait Islander people’s mental health have been evaluated, and those that have rarely provide insight into the participants' perspectives. Some of the existing findings suggest that cultural safety, respect and trust, and sharing experiences (including yarning and story-telling) are valued elements for Aboriginal and Torres Strait Islander people. * Increasing the number of Aboriginal and Torres Strait Islander primary mental health workers (including Aboriginal Health Workers dedicated to children and young people) and building the cultural competence of the overall mental health workforce are also considered important in supporting Aboriginal and Torres Strait Islander people’s mental health. |
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| Box 8.7.2 Measures of mental health |
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| There is one main measure for this indicator:   * *Psychological distress*[[26]](#footnote-26) is defined as the proportion of people aged 18 years or over reported as experiencing high/very high levels of psychological distress (all jurisdictions; national data by remoteness, age and stressors). ‘Psychological distress’ refers to a combination of symptoms that are grouped in a way that is intended to reflect ‘non-specific’ psychological distress rather than a specific mental health disorder. Data for the main measure are available from the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)/National Aboriginal and Torres Strait Islander Social Survey (NATSISS), with the most recent available data for 2018-19. Data for the non-Indigenous population are sourced from the ABS National Health Survey (NHS), with the most recent data for 2017-18.   Three supplementary measures are also reported:   * *Treatment rate* is defined as the rate of patients treated for mental health by emergency departments (national), community and residential mental health care (all jurisdictions), and general practitioners (national). * *Hospitalisation rate* is defined as the rate of hospitalisations for mental and behavioural disorders per 100 000 population (all jurisdictions: sex and remoteness). * *Deaths from potentially avoidable mental and behavioural disorders* is defined as the rate of deaths from mental and behavioural disorders per 100 000 population (NSW, Queensland, WA, SA and the NT: age and sex). Data are available only for NSW, Queensland, WA, SA and the NT, as these jurisdictions have sufficient levels of Indigenous identification and numbers of deaths to support analysis. |
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Mental health is important to everyone. Although the term can mean different things to different people at different points in their lives — but the capacities to enjoy life, cope with stress and be resilient in response to adversity, set and fulfil goals, and build and maintain relationships are key aspects of being mentally healthy and participating in the community (PC 2019).

* Mental health is a state of *wellbeing* in which an individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. Mental health can be affected by a broad range of factors, including domestic violence (see section 4.12 *Family and community violence*), alcohol and substance misuse (see sections 11.1 *Alcohol consumption and harm* and 11.2 *Drug and other substance use and harm*), physical health problems, incarceration (see section 4.13 *Imprisonment and youth detention*), family breakdown and social disadvantage.
* Mental *illness* describes a range of behavioural and psychological conditions that can affect an individual’s mental health functioning and quality of life, including educational attainment (see section 4.6 *Year 12 attainment*) and income (see section 4.10 *Household and individual income*). The most common mental illnesses are anxiety, affective disorders (including depression) and substance use disorders (AIHW 2019). Mental illness also includes low prevalence conditions such as schizophrenia, other types of psychoses, and severe personality disorder.
* People experiencing a mental illness are more likely to have high or very high levels of psychological distress. Research shows an association between higher levels of psychological distress and lower levels of education, employment, income or home ownership (Cunningham and Paradies 2012). High psychological distress also has a strong association with morbidity and physical disability (McNamara et al. 2018).

For Aboriginal and Torres Strait Islander people, social and emotional wellbeing is the foundation for both physical and mental health (Commonwealth of Australia 2017; Dudgeon et al. 2016, 2020; Dudgeon, Milroy and Walker 2014; Marmor and Harley 2018). It is a holistic concept that includes mental health, but also reflects the interconnectedness of individuals, family, kin, and community, and it recognises an individual’s connection to land (central to wellbeing), culture, spirituality and ancestors — as illustrated in figure 8.7.1. When the harmony of these interrelations is disrupted, ill health persists (Dudgeon, Milroy and Walker 2014).

| Figure 8.7.1 A model of social and emotional wellbeing from the perspective of an Aboriginal and Torres Strait Islander person |
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| | Figure 8.7.1 A model of social and emotional wellbeing from the perspective of an Aboriginal and Torres Strait Islander person  More details can be found within the text surrounding this image. | | --- | |
| *Source*: Gee, Dudgeon, Schultz, Hart and Kelly (2013) in Dudgeon P, Milroy M, and Walker R (eds.) (2014) *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Commonwealth of Australia, Canberra. |
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### Aboriginal and Torres Strait Islander people are resilient — despite the many challenges they face, two-thirds of Aboriginal and Torres Strait Islander adults reported low or medium levels of distress…

Aboriginal and Torres Strait Islander people are resilient. Despite the many challenges Aboriginal and Torres Strait Islander people face (as outlined in other sections of this Report), two-thirds of adults reported low or medium levels of psychological distress in 2018-19 (table 8A.7.1). Furthermore, on a range of selected indicators of positive wellbeing, almost 80 per cent of Aboriginal and Torres Strait Islander people described themselves as calm and peaceful and full of life, with 87 per cent describing themselves as happy (table 8A.7.6).

Many factors protect Aboriginal and Torres Strait Islander people from feeling distressed and unhappy, and enable them to be strong and resilient in challenging circumstances. These factors include being socially connected and having a sense of belonging, connection to land and culture, living on their traditional lands, self-determination, and strong community governance (Beyond Blue Australia 2020). For example, in one study, Aboriginal and Torres Strait Islander children were found to have an inner strength or fortitude despite challenging circumstances. A strong sense of cultural identity and safe, stable and supportive family environments promoted these resilient behaviours (Young et al. 2017). In a study involving Aboriginal and Torres Strait Islander prisoners, cultural engagement was associated with lower levels of psychological distress (Shepherd et al. 2018).

### … but one in three reported high/very high levels of psychological distress, more than double the rate for non-Indigenous adults

In 2018-19, about one-third (31 per cent) of Aboriginal and Torres Strait Islander adults reported high/very high levels of psychological distress, an increase from 27 per cent in 2004-05 (table 8A.7.1). After adjusting for differences in population age structures, the proportion of Aboriginal and Torres Strait Islander adults experiencing high/very high levels of psychological distress was more than twice the proportion for non-Indigenous adults (figure 8.7.2). Analysis of 2014-15 data show that Aboriginal and Torres Strait Islander people who were removed from their families as part of the stolen generation are 1.5 times, and their descendants 1.3 times, as likely to have poor mental health as those who were not removed (AIHW 2018).

A higher proportion of Aboriginal and Torres Strait Islander women experience high/very high levels of psychological distress than Aboriginal and Torres Strait Islander men; this pattern is also observed for non-Indigenous people, though from a lower base of distress (figure 8.7.2). There were no significant differences by age and no clear patterns in the data in relation to remoteness (tables 8A.7.1 and 8A.7.3). However, research suggests that living in areas where Aboriginal or Torres Strait Islander people are in the majority (as is the case in some remote communities) may mitigate the risk of psychological distress (Cunningham and Paradies 2012).

| Figure 8.7.2 Adults with high/very high psychological distress, by Indigenous status, by sex, 2017–19 (age-standardised)**a** |
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| Figure 8.7.2 Adults with high/very high psychological distress, by Indigenous status, by sex, 2017–19 (age-standardised)  More details can be found within the text surrounding this image. |
| a See table 8A.7.5 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (2019) *National Aboriginal and Torres Strait Islander Health Survey*, *2018-19*, cat. no. 4715.0; table 8A.7.5. |
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Aboriginal and Torres Strait Islander people are more likely to report high/very high levels of psychological distress and mental ill health, due to:

* unique risk factors, which are also intergenerational — including the grief, loss and trauma relating to the removal of children over many generations, separation from culture and identity, and discrimination based on race (Beyond Blue Australia 2020; Calma, Dudgeon and Bray 2017).
* Racism can be a key source of stress and can affect the mental health of Aboriginal and Torres Strait Islander people and families (Calma, Dudgeon and Bray 2017; Temple, Kelaher and Paradies 2020). A Victorian study suggests that Aboriginal and Torres Strait Islander people who experience racism are more likely than those who do not experience racism to be above the threshold for high or very high psychological distress (Ferdinand, Paradies and Kelaher 2013; Kelaher, Ferdinand and Paradies 2014). Racism can be internalised as negative concepts of self at an early age, leading to lower self-esteem, higher anxiety, stress and depression (Macedo et al. 2020; Priest et al. 2019).
* greater exposure to commonly documented risk factors associated with high levels of psychological distress — including poverty, unemployment and homelessness (AIHW 2019).
* Aboriginal and Torres Strait Islander children and youth who live in out-of-home care and/or have carers who are chronically ill or unemployed, are more likely to present at hospital for mental health conditions (Williamson et al. 2018).

The cumulative nature of these factors can wear down resilience and have a detrimental impact on Aboriginal and Torres Strait Islander people’s mental health (Calma, Dudgeon and Bray 2017).

### The proportion of Aboriginal and Torres Strait Islander people receiving clinical mental health services is not commensurate with the proportions of those reporting high/very high levels of psychological distress…

With higher rates of psychological distress, higher rates of people receiving clinical mental health services could be expected. However, whilst a higher proportion for Aboriginal and Torres Strait Islander people (compared with non-Indigenous people) accessed specialised public mental health services in 2017-18, there was no difference in the proportion who accessed services from the Medicare Benefits Schedule (which make up the majority of services used) (table 13A.17 in section 13 of SCRGSP 2020).

Even assuming that individuals counted as accessing public mental health services do not access Medicare-funded services the proportion counted as accessing services is about 16 per cent — compared with the one‑third of Aboriginal and Torres Strait Islander people experiencing high/very high levels of distress (table 13A.17 in section 13 of SCRGSP 2020). For non‑Indigenous people the proportion of people using mental health services is around 12 per cent, a similar proportion to the 13 per cent with high/very high levels of distress (table 8A.7.1, and table 13A.17 in SCRGSP 2020).

### … and Aboriginal and Torres Strait Islander people continue to be overrepresented in hospitalisations and deaths from mental health and behavioural conditions

In line with the higher proportion of Aboriginal and Torres Strait Islander adults with high/very high levels of psychological distress, Aboriginal and Torres Strait Islander people are overrepresented in hospitalisations for mental and behavioural disorders. For Aboriginal and Torres Strait Islander people, there were around 2650 hospitalisations for every 100 000 people in the community in 2016–2018 (table 8A.7.27). After adjusting for differences in population age structures, the Aboriginal and Torres Strait Islander hospitalisation rate for mental and behavioural disorders was almost twice the rate for non‑Indigenous people (table 8A.7.23). For both Aboriginal and Torres Strait Islander and non‑Indigenous people, the hospitalisation rate was higher in major cities than in regional and remote areas (table 8A.7.26).

The main component of the higher hospitalisation rates from mental and behavioural disorders for Aboriginal and Torres Strait Islander people was substance use disorder. In 2016–2018, substance use disorders accounted for 40 per cent of hospitalisations for Aboriginal and Torres Strait Islander people, and after adjusting for differences in population age structures the hospitalisation rate for this subset was almost four times the rate for non‑Indigenous people (table 8A.7.27).

The rate of deaths from mental and behavioural disorders for Aboriginal and Torres Strait Islander people was around 13 per 100 000 people in the community (table 8A.7.30). After adjusting for differences in population age structures, this rate was 1.4 times the rate for non‑Indigenous people (table 8A.7.30). The majority of deaths for both Aboriginal and Torres Strait Islander and non-Indigenous people were among people aged 45 years or over — 94 per cent and 99 per cent respectively (table 8A.7.31).

### What is known about programs and services that facilitate improved mental health for Aboriginal and Torres Strait Islander people?

Healing practices for physical, mental, emotional and spiritual wellbeing have been integral to Aboriginal and Torres Strait Islander cultures for many thousands of years. In the last few decades, there has been a resurgence in traditional therapeutic practice as the mental health movement has aligned with efforts to strengthen policy and service delivery toward greater self-determination (Dudgeon and Bray 2018). There is anecdotal evidence that traditional healing practices support mental health and wellbeing, but a stronger evidence base would provide further support. By supporting access to person-centred mental health services, cultural healers and culturally informed and evaluated healing methods, in addition to clinical practice, a better standard of mental health for Aboriginal and Torres Strait Islander people can be achieved (Dudgeon et al. 2016; Dudgeon and Bray 2018).

Few programs to support Aboriginal and Torres Strait Islander people’s mental health have been evaluated and those that have rarely provide insight into the participants' perspectives (Murrup‐Stewart et al. 2019). Findings from two studies asking about participants’ perspectives in mental health programs both identified sharing experiences (including yarning and story-telling) as valued elements, with one also identifying cultural safety, respect and trust (Carlin, Atkinson and Marley 2019; Murrup‐Stewart et al. 2019). Likewise, there is little research into treatment pathways that meet the particular needs of Aboriginal and Torres Strait Islander children and young people (Kilian and Williamson 2018).

A systematic review by Perdacher, Kavanagh and Sheffield (2019) focused on colonised countries under a Western model of health and justice, found only five evaluations globally of mental health and wellbeing interventions for Indigenous people in custody. While none quantitatively assessed mental health and wellbeing outcomes, the authors found that culturally-based interventions showed some promise. This is an important finding given the overrepresentation of Aboriginal and Torres Strait Islander people in prison (see section 4.13 *Imprisonment and youth detention*), and the evidence that, at least some Aboriginal and Torres Strait Islander Community Controlled Health Organisations, face barriers to providing health services (including mental health services) to prisoners (Pettit et al. 2019).

The research available indicates that having Aboriginal and Torres Strait Islander health workers working alongside doctors and building the cultural competence of the overall mental health workforce are both considered important in supporting the mental wellbeing of Aboriginal and Torres Strait Islander people (Kalucy et al. 2019).

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## 8.8 Suicide and self‑harm[[27]](#footnote-27)

| Box 8.8.1 Key messages |
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| * Suicide is one of the most serious public health challenges and causes substantial grief, pain and loss within and across communities. * At least 2390 Aboriginal and Torres Strait Islander people have died from suicide in the 20 years to 2018, with three‑quarters of them male. * The suicide rate for Aboriginal and Torres Strait Islander people remains about twice the rate for non‑Indigenous people, a ratio unchanged for the past six years. * Suicide rates vary across age groups; they are higher for Aboriginal and Torres Strait Islander people across all age groups except the oldest age group (aged 45 years or over), in which rates are higher for non‑Indigenous people. * Hospitalisation rates for intentional self‑harm have increased over time for Aboriginal and Torres Strait Islander people and are higher than for non‑Indigenous people. * Aboriginal and Torres Strait Islander women are more likely to be hospitalised for self‑harm than Aboriginal and Torres Strait Islander men, but are less likely to die from that self‑harm — mirroring the pattern seen for non‑Indigenous people. * A range of interrelated factors contribute to the higher rate of intentional self‑harm in Aboriginal and Torres Strait Islander communities. They include the intergenerational trauma attributable to colonisation and dispossession, exposure to multiple and cumulative life stressors, higher levels of psychological distress, exposure to suicide of other family members, poorer access to mental health services for people who are at risk of suicide, higher rates of alcohol use, and the use of illicit substances. * The common factor in successful approaches to preventing Aboriginal and Torres Strait Islander suicide is their development and implementation with Aboriginal and Torres Strait Islander leadership and in partnership with local Aboriginal and Torres Strait Islander communities. |
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| Box 8.8.2 Measures of suicide and self‑harm |
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| There is one main measure for this indicator. *Suicide deaths* is defined as the number of deaths from intentional self‑harm per 100 000 population (NSW, Queensland, WA, SA and NT; age; sex). Data for this measure are sourced from the ABS Causes of Death collection, with the most recent available data for 2018.  Data are only available for NSW, Queensland, WA, SA and the NT, as these jurisdictions have sufficient levels of Aboriginal and Torres Strait Islander identification and numbers of deaths to support analysis.  Data are also provided for one supplementary measure, the *number of non‑fatal hospitalisations from intentional self‑harm per 100 000 population* (all jurisdictions; sex; remoteness). Prior to 2010‑11, six jurisdictions (NSW, Victoria, Queensland, WA, SA and the NT) were considered to have adequate identification of Aboriginal and Torres Strait Islander people in hospitalisation data. Hospitalisation data for all jurisdictions are reported from 2010‑11 to 2018‑19; data for the six jurisdictions are reported for 2004‑05 to 2018‑19. |
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Suicide is one of the most serious public health challenges and the leading cause of death for young people (including young Aboriginal and Torres Strait Islander people) (AIHW 2019). However, preventing suicide is possible with the right approaches (Mendoza and Rosenberg 2010; WHO 2014).

Suicide causes substantial grief, pain and loss within and across communities. For every suicide death, many other people are affected — particularly close friends and family, who can suffer from intense grief for many years (Cerel et al. 2019; Comans, Visser and Scuffham 2013; Silburn et al. 2014). Suicides can occur in clusters within a community over a limited period; these clusters have particularly negative effects on communities due to the risk of further suicides, significant grief reactions and the ongoing trauma and ‘bereavement overload’, which in turn can contribute to future suicidal behaviours (AHA 2014; Hanssens 2016; Robinson et al. 2016; Too et al. 2017).

Suicide often occurs among people suffering from mental health challenges or illnesses; however, it can also happen impulsively in moments of crisis, such as when people have health or financial problems or after exposure to other suicides (Hanssens 2010; Robinson et al. 2016; WHO 2014). Self‑harm and suicidal ideation are signals of considerable emotional distress and are associated with a higher risk of eventual death by suicide (Bergen et al. 2012; Hawton et al. 2015; Ribeiro et al. 2016). Section 8.7 *Mental health* reports on mental health in more detail.

### At least 2390 Aboriginal and Torres Strait Islander people have died from suicide in the past 20 years, with three‑quarters of them male

Over the two decades to 2018, at least 2390[[28]](#footnote-28) Aboriginal and Torres Strait Islander people died from intentionally harming themselves (table 8A.8.1).

As with non‑Indigenous people, suicide is more common among Aboriginal and Torres Strait Islander men than women. Between 2008 and 2018, after adjusting for differences in population age structures, the suicide rate for Aboriginal and Torres Strait Islander males was about three‑and‑a‑half times that of females (and this ratio is rising); this ratio was also similar to that between non‑Indigenous males and females (figure 8.8.1 and table 8A.8.1).

| Figure 8.8.1 Suicide for Aboriginal and Torres Strait Islander people, NSW, Queensland, WA, SA and the NT combined, by sex (age‑standardised rates)**a** |
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| | Figure 8.8.1 Suicide for Aboriginal and Torres Strait Islander people, NSW, Queensland, WA, SA and the NT combined, by sex (age-standardised rates)  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.8.1 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW and ABS analysis of National Mortality Database; table 8A.8.1. |
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### The suicide rate for Aboriginal and Torres Strait Islander people remains at about twice the rate for non‑Indigenous people

Aboriginal and Torres Strait Islander people have higher death rates from suicide than non‑Indigenous people (figure 8.8.2). For the period 2013 to 2018, after adjusting for differences in population age structures, the rate of deaths for Aboriginal and Torres Strait Islander people due to suicide remained about twice the rate for non‑Indigenous people (table 8A.8.1).

| Figure 8.8.2 Rates of suicide, NSW, Queensland, WA, SA and the NT combined, by Indigenous status, by year (age‑standardised rates)**a** |
| --- |
| | Figure 8.8.2 Rates of suicide, NSW, Queensland, WA, SA and the NT combined, by Indigenous status, by year (age-standardised rates)  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.8.1 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW and ABS analysis of the National Mortality Database; table 8A.8.1. |
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### Suicide rates vary across age groups, with rates higher for younger Aboriginal and Torres Strait Islander adults

Suicide rates vary considerably by age group. For the period 2014–2018 for NSW, Queensland, WA, SA and the NT combined (and individually with the exception of SA), the suicide rate was highest for Aboriginal and Torres Strait Islander people aged 25–34 years (at 47 per 100 000 population overall), and was over three times the rate for non‑Indigenous people of the same age (figure 8.8.3). Interestingly, for Aboriginal and Torres Strait Islander adults in the oldest age group (age 45 years or over), the suicide rate is significantly lower and rates are less than, or on par with, the rates for non‑Indigenous people (figure 8.8.3).

| Figure 8.8.3 Rates of suicide, NSW, Queensland, WA, SA and the NT combined, by Indigenous status and age group, 2014–2018**a** |
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| | Figure 8.8.3 Rates of suicide, NSW, Queensland, WA, SA and the NT combined, by Indigenous status and age group, 2014–2018  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.8.3 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) Causes of Death collection; table 8A.8.3. |
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For Aboriginal and Torres Strait Islander people, after adjusting for differences in population age structures, the difference in the rates outside of and within capital cities is less than 1 death per 100 000 people (with both at around 23‑24 deaths per 100 000 people). For non‑Indigenous people, the difference across these areas is greater, with around 11 deaths per 100 000 people in capital cities compared with 15 deaths per 100 000 people in other areas (table 8A.8.4).

### Aboriginal and Torres Strait Islander women have a higher incidence of hospitalisation for self‑harm than Aboriginal and Torres Strait Islander men, but are less likely to die from that self‑harm; the same is seen for non‑Indigenous people

Nationally, Aboriginal and Torres Strait Islander women have the highest rates of hospitalisations for intentional self‑harm, higher than for Aboriginal men and for non‑Indigenous men and women (table 8A.8.5).

If hospitalisations for intentional self‑harm are considered alongside rates of suicide, Aboriginal and Torres Strait Islander women have the highest incidence of self‑harming behaviour but are less likely to die from self‑harm than Aboriginal and Torres Strait Islander men. The same can be seen for non‑Indigenous people (tables 8A.8.1 and 8A.8.6).

**Hospitalisation rates for intentional self‑harm have increased over time for Aboriginal and Torres Strait Islander people**

Hospitalisations for intentional self‑harm are increasing for Aboriginal and Torres Strait Islander people. Since 2004‑05, after adjusting for differences in population age structures, the rate has more than doubled for females and has increased by 85 per cent for males (table 8A.8.6). By contrast, hospitalisations for intentional self‑harm for non‑Indigenous people have remained relatively stable (albeit higher for females than males) — and so the rate for Aboriginal and Torres Strait Islander people has increased from 1.5 to 3.2 times the rate for non‑Indigenous people (with the ratio 3.5:1 for males and 3.0:1 for females in 2018‑19) (figure 8.8.4).

| Figure 8.8.4 Rates of hospitalisations for self‑harm, NSW, Queensland, WA, SA and the NT combined, by Indigenous status and sex (age‑standardised rates)**a** |
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| | Figure 8.8.4 Rates of hospitalisations for self harm, NSW, Queensland, WA, SA and the NT combined, by Indigenous status and sex (age-standardised rates)  More details can be found within the text surrounding this image. | | --- | |
| a See table 8A.8.6 for detailed definitions, footnotes and caveats.. |
| *Source*: ABS (unpublished) Causes of Death collection; table 8A.8.6. |
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Over time, the rates for Aboriginal and Torres Strait Islander people have increased by more in major cities and regional areas, whereas for non‑Indigenous people there have been greater increases in rates in regional and remote areas (table 8A.8.7).

### What factors lead to higher rates of suicide for Aboriginal and Torres Strait Islander people, and how can these rates be reduced?

Understanding the reasons why Aboriginal and Torres Strait Islander people may end their lives is key to developing effective suicide and self‑harm prevention approaches. Contributing factors to suicide that are particularly relevant to Aboriginal and Torres Strait Islander people include:

* the intergenerational trauma attributable to colonisation, dispossession and assimilation policies that forcibly removed children from their families and traditional lands, all of which contributed to a breakdown in community functioning (Dudgeon, Calma and Holland 2017; Fogliani 2019; Silburn et al. 2014)
* exposure to multiple and cumulative life stressors such as childhood abuse, the death of family members, ill health, being incarcerated and unemployment (Coroners Court of Victoria 2020; Dudgeon, Calma and Holland 2017; Fogliani 2019).
* higher rates of use of alcohol and illicit substances that are risk factors for suicides (Coroners Court of Victoria 2020; Dickson et al. 2019) (see sections 11.1 *Alcohol consumption and harm* and 11.2 *Drug and other substance use and harm*)
* higher levels of psychological distress (Calma, Dudgeon and Bray 2017; Temple, Kelaher and Paradies 2020), with racism a key source of stress affecting the mental health of Aboriginal and Torres Strait Islander people (Dickson et al. 2019; Dudgeon, Calma and Holland 2017)
* inadequate access to mental health services for those at risk of suicide, given their needs. Research shows that of 400 Aboriginal and Torres Strait Islander people who took their own life by suicide in Queensland between 1994 and 2006, three‑quarters had never received treatment from a mental health professional in their lifetime (De Leo et al. 2011). While this research is more than a decade old, recent data from a coronial inquiry into 13 suicides of young people in the Kimberley region of WA shows similar results (Fogliani 2019). Other data (see section 8.7 *Mental health*) also indicate that clinical mental health services are not meeting needs, with the proportion of Aboriginal and Torres Strait Islander people receiving these services not commensurate with the rates of those with high/very high levels of psychological distress
* Adequate access does not just mean enough services for the numbers of people at risk, but also the right services to meet their needs. The cultural safety of those services is key for Aboriginal and Torres Strait Islander people.
* exposure to suicide, including suicide attempts and suicide within families or by people who are close associates (Fogliani 2019) — common factors in suicide clusters (Dudgeon, Calma and Holland 2017; Hanssens 2016).

As the factors that contribute to suicide in Aboriginal and Torres Strait Islander communities are numerous and interrelated, suicide rates need to be addressed at multiple levels.

While the evidence‑base for the effectiveness of suicide prevention programs and activities remains limited (WHO 2014), approaches to reduce suicide in the context of Aboriginal and Torres Strait Islander communities (Dudgeon et al. 2016) have been suggested at three levels:

* Community‑wide — aimed at increasing community‑wide protective factors, such as increasing employment and improving mental health and reducing risk factors, such as incarceration. These include approaches to strengthen social and emotional wellbeing and culture (see section 8.7 *Mental health*), to promote healing and increasing resilience in individuals, families and communities and to prevent or reduce alcohol and drug use (see sections 11.1 *Alcohol consumption and harm* and 11.2 *Drug and other substance use and harm*), and reducing child abuse and family violence (see section 4.12 *Family and community violence*) (Coroners Court of WA 2019). They could also include community forums providing education to support help‑seeking behaviour for those who need it, or to help other community members to identify those who need support and how they might support them (Dudgeon et al. 2016; Westerman and Sheridan 2020, Coroners Court of WA 2019).
* For at‑risk groups — aimed at groups who are most at risk of suicide. As noted above, Aboriginal and Torres Strait Islander young adults are at higher risk of suicide than other age groups. Some of the successful approaches include teaching Aboriginal and Torres Strait Islander cultures in schools (see section 5.6 *Indigenous cultural studies*), promoting engagement with programs such as sport (see section 5.7 *Participation in community activities*) and connecting to cultures/Country/Elders (see section 5.8 *Access to traditional lands and* *waters*) (Dudgeon et al. 2016; Hanssens 2016).
* For at‑risk individuals — aimed at individuals identified as being at risk of suicide, or who have attempted suicide, but not died. This might mean increasing the accessibility of mental health and other support services that provide timely therapeutic treatment in a culturally safe environment with access to Aboriginal and Torres Strait Islander staff or culturally competent staff (see section 8.7 *Mental health*), including through Aboriginal Community Controlled Health Services (ACCHSs) (Dudgeon et al. 2016; Dudgeon, Calma and Holland 2017). Aboriginal and Torres Strait Islander people report that ACCHSs influence their health more positively than other health services as they are more welcoming, holistic in responding to needs and culturally safe (see section 8.1 *Access to primary health care*).

The common factor in successful approaches to preventing suicide among Aboriginal and Torres Strait Islander people, across these three levels, is their development and implementation with Aboriginal and Torres Strait Islander leadership and in partnership with the local Aboriginal and Torres Strait Islander communities (Dudgeon et al. 2016).

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1. The Steering Committee notes its appreciation to Dr Sanchia Shibasaki, Lowitja Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-1)
2. Telehealth services use telecommunications technologies to provide health advice via telephone, video consultations and remote monitoring of health metrics through electronic devices. [↑](#footnote-ref-2)
3. Aboriginal and Torres Strait Islander people can receive an annual health check funded through Medicare(Department of Health 2016). The aim of this health check is to detect early and treat common conditions that cause ill health and early death — for example, diabetes and heart disease. The doctor can also refer the person to other health care professionals for follow-up care as needed — for example, physiotherapists, podiatrists or dieticians. [↑](#footnote-ref-3)
4. Immunisation is effective in preventing sickness and death from vaccine preventable diseases. The Australian Childhood Immunisation Register (ACIR) assesses children for immunisation coverage at 12‑15 months (one year), 24–27 months (two years) and 60–63 months (five years), by Indigenous status, for all jurisdictions. [↑](#footnote-ref-4)
5. The data available about visits to primary health care services vary by remoteness. In non-remote areas, they include visits to GPs and/or specialists, while in remote areas they also include visits to nurses, sisters and Aboriginal and Torres Strait Islander health workers. [↑](#footnote-ref-5)
6. Culturally safe health care systems are established through cultural awareness, cultural sensitivity (the acknowledgement and respect of difference) and cultural competence ( which focuses on skills, knowledge and attitudes of practitioners) (NCCIH 2013). Cultural respect is achieved when the health system is accessible, responsive and safe for Aboriginal and Torres Strait Islander people, and cultural values, strengths and differences are respected (Australian Health Ministers’ Advisory Council’s National Aboriginal and Torres Strait Islander Health Standing Committee 2016). [↑](#footnote-ref-6)
7. The Steering Committee notes its appreciation to Dr. Sanchia Shibasaki, of the Lowitja Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-7)
8. Relate to serious short-term illness and could possibly be prevented or severely minimised, through access to effective primary health care services. [↑](#footnote-ref-8)
9. Chronic obstructive pulmonary disease (COPD) is an umbrella term used to describe progressive lung diseases. In the vast majority of cases, lung damage caused by smoking (including second-hand smoke) is the cause of COPD. However, not all smokers develop COPD and it may also be related to air pollution, long term exposure to hazards in the workplace or genetic susceptibility (Mayo Clinic 2020). [↑](#footnote-ref-9)
10. Cellulitis is a bacterial skin infection that can develop from an open wound on any part of the body, but most commonly affects the lower leg (AIHW 2020a). [↑](#footnote-ref-10)
11. The complete list of ICD-10-AM codes included in this category and all other categories of potentially preventable hospitalisations can be found in table 8A.2.3. [↑](#footnote-ref-11)
12. The Steering Committee notes its appreciation to Dr Sanchia Shibasaki, Lowitja Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-12)
13. A list of causes for potentially avoidable deaths is available in table 8A.3.6. [↑](#footnote-ref-13)
14. Avoidable mortality is not available for other states and territories due to low numbers of Aboriginal and Torres Strait Islander people. [↑](#footnote-ref-14)
15. Not all types of cancers are included in potentially avoidable deaths. See table 8A.3.6 for details. [↑](#footnote-ref-15)
16. The Steering Committee notes its appreciation to Dr Sanchia Shibasaki, Lowitja Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-16)
17. Current daily smokers are people who smoked one or more cigarettes (or pipes or cigars) per day at the time of their survey interview. [↑](#footnote-ref-17)
18. An outcomes evaluation of the Tackling Indigenous Smoking program is in progress, but results are not yet available (Department of Health unpublished). [↑](#footnote-ref-18)
19. The Steering Committee notes its appreciation to Dr Sanchia Shibasaki from The Lowitja Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-19)
20. Body Mass Index is the calculation of a person’s weight (kilograms) divided by the square of their height (metres). [↑](#footnote-ref-20)
21. The Steering Committee notes its appreciation to Dr Sanchia Shibasaki, Lowitja Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-21)
22. DMFS/dmfs: uppercase denotes permanent (adult) teeth, and lowercase deciduous (infant) teeth. ‘DMFS’/‘dmfs’ is the sum of decayed, missing and filled teeth surfaces. [↑](#footnote-ref-22)
23. Prior to 2010-11, six jurisdictions (NSW, Victoria, Queensland, WA, SA and the NT) were considered to have an acceptable quality of Aboriginal and Torres Strait Islander identification in hospitalisation data. The attachment tables for this report include hospitalisation data for all jurisdictions from 2010-11 to 2018‑19, as well as data for those six jurisdictions from 2004-05 to 2018-19. [↑](#footnote-ref-23)
24. Dentate means people who have one or more teeth. [↑](#footnote-ref-24)
25. The Steering Committee notes its appreciation to Dr Graham Gee, Murdoch Children’s Research Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-25)
26. Based on Kessler Psychological Distress Scale 10 (K10) modified to five questions (K5) which measure an individual’s level of psychological distress in the past four weeks. [↑](#footnote-ref-26)
27. The Steering Committee notes its appreciation to the Dr Graham Gee, Murdoch Children’s Research Institute, who reviewed a draft of this section of the Report. [↑](#footnote-ref-27)
28. This number does not include suicides recorded in Victoria, Tasmania and the ACT. [↑](#footnote-ref-28)