Australian Government
Australian Institute of Health and Welfare

AIHW

# Australia's health 2026

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

This publication is part of the Australian Institute of Health and Welfare's *Australia's health* series. A complete list of the Institute's publications is available from the Institute's website www.aihw.gov.au.

ISBN 978-1-923553-31-6 (Online)
ISBN 978-1-923553-32-3 (Print)
ISSN 2651-978X (Online)
ISSN 1032-6138 (Print)
DOI 10.25816/cy49-1m75

**Suggested citation**

AIHW (Australian Institute of Health and Welfare) (2026) *Australia's health 2026*, AIHW, Australian Government.

Any enquiries about or comments on this publication should be directed to:
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Tel: (02) 6244 1000
Email: info@aihw.gov.au

Published by the Australian Institute of Health and Welfare.

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

Australian Government
Australian Institute of
Health and Welfare

AIHW

The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme
Parliament House
Canberra ACT 2600

Dear Minister

On behalf of the Board of the Australian Institute of Health and Welfare (AIHW), I am pleased to present to you *Australia's health 2026*, as required under subsection 31(1) of the *Australian Institute of Health and Welfare Act 1987*.

The Australia's health suite of products continues the AIHW tradition of delivering high quality evidence and value-added analysis on the health of Australians. The *Australia's health 2026* report provides a summary of key health-related findings and a discussion of selected contemporary health issues. The report is complemented by a collection of webpages that provide comprehensive coverage of health topics and data improvements.

I commend *Australia's health 2026* to you as a significant contribution to national information on the health of people in Australia and provision of services that support good health. This information can be used to inform the development and the review of policies and programs in Australia.

Yours sincerely

The Hon Nicola Roxon
Chair, AIHW Board
24 June 2026

1 Thynne Street, Bruce ACT 2617
GPO Box 570, Canberra ACT 2601
www.aihw.gov.au
+61 2 6244 1000
info@aihw.gov.au

# Message from the CEO

*Australia's health 2026* marks the 20th edition of the biennial health series by the Australian Institute of Health and Welfare (AIHW). It forms part of the AIHW's flagship products, with Australia's health and Australia's welfare released in alternate years.

Australia's health is a trusted source of authoritative and accessible health-related information for decision makers, policy advisers, service providers, researchers, and the public. It provides contemporary insights into the nation's health and wellbeing, highlights key developments in health data and emphasises the need for robust evidence to support timely, informed decision making across service delivery, policy and funding prioritisation.

As Australia's health has done for almost 40 years, this report charts our nation's progress while also informing priorities for future improvement.

At the time of the first release in 1988, Medicare had only been operating for 4 years. There was an increase in health policy relating to prevention, including the introduction of a nationwide smoking ban on domestic airline flights. The concept of burden of disease – now widely used to estimate the total population impact of diseases, injuries, and risk factors – had not yet been developed. Population-based health surveys were expanding available data, in particular, enabling insights about the health of people with disability.

In the years since, Australia's life expectancy has increased but the gains have slowed. Chronic conditions are responsible for the majority of deaths and disease burden. As the population ages, dementia has emerged as Australia's leading cause of death. Hospitals are under increased pressures, prompting new models of care, such as Medicare Urgent Care Clinics. The impacts of poor mental health, and the importance of diagnosing and managing mental health conditions are increasingly recognised. Deaths from cardiovascular disease have declined owing to improvements in detection, prevention and care, along with declines in tobacco smoking, high blood pressure and high cholesterol. Improvements in cancer survival are another substantial public health gain.

Telehealth is making health services more accessible, particularly for people living in remote areas, and captioning helps support people with communication. Medical equipment, from personal monitoring devices to MRI scanners, is increasingly available nationwide. Artificial Intelligence (AI) is also supporting diagnostics, documentation, risk assessment, and clinical decision making in various health settings.

While there have been significant improvements in social determinants and health outcomes for First Nations people, continued efforts are needed from governments, policy makers and service providers to address disparities. The AIHW has recently established a First Nations Governance Group which operates as a strategic partnership between First Nations people who have significant sectoral experience and the AIHW. Its purpose is to inform the AIHW in their commitment to transformed relationships with First Nations communities and ensure that First Nations knowledges, perspectives, and priorities guide the development, use, and dissemination of information and evidence relating to First Nations people.

Today, the integration of health and welfare data is enabling valuable new insights into how Australians interact with services and systems, which is essential for the care of people with complex or long-term needs. For example, people moving between health, disability and aged care systems as their support and care needs change. Important data gaps persist, with robust national primary care and health workforce data still lacking, for example.

In 2026, Australia's health comprises 2 products:

- *Australia's health 2026* (this report) – presents the latest key findings and a selection of short topic-based narratives, offering insights into contemporary health and wellbeing issues.
- Australia's health topic summaries – a collection of 65 web pages providing comprehensive statistics on health, the health system and health services, as well as key data improvement activities.

I extend my gratitude to everyone who contributed to this report and acknowledge the valuable insights and input provided by many experts and consumers during the process.

We are committed to improving the usefulness and relevance of our flagship reports and welcome your feedback via flagships@aihw.gov.au

Dr Zoran Bolevich

Chief Executive Officer, AIHW

# Acknowledgement of Country

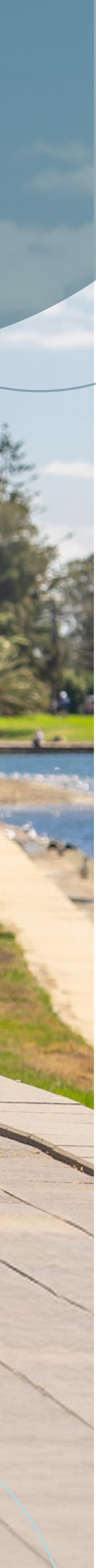
The AIHW acknowledges the Traditional Owners of Country throughout Australia and recognises their continuing connection to lands, waters and communities. We pay our respect to the people, the cultures and Elders past and present.

Artwork “Data & Diversity”, by Jay Hobbs
(proud Kuku Yalanji & Meriam-Mir Man)

# Contents

Focus areas

# Key findings



# What is health?

Health is more than the absence of illness and injury; it encompasses physical, mental and social wellbeing. For many individuals and communities, the concept of health also includes spiritual and cultural wellbeing, with language and traditions playing an important role. For Aboriginal and Torres Strait Islander (First Nations) people, connection to Country is also integral. Country refers to the land, waters and seas with which First Nations people have longstanding traditional or spiritual association.

Our health and our experiences within the health system vary from person to person. Health is shaped by various factors, such as genetics, place of residence, education, income, behaviours, and social and community connections. These factors can also influence our access to and use of health services; from prevention and early intervention to treatment, and end-of-life care.

Recognising and monitoring differences in what affects our health, how health services are being used, and health outcomes can inform decision making to support better policy and service design.

For information about the broader support systems that impact health, see Australia’s welfare.

## Key findings

# Australia’s population

Almost 28 million people were living in Australia at 30 June 2025.

In 2024, Australia’s total fertility rate was 1.5 babies per woman, remaining below the replacement level of 2.1 since 1976.

Overseas migration has been the main driver of population growth in Australia over the last 30 years.

The projected population by 2035–36 is 31.5 million and 41 million by 2065–66.

(ABS 2025a; AIHW 2026ad; Centre for Population 2026)

## Australia’s population is culturally diverse, highly urbanised and has an older age profile

**1 in 26**
(3.8%) identify as being of Aboriginal and/or Torres Strait Islander origin (First Nations people)

**1 in 3**
are born overseas

**3 in 4**
live in major cities

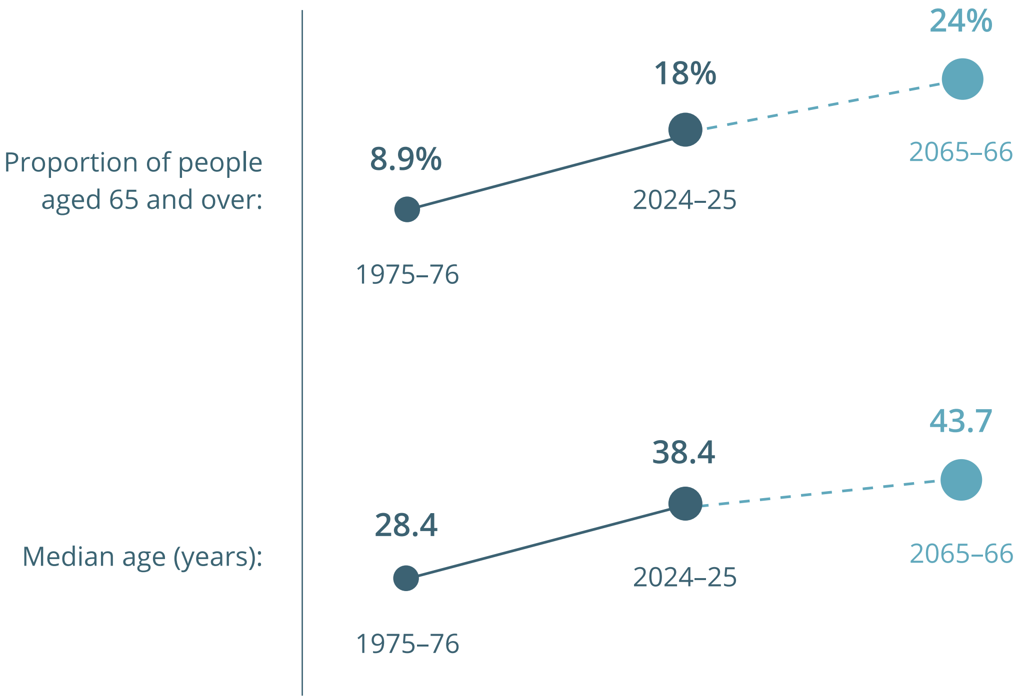
**1 in 5**
have some form of disability

**1 in 6**
are aged 65 or over

**1 in 8**
provide unpaid care for someone else

(ABS 2023a, 2024a; AIHW 2025k, 2026ad)

# The proportion of older people is expected to continue to increase



The population aged 85 and over is projected to grow more rapidly over the next 40 years than the broader population aged 65 and over:

- **aged 65 and over:** projected to double from 4.8 million in 2024–25 to 9.7 million in 2065–66
- **aged 85 and over:** projected to triple from 603,000 in 2024–25 to 1.9 million in 2065–66.

(Centre for Population 2026)

Key findings

# How healthy are Australians?

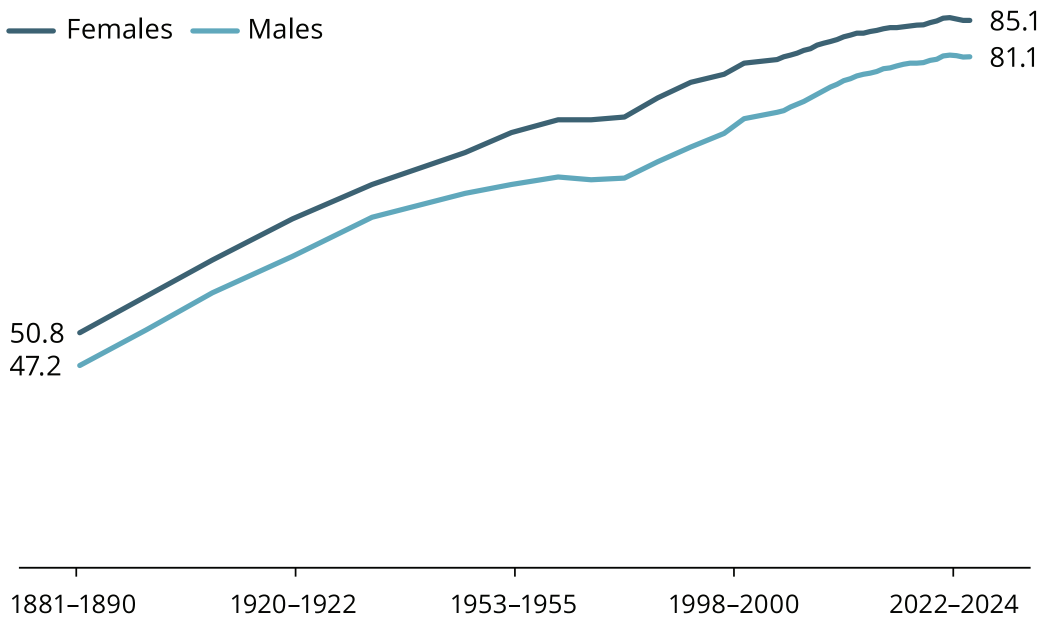
## Life expectancy at birth has improved over time, with females continuing to have a higher life expectancy

Life expectancy at birth in 2022–2024 was:

81.1 years for males

85.1 years for females

Life expectancy has risen dramatically since the late 19th century, with a recent decrease seen across the years impacted by the COVID-19 pandemic:



(AIHW 2026g)

# Chronic and ageing-related conditions are driving deaths and disease burden

Dementia is now the leading cause of death in Australia; previously coronary heart disease. Over the last decade the number of deaths caused by:

Dementia has risen by 39% (from 12,641 deaths in 2015 to 17,550 deaths in 2024)

Coronary heart disease has decreased by 18% (from 19,926 deaths in 2015 to 16,326 deaths in 2024)

In 2024, dementia accounted for almost:

**1 in 10** deaths

This reflects the sharp increase in dementia risk with age, as more Australians are now reaching ages where dementia is more common

In 2022:

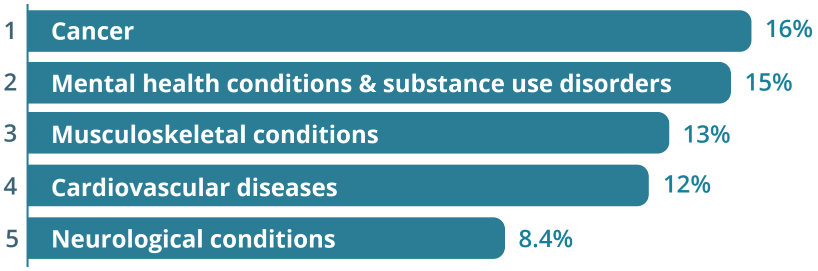
**3 in 5**

Australians were living with at least one chronic condition

**2 in 5**

Australians were living with 2 or more chronic conditions

In 2024, the top 5 disease groups causing the most disease burden were:



Burden of disease measures the combined impact of illness and premature death (total or disease burden), by adding years lived in ill health (non-fatal burden) with years lost due to premature death (fatal burden).

(ABS 2025b; AIHW 2024a, 2025n, 2026e)

# Around one-third (36%) of Australia's disease burden could be prevented or reduced by modifying risk and environmental factors

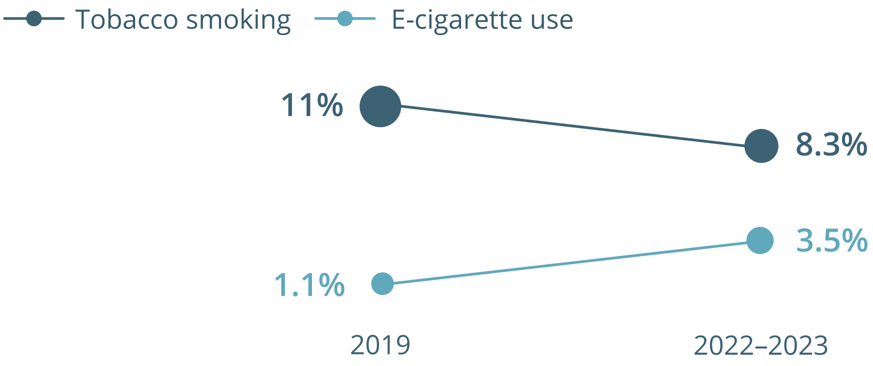
Overweight (including obesity) has overtaken tobacco use as the leading risk factor contributing to disease burden in Australia.

In 2022–24:

**67%**
adults were living with overweight or obesity (13.2 million)

**27%**
children and adolescents were living with overweight or obesity (1.4 million)

Among Australians aged 14 and over, self-reported daily tobacco smoking has declined. However, daily e-cigarette use has increased:



Tobacco smoking is highest among people aged 50–59 (12%)

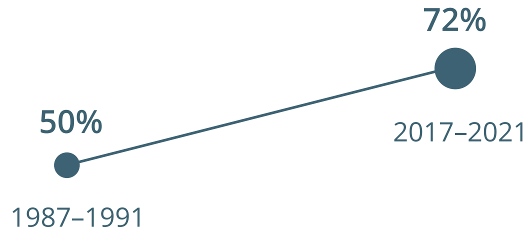
E-cigarette use is highest among people aged 18–24 (9.3%)

Results from the 2025 National Drug Strategy Household Survey will be released in tranches in 2026, with the first to include high level findings on tobacco, e-cigarette and nicotine use.

(AIHW 2024a, 2025q, 2026c, 2026z)

# Cancer outcomes continue to improve, reflecting advances in diagnosis and treatment

People diagnosed with cancer today are surviving longer than ever before, with 5-year relative survival increasing over time:



5-year relative survival differs by cancer type. For 2017–2021, this was:

- over 95% for testicular, thyroid and prostate cancer
- less than 15% for pancreatic cancer and mesothelioma

Between 2000 and 2025, cancer diagnoses among people in their 30s and 40s have increased from:

↑ 121 to an estimated 135 cases per 100,000 for people in their 30s

↑ 280 to an estimated 313 cases per 100,000 for people in their 40s

However, cancer survival has improved and cancer death rates have generally declined in these age groups.

In response to increasing rates of early onset cancer, Cancer Australia has commissioned a review to identify risk factors, research gaps and inform interventions, alongside updating general practitioner (GP) guidance to support earlier diagnosis of people with signs and symptoms of cancer. Early onset cancer is also a strategic research priority under the Cancer Australia Research Initiative.

(AIHW 2025b)

# Mental health conditions affect many Australians and are rising among young people

In 2020–2022, around:

**1 in 5** Australians
aged 16–85 (22%) had experienced a mental disorder in the previous 12 months. This was higher in females (25%) than males (18%)

The proportion of young people (aged 16–24) experiencing a mental disorder has increased over time, however the overall proportion has remained stable:

In 2024–25:

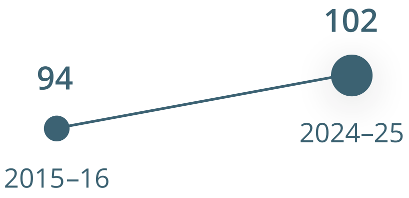
**1 in 10** Australians
received Medicare-subsidised mental health services (or 2.8 million people)

Young adults aged 18–34 had the highest rates of use, compared with other age groups.

The higher rates among young adults were largely driven by females, with rates almost twice that of males.

While Australia performs well internationally in terms of the scope and scale of mental health-related activity able to be reported publicly, there are a number of data gaps. These include psychosocial support services outside of the NDIS, mental health services contracted by Primary Health Networks, other NGO services, mental health services delivered in educational settings and services covered under private health insurance.

There was an almost 9% increase in the rate of people (patients per 1,000 population) receiving Medicare-subsidised mental health services, from:



The largest rate increase was for females aged 25–34, increasing by 26% over the decade from 149 patients per 1,000 population in 2015–16 to 188 patients in 2024–25.

This peaked at 201 patients per 1,000 in 2021–22, as access expanded to support mental health impacts from the COVID-19 pandemic.

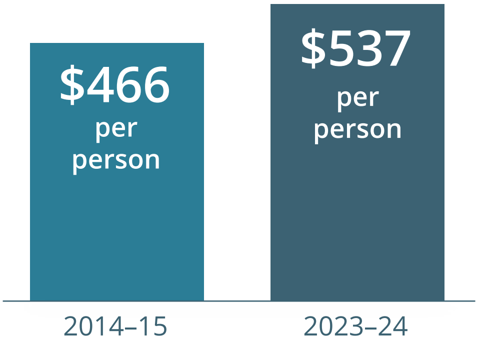
Use of mental health related medications has increased overall between 2015–16 and 2024–25, with increased dispensing of:

Antidepressants

Up from 120 to 139 people per 1,000

Psychostimulants, agents used for ADHD and nootropics

Up from 6 to 28 people per 1,000



Spending on mental health services has risen in the past decade, accounting for inflation.

This was driven by increased spending on state and territory specialised mental health services.

(AIHW 2025t, 2026j, 2026t, 2026v, 2026w)

# Hospitals are still in demand, and wait times have increased

In 2024–25, of people aged 15 and over:

1 in 8

were admitted to hospital (13%, or 2.8 million people)

1 in 6

visited an emergency department (16%, or 3.4 million people)

In 2024–25, there were:

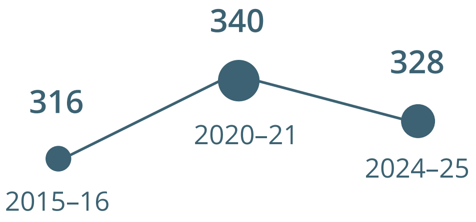
12.8 million

hospital admissions

9.1 million

emergency department presentations

The rate of emergency department presentations per 1,000 population has decreased in recent years, following a peak during the initial years of the COVID-19 pandemic:



In 2024–25, there were 416 hospital admissions per 1,000 people. This rate has fluctuated over the last 10 years, with a rate of 413 in 2015–16.

↓ The share of emergency department patients ‘seen on time’ (care starting within the triage time target) decreased from 74% in 2015–16 to 67% in 2024–25.

↑ There were 791,000 admissions from public hospital elective surgery waiting lists in 2024–25, compared with 712,000 in 2015–16.

↑ 50% of patients were admitted for elective surgery within 45 days in 2024–25, compared with 37 days in 2015–16.

(ABS 2025d; AIHW 2026b, 2026h, 2026i)

# Visiting GPs and dentists have many benefits, but cost, availability and wait times are key barriers

Of the 18.5 million Australians aged 15 and over who needed to see a GP in 2024–25:

1 in 4 (27%) reported delaying their GP visit at least once or did not see a GP. This is the same as a decade prior (27% in 2015–16).

1 in 13 (7.7%) reported delaying or not seeing a GP due to cost. This has increased from 4.1% in 2015–16.

The Australian Government has introduced a range of initiatives intended to support improved access to GP services and affordability, including expanding the bulk billing incentives, increasing the GP workforce and introducing new care models. See the Medicare statistics collection for the most recent bulk-billing data and Medicare bulk billing of GP attendances for data by age and geographical areas.

In 2024–25, 78% of GP attendances were bulk-billed, down from 85% in 2015–16. Since the introduction of the initiatives, the GP bulk-billing rate has increased and in January–March 2026 it was 82%.

In 2024–25, among people aged 15 and over:

Just over half (54%) reported seeing a dental professional in the last 12 months, up from 48% in 2015–16.

1 in 4 (25%) who needed to see a dental professional, delayed or did not use dental services.

Cost was a common reason for not seeing a dentist (16% of those who needed to see a dental professional).

**$13.2 billion**
spent on dental services in Australia in 2023–24

**61%**
paid by patients directly (around $8.0 billion)

After adjusting for inflation, out-of-pocket costs on dental services has increased at an average annual growth rate of 2.9%, up from $5.7 billion in 2012–13.

(ABS 2025d; AIHW 2025i, 2025r, 2026s)

# Australia’s health spending and healthcare workforce continues to increase

In 2023–24, after accounting for inflation, Australia spent an estimated:

**$270.5 billion**
on health goods and services

This includes spending by Governments, health insurance providers, individuals and other non-government sources.

Hospital care accounted for the largest share of total health spending ($113.8 billion, or 42%).

Primary health care (including public health) accounted for $89.1 billion, or 33%.

The gap between expenditure on hospital services and primary health care (including public health) as a share of total health spending continues to widen.

Total health spending per person

**$8,615** per person 2014–15

**$10,037** per person 2023–24

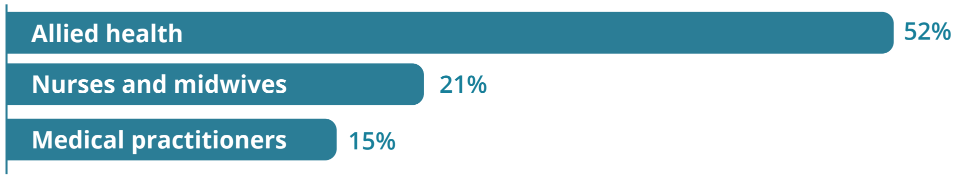
(adjusted for inflation)

Out-of-pocket spending remains the largest non-government contribution, reaching $44 billion or $1,634 per person.

This has increased on average 1.4% each year since 2013–14.

Between 2015 and 2024, there was a 26% increase in the number of registered healthcare professionals actively working in their field per 1,000 population.

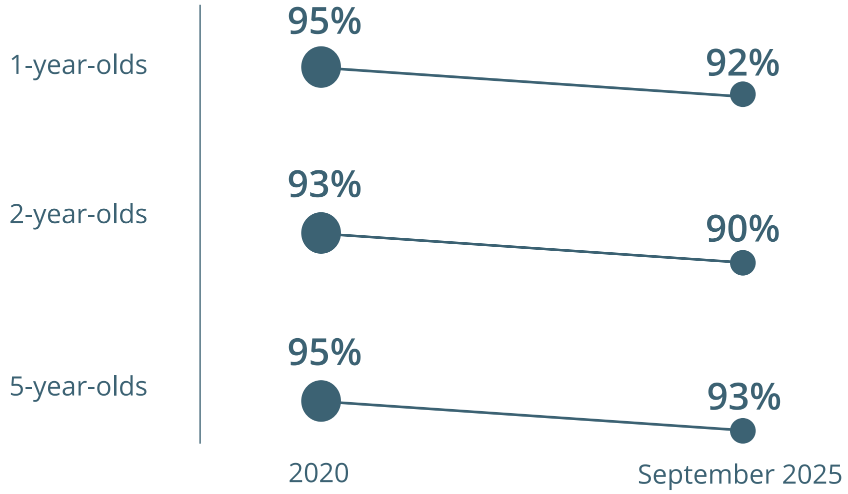
Growth was highest in:



(AIHW 2025i, 2026n)

# Immunisation coverage among children is falling

The impact of infectious diseases is greatly reduced by the National Immunisation Program, but immunisation coverage rates among children have fallen in recent years.



(Department of Health, Disability and Ageing 2025c, 2026c)

# While death rates overall have improved, differences across population groups show the effect of inequality

After adjusting for age-differences, in the 2022–2024 period, death rates were:

**1.6 times as high**

among those living in *Very remote* areas, compared with people in *Major cities*

(774 deaths and 497 deaths per 100,000 respectively)

**1.5 times as high**

among those living in the lowest socioeconomic areas, compared with people in the highest socioeconomic areas

(631 deaths and 418 deaths per 100,000 respectively)

(AIHW 2026g)

Key findings

# Health of First Nations people

## Australia’s First Nations population is growing

In Australia as at 30 June 2021, there were an estimated:

984,000
Aboriginal and
Torres Strait Islander
(First Nations) people

47%
increase in the First Nations population in 10 years

The increase in the First Nations population since 2011 is not completely explained by demographic factors. Other factors, such as changing identification in the Census and throughout life, greater participation and a higher response rate to the question on Indigenous status in the 2021 Census, have also contributed.

(ABS 2013, 2023a, 2023b)

Life expectancy at birth in 2020–2022 was:

71.9 years for males

75.6 years for females

Overall, the First Nations population has a relatively young age profile, with a median age of 24 years (at 30 June 2021).

At 30 June 2021, of First Nations people in Australia:

85%
lived in non-remote areas

41% *Major cities*

25% *Inner regional* areas

19% *Outer regional* areas

15%
lived in *Remote and very remote* areas

(AIHW 2025a, 2025u)

# Decreasing burden of disease among First Nations people

The burden of disease among First Nations people decreased by 6.3% between 2011 and 2022 (from 455 to 430 disability-adjusted life years per 1,000 people, after adjusting for age). This was driven by declines in premature deaths from cardiovascular diseases.

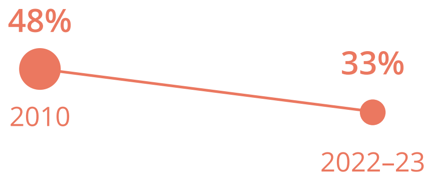
Burden of disease measures the health impact of diseases and injuries on a population. Disease burden (or total burden) combines the years of healthy life lost due to living with ill health (non-fatal burden) with the years of life lost due to dying prematurely (fatal burden).

(AIHW 2026l)

# Tobacco smoking and risky alcohol use are declining

The proportion of First Nations people aged 15 and over who:

consume alcohol at risky levels has declined



smoke tobacco daily (excluding e-cigarettes/vapes) has declined

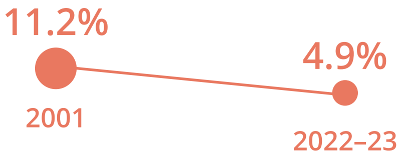
First Nations people are more likely to abstain from alcohol than non-Indigenous Australians.

In 2022–23, 13% of First Nations people aged 15 and over had never consumed alcohol and a further 17% had not consumed alcohol in the previous year.

(AIHW 2025f)

## Eye and hearing health problems among First Nations children have improved over the last 2 decades

Proportion of children aged 0–14 who reported a long-term ear or hearing problem has decreased:



Proportion of children aged 5–9 with trachoma among at-risk communities has decreased:

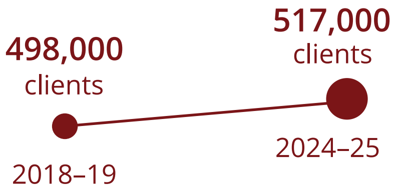
The successful reduction of trachoma (an infectious disease that can lead to blindness) means trachoma no longer represents a public health problem in Australia.

(AIHW 2025c, 2026k)

## Use of First Nations-specific health care is increasing

In 2024–25, around 4.0 million episodes of care were provided by First Nations-specific primary health care organisations, up from 3.7 million in 2018–19.

The number of clients seen by these organisations has increased over time:



**25%**
of First Nations people had an annual health check in 2024 (compared with 23% in 2022)

**4 in 10**
had a follow-up service within 6 months

These are Medicare-funded health checks available to all First Nations people that are tailored to their needs.

(AIHW 2025g, 2026a)

# Despite progress, inequities remain

After adjusting for age differences between populations, First Nations people had higher rates of:

**2.1** times as high

**Disease burden** as the rate among non-Indigenous Australians, in 2022.

This gap has narrowed since 2011.

**1.9** times as high

**Mortality** as the rate among non-Indigenous Australians, in 2022–2024.

First Nations people had a lower life expectancy at birth than non-Indigenous Australians in 2020–2022.

Males
9 year
gap

Females
8 year
gap

(AIHW 2026g, 2026l)

# Further improvement is needed

20%
of the total burden in 2022 was due to mental health conditions and substance use disorders (the leading contributor).

70%
of First Nations people reported living with one or more chronic conditions in 2022–23, compared with 67% in 2018–19.

58%
of deaths among First Nations people aged under 75 during 2022–2024 were from potentially avoidable causes such as coronary heart disease, diabetes, chronic obstructive pulmonary disease and suicide.

(AIHW 2026g, 2026l, 2026m)

For more information, see Focus area 3: *Factors influencing the health of First Nations people.*

Key findings

# How does Australia's health compare with other countries?

## Australia performs well internationally across many health measures, based on the latest internationally comparable data

**83.0** years

**Australia**

**81.1** years

**OECD average**

Life expectancy at birth in Australia is above the OECD average.

Based on the Global Burden of Disease Study, Australians spend more years living with disability (YLD, or non-fatal burden) but have fewer years of life lost (YLL, or fatal burden) due to premature death, compared with the average for OECD countries:

Non-fatal burden

| Australia | OECD average |
|---|---|
| 125 YLD per 1,000 people | 120 YLD per 1,000 people |

Fatal burden

| Australia | OECD average |
|---|---|
| 77 YLL per 1,000 people | 120 YLL per 1,000 people |

Annually, Australia spends more on health care than the OECD average:

**AUD $10,500**
per person
**Australia**

**AUD $8,400**
per person
**OECD average**

Compared with OECD countries, Australians:

| | Australia | OECD average |
|---|---|---|
| are less likely to smoke daily | 8.5% | 15% |
| are more likely to vape regularly | 5.7% | 4.8% |
| consume more alcohol on average | 9.8 litres per person per year | 8.4 litres per person per year |
| are more likely to live with overweight or obesity | 64% | 59% |

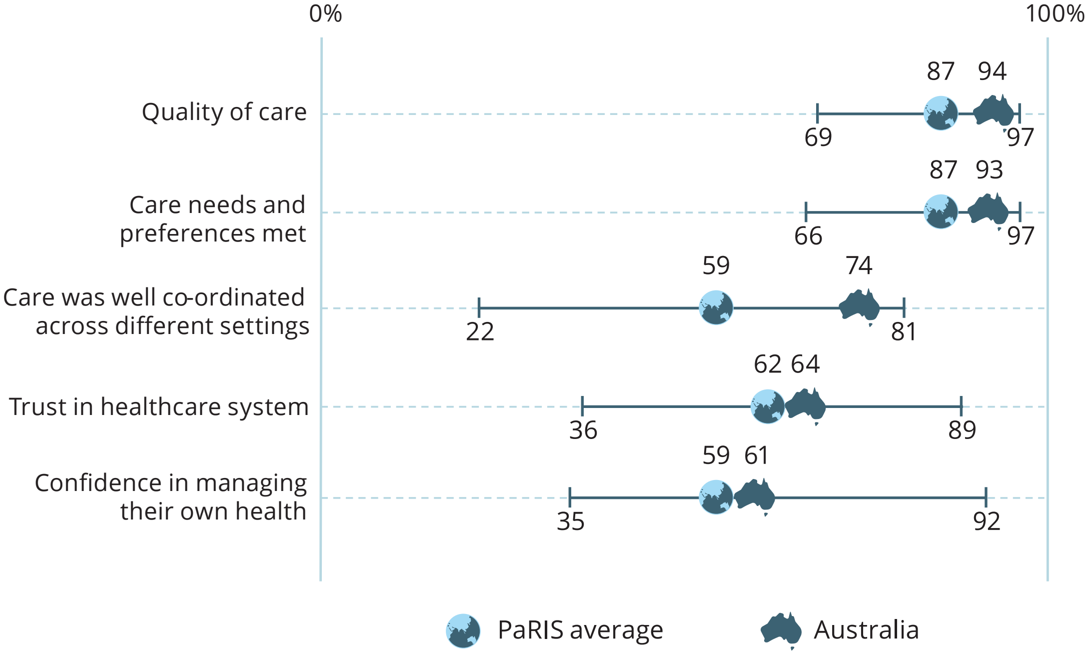
(AIHW 2026c, 2026r; IHME 2025; OECD 2025a)

# Australians with chronic conditions report more positive experiences of health care compared with other countries

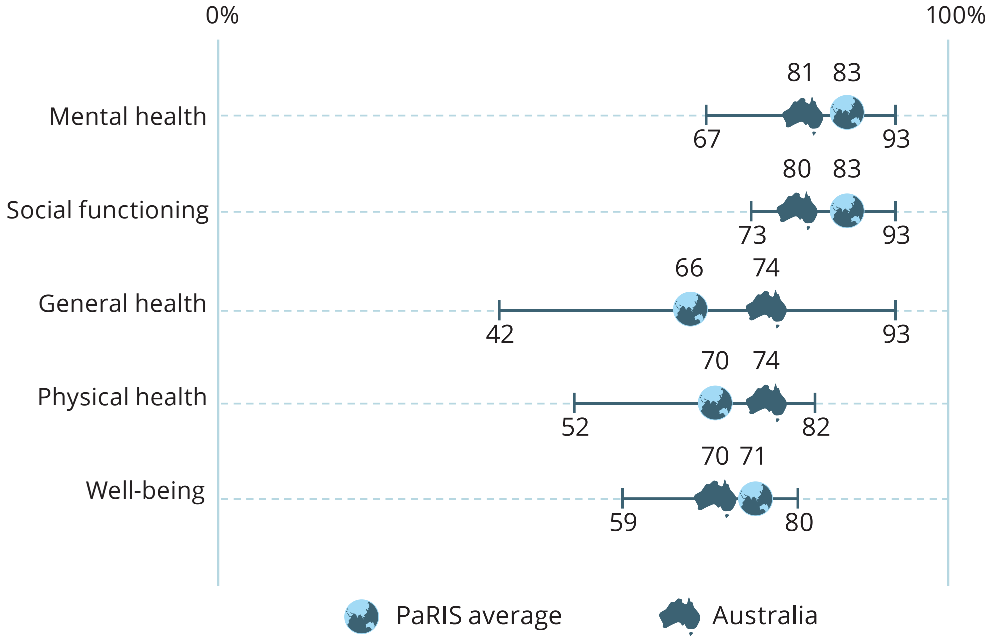
The Patient Reported Indicator Survey (PaRIS) compares the wellbeing and care experiences of people in 19 countries, who are aged 45 and over and living with at least one chronic condition.

A higher percentage for each indicator is indicative of a better experience or outcome.

Australia scored above or close to the PaRIS average for all patient experiences:



Australia scored around the PaRIS average for all patient outcomes:



(OECD 2025b)

# Focus areas

# Insights into contemporary health topics in Australia

In many respects, Australians benefit from strong foundations for health and wellbeing, including high levels of education and employment. However, these benefits are not shared evenly.

The health system plays a critical role in supporting people's wellbeing, but it does not operate in isolation. It is one part of a broader network of systems – including aged care, disability, housing, education, and income support – that together shape people's health experiences and outcomes. Australia's health policies are evolving in recognition of this.

There is a wealth of data available to inform our understanding of what influences the health of the nation and how the health system is performing. Recent data improvements and innovative data linkages powerfully illustrate the intersections and interconnectedness of health and welfare. However, key data gaps persist.

**From the many possible stories that could be told about Australia's health, this report highlights 6 Focus areas. Together, they illustrate contemporary and emerging issues that are central to understanding the health of the nation.**

# 1

# Understanding chronic conditions: patterns, prevention and outcomes

Improvements in living conditions, medical care and public health have contributed to longer lives in Australia. With Australians living longer, a growing number of people are living with chronic conditions. These conditions have lasting and persistent effects and require regular contact with the health system for ongoing monitoring, treatment, and support. Managing chronic conditions usually requires coordinated, multidisciplinary care.

Many conditions share the same preventable lifestyle risk factors, such as unhealthy diet, lack of physical activity, smoking or vaping, and alcohol use. These risks could be reduced through public health and clinical approaches, supported by public policy focused on prevention.

## Patterns of chronic conditions in Australia

Chronic conditions sit at the centre of Australia's health story. Around 3 in 5 Australians (61% of Australia's population) and most Australians aged 85 and over (94%) are living with one or more chronic conditions, including physical, neurodevelopmental and mental health conditions (AIHW 2026e). Conditions such as coronary heart disease, dementia, back pain and problems, anxiety disorders, and chronic obstructive pulmonary disease (COPD) contribute heavily to overall disease burden, reflecting their long-term impact on daily life (AIHW 2024a).

More Australians are now reaching older age and developing multiple chronic conditions. This can increase the complexity of their care. Australians with chronic conditions experience poorer health and higher use of health services, contributing to pressure on the health system.

These outcomes reflect broader changes in how long Australians live and how healthy those years are. Between 2003 and 2024, life expectancy and years lived in full health increased, but the average time spent in ill health also rose (by 1.2 years for males and 1.5 years for females) (AIHW 2024a).

**Around 2 in 5 (38%) Australians were living with 2 or more chronic conditions in 2022**

Living with 2 or more chronic conditions (multimorbidity) is linked to poorer health outcomes.

Compared with adults with no chronic conditions, people with 2 or more chronic conditions were much more likely to rate their health as fair or poor (28% compared with 3.2%). They were also more likely to report disability (41% compared with 2.0%) and moderate to very severe bodily pain (41% compared with 8.2%) (AIHW 2025n).

This focus area also includes short spotlight stories highlighting select conditions and issues of particular significance. Together, these illustrate emerging pressures across the broader chronic conditions landscape and highlight where data developments are needed to improve the evidence base.

## Cancer screening, early detection and survival

Australia delivers nationally coordinated, population-based screening programs for breast, cervical, bowel and, more recently, lung cancer. These programs are a core preventive health measure, supporting earlier diagnosis and improving treatment options and survival.

Cancer survival in Australia has improved substantially over recent decades, largely due to earlier detection and advances in treatment. Five year relative survival for all cancers rose from 50% in 1987–1991 to 72% in 2017–2021, but outcomes vary widely by cancer type and stage at diagnosis (AIHW 2025b). Most cancers which are detected early have a higher relative survival, while those typically diagnosed late have a lower relative survival.

Lung cancer provides a clear example of why earlier detection is critical. Lung cancer is frequently diagnosed at later stages, contributing to poorer outcomes and higher care needs. The National Lung Cancer Screening Program, introduced in July 2025, aims to address this through earlier detection among high-risk people. The program targets asymptomatic adults aged 50–70 with a current or recent history of heavy smoking. Government modelling suggests screening will substantially shift diagnosis to earlier stages, increasing the proportion of lung cancers detected at Stage 1 from 16% to 60% (Department of Health, Disability and Ageing 2025a).

Lung cancer is more common among people living in the lowest socioeconomic areas, with rates around 1.8 times as high as the highest socioeconomic areas. It has been a leading cancer diagnosis among First Nations people. Cancer accounts for a substantial share of end of life care, representing the principal diagnosis for 40% of palliative care hospitalisations. Together, these patterns highlight how population level preventive health measures, such as screening, can improve outcomes and help reduce inequities (AIHW 2024b, 2026aa).

To better understand patterns of diagnosis, progression and outcomes for cancer, the AIHW is collaborating on initiatives to improve data for specific cancers, including the first national estimates of the number of people with metastatic breast cancer. This work includes improving cancer data at the source through the Australian Cancer Data Alliance, finding new methods to look at how cancer care and patient outcomes are changing in Australia, and linking cancer case data with the National Health Data Hub (a major national data linkage system for health and welfare research and analysis).

## Dementia overtakes coronary heart disease as Australia's leading cause of death

Dementia became the leading cause of death in Australia in 2024, accounting for 17,500 deaths (around 1 in 10 deaths; or 9.4%), overtaking coronary heart disease (ABS 2025b). This shift marks the first change in Australia's leading cause of death since the early 20th century, reflecting a major change in the pattern of illness and death as Australians live longer (ABS 2025b; AIHW 2024e). However, patterns vary by remoteness; dementia was the leading cause of death in *Major cities* and *Inner regional* areas, while coronary heart disease remained the leading cause in *Outer regional*, *Remote* and *Very remote* areas (ABS 2025b).

To strengthen the evidence base for dementia and other neurological conditions, the AIHW is undertaking data development work. This includes partnering with the University of Queensland to develop new methods for estimating the number of people living with dementia using linked Census, hospital and aged care data.

Work is also underway by the AIHW to produce a more accurate estimate of prevalence and the indirect costs of migraine. Migraine is the most common neurological condition in Australia and the 2nd leading contributor (after dementia) to disease burden caused by neurological conditions. Migraine disproportionately affects women and people of working age (AIHW 2025m).

## Progress in managing cardiovascular disease

Cardiovascular disease is a broad term for conditions that affect the heart and blood vessels. Common forms include coronary heart disease, stroke and heart failure, as well as conditions such as atrial fibrillation, peripheral arterial disease, rheumatic heart disease and congenital heart disease.

Coronary heart disease is one example of how prevention and long-term management can reduce disease burden over time. Among people aged 45–49 and 50–54, it was the leading cause of disease burden in 2003, but by 2024 it had fallen to the sixth and third leading causes, respectively (AIHW 2024a).

This shift reflects improvements across prevention and treatment. Preventive initiatives, such as Heart Health Checks delivered through primary care, support earlier identification and management of modifiable risk factors including high blood pressure, elevated-cholesterol, blood glucose and smoking. At the same time, advances in clinical care and widespread use of cardiovascular medicines and other pharmacological interventions have improved disease management. In 2024–25, almost 113 million prescriptions for cardiovascular medicines under the Pharmaceutical Benefits Scheme (PBS) were dispensed to the community, accounting for 34% of all PBS prescriptions. Together, these developments highlight how sustained investment in prevention and treatment can reduce disease burden over time (AIHW 2026o).

## Care needs for chronic conditions differ throughout life

In childhood and early adulthood, neurodevelopmental conditions such as autism, and mental health conditions such as anxiety and depression, are more common, shaping early care needs.

Around 1 in 10 Australians live with both anxiety and depression, reflecting the frequent co-occurrence of mental health conditions and the need for integrated, early and ongoing support (AIHW 2025n). In 2024, suicide and self-inflicted injuries was the leading cause of disease burden among males aged 15–44. Whereas for females of the same age it was anxiety, followed by depressive disorders. For many young people, care extends beyond the health system. It includes disability services, education supports and informal support from friends and family (AIHW 2024a).

In later life, ageing-related conditions start to dominate such as musculoskeletal conditions, cancers, cardiovascular diseases, and neurological conditions. In 2024, coronary heart disease was the leading contributor to disease burden among males aged 45–84. For females aged 45–64, back pain was the leading contributor (AIHW 2024a).

Dementia was the leading cause of disease burden among males aged 85 and over and females aged 65 and over. As people age, multimorbidity can increasingly affect mobility, cognition and independence, leading to more complex care needs that require ongoing clinical management, rehabilitation, assistive supports and help with daily activities. Care is often delivered across multiple settings,  including primary care, hospitals, aged care and community services. This places greater demands on coordinated, continuous care that is centred on people's needs and preferences.

The health care system has had to adapt – and will need to continue adapting – to changing needs, supporting complex care through integrated services, multidisciplinary teams and sustained support for people, families and carers. See Focus area 2: *Supporting people across health, aged care and disability systems* for information on current challenges when supporting people across health, aged care and/or disability systems.

**The leading contributors to disease burden in Australia in 2024 varied substantially by age and sex:**

**Males**

Age group (years)

| | Under 5 | 5–14 | 15–24 | 25–44 | 45–64 | 65–84 | 85+ |
|---|---|---|---|---|---|---|---|
| 1st | Pre-term birth and low birth weight complications | Autism spectrum disorders | Suicide and self-inflicted injuries | Suicide and self-inflicted injuries | Coronary heart disease | Coronary heart disease | Dementia |
| 2nd | Birth trauma and asphyxia | Asthma | Anxiety disorders | Back pain and problems | Back pain and problems | COPD | Coronary heart disease |
| 3rd | Cardiovascular defects | Anxiety disorders | Depressive disorders | Anxiety disorders | Suicide and self-inflicted injuries | Dementia | COPD |

**Females**

Age group (years)

| | Under 5 | 5–14 | 15–24 | 25–44 | 45–64 | 65–84 | 85+ |
|---|---|---|---|---|---|---|---|
| 1st | Pre-term birth and low birth weight complications | Asthma | Anxiety disorders | Anxiety disorders | Back pain and problems | Dementia | Dementia |
| 2nd | Birth trauma and asphyxia | Anxiety disorders | Depressive disorders | Depressive disorders | Osteoarthritis | COPD | Coronary heart disease |
| 3rd | Cardiovascular defects | Depressive disorders | Eating disorders | Back pain and problems | Anxiety disorders | Coronary heart disease | COPD |

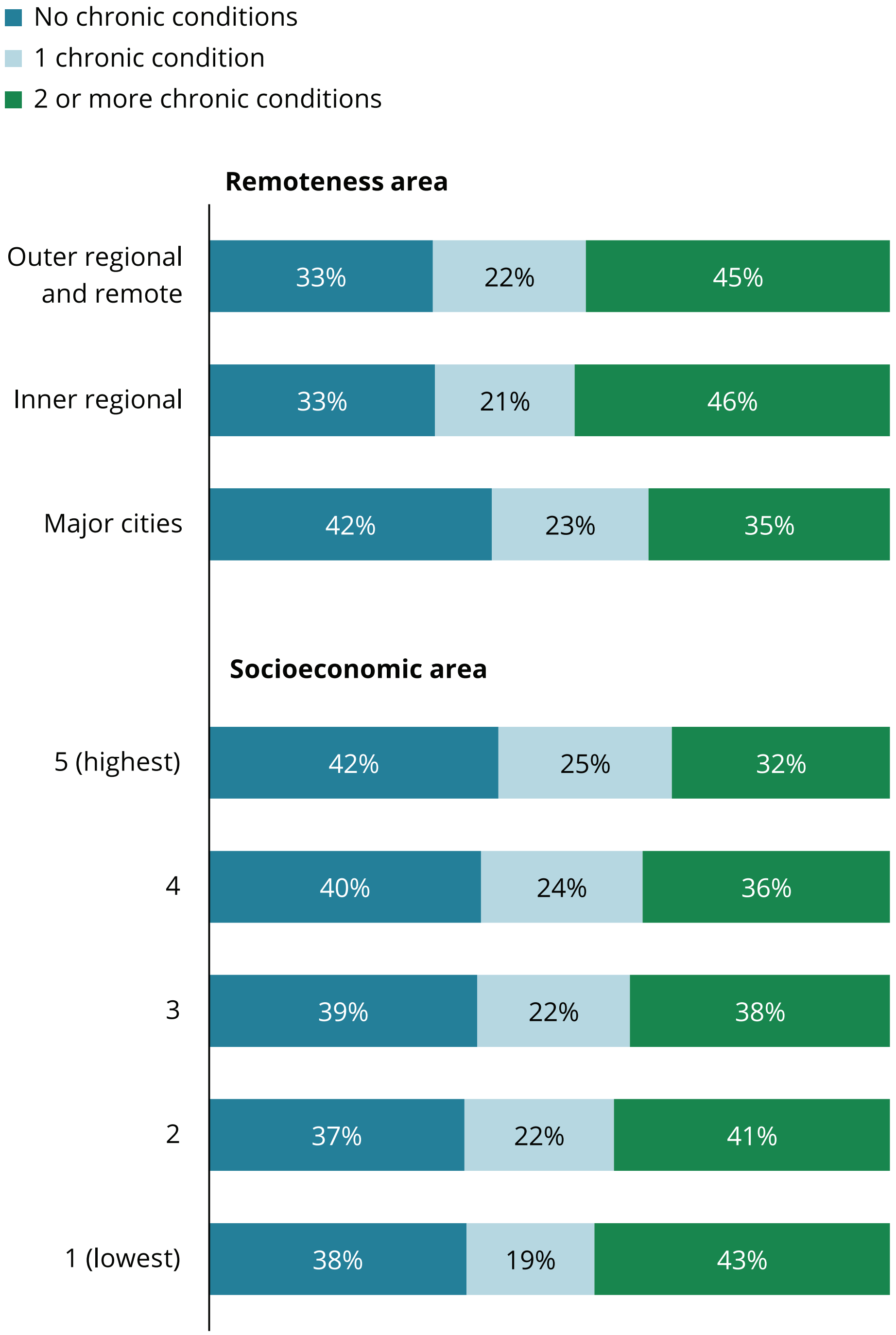
■ Infant and congenital conditions
■ Mental and substance use disorders
■ Musculoskeletal disorders
■ Respiratory diseases
■ Neurological conditions
■ Injury (external cause)
■ Cardiovascular diseases

Source: Australian Burden of Disease Study 2024, AIHW (2024).

## Social determinants of health, such as where people live, their background, and their current circumstances shape health outcomes

Access to health care is a key social determinant of health. It plays a central role in shaping health outcomes by determining how easily people can obtain care when they need it. Timely and appropriate care supports prevention and the effective management of chronic conditions. When access is limited, conditions may go undetected or unmanaged, leading to poorer outcomes.

## Socioeconomic disadvantage and remoteness are associated with higher multimorbidity:



Source: AIHW analysis of Microdata and TableBuilder: National Health Survey 2022, ABS (2023).

People living in rural and remote areas use chronic condition management services less often than those in *Major cities*. Medicare claims data for 2023–24 show that non-hospital, non-referred attendances per person, such as general practitioner (GP) visits, were lowest in *Remote* and *Very remote* areas, at 4.1 and 3.3 visits per person, compared with 6.3 visits per person in *Major cities* (AIHW 2025v). This may reflect longer travel distances and limited service availability, and these access challenges are associated with poorer outcomes. People in rural and remote areas experience higher mortality rates, more potentially avoidable deaths, and earlier death than those living in *Major cities* (AIHW 2025v).

Socioeconomic disadvantage also shapes chronic condition risk, with Australians living in the highest socioeconomic areas more likely to have a chronic condition than those in the lowest socioeconomic areas (63% compared with 56%). This reinforces the need for equitable and targeted health system responses (AIHW 2026e).

# Managing chronic conditions across the health system

## Health system spending on chronic conditions

People living with chronic conditions are frequent users of health services. Chronic conditions cost the health system around $98 billion in 2023–24; more than half (54%) of all disease spending (AIHW 2025h).

### Chronic conditions account for a substantial share of hospital care in Australia

**In 2024–25, compared with people living with no chronic conditions, those with one or more chronic conditions were 2.7 times as likely to be admitted to hospital (ABS 2025d).**

**Over half (55%) of hospitalisations were associated with chronic conditions in 2023–24, representing around 19,000 separations every day and 7 million per year (AIHW 2026e).**

**Between 2018–19 and 2022–23, around 1 in 6 (16%) emergency department presentations were associated with chronic conditions each year (AIHW 2024e).**

**Almost two-thirds (63%; $61.9 billion) of the total health expenditure for chronic conditions in 2023–24 was spent on hospital services (AIHW 2025h).**

## Use of primary care and multidisciplinary support

Ongoing treatment and management of chronic conditions is delivered largely in primary care settings, by GPs, nurses and allied health professionals (RACGP 2023). In 2024–25, around 1 in 6 Australians (4.6 million people) accessed structured, multidisciplinary support through a GP chronic condition management plan (formerly known as chronic disease management plans) (AIHW 2026u).

Improving primary and emergency care is central to strengthening continuity of care across the health system. Under the National Health Reform Agreement 2026–2031, this includes strengthening primary health care and expanding urgent care models delivered virtually or outside hospital settings. See Focus area 2: *Supporting people across health, aged care and disability systems* for more information on the interface of primary care and hospitals, and the establishment of Medicare Urgent Care Clinics.

## Affordability, service availability and access to care

Coordinated, ongoing care is essential to manage interacting conditions and prevent deterioration in health. Access to primary care can be difficult for some people with chronic conditions, particularly when timely appointments with a regular GP are not available or a long way from home. While GPs often play a central role in assessment, care coordination and ongoing management, some aspects of care require access to other health professionals, services or timely referrals, which may not always be readily available. Cost is also a substantial barrier to care. People with one or more chronic conditions are more likely to delay or forgo needed health services due to cost than those without a long-term health condition (9.2% compared with 5.5%), highlighting ongoing affordability pressures (ABS 2025d).

### Improving early diagnosis of chronic kidney disease across the health system

Chronic kidney disease (CKD) is placing a growing burden on Australians and the health system. After adjusting for age, CKD hospitalisation rates (excluding dialysis) increased by 72% between 2000–01 and 2023–24. The number of people receiving dialysis or kidney transplant (kidney replacement therapy, KRT) more than doubled (AIHW 2026f). First Nations people are disproportionately affected, with KRT incidence 5.1 times as high as non-Indigenous Australians (AIHW 2026f).

CKD is often diagnosed late, and biomedical testing (such as blood tests) suggests it is more common than self-reported data indicate. In 2022–24, around 1 in 7 (14%) adults aged 18 and over had a biomedical indicator of CKD, compared with 11% a decade earlier (ABS 2025c). This highlights low awareness and the importance of early detection through regular health checks (AIHW 2026f).

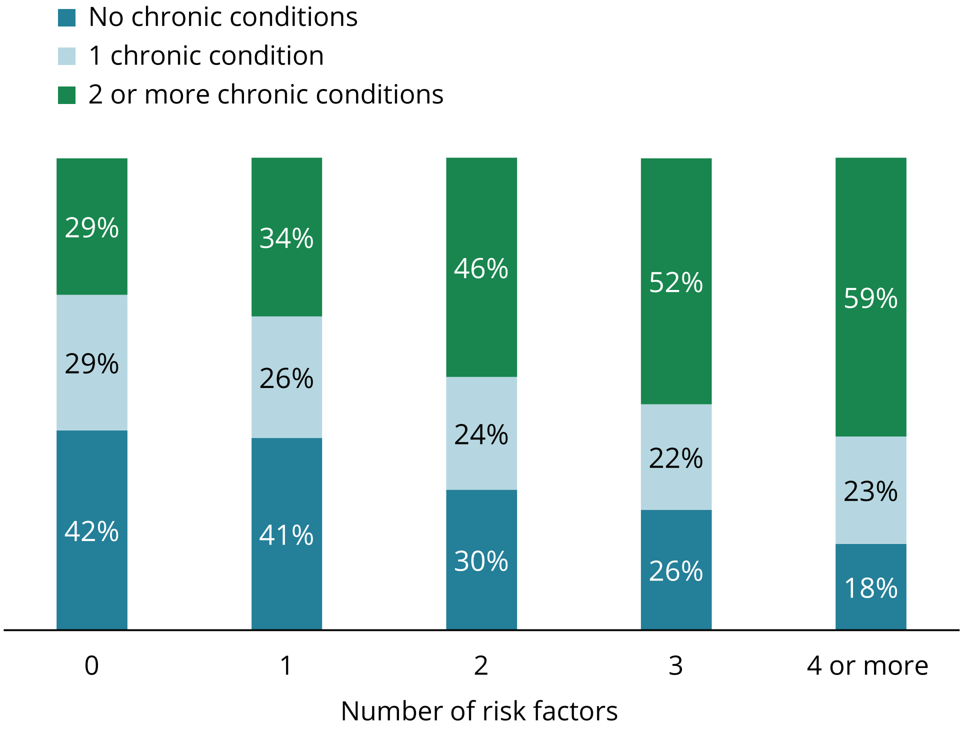
# Preventable risk factors remain a major driver of chronic conditions

Many chronic conditions share risk factors, some of which are potentially preventable. These 'modifiable risk factors' can be reduced through public health, clinical and policy approaches that support prevention. Examples include tobacco control, physical activity promotion, early management of high blood pressure and health-promoting national food policies.

In 2024, modifiable risk factors such as tobacco use, overweight (including obesity), physical inactivity, alcohol use and unhealthy diet, together accounted for around one-third (36%) of Australia's total disease burden (AIHW 2024a).

In 2022, 59% of adults with 4 or more selected risk factors had multimorbidity, compared with 29% of those with none (AIHW 2025n).

**Having more risk factors increases the likelihood of having multimorbidity, reflecting their cumulative impact on long-term health:**



Note: In the ABS National Health Survey, conditions are described as 'long-term health conditions'. For the purposes of this report, these are referred to as 'chronic conditions'.

Source: AIHW analysis of Microdata and TableBuilder: National Health Survey 2022, ABS (2023).

## Tobacco control reduces chronic condition burden, but e-cigarettes pose new challenges

Preventable risk factors are not evenly distributed across the population. They are shaped by a range of factors such as where people live, their income, education, housing, work and access to services. As a result, prevention efforts are most effective when they focus on population-level policies, such as system and environmental changes, rather than individual behaviour change alone.

Population-level policies to combat the health impacts of tobacco smoking are a key example. Australia's comprehensive tobacco control policies – including high excise taxes, plain packaging and advertising bans – have been highly effective in reducing smoking rates and smoking-related harm over time. As a result, the total burden attributable to tobacco has fallen by 41% between 2003 and 2024, from 21.6 to 12.7 disability-adjusted life years (DALYs) per 1,000 population, after adjusting for age (AIHW 2026c).

As tobacco smoking has declined, other preventable risks shaped by social and commercial environments have become more prominent, particularly the use of e-cigarettes (vapes). The proportion of people aged 14 and over self-reporting current use of e-cigarettes increased from 2.5% in 2019 to 7.0% in 2022–2023. Use is highest among young adults, with 21% of people aged 18–24 reporting use either daily, weekly, monthly or less often than monthly (AIHW 2025q). Use of e-cigarettes is higher among groups with lower pre-existing rates of smoking, including young people and people living in the least disadvantaged areas.

Most people first use vapes out of curiosity rather than to quit tobacco smoking (58% of people aged 14 and over compared with 21%, respectively, in 2022–2023) (AIHW 2025q). Among young people, experimentation can lead to ongoing nicotine use. Rising dual use suggests e-cigarettes often supplement rather than replace tobacco smoking. In 2022–2023, 2.3% of people in Australia reported regularly smoking cigarettes and using e-cigarettes, up from 0.7% in 2016 (AIHW 2025q).

The illicit tobacco and e-cigarette market is an emerging public health concern in Australia. The Illicit Tobacco and E-cigarette Commissioner's office estimates that around half (50–60%) of all tobacco products sold in Australia in 2024–25 were illicit. Much of the e-cigarette market operates outside established health and regulatory safeguards, with around 96% of the market operating illicitly. This limits oversight of product safety, quality and access, undermining measures intended to reduce harm and prevent uptake (ITEC 2025). New ABS experimental analysis also indicates a substantial shift towards illicit tobacco and illegally sold nicotine products in Australia. National nicotine consumption was estimated to have increased by almost 40% between 2017 and 2025, with illicit sources increasing from an estimated 12% to 80% of total consumption (ABS 2026).

# More Australians are living with obesity, calling for holistic preventive approaches and accessible treatment options to reduce its impacts

**Overweight and obesity have emerged as the leading contributors to disease burden, accounting for 8.3% of disease burden in Australia in 2024. Excess weight is a major risk factor for a range of chronic conditions such as cardiovascular diseases, dementia, type 2 diabetes, musculoskeletal conditions and some cancers. Population-wide prevention approaches are needed to reduce its impacts (AIHW 2024a).**

The prevalence of obesity has increased over time, with an estimated 33% of Australian adults aged 18 and over and 8.5% of children aged 2–17 living with obesity, in 2022–24 (AIHW 2026z). Australians born more recently are more likely to be living with obesity. For example, almost 9 additional adults in every 100 adults aged 25–34 were living with obesity in 2022–24 (29%), compared with those at the same age in 2011–12 (20%) (AIHW 2026z).

The increase in obesity prevalence has significant implications and impacts due to more years lived with ill-health, and increased mortality. People living with overweight or obesity often experience weight stigma, due to the perception that obesity is a personal responsibility. However, the causes of overweight and obesity are complex and driven by strong social, biological and environmental factors (The Obesity Collective 2023).

*National Obesity Strategy 2022–2032* prioritises prevention and supportive environments, alongside early intervention, access to appropriate care and tackling weight stigma for people living with overweight and obesity (Department of Health 2022).

The objectives of the *National Obesity Strategy 2022–2032* are supported through several national programs implemented in parallel. These include reformulation of processed foods through the Healthy Food Partnership, national dietary guidance through Eat for Health, and 24-hour movement guidelines. Collectively, these initiatives aim to guide and support Australians to live healthier lives (Department of Health and Aged Care 2024c).

Management and treatment of overweight and obesity requires a holistic plan tailored to a person's individual needs and goals. Interventions may include nutrition, movement, sleep and psychological support, medicines or bariatric surgery.

The use of weight-loss medicines, particularly glucagon-like peptide-1 (GLP-1) receptor agonists such as semaglutide (for example, Ozempic), has increased rapidly in Australia in recent years (Kuo et al. 2026). However, national data on the use of medicines for obesity in Australia are limited. Evidence suggests these medications are only effective during treatment, with discontinuation commonly leading to weight regain and recurrence of weight-related comorbidities and more evidence is needed on long-term safety, effectiveness and side effects (Forner and Hocking 2025; West et al. 2026; WHO 2025b).

The current high cost of weight-loss medicines is one of many barriers to accessing treatment and support for people living with obesity, especially for those in lower socioeconomic areas. This could contribute to ongoing health inequalities, with people with the greatest need less able to use these medicines (Hasselbalch et al. 2025; Wheate et al. 2024).

Sustained and targeted interventions and prevention actions aimed at changing the environments which promote obesity and inhibiting equitable access to care is required to reduce the burden of obesity and related chronic conditions.

## Evidence and data for chronic conditions

High quality data are essential to understanding patterns of chronic conditions, how they change over time, and how people move through detection, diagnosis and care. Better chronic condition data help decision-makers invest in prevention, funding and delivery of care and support services that meet people’s needs.

However, data gaps persist. Nationally consistent primary health care data is a known information gap, limiting our understanding of how chronic conditions are managed and the outcomes for patients. The AIHW continues to work towards a National Primary Health Care Data Collection. For more information on Australia’s health data landscape, see Focus area 6: *From silos to systems: strengthening Australia’s health data*.

See also our Chronic conditions dashboard which provides an overview of prevalence and incidence by age and sex. It includes time series data and breakdowns for selected population groups across 8 broad condition groups and more than 40 specific conditions.

# 2

# Supporting people across health, aged care and disability systems

Australia is experiencing demographic and health changes. This includes an ageing population, more people with disability, and a growing number of people living with chronic conditions. These trends are increasing demand for care and support services that span multiple systems. Where these systems intersect, effective coordination between people, services and data is essential to deliver high-quality care.

## Integrating Australia's care and support systems is essential to meet growing demand

Australia's care and support systems – notably health (including mental health), aged care and disability – support a growing number of people with complex and ongoing needs. As people frequently move between hospital care, primary and community care, disability supports and aged care, effective coordination across systems is essential. To ensure continuity of care, these systems must be well coordinated across states and territories, where lines of responsibility need to be clearly defined, while still providing end-to-end support.

Challenges in one part of the system can affect others. Both the Royal Commission into Aged Care Quality and Safety (2021) and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) identified ongoing challenges at points where people and service systems meet, interact and overlap (also referred to as the interface). This especially impacts people with complex needs, those with limited informal supports (such as family members who prepare meals and provide personal care) and groups facing compounded barriers.

This focus area examines contemporary challenges at key system interfaces, where people experience difficulties transitioning between systems, or where care and support may be more appropriately delivered by a different part of the system. This includes the use of emergency departments (EDs) for non-life-threatening conditions, delayed discharge from hospital, gaps in support for people with psychosocial disability and efforts to transition younger people out of residential aged care. It also highlights recent initiatives aimed at addressing these challenges and supporting more appropriate, coordinated and continuous care.

The National Health Reform Agreement (NHRA) Addendum 2026–2031 was signed by the Australian Government and state and territory governments on 27 February 2026 and will take effect on 1 July 2026. The NHRA includes $25 billion in additional hospital funding and structural reforms aimed at stabilising demand and improving sustainability (PM&C 2026). Schedule C – System Interface Reform of the NHRA aims to improve care at the interface of public, private and not-for-profit health systems. It focuses on reforms addressing barriers between Local Hospital Networks and the primary care, aged care and disability care systems.

High-quality data are essential for evidence-based policy, informed funding decisions, and designing services that meet people's needs. This focus area highlights the challenges posed by limited national data at system interfaces and in monitoring outcomes through and after transitions. For more details on efforts to improve Australia's health data connectivity, standardisation and utility, see Focus area 6: *From silos to systems: strengthening Australia's health data*.

## Emergency department use for non-urgent conditions that could be managed in primary care

Primary care is health care that people often seek first in the community, such as from general practitioners (GPs). Primary care and hospitals are distinct but connected parts of the health system. Primary care provides opportunity for prevention, diagnosis, early intervention and disease management. Whereas, hospitals provide episodic, high-intensity and specialised care. A key challenge at this interface is the management of hospital admissions and ED presentations that could potentially be treated in primary care.

Around one-third (32%) of ED presentations in 2023–24 were triaged as 'lower urgency' (AIHW 2025aa). People attend EDs instead of GPs for a range of reasons. In 2023–24, of people aged 15 and over who visited an ED:

- almost half (46%) reported that the main reason they went to an ED instead of a GP was because they were taken by ambulance, or the condition was serious
- 1 in 5 (22%) reported that the main reason was because a GP was not available when required or that the waiting time for a GP appointment was too long
- 1 in 6 (16%) reported that their GP did not have the required equipment or facilities (ABS 2024c; AIHW 2025aa).

In 2024–25, 6.3% of hospitalisations were for conditions that might be managed through better primary care across the life course (AIHW 2026ac). However, these hospitalisations also reflect factors beyond access to primary care, including the growing burden of chronic disease and underlying social and geographic inequalities.

The Australian Government are establishing 137 Medicare Urgent Care Clinics nationwide to ease pressures on EDs and hospitals. These clinics provide urgent care services for conditions and illnesses that are non-life-threatening, allowing hospitals and EDs to focus on patients with higher urgency and life-threatening conditions (Department of Health, Disability and Ageing 2026a).

Continuity and coordination of care across the primary care and hospital interface is also a challenge. In 2024–25, among people aged 15 and over:

- over one-quarter (29%) of those who saw at least 3 health professionals for the same condition reported that no health professionals helped coordinate their health care.
- around 1 in 6 (16%) experienced issues caused by a lack of communication between multiple health professionals (ABS 2025d).

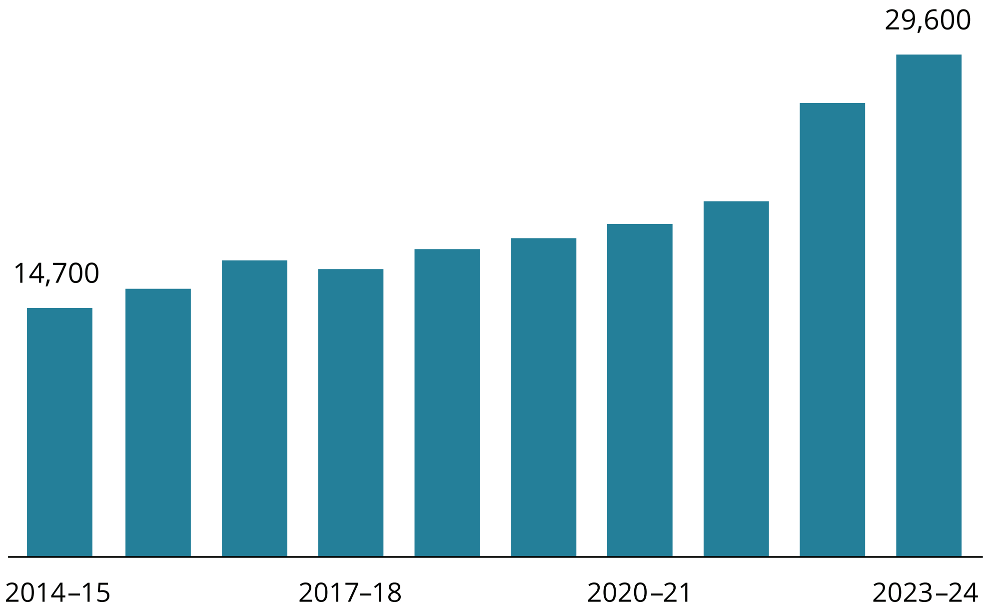
Australia currently lacks consistent national data on primary health care, making it difficult to monitor and understand access, quality, outcomes and unmet needs. To address this, the AIHW is working towards a National Primary Health Care Data Collection. For more, see Focus area 6: *From silos to systems: strengthening Australia's health data*.

## Delayed discharge from hospital

Delayed discharge occurs when patients remain in hospital when they no longer require admitted patient care. This may happen for various complex and interconnected reasons. Reasons for delayed discharge may be related to hospital or health service processes, or availability of other services including aged care, guardianship or legal issues, and patient and family decision making. Delayed discharge occurs more commonly among older people and among younger people with disability, people with complex needs, cognitive issues, mental health conditions, and/or limited post-hospital supports and/or accommodation.

Nationally consistent reporting on delayed discharge is limited. Historical data on hospital care for individuals who require ongoing support, but no longer need hospital treatment, indirectly suggests that this is an increasing substantial issue. However, these findings are limited by differing hospital coding practices, differing definitions applied by state and territory health/hospital systems, and differing models of state and territory aged care. This makes it difficult to guide policy, planning and funding.

**Public hospital separations for older patients awaiting residential aged care or support at home doubled between 2014–15 and 2023–24:**



Note: Includes completed separations (episode of care ended through discharge, transfer, change in care type or death) with a care type of maintenance care for people aged 65 and over and Aboriginal and Torres Strait Islander people aged 50–64 years, with a principal or additional diagnosis of Z75.11 or Z74.2. Changes in care type or transfers to other hospitals are not combined to reflect the full length of hospital stay.

Source: AIHW analysis in Report on Government Services 2026, 14 Aged care services, Productivity Commission (2026).

Several states and territories capture information about patients experiencing delayed discharge in near real time. This is done through regular point-in-time censuses of hospital patients, real-time monitoring in hospital electronic medical record systems, or drawing on real-time patient information from embedded information systems that support management of patient flow. However, without nationally consistent definitions or linked data, it is difficult to measure issues, assess trends, evaluate interventions or compare system performance. It is also difficult to assess, at present, whether certain diagnoses or personal circumstances are associated with delayed discharge.

Work is underway to establish nationally consistent definitions of delayed discharge that can be applied across states and territories and reflect different causes and circumstances. At the same time, data integration is connecting hospital records with aged care data. This is enabling retrospective analysis of aged care service use before and after hospitalisations involving delayed discharge among older people. It includes examining when older people are assessed for aged care eligibility. The next step is to embed these developments into routine, nationally comparable reporting.

The AIHW is working in collaboration with states and territories and the Department of Health, Disability and Ageing to enhance cross-system visibility at the health-aged care interface as it relates to delayed discharge of older patients (DDOP), and support implementation of health and aged care reforms.

The data standards, collection and reporting work stream includes two complementary projects:

1. developing national standards for collection and reporting on DDOP
2. development of new national collection and reporting mechanisms for transparency, planning and system improvement.

Data standards and provisional reporting to governments is anticipated by end of 2026, and baseline reporting from the national collection by 30 June 2027.

In addition, the AIHW is performing analyses using linked data to assess whether older patients with certain conditions are more likely to experience a delayed discharge from hospital, for example, dementia diagnosis. These analyses will provide novel insights for policy and practice into risk factors associated with delayed hospital discharge.

While delayed discharges are the immediate focus of national consistency, the approach has broader relevance. Many other health system areas share similar data challenges.

## Support for people with psychosocial disability

According to the 2022 Survey of Disability, Ageing and Carers, 6.5% of Australians had psychosocial disability, up from 4.6% in 2018 (ABS 2025e).

Psychosocial disability arises when mental health challenges (such as those caused by nervous or emotional conditions, mental illness, and/or behavioural difficulties) affect a person's ability to participate in everyday life, including work, education, housing, social connections and relationships. This can include challenges with day-to-day tasks, such as sustaining routines, organising everyday responsibilities, making decisions and managing money.

Psychosocial support services play a critical role in enabling individuals with severe mental health challenges to lead independent and meaningful lives. By 31 December 2025, just over 65,800 people with a primary psychosocial disability were part of the National Disability Insurance Scheme (NDIS), making them the fourth largest group – about 9% of all participants (NDIA 2026).

Participant feedback indicates positive outcomes from the NDIS. Among people aged 15 and over with psychosocial disability, 82% reported at their most recent assessment (Quarter 2, 2025–26) that the NDIS helped them gain greater choice and control in their lives (AIHW 2026y).

While the NDIS is delivering positive outcomes for many eligible participants, it does not, however, meet the needs of all people with psychosocial disability. Some people are not supported by the NDIS because their conditions are not permanent, but ongoing and episodic in nature. People who do not meet the NDIS requirements may access psychosocial support services provided by the Commonwealth or state and territory governments or have limited, or no, access to appropriate supports (Department of Health and Aged Care 2024a). Improved data on this group would strengthen understanding of their needs, service pathways and outcomes – to help guide improvements to service access, design, and delivery.

The NDIS is one of Australia's most important social reforms that has improved access to disability supports. However, its sustainability is under pressure due to rapid participant growth, market issues and rising costs. Recent NDIS reforms aim to secure the scheme's long-term sustainability, while current psychosocial disability reforms are focused on strengthening supports outside the NDIS, improving system integration, and reducing reliance on NDIS eligibility as the primary pathway to assistance. Addressing unmet psychosocial needs outside of the NDIS is also being considered in the next National Mental Health and Suicide Prevention Agreement.

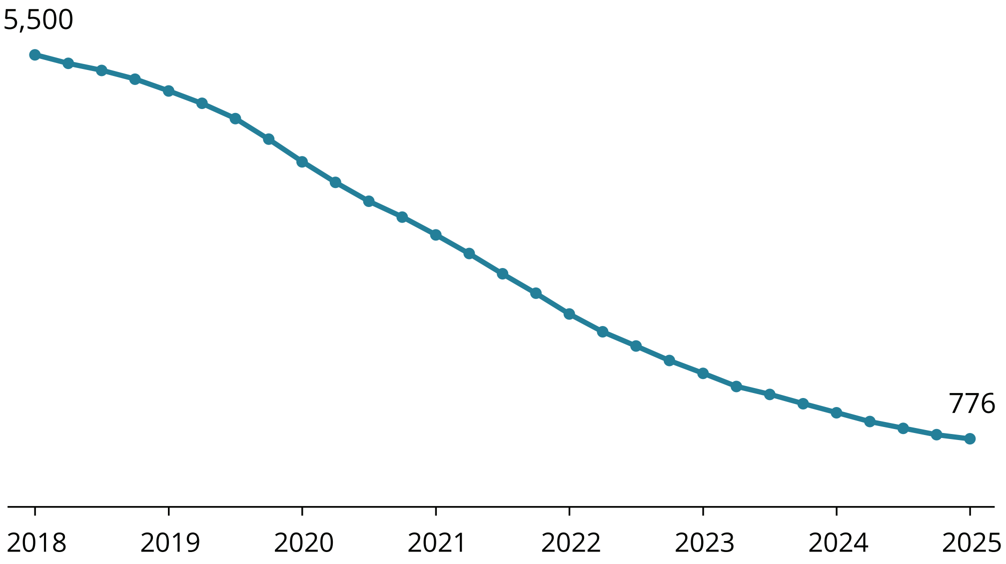
## Transitioning younger people in residential aged care to age-appropriate care

While permanent residential aged care may meet basic care needs for younger people (aged under 65) with disability who require ongoing support, it is rarely designed to support their independence, social participation or life goals.

Targeted government initiatives have led to substantial reductions in younger people in permanent residential aged care. Between 30 September 2018 and 31 December 2025, the number of younger people living in permanent residential aged care:

- decreased by 86%, from 5,513 to 776 people (excluding First Nations people aged 50–64)
- decreased by 44% for First Nations people aged 50–64, from 361 to 203 (AIHW 2026ah).

**Considerable progress has been made in reducing the number of younger people in permanent residential aged care:**



Source: Younger people in residential aged care, AIHW (2026).

Nationally, there is limited understanding of how well younger people do after leaving permanent residential aged care, including whether their community living is stable and if services are sufficient. Linked-data analyses showed that historically many younger individuals did not move into age-appropriate accommodation. This underscores the need for outcome-focused monitoring of younger people with disability in Australia (AIHW 2023c).

Specialist Disability Accommodation (SDA) under the NDIS can offer a suitable alternative to permanent residential aged care for people with high or complex support needs. However, supply needs to be sufficient to meet demand. Linked-data analysis of younger NDIS participants in residential aged care during 2017 to 2022 found that that fewer than 1 in 3 (30%) participants with SDA funding were using it, likely reflective of limited SDA availability at the time (AIHW 2026x).

# The hidden cost: impacts on unpaid carers

As Australians are living longer with chronic conditions, disability and age-related care needs – and as policy increasingly supports people to remain at home – family members and friends are taking on a growing share of care through informal, unpaid roles.

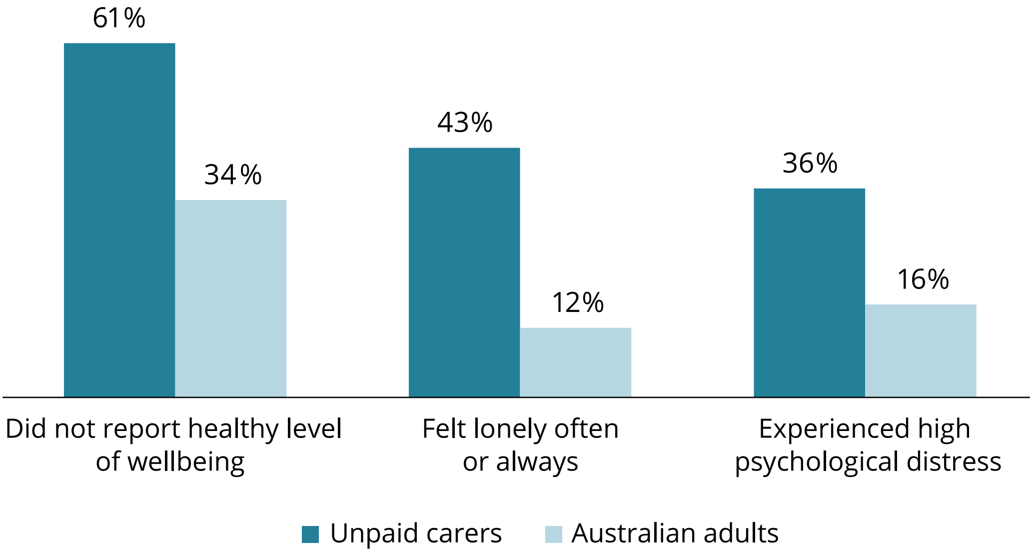
In 2022, around 3 million Australians provided informal care, including 1.2 million primary carers (AIHW 2025k).

Support systems are not keeping pace with carers' needs and expectations:

- Fewer than half (45%) of primary carers in 2022 were satisfied with available services (AIHW 2024c).
- Almost half (48%) of carers of people with dementia in 2024 identified poor care coordination as a major barrier to accessing support (AIHW 2025p).

Unpaid carers experience poorer health and wellbeing outcomes than the general adult population (Mylek and Schirmer 2025). Carer strain may result in poorer outcomes for care recipients, leading to increased demand for services from health, disability and aged care systems. Without better-coordinated and more responsive formal support, pressures on unpaid carers may intensify.

**Unpaid carers experienced poorer health and wellbeing outcomes than the general population in 2025:**



Note: The Personal Wellbeing Index was used to measure wellbeing, where carers self-rate their level of satisfaction on their standard of living, relationships, community, future security, what they are achieving, health and safety. These ratings are transformed to a score between 0 to 100. A score over 60 indicates healthy wellbeing.

Source: Carer wellbeing survey 2025 report, Carers Australia (2025).

# 3

# Factors influencing the health of First Nations people

Aboriginal and Torres Strait Islander (First Nations) people are the first peoples of Australia. They comprise hundreds of groups that have their own distinct set of languages, histories and cultural traditions.

For First Nations people, good health is more than the absence of disease or illness; it is a holistic concept that includes physical, social, emotional, cultural, spiritual and ecological wellbeing.

## What influences First Nations people's health?

The health and wellbeing of First Nations people and communities are shaped by cultural, historical, political and social determinants over their lives. These factors influence physical and mental health, health behaviours, service use, experiences and outcomes (Department of Health 2021). Socioeconomic conditions, cultural connection, policies and individual characteristics all affect health outcomes such as life expectancy and development of chronic conditions.

### First Nations people have strong connections to their family, community and culture

In 2022–23, among First Nations people aged 18 and over, an estimated:

- 76% recognised an area as a homeland/traditional Country
- 66% identified with a tribal group, language, clan, mission or regional group
- 22% lived on their homeland (AIHW 2025u).

**Social and emotional wellbeing is a holistic concept of First Nations people's health:**

Source: Adapted from Gee at al 2014, Empowering Access – Social and emotional wellbeing (SEWB), Transforming Indigenous Mental Health and Wellbeing Project (2022).

## Culture as a protective factor for health and wellbeing

Culture and connections are central to First Nations people's health and wellbeing, underpinning resilience, and community or collective strength and endurance. Cultural identity, family and kinship, connection to Country, knowledge and beliefs, language and participation in cultural activities are all key determinants. The distinctive cultural, spiritual, physical and economic relationship that First Nations people have with their land and waters can be protective factors that enhance resilience and support good health and wellbeing (Department of Health 2021).

The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 and National Agreement on Closing the Gap recognise culture, family and connection to land and waters as foundational to health and wellbeing. For example, contemporary housing must consider kinship, family and community living arrangements (Department of Health 2021).

# Some improvement in the social factors that underpin good health

The social and economic conditions that play a key role in influencing health and wellbeing of First Nations people include education, housing, and work. For example, education can equip people to find, understand, and apply health information, which can have a direct impact on a person's health (AIHW 2025a). Over the past decade, there have been positive shifts across several of these areas.

## Education and employment

Higher levels of education and employment are associated with greater health literacy, increased use of health services and healthier behaviours. Levels of educational attainment and employment among First Nations people have improved, with increases in:

- national apparent retention rates of full-time students for Year 7/8 to Year 12 (59% in 2021, up from 45% in 2009) (AIHW 2023d)
- the proportion of those aged 20–24 who had attained at least a Year 12 or equivalent qualification (68% in 2021, up from 52% in 2011) (AIHW 2023d)
- the proportion of those aged 25–34 who had completed a tertiary qualification as their highest educational attainment (47% in 2021, up from 33% in 2011) (AIHW 2025d)
- the proportion of First Nations people aged 15–64 who are employed (57% in 2022–23, up from 46% in 2012–13) (AIHW 2025e).

## Income

An adequate income is fundamental to being able to live a healthy life. It gives a person greater access to nutritious food, better housing, health and other services, as well as a greater ability for social participation (AIHW 2025a). Between 2011 and 2021, a growing proportion of First Nations adults moved into the upper half of the income distribution, indicating some improvement over the decade (AIHW 2023e).

## Housing

Safe, secure, and culturally appropriate housing supports physical health, mental wellbeing, cultural connection, and access to services, while housing disadvantage contributes to illness, stress, and ongoing health inequities. There have been improvements, with decreases in overcrowding, increases in home ownership and a reduction in homelessness for First Nations people over the last decade (AIHW 2025j).

**Safety and justice**

Contact with the justice system is strongly linked to poor physical and mental health outcomes, disability, substance use and intergenerational trauma. It can also compound existing social and economic disadvantages. Some improvement has been seen, with rates of First Nations young people under youth justice supervision trending downwards for both community-based supervision and detention since 2016–17 (AIHW 2025w).

## Culturally safe care is essential in improving health and wellbeing

Access to culturally appropriate and high-quality health care services is critically important for First Nations people's use of services, experiences and outcomes (AIHW 2023b). A culturally safe health system is one that respects the cultural values, strengths and differences of First Nations people, and addresses racism and inequity. Culturally responsive care builds trust and improves engagement, which are critical to delivering effective health care, especially for suicide prevention. Disrespectful or culturally unsafe encounters can compound historical and intergenerational trauma, particularly given the legacy of colonisation and policies such as child removal, which continue to affect the social and emotional wellbeing of First Nations people today.

### Majority of First Nations people feel respected by health professionals

**Based on the latest data from 2022–23, most First Nations people aged 15 and over felt that in the last 12 months:**

- **their culture, traditions, customs and beliefs were always or usually respected by GPs (88%)**
- **they were respected by staff at their most recent hospital admission (80%) (ABS 2024b).**

Aboriginal Community Controlled Health Organisations (ACCHOs) are central to the delivery of culturally safe and culturally appropriate care (Pearson et al. 2020). They provide community-run primary health care that supports not only physical health but also the social, emotional, and cultural wellbeing of individuals, families, and communities. This model enables earlier diagnosis, improved chronic disease management and continuity of care, particularly for those who have experienced discrimination or have no strong cultural ties.

Growth in the First Nations health workforce further supports culturally responsive care, system leadership and self-determination. An appropriately skilled, available and responsive First Nations health workforce is essential for delivering integrated models of care across all health, mental health, disability and aged care systems and services (Department of Health 2021).

### Strengthening First Nations health care

**First Nations-specific primary health care organisations play a critical role in improving the health of First Nations people. Overall, there have been increases in:**

- **the number of these organisations (from 210 in 2018–19 to 215 in 2024–25)**
- **the number of First Nations FTE staff employed (from 4,130 at 30 June 2019 to 5,069 at 30 June 2025) (AIHW 2026a).**

## Improvements in health outcomes

Recent improvements in population health outcomes for First Nations people reflect progress across key social determinants of health, alongside the expansion of culturally safe, First Nations-led care. One way to assess these changes is through burden of disease, a valuable summary measure that combines the fatal and non-fatal impacts of disease, illness and injury in a comparable way.

The latest available data shows that, after adjusting for population growth and ageing, the total disease burden for First Nations people decreased between 2011 and 2022, driven by a drop in fatal burden, while non-fatal burden remained largely unchanged (AIHW 2026l).

### Targeted public health actions have contributed to declining disease burden among First Nations people

The burden due to coronary heart disease – the leading individual cause of health loss among First Nations people – declined by 30% between 2011 and 2022 (AIHW 2026l). This improvement was supported by the introduction of Better Cardiac Care, a targeted initiative that improved access and availability of services, risk factor management, treatment, and care coordination for First Nations people (AIHW 2026l).

Deaths from diabetes have also declined (14% decrease in age-standardised rate between 2016 and 2021) (AIHW 2026p). As kidney disease, heart disease and diabetes are closely linked and share common risk factors, continued progress will depend on addressing each of these conditions through improving prevention, early detection and treatment.

Improvements have also been observed across a range of other health indicators in recent decades. These include:

- declines in smoking, including a decrease in the proportion of First Nations mothers smoking during pregnancy, after adjusting for differences in age (from 48% in 2011 to 44% in 2020) (AIHW 2025a)
- increased immunisation coverage (94% of First Nations 5-year-olds as at September 2025, compared with 78% in 2007). However, this has started to decline in recent years (Department of Health, Disability and Ageing 2025b, 2026b)
- greater use of health services such as antenatal care, health assessments and chronic disease management (AIHW 2020, 2025a)
- declines in hospitalisation rates that end before treatment has completed (from 4.6% to 3.8% between 2011–12 and 2020–21, after adjusting for differences in age) (AIHW 2024d).

## Further improvements are needed in health and wellbeing outcomes

Improvement in First Nations people's health and wellbeing outcomes needs to be grounded in an understanding of the interconnectedness of health and the social, economic and cultural determinants. Since disadvantage can accumulate, action and improvement are needed for all determinants.

Key measures of all-cause mortality, suicide, potentially preventable hospitalisations, and female hospitalisation due to assault have either not improved or worsened in recent decades.

Underlying social, political and economic factors – often called structural determinants – continue to drive inequity:

- First Nations people have substantially less access to affordable, secure and quality housing, being over-represented in the national homeless population and as users of specialist homelessness services (AIHW 2025j).
- Income levels for First Nations people remain well below those of non-Indigenous Australians (AIHW 2023e).
- First Nations people experience higher rates of disability, and for those with disability, greater barriers across health, education, housing and justice systems compared with non-Indigenous Australians (AIHW 2025x, 2026q).

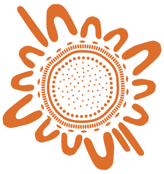
# Strengthening the evidence base

Improving health and wellbeing outcomes of First Nations people requires working in partnership with First Nations people and organisations. This includes strengthening the evidence base to support better policies, services and outcomes.

There are well-documented limitations that affect statistics about First Nations people and their health, including:

- uncertainty around the size and composition of the First Nations population
- a need for more accurate identification of First Nations people in data collections to improve the quality of all key health measures, including mortality and morbidity
- a lack of data reflecting key health issues for First Nations people, such as access to culturally safe health services and experience of family violence (AIHW 2025w).

The AIHW is working in partnership with a First Nations Expert Committee on Health System Metrics to assess the effectiveness of health system reforms for First Nations people under the National Health Reform Agreement 2026–2031. Work is underway to review and develop health system measures, with a focus on indicators relating to access, health outcomes, cultural safety and racism, social and emotional wellbeing, and equity across the health system for First Nations people. A data dashboard will be developed to track progress against agreed metrics.



# 4

# Connecting evidence and policy at the intersection of health and welfare

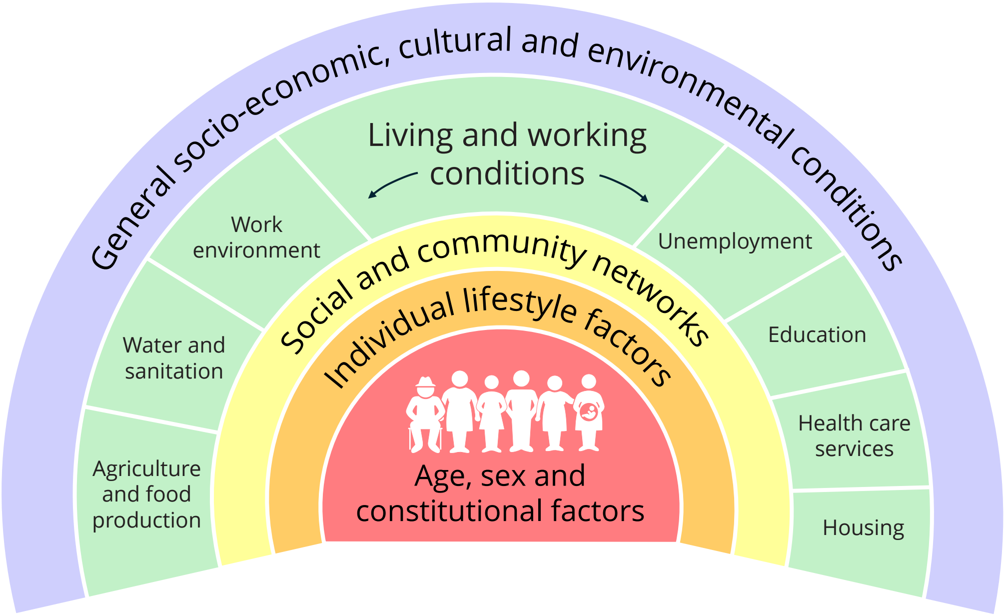
People experiencing disadvantage often receive support from multiple health and welfare systems during the most difficult periods of their lives. Information about these experiences and outcomes are often held in separate, disconnected data systems, which in turn limits the understanding of which groups of people navigate multiple service systems. Linked data environments are changing this, by generating evidence about how people move across systems and supporting a more person-centred approach to service design. These insights support policy agencies to collaboratively design programs and services that are easier for people to navigate and more efficiently and effectively improve outcomes.

## Compounding disadvantage and the role of linked data in supporting person-centred policy design

The environment in which people live and their level of access to material and psychosocial supports can make people more or less vulnerable to poor health. These factors are known as the social determinants of health (AIHW 2026af, 2026ag; WHO 2026). Inequalities in social circumstances contribute substantially to preventable health conditions, with people with disability, and those in lower socioeconomic positions much more likely to experience preventable health conditions.

The term ‘vulnerable groups’ can be used to describe sections of the population that are identified for focused attention because they experience greater health needs, poorer health outcomes, or barriers to accessing services compared with the general population.

**Model showing layers of health determinants:**



Source: Figure adapted from The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows, Dahlgren and Whitehead (2021).

The relationship between specific social determinants and health outcomes is complex and often influenced by multiple interacting factors. For example, the contribution of poor housing to ill health varies depending on circumstances such as climate, levels of overcrowding and proximity to essential services. As a result, evidence is not available for every possible combination of socioeconomic factors and health outcomes.

Research and analysis of available data tend to provide evidence of links between social characteristics and health outcomes. However, these don’t always take into consideration the complexities of multiple factors that describe the causal pathways between factors across a person’s life. This means that policy responses tend to be siloed in their design and poorly informed about the complex causes of inequalities and health outcomes. Specific government departments are responsible for designing, implementing and evaluating individual programs, but do not have a person-centred picture that would provide a holistic understanding of the recipients’ experiences.

People frequently experience multiple, co-occurring risk factors and may engage with several health and welfare services at the same time and over their lives. Historically, the data about these interactions has been isolated within individual service systems, limiting the understanding of how people navigate across these systems. This also makes it difficult to attribute changes in health outcomes to any single program, as people typically engage with a range of services concurrently and over time.

Linked data addresses this by bringing together information from the disparate programs, services and systems to build a person-centred view. This combined data can identify population cohorts experiencing overlapping socioeconomic disadvantage, and reveal system gaps related to poorer health and welfare outcomes.

## Case study: Understanding deaths among people receiving homelessness and drug and alcohol support services using linked data

People at risk of, or experiencing, homelessness and those with drug and/or alcohol issues have poorer health outcomes, and are likely to follow different health service pathways compared with the general population. Most health services are designed for people with stable accommodation, a permanent address and resources and support networks. It can be difficult for people without stable living arrangements and/or support networks to access health services when needed, because the system is not designed for them.

Specialist homelessness services (SHS) provide support to people at risk of, or experiencing, homelessness. Alcohol and other drug treatment services (AODTS) provide treatment to people seeking assistance for drug and alcohol use.

People receiving support from SHS or AODTS are likely to have a range of cumulative and persistent socioeconomic risk factors, resulting in poor health outcomes. National data on early death (premature mortality) amongst people engaging with both service systems is not routinely available.

To examine mortality among people receiving these supports, the AIHW linked over a decade of administrative data from these systems with health service system data (Medicare Benefits Schedule and Pharmaceutical Benefits Scheme) and the National Death Index data set (AIHW 2025y). The resulting longitudinal data set, called NACS, delivers evidence of mortality rates at the national level among people using either or both health (AODTS) and welfare (SHS) services. These findings could help to identify where changes to policy or service delivery may be needed before or during people's engagement with these services to improve outcomes.

In 2022–23, AODTS clients, after adjusting for differences in age, were 3.3 times more likely to die than those who had not received treatment. This was higher for males (3.6) than females (2.9) (AIHW 2026ab). Those who received SHS support were 1.6 times more likely to die than those who had not received support; similarly, higher among males (1.9) than females (1.4) (AIHW 2025s).

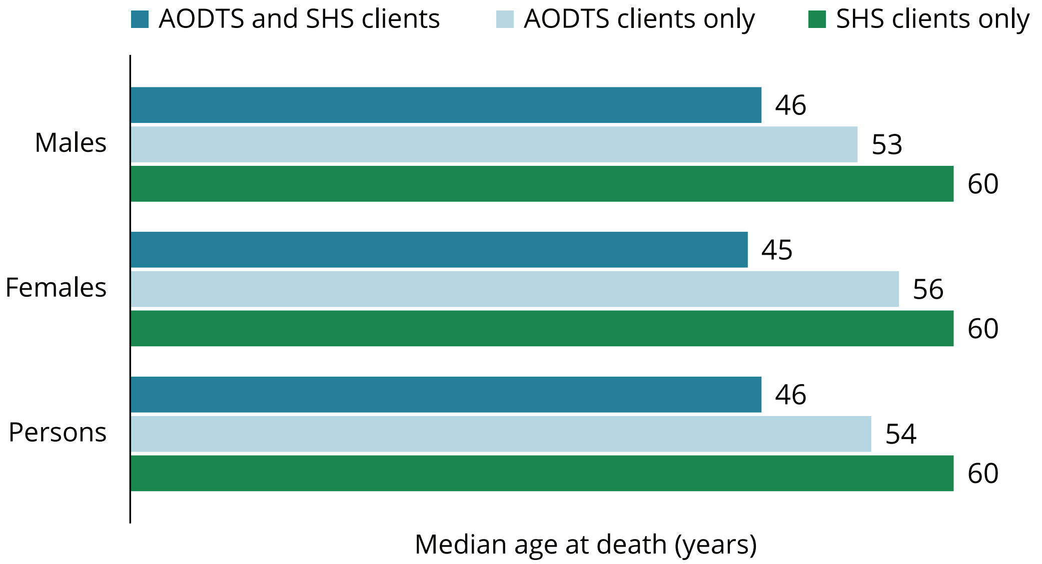
The increased risk of mortality among people needing support from specialist health and welfare services reflects their complex health conditions and life circumstances, not due to them receiving these specific services. The results highlight opportunities for targeted interventions to reduce mortality among these groups.

**Throughout 2012–13 to 2022–23, the most common underlying causes of death among people receiving AODTS or SHS services in their last year of life were accidental poisoning, suicide and liver disease (AIHW 2025s, 2026ab).**

When combining data across both sectors, the mortality impacts among people who have received both AODTS and SHS services were generally greater than among people who received only one service type.

Among people who received both AODTS and SHS services between 2012 and 2023, the median age at death was 46 years – 14 years younger than people who received SHS only, and 8 years younger than those who received AODTS only (AIHW 2026ae).

**People who accessed both homelessness and drug/alcohol treatment services died younger than those who only accessed one service type:**



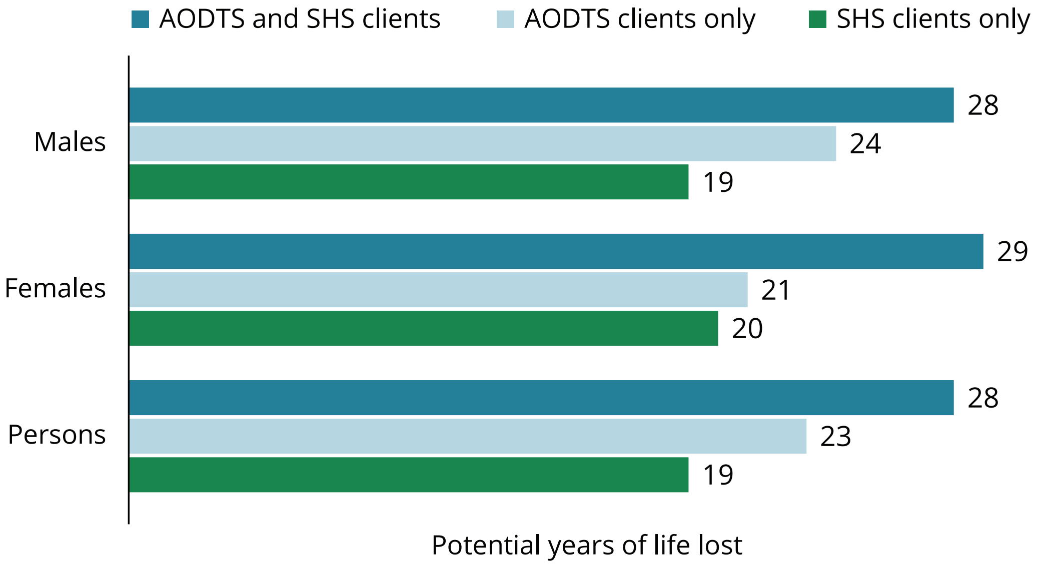
Note: Includes people who had received alcohol and other drug treatment services (AODTS) and/or specialist homelessness services (SHS) at any time throughout 2012–23.

Source: AIHW analysis of Specialist homelessness services: feature analysis: People who received specialist homelessness services and alcohol and other drug treatment services who have died, AIHW (2026).

Early deaths can be described in terms of the potential years of life lost, based on deaths occurring before the age of 75.

The average potential years of life lost for people who received both AODTS and SHS services was 28 years – 9 years more than those who received SHS only and 5 years more than those who received AODTS only (AIHW 2026ae).

**People who accessed both homelessness and drug/alcohol treatment services lost more potential years of life than those who only accessed one service type:**

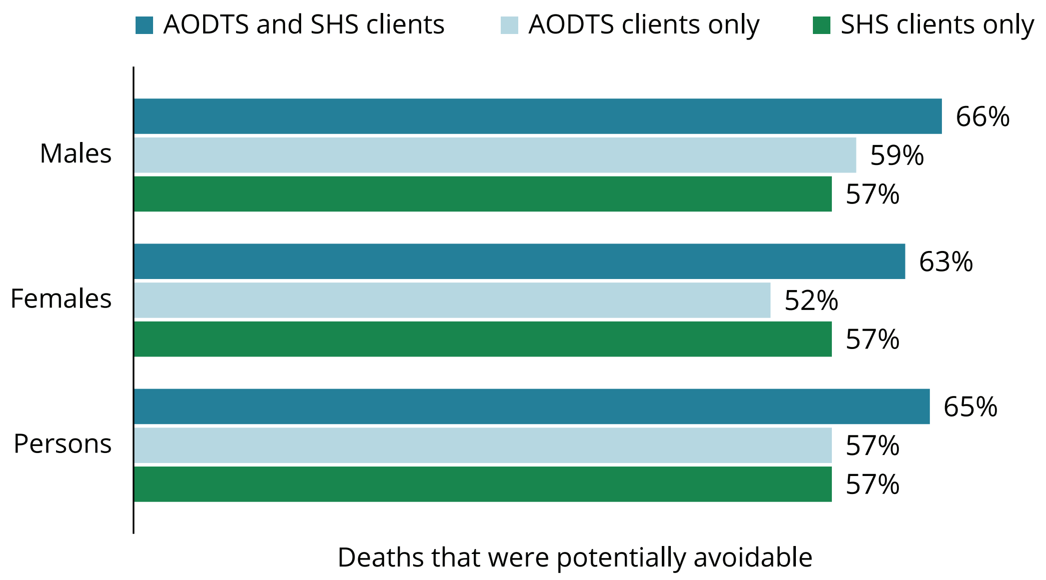


Note: Includes people who died in 2018–23 and who had received alcohol and other drug treatment services (AODTS) and/or specialist homelessness services (SHS) at any time throughout 2012–23.

Source: AIHW analysis of Specialist homelessness services: feature analysis: People who received specialist homelessness services and alcohol and other drug treatment services who have died, AIHW (2026).

Overall, 65% of deaths among people who had received both AODTS and SHS services were potentially avoidable. These are deaths due to conditions that could have been prevented with personalised care or effectively treated through existing primary or hospital care. In comparison, 57% of deaths among people who received only SHS or only AODTS services were potentially avoidable (AIHW 2026ae).

**People who accessed both homelessness and drug/alcohol treatment services had higher rates of potentially avoidable deaths than those accessing only one service type:**



Note: Includes people who died in 2018–23 and who had received alcohol and other drug treatment services (AODTS) and/or specialist homelessness services (SHS) at any time throughout 2012–23.

Source: AIHW analysis of Specialist homelessness services: feature analysis: People who received specialist homelessness services and alcohol and other drug treatment services who have died, AIHW (2026).

These results provide estimates of the total cost of premature mortality among clients of homelessness and drug/alcohol treatment services. The results point to opportunities in overdose prevention, suicide prevention, chronic disease management and access to specialist care.

Work using the linked data set is underway using a variety of specialised analysis methods, such as pathways analysis and regression modelling, to further understand the socioeconomic risk factors contributing to premature death. The data set is also available for approved researchers, supported by the AIHW.

# Linked data demonstrates the need for cross-portfolio policy development

The results show how linked data can provide evidence about vulnerable groups interacting with health and welfare service systems. Embedding linked data into regular reporting and outcomes frameworks (rather than relying on data from single systems or programs) would enable more robust measures of health outcomes for these groups.

This example points to opportunities for better-designed, cross-portfolio policy responses that account for the complex and overlapping experiences of people using multiple services. Government agencies can work together using these data to design coordinated policy and system responses to improve outcomes among vulnerable groups.

# 5

# Australia’s mothers and babies: maternity care and outcomes

Each year in Australia, around 300,000 babies are born. The outcomes and experiences of mothers and babies are closely shaped by the social determinants of health. Factors such as geography, education, income, culture, social support, health behaviours and biology interact to influence the maternal and perinatal periods.

While Australia is one of the safest places for a baby to be born, inequities persist for some women and babies. Some poorer outcomes may reflect gaps in access to maternal care.

## The characteristics of mothers in Australia are changing

Some of the characteristics of mothers can impact their experiences of pregnancy and birth including their access to services. These characteristics are changing over time.

In Australia, women are having children later in life. The average age of mothers has risen from 28.9 years in 1998 to 31.3 in 2023. The average age of first-time mothers has also increased, from 28.3 years in 2010 to 29.9 in 2023 (AIHW 2026d).

**There has been a decrease in the proportion of mothers born in Australia (from 69% in 2012 to 65% in 2023) (AIHW 2026d). A woman's cultural and linguistic background may influence their experience of pregnancy and maternity care.**

Changes can also be seen across various health measures. The proportion of women who gave birth:

- with gestational diabetes has increased (from 15% in 2020 to 17% in 2023)
- who were overweight or obese has increased (from 21% to 27% and from 16% to 23%, between 2011 and 2023, respectively)
- who reported smoking at any time during pregnancy decreased (from 13% in 2011 to 7.8% in 2023) (AIHW 2026d).

# Use of maternity care is changing in Australia

Australian women have some choice about the health providers and care they receive during the pregnancy, birth and postnatal periods; however, this may depend on where they live and their individual circumstances.

Women may access maternity care through the public health system or privately, and care may involve midwives, obstetricians, general practitioners and other health care providers.

Changes in how and where women give birth have implications for hospitals and service planning.

The latest data show an increasing proportion of women accessing antenatal care services in their first trimester (from 61% in 2013 to 79% in 2023); a service associated with positive maternal and child health outcomes (AIHW 2026d).

While most births occur in a hospital (97% in 2023) there have been some changes in where women give birth:

- a decrease in the proportion of women giving birth in private hospitals over the last decade (from 28% of hospital births in 2013 to 25% in 2023)
- a slight annual increase in the number of home births – planned, and attended by a midwife or other medical professional – in recent years (from 923 (0.3%) in 2019 to 2,081 (0.7%) in 2023)
- a slight decrease in the proportion of births taking place in birth centres from 2.3% in 2019 to 1.5% in 2023, with 0.6%–0.9% of births during that period taking place in other settings such as before arrival at a hospital (AIHW 2026d).

Due to the small numbers and variation between states and territories, these data should be interpreted with caution.

# More maternity services offer continuity of carer, but workforce challenges are limiting use

Maternity services are available to all women in Australia, but the types of care available can vary by service.

An increasing proportion of maternity services are providing *midwifery group practice caseload care* (46% in 2025) – a publicly funded model of care where women see the same midwife throughout the maternity period (continuity of carer) (AIHW 2025l). Evidence suggests this model of care may reduce some interventions and improve outcomes for mothers and babies (Sandall et al. 2016, 2024). However, the proportion of women accessing this model remains low at 11% of women who gave birth in 2023 in Victoria, Queensland and Western Australia combined (the states with available data on models of care) (AIHW 2026d). Midwifery group practice models of care require scaling up in flexible ways to meet demand.

Efforts are underway to strengthen Australia's maternity workforce (Department of Health, Disability and Ageing 2026d). Current challenges for the maternity workforce include high turnover among early career midwives, obstetrician shortages alongside overall shortages in rural/remote areas, a significant loss of experienced midwives, increased workloads and burnout (Department of Health and Aged Care 2024b). National policy initiatives, including the National Maternity Workforce Strategy 2026–2036, have been developed to address workforce sustainability and support equitable, culturally safe maternity care across Australia.

## Differences persist in access to maternity services in rural and remote Australia

Location can determine how easy it is for women to access care. Women living in remote areas of Australia may face challenges in accessing appropriate maternal care due to geographic isolation, lack of transport, closure of maternity services and limitations in workforce availability. Differences in the use of antenatal care – from conception to birth – highlight some of these access challenges.

Rural maternity services help families stay close to home. They support strong, connected communities and give babies a safe and healthy start in life. These services also help rural towns grow and remain sustainable (NRHA 2025). The National Consensus Framework for Rural Maternity Services (second edition) provides a set of principles and strategies to frame policy and planning and to support quality maternity services in rural and remote Australia.

The improvement in the proportion of women who attended antenatal care in the first trimester (less than 14 weeks' gestation) was not consistent across remoteness areas. In 2023, the proportion was around 80% for women living in *Major cities*, *Inner* and *Outer regional* areas, compared with 67% in *Remote* areas and 63% in *Very remote* areas (AIHW 2026d).

**Women living in remote areas are less likely to have their first antenatal appointment within the recommended first 10 weeks of pregnancy, as outlined by the Australian Pregnancy Care Guidelines (AIHW 2025o).**

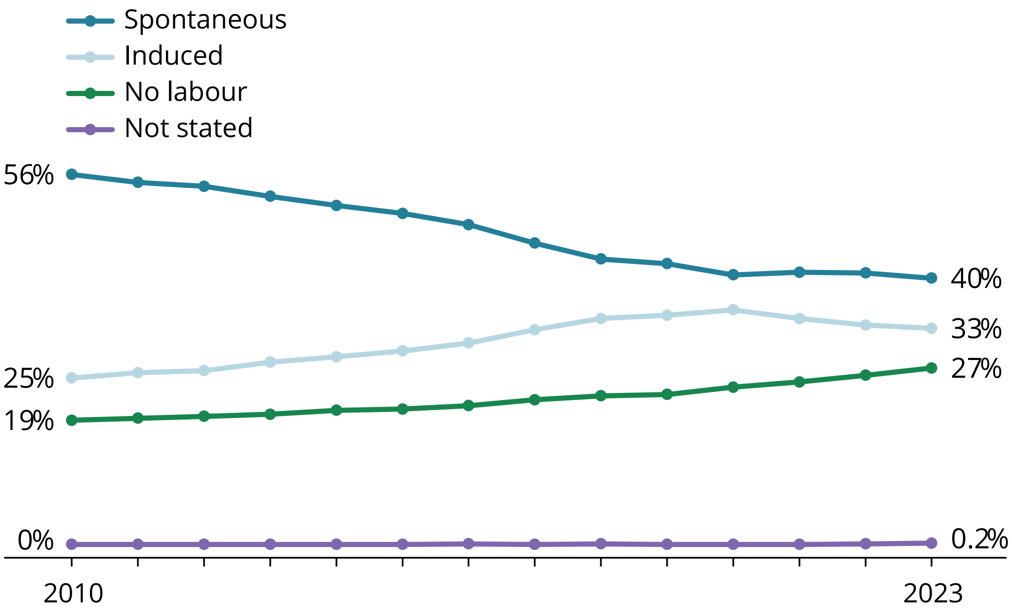
# Birth intervention rates are rising, particularly inductions and caesarean sections

There are a range of possible interventions in the birthing process. They are often chosen to minimise complications and increase the likelihood of positive pregnancy outcomes. However, they can carry risks for the woman and baby and have implications for the health system.

## In Australia, 1 in 3 women have an induced labour

The proportion of women starting labour spontaneously declined from 56% to 40% between 2010 and 2023 (AIHW 2026d). Spontaneous labour remains the most common way in which labour starts, but increasing proportions of women are having induced labour or no labour (such as when a caesarean section is performed before labour starts). The proportion of women having an induced labour increased from 25% in 2010 to a peak of 36% in 2020, however, it has decreased in the last few years to 33% in 2023 (AIHW 2026d).

**Between 2010 and 2023, spontaneous labour decreased while inductions and no labour increased:**



Note: 'Induced' may include cases where induction of labour was attempted but labour did not result.

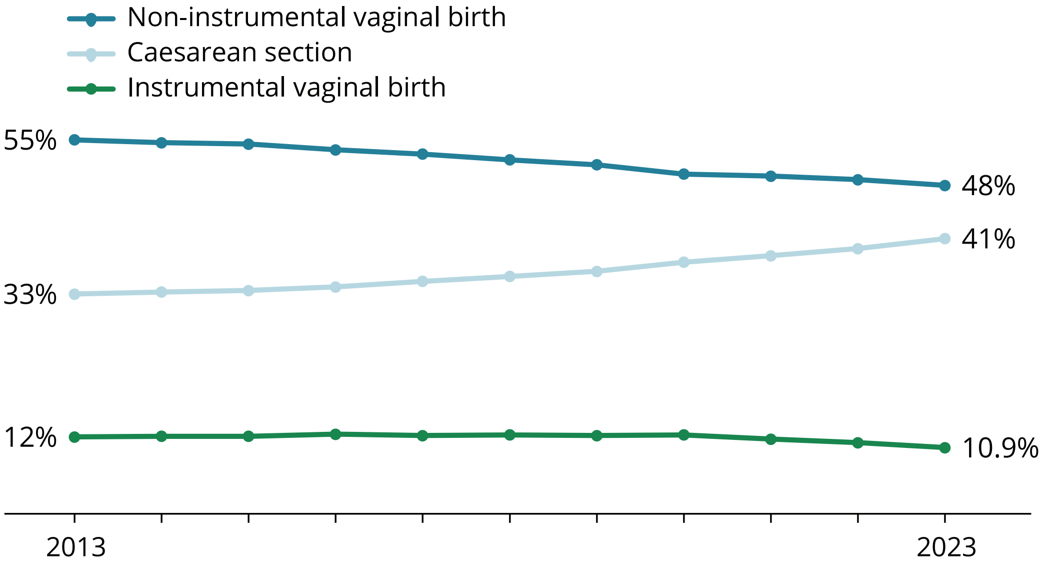
Source: Australia's mothers and babies - Onset of labour, AIHW (2026).

Most women who have induced labour, and their babies, do well. Some women report less positive birthing experiences when compared with spontaneous labour. There are also increased risks of infection and bleeding, and mixed evidence on whether it increases the likelihood of emergency caesarean section (AIHW 2025o).

## Caesarean sections are increasingly common

The proportion of women who had a caesarean section birth in Australia increased from 29% in 2004 to 41% in 2023 (AIHW 2026d). An increase is seen across all maternal age groups, body mass index (BMI) categories, remoteness areas, socioeconomic areas, numbers of previous births (from none to 4 or more), and for births in both public and private hospitals (AIHW 2026d).

**Over the past decade, caesarean section births increased, while non-instrumental vaginal births decreased:**



Source: Australia’s mothers and babies - Method of birth, AIHW (2026).

In 2023, the proportion of women having caesarean section births:

- increased with increasing age, ranging from 23% of those aged under 20, to 59% of those aged 40 and over
- was higher in private hospitals (54%) compared with public hospitals (38%)
- was higher among those in the highest socioeconomic areas (44%) compared with those in the lowest socioeconomic areas (37%) (AIHW 2026d).

## First birth caesarean sections increase the likelihood of subsequent caesareans

In 2023, most mothers (76%) who had previously given birth and had a caesarean section had a repeat caesarean section (AIHW 2026d). Having had a previous caesarean section was the most common main reason reported for having a caesarean section.

The proportion of women who had their second birth vaginally after having their first birth by caesarean section was nearly 3 times as high in public hospitals compared with private hospitals (14% and 5.2% respectively in 2023) (AIHW 2025o).

# Childbirth in Australia is generally safe, but deaths still occur

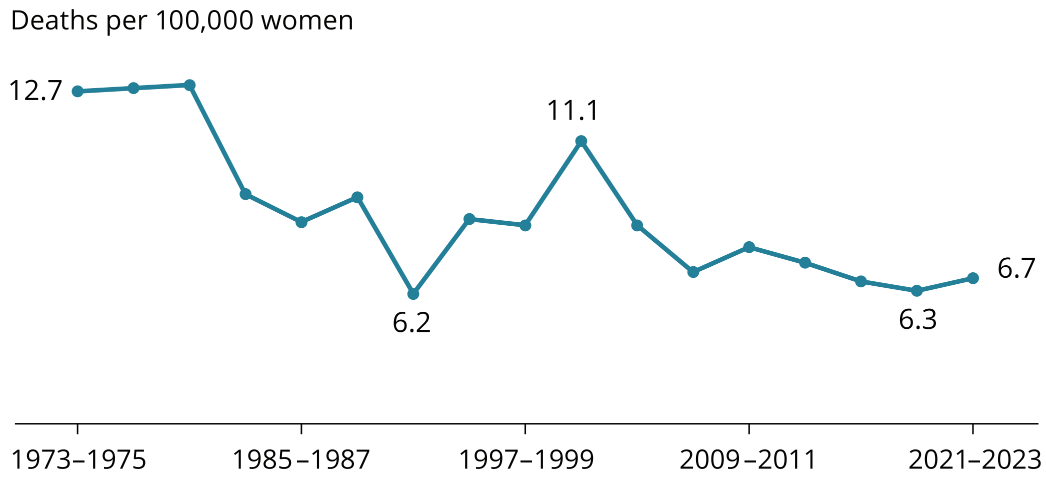
**Content warning:** This content contains information some readers may find distressing as it relates to maternal deaths, stillbirth and the loss of a newborn.

Australia remains one of the safest places in the world for childbirth. Most babies are born at term (91%), with a normal birthweight (92%) and with clinical indications they are adapting well to the environment (Apgar score of 7 or higher, 98%) (AIHW 2026d). However, recent data show rising stillbirth rates and a slight increase in maternal deaths, highlighting areas for ongoing attention and improvement.

The stillbirth rate in 2023 was the highest reported in over 20 years, and a continuation of the increasing stillbirth rates observed in recent years; 8.7 per 1,000 births in 2023, up from 8.0 in 2022, and 7.1 in 2003 (AIHW 2026d). The increasing stillbirth rate may be due to a number of factors (for more information, see Australia's mothers and babies – Stillbirths and neonatal deaths).

Internationally, Australia has one of the lowest maternal mortality ratios; a measure of the number of maternal deaths relative to the number of births, or women who gave birth, over a set period (WHO 2025a; AIHW 2026d).

**Compared with 50 years ago, Australia's maternal mortality ratio has fallen, with a slight increase in the most recent years:**



Source: Australia's mothers and babies – Maternal deaths, AIHW (2026).

Of the women who died during 2014–2023, women aged under 20 had the highest maternal mortality ratio, followed by those aged 40 and over (19.2 and 14.8 per 100,000 women giving birth, respectively) (AIHW 2026d).

## First Nations mothers and babies

Culturally safe, evidence-based models of care can contribute to First Nations babies being born healthy and strong – making progress against outcome 2 under the National Agreement on Closing the Gap (AIHW 2025l, 2026d).

In 2023, most babies of First Nations mothers were born at term (86%) and with a healthy birthweight (87%). Almost all babies of First Nations mothers (96%) had an Apgar score of 7–10, indicating that they have adapted well post-birth (AIHW 2026d).

### Maternity care

First Nations mothers are more likely to engage with maternity care services when First Nations peoples are involved in the design and delivery of services and when care is woman-centred, culturally safe and involves continuity of care (AIHW 2023a).

- In 2025, 38% of maternity services had a model of care designed for First Nations women, compared with 36% in 2024 (AIHW 2025l).
- In 2023 in Victoria, Queensland and Western Australia combined, 29% of First Nations women who gave birth accessed a midwifery group practice model of care, providing midwifery continuity of care. This compares with 11% of all women (AIHW 2026d).

### Recent improvements

Improvements in outcomes among First Nations mothers include:

- an increase in the proportion of First Nations mothers attending an antenatal visit in the first trimester (from 51% in 2013 to 70% in 2023)
- a decrease in the proportion of First Nations mothers who reported smoking at any time during pregnancy (from 49% in 2011 to 38% in 2023) (AIHW 2026d).

See also Focus area 3: *Factors influencing the health of First Nations people*.

For more, see: AIHW topic summary Health of mothers and babies.

# 6

# From silos to systems: strengthening Australia’s health data

High quality health data are essential for policy, service management, research and patient care. In Australia, data and statistics support decisions about funding and service planning, enable monitoring of population health and disparities and underpin assessment of whether the health system is delivering outcomes and value.

Over time, national health data assets have expanded and evolved, improving how data are connected, standardised and used to understand health and welfare systems. This reflects growing recognition that many policy challenges span multiple sectors, necessitating a move away from fragmented data collections toward a more integrated national health data system.

Continued efforts are needed to further strengthen data coverage, integration and accessibility to support decision making across Australia's health and welfare systems.

## Current data development efforts are converging around 4 system-level priorities

Across Australia, current data development activity can be grouped into 4 closely related areas:

1. Sustained effort to address long recognised gaps in national data coverage, particularly in primary health care.
2. Focus on large scale data linkage to better understand patient pathways and outcomes across health-care settings.
3. Emphasis on national consistency through shared definitions, data standards, and interoperability arrangements.
4. Advancing the principles of Aboriginal and Torres Strait Islander data governance including shared decision making and access to data.

While these activities differ in scope and maturity, they are increasingly aligned around a common goal: enabling a whole of system view of activity, performance and outcomes.

# Expanding primary health care data is vital to understanding system performance

General practice and other community based primary care services account for the majority of healthcare encounters in Australia, yet historically have not been included in comprehensive, nationally consistent data sets. This has limited our ability to understand patterns of access, quality, outcomes, and unmet needs outside hospital settings.

Current data development efforts aim to address this gap by establishing nationally consistent approaches to collecting and using primary care data, supported by clear data governance arrangements. One example of these efforts is the development of a National Primary Health Care Data Collection, which focuses on harmonising data recorded in clinical systems – such as patient characteristics, reasons for encounter and diagnoses – so information can be analysed securely and routinely for national and local reporting. Early pilots and demonstration projects have shown that this is feasible, while also highlighting the complexity of the primary health care data environment that can benefit from coordinated national support.

The AIHW has partnered with 17 Primary Health Networks (PHNs) on a data demonstration project to understand dementia diagnosis in general practice using aggregate general practice data. This project demonstrated that general practice data have the potential to provide insights into the health conditions that impact the Australian population, and highlighted the value of collaboration between the AIHW and PHNs (AIHW 2025z).

**Expanding on this first project, the AIHW and PHNs are collaborating on additional data demonstration projects including:**

- **analysing primary care and health outcomes of people diagnosed with mental illness**
- **estimating the prevalence and burden of various health conditions presenting in primary care**
- **addressing health data gaps and enhancing quality improvement measures through the exploration of general practice data.**

For more information about these projects, see Data demonstration projects on the AIHW website.

# Integrating data across sectors is enabling visibility of patient pathways and outcomes

Alongside filling data gaps, integrating (linking) existing data sets to create a national health data system has become a major focus of health data development. Linked data enables analysis of how people move through the health system over time, how different services interact, and how policy and program changes affect outcomes. It enables comparison of different ways of managing illnesses to see which is the more effective in the real-life setting of clinical care. This is especially important at interfaces such as between primary care, hospital care, disability, aged care and other community services, where fragmented data have obscured system performance.

**The National Linked Data System comprises several linkage systems such as the AIHW's National Health Data Hub (NHDH), ABS's Person Level Integrated Data Asset (PLIDA), Population Health Research Network (PHRN) linkage nodes, state and territory linkage nodes and other bespoke linkages and assets. These linked data systems and assets are designed to be interoperable, meaning that sharing of linked data is (or will become) streamlined and will not require the sharing of personal information.**

The AIHW data integration system supports analysis of pathways across hospitals, aged care and disability services – including current AIHW work on aged care service use before and after hospitalisations involving delayed discharge among older people. Disability flags – which will enhance the detection of disability in linked data – are due to be added in late 2026. See Focus area 2: *Supporting people across health, aged care and disability systems* for further information, and Focus area 4: *Connecting evidence and policy at the intersection of health and welfare* for an example of how linked data are providing evidence on people at risk or experiencing homelessness and those with drug and/or alcohol issues.

The NHDH is a major enduring linked data system that brings together multiple health data sets to support insights into people's journeys through the health system. It has expanded significantly in recent years, both in the breadth of data included and the range of applications it supports. Recent developments include the addition of cancer data collections and the progressive inclusion of data from welfare services, such as specialised community mental health services, child protection and specialised homelessness services. These additions strengthen the ability to examine interactions between health and non-health services, particularly for populations with complex needs.

Demand for access to the NHDH has also grown, reflecting its increasing value as a national data asset. This demand reflects both the growing coverage of the asset and increasing recognition of the insights that linked data can provide, particularly where analysis requires following individuals across multiple parts of the system over time.

A range of projects are currently underway using the NHDH. One project is outlined in detail in Focus area 1: *Understanding chronic conditions: patterns, prevention and outcomes*. Further details are available about approved projects and use cases.

Building on these linkage initiatives, the Australian Centre for Disease Control (CDC) is creating a Public Health Data Network by linking nationally notifiable diseases data and other public health data sets with existing administrative health and welfare data sets. Its objective is to maximise the value of data that already exists for public health purposes by connecting across existing assets to support effective national coordination of the prevention, detection and response to public health concerns of national importance.

State-based programs such as the NSW Lumos program have demonstrated the value of integrating general practice and hospital data for local planning and quality improvement. They have also provided practical models that can be scaled nationally in the proposed National Primary and Acute Care Data Linkage Project. As these integration efforts mature, they create the foundation for routine reporting on patient pathways, outcomes, and the system wide impacts of reform.

## National coordination is essential for using linked data at scale

Efforts to fill data gaps and integrate datasets depend on effective national coordination. This requires shared approaches to interoperability, clear documentation, and agreed technical foundations that allow data to be combined, interpreted and analysed appropriately at scale. It does not require complete uniformity in how data are collected across different settings, nor the elimination of local variation in practice. However, greater consistency in data definitions and collection approaches can improve comparability and reduce the complexity of data integration where it is feasible to achieve.

For example, hospital data collected by states and territories reflect local administrative practices and system requirements, resulting in differences in definitions, formats and collection processes. National coordination does not necessarily seek to standardise these data sets entirely. Instead, it emphasises the development of metadata standards, concordances and linkage methods that allow data to be interpreted and analysed together. At the same time, greater alignment in core data elements and definitions – where practical – can strengthen the quality and efficiency of national analyses.

Recent national initiatives, such as CSIRO's Sparked program and the development of the Australian Clinical Data for Interoperability (AUCDI), emphasise agreement on core concepts, data elements and interoperability arrangements across jurisdictions and sectors. These efforts include both defining common data elements and supporting standards for how data are collected, transmitted and shared. Together, they aim to improve the consistency of key data while enabling interoperability through shared technical standards.

In practice, integration relies not only on improving consistency in data collection, but also on making differences among data sets explicit. Clear metadata, transparent documentation, and well described data sources enable users to understand how data are captured in practice and how comparisons should be interpreted. These developments can reduce duplication, improve data quality and usability, and increase the value of existing data – both by supporting comparability across diverse sources and, where appropriate, by encouraging greater standardisation over time.

## Strengthening First Nations data governance is essential to a system-level health data approach

Efforts to move from siloed data sets to an integrated data system must be accompanied by strong and explicit First Nations data governance. Aboriginal and Torres Strait Islander peoples have consistently emphasised that data relating to them are not neutral technical assets, but reflect lived experience, culture and community priorities. Improving how data are connected and used to understand health outcomes and pathways therefore requires governance arrangements that align with the principles of Indigenous Data Sovereignty and support self-determination.

In practice, examining health outcomes and variation in care can require linking health system data with data from other sectors, such as housing, education, social services and justice. In 2024, the National Indigenous Australians Agency released the Framework for

Governance of Indigenous Data, providing practical guidance for Australian Government agencies on working with Indigenous data. The framework places First Nations people at the centre of decision-making and emphasises partnership, capability-building, transparency about data assets, and the development of data systems that includes First Nations people in all parts of the data cycle. These principles apply across the data lifecycle, from collection and linkage through to analysis, reporting and reuse.

For health system performance reporting, stronger First Nations data governance has several system-level implications. It requires that data linkage and integration initiatives be designed with Indigenous governance 'by default', rather than applied retrospectively. It also reinforces the importance of clear documentation, culturally appropriate interpretation, and shared oversight of how data are used to inform policy and public reporting. When embedded effectively, these principles not only improve trust and data quality, but also strengthen the value of integrated data for understanding equity, outcomes and variation in care.

As Australia's data infrastructure becomes more interconnected, aligning data development efforts with First Nations data governance principles is critical to ensure that a whole-of-system view of performance is both analytically robust and socially legitimate. Doing so supports better policy decisions, clearer accountability, and progress toward more equitable health outcomes for First Nations people.

## Sustaining current data development efforts is essential to whole of system stewardship

Through the National Health Reform Agreement, states, territories and the Commonwealth have committed to transforming Australia's health data landscape from a collection of strong but siloed data sets toward a more connected and purposeful national health data system. Current data development efforts demonstrate a clear direction: filling critical gaps, linking data to understand pathways and outcomes, and strengthening national consistency so information can be used for policy and planning.

Data development is an ongoing process that must adapt as the health system changes. Continued investment in data capability, quality, sharing and governance is essential, as is maintaining public trust through strong privacy and ethical safeguards. Above all, data development must remain focused on improving outcomes and equity for people who use the health system.

By building on existing capabilities and strengthening national data infrastructure – informed by current challenges such as measuring the impact of virtual care or the Medicare Urgent Care Clinics – Australia can improve its ability to manage the health system as a connected whole. Better data will support clearer accountability, more targeted policy responses, and a shift from measuring only activity to understanding impact.

For more, see: AIHW topic summary Improving Australia's health data.

# Acknowledgements

This report was prepared by the AIHW's Flagship Reporting Unit (Hannah Christie, Melanie Dunford, Kathryn Gillies, Tim Hourigan, Sarah Kamppi and Matilda Pulford) under guidance from Louise Gates, Andrew Kettle, and the AIHW executive team.

Efforts from the following AIHW staff are gratefully acknowledged:

- Rachel Burnett, Chris Killick-Moran, Nikki Schroder and Louise Tierney (Focus area 4 authors); Robert Callan and Katherine Faulks (Focus area 6 authors)
- Carole Condon, Nicholas Griffin, Isabella Lewis, Helen Tse and Caleb Weeden from the Web, Publishing and Data Visualisation Unit
- Lauren Adcock, Jasmine Dempsey, Elizabeth Ingram, Leana Mancuso, Rebecca Richter, Jen Robertson, Joshua Steel, Mitchell Sullivan and Shreya Thakur from the Communications and Engagement Unit.

Many other AIHW staff contributed time and expertise to Australia's health 2026. Their contributions are gratefully acknowledged.

We sincerely appreciate the valuable input and thorough reviews from:

## *Australia's health 2026* Expert Editorial Board

- Dr Preeya Alexander, ABC Radio National
- Dr Paul Burgess, NT Health and AIHW Board member
- Dr Michelle Cretikos, NSW Ministry of Health
- Mr Misha Ketchell, *The Conversation*
- Professor Rosemary Korda, Australian National University
- Professor Stephen Leeder, University of Sydney
- Associate Professor Jessa Rogers, University of Melbourne

## External contributors and reviewers of this report

- Australian Centre for Disease Control
- Department of Health, Disability and Ageing

# About Australia's health

The Australia's health product suite brings together the latest findings across a broad range of health topics.

This *Australia's health 2026* report is complemented by Australia's health: topic summaries, a collection of 65 web pages that present the latest data and information about health conditions, health determinants, the health of population groups, health service use and the health system more broadly. They outline data improvement activities currently underway, and highlight existing data gaps.

This report draws from the rich content presented in the topic summaries, as well as from other key sources. The types of content found in topic summaries are described below.

- **Health status**: This set of 21 topic summaries cover the leading causes of ill health in Australia such as dementia, diabetes, heart disease and mental health, as well as how we compare internationally for a variety of health measures. A new topic summary for 2026 examines neurological conditions.
- **Determinants of health**: These 14 topic summaries examine many issues and risk factors affecting our health, including (but not limited to) family, domestic and sexual violence, alcohol, vaping, physical activity, and stress and trauma.
- **Health system**: This collection of 17 topic summaries examines how Australia's health system works, who funds it, key services provided and an overview of the workforce that supports it.
- **First Nations people**: The 4 topic summaries in this set explore the health status, determinants of health and use of the health services for First Nations people; along with a population profile.
- **Health of population groups**: This set of 9 topic summaries examines the different health experiences of particular population groups in Australia such as mothers and babies, people in prison, people with disability, veterans, and people in rural and remote areas.

# About the AIHW

The AIHW is an independent statutory Australian Government agency with more than 35 years of experience working with health and welfare data.

**Our vision is to provide stronger evidence (data and information) for better decisions and improved health and welfare for all Australians.**

We create and provide meaningful information and statistics for the benefit of the Australian people, on a range of health and welfare topics.

Our role is to:

- develop, maintain and promote statistical information standards for the health, community services and housing assistance sectors
- collect and manage data on health and welfare issues, including from state, territory and federal Government agencies
- analyse and release a range of health and welfare products (data and reports) to key policy areas, to support better policy and service delivery decisions
- enhance data resources with the addition of new health and welfare data assets to the AIHW's data holdings to fill data gaps in the health and welfare sectors
- modernise the presentation and availability of national health and welfare products to meet the needs of diverse audiences such as state, territory and federal government agencies, universities, research centres, and non-government organisations.

For more, see AIHW About us

# References

ABS (Australian Bureau of Statistics) (2013) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*, ABS website, accessed 1 May 2026.

ABS (2023a) *Estimates of Aboriginal and Torres Strait Islander Australians*, ABS website, accessed 1 May 2026.

ABS (2023b) *Understanding change in counts of Aboriginal and Torres Strait Islander Australians: Census*, ABS website, accessed 1 May 2026.

ABS (2024a) *Disability, ageing and carers, Australia: Summary of findings*, ABS website, accessed 5 June 2026.

ABS (2024b) *National Aboriginal and Torres Strait Islander health survey*, ABS website, accessed 1 May 2026.

ABS (2024c) *Patient experiences 2023–24*, ABS website, accessed 29 April 2026.

ABS (2025a) *Births, Australia*, ABS website, accessed 4 May 2026.

ABS (2025b) *Causes of death, Australia*, ABS website, accessed 4 May 2026.

ABS (2025c) *National health measures survey*, ABS website, accessed 4 May 2026.

ABS (2025d) *Patient experiences 2024–25*, ABS website, accessed 4 May 2026.

ABS (2025e) *Psychosocial disability in Australia, 2022*, ABS website, accessed 20 May 2026.

ABS (2026) *Household consumption of illicit tobacco and nicotine products*, ABS website, accessed 11 June 2026.

AIHW (Australian Institute of Health and Welfare) (2020) *Measures, Aboriginal and Torres Strait Islander health performance framework website*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2023a) *Aboriginal and Torres Strait Islander mothers and babies*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2023b) *Cultural safety in health care for Indigenous Australians: monitoring framework*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2023c) *Exploring pathways for younger people living in residential aged care*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2023d) *Measure 2.05 Education outcomes for young people, Aboriginal and Torres Strait Islander health performance framework website*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2023e) *Measure 2.08 Income, Aboriginal and Torres Strait Islander health performance framework website*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2024a) *Australian burden of disease study 2024*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2024b) *Cancer*, AIHW, Australian Government, accessed 19 May 2026.

AIHW (2024c) *Carer satisfaction with support*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2024d) *Measure 3.09 Self-discharge from hospital, Aboriginal and Torres Strait Islander health performance framework website*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2024e) *The ongoing challenge of chronic conditions in Australia*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025a) *Aboriginal and Torres Strait Islander health performance framework: summary report*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025b) *Cancer data in Australia*, AIHW, Australian Government, accessed 28 May 2026.

AIHW (2025c) *Ear and hearing health of Aboriginal and Torres Strait Islander people 2025*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025d) *Education of First Nations people*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025e) *Employment of First Nations people*, AIHW, Australian Government, accessed 5 June 2026.

AIHW (2025f) *Experiences of alcohol and other drugs among First Nations people*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025g) *Health checks and follow-ups for Aboriginal and Torres Strait Islander people*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025h) *Health system spending on disease and injury in Australia 2023–24*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025i) *Health expenditure Australia 2023–24*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025j) *Housing circumstances of First Nations people*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025k) *Informal carers*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025l) *Maternity models of care in Australia*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025m) *Migraine and headaches in Australia*, AIHW, Australian Government, accessed 9 June 2026.

AIHW (2025n) *Multimorbidity in Australia*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025o) *National core maternity indicators*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025p) *National dementia action plan indicators dashboard*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025q) *National drug strategy household survey 2022–2023*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025r) *Oral health and dental care in Australia*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025s) *People receiving specialist homelessness services support in the last year of life*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025t) *Prevalence and impact of mental illness*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025u) *Profile of First Nations people*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025v) *Rural and remote health*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025w) *Safety and justice for First Nations people*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025x) *Specialised support and informal care for First Nations people with disability*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2025y) *Specialist Homelessness Services: feature analysis*, AIHW, Australian Government, accessed 11 May 2026.

AIHW (2025z) *Towards a national primary health care data collection – dementia demonstration project*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2025aa) *Use of emergency departments for lower urgency care 2017–18 to 2023–24*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026a) *Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2026b) *Admitted patient care – Hospitals*, AIHW, Australian Government, accessed 10 June 2026.

AIHW (2026c) *Alcohol, tobacco & other drugs in Australia*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026d) *Australia's mothers and babies*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2026e) *Chronic conditions*, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026f) *Chronic kidney disease: Australian facts*, AIHW, Australian Government, accessed 27 May 2026.

AIHW (2026g) *Deaths in Australia*, AIHW, Australian Government, accessed 18 June 2026.

AIHW (2026h) *Elective surgery – Hospitals*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026i) *Emergency department care – Hospitals*, AIHW, Australian Government, accessed 10 June 2026.

AIHW (2026j) *Expenditure on mental health-related services*, AIHW, Australian Government, accessed 12 May 2026.

AIHW (2026k) *Eye health measures for Aboriginal and Torres Strait Islander people 2025*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2026l) *First Nations burden of disease study 2022*, AIHW, Australian Government, accessed 17 June 2026.

AIHW (2026m) *Health and wellbeing of First Nations people*, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026n) *Health workforce*, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026o) *Heart, stroke and vascular disease: Australian facts*, AIHW, Australian Government, accessed 27 May 2026.

AIHW (2026p) *Measure 1.09 Diabetes, Aboriginal and Torres Strait Islander health performance framework website*, AIHW, Australian Government, accessed 11 June 2026.

AIHW (2026q) *Measure 1.14 Disability, Aboriginal and Torres Strait Islander health performance framework website*, AIHW, Australian Government, accessed 1 May 2026.

AIHW (2026r) *International comparisons of health data*, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026s) *Medicare bulk billing of GP attendances: monthly data*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026t) *Medicare mental health services*, AIHW, Australian Government, accessed 12 May 2026.

AIHW (2026u) *Medicare-subsidised GP, allied health and specialist health care across local areas*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026v) *Mental health-related prescriptions*, AIHW, Australian Government, accessed 12 May 2026.

AIHW (2026w) *Mental health services*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026x) *National Disability Insurance Scheme participation by younger people living in residential aged care*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026y) *NDIS participants choice and control*, AIHW, Australian Government, accessed 4 May 2026.

AIHW (2026z) *Overweight and obesity*, AIHW, Australian Government, accessed 24 June 2026.

AIHW (2026aa) *Palliative care services in Australia*, AIHW, Australian Government, accessed 2 June 2026.

AIHW (2026ab) *People with a history of specialist alcohol and other drug treatment services who have died*, AIHW, Australian Government, accessed 17 June 2026.

AIHW (2026ac) *Potentially preventable hospitalisations – Hospitals*, AIHW, Australian Government, accessed 25 June 2026.

AIHW (2026ad) *Profile of Australia's population*, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026ae) *Specialist homelessness services: feature analysis: People who received specialist homelessness services and alcohol and other drug treatment services who have died*, AIHW, Australian Government, accessed 17 June 2026.

AIHW (2026af) *Social determinants of health*, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026ag) What are determinants of health?, AIHW, Australian Government, accessed 9 July 2026.

AIHW (2026ah) *Younger people in residential aged care*, AIHW, Australian Government, accessed 19 May 2026.

Centre for Population (2026) *2025 Population statement,* Department of the Treasury, Australian Government, accessed 4 May 2026.

Department of Health (2021) *National Aboriginal and Torres Strait Islander health plan 2021–2031,* Department of Health, Australian Government, accessed 1 May 2026.

Department of Health (2022) *National obesity strategy 2022–2032,* Department of Health, Australian Government, accessed 4 May 2026.

Department of Health and Aged Care (2024a) *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report*, Department of Health and Aged Care, Australian Government, accessed 11 May 2026.

Department of Health and Aged Care (2024b) *The national maternity workforce review (phase 1) – final report,* Department of Health and Aged Care, Australian Government, accessed 1 May 2026.

Department of Health and Aged Care (2024c) *What we're doing about food and nutrition*, Department of Health, Disability and Ageing website, accessed 4 May 2026.

Department of Health, Disability and Ageing (2025a) *About the National Lung Cancer Screening Program*, Department of Health, Disability and Ageing website, Australian Government, accessed 19 May 2026.

Department of Health, Disability and Ageing (2025b) *Historical coverage data tables for Aboriginal and Torres Strait Islander children*, Department of Health, Disability and Ageing website, accessed 29 April 2026.

Department of Health, Disability and Ageing (2025c) *Historical coverage data tables for all children*, Department of Health, Disability and Ageing website, accessed 4 May 2026.

Department of Health, Disability and Ageing (2026a) *About Medicare Urgent Care Clinics*, Department of Health, Disability and Ageing website, accessed 4 May 2026.

Department of Health, Disability and Ageing (2026b) *Current coverage data tables for Aboriginal and Torres Strait Islander children,* Department of Health, Disability and Ageing website, accessed 4 May 2026.

Department of Health, Disability and Ageing (2026c) *Current coverage data tables for all children*, Department of Health, Disability and Ageing website, accessed 4 May 2026.

Department of Health, Disability and Ageing (2026d), *National maternity workforce strategy 2026–2036*, Department of Health, Disability and Ageing, Australian Government, accessed 4 May 2026.

Forner P and Hocking S (2025) 'Pharmacotherapy for the management of overweight and obesity', *Australian Journal of General Practice*, 54(4):196–201, doi:10.31128/AJGP-09-24-7411

Hasselbalch RB, Andrea MK, Nolsøe CV, Hindborg M, Yazdanfard PDW, Sørensen KK, Blomberg SNF, Christensen HC, Graff C, Denholt CS, Afzal S, Nordestgaard BG, Kragholm K, Bundgaard H, Iversen KK, Torp-Pedersen C and Andersen MP (2025) 'Association between socioeconomic factors and semaglutide use for weight loss: a population-based cross-sectional study in Denmark', *The Lancet Regional Health Europe*, 56:101398, doi:10.1016/j.lanepe.2025.101398

IHME (Institute for Health Metrics and Evaluation) (2025) *GBD compare data visualisation*, IHME, University of Washington, accessed 4 May 2026.

ITEC (Illicit Tobacco and E-cigarette Commissioner) (2025) *Illicit Tobacco and E-cigarette Commissioner report 2024–25*, Department of Home Affairs, Australian Government, accessed 4 May 2026.

Kuo NIH, Arnott C, Douglas K, Barbieri S, Ferdousi S, Gandomkar Z, Gallego-Luxan B, Woodward M and Jorm L (2026) 'Initiators of Semaglutide in General Practice in New South Wales, 2020–2023: a retrospective cohort study', *Heart, Lung and Circulation*, 35(4):554–562, doi:10.1016/j.hlc.2025.09.012

Mylek M and Schirmer J (2025) *Caring for others and yourself: the 2025 Carer Wellbeing Survey*, Carers Australia, accessed 4 May 2026.

NDIA (National Disability Insurance Agency) (2026) *Q2 2025–26 quarterly report to disability ministers, summary part A*, NDIA, Australian Government, accessed 4 May 2026.

NRHA (National Rural Health Alliance) (2025) *Second edition national consensus framework for rural maternity services*, NRHA, accessed 1 May 2026.

The Obesity Collective (2023) *What is obesity?*, The Obesity Collective, accessed 5 May 2026.

OECD (Organisation for Economic Co-operation and Development) (2025a) *Health expenditure and financing* [data set], OECD, accessed 4 May 2026.

OECD (2025b) *Patient-reported indicator surveys (PaRIS)* [data set], OECD, accessed 4 May 2026.

Pearson O, Schwartzkopff K, Dawson A, Hagger C, Karagi A, Davy C, Brown A and Braunack-Mayer A (2020) 'Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia', *BMC Public Health*, 20(1), doi:10.1186/s12889-020-09943-4

PM&C (Department of Prime Minister & Cabinet) (2026) *Record funding for public hospitals and disability reform* [media statement], PM&C, Australian Government, accessed 4 May 2026.

RACGP (Royal Australian College of General Practitioners) (2023) *General practice: health of the nation 2023*, RACGP, accessed 4 May 2026.

Royal Commission into Aged Care Quality and Safety (2021) *Final report: care, dignity and respect*, Commonwealth of Australia, accessed 4 May 2026.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) *Final report*, Commonwealth of Australia, accessed 4 May 2026.

Sandall J, Soltani H, Gates S, Shennan A and Devane D (2016) 'Midwife-led continuity models versus other models of care for childbearing women', *Cochrane Database of Systematic Reviews,* 2016(4), doi:10.1002/14651858.CD004667.pub5

Sandall J, Fernandez Turienzo C, Devane D, Soltani H, Gillespie P, Gates S, Jones LV, Shennan AH and Rayment-Jones H (2024) 'Midwife continuity of care models versus other models of care for childbearing women', *Cochrane Database of Systematic Reviews*, 2024(5), doi:10.1002/14651858.CD004667.pub6

West S, Scragg J, Aveyard P, Oke JL, Willis L, Haffner SJP, Knight H, Wang D, Morrow S, Heath L, Jebb SA and Koutoukidis DA (2026) 'Weight regain after cessation of medication for weight management: systematic review and meta-analysis', *BMJ*, 392:e085304, doi:10.1136/bmj-2025-085304

Wheate N, Collins C, Beckett E, Karnon J and Sumithran P (2024) *Should governments subsidise drugs like Ozempic for weight loss? We asked five experts*, University of Sydney, accessed 4 May 2026.

WHO (World Health Organization) (2025a) *Trends in Maternal Mortality 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division*, WHO, Geneva, accessed 4 May 2026.

WHO (2025b) *WHO issues global guideline on the use of GLP-1 medicines in treating obesity*, WHO, accessed 12 May 2026.

WHO (2026) *Social determinants of health*, WHO, accessed 4 May 2026.

*Australia's health 2026* presents a holistic summary of health in Australia with key findings on the health system, the health of Australians and factors that can influence our health.

1 Thynne Street, Bruce ACT 2617
GPO Box 570, Canberra ACT 2601
+61 2 6244 1000 info@aihw.gov.au
www.aihw.gov.au follow us:

AIHW

Stronger evidence,
better decisions,
improved health and welfare