



Australian Government

Australian Institute of  
Health and Welfare

# People with disability in Australia

2026

The logo for the Australian Institute of Health and Welfare (AIHW), consisting of the letters 'AIHW' in a bold, sans-serif font. Each letter is a different color: 'A' is teal, 'I' is green, 'H' is blue, and 'W' is purple.

**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.**

© The Australian Institute of Health and Welfare 2026



All material presented in this document is provided under a Creative Commons Attribution 4.0 International licence, with the exception of the Commonwealth Coat of Arms (the terms of use for the Coat of Arms are available at <https://www.pmc.gov.au/government/commonwealth-coat-arms>) or any material owned by third parties, including for example, design, layout or images obtained under licence from third parties and signatures. All reasonable efforts have been made to identify and label material owned by third parties.

The details of the relevant licence conditions are available on the Creative Commons website (available at <https://creativecommons.org>), as is the full legal code for the CC BY 4.0 license.

A complete list of the Institute's publications is available from the Institute's website [www.aihw.gov.au](http://www.aihw.gov.au).

ISBN 978-1-923553-37-8 (Online)

ISBN 978-1-923553-38-5 (Print)

### **Suggested citation**

Australian Institute of Health and Welfare (2026) *People with disability in Australia 2026*, catalogue number DIS 082, AIHW, Australian Government.

### **Australian Institute of Health and Welfare**

Board Chair

The Hon Nicola Roxon

Chief Executive Officer

Dr Zoran Bolevich

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](mailto: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](http://www.aihw.gov.au) for any amendments.**

# Contents

- Summary.....2**
- About this report .....19**
  - Defining disability ..... 22
  - The disability policy environment ..... 25
- Disability population and characteristics of disability .....30**
  - Key disability populations at a glance ..... 31
  - How many people have disability? ..... 35
  - Need for assistance with activities ..... 55
  - Use of aids ..... 63
  - Disability-free life expectancy ..... 71
- Health .....78**
  - Health status ..... 81
  - Health risk factors and behaviours ..... 94
  - Chronic conditions and disability ..... 117
  - Access to health services..... 124
- Key data gaps .....142**
  - Existing data sources and challenges ..... 143
  - What can be done to improve the evidence? ..... 148
  - References..... 154
- Technical notes .....155**
  - Abbreviations ..... 155
  - Data sources ..... 156
- Acknowledgements .....161**

# Summary

## Introduction

This summary presents key findings on experiences and outcomes for people with disability in various areas of life. The *People with disability in Australia 2026* report includes detailed information on '[Disability population and characteristics of disability](#)' and '[Health of people with disability](#)'. Detailed analyses on other topics will be released in future updates of this report.

Topics 'How many people have disability' and 'Health of people with disability' are also available as downloadable fact sheets. These fact sheets can be accessed from the '[Related material](#)' link in the left navigation menu. Fact sheets for other topics will follow in future releases.

### What is disability?

The World Health Organisation's (WHO) [International Classification of Functioning, Disability and Health](#) (ICF) describes disability as any or all of the following:

- impairment – differences in body function or structure
- activity limitation – difficulties in executing activities
- participation restriction – barriers or restrictions a person may experience when engaging in various life situations.

Disability is understood as a dynamic interaction between a person's health condition(s), environmental factors, and personal factors.

Disability may affect people directly or indirectly, and may have large or small effects on people's daily lives. Increasingly, disability is recognised as something that affects most people, to varying degrees and at different life stages.

More information can be found in '[Defining disability](#)'.

## How many people have disability?

In 2022, there were an estimated **5.5 million** Australians with disability (**21%** of the total population).

Most (97%) people with disability live **in the community** (in households), and 3.3% live in cared accommodation such as group homes or aged care facilities.

**People with disability are diverse.** They have different types of disability and different support needs, and come from all demographic and socioeconomic groups.

For example, of people with disability in 2022:

- 51% were female
- 9.4% were aged under 15, 49% were aged 15–64, and 42% were aged 65 and over
- 3.5% (of those living in households) identified as First Nations people
- 26% were born overseas, including 15% in non-English speaking countries
- 25% reported a mental or behavioural disorder as their main condition (the condition causing them the most problems) and 75% reported a physical disorder as their main condition
- 37% had severe or profound disability – that is, needed assistance with one or more core activities of self-care, mobility, and communication
- 51% (of those aged 5 and over and living in households) had a schooling or employment restriction.

6 in 10 people with disability living in households needed **assistance with one or more activities** of daily living:

- 30% needed assistance with health care
- 25% needed assistance with cognitive or emotional tasks
- 25% needed assistance with mobility
- 46% of those aged 65 and over needed assistance with property maintenance (24% of those aged 15–64).

Just over half (53%) of people with disability (living in households) **use aids or equipment** to assist with daily tasks:

- 24% use aids to assist with communication
- 23% use medical aids to manage health conditions
- 16% use aids to assist with mobility.

**Disability rates increase with age** – the longer people live, the more likely they are to experience some form of disability. In 2022:

- 11% of children aged 0–14 years had disability

- 14% of people aged 15–24 years had disability
- 17% of people aged 25–64 years had disability
- 52% of people aged 65 years and over had disability.

The rate of disability in Australia increased between 2018 and 2022, from 18% to 21%. This could be because people have a better understanding of disability now than they did in the past. It could also be because some health conditions have become more common, or because new 2022 data collection methods were better at identifying disability.

**People in Australia are living longer.** As life expectancy goes up, so do the numbers of years people can expect to live with and without disability. Living with disability does not mean poor health, and the years lived with and without disability are equally valuable. Knowing the number of years people are expected to live with and without disability helps shape policies and services to support good health, independence, and community involvement.

- **Boys born in 2003** could expect to live 78 years on average, of them 59 years without disability and 19 years with disability. **Girls born in 2003** could expect to live 83 years on average, of them 62 years without disability and 21 years with disability.
- **Boys born in 2022** can expect to live 81 years on average, of them 62 years without disability and 20 years with disability. **Girls born in 2022** can expect to live 85 years on average, of them 64 years without disability and 22 years with disability.

### Where can I find out more?

More information about how many people have disability, types of disability, activities people with disability need assistance with, use of aids by people with disability, and disability-free life expectancy can be found in '[Disability population and characteristics of disability](#)'.

### Where did these data come from?

All findings in this section are based on data from the ABS Survey of Disability, Ageing and Carers (SDAC) 2022. They either come from ABS (2024) Summary of Findings, or were derived by the AIHW from the ABS detailed microdata. For more information about specific data sources, refer to '[Disability population and characteristics of disability](#)'.

## Health of people with disability

People with disability are more likely than those without disability to have poor **general and mental health**, and higher levels of **bodily pain**.

In 2022:

- **32%** of adults (aged 18 and over) with disability said their **health was excellent or very good**, compared with 69% of those without disability
- **27%** of adults with disability experienced **high or very high psychological distress** in the last 4 weeks, compared with 6.7% of those without disability
- **17%** of adults with disability experienced **severe or very severe bodily pain** within the last 4 weeks, compared with 2.1% of those without disability.

People with disability have higher **health risk factors** than those without disability. In 2022:

- 14% of adults (aged 18 and over) with disability smoked daily, compared with 8.7% of those without disability.
- 39% of adults with disability had a BMI in the obese range, compared with 28% of those without disability.

Health risk factors are higher for some groups of people with disability than others. For example, in 2022:

- 37% of men (aged 18 and over) with disability exceeded alcohol consumption guidelines, compared with 18% of women with disability. This pattern is similar to the general Australian population.
- 41% of people with disability aged 65 and over had uncontrolled high blood pressure, compared with 22% of those aged 18–64.

Some people with disability experience **barriers to accessing and using health services**. These include long waiting times, high cost of services, the accessibility of buildings, and a need for coordination of care among health professionals. In 2022:

- 46% of people with disability who did not see a dental professional when needed said cost was the main reason
- 43% of people with disability who did not see a GP when needed said waiting time or service availability was the main reason
- nearly half (47%) of people with severe or profound disability saw 3 or more health professionals for the same condition, as did one-third (35%) of people with disability other than severe or profound
- more than 1 in 10 (11%) people with disability aged 5 and over who had challenges with communication or mobility had difficulty accessing medical facilities.

**Attitudes of health workers** are an important factor in service use experience. In 2024, 15% of adults (aged 18+) with disability who had used health services in the past

12 months felt they would have been treated better by health workers if they did not have disability.

### Where can I find out more?

More information about health outcomes, interaction of selected chronic conditions and disability, health behaviours, and access to health services by people with disability can be found in the [‘Health’](#) chapter of this report.

### Where did these data come from?

Findings in this section are based on data from 3 surveys:

- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022
- the ABS National Health Survey (NHS) 2022
- Australia’s Disability Strategy Survey 2024.

For more information about specific data sources, refer to the [‘Health’](#) chapter of this report.

## Social support

In this report, social support refers to government-funded supports provided by specialist disability services. This topic also covers social inclusion and the experiences of people with disability when accessing key mainstream services.

Government-funded specialist disability support services are now largely provided through the **National Disability Insurance Scheme (NDIS)**.

In December 2025, the NDIS had more than **761,000** active participants, of whom **42%** were aged under 15.

Among NDIS participants in December 2025:

- 61% were males and 38% were females
- 43% had autism as their primary disability
- 8.3% identified as First Nations people
- 8.7% identified as culturally and linguistically diverse
- 1.5% were from remote and very remote areas (NDIA 2026).

In 2022, around 6 in 10 (61%) people with disability needed **assistance with activities of daily living** (AIHW analysis of ABS 2024b). Of people who needed assistance:

- 57% received assistance from **formal service providers** (organisations or individuals providing regular paid care; the services they cover may include mainstream services and specialist disability services such as those provided by the

NDIS). Most of this group also received some assistance from informal providers (such as friends and family).

- 33% received assistance from **informal providers only**
- 10% received **no assistance** (AIHW analysis of ABS 2024b).

About a third (35%) of people with disability who needed assistance with activities had an **unmet need for formal assistance**. This meant they either received some formal assistance but needed more (22%), or needed formal assistance but did not receive any (13%) (AIHW analysis of ABS 2024b).

**Satisfaction with assistance from formal providers** varied in 2022. Among people with disability aged 15 and over living in households who received assistance from formal providers:

- 83% were satisfied with the quality of services, and 57% were satisfied with the range of services available (where levels of satisfaction could be determined) (AIHW analysis of ABS 2024b).

People with disability may experience lower rates of **social participation** and greater risk of **isolation and loneliness** than those without disability:

- About 1 in 18 (5.6%) people with disability (aged 15 and over and living in households) had not seen family or friends living outside of the same household in the last 3 months in 2022 (ABS 2024a).
- 1 in 5 (19%) people with disability aged 15–64 experienced social isolation (lack of social contact with others) in 2021, compared with 9.5% of those without disability (AIHW analysis of DSS & MIAESR 2022).
- 3 in 10 (29%) people with disability aged 15–64 reported in 2021 that they often felt lonely, compared with 17% of those without disability (AIHW analysis of DSS & MIAESR 2022).

Positive **experiences when accessing services** are essential in enabling full social and economic participation of people with disability. In 2024, among people with disability aged 18 and over who accessed key mainstream services (health care, education, personal and community support, and justice and legal):

- around 9 in 10 said they were treated with respect when accessing the services (AIHW 2025a)
- people with severe or profound disability, those who are younger, and people with intellectual or psychosocial disability had less positive service experiences (AIHW 2025a).

### Where can I find out more?

Detailed information about specialist disability services, social participation of people with disability, and their experiences receiving formal supports or accessing key services will be published in later updates of this report.

Information about specialist disability supports can also be found in *Australia's welfare 2025* topic summary [People with disability – specialised support services](#).

### Where did these data come from?

Findings in this section are based on data from:

- the National Disability Insurance Scheme (NDIS)
- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022
- the Household, Income and Labour Dynamics in Australia (HILDA) Survey 2021
- Australia's Disability Strategy Survey 2024.

More information about specific data sources can be found in ['References'](#).

## Safety, rights and justice

In 2025, **24%** of people with disability aged 15 and over reported experiencing **some form of discrimination** during the past year, as did **16%** of those without disability (ABS 2026).

Each year, the Australian Human Rights Commission (AHRC) receives more **complaints about disability discrimination** than about any other form of discrimination. In 2024–25, 47% of AHRC complaints were about disability discrimination (AHRC 2025).

In 2022, of people aged 15–64 with disability living in households:

- 15% had experienced **disability discrimination** in the past year
- 45% had **avoided situations** because of their disability in the past year (ABS 2024a).

**Barriers to accessing buildings and facilities** can represent a form of discrimination.

In 2022, among people aged 5–64 with disability living in households and who went to places away from their place of residence:

- 1 in 3 (34%) had difficulty using at least some forms of public transport, or were unable to use public transport at all
- 1 in 4 (23%) of those who had challenges with mobility or communication had difficulty accessing buildings or facilities (AIHW 2024c).

### Experiences of violence

Men are much more likely to experience **physical violence** than women.

The proportions of men who reported in 2021–22 that they have experienced physical

violence in the last 2 years were similar for men with disability (9.8%) and men without disability (9.0%) (ABS 2023a).

Women with disability (aged 18 and over) are more likely to have **recent experiences of violence** than women without disability. In 2021–22:

- 5.8% of women with disability have experienced physical violence in the last 2 years, compared with 4.2% without disability (ABS 2023a)
- 4.0% experienced sexual violence in the last 2 years, compared with 2.5% (ABS 2023b)
- 7.0% experienced emotional abuse by a cohabiting partner in the last 2 years, compared with 4.6% (ABS 2023c)
- 4.6% experienced economic abuse by a cohabiting partner in the last 2 years, compared with 2.4% (ABS 2023c)
- 14% experienced sexual harassment in the last 12 months, compared with 12% (ABS 2023d).

Some groups of women with disability are more likely to have experienced violence. Women with **psychosocial disability** (such as disability arising from emotional, nervous, or mental health condition, memory problems, or social or behavioural difficulties) are more likely to have recent experiences of violence, abuse and harassment than other women with or without disability (ABS 2023a, 2023b, 2023c, 2023d).

### Where can I find out more?

Detailed information about disability discrimination, recent experiences of violence, and general feelings of safety among people with disability will be published in later updates of this report.

### Where did these data come from?

Findings in this section are based on data from:

- the Australian Human Rights Commission (AHRC)
- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022
- the ABS Personal Safety Survey 2021–22.

More information about specific data sources can be found in [‘References’](#).

## Housing

Most people with disability live in the community (in private dwellings). People with disability are more likely to live in social housing, and to live alone, than those without disability.

Housing plays a key role in the health and wellbeing of people with disability, by providing shelter, safety and security. The availability of affordable, sustainable and appropriate housing helps people with disability participate in social, economic and community aspects of life.

**Most people with disability live in the community**, in private dwellings like houses or apartments or self-care retirement villages. In 2022:

- 97% of people with disability lived in the community and 3.3% lived in cared accommodation such as hospitals, nursing homes, or group homes
- among people with severe or profound disability, 85% lived in the community
- almost all people with disability aged under 65 lived in the community, while 2.6% of people with disability aged 65–79 and 17% of those aged 80 and over lived in cared accommodation
- 22% of people with disability living in the community were living alone, compared with 8.0% of people without disability
- 11% of people with disability living in the community were living in a dwelling that was modified to their needs (ABS 2024a).

Most people with disability live in a home that is owned by themselves or their families (for dependent children) (57% in 2022), either with or without a mortgage (AIHW analysis of ABS 2024c). If renting, people with disability are more likely to be **living in social housing** than people without disability; in 2022, this was the case for 20% of renters with disability and 4.2% for those without disability (AIHW analysis of ABS 2024c).

At June 2024, 1 in 5 (21%) individuals and families receiving **Commonwealth Rent Assistance (CRA)** received Disability Support Pension (DSP) as their primary income support payment. About 3 in 10 (30%) individuals and families receiving CRA and DSP were in rental stress (after CRA); this was lower than for all CRA recipients (42%) (AIHW 2025b).

At June 2024, almost 4 in 10 (38%) households living in **social housing** had at least one person with disability (AIHW 2025b).

- A quarter (24%) of social housing households with disability lived in overcrowded conditions (at June 2024), compared with 52% of households with no reported disability (AIHW 2025b).
- In 2023, 71% of social housing households that had at least one person with disability had their needs for safety and security of home met; 63% were satisfied with thermal comfort of their home (AIHW 2024a).

Among **Specialist Homelessness Services (SHS)** clients in 2024–25, 3.1% (or 9,100) had severe or profound disability (AIHW 2025c). SHS clients with disability tend to have **higher housing-related support needs**:

- 63% of clients with severe or profound disability had a need for accommodation provision (compared with 59% of all clients), 33% needed assistance to sustain housing tenure (30% of all clients), and 12% needed mental health assistance (8.4% of all clients).
- clients with severe or profound disability had on average 2.1 support periods in 2024–25 (compared with 1.7 for all clients) (AIHW 2025c).

### Where can I find out more?

Detailed information about housing and living arrangements of people with disability, their housing-related needs, housing assistance and homelessness services accessed by people with disability will be published in later updates of this report.

### Where did these data come from?

Findings in this section are based on data from:

- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022
- income support (Centrelink) data managed by the Department of Social Services (DSS)
- the AIHW's Specialist Homelessness Services Collection
- national housing assistance data collections managed by the AIHW
- the AIHW's National Social Housing Survey 2023.

More information about specific data sources can be found in ['References'](#).

## Education and skills

In 2022, according to the latest survey data, there were an estimated 946,000 children and young people aged 0–24 with disability (12% of the population in this age group) (ABS 2025).

In 2024:

- 17,600 children with disability aged 4–5 were enrolled in a preschool program in the year before formal schooling (7.6% of all enrolments) (PC 2026).
- Around 1.0 million school students received adjustments due to disability (26% of all enrolments) (ACARA 2024).
- 197,000 Vocational Education and Training (VET) students reported that they had disability (3.8% of all VET students) (NCVER 2025).
- 135,000 domestic higher education students reported that they had disability (12% of all students) (Department of Education 2025).

In 2022, **86%** children and young people with disability aged 5–20 were **attending a school or other educational institution** (ABS 2025).

Some children with disability cannot attend school due to their disability. Those who do attend school can attend a mainstream school or a specialist school. Some students in mainstream schools also attend special classes at their school.

In 2022, among children and young people aged 5–20 with disability (and who were either attending school or could not attend due to disability):

- 18% attended special classes in a mainstream school
- 10% went to a specialist school
- 5.5% could not attend school because of disability (ABS 2025).

In 2022, about 6 in 10 (59%) children and young people aged 5–20 with disability (and who attended school or other educational institution) received **study-related supports** (ABS 2025). The remaining 41% did not receive supports. Many students with disability had **unmet need** for educational supports:

- of those who were receiving supports, 40% needed more
- of those who did not receive supports, 26% needed them (ABS 2025).

People with disability generally have lower **educational attainment and post-school engagement** than people without disability. In 2022:

- 55% of people with disability aged 15–64 had completed year 12 or equivalent in school, compared with 73% of those without disability (ABS 2024a)
- 22% of people with disability aged 15–64 had completed a bachelor's degree or higher, compared with 37% of those without disability (ABS 2024a)
- 53% of young people with disability (aged 15–24) were engaged in full-time or part-time studies, compared with 65% of those without disability (ABS 2025).

### **Where can I find out more?**

Detailed information about engagement in education, educational attainment, and education participation needs and challenges experienced by people with disability will be published in later updates of this report.

### **Where did these data come from?**

Findings in this section are based on data from:

- state and territory pre-school education data
- Australian Curriculum, Assessment and Reporting Authority (ACARA)
- National Centre for Vocational Education Research (NCVER)
- higher education statistics collected by the Department of Education
- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022.

More information about specific data sources can be found in [‘References’](#).

## Employment

In 2022, **56%** of people aged 15–64 with disability were employed (**82%** without disability). **39%** of people aged 15–64 with disability were not in the labour force; almost half of this group were permanently unable to work.

Employment is linked not only to income and economic security, but also to other aspects of a person’s wellbeing. Barriers to finding or keeping employment can affect a person’s standard of living and mental health as well as have broader impacts on their family and the community.

People with disability are less likely to **participate in the labour force** than people without disability. In 2022, for people aged 15–64:

- 61% of people with disability were **in the labour force** (working or looking for work), compared with 85% of those without disability. Among people with severe or profound disability, 37% were in the labour force.
- The labour force participation rate was similar for males and females with disability (60% and 61%, respectively).
- Of people with disability who were not in the labour force, 46% were **permanently unable to work** (ABS 2024a).

People with disability are less likely to be employed, and if employed, are more likely to work part time, compared with those without disability. In 2022, for people aged 15–64:

- 56% of people with disability were **employed** (82% without disability).
- 33% of people with disability were working **full time** (58% without disability), and 23% were working **part time** (24% without disability).
  - Among people who were employed, 41% of those with disability were working part time, compared with 30% of those without disability.
- Just under 1 in 20 (4.4%) people with disability and 4.2% of people without disability were **underemployed** (worked part time and wanted to work more hours).
- The **unemployment rate** was twice as high for people with disability (7.5%) as for those without disability (3.1%) (ABS 2024a).

Most employed people with disability aged 15–64 do not require **additional supports** from their employer to work (88% in 2022) and do not need additional time off from work due to their disability (83% in 2022) (ABS 2024a).

From the employers’ perspective, **challenges in employing people with disability** ranged from difficulty in finding qualified people (76% in 2024) to managers’ attitudes (55%). Just over 1 in 4 (27%) employers said their workplaces were more prepared to

hire someone with disability now than they were 12 months ago (11% were less prepared, and 62% were unchanged from last year) (AIHW 2025a).

### Where can I find out more?

Detailed information about labour force participation, employment, underemployment and unemployment of people with disability, their employment participation needs and challenges, and employer perspectives on hiring people with disability will be published in later updates of this report.

### Where did these data come from?

Findings in this section are based on data from 2 surveys:

- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022
- Australia's Disability Strategy Survey 2024.

More information about specific data sources can be found in ['References'](#).

## Income and finance

In 2022, the median gross personal **income gap** between people aged 15–64 with disability and those without disability was **\$480 per week**.

The type and level of income can provide insights into people's standard of living and economic security. Stable income can provide economic security to support a standard of living and cover essential needs, both now and in the future. Economic security can enhance a person's overall wellbeing and enable full participation in social, economic, political and cultural life.

People with disability are less likely to receive income **from wages or salary**, and more likely to receive income **from government payments** than those without disability. In 2022, for people aged 15–64:

- 49% of people with disability received income mainly from wages or salary (76% without disability)
- 28% of people with disability received income mainly from government payments (5.0% without disability) (ABS 2024a).

People with disability are more likely to live in a **low-income household** than people without disability. In 2022:

- 19% of people with disability aged 15–64 lived in a household with low weekly equivalised household income (bottom 20% of the distribution), compared with 9.2% of people without disability

- in the 65 and over age group, 33% of people with disability and 26% without disability had household income in the bottom 20% (ABS 2024a).

The **median income** of people with disability aged 15–64 was \$575 per week, compared with \$1,055 for those without disability – an **income gap of \$480 per week**. For people with severe and profound disability, median income was \$450 per week, meaning an income gap of \$605 per week compared with people without disability (AIHW 2024b).

For employed people aged 15–64 with disability, the median weekly income in 2022 was \$1,100. While this figure is closer to the income of employed people without disability (\$1,247), a gap of \$147 per week still remains (AIHW 2024b).

People with disability are more likely to experience **financial insecurity**. In 2021:

- 25% of people with disability aged 15–64 said they would not be able to raise \$3,000 in a week for **an emergency** (9.4% without disability)
- 8.8% of people with disability aged 15–64 **went without meals** due to a shortage of money (2.3% without disability)
- 16% of people with disability **could not pay utility bills** on time (9.1% without disability) (AIHW analysis of DSS & MIAESR 2022).

**Disability Support Pension (DSP)** is one of Australia’s most prevalent income support payments for people of working age. Around 1 in 4 (27%) income support payment recipients aged 16–64 were in receipt of DSP in March 2026 (DSS 2026).

### Where can I find out more?

Detailed information about income, finances, and income support receipt of people with disability will be published in later updates of this report.

More information about income support recipients of working age can be found in *Australia’s welfare 2025* topic [Income support payments for the working age population](#).

### Where did these data come from?

Findings in this section are based on data from:

- the ABS Survey of Disability, Ageing and Carers (SDAC) 2022
- the Household, Income and Labour Dynamics in Australia (HILDA) Survey 2021
- income support (Centrelink) data managed by the Department of Social Services (DSS).

More information about specific data sources can be found in ‘[References](#)’.

## Key data gaps

*People with disability in Australia* report uses information from many data sources, including surveys and administrative (government) data. While these help us better understand experiences of people with disability, there are still some things we do not know.

For example, there is a lack of information on:

- what services (both mainstream and specialist) people with disability use
- unmet need for services (within and outside the NDIS)
- the use of restrictive practices (such as seclusion and physical or chemical restraints)
- people with disability in closed and segregated settings (such as specialist schools or group homes)
- supported decision-making for people with disability, such as whether people with disability feel supported to make their own choices and remain in control of their lives
- transition pathways of people with disability at key life points, such as from school to further education or employment
- how much contact people with disability have with the justice and child protection systems, as victims and as offenders
- the quality and sustainability of the disability workforce
- causes of death of people with disability – such as potentially avoidable deaths.

These gaps are mainly due to issues with existing data. These include different definitions of disability, barriers to data sharing, or services not collecting information about disability.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability noted these data gaps and gave recommendations on what needs to be fixed. The Commission's recommendations touched on upholding the rights of people with disability, supporting them make their own choices, making it easier to use services, and making sure everyone can take part in education, have a job, and live in suitable housing.

Opportunities to enhance the evidence base about people with disability include:

- improving the quality and comparability of data across sources by adopting more consistent definitions, or adding a disability 'flag' to mainstream data collections
- maximising the use of existing data sources by bringing together information from multiple sources, such as in this report
- adding to data sources, including by developing new data collections and through data linkage.

An example of a recent data linkage initiative is the **National Disability Data Asset**. The asset was developed by the Australian and state and territory governments in partnership with people with disability and the wider disability community. It brings together de-identified data from different government agencies. The purpose of the asset is to better understand and meet the needs of people with disability. The first step towards achieving that purpose was the development of disability flags ([Measuring disability factsheet | NDDA](#)).

Another example of a new data source is the Australia's Disability Strategy Survey (ADS Survey). The ADS Survey was set up by the Australian Government as part of *Australia's Disability Strategy 2021–2031*. The first round of data was collected in 2022. The aim of the survey is to collect data about disability awareness and attitudes in key service sectors (such as education and health care) and in the broad community. The survey also asks people with disability about their experiences when interacting with the services and being in the community. Reports on the survey can be found at [Australia's Disability Strategy Hub – Data and Research](#).

The data gaps and opportunities discussed here are just a starting point. The AIHW continues to work with other statistical agencies and data custodians to make the data about people with disability more complete and easier to collect, share, and use.

### Where can I find out more?

More information about Australian disability policy environment, the key challenges with existing disability data sources, and what is being done to improve the disability evidence base can be found in 'The disability policy environment' and 'Key data gaps' chapters of this report.

## References

- ABS (Australian Bureau of Statistics) (2023a) *Physical violence, 2021–2022*, ABS, accessed 23 April 2026.
- ABS (2023b) *Sexual violence, 2021–2022*, ABS, accessed 23 April 2026.
- ABS (2023c) *Partner violence, 2021–2022*, ABS, accessed 23 April 2026.
- ABS (2023d) *Sexual harassment, 2021–2022*, ABS, accessed 23 April 2026.
- ABS (2024a) *Disability, Ageing and Carers, Australia: Summary of Findings, 2022*, ABS, accessed 19 March 2026.
- ABS (2024b) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022*, AIHW analysis of detailed microdata in DataLab, accessed 22 January 2025.
- ABS (2024c) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022*, AIHW analysis of detailed microdata in TableBuilder, accessed 20 March 2026.
- ABS (2025) *Children and young people with disability, 2022*, ABS, accessed 19 March 2026.

ABS (2026) *General Social Survey: Summary Results, Australia, 2025*, ABS, accessed 6 May 2026.

ACARA (Australian Curriculum, Assessment and Reporting Authoring) (2024) *National Report on Schooling in Australia: School students with disability*, ACARA, accessed 18 March 2026.

AHRC (Australian Human Rights Commission) (2025) *Annual Report 2024–25: Complaint Statistics*, AHRC, accessed 18 March 2026.

AIHW (Australian Institute of Health and Welfare) (2024a) *National social housing survey 2023*, AIHW, accessed 19 March 2026.

AIHW (2024b) *Reporting on Australia's Disability Strategy 2021–2031: Employment and financial security – Median gross income gap* [website], accessed 20 March 2026.

AIHW (2024c) *Reporting on Australia's Disability Strategy 2021–2031: Data tables: Inclusive homes and communities*, accessed 1 May 2026.

AIHW (2025a) *Australia's Disability Strategy Survey: Wave 2 Report*, Australian Department of Health, Disability and Ageing, accessed 19 March 2026.

AIHW (2025b) *Housing assistance in Australia*, AIHW, accessed 19 March 2026.

AIHW (2025c) *Specialist homelessness services annual report 2024–25*, AIHW, accessed 19 March 2026.

Department of Education (2025) *Key findings from the 2024 Higher Education Student Statistics*, Department of Education, accessed 18 March 2026.

DSS (Department of Social Services) (2026) *Customised data request based on Services Australia administrative data (Department of Social Services Blue Book dataset)*, accessed 25 May 2026.

DSS and MIAESR (Melbourne Institute of Applied Economic and Social Research) (2022) *The Household, Income and Labour Dynamics in Australia (HILDA) Survey, General Release 21*, wave 21, doi:10.26193/KXNEBO, ADA Dataverse, V3, AIHW analysis of unit record data, accessed 26 April 2026.

NCVER (National Centre for Vocational Education Research) (2025) *Total VET students and courses 2024: students DataBuilder*, NCVER, accessed 18 March 2026.

NDIA (National Disability Insurance Agency) (2026) *Quarterly report to disability ministers Q2 2025–26*, NDIA, accessed 19 March 2026.

PC (Productivity Commission) (2026) *Report on Government Services: Part B Child care, education and training*, PC, accessed 18 March 2026.

# About this report

Disability affects many people, directly or indirectly. It may have large or small effects on people's daily lives. Increasingly, disability is recognised as something that affects most people, to varying degrees and at different life stages.

Capturing the diverse experiences of people with disability in a reporting context is challenging. People with disability are not a homogeneous group. They have different types of disability and different support needs; come from all demographic and socioeconomic groups; and interact with every aspect of life in Australia. In addition, data collections, services and programs may have differing views of what disability is and how to best capture it in data.

This report is the latest in the series first released in September 2019. It presents key statistics about experiences and outcomes of people with disability in health, housing, education, employment, justice and safety, and social inclusion and support. In drawing this information together, the report also highlights key data gaps (["Key data gaps"](#)).

This report is part of a wider system of data and reporting about people with disability in Australia. As such, rather than duplicate other efforts, it refers readers to other resources throughout. These include:

- [Reporting on Australia's Disability Strategy 2021–2031](#) – reporting and tracking the progress of measures in Australia's Disability Strategy Outcomes Framework
- Productivity Commission's annual [Report on Government Services](#) – information on equity, effectiveness and efficiency of government services in Australia relating to people with disability
- National Disability Insurance Agency's (NDIA) [quarterly reporting](#) on the National Disability Insurance Scheme (NDIS) – information on the NDIS in each jurisdiction.

The online report format makes it possible to readily update existing information and to add new content as data become available.

## 2026 update

From 2026, this report will be updated in stages, as more findings become available.

The first 2 main chapters to be updated are:

1. Disability population and characteristics of disability. This chapter includes information on:
  - How many people have disability
  - Need for assistance with activities
  - Use of aids by people with disability
  - Disability-free life expectancy.

2. Health of people with disability. This chapter includes information on:

- Health status of people with disability
- Health risk factors and behaviours
- Chronic conditions and disability
- Access to health services.

Other chapters will be added to the report pages over time.

## **What this report does not do**

This report does not include information about several areas of significant interest to people with disability or the wider disability community. These areas include: carers; the disability workforce; pathways and transitions (for example, from school to work); and interactions between different life areas in determining outcomes for people with disability.

Some of these areas may be covered in subsequent releases of this report. However, little or no data are currently available for some topics. These will require data development or data linkage before findings can be reported (for more information, refer to '[Key data gaps](#)').

The analyses presented in this report highlight differences in outcomes and experiences of different groups of people, or varying time trends. In many cases, there can be multiple possible reasons for these differences, including changes in government policies or variations in delivery of programs and services. However, this report does not make any such attributions, nor does it make any inferences about causation.

## **Person-centred reporting**

This report uses a person-centred reporting framework, which places the person at the core of understanding life pathways and experiences. This acknowledges that people's experiences can vary, even for people who have similar conditions and support needs.

The report uses 7 broad life domains across which people pursue life outcomes (Figure ABOUT.1). The domains also represent common social policies and programs, both disability-specific and mainstream. The domains interact with each other, and with the environmental and personal factors, to shape the individual experience of disability (refer to '[Defining disability](#)').

**Figure ABOUT.1: Person-centred reporting and life domains**



## Defining disability

In Australia, many data collections identify disability based on concepts from the World Health Organization's (WHO) [International Classification of Functioning, Disability and Health](#) (ICF).

The ICF defines a person's functioning – body functions and structure, activities, and participation – as a dynamic interaction between health conditions and environmental or personal factors (Figure ABOUT.2; WHO 2002).

Disability is an umbrella term for any or all of the following:

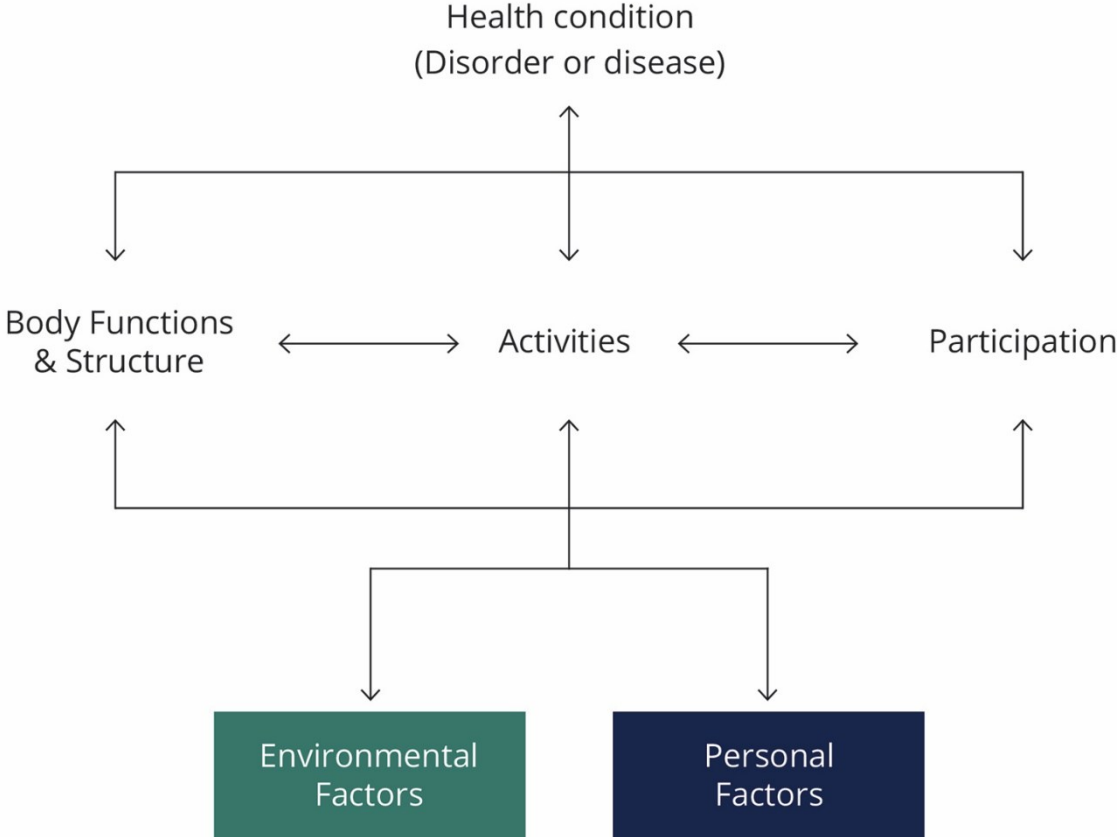
- impairments – differences in body function or structure
- activity limitations – difficulties in executing activities
- participation restrictions – barriers or restrictions a person may experience when engaging in various life situations.

Disability is an outcome of interaction between a person's health condition(s) and personal and environmental factors.

People with disability experience different degrees of impairment, activity limitations and participation restrictions. Disability can be related to genetic disorders, illnesses, accidents, ageing, injuries, or a combination of these factors. Importantly, how people experience disability is affected by both personal and environmental factors.

Environmental factors include things like community attitudes, accessibility of buildings and facilities, and available opportunities, services and supports. Personal factors include things like age and gender, life events and experiences, education and socio-economic status.

**Figure ABOUT.2: International Classification of Functioning, Disability and Health**



Source: Modified from WHO 2002.

The definition and identification of disability used in each data collection can vary, depending on the collection’s type and purpose. For example:

- The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) uses a comprehensive set of questions to identify disability and is considered the gold standard of disability identification in Australia.
- Other ABS surveys, such as the National Health Survey, use a shorter set of questions to identify disability (the Short Disability Module).
- The NDIS bases eligibility on a narrower concept of disability which involves significant impairment to a person’s functional capacity.
- Some data collections, such as on hospital admissions, do not identify disability at all.

The data collections that capture disability information may also identify different characteristics of disability. These could include type of disability (such as sensory, physical, or psychosocial) or needs for support (how much of a restriction, difficulty, or need for aids or assistance a person may have). The degree of support is needed due to disability is also sometimes called severity of disability.

This report uses the definitions of disability and disability characteristics as specified in each data source. The '[Data sources](#)' section of this report provides these definitions for each data source used in the report, along with information on the in-scope population. This information is also summarised in **Data table: Definitions of disability** (available from [Data tables](#)).

Differences in definitions across data sources can make it difficult to compare data from different data collections (for more information, refer to '[Key data gaps](#)').

## References

WHO (World Health Organization) (2002) *ICF Beginner's Guide: Towards a common language for functioning, disability, and health: ICF. The International Classification of Functioning, Disability and Health*, WHO, accessed 9 May 2026.

# The disability policy environment

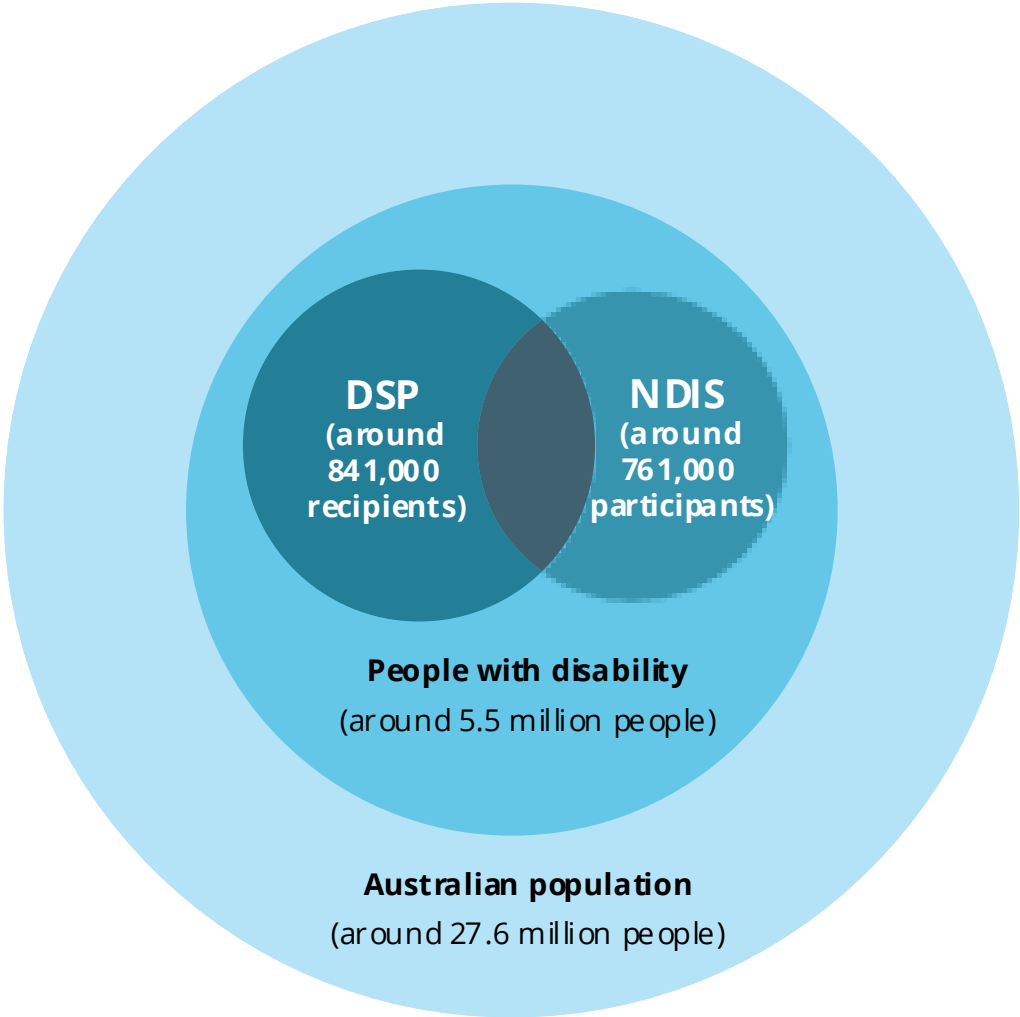
The disability policy environment has significantly changed in recent years, especially in relation to service delivery. This includes:

- the launch of [Australia's Disability Strategy 2021–2031](#) (the Strategy) to replace the [National Disability Strategy 2010–2020](#), and reporting against the Strategy's outcomes framework via a [dedicated website](#) and a series of [annual reports](#)
- the implementation of the [National Disability Insurance Scheme \(NDIS\)](#)
- the establishment of the [NDIS Quality and Safeguards Commission](#)
- the continuing development of the [National Disability Data Asset](#)
- the implementation of a [Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability](#) and subsequent commitments by governments based on the Commission's recommendations.
- a focus on changing community attitudes and improving awareness of disability.

Common themes running through these changes include:

- making mainstream services (like health and education) accessible for people with disability
- quality and safety of specialist disability support and mainstream services
- the readiness of the market and workforce to deliver needed supports
- acknowledgment that specialist disability support services, such as those delivered through the NDIS, are only one part of a broader and interacting system of supports
- recognition that, to improve the wellbeing of people with disability and their carers, sectors and organisations need to work together to meet the needs of all people with disability, including NDIS participants and those who do not use the NDIS (Figure ABOUT.3)
- the need to improve how we track and report on wellbeing of people with disability, and reducing key data gaps in this area.

**Figure ABOUT.3: Key disability cohorts in the Australian population**



**Notes:**

DSP = Disability Support Pension. NDIS = National Disability Insurance Scheme.

- 1. People with disability estimates are as at 2022; population estimates are as at 30 June 2025; DSP recipient and NDIS participant numbers are as at December 2025.
- 2. Figure is not to scale.

**Sources:** ABS 2024, ABS 2025, DSS 2026, NDIA 2026.

## **United Nations Convention on the Rights of Persons with Disabilities**

Australia ratified the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) in 2008. The Convention’s purpose is to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’ (UN 2008).

Australia’s Disability Strategy plays an important role in protecting, promoting and realising the human rights of people with disability in line with Australia’s commitments

under the UN CRPD. The principles of the UN CRPD are also reflected in the [Australian Human Rights Commission Act 1986](#) and in the mechanisms for the delivery of services to people with disability (such as the NDIS).

## **Australia's Disability Strategy 2021–2031**

The Strategy is Australia's national disability policy framework. It sets out a plan for continuing to improve the lives of people with disability in Australia over the 10 years to 2031. The Strategy was launched on 3 December 2021 and builds on its predecessor, the National Disability Strategy 2010–2020.

The Strategy helps to protect, promote and realise the human rights of people with disability in line with Australia's commitments under the UN CRPD.

The Strategy covers all people with disability, irrespective of whether they need or use specialist disability services. The Strategy aims to:

- provide national leadership towards greater inclusion of people with disability
- guide activity across all areas of public policy to be inclusive and responsive to people with disability
- drive mainstream services and systems to improve outcomes for people with disability
- engage, inform and involve the whole community in achieving a more inclusive society.

The Strategy and its supporting documents are available on the [Disability Gateway website](#).

The AIHW regularly reports on the progress of the Strategy via a dedicated website [Reporting on Australia's Disability Strategy 2021–2031](#).

## **National Disability Insurance Scheme**

The NDIS was progressively rolled out across Australia from July 2016, after a trial in 2013. From 1 July 2020, the NDIS has been made available to all eligible Australians, no matter where they live (Minister for the National Disability Insurance Scheme 2020).

The NDIS was a fundamental shift in the way Australians with significant and permanent disability access supports. It is based on insurance principles and aims to provide Australians who have permanent and significant disability with reasonable and necessary supports to live more independently and participate more fully in society (NDIA 2020). People with disability are directly funded under the NDIS. This is distinct from the previous system of funding to agencies and community organisations that provided disability support services under the National Disability Agreement (NDIA 2020).

The number of NDIS participants has continued to grow even after the Scheme's full roll out. This has raised questions about the Scheme's long-term sustainability. At present, the NDIS is undergoing reforms to stabilise its growth and expenses. The reforms

include changes to laws and the operations of the National Disability Insurance Agency (NDIA). The reforms also aim to introduce additional support services within and outside of the NDIS (NDIA 2025).

## **NDIS Quality and Safeguards Commission**

The NDIS Quality and Safeguards Commission (NDIS Commission) is an independent agency which aims to improve the quality and safety of NDIS supports and services. It started in July 2018 in New South Wales and South Australia, and gradually expanded across all states and territories, achieving national coverage on 1 December 2020.

The NDIS Commission uses a nationally-consistent approach to regulate the NDIS. It handles provider registration, complaints, reportable incidents, oversight of behaviour support, and compliance and enforcement. States and territories retain responsibility for NDIS worker screening, the authorisation of restrictive practices, and community visitor schemes.

## **National Disability Data Asset**

The Australian and state and territory governments are working together with people with disability and the wider disability community on the [National Disability Data Asset](#) (NDDA). The NDDA brings together de-identified information from different government agencies about all Australians. These data will help us better understand experiences of people with disability and will give us more information about programs and services used by people with disability.

The National Disability Data Asset will be used to:

- provide a more complete picture of programs and services used by people with disability
- help governments improve these programs and services
- share information about how opportunities and outcomes could be improved
- improve reporting on outcomes for people with disability under [Australia's Disability Strategy 2021–2031](#).

## **Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability**

The [Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability](#) (Royal Commission) was established in April 2019. It was one of the most extensive inquiries into the experiences of people with disability in Australia. It involved 32 public hearings, 1,785 private sessions, and heard from nearly 10,000 people.

The Royal Commission's [Final Report](#) was delivered to the Australian Government on 29 September 2023 (DRC 2023). In the Report, the Royal Commission made 222 recommendations. Of these recommendations:

- 50 relate to areas of sole state and territory responsibility
- 85 relate to areas of joint Commonwealth and state/territory responsibility
- 87 relate to areas of sole Commonwealth responsibility.

Recommendations cover key themes of safety, protection, rights, inclusion, and accessibility for all people with disability. They set out a vision for Australia where people with disability are safe from violence, abuse, neglect, exploitation, and discrimination.

Governments responded to the Royal Commission's recommendations on 31 July 2024 (Australian Government 2024). The response noted that the recommendations need to be implemented in stages given the broad range of required reforms.

All governments agreed to report every year on the progress of Royal Commission's recommendations. [The 2025 Progress Report](#) provides the latest whole-of-government update (Australian Government 2025). The next progress report is expected to be published in late 2026.

## References

ABS (Australian Bureau of Statistics) (2024) [Disability, Ageing and Carers, Australia: Summary of Findings](#), 2022, ABS, accessed 18 December 2025,

ABS (2025) [National, state and territory population, June 2025](#), ABS, accessed 18 December 2025.

Australian Government (2024) [Australian Government Response to the Disability Royal Commission](#), Commonwealth of Australia, accessed 12 May 2026.

Australian Government (2025) [Disability Royal Commission Progress Report 2025](#), Commonwealth of Australia, accessed 12 May 2026.

DRC (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability) (2023) [Final report](#), Disability Royal Commission, Canberra, accessed 7 December 2023.

DSS (Department of Social Services) (2026) [Expanded DSS Benefit and Payment Recipient Demographics – December 2025](#), DSS, accessed 8 May 2026.

Minister for the National Disability Insurance Scheme (1 July 2020) [Delivering the NDIS: roll-out complete across Australia as Christmas and Cocos Islands join world-leading scheme](#) [media release], NDIA, accessed 9 May 2022.

NDIA (National Disability Insurance Agency) (2020) [NDIA 2019–20 annual report](#), NDIA, accessed 9 May 2022.

NDIA (2025) [Annual financial sustainability report 2024–25](#), NDIA, accessed 6 February 2026.

NDIA (2026) [Quarterly Report to disability ministers Q2 2025–26](#), NDIA, accessed 8 May 2026.

UN (United Nations) (2008) [From concept to reality: promoting universal human rights of persons with disabilities](#), UN, accessed 24 August 2020.

# Disability population and characteristics of disability

The disability population in Australia is large and diverse. It includes people with different types of disability and needs for support, across all socioeconomic and demographic groups.

Knowing how many people in Australia have disability, and their characteristics, helps us understand their varied experiences. It also helps to plan and provide the supports, services and communities that enable people with disability to participate fully in all aspects of life.

## Key findings

1. **How many people have disability:** In 2022, an estimated 1 in 5 (21%) people in Australia had disability (about 5.5 million people).
2. **Severe or profound disability:** In 2022, more than a third (37%) of people with disability had severe or profound disability (about 2.0 million).
3. **Assistance needs:** In 2022, about 3 in 10 people with disability living in households needed assistance with property maintenance or health care (30% each).
4. **Aids use:** More than half of people with disability use aids or equipment to assist with various activities of daily living (54%, or 3.0 million in 2022).
5. **Disability and life expectancy – boys:** Boys born in 2022 can expect to live 81 years on average, including 20 years (24%) with disability.
6. **Disability and life expectancy – girls:** Girls born in 2022 can expect to live 85 years on average, including 22 years (25%) with disability.

## Key disability populations at a glance

Figure POPULATION.1 provides a quick comparison between the total population of Australia and three key disability cohorts, which include:

- all people with disability
- National Disability Insurance Scheme (NDIS) participants
- recipients of the Disability Support Pension (DSP).

In 2022, there were **5.5 million** people with disability in Australia (ABS 2024a). Most of them were not in the NDIS and were not receiving DSP. It is estimated that, in 2022, about **1.4 million** people received government disability-related payments and supports (NDDA 2025).

Data about these 3 cohorts of people with disability comes from different sources. These data sources differ in their coverage and timeliness of data. The latest estimates for the number of people with disability in Australia are from survey data collected in 2022, while information about DSP recipients and NDIS participants comes from government records, with the latest data from 2025. To compare these groups, the latest data are used, even though they are drawn from different years.

There are some differences in the age structure of these 4 groups (Figure POPULATION.1):

- People with disability are older, on average, than those without disability; 42% of people with disability are aged 65 or over (AIHW analysis of ABS 2024b), compared with 18% in the total Australian population (ABS 2025b).
- DSP recipients have the largest share of older working age adults (aged 45–64). As at December 2025, nearly half (49%) of DSP recipients were in that age group (DSS 2026a). This is in line with DSP's purpose of providing financial support to people of working age who cannot work due to disability.
- NDIS participants have the youngest age profile of all populations, with 42% aged under 15 (NDIA 2026).

There are slightly more females than males among people with disability (Figure POPULATION.1). However, more than half of DSP recipients and NDIS participants are male.

- 48% of people with disability were born male and 51% female (AIHW analysis of ABS 2024c).
- In comparison, 53% of DSP recipients (DSS 2026) and 61% of NDIS participants are male (NDIA 2026).

There are higher proportions of First Nations (Aboriginal and/or Torres Strait Islander) people in the DSP and NDIS cohorts than in the broader disability population, or in the total population of Australia:

- In 2022, there were 183,700 First Nations people with disability living in households (ABS 2025a). This represented 3.5% of the estimated 5.3 million people with

disability living in households (ABS 2024a). It should be noted that these numbers do not include very remote areas or discrete Aboriginal and Torres Strait Islander Communities.

- 3.8% of the total Australian population identify as First Nations people (ABS 2023).
- 8.3% of NDIS participants and 8.8% of DSP recipients identify as First Nations people (NDIA 2026, DSS 2026a).

People with disability are less likely to be born outside Australia or in a non-English speaking country than people in the general population:

- 32% of people in Australia were born overseas, including 24% in non-English speaking countries (ABS 2025b)
- 26% of people with disability were born overseas, including 15% in non-English speaking countries (AIHW analysis of ABS 2024c)
- 14% of DSP recipients were born in non-English speaking countries (DSS 2026b)
- 8.7% of NDIS participants are from CALD backgrounds (born in non-English speaking countries and/or mainly use a language other than English at home) (NDIA 2026).

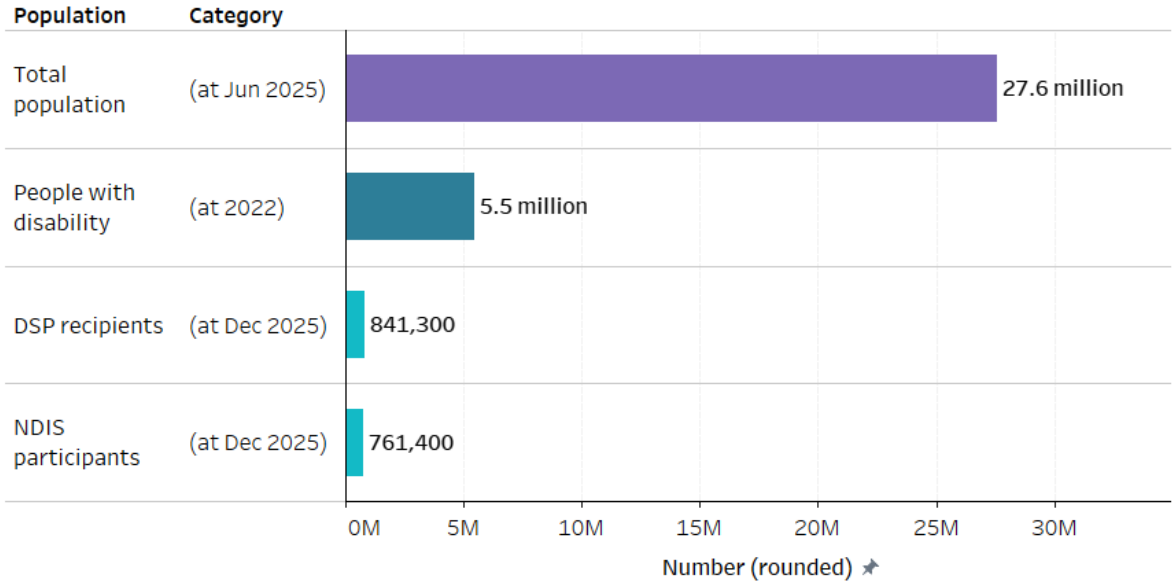
People with disability are more likely to live in regional or remote areas than people without disability:

- 35% of people with disability live outside of *Major cities* (AIHW analysis of ABS 2025b), compared with 27% in the total population (AIHW 2025)
- 31% of NDIS participants (NDIS 2026) and 37% of DSP recipients (DSS 2026b) live outside of *Major cities*.

# Figure POPULATION.1: Key disability cohorts and total population of Australia

Select view:

- Total number
- Age group
- Sex
- Indigenous status
- Remoteness
- Country of birth



\*CALD=culturally and linguistically diverse.  
 Sources: ABS 2023, 2024a, 2025a, 2025b, AIHW analysis of ABS 2024b, AIHW 2025, DSS 2026a and 2026b, NDIA 2026.  
<https://www.aihw.gov.au>

**Note:** DSP recipients are people aged 16 and over.

**Sources:** ABS 2023, 2024a, 2025a, 2025b, AIHW analysis of ABS 2024b, AIHW 2025, DSS 2026a and 2026b, NDIA 2026.

## References

ABS (2023) *Estimates of Aboriginal and Torres Strait Islander Australians, 30 June 2021*, ABS, accessed 1 April 2026.

ABS (2024a) *Disability, ageing and carers, Australia: summary of findings, 2022*, ABS, accessed 6 November 2025.

ABS (2024b) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia*, ABS, AIHW analysis of detailed microdata, accessed 11 February 2025.

ABS (2024c) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia*, ABS, AIHW analysis of microdata in TableBuilder, accessed 30 March 2026.

ABS (2025a) *Aboriginal and Torres Strait Islander peoples with disability, 2022*, ABS, accessed 1 April 2026.

ABS (2025b) *National, state and territory population, June 2025*, ABS, accessed 1 April 2026.

AIHW (Australian Institute of Health and Welfare) (2025) *Rural and remote health*, AIHW, accessed 8 April 2026.

DSS (Department of Social Services) (2026a) *DSS Benefit and Payment Recipient Demographics – quarterly data – December 2025*, accessed 30 March 2026.

DSS (2026b) *DSS Benefit and Payment Recipient Demographics – December 2025*, customised data request, accessed 22 May 2026.

NDDA (National Disability Data Asset) (2025) *Measuring disability in the National Disability Data Asset*, NDDA website, accessed 12 February 2026.

NDIA (National Disability Insurance Agency) (2026) *Quarterly report to disability ministers Q2 2025-26 Full report*, accessed 31 March 2026.

# How many people have disability?

## Key findings

- **Australians with disability:** In 2022, an estimated 1 in 5 (21%) people in Australia had disability (about 5.5 million people).
- **Severe or profound disability:** In 2022, more than a third (37%) of people with disability had severe or profound disability (about 2.0 million).
- **Main health condition:** In 2022, for 1 in 4 (25%) people with disability, their main health condition was mental or behavioural.

Around 1 in 5 (21%) people in Australia – or about 5.5 million – have disability. This is known as disability rate (or disability prevalence). Another 23% (or 6.0 million) of people in Australia have a long-term health condition but no disability, and the remaining 55% (or 14.1 million) have no disability or long-term health condition (ABS 2024b).

More than one-third (37%) of people with disability – about 2.0 million people or 7.9% of the Australian population – have severe or profound disability. This means they sometimes or always need assistance with self-care, mobility or communication activities, have difficulty understanding or being understood by family or friends, or communicate more easily using sign language or other non-spoken forms of communication (ABS 2024a).

## What is disability rate?

Disability rate, or disability prevalence, is proportion of the population who have disability at a given time. It is calculated as the number of people with disability divided by the number of people in the total population.

Disability rates can be age-specific (for a particular age group) or age-standardised (controlling for age, so that populations with different age profiles can be compared).

## What affects disability rates?

Changes to life expectancy, survival rates for specific health conditions, the age at which a health condition first occurs, and remission and rehabilitation rates can all affect disability prevalence rate.

The rate estimated by the national Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers can vary, even when the actual prevalence might not, because of changes in social attitudes, government policy and survey methods.

## Why is it important?

Knowing how many people have disability, and their characteristics, helps plan services and build inclusive communities to enable people's full participation in society.

## Data note

Data on this page are sourced from the ABS **2022 Survey of Disability, Ageing and Carers (SDAC)**. More information about the SDAC, including the concepts of disability, disability groups, and remoteness categories used by the SDAC can be found in '[Data sources](#)'.

## Disability rates by sex and age

The proportion of people with disability in the population generally increases with age (Figure POPULATION.2). This means the longer people live, the more likely they are to experience some form of disability:

- 11% of children aged 0–14 have disability
- 14% of people aged 15–24 have disability
- 30% of people aged 55–64 have disability
- 79% of people aged 85 and over have disability (AIHW analysis of ABS 2024c).

## Sex and gender

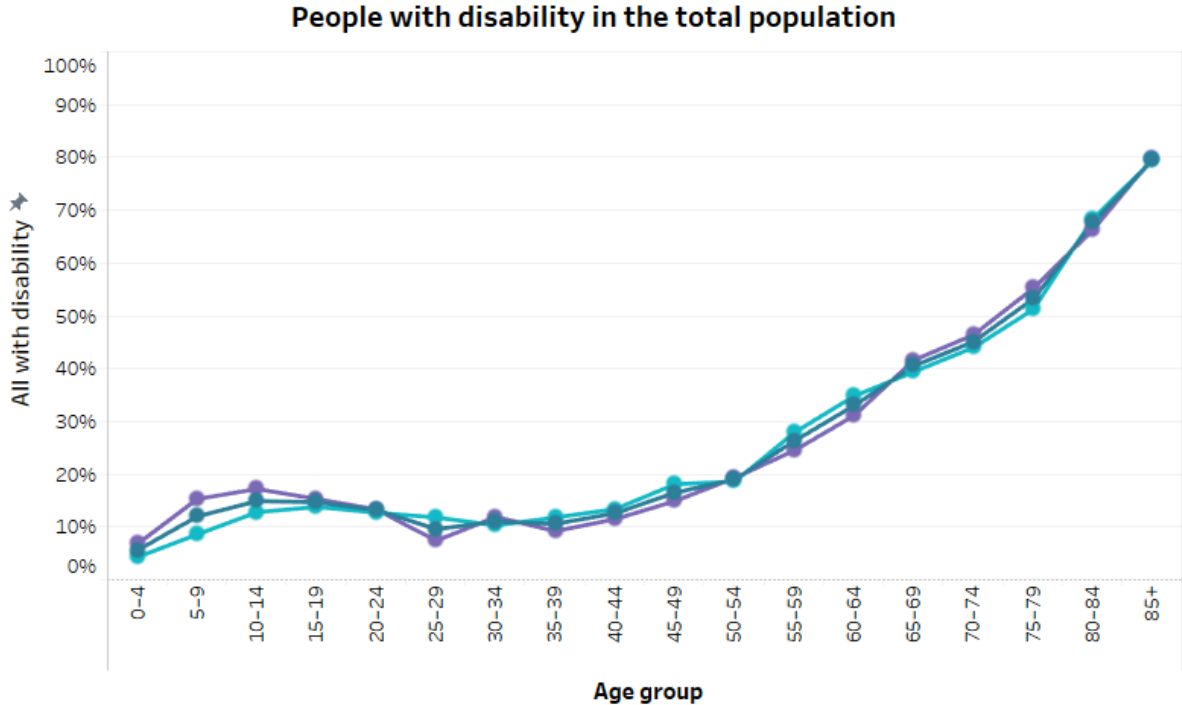
In this report, findings based on the ABS survey data are reported by sex recorded at birth. Sex at birth can be reported as 'Male', 'Female', or 'Another term'. Due to small number of respondents whose sex at birth was recorded as 'Another term', findings for this group are not reported on separately but are included in the 'All persons' totals.

This report uses the terms 'men and women' to mean 'male and female at birth' for people aged 18 and over, and 'boys and girls' for people aged under 15. We acknowledge that some people may not identify with these terms.

**Figure POPULATION.2: Proportion of people with disability in the total population, by age group and sex at birth, 2022**

Select disability status:  
 All with disability  
 Severe or profound disability

Select to highlight sex at birth:  
 All persons  
 Females  
 Males



'All persons' includes people whose sex at birth is recorded as 'Another term'.  
 Source: AIHW analysis of ABS 2024c. Data tables: How many people have disability, Table POP2.  
<https://www.aihw.gov.au/>

**Note:** 'All persons' includes people whose sex at birth is recorded as 'Another term'.

**Source:** AIHW analysis of ABS 2024c. [Data tables:](#) How many people have disability, Table POP2.

**Key takeaways from Figure POPULATION.2**

1. Proportion of people with disability in the population increases sharply from around age 55.
2. Boys aged 0–14 are more likely to have disability than girls in that age group. For other ages, disability rates are similar for males and females.
3. For children aged 0–14, severe or profound disability is more prevalent among boys than girls. However, from about age 75, women are more likely to have severe or profound disability than men.

The rate of disability varies by sex for children under 15, and less so for people aged 15 and over:

- boys aged 0–14 are more likely to have disability than girls (13% of boys and 8.7% of girls aged 0–14 have disability)

- 14% of males and 13% of females aged 15–24 have disability
- 16% of men and 18% of women aged 25–64 have disability
- 53% of men and 52% of women aged 65 and over have disability (AIHW analysis of ABS 2024d, Figure POPULATION.2).

The rate of severe and profound disability varies by sex for children under 15 and for people aged 65 and over, but not for those aged 15–64:

- 8.5% of males and 4.6% of females aged 0–14 have severe or profound disability
- 5.8% of males and 4.6% of females aged 15–24 have severe or profound disability
- 4.2% of men and 4.9% of women aged 25–64 have severe or profound disability
- 20% of men and 23% of women aged 65 and over have severe or profound disability (AIHW analysis of ABS 2024d, Figure POPULATION.2).

## Changes in disability rates over time

Between 2003 and 2018, the proportion of people with disability in the Australian population decreased. During this time, the disability prevalence rate fell from 20.0% in 2003 to 17.7% in 2018 (ABS 2024a). However, between 2018 and 2022 the disability rate increased significantly, from 17.7% to 21.4% (ABS 2024a).

The Australian Bureau of Statistics (ABS 2024a) noted that several factors may have contributed to the rise in estimated disability rates, including:

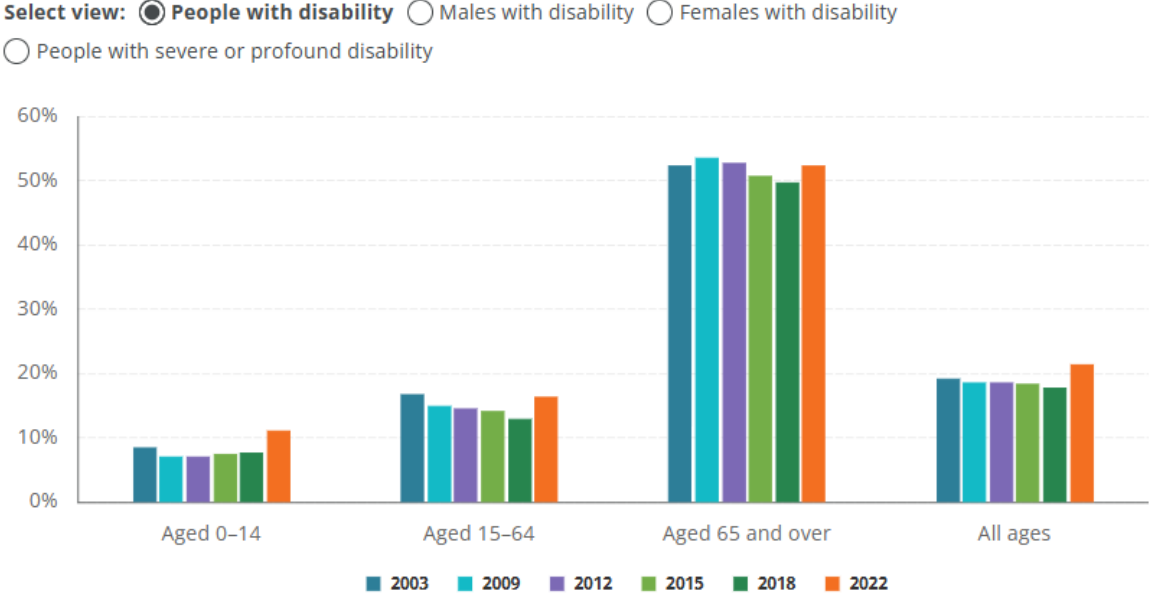
- a growing awareness of disability in Australia
- an increase in prevalence of some long-term health conditions
- changes in data collection methods
- an ageing population.

While each of these factors may have played a role in the increase of estimated disability rates, it is not possible to determine how much impact each individual factor may have had (ABS 2024a).

Figure POPULATION.3 shows how the disability rates changed between 2003 and 2022, including for severe and profound disability, across age groups, and for males and females. Between 2018 and 2022, the disability prevalence rate increased for all sub-groups:

- for children aged 0–14, the disability rate increased from 9.5% in 2018 to 13% in 2022 for males, and from 5.7% to 8.7% for females
- for people aged 15–64, the disability rate increased from 13% in 2018 to 15% in 2022 for males, and from 13% to 17% for females
- for people aged 65 and over, the disability rate increased from 49% to 53% for men and from 50% to 52% for women (AIHW analysis of ABS 2024d).

**Figure POPULATION.3: Proportion of people with disability in the population, by age group, sex at birth and disability severity, 2003 to 2022**



CI = 95% confidence interval.

Source: AIHW analysis of ABS 2024d.

**Key takeaways from Figure POPULATION.3**

The proportions of people with disability in the population decreased between 2003 and 2018, and increased from 2018 to 2022. This was the case for all age groups (under 15, 15-64, 65 and over), for both sexes, and for severe or profound disability.

**Age-standardised disability rate**

The changes in the overall (crude) disability rates reported above may reflect changes in the age structure of the Australian population.

The Australian population is ageing due to increasing life expectancy and declining fertility rates (more information on this topic can be found in [Older Australians, Demographic profile](#)). Since people in the older age groups (65 and over) are more likely to have disability, the ageing population can make it more difficult to compare changes in the overall disability rates over time.

Age-standardised rates account for the differences in population structure, thus allowing better comparisons over time. The results show that:

- between 2003 and 2018, the age-standardised disability prevalence rate fell from 20% to 16%, before increasing to 19% in 2022
- the age-standardised prevalence rate of severe or profound disability fell from 6.2% in 2003 to 5.2% in 2018, before increasing to 7.1% in 2022 (ABS 2024a).

## Disability group

### Disability group and type of disability

Disability group is a broad categorisation of disability. It is based on underlying health conditions and on impairments, activity limitations and participation restrictions. It is not a diagnostic grouping, nor is there a one-to-one correspondence between a health condition and a disability group.

The ABS SDAC broadly groups disabilities depending on whether they relate to functioning of the mind, the senses, or the physical body structures. Each disability group may refer to a single disability or be composed of a number of types of disability affecting similar areas of functioning. The SDAC identifies 6 disability groups based on particular types of disability:

- sensory or speech disability group (includes loss of sight, loss of hearing, and speech difficulties disability types)
- learning and understanding (relates to difficulty learning or understanding things)
- physical (includes such disability types as breathing difficulties, blackouts, seizures or loss of consciousness, chronic or recurrent pain, incomplete use of limbs, and more)
- psychosocial (includes nervous or emotional conditions, mental illness, memory problems, and social or behavioural difficulties disability types)
- head injury, stroke or acquired brain injury disability group
- other disability (includes restrictions in everyday activities due to other long-term conditions or ailments) (ABS 2024d).

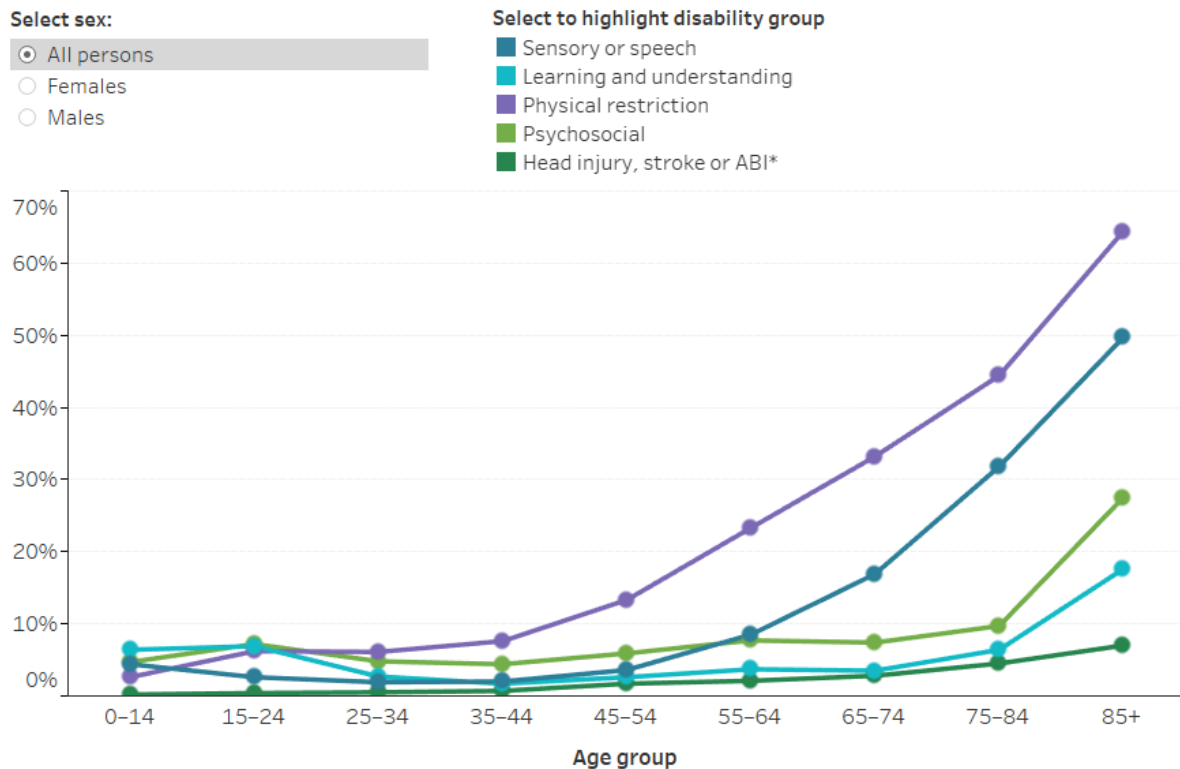
Specific types of disability are discussed in 'Disability type' section of this report.

The rate of all disability groups in the total population increases with age (Figure POPULATION.4). There are sharp increases from about age 45–54 for physical disability, 55–64 for sensory or speech disability, and 75–84 for learning and understanding disability, psychosocial disability, and disability associated with head injury, stroke or acquired brain injury.

For sensory or speech, and learning and understanding disability, the prevalence rates are higher during childhood than in early adulthood (Figure POPULATION.4). This is especially true for males:

- 5.3% (or 127,000) of males aged 0–14 have sensory or speech disability, compared with 2.8% (or 45,000) of males aged 15–24 and 2.4% (or 43,000) of males aged 25–34
- 8.3% (or 201,000) of males aged 0–14 and 8.4% (or 134,000) of males aged 15–24 have learning and understanding disability, compared with 2.5% (or 45,000) of males aged 25–34 (AIHW analysis of ABS 2024c).

**Figure POPULATION.4: Prevalence of disability groups, by age group, 2022**



\*ABI=acquired brain injury.

Source: AIHW analysis of ABS 2024a. Data tables: How many people have disability, Table POP3.

<https://www.aihw.gov.au>

**Source:** AIHW analysis of ABS 2024c. [Data tables:](#) How many people have disability, Table POP3.

### Key takeaways from Figure POPULATION.4

1. For all disability groups, the rates in the population start increasing from about age 25.
2. Physical disability is the most common disability group from around age 25. The second most common disability group between ages 25 and 54 is psychosocial. From about age 55, sensory or speech disability becomes the second most common disability group.
3. Boys under 15 are more likely than girls to have sensory or speech, learning and understanding, physical, or psychosocial disability.
4. From about age 55, more men than women have sensory or speech disability, and more women than men have physical disability.

Boys aged 0-14 are more likely to have disability than girls across several disability groups:

- 5.3% (or 127,000) of boys and 3.3% (or 76,000) of girls aged 0-14 have sensory or speech disability
- 8.3% (or 201,000) of boys and 4.5% (or 102,000) of girls have learning and understanding disability

- 3.1% (or 75,000) of boys and 2.1% (or 47,000) of girls have physical disability
- 5.8% (or 141,000) of boys and 3.6% (or 84,000) of girls have psychosocial disability (AIHW analysis of ABS 2024c).

Between ages 15 and 54, the rate of various disability groups is similar for males and females. The only exception is learning and understanding disability among people aged 15–24, with 8.4% of males and 5.4% of females having this type of disability.

From about age 55, men are more likely to have sensory or speech disability than women of the same age (AIHW analysis of ABS 2024c):

- 9.9% of men and 7.2% of women aged 55–64 have sensory or speech disability
- 22% of men and 12% of women aged 65–74
- 39% of men and 26% of women aged 75–84.

At the same time, women aged 55 and over are more likely to have physical disability than men (AIHW analysis of ABS 2024c):

- 26% of women and 21% of men aged 55–64 have physical disability
- 35% of women and 31% of men aged 65–74
- 47% of women and 41% of men aged 75–84.

The proportions of people with learning and understanding disability, psychosocial disability, and disability related to head injury, stroke or acquired brain injury remain generally similar for men and women beyond age 55.

## Disability severity

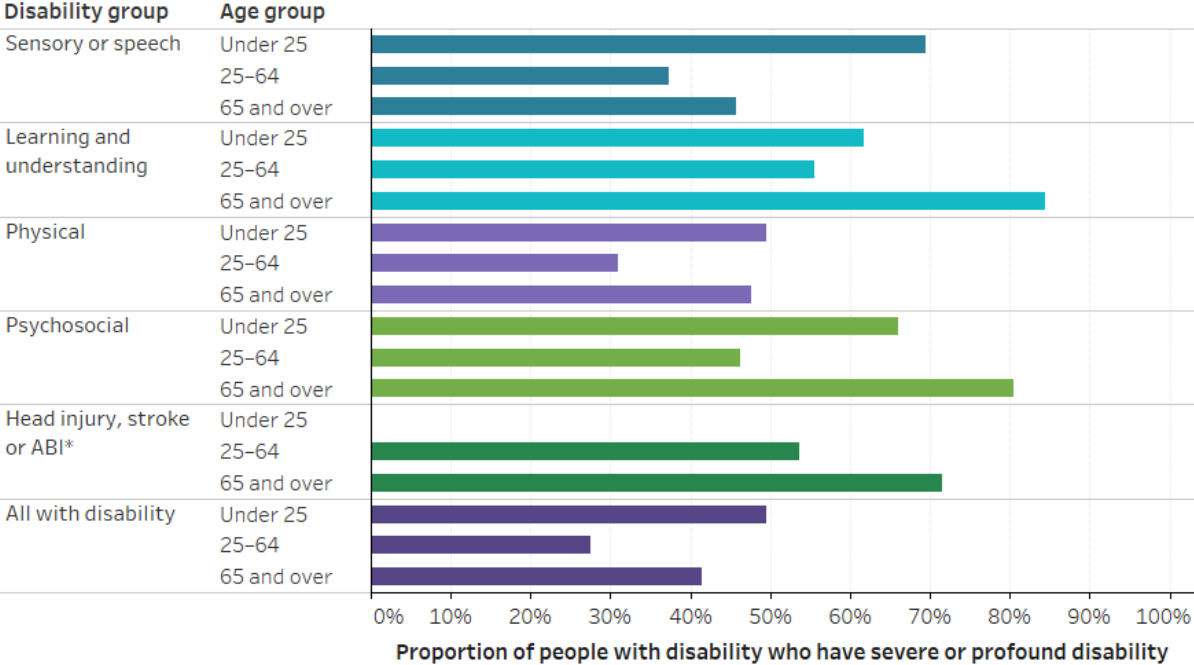
Whether people with disability have severe or profound disability differs by age group, sex and disability group (Figure POPULATION.5):

- Of all people with disability, those aged under 25 are the most likely to have severe or profound disability (50% or 470,000), and those aged 25–64 are the least likely (28% or 619,000).
- People aged 65 and over with learning and understanding, or psychosocial disability are the most likely to have severe or profound disability; 84% (or 225,000) of people with learning and understanding disability and 80% (or 369,000) of people with psychosocial disability in this age group have severe or profound disability.
- Although females are less likely to have sensory or speech disability than males (Figure POPULATION.4), those that do have it are more likely to have severe or profound disability; 51% (or 420,000) of females with sensory or speech disability have severe or profound disability, compared with 44% (or 480,000) of males (AIHW analysis of ABS 2024c).

**Figure POPULATION.5: Severe or profound disability in people with disability, by disability group, age group and sex, 2022**

Select to view by age group or sex at birth:

- Age group
- Sex at birth



\*ABI = acquired brain injury.

Source: AIHW analysis of ABS 2024a. Data tables: How many people have disability, Tables POP5 and POP6.

<https://www.aihw.gov.au>

**Note:** Data for people with head injury, stroke or ABI (acquired brain injury) aged under 25 are not shown due to uncertainty over data quality.

**Source:** AIHW analysis of ABS 2024a. [Data tables:](#) How many people have disability, Tables POP5 and POP6.

**Key takeaways from Figure POPULATION.5**

1. People with disability aged 25-64 are the least likely to have severe or profound disability.
2. Among people with sensory or speech disability, those aged under 25 are the most likely to have severe or profound disability.
3. For people with learning and understanding or psychosocial disability, people aged 65 and over are the most likely to have severe or profound disability.
4. Females with sensory or speech disability are more likely to have severe or profound disability than males with this disability.

### **Findings by disability group – important things keep in mind**

Disability often causes limitations and restrictions that affect multiple areas of functioning of a person's body or mind. In fact, 56% of people with disability in 2022 had disability that was classified into multiple disability groups (AIHW analysis of ABS 2024c). This may be due to one condition causing multiple restrictions or limitations, or a result of several co-existing health conditions that affect different areas of functioning.

For example, among people who have physical disability, more than 2 in 3 (68%) also had another disability, such as psychosocial, or learning and understanding. This proportion was even higher among people with psychosocial disability, among whom 87% also have physical, sensory or speech, learning and understanding disability, disability related to head injury, stroke or acquired brain injury, or other disability (AIHW analysis of ABS 2024c).

Therefore, when we look at findings by disability group, it is important to remember that these groups are not mutually exclusive – people in one disability group may also be included in another group. Each person is only counted once in the 'All people with disability' total.

### **How does co-existence of multiple disability groups affect reported outcomes?**

When a person's disability is more severe, it is likely to cause a greater range of limitations, across more areas of functioning.

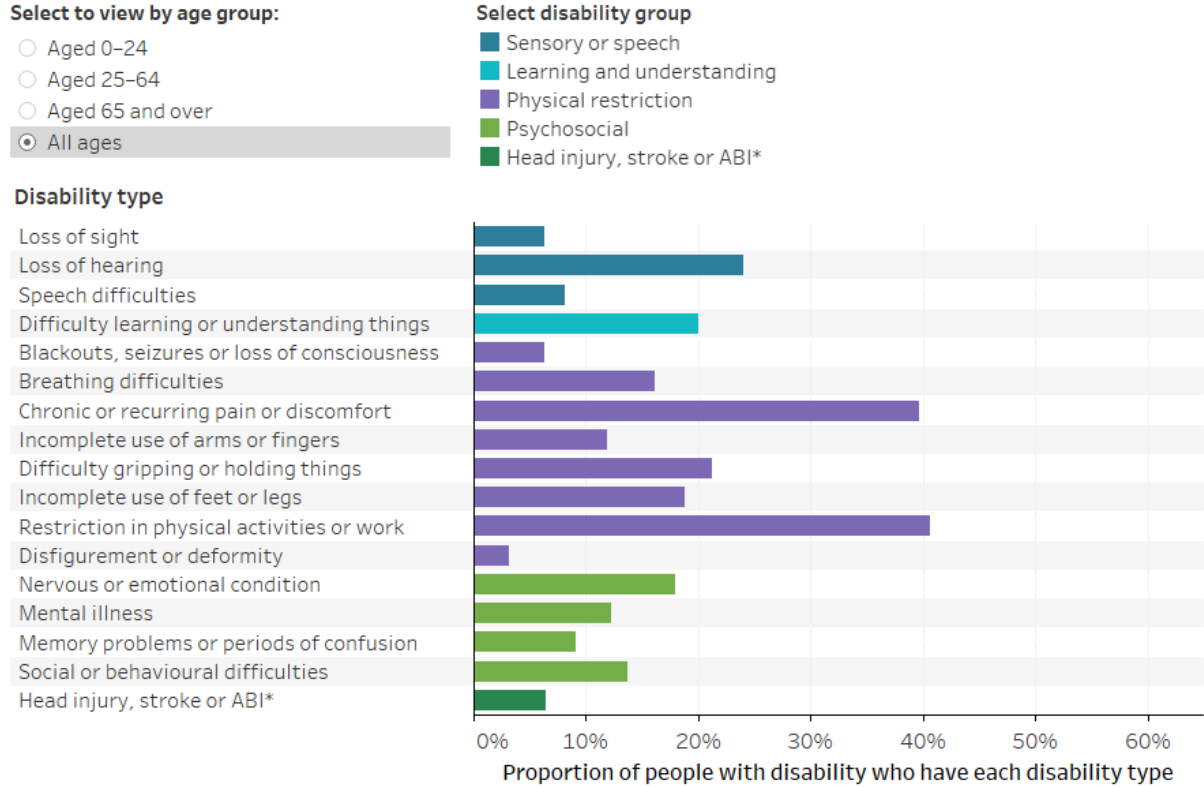
In 2022, 79% of people with severe or profound disability had disability classified into multiple groups, compared with 42% of people with less severe forms of disability (AIHW analysis of ABS 2024c). This results in higher reported rates of disability severity within each disability group, compared with the average rate of disability severity for all people with disability (Figure POPULATION.6).

## **Disability type**

Each disability group includes different types of disability. This section looks at prevalence of different disability types.

The most prevalent disability types vary by age and sex. This section looks at disability types within 3 broad age groups: under 25 years, 25–64 years, and 65 years and over (Figure POPULATION.6).

**Figure POPULATION.6: Disability type of people with disability, by age group, 2022**



\*ABI = acquired brain injury.  
 Source: AIHW analysis of ABS 2024a. Data tables: How many people have disability, Table POP9.  
<https://www.aihw.gov.au>

**Source:** AIHW analysis of ABS 2024a. [Data tables:](#) How many people have disability, Table POP9.

**Key takeaways from Figure POPULATION.6**

1. For people with disability aged under 25, difficulty learning and understanding things is the most common type of disability.
2. For the 25-64 age group, the most common disability types are chronic or recurring pain, and restriction in physical activity or work.
3. For the 65 and over age group, the most common disability types are restriction in physical activity or work, chronic or recurring pain, and loss of hearing.

**Aged under 25**

For people with disability aged under 25, the most common types of disability are:

- difficulty learning or understanding things – this affects 54% (or 516,000) of all people with disability in this age group
- social or behavioural difficulties – 33% (or 309,000)
- nervous or emotional condition – 25% (or 237,000)
- speech difficulties – 25% (or 234,000)
- mental illness – 24% (or 223,000) (AIHW analysis of ABS 2024c).

There are some differences between sexes in this age group:

- males aged under 25 with disability are more likely to have difficulty learning or understanding things (61% or 334,000) than females (46% or 183,000)
- females aged under 25 with disability are more likely to have a nervous or emotional condition (30% or 120,000) than males (21% of 117,000) (AIHW analysis of ABS 2024c).

### **Aged 25–64**

For people with disability aged 25–64, the most common types of disability are:

- chronic or recurring pain or discomfort – this affects 47% (or 1.1 million) people with disability in this age group
- restriction in physical activities or work – 40% (or 900,000)
- nervous or emotional condition – 24% (or 533,000) (AIHW analysis of ABS 2024c).

Women with disability in this age group are more likely than men to have chronic or recurring pain or discomfort:

- 50% (or 608,000) of women aged 25–64 with disability have chronic pain or discomfort, compared with 43% (or 442,000) of men with disability (AIHW analysis of ABS 2024c).

### **Aged 65 and over**

For people with disability aged 65 and over, the most common types of disability are:

- restriction in physical activities or work – this affects 52% (or 1.2 million) of people with disability in this age group
- chronic or recurring pain or discomfort – 45% (or 1.0 million)
- loss of hearing – 41% (or 939,000)
- difficulty gripping or holding things – 31% (or 703,000)
- incomplete use of feet or legs – 27% or 620,000 (AIHW analysis of ABS 2024c).

Women with disability in this age group are more likely than men to have the type of disability that results in physical restriction:

- 54% (or 658,000) of women are restricted in physical activities or work, compared with 49% (or 530,000) of men
- 49% (or 598,000) of women aged 65 and over with disability have chronic or recurring pain or discomfort, compared with 41% (or 436,000) of men
- 39% (or 467,000) of women have difficulty gripping or holding things, compared with 22% (or 234,000) of men (AIHW analysis of ABS 2024c).

At the same time, loss of hearing is much more common among men with disability in this age group (50% or 541,000) than among women (33% or 396,000) (AIHW analysis of ABS 2024c).

## Long-term health conditions of people with disability

In the ABS survey data, people with disability are considered to have **at least one underlying long-term health condition**. This aligns with the International Classification of Functioning, Disability and Health (ICF) definition, which views disability as the result of interaction between a person's health conditions and environmental and personal factors.

People with disability may have one or more long-term health conditions. In 2022:

- 17% of people with disability had one long-term health condition, and a further 17% had two conditions
- almost 2 in 3 (65%) people with disability had 3 or more long-term health conditions (AIHW analysis of ABS 2024d).

People with severe or profound disability, and those who are older, are more likely to have multiple long-term health conditions:

- among those aged under 65, 59% of people with severe or profound disability have 3 or more conditions, as do 49% of people whose disability is not severe or profound
- among those aged 65 and over, 91% of people with severe or profound disability have 3 or more conditions, as do 79% of people whose disability is not severe or profound (AIHW analysis of ABS 2024d).

Females with disability are somewhat more likely to have 3 or more long-term health conditions than males with disability (67% compared with 63%) (AIHW analysis of ABS 2024d).

The most common types of long-term conditions are (refer Box 1 for examples):

- diseases of the musculoskeletal system and connective tissue – these are present in 53% of people with disability
- mental health and behavioural conditions – 46% of people with disability have these conditions
- diseases of the circulatory system – 37% of people with disability (AIHW analysis of ABS 2024d).

### Box 1. Examples of long-term health conditions referred to in this section

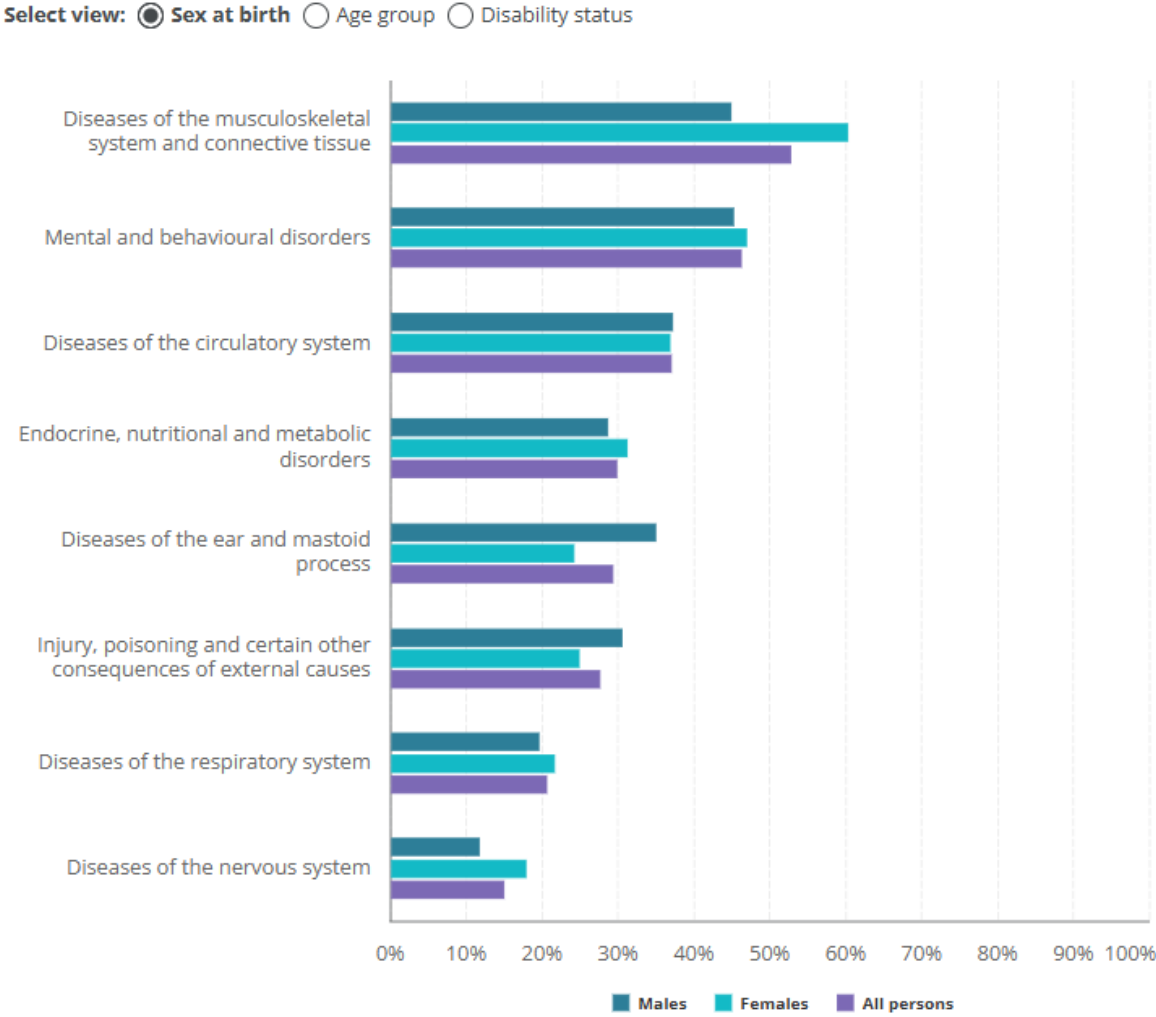
The table below lists examples of long-term health conditions mentioned on this page. This list is not complete; it simply shows the range of disorders within the more common types of health conditions.

Selected types of health condition	Examples
Diseases of the circulatory system	Heart disease, high blood pressure, stroke
Diseases of the ear and the mastoid process	Deafness, otitis media, tinnitus
Diseases of the musculoskeletal system and connective tissue	Arthritis, back problems, osteoporosis, repetitive strain injury (RSI)
Diseases of the nervous system	Alzheimer's disease, cerebral palsy, migraine, Parkinson's disease
Diseases of the respiratory system	Asthma, bronchitis, emphysema, hay fever
Endocrine, nutritional and metabolic disorders	Diabetes, disorders of the thyroid gland, high cholesterol, obesity
Mental health and behavioural conditions	ADHD, anxiety, autism spectrum disorders, dementia, depression, intellectual impairment, schizophrenia

The most common types of long-term health conditions of people with disability vary by age and sex (Figure POPULATION.7):

- Diseases of the musculoskeletal system and connective tissue are more common among females and older people with disability. For people with disability aged under 65, 46% of females and 34% of males have these conditions. Among those aged 65 and over, 79% of females and 60% of males have these conditions.
- Mental health and behavioural conditions are more common for younger people with disability: 58% of people with disability aged under 65 have these conditions, compared with 30% of people with disability aged 65 and over.
- Other conditions that are more common for older people with disability are:
  - diseases of the circulatory system – 63% of people aged 65 and over, and 18% of people aged under 65 with disability have these conditions
  - diseases of the ear and the mastoid process – 49% and 16%
  - endocrine, nutritional and metabolic disorders – 47% and 17%.
- Diseases of the ear and the mastoid process are more common among males than females, especially in the 65 and over age group: 58% of men and 40% of women with disability in this age group have these conditions (AIHW analysis of ABS 2024d).

**Figure POPULATION.7: Selected common long-term health conditions of people with disability, by sex, age, and severity of disability, 2022**



**Source:** AIHW analysis of ABS 2024d. **Data tables:** How many people have disability, Tables POP10 and POP11.

**Key takeaways from Figure POPULATION.7**

1. Females with disability are more likely than males to have musculoskeletal conditions; males are more likely to have ear-related conditions.
2. Older people (65+) with disability are more likely to have ear-related, musculoskeletal, circulatory, or endocrine conditions. Younger people (under 65) are more likely to have mental and behavioural conditions.

Some long-term conditions (such as endocrine, nutritional and metabolic disorders, diseases of the circulatory system, and diseases of the nervous system) are associated with more severe forms of disability. The difference is most striking for mental health and behavioural conditions: these conditions are present in 61% of people whose disability is severe or profound, compared with 38% of people with less severe forms of disability (AIHW analysis of ABS 2024d).

## Main health condition

The SDAC also collects information about the main health condition – the one that causes the most problems. For about 3 in 4 (75%) people with disability, their main health condition is physical (ABS 2024a).

Physical conditions include all conditions other than mental or behavioural, such as the diseases of the:

- musculoskeletal system and connective tissue (such as back problems and arthritis) – 28% of people with disability have these as their main condition
- ear and mastoid process (such as hearing loss and tinnitus) – 7.2%
- nervous system (such as cerebral palsy and multiple sclerosis) – 5.6%
- circulatory system (such as heart disease and stroke) – 5.3% (AIHW analysis of ABS 2024d).

For 1 in 4 (25%) people with disability, their main condition is mental or behavioural, including:

- anxiety disorders – 7.4%
- psychological development conditions such as autism spectrum disorders or dyslexia – 4.9%
- behavioural, cognitive or emotional conditions with usual onset in childhood or adolescence such as attention deficit hyperactivity disorder (ADHD) – 4.4% (AIHW analysis of ABS 2024d).

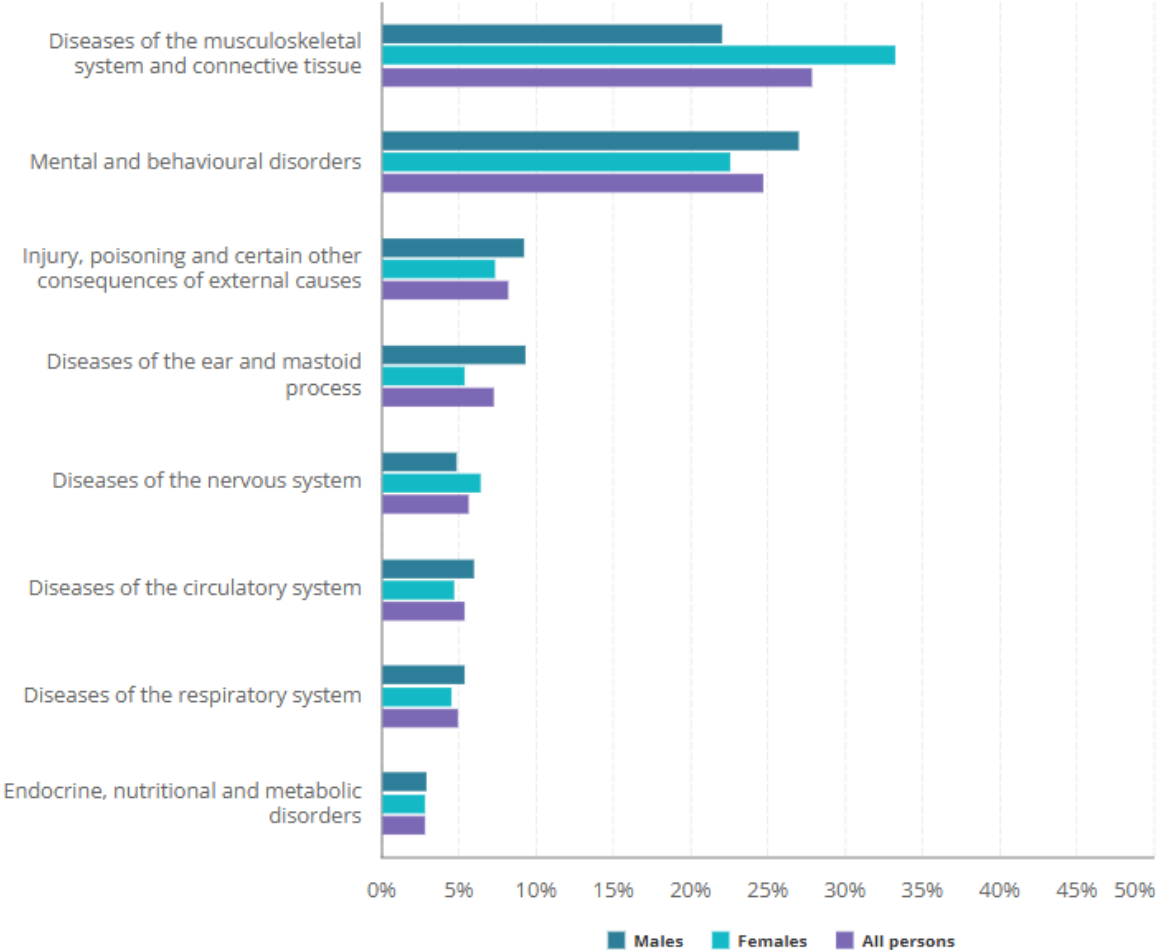
There is some variation in the most common types of main condition depending on the person's age and sex (Figure POPULATION.8):

- Younger people with disability are more likely to have mental or behavioural conditions as their main health condition – 37% of people with disability aged under 65 have these as their main health condition, compared with 8.0% of those aged 65 and over.
- Older people with disability are more likely to have diseases of the musculoskeletal system and connective tissue as their main condition – 22% of people with disability aged under 65 have these as their main health condition, compared with 36% of those aged 65 and over.
- Females with disability are more likely than males to have diseases of the musculoskeletal system and connective tissue as their main condition – 22% of males and 33% of females with disability have this main condition.
- Males with disability are more likely to have mental or behavioural conditions as their main condition. This is especially the case for people aged under 65, with 41% of males and 33% of females in this age group having mental or behavioural conditions as their main condition. Older males (aged 65 and over) are more likely to have diseases of the ear or mastoid process as their main condition compared with females (16% of males and 7.2% of females in this age group) (AIHW analysis of ABS 2024d).

**Figure POPULATION.8: Selected common main health conditions of people with disability, by sex, age, and severity of disability, 2022**

View: Sex at birth

Select view:  Sex at birth  Age group  Disability status



Source: AIHW analysis of ABS 2024d. Data tables: How many people have disability, Tables POP12 and POP13.

**Key takeaways from Figure POPULATION.8**

1. Musculoskeletal conditions are a more common main condition among females and older people older people (65+) with disability.
2. Mental and behavioural conditions are a more common main condition among younger people (under 65) with disability, males, and people with severe or profound disability.

People with severe or profound disability are more likely to have mental or behavioural conditions as their main condition – 32% of people with severe or profound disability have this type of condition as their main condition, compared with 21% of people with less severe forms of disability (AIHW analysis of ABS 2024d).

The rate (or prevalence) of disability among people with specific health conditions is not covered in this section. Detailed information on this topic for selected chronic conditions can be found in '[Chronic conditions and disability](#)'.

### **What is the relationship between health conditions and disability?**

Disability and health conditions have a complex relationship – long-term health conditions can cause disability, and disability can contribute to new or worsening health problems.

Disability is a multi-dimensional concept that involves the interaction between a health condition and:

- environmental factors, such as community attitudes and access to services
- personal factors, such as a person's age and sex.

As a result, people with similar health conditions can have different experiences of disability, and the same health condition may contribute to disability in one person but not in another.

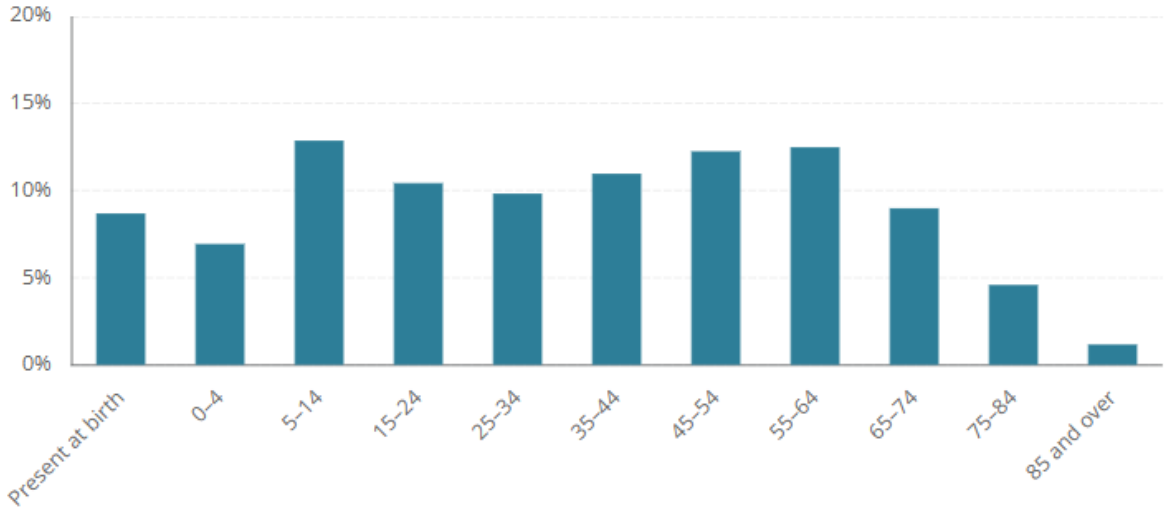
The ABS Survey of Disability, Ageing and Carers (SDAC) does not collect data on the causes of disability, however it collects data about the cause and age of onset of the person's main health condition – the condition causing the most problems. When considering the information presented in this section it should be remembered that, for people with disability, their current main health condition may or may not have been the cause of their disability.

### **Age of onset of the main condition**

While the prevalence of disability tends to increase with age (especially after about 55), the age of onset of the main condition (or, if main condition was caused by an accident, the age the accident occurred) is much more evenly distributed across age groups (Figure POPULATION.9). For almost half of people with disability living in households (49%, or 2.6 million), their main condition came on (or the accident occurred) before the age of 35 (AIHW analysis of ABS 2024c).

For 8.6% of people with disability living in households, their main condition was present at birth. This is even higher for people with severe or profound disability, 13% of whom had their main condition present at birth (AIHW analysis of ABS 2024c).

**Figure POPULATION.9: Age of onset of the main health condition for people with disability, 2022**



**Source:** AIHW analysis of ABS 2024c. [Data tables:](#) How many people have disability, Table POP14.

**Key takeaways from Figure POPULATION.9**

1. 8.6% of people with disability had their main condition from birth.
2. After birth, the age of onset is spread relatively evenly across age groups.
3. Slightly more people with disability develop their main condition in childhood or adolescence (5–14 years), or between ages 45 and 64.

**Cause of the main health condition**

In terms of what caused the main health condition, for more than 1 in 4 people with disability (26% or 1.4 million), the cause is not known. For a further 15% (or 804,000), the condition ‘just came on’ or was due to ageing. For 13% (or 697,000) of people with disability, the main condition was hereditary or a result of illness or disease, and for 11% (620,000) it was caused by accident or injury (AIHW analysis of ABS 2024c).

For males with disability, the main condition is more likely to be caused by:

- accident or injury –13% of males with disability and 9.6% of females with disability
- overuse (work or non-work related) – 11% of males and 6.3% of females (AIHW analysis of ABS 2024c).

For females with disability, the main condition is more likely to be brought on by:

- old age or just came on – 17% of females with disability and 12% of males
- disease, illness, or hereditary causes – 14% of females and 11% of males
- stress, personal or family problems, or death – 7.1% of females and 4.8% of males (AIHW analysis of ABS 2024c).

When it comes to disability groups, the most common causes (other than 'not known') for each disability group are:

- for people with sensory or speech disability, the most common cause of the main condition was that it just came on or happened as part of ageing – this was the case for 21% (or 399,000) of people with sensory or speech disability. This compares with 15% for all people with disability.
- for people with learning and understanding disability, 24% (or 267,000) had their main condition present at birth. This compares with 8.4% of all people with disability.
- among people with physical disability, for 16% (or 583,000) their main condition just came on or was due to old age. For 15% (or 550,000), their main condition was caused by accident or injury, compared with 11% of all people with disability.
- among people with disability related to head injury, stroke or acquired brain injury, 25% (or 88,000) had their main condition caused by accident or injury
- for people with psychosocial disability, stress, personal or family problems, or death caused the main condition for 13% (or 221,000). This compares with 6.0% of all people with disability (AIHW analysis of ABS 2024c).

For people with disability whose main condition was caused by accident or injury, most accidents had occurred at work (34% of all cases), on a street, road or highway (25% of cases), at home (15%) or at a sporting venue (including ski fields) (10%). Together, these locations account for more than 80% of all cases of people with disability whose main condition was due to an accident or injury (AIHW analysis of ABS 2024c).

## Where can I find out more?

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022](#).

## References

ABS (2024a) *Disability, ageing and carers, Australia: summary of findings, 2022*, ABS, accessed 6 November 2025.

ABS (2024b) *Disability, ageing and carers, Australia: summary of findings methodology, 2022*, ABS, accessed 8 April 2026.

ABS (2024c) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia*, ABS, AIHW analysis of detailed microdata, accessed 11 February 2025.

ABS (2024d) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia*, ABS, AIHW analysis of microdata in TableBuilder, accessed 30 March 2026.

## Need for assistance with activities

### Key findings

- **Need for assistance:** In 2022, 61% of people with disability living in households needed assistance with at least one activity of daily living.
- **Activities where assistance is needed:** The most common activities where assistance is needed are property maintenance and health care (30% each for people with disability living in households in 2022).
- **Schooling or employment restriction:** In 2022, 1 in 2 (51%) people with disability aged 5 and over living in households had a schooling or employment restriction.

People with disability may need support to do daily activities, live more independently, and fully participate in social and economic life. While broad supports include long-term planning and skill-building, this section focuses on needs for specific, task-based assistance provided by another person. This may involve someone helping a person with disability to perform certain activities, or being there while the person with disability performs the activity. Understanding these needs can support better service planning and more inclusive communities.

### Data note

Data on this page are sourced from the Australian Bureau of Statistics (ABS) **2022 Survey of Disability, Ageing and Carers (SDAC)**. More information about the SDAC, including the concepts of disability, disability groups, and remoteness categories used by the SDAC can be found in '[Data sources](#)'.

## Need for assistance with activities of daily living

Three in 5 (61% or 3.2 million) people with disability living in households need assistance with at least one of 10 activities of daily living (AIHW analysis of ABS 2024c). Assistance is most commonly needed with property maintenance, health care, cognitive or emotional tasks, and mobility (Table ACTIVITIES.1).

**Table ACTIVITIES.1: Activities people with disability need assistance with, by place of residence, 2022 (%)**

Activity	Living in households	Living in cared accommodation	All people with disability
Self-care	17.4	95.4	19.9
Mobility	24.7	92.3	26.9
Communication	13.6	56.6	15.1
Cognitive or emotional tasks	24.8	85.0	26.8
Health care	29.6	97.8	31.8
Reading or writing	8.5	82.3	10.9
Household chores	24.2	-	-
Private transport	20.1	-	-
Property maintenance	30.1	-	-
Meal preparation	10.3	-	-
<b>At least one of the above activities (%)</b>	<b>60.5</b>	<b>99.3</b>	<b>-</b>
<b>Total number of people with disability</b>	<b>5.3 million</b>	<b>180,000</b>	<b>5.5 million</b>

**Note:** Data on need for assistance with household chores, private transport, property maintenance, and meal preparation are not collected for people with disability living in cared accommodation, as it is expected that the cared accommodation facility would provide these services to residents. Therefore, this table reports data on needs for assistance with these activities for people living in households only.

**Source:** AIHW analysis of ABS 2024c.

## Place of residence

The SDAC collects data for people living in households (in the community) and in cared accommodation.

### Households

In the SDAC, households refer to private dwellings including self-cared accommodation for the retired or aged, and other private dwellings, including houses, flats, home units, garages, tents and other structures used as private places of residence.

### Cared accommodation

Cared accommodation is usually long term and may be institutional in style. In the SDAC, cared accommodation includes hospitals, residential aged care, cared components of retirement villages, aged care hostels, psychiatric institutions, and other homes (such as group homes for people with disability). To be included the person must have been, or is

expected to be, a resident of the cared accommodation for 3 months or more. The accommodation must include all meals for its occupants and provide 24-hour access to assistance for personal and/or medical needs (ABS 2024b).

### **The majority of people with disability live in households**

- Almost all of the 3.2 million people aged under 65 with disability live in households; only 0.3% (around 9,000) live in cared accommodation.
- 92% (or 2.1 million) of people aged 65 and over with disability live in households and the remaining 7.5% (or 172,000) live in cared accommodation (AIHW analysis of ABS 2024c).

People with disability living in cared accommodation tend to have much higher assistance needs than those living in households (Table ACTIVITIES.1). Since cared accommodation facilities provide home-care services to residents, the SDAC does not collect data on need for assistance with chores, property maintenance, meal preparation or private transport for people in cared accommodation. Almost all (99%, or 180,000) people with disability living in cared accommodation need some assistance with a least one of the remaining 6 activities of daily living (AIHW analysis of ABS 2024c).

People with severe or profound disability are more likely to need assistance than those with other disability status:

- Among people living in households, 97% (or 1.8 million) of people with severe or profound disability need assistance with at least one of 10 activities of daily living. This compares with 41% (or 1.4 million) of people with other disability status.
- Among residents of cared accommodation, all (100% or 176,000) people with severe or profound disability need assistance with at least one of 6 activities of daily living. Almost all people with disability living in cared accommodation have severe or profound disability (AIHW analysis of ABS 2024c).

For people with disability living in households, need for assistance with any of the 10 activities of daily living varies by sex and age group (Figure ACTIVITIES.1):

- Young people with disability (aged under 15) have higher assistance needs than other age groups. In the under 15 group, almost 3 in 4 (72% or 371,000) need assistance with activities. This is even though this age group is not asked about needs for assistance with home-care activities (such as household chores), private transport, or reading and writing.
- Among people with disability aged 65 and over, 68% (or 1.4 million) needed assistance. Among those aged 15–64, just over half (53% or 1.4 million) needed assistance.
- On average, females with disability are more likely to need assistance with activities than males.

However, for males and females the age groups most in need of assistance are different:

- Among males with disability, those aged under 15 had the highest need for assistance. In this age group, 76% (or 245,000) needed assistance with activities,

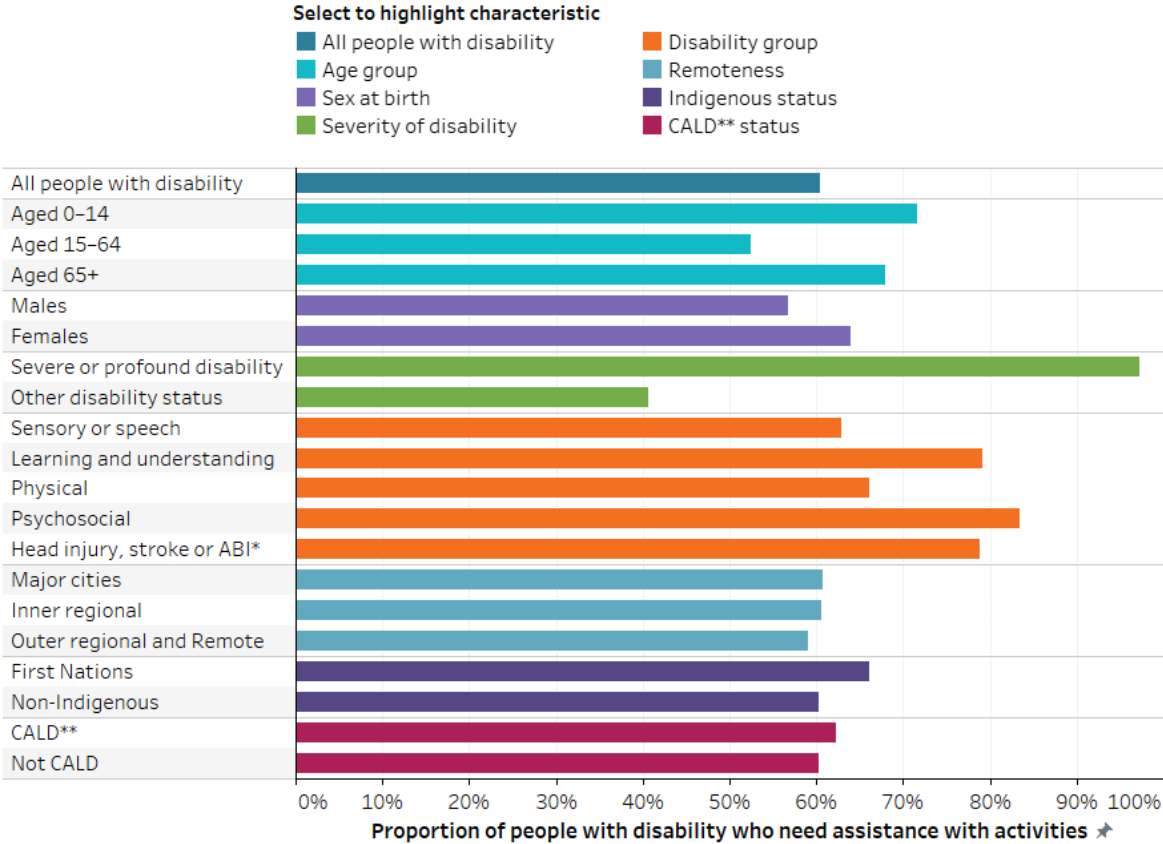
compared with 50% (or 626,000) of those aged 15–64, and 59% (or 603,000) of those aged 65 and over.

- For females with disability, those aged 65 and over were the most likely to need assistance. In this age group, 76% (or 832,000) needed assistance with activities, compared with 64% (or 126,000) of those under 15, and 55% (or 770,000) of those aged 15–64 (AIHW analysis of ABS 2024c).

The need for assistance also varies between disability groups (Figure ACTIVITIES.1). The proportion of people with disability living in households who need assistance with at least one activity of daily living is:

- 83% (or 1.3 million) of those with psychosocial disability
- 79% (or 828,000) of those with learning and understanding disability
- 79% (or 254,000) of those with head injury, stroke or acquired brain injury
- 66% (or 2.3 million) of those with physical disability
- 63% (or 1.1 million) of those with sensory or speech disability (AIHW analysis of ABS 2024c; Figure ACTIVITIES.1).

**Figure ACTIVITIES.1: Need for assistance with activities among people with disability living in households, by selected characteristics, 2022**



\*ABI = acquired brain injury. \*\*CALD = culturally and linguistically diverse.  
 Source: AIHW analysis of ABS 2024c. Data tables: Activities people need assistance with, Table ACTI2.  
<https://www.aihw.gov.au>

**Notes:**

1. The numbers reported in this chart are based on the maximum of 10 activities. Not all activities are applicable to all people with disability. Data on need for assistance with health care are not collected for people under 5, and data on need for assistance with reading or writing, household chores, private transport, property maintenance, and meal preparation are not collected for people under 15. People whose disability is not severe or profound, by definition, have no need for assistance with core activities (self-care, mobility, and communication) and therefore have no data reported for these activities.
2. The CALD cohort includes people born outside of main English-speaking countries and people who mainly speak a language other than English at home.

**Source:** AIHW analysis of ABS 2024c. [Data tables:](#) Activities people need assistance with, Table ACTI2.

**Key takeaways from Figure ACTIVITIES.1**

People with disability who are more likely to need assistance with activities include:

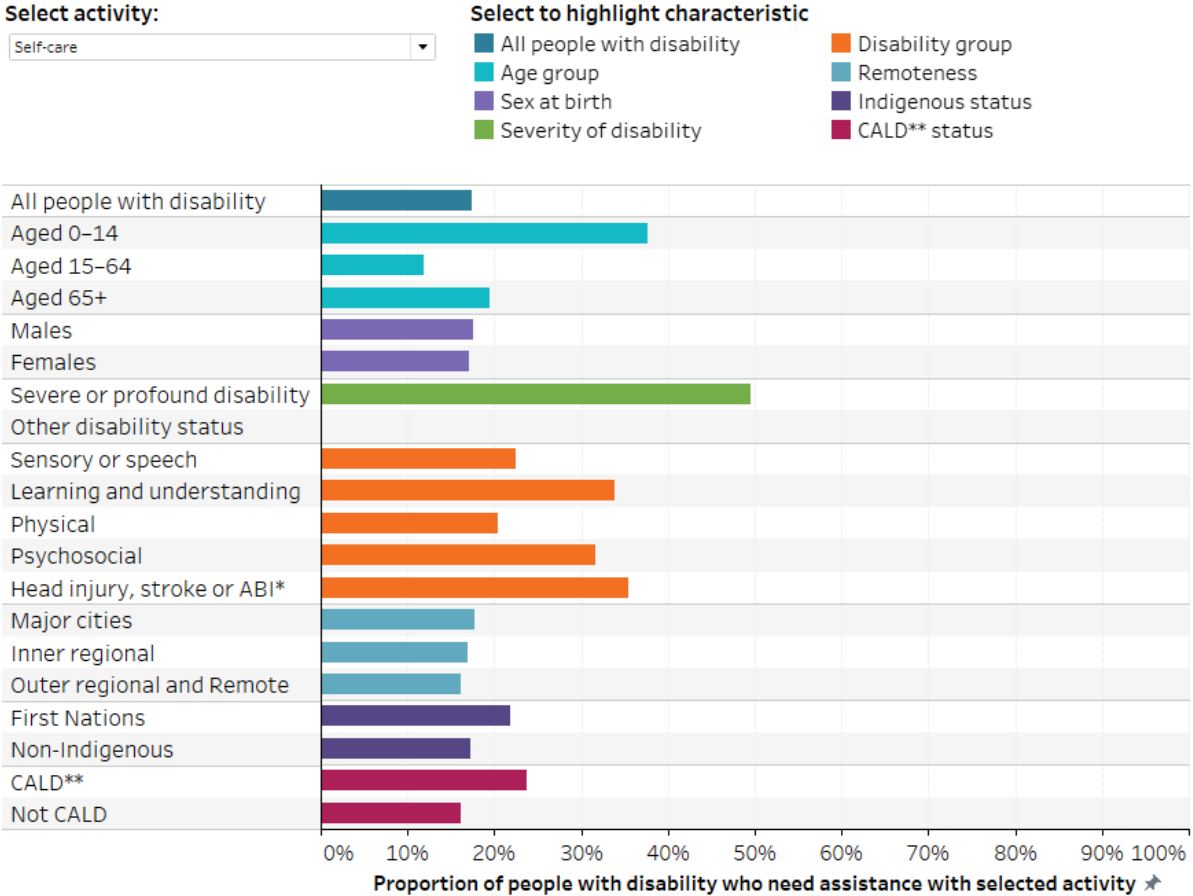
- those under 15 years of age, as well as those aged 65 and over
- females
- people with severe or profound disability
- people with learning and understanding or psychosocial disability.

## Types of activities where assistance is needed

The types of support people with disability (living in households) need vary according to their age, sex, severity of disability and other characteristics (Figure ACTIVITIES.2):

- As mentioned above, people with disability aged under 15 have higher overall needs for assistance with activities than those aged 15–64. In particular, cognitive or emotional tasks are the area where 57% (or 296,000) people with disability in this age group require assistance.
- For the 15–64 age group, cognitive or emotional tasks remain the most common activity where assistance is needed, with 29% (or 763,000) of people in this age group needing assistance with this type of activity. This is followed by property maintenance, with 24% (or 630,000) of people needing assistance.
- For people with disability aged 65 and over, assistance is most commonly needed with property maintenance (46% or 969,000) and health care (42% or 899,000).
- Females are more likely than males to need assistance with property maintenance (37% of females and 23% of males with disability) and household chores (30% of females and 18% of males). Males are somewhat more likely than females to need assistance with communication (16% of males and 11% of females with disability).
- People with severe or profound disability are much more likely to need assistance across all individual activities than people with other disability status. For instance, 58% (or 1.1 million) of people with severe or profound disability need assistance with health care, compared with 15% (or 500,000) of those with disability status other than profound or severe.
- People with psychosocial disability, or learning and understanding disability, are more likely to need assistance with cognitive or emotional tasks. Six in 10 (59% or 903,000) people with psychosocial disability and 58% (or 610,000) of those with learning and understanding disability need assistance with these tasks.
- First Nations people with disability are more likely than non-Indigenous Australians to need assistance with cognitive or emotional tasks, and with communication. Four in 10 (39%) First Nations people with disability need assistance with cognitive or emotional tasks, compared with 24% of non-Indigenous people. One in 5 (21%) First Nations people with disability need assistance with communication, compared with 13% of non-Indigenous people with disability.
- People with disability who come from culturally and linguistically diverse (CALD) backgrounds are more likely to need assistance across a range of activities, including self-care, mobility, health care, and home-care tasks such as property maintenance or chores. At the same time, non-CALD people with disability are more likely to need assistance with cognitive or emotional tasks than people with disability from CALD backgrounds (AIHW analysis of ABS 2024c).

**Figure ACTIVITIES.2: Activities where assistance is needed, for people with disability living in households, by activity and selected characteristics, 2022**



n.p. = not published. \*ABI = acquired brain injury. \*\*CALD = culturally and linguistically diverse.  
 Source: AIHW analysis of ABS 2024c. Data tables: Activities people need assistance with, Tables ACT12-ACT17.  
<https://www.aihw.gov.au>

**Notes:**

1. The numbers reported in this chart are based on the maximum of 10 activities. Not all activities are applicable to all people with disability. Data on need for assistance with health care are not collected for people under 5, and data on need for assistance with reading or writing, household chores, private transport, property maintenance, and meal preparation are not collected for people under 15.
2. People with disability status other than severe or profound, by definition, have no need for assistance with and no data reported for core activities (self-care, mobility, and communication).
3. The CALD cohort includes people born outside of main English-speaking countries and people who mainly speak a language other than English at home.

**Source:** AIHW analysis of ABS 2024b. **Data tables:** Activities people need assistance with, Tables ACT12-ACT17.

**Key takeaways from Figure ACTIVITIES.2**

Needs for assistance with specific activities vary among people with disability depending on disability characteristics and demographic factors such as age, sex, and cultural diversity.

## Schooling and employment restrictions

### What is an employment or schooling restriction?

Having a schooling or employment restriction means a person with disability experiences some degree of difficulty, requires the assistance of another person, or needs aids or special equipment to participate in education or employment.

In 2022, 1 in 2 (51%, or 2.7 million) people with disability aged 5 and over living in households had a schooling or employment restriction. This was higher for those aged under 65 (67%, or 2.1 million) than for those aged 65 and over (28%, or 599,000) (AIHW analysis of ABS 2024c).

For people with disability aged 5–64 living in households:

- those with severe or profound disability were more likely to have schooling or employment restrictions – 89% (or 909,000) compared with 56% (or 1.2 million) of those with other disability status
- males and females had similar rates of restriction – 68% (or 1.0 million) of males and 65% (or 1.0 million) of females
- among people with psychosocial disability, 84% (or 985,000) had a schooling or employment restriction, as did 84% (or 688,000) of people with learning and understanding disability (AIHW analysis of ABS 2024c).

### Where can I find out more?

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022.](#)

## References

ABS (Australian Bureau of Statistics) (2024a) *Disability, ageing and carers, Australia: summary of findings, 2022*, ABS, accessed 6 November 2025.

ABS (2024b) *Disability, ageing and carers, Australia: summary of findings methodology, 2022*, ABS, accessed 8 April 2026.

ABS (2024c) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia*, ABS, AIHW analysis of detailed microdata, accessed 11 February 2025.

## Use of aids

### Key findings

- **How many people use aids:** Just over half (54%, or 3.0 million) of people with disability use aids or equipment to assist with various activities of daily living.
- **Types of aids used:** The 2 most common types of aids are communication aids and medical aids to manage health conditions (used by 24% and 23%, respectively, of people with disability living in households).
- **Unmet need for aids:** While most (78%) people with disability living in households do not have unmet needs for aids or equipment, 7.4% do, and the remaining 15% are not sure.

People with disability may use various aids and technologies to help them carry out the tasks of daily living and to fully participate in the community, in work, and in social life. Aids can range from low tech mobility equipment and tools to advanced technologies. They are collectively designed to enhance self-care and independence, safety and participation in everyday activities.

It is important to understand who uses aids and for what purpose to get insights into the diversity of support needs across the disability community, and to understand unmet needs.

### Data note

Data on this page are sourced from the Australian Bureau of Statistics (ABS) **2022 Survey of Disability, Ageing and Carers (SDAC)**. More information about the SDAC, including the concepts of disability, disability groups, and remoteness categories used by the SDAC can be found in '[Data sources](#)'.

## Who uses aids

In 2022, just over half (54%, or 3.0 million) of people with disability were using aids or equipment to assist with various activities of daily living. The proportions using aids were much higher among people with disability living in cared accommodation; 94% (or 170,000) of people with disability in cared accommodation used aids or equipment. This compares with 53% (or 2.8 million) of people with disability of all ages living in households (AIHW analysis of ABS 2024).

The remainder of this section focuses on the use of aids by people with disability living in households.

For people with disability living in households, use of aids and equipment was higher among those aged 65 and over. Almost 3 in 4 (74% or 1.6 million) people with disability in this age group used aids, compared with 39% (or 1.2 million) of those aged under 65 (Figure AIDS.1).

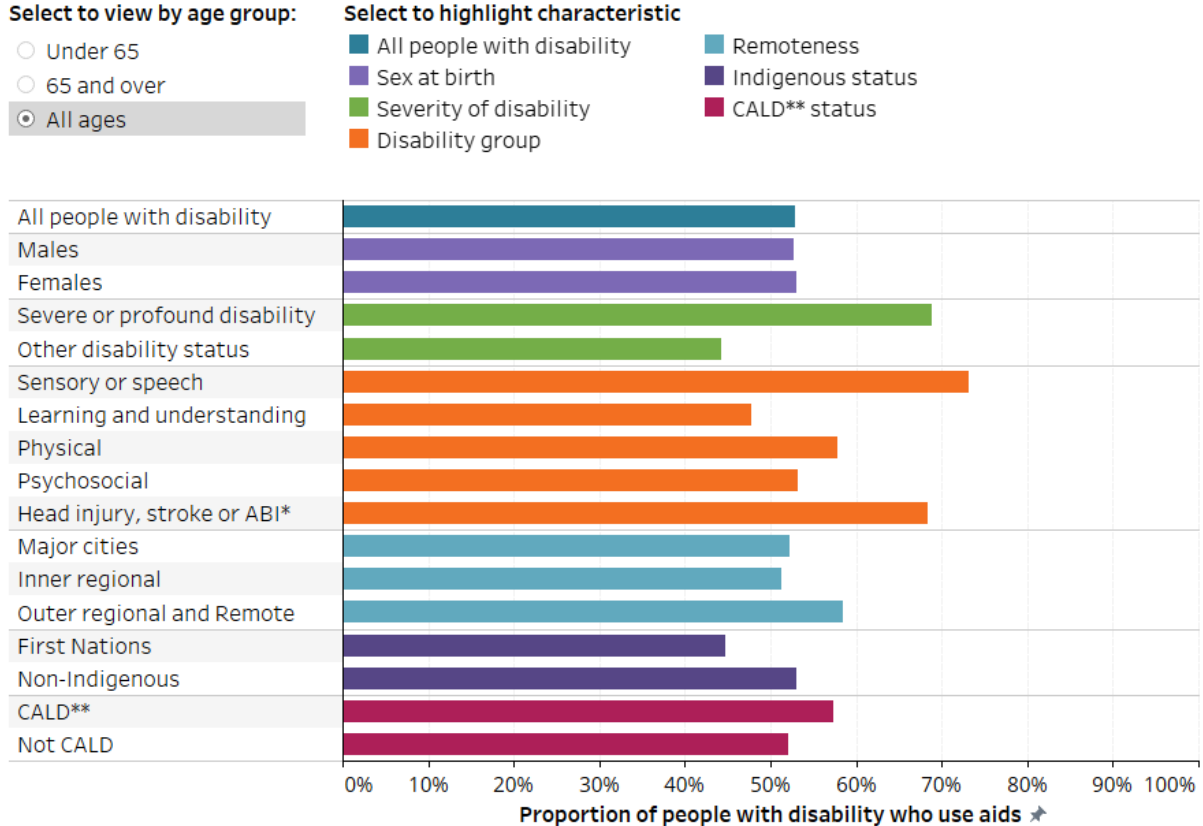
Among younger people with disability (aged under 65) living in households, use of aids and equipment was higher for:

- people with severe or profound disability – 56% (or 606,000) of people with severe or profound disability aged under 65 used aids or equipment, compared with 30% (or 626,000) of those with other disability status in this age group
- people with sensory or speech disability, and those with disability related to head injury, stroke or acquired brain injury – 54% (or 424,000) and 60% (or 108,000), respectively, were using aids or equipment, compared with 39% for all people with disability in this age group
- people living in *Outer regional or Remote areas* – 46% (or 171,000) of people in these areas used aids, compared with 37% (or 263,000) in *Inner regional areas* and 38% (or 797,000) in *Major cities* in this age group
- people from CALD backgrounds – 41% (or 172,000) in the CALD group were using aids, compared with 38% (or 1.1 million) in the non-CALD group (Figure AIDS.1; AIHW analysis of ABS 2024).

Among older people with disability (aged 65 and over), use of aids and equipment was slightly higher among men. More than 3 in 4 (76%, or 772,000) men with disability were using aids, compared with 73% (or 799,000) of women with disability in this age group (Figure AIDS.1).

First Nations people with disability are less likely to use aids or equipment than non-Indigenous people with disability. More than half (53%, or 2.7 million) of non-Indigenous people were using aids, compared with 45% (or 83,000) of First Nations people (Figure AIDS.1).

**Figure AIDS.1: Proportion of people using aids or equipment, for people with disability living in households, by age group and selected characteristics, 2022**



n.p. = not published. \*ABI = acquired brain injury. \*\*CALD = culturally and linguistically diverse.  
 Source: AIHW analysis of ABS 2024. Data tables: Use of aids, Tables AIDS2–AIDS7.  
<https://www.aihw.gov.au>

**Note:** Data for 65 and over age group by Indigenous status are not published due to concerns over data quality.

**Source:** AIHW analysis of ABS 2024. [Data tables:](#) Use of aids, Tables AIDS2–AIDS7.

**Key takeaways from Figure AIDS.1**

Among people with disability living in households, use of aids and equipment is higher for:

- people aged 65 and over
- people with severe or profound disability
- people with sensory or speech disability, or disability caused by head injury, stroke or acquired brain injury
- non-Indigenous people and people from culturally and linguistically diverse backgrounds.

## **Types of aids used**

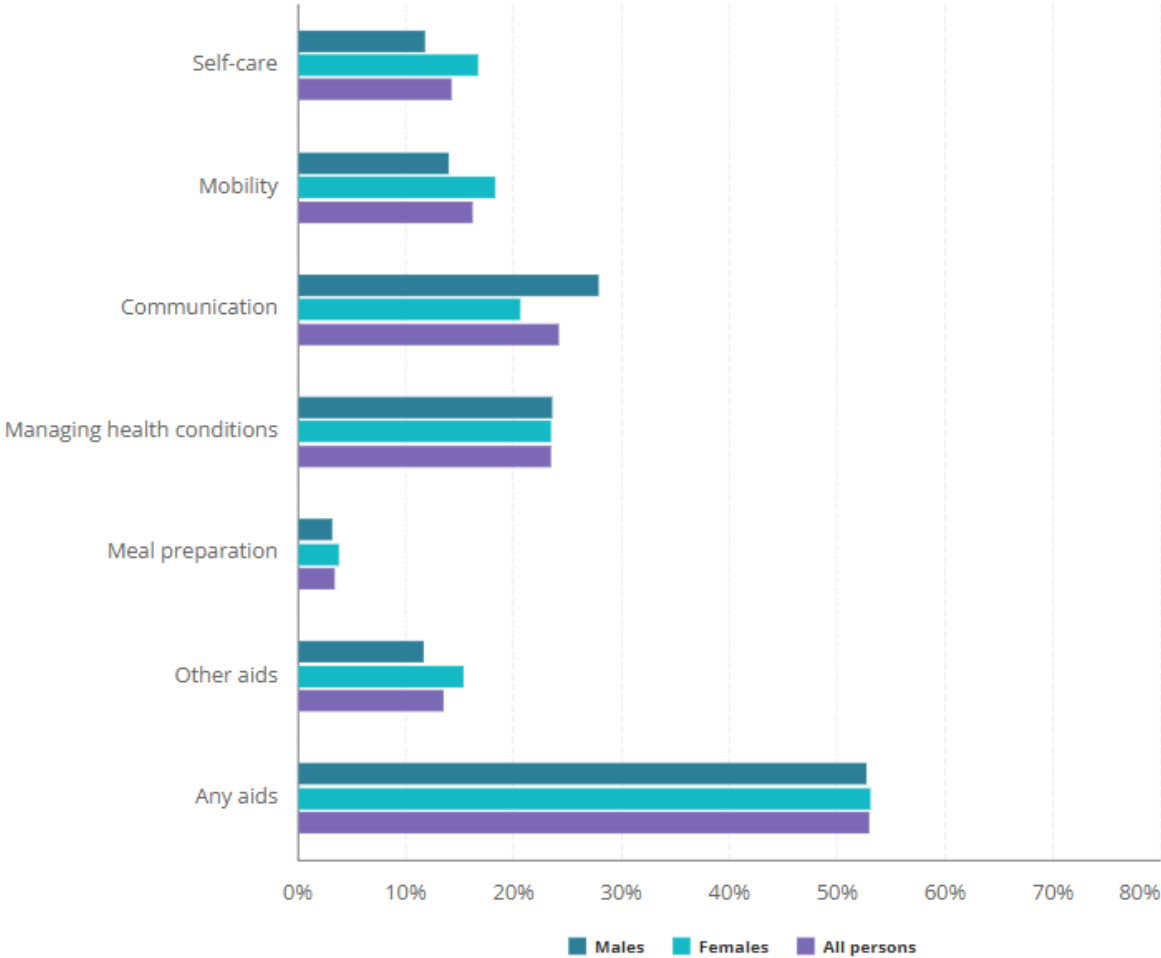
For people with disability living in households, the 2 most common types of aids used are communication aids and medical aids to manage health conditions (Figure AIDS.2). These types of aids are used by 24% (or 1.3 million) and 23% (or 1.2 million) of people with disability, respectively. Other common types of aids are aids to assist with mobility tasks (used by 16%, or 861,000 people) and self-care aids (used by 14%, or 755,000 people) (AIHW analysis of ABS 2024).

Among aids to assist with mobility tasks, the most common types are aids that help moving around in places away from home. These aids are used by 12% (or 625,000) of all people with disability living in households. As for self-care aids, these are most often used to help with showering or bathing – by 9.8% (or 521,000) of people with disability living in households (AIHW analysis of ABS 2024).

Use of most types of aids increases with age. People with disability aged 65 and over (and living in households) are generally two or more times likely to use specific aids than those aged under 65. One exception is aids for meal preparation, which are used at similar rates by the two age groups (Figure AIDS.2).

**Figure AIDS.2: Types of aids used by people with disability living in households, 2022**

Select view:  Sex at birth  Age group  Disability status



Source: AIHW analysis of ABS 2024. Data tables: Use of aids, Tables AIDS2–AIDS7.

**Key takeaways from Figure AIDS.2**

Use of different types of aids differs by:

- age – people aged 65 and over are more likely to use various types of aids
- sex – males are more likely to use communication aids, while females are more likely to use aids for mobility and self-care tasks
- support needs – people with severe or profound disability are more likely to use various types of aids.

The use of different types of aids also varies by sex (Figure AIDS.2). Females are more likely to use mobility or self-care aids (18% and 17%, respectively) compared with males (14% and 12%, respectively). At the same time, males are more likely to use communication aids than females (28% compared with 21%) (AIHW analysis of ABS 2024). This is likely related to different types of disability being more common among males and females, especially in the older age groups. As reported in 'Disability group' and 'Disability type' sections of this report, from about age 55 women are more likely to have physical disability than men, while men are more likely to have sensory or speech disability (specifically, hearing impairment) than women.

People with severe or profound disability are much more likely to use any specific types of aids than people with less severe forms of disability (Figure AIDS.2). The differences are particularly large for aids and equipment to help with mobility tasks and self-care aids. Aids for mobility tasks are used by 35% of people with severe or profound disability, compared with 6.1% of people with other disability status. Aids for self-care are used by 31% of people with severe or profound disability and 5.5% of people with other disability status (AIHW analysis of ABS 2024).

Use of communication aids is particularly common among people with sensory or speech disability. This is especially the case for people aged 65 and over with this disability, of whom 74% use communication aids. Use of aids to assist with mobility and self-care is particularly common for people who have disability associated with head injury, stroke or acquired brain injury. Among people with this disability, 35% use aids to assist with mobility tasks and 29% use self-care aids (AIHW analysis of ABS 2024).

As reported in the previous section, the overall use of aids is higher for non-Indigenous people with disability, and people with disability living in *Outer regional or Remote* areas. However, there are no differences in the use of specific types of aids depending on remoteness. There appear to be higher rates of use of communication aids and medical aids to manage health conditions among non-Indigenous people with disability compared with First Nations people. However, due to smaller sample size for First Nations people with disability, it is not possible to confirm this finding statistically.

People with disability from CALD backgrounds are more likely than those in the non-CALD group to use aids for:

- mobility tasks – 19% of people from CALD backgrounds and 16% in the non-CALD group use these aids
- communication – 27% and 24% in each group
- medically managing their health conditions – 29% and 22% in each group (AIHW analysis of ABS 2024).

## **Mobility aids**

About 1 in 6 (18%, or 968,000) people with disability use mobility aids such as walking frames or sticks, wheelchairs, or canes (AIHW analysis of ABS 2024). Earlier sections refer to aids for mobility tasks. Mobility aids are one type of aids for mobility tasks; others include non-mobility aids such as grab rails.

Use of mobility aids is much more common among people with disability living in cared accommodation. About 8 in 10 (79%, or 143,000) people with disability in cared accommodation use mobility aids, compared with 16% (or 823,000) of those living in households. Females are more likely to use mobility aids than males (20% and 14%, respectively). Finally, the use of mobility aids is more common among people aged 65 and over, at 29%, compared with 9.7% of those aged under 65 (AIHW analysis of ABS 2024).

The most commonly used mobility aids are:

- walking frames (used by 7.3% of all people with disability)
- walking sticks (6.2%)
- wheelchairs – mostly manual (used by 3.5% of all people with disability) but also electric (0.7% of people with disability)
- technology aids to reduce movement around home or residence (3.5% of all people with disability) (AIHW analysis of ABS 2024).

For people with disability living in cared accommodation, the most commonly used mobility aids are walking frames, manual wheelchairs, and lifting machines or hoists (used by 47%, 42% and 28%, respectively) (AIHW analysis of ABS 2024).

## **Communication aids**

About 1 in 4 (25%, or 1.3 million) people with disability use communication aids. This type of aids includes hearing aids or technology to assist with speaking, reading, or writing (AIHW analysis of ABS 2024).

People with disability living in cared accommodation are much more likely to use communication aids than for those living in households, although the difference is not as large as for mobility aids. About 4 in 10 (38% or 69,000) people with disability in cared accommodation use communication aids, compared with 24% (1.3 million) of those living in households. Males are more likely than females to use communication aids (28% and 21%, respectively). People aged 65 and over are also more likely to use these aids than people under 65 (38% and 15%, respectively) (AIHW analysis of ABS 2024).

The most commonly used type of communication aids is hearing aids. These are used by 1 in 6 (17%, or 930,000) people with disability. Men aged 65 and over are particularly likely to use hearing aids (40% or 431,000), although the use of hearing aids is also common for women in this age group (27% or 320,000) (AIHW analysis of ABS 2024).

High technology communication aids have become more common in the recent years. The data about the use of this type of aids have been collected for the first time in 2022. About 3.2% (or 177,000) of people with disability use high technology aids to assist with reading or writing, and 2.9% (or 161,000) use high technology aids to assist with speaking (AIHW analysis of ABS 2024).

## Unmet need for aids

Of all people with disability living in households, 7.4% (or 392,000) have unmet need for aids. This means they need more aids or equipment than they have. A further 78% (or 4.1 million) do not need more aids, and the remaining 15% (or 791,000) are not sure (AIHW analysis of ABS 2024).

The unmet need for aids is slightly higher for people aged 65 and over (8.2% or 173,000) than for those aged under 65 (6.8% or 218,000). People with severe or profound disability are much more likely to have unmet need for aids (13% or 247,000) than people with less severe forms of disability (4.2% of 144,000) (AIHW analysis of ABS 2024).

The rates of unmet need for aids are similar for people living in *Major cities, Inner regional areas, and Outer regional and Remote areas*. The rate of unmet need is also similar for First Nations and non-Indigenous people with disability. However, people with disability from CALD backgrounds are more likely than those in the non-CALD group to have unmet need for aids. About 1 in 10 (9.4%, or 78,000) people with disability from CALD backgrounds need more aids than they have, compared with 7.0% (or 315,000) in the non-CALD group. People from CALD backgrounds are also more likely to be unsure as to whether they need more aids, at 19% (or 159,000) compared with 14% (or 631,000) (AIHW analysis of ABS 2024).

The most common type of aids with unmet need are aids to assist with mobility tasks, followed by self-care aids. Overall, 2.7% (or 142,000) of people with disability living in households need more aids to assist with mobility, and 1.8% (or 94,000) need more aids to assist with self-care (AIHW analysis of ABS 2024).

### Where can I find out more?

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022](#).

### References

ABS (Australian Bureau of Statistics) (2024) [Microdata: disability, ageing and carers, Australia](#), ABS, AIHW analysis of detailed microdata, accessed 8 April 2025.

# Disability-free life expectancy

## Key findings

- **At birth:** Girls born in 2022 can expect to live 25% (22 years) of their overall life expectancy with disability. Boys born in 2022 can expect to live 24% (20 years) of their overall life expectancy with disability.
- **At age 65 – men:** Men aged 65 in 2022 can expect to live 56% (11 years) of their remaining lives with disability.
- **At age 65 – women:** Women aged 65 in 2022 can expect to live 56% (13 years) of their remaining lives with disability.

People in Australia are living longer. How healthy people are in older age matters for overall population health and for the health and care systems.

This section looks at how long people are living in Australia and how this has changed in recent years. It also looks at how many of those years people can expect to live with and without disability.

It is important to understand that disability does not equate to poor health or illness, although a person may have disability and have poor health. Years lived with disability are not less important than years lived without disability. For example, someone may have poor health when a condition first develops, but once it is stable, they may be in good health, especially with the right supports and opportunities to take part in daily life. Disability can also be a positive part of identity, community and belonging.

This part of the report aims to improve understanding of how disability, health, ageing and support needs are experienced across the population. It is intended to inform policy, service design and resource allocation. It should not be read as judging the value of lives lived with disability.

This section should be read with other parts of the report that show the wide range of disability experiences. These include how disability can occur alongside long-term health conditions, pain, changes in ability or movement, ageing, and the need for care and support. Understanding this helps governments plan policies and services that support people's wellbeing, independence, participation, and ability to live as healthily as possible throughout their lives.

## How do we measure life expectancy?

Life expectancy is a common way to measure and assess the population's overall health. It is expressed as the:

- number of years a newborn baby is expected to live, or
- expected years of life remaining for a person at a given age.

Life expectancy is estimated from population death rates. It is the expected number of years of life left for a person at a particular age if death rates do not change. More information on life expectancy can be found in [AIHW life expectancy and deaths](#).

This section also presents 4 measures of how many years, out of their total life expectancy, a person can expect to live:

- with disability
- with severe or profound disability (a subset of years of life with disability)
- without severe or profound disability
- without disability (a subset of years of life without severe or profound disability).

These estimates have been calculated using the Sullivan Method (Sullivan 1971). This method calculates the average number of remaining years, at a particular age, a population can expect to live with or without disability.

More information can be found in [AIHW Life expectancy and disability in Australia: appendixes A–C](#).

## Data note

Life expectancy estimates on the page were calculated by the AIHW. In calculating these numbers, several data sources were used. For historic data (2003 to 2018), unpublished ABS abridged life tables were used with unpublished age- and sex-specific disability prevalence rates from the Australian Bureau of Statistics (ABS) **Survey of Disability, Ageing and Carers (SDAC)**. For the latest data (2022), publicly available ABS life expectancy numbers were used together with the ABS SDAC detailed microdata.

More information about the SDAC, including the concepts of disability, disability groups, and remoteness categories used by the SDAC can be found in '[Data sources](#)'.

## At birth

Boys born in 2022 can expect to live an average of around 81 years. Of this time, an estimated:

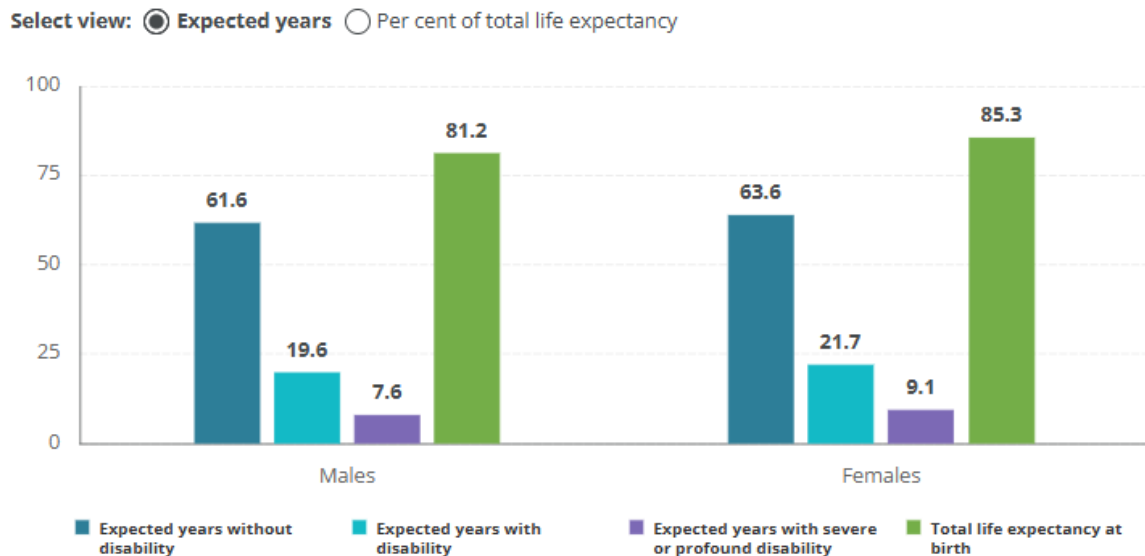
- 62 years will be lived free of disability
- 20 years will be with disability, including around 7.6 years with severe or profound disability (Figure LIFE EXPECTANCY.1).

Girls born in 2022 can expect to live an average of around 85 years. Of this time, an estimated:

- 64 years will be lived free of disability
- 22 years will be with disability, including around 9.1 years with severe or profound disability (Figure LIFE EXPECTANCY.1).

For people born in 2022, this equates to living around one-quarter of their life with disability (24% for males and 25% for females) (Figure LIFE EXPECTANCY.1).

**Figure LIFE EXPECTANCY.1: Expected years with and without disability and total life expectancy, by sex at birth, for people born in 2022**



**Source:** AIHW analysis of ABS 2019a, 2019b, 2023, and 2024. **Data tables:** Disability-free life expectancy, Table DFLE1.

## At age 65

Focusing on health expectancy at age 65 is a useful measure for monitoring healthy ageing within the population.

Men aged 65 in 2022 can expect to live, on average, another:

- 8.9 years without disability (Figure LIFE EXPECTANCY.3)
- 11 years with disability, including around 4.6 years with severe or profound disability (Figure LIFE EXPECTANCY.4).

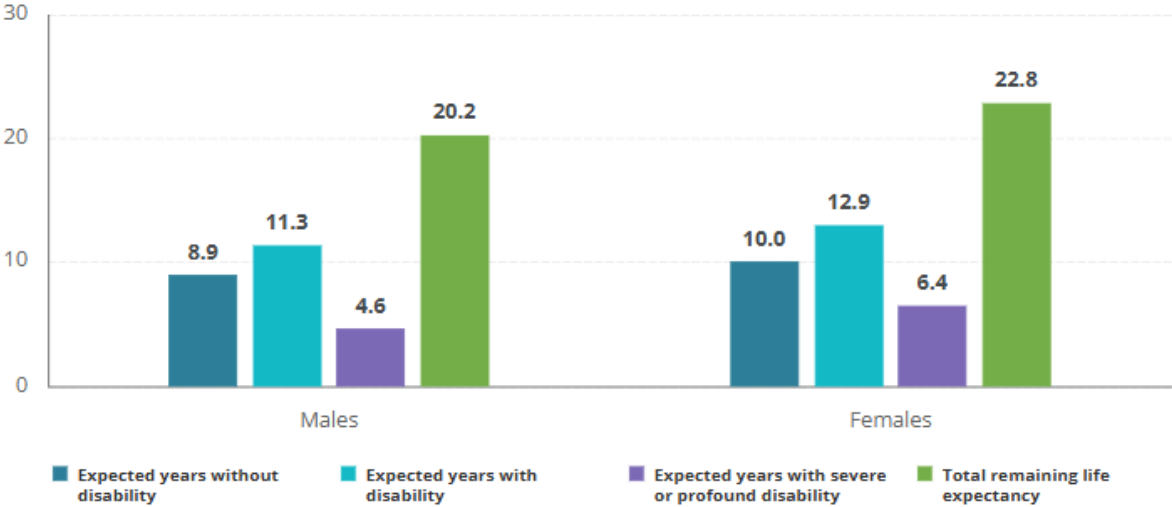
Women aged 65 in 2022 can expect to live, on average, another:

- 10 years without disability (Figure LIFE EXPECTANCY.3)
- 13 years with disability, including around 6.4 years with severe or profound disability (Figure LIFE EXPECTANCY.4).

For people aged 65 in 2022 this equates to living just over half of their remaining lives with some level of disability (56% for both men and women).

**Figure LIFE EXPECTANCY.2: Expected years with and without disability and total remaining life expectancy, by sex at birth, for people aged 65 in 2022**

Select view:  Expected years  Per cent of total remaining life expectancy



Source: AIHW analysis of ABS 2019a, 2019b, 2023, and 2024. Data tables: Disability-free life expectancy, Table DFLE2.

**Throughout life and over time**

As individuals age, the number of years they can expect to live without disability reduces. Over time, however, the number of estimated years living without disability at any age has increased for men and women (Figure LIFE EXPECTANCY.3).

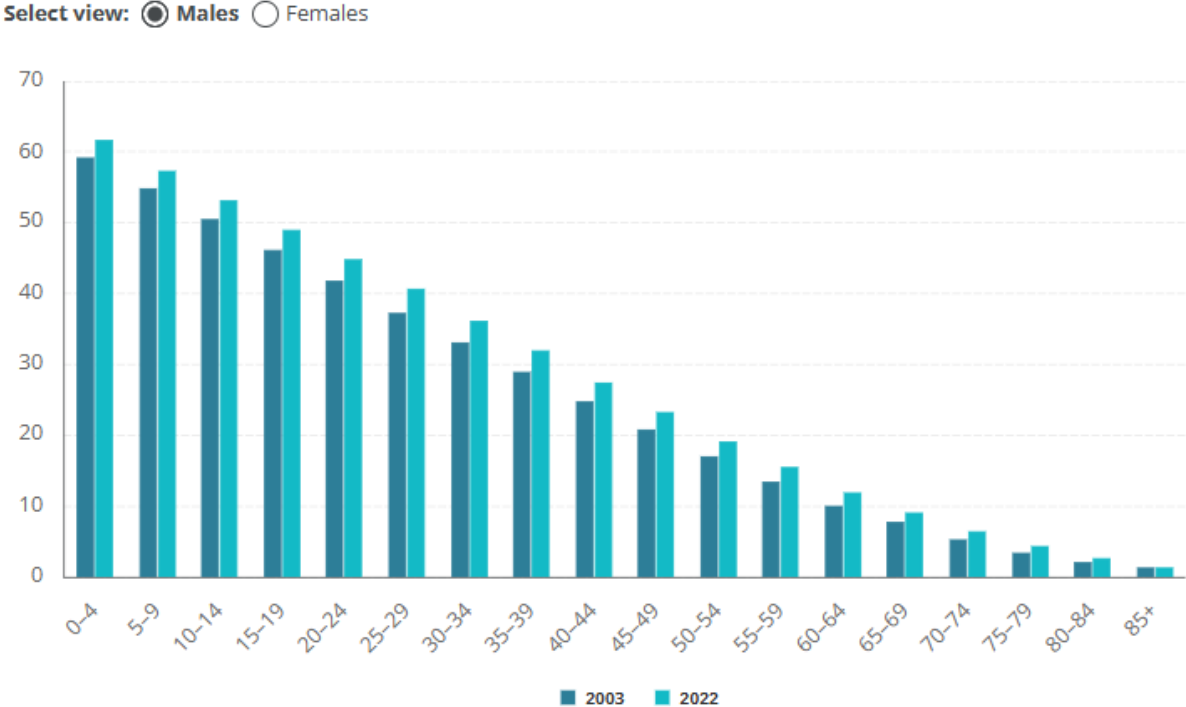
Men aged:

- 25–29 in 2003 can expect to live an additional 37 years without disability, increasing to 40 years for men of that age in 2022
- 50–54 in 2003 can expect to live an additional 17 years without disability, increasing to 19 years for men of that age in 2022
- 75–79 in 2003 can expect to live an additional 3.3 years without disability, increasing to 4.2 years for men of that age in 2022.

Women aged:

- 25–29 in 2003 can expect to live an additional 40 years without disability, increasing to 42 years for women of that age in 2022
- 50–54 in 2003 can expect to live an additional 18 years without disability, increasing to 20 years for women of that age in 2022
- 75–79 in 2003 can expect to live an additional 4.0 years without disability, increasing to 4.8 years for women of that age in 2022.

**Figure LIFE EXPECTANCY.3: Expected years without disability, in 2003 and 2022, by age group and sex at birth**



**Source:** AIHW analysis of ABS 2019a, 2019b, 2023, and 2024. **Data tables:** Disability-free life expectancy, Table DFLE3.

### Sex gap in life expectancy

Females generally have a longer life expectancy. They can expect to live longer with and without disability compared to males.

**Sex gap in life expectancy**

Sex gap in life expectancy is the difference in life expectancy for males and females. It is calculated by subtracting expected years of life for males from expected years for females. Positive gap means that females have longer life expectancy, and negative gap means that males have longer life expectancy.

The sex gap in total life expectancy has narrowed between 2003 and 2022, indicating greater gains in life expectancy for males than for females over this period:

- for example, females who were 0–4 years in 2003 can expect to live 5 years longer than males, while females aged 0–4 in 2022 can expect to live 4 years longer than males. This indicates that the sex gap in life expectancy has decreased by 1 year for this age group (Figure LIFE EXPECTANCY.4).

The sex gap in the expected years without disability has also narrowed during this time:

- for example, females who were 0–4 years in 2003 can expect to live without disability for 3 more years than males. Females aged 0–4 in 2022 can expect to live

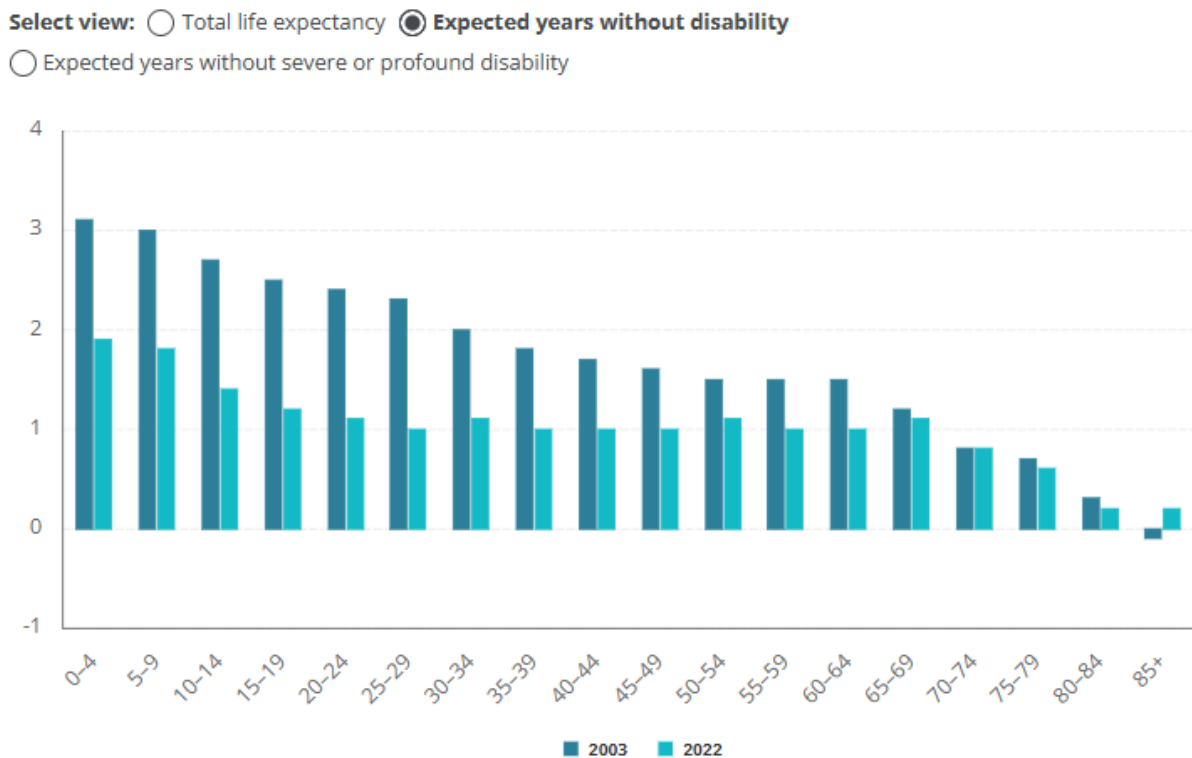
without disability for 2 more years than males. This indicates that the sex gap in expected years without disability has decreased by 1 year for this age group (Figure LIFE EXPECTANCY.4).

However, the sex gap in expected years without severe or profound disability has somewhat increased:

- for example, females who were 0–4 years in 2003 can expect to live without severe or profound disability 2.2 more years than males. Females aged 0–4 in 2022 can expect to live without severe or profound disability 2.5 more years than males. This indicates that the sex gap in expected years without severe or profound disability has increased by 0.3 years for this age group (Figure LIFE EXPECTANCY.4).

This last finding is likely the result of changes in prevalence of severe or profound disability, depending on sex and age group.

**Figure LIFE EXPECTANCY.4: Sex gap in life expectancies, by age group, 2003 and 2022**



**Note:** Sex gap in life expectancy is calculated by subtracting expected years for males from expected years for females. Positive numbers indicate longer life expectancy for females, and negative numbers indicate longer life expectancy for males.

**Source:** AIHW analysis of ABS 2019a, 2019b, 2023, and 2024. [Data tables:](#) Disability-free life expectancy, Table DFLE3.

## Where can I find out more?

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022](#).
- [AIHW Disability-free life expectancy](#).

## References

ABS (Australian Bureau of Statistics) (2019a) *Life Tables 2001–2003, 2007–2009, 2010–2012, 2013–2015 and 2016–2018*, ABS, AIHW analysis of unpublished customised data request, accessed 18 December 2019.

ABS (2019b) *Survey of Disability, Ageing and Carers 2003, 2009, 2012, 2015 and 2018*, ABS, AIHW analysis of unpublished customised data request, accessed 16 December 2019.

ABS (2023) *Life expectancy, 2020–2022*, ABS, AIHW analysis of 'Table 1.9 Life Tables, Australia, 2020–2022', accessed 1 April 2025.

ABS (2024) *Microdata: disability, ageing and carers, Australia*, ABS, AIHW analysis of detailed microdata, accessed 8 April 2025.

Sullivan DF (1971) 'A single index of mortality and morbidity', *Health Services and Mental Health Administration Health reports*, 86(4):347–354, accessed 5 May 2022.

# Health

Disability and health have a complex relationship. Long-term health conditions might lead to disability, and disability can contribute to health problems. Disability may affect a person's health by limiting access to and participation in social and physical activities. Health outcomes of people with disability may also be affected by disadvantage or inequality in social determinants of health, such as education, employment, social support, or housing. More information about social determinants of health is available in [Social determinants of health](#) in [Australia's health](#), or in the 'Summary' of this report.

In general, people with disability report poorer general and mental health and higher levels of bodily pain than people without disability. People with disability also have higher rates of some modifiable health risk factors and behaviours, such as obesity and smoking, than people without disability.

This chapter explores aspects of health for people with disability, including health status, health risk factors and behaviours, chronic conditions, use of health services, and barriers to accessing health services.

## Key findings

1. **Good health:** In 2022, 32% of adults (aged 18+) with disability rated their health as excellent or very good, compared with 69% of those without disability.
2. **Psychological distress:** In 2022, 27% of adults with disability experienced high or very high levels of psychological distress, compared with 6.7% of those without disability.
3. **Daily smoking:** In 2022, 14% of adults with disability were smoking daily, compared with 8.7% of those without disability.
4. **Health conditions and disability:** Having a chronic health condition is often associated with disability. In 2022, 58% of people with arthritis as their main condition had disability.
5. **Cost as barrier to health care:** In 2022, 46% of people with disability who did not see a dental professional when needed said cost was the main reason.
6. **Coordination of care:** In 2022, 47% of people with severe or profound disability saw 3 or more health professionals for the same condition.

## Reporting on health and wellbeing of people with disability for Australia's Disability Strategy

[Australia's Disability Strategy 2021–2031](#) (the Strategy) is Australia's national disability policy framework. It sets out a plan for continuing to improve the lives of people with disability in Australia over the 10 years to 2031.

The Strategy is supported by an [Outcomes Framework](#). The Outcomes Framework is a key initiative under the Strategy to measure, track and report on the outcomes for people with disability across 7 outcome areas.

One of these outcome areas is [Health and wellbeing](#). This outcome area is about making it easier for people with disability to get good health care and services when they need it. It includes 4 priorities with a total of 12 measures that are used to track what changes over time (10 of which currently have reportable data and 2 require [future data development](#)):

- Health and wellbeing priority:
  - [Potentially avoidable deaths](#): Number of potentially avoidable deaths in hospital for people receiving government disability supports (**238 per 100,000** in 2021–22), compared with people who do not receive these supports (**33 per 100,000** in 2021–22)
  - [Community health care satisfaction](#): Proportion of people with disability who are satisfied with the quality of care provided by community allied health care sector (**89%** in 2024)
  - [Self-reported health](#): Proportion of people with disability who reported excellent, very good or good health (**68%** in 2022), compared with people without disability (**95%** in 2022)
- Prevention and early intervention priority:
  - [GP-type emergency presentations](#): Number of GP-type emergency department presentations for people receiving government disability supports (**17,608 per 100,000** in 2021–22)
  - [Medical facility accessibility](#): Proportion of people with disability with difficulty accessing medical facilities (GP, dentist, hospital) (**11%** in 2022; restricted to people with disability who have challenges with mobility or communication)
  - [Access to preventive health care](#): Proportion of people with disability who accessed preventive and early intervention health care services without difficulty in the last 12 months (**66%** in 2024), compared with people without disability (**82%** in 2024)
- Mental health priority:
  - [Involuntary hospital admissions](#): Number of involuntary hospital admissions per 100,000 people receiving government disability supports (**1,841** in 2021–22)
  - [High psychological distress](#): Proportion of adults (aged 18 and over) with disability with high or very high levels of psychological distress (**31%** in 2022)
  - [NDIS participants life satisfaction](#): Proportion of NDIS participants who report feeling satisfied about their life as a whole (**56%** in 2024–25)
  - Acute mental health restraint use: Rates of restraint of people with disability in acute mental health hospital services (future data development)
- Emergency responses priority:
  - [Accessing emergency services](#): Proportion of people with disability reporting satisfaction in the accessibility of emergency, disaster preparedness and response information and services (**86%** in 2024)

- Inclusive disaster management: Proportion and number of disaster management services that have disability inclusive plans in place (future data development).

**Note:** numbers in this summary box and on the [Reporting on Australia's Disability Strategy 2021-2031](#) website may be different from numbers reported elsewhere in this report. This is because they come from different data sources or time periods.

# Health status

## Key findings

- **Good health:** In 2022, 32% of adults (aged 18+) with disability rated their health as excellent or very good, compared with 69% of those without disability.
- **Psychological distress:** In 2022, 27% of adults with disability experienced high or very high levels of psychological distress (6.7% without disability).
- **Bodily pain:** In 2022, 87% of adults with disability reported recently experiencing bodily pain, compared with 62% of those without disability.

One way to measure health and wellbeing is to ask people how they feel about their health, their state of mind and their life in general. This section looks at the health of Australians with disability based on survey tools such as:

- self-assessed health status
- Kessler Psychological Distress Scale (K10)
- bodily pain
- satisfaction with personal health and life in general.

This section also looks at how general health, pain, psychological distress, and life and health satisfaction vary for different groups of people with disability.

## Data note

Unless indicated otherwise, all findings in this section refer to 2022.

Data in this section are largely sourced from the Australian Bureau of Statistics (ABS) **National Health Survey (NHS) 2022**. More information about the NHS, including the concepts of disability, disability groups, and remoteness categories used by the NHS, can be found in '[Data sources](#)'.

The ABS **Survey of Disability, Ageing and Carers (SDAC)** also collects information on the health status of people with disability. It does not, however, collect this information for people without disability, so it cannot be used to compare outcomes of people with and without disability. Data using the SDAC 2022 are included in the supplementary data tables for reference. More information about SDAC can be found in '[Data sources](#)'.

**Living arrangements:** Reporting on self-perceived health status is restricted to people living in households (in private dwellings in the community).

## General health

People with disability generally report worse health than people without disability. Around 1 in 3 (32%) adults (people aged 18 and over) with disability consider their health excellent or very good, compared with more than 2 in 3 (69%) adults without disability.

This health gap has widened over the past decade. The proportion of adults with disability reporting excellent or very good health fell from 35% in 2011–12 to 32% in 2022. At the same time, the proportion of adults without disability in excellent or very good health rose from 66% to 69% (AIHW analysis of ABS 2024).

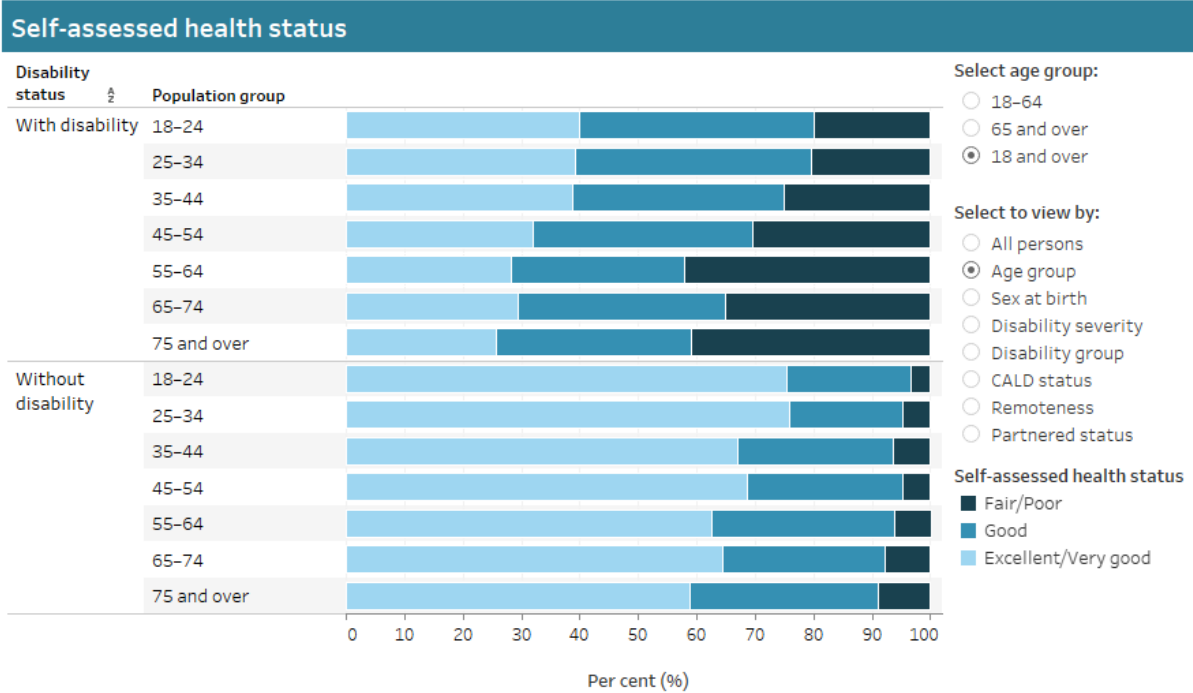
### Self-assessed health status

Self-assessed health status is a commonly used measure of overall health in which a person is asked to compare their own health with others around them.

The measure reflects a person's perception of their own health at a given point and provides a broad picture of a population's overall health. It has some limitations, including being influenced by factors such as a person's access to health services (for example, for diagnosis and treatment), and level of education.

In the ABS NHS, self-assessed health status is collected for people aged 15 and over against a 5-point scale from excellent to poor. The results presented in this report and accompanying supplementary data tables are in most cases limited to adults aged 18 and over.

**Figure STATUS.1: Self-assessed health status of adults, by disability status and selected characteristics, 2022**



\* Proportion has a high margin of error and should be used with caution.  
 CALD = culturally and linguistically diverse; ABI = acquired brain injury.  
 Source: AIHW analysis of ABS 2024. Data tables: Health status (ABS NHS 2022), Tables STAT2 and STAT3.  
<https://www.aihw.gov.au>

**Notes**

1. Restricted to people aged 18 and over living in households.
2. People from CALD backgrounds are defined as those born outside of main English-speaking countries, and those who mainly speak a language other than English at home.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.
4. Some categories are not shown due to small sample numbers and to protect confidentiality.

**Source:** AIHW analysis of ABS 2024. **Data tables:** Health status (ABS NHS 2022), Tables STAT2 and STAT3.

**Key takeaways from Figure STATUS.1**

1. People with disability tend to report worse general health than people without disability. For all adults (aged 18 and over), health declines with age.
2. Among people with disability, men, people from non-CALD backgrounds, people in a partnered relationship, and those with higher levels of education report better general health.
3. People with severe or profound disability and people with psychosocial disability tend to report worse general health than others with disability.

Adults with disability – especially those with severe or profound disability – are more likely to report fair or poor health than adults without disability:

- 1 in 3 adults with disability (33%) rate their health as fair or poor. This is around 6 times the rate for adults without disability (5.6%).
- 2 in 3 adults with severe or profound disability (68%) assess their health as fair or poor. This is more than twice the rate for adults with other disability status (28%) and around 12 times the rate for adults without disability (5.6%) (Figure STATUS.1).

Women with disability are slightly more likely to rate their health as fair or poor (35%) than men with disability (31%). Self-assessed health also varies among adults with disability by age, disability group, cultural background, partnered status, and education (Figure STATUS.1):

- 34% of adults with disability aged 18–64 rate their health as excellent or very good, compared with 28% among those aged 65 and over
- 32% of adults with sensory or speech disability rate their health as excellent or very good, compared with 19% of those with psychosocial disability, 22% of those with learning and understanding disability, and 26% of those with physical disability
- 23% of adults with disability from culturally and linguistically diverse (CALD) backgrounds rate their health as excellent or very good, compared with 34% among those from non-CALD backgrounds
- 35% of adults in a partnered relationship report excellent or very good health, compared with 28% of those without a partner
- 23% of adults with Year 10 or 11 as their highest level of education rate their health as excellent or very good, compared with 42% of those with a Bachelor degree or higher (ABS 2024).

### **Australia's Disability Strategy reporting**

Self-assessed general health is one of the measures reported under the Australia's Disability Strategy Outcomes Framework. It can be found in [Self-reported health](#) on [Reporting on Australia's Disability Strategy 2021–2031](#) website.

### **Aboriginal and Torres Strait Islander (First Nations) people**

The NHS was not used for health-related reporting for First Nations people, as it was not designed to collect a representative sample of First Nations people. The 2022–23 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) was used instead, as it includes these areas and communities.

In 2022–23 based on NATSIHS data, 56% of First Nations people with disability rated their health as excellent, very good or good. In comparison, 68% of non-Indigenous people with disability reported excellent, very good or good health in 2022 based on NHS data.

## Mental health

Psychological distress is an important indicator of the overall mental health of a population. Signs of psychological distress can include nervousness, agitation, psychological fatigue and depression. This report uses the Kessler Psychological Distress Scale (K10) as the measure of psychological distress. A person experiencing psychological distress will not necessarily be experiencing mental illness, however there is a strong correlation between higher scores on the K10 and the presence of depressive or anxiety disorders (Andrews and Slade 2001).

### **Kessler Psychological Distress Scale (K10)**

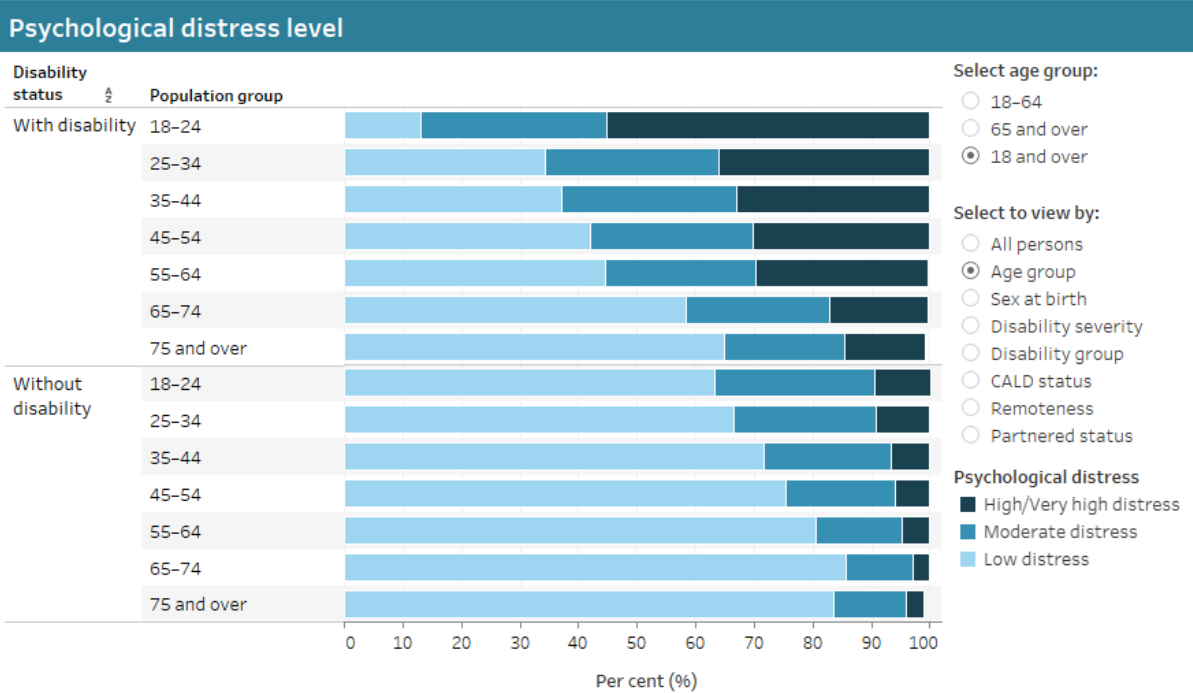
The Kessler Psychological Distress Scale (K10) is a set of 10 questions used to measure non-specific psychological distress in people. The questions ask about negative emotional states people may have experienced in the 4 weeks before their interview. K10 scores are grouped into 4 categories: 'low', 'moderate', 'high' and 'very high'. Higher levels of psychological distress indicate that a person may have, or is at risk of developing, mental health issues.

The ABS NHS collects K10 for people aged 18 and over, excluding interviews conducted with proxy respondents (where the selected respondent is not able to answer for themselves).

Low levels of psychological distress generally indicate that the person has little or no stress and is likely to be well. People with disability are less likely to have low distress levels than those without disability. Less than half (46%) of adults with disability have a low level of psychological distress, compared with almost three-quarters (73%) of adults without disability (AIHW analysis of ABS 2024).

The proportion of adults with low psychological distress level declined for both people with and without disability over the past decade, indicating an increase in psychological distress. For people with disability, the proportion who experience low distress fell from 56% in 2011–12 to 46% in 2022 (and from 79% to 73%, for people without disability) (AIHW analysis of ABS 2024).

**Figure STATUS.2: Psychological distress (K10 score) of adults, by disability status and selected characteristics, 2022**



\* Proportion has a high margin of error and should be used with caution.  
 CALD = culturally and linguistically diverse.  
 Source: AIHW analysis of ABS 2024. Data tables: Health status (ABS NHS 2022), Tables STAT4 and STAT5.  
<https://www.aihw.gov.au>

**Notes**

1. Restricted to people aged 18 and over living in households who were present at interview.
2. People from CALD backgrounds are defined as those born outside of main English-speaking countries, and those who mainly speak a language other than English at home.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.
4. Some categories are not shown due to small sample numbers and to protect confidentiality.

**Source:** AIHW analysis of ABS 2024. **Data tables:** Health status (ABS NHS 2022), Tables STAT4 and STAT5.

**Key takeaways from Figure STATUS.2**

1. People with disability tend to report higher levels of psychological distress than people without disability. Psychological distress is highest for young adults (aged 18–24).
2. Among adults with disability, psychological distress levels are higher for women, people who do not have a partner, those with lower levels of education and people who are not heterosexual.
3. People with severe or profound disability, and people with psychosocial or learning and understanding disability tend to report higher levels of psychological distress than others with disability.

In general, adults with disability (especially those with severe or profound disability) experience higher levels of psychological distress than those without disability (Figure STATUS.2):

- 27% of adults with disability experience high or very high psychological distress. This is 4 times as high as those without disability (6.7%).
- 45% of adults with severe or profound disability experience high or very high psychological distress, compared with 25% of those with other disability status (Figure STATUS.2).

Among adults with disability, high or very high levels of psychological distress are more likely to be experienced by (Figure STATUS.2):

- women with disability (32%), compared with men with disability (22%)
- younger adults with disability (34% of those aged 18–64), compared with those aged 65 and over (15%). The proportions experiencing high or very high psychological distress are even higher for people with disability aged 18–24, at 55%.
- adults aged 18–64 who do not have a partner (42%), compared with those who are married or in a de facto relationship (29%)
- adults aged 18–64 with lower levels of education. Four in 10 people whose highest level of education is Year 12 (42%) or Year 10/11 (39%) experience high or very high psychological distress. This compares with 26% of those with Bachelor degree or above (AIHW analysis of ABS 2024).
- adults aged 18–64 who are not heterosexual. Half (49%) of those who identify as gay, lesbian, bisexual, or different sexual orientation experience high or very high psychological distress, compared with one-third (33%) of those who identify as heterosexual (AIHW analysis of ABS 2024).

Among disability groups, high or very high psychological distress is most common for adults with:

- psychosocial disability (66%)
- learning and understanding disability (62%) (Figure STATUS.2).

The least likely to experience high or very high psychological distress are adults with:

- sensory or speech disability (25%)
- physical disability (29%) (Figure STATUS.2).

### **Australia's Disability Strategy reporting**

Psychological distress is one of the measures reported under the Australia's Disability Strategy Outcomes Framework. It can be found in [High psychological distress](#) on [Reporting on Australia's Disability Strategy 2021–2031](#) website. Please note that the website uses a different data source (2022 SDAC) to report on this measure.

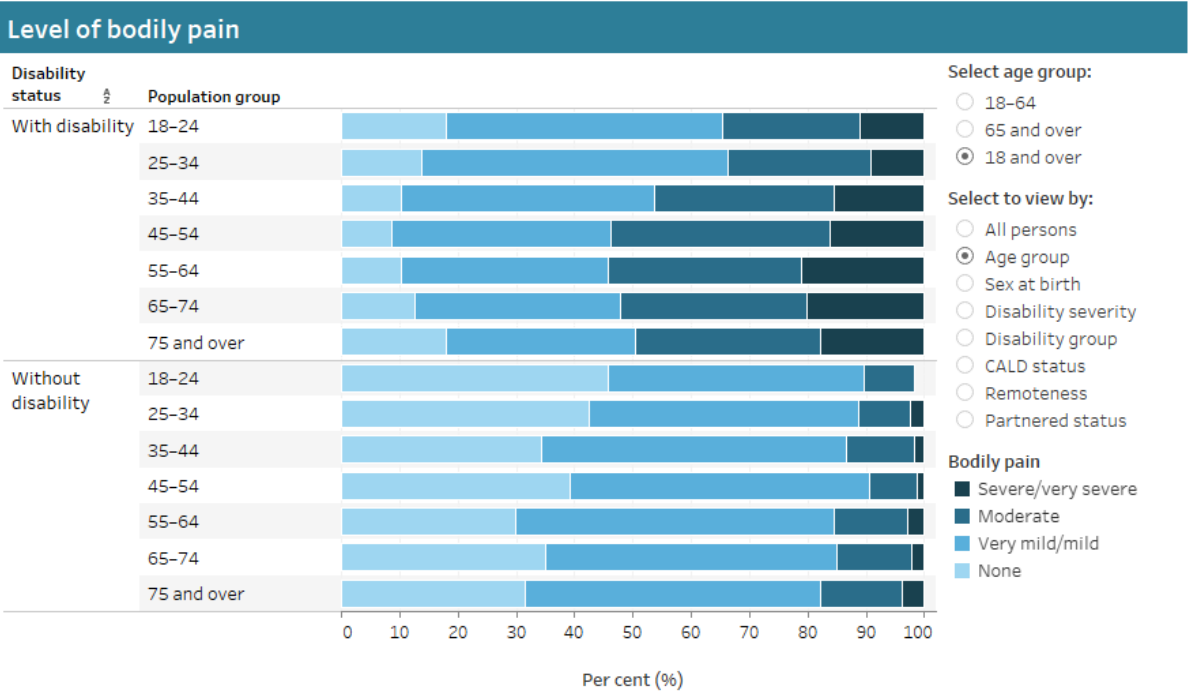
## **Bodily pain**

### **Bodily pain**

In addition to general health and mental wellbeing, the ABS NHS also collects information about bodily pain. Adult respondents aged 18 and over are asked to rate the intensity of physical and bodily pain they may have experienced during the past 4 weeks on a 6-point scale from none to very severe.

Adults with disability are more likely to have experienced any bodily pain (87%) within the last 4 weeks than those without disability (62%), and 8 times as likely to have experienced severe or very severe bodily pain (17% compared with 2.1%) (Figure STATUS.3).

**Figure STATUS.3: Bodily pain of adults, by disability status and selected characteristics, 2022**



\* Proportion has a high margin of error and should be used with caution.  
 CALD = culturally and linguistically diverse.  
 Source: AIHW analysis of ABS 2024. Data tables: Health status (ABS NHS 2022), Tables STAT8 and STAT9.  
<https://www.aihw.gov.au>

**Notes**

1. Restricted to people aged 18 and over living in households.
2. People from CALD backgrounds are defined as those born outside of main English-speaking countries, and those who mainly speak a language other than English at home.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.
4. Some categories are not shown due to small sample numbers and to protect confidentiality.

**Source:** AIHW analysis of ABS 2024. **Data tables:** Health status (ABS NHS 2022), Tables STAT8 and STAT9.

**Key takeaways from Figure STATUS.3**

1. People with disability report higher levels of bodily pain than people without disability.
2. Among adults with disability, bodily pain is highest for people aged between 45 and 74. Women report higher levels of pain than men.
3. People with severe or profound disability, and people with psychosocial or physical disability tend to report higher levels of bodily pain than others with disability.

Among adults with disability:

- those with severe or profound disability are 3 times as likely (41%) to have experienced severe or very severe bodily pain within the last 4 weeks as those with other disability status (14%)
- women are more likely (19%) to have experienced severe or very severe bodily pain than men (14%)
- 16% of those with sensory or speech disability have experienced severe or very severe bodily pain, 21% of those with learning and understanding disability, 22% of those with physical restriction, and 25% of those with psychosocial disability (Figure STATUS.3).

## Satisfaction with own health and life

### Data note

Data in this section are sourced from the **2021 Household, Income and Labour Dynamics in Australia (HILDA) Survey**. More information about HILDA, including the concepts of disability, disability groups, and remoteness categories used by HILDA can be found in '[Data sources](#)'.

### Satisfaction with aspects of life

Each year, the HILDA Survey participants are asked to rate their satisfaction with 8 aspects of their life on a 0–10 scale (10 represents the highest level of satisfaction and 0 the lowest):

1. the home in which they live
2. their employment opportunities
3. their financial situation
4. how safe they feel
5. feeling part of their local community
6. their health
7. the neighbourhood in which they live
8. the amount of free time they have.

Respondents are also asked how satisfied they are with their life overall.

In this report, people who indicated a satisfaction level between 8 and 10 are considered to be highly satisfied with that aspect of their life. This chapter looks at satisfaction with health and life overall, as a more general measure of wellbeing.

## Satisfaction with health

Based on 2021 HILDA data, almost 2 in 3 (65%) people aged 15 and over without disability are highly satisfied with their health. Among people with disability, less than 1 in 3 (29%) are highly satisfied (AIHW analysis of DSS and MIAESR 2022).

Satisfaction with health varies by age (Figure STATUS.4). People aged 15–24 with disability are the most likely to be highly satisfied (40%) and people aged 45–64 are the least likely (21%). People aged 65 and over with disability report relatively high satisfaction with their health (33% highly satisfied). This may be due to changing expectations of health with ageing, as declines in health may become more common and expected.

Of people with disability aged 15–64:

- males are more likely to be highly satisfied with their health (30%) than females (23%)
- those with severe or profound disability are less likely (14%) to be highly satisfied with their health than those with other disability status (28%)
- people with physical disability are less likely (18%) to be highly satisfied with their health than those with intellectual disability (37%) or sensory disability (31%) (AIHW analysis of DSS and MIAESR 2022).

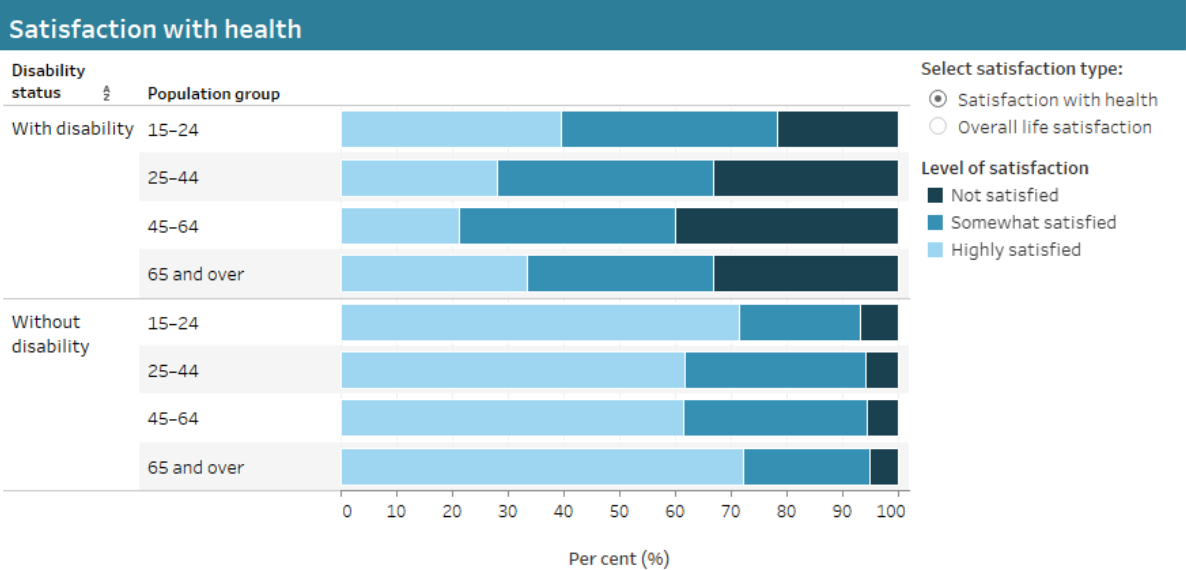
## Overall life satisfaction

About half (52%) of people with disability aged 15–64 are highly satisfied with their life overall. This is lower than for people without disability, of whom 70% are highly satisfied. People aged 65 and over with disability are more likely to be highly satisfied with their life (70%) than those with disability aged 15–64, but less likely than those aged 65 and over without disability (86%) (Figure STATUS.4; AIHW analysis of DSS and MIAESR 2022).

Of people aged 15–64 with disability:

- females are as likely (52%) to be highly satisfied with their life as males (53%)
- those with severe or profound disability are less likely to be highly satisfied (42%) than people with other disability status (54%) (AIHW analysis of DSS and MIAESR 2022).

**Figure STATUS.4: Satisfaction with own health and overall life satisfaction of people aged 15 and over, by disability status and age group, 2021**



\* Proportion has a high margin of error and should be used with caution.  
 Source: AIHW analysis of DSS and MIAESR 2022. Data tables: Health status (DSS & MIAESR HILDA 2021), Tables HLST1 and HLST6.  
<https://www.aihw.gov.au>

**Notes**

1. Satisfaction is collected on an ordinal scale from 0 (totally dissatisfied) to 10 (totally satisfied).
2. 'Highly satisfied' includes category 8, 9 and 10 (totally satisfied).

**Source:** AIHW analysis of ABS 2024. **Data tables:** Health status (DSS and MIAESR HILDA 2021), tables HLST1 and HLST6.

**Key takeaways from Figure STATUS.4**

1. People with disability are less likely to be satisfied with their life in general, and much less likely to be satisfied with their health, than people without disability.
2. Among people with disability, satisfaction with own health is lowest for 25–64 age group. Satisfaction with life overall is lowest for 45–64 age group.

**Where can I find out more?**

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022.](#)
- [ABS National Health Survey: First Results methodology, 2022.](#)
- [The Household, Income and Labour Dynamics in Australia Survey.](#)

## References

ABS (Australian Bureau of Statistics) (2024) *Microdata and TableBuilder: National Health Survey*, ABS, AIHW analysis of detailed microdata in DataLab, accessed 20 November 2024 and 20 February 2026.

Andrews G and Slade T (2001) 'Interpreting scores on the Kessler Psychological Distress Scale (K10)', *Australian and New Zealand journal of public health*, 25(6):494–497, <https://doi.org/10.1111/j.1467-842x.2001.tb00310.x>, accessed 17 November 2025.

DSS (Department of Social Services) and MIAESR (Melbourne Institute of Applied Economic Social Research) (2022) *The Household, Income and Labour Dynamics in Australia (HILDA) Survey, General Release 21 (wave 21)*, doi:10.26193/KXNEBO, ADA Dataverse, V3, AIHW analysis of unit record data, accessed 7 December 2022.

# Health risk factors and behaviours

## Key findings

- **High blood pressure:** In 2022, 41% of people with disability aged 65 and over had uncontrolled high blood pressure, compared with 22% of those aged 18–64.
- **Daily smoking:** In 2022, 14% of adults with disability (aged 18+) were smoking daily, compared with 8.7% of those without disability.
- **Excessive alcohol consumption:** In 2022, more than 1 in 3 (37%) men with disability exceeded 2020 alcohol consumption guideline compared with 18% of women with disability.

Health risk factors and behaviours – such as poor diet, physical inactivity, tobacco smoking, and excessive alcohol consumption – can have a detrimental effect on a person's health.

Many health problems can be prevented or reduced by decreasing exposure to modifiable risk factors where possible. At the same time, people who were not exposed to health risk factors can still develop diseases. Also, if a person develops a disease after being exposed to health risk factors it does not necessarily mean the risk factors caused the disease.

People with disability often have higher rates of some health risk factors that can be changed than people without disability. However, it can be harder for people with disability to make these changes. For example, they may need extra support to be physically active, or some medicines may increase appetite.

## What are health risk factors?

Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. They can be behavioural, biomedical, or environmental.

Behavioural risk factors are those that individuals have the most ability to modify – for example, diet, tobacco smoking, and alcohol consumption.

Biomedical risk factors are bodily states that pose direct and specific risks for health – for example, overweight and obesity and high blood pressure. They are often influenced by health behaviours, such as diet and physical activity, but can also be influenced by genetic, environmental, socioeconomic, and psychological factors.

Environmental risk factors can occur in the natural environment (such as exposure to poor air quality or extreme weather) and built environment (including features of housing and neighbourhoods). While these factors are important determinants of health, they are not covered in this report.

Modifying behavioural and biomedical risk factors can reduce a person's risk of developing chronic conditions and result in large health gains by reducing illness and rates of death.

## Data note

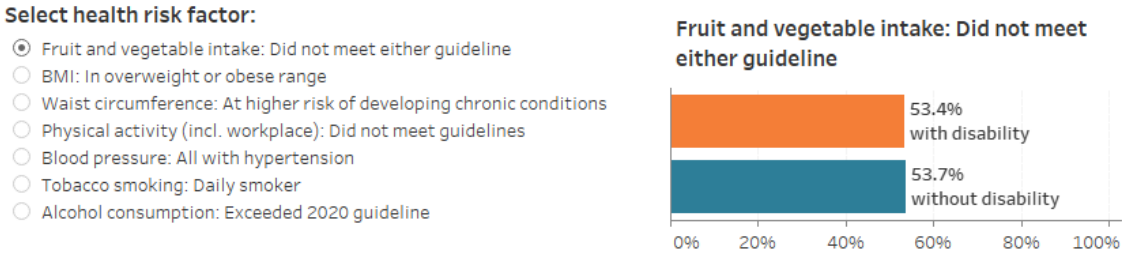
Data in this section are sourced from the Australian Bureau of Statistics (ABS) **National Health Survey (NHS) 2022**. More information about the NHS, including the concepts of disability, disability groups, and remoteness categories used by the NHS, can be found in [‘Data sources’](#).

Unless otherwise indicated, all findings in this section refer to 2022.

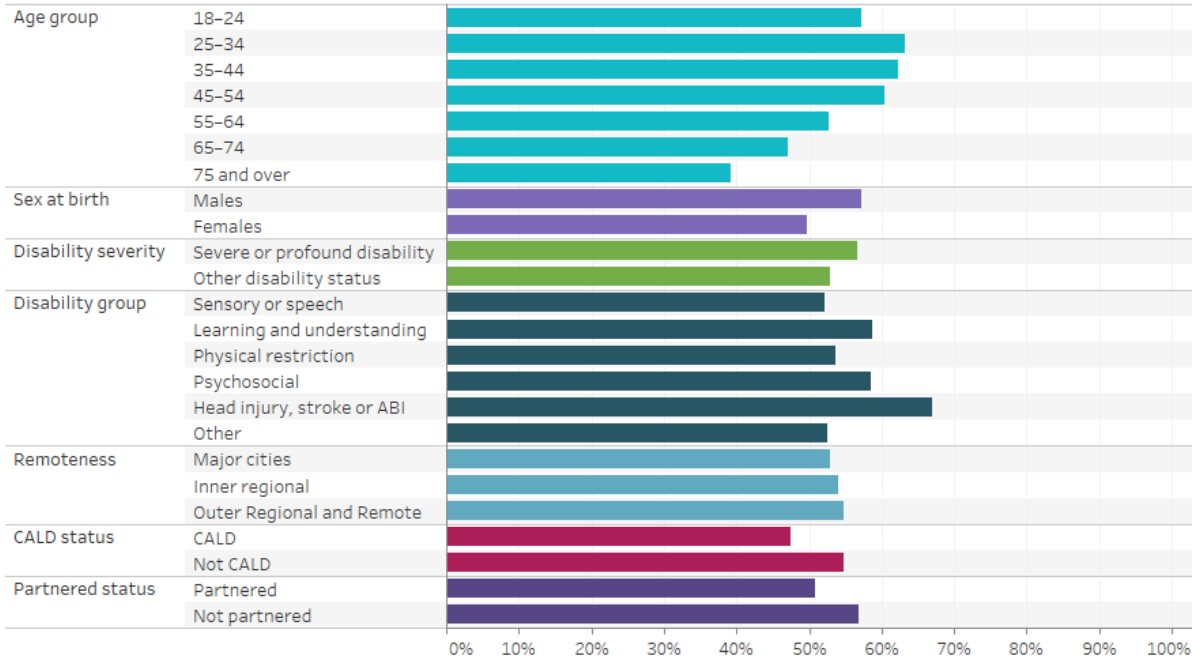
**Living arrangements:** Reporting on health risk factors and behaviours is restricted to people living in households (in private dwellings in the community).

Figure RISK.1 provides an overview of all health risk factors and behaviours discussed in this section. More information about each risk factor is provided in the relevant sections below.

**Figure RISK.1: Health risk factors and behaviours, by disability status and selected characteristics, 2022**



**Proportion of adults with disability who are not meeting fruit and vegetable consumption guideline, by population group**



\* Proportion has a high margin of error and should be used with caution.  
 CALD = culturally and linguistically diverse. ABI = acquired brain injury.  
 Source: AIHW analysis of ABS 2024a. Data tables: Health risk factors and behaviours, Tables RISK2-RISK23.  
<https://www.aihw.gov.au>

**Notes:**

1. Restricted to people aged 18 and over living in households.
2. People from CALD backgrounds are defined as those born outside of main English-speaking countries, and those who mainly speak a language other than English at home.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a. **Data tables:** Health risk factors and behaviours, tables RISK2-RISK23.

**Key takeaways from Figure RISK.1**

1. Health risk factors vary by demographic and disability characteristics.
2. Some health risk factors (such as those related to smoking, weight and waist circumference, and high blood pressure) are more common for people with disability

than those without disability. Others (physical activity, alcohol consumption, fruit and vegetable intake) are similar for people with and without disability.

## Fruit and vegetable consumption

Our diet, including sufficient consumption of fruit and vegetables, plays an important role in overall health and wellbeing. A good diet can contribute to quality of life, help maintain a healthy body weight, protect against infection, and reduce the risk of developing chronic conditions.

Health conditions often affected by diet include:

- overweight and obesity
- coronary heart disease
- stroke
- high blood pressure
- some forms of cancer
- type 2 diabetes.

### Fruits and vegetables

*Australian dietary guidelines (NHMRC 2013)* recommend that adults eat at least 2 serves of fruit and 5 to 6 serves of vegetables per day (depending on sex and age). For children and adolescents, the guidelines recommend a minimum of 1 to 2 serves of fruit and 2½ to 5½ serves of vegetables per day depending on age and sex. Guidelines are different for pregnant and breastfeeding women.

The guidelines do not apply to people needing special dietary advice for a medical condition, or to the frail elderly. As such, they should be treated with caution for some people with disability (for example, those with medical conditions requiring a special diet).

The ABS NHS collects data about people's daily consumption of fruit and vegetables to determine if a person met the fruit and vegetable guidelines. If a person eats less than the recommended serves of fruit and less than the recommended serves of vegetables each day, they are considered to not meet either guideline, or to have inadequate fruit and vegetable intake.

The data on fruit and vegetable consumption are collected for people aged 2 and over. The results presented in this report and accompanying supplementary data tables are in most cases limited to adults aged 18 and over.

Many people, including those with disability, do not eat enough fruit and vegetables for optimum health and wellbeing.

For both people with and without disability, fruit guidelines are met more often than vegetable guidelines. In 2022, based on self-reported data, adults aged 18 and over with disability were more than 6 times as likely to meet the fruit consumption guideline as to

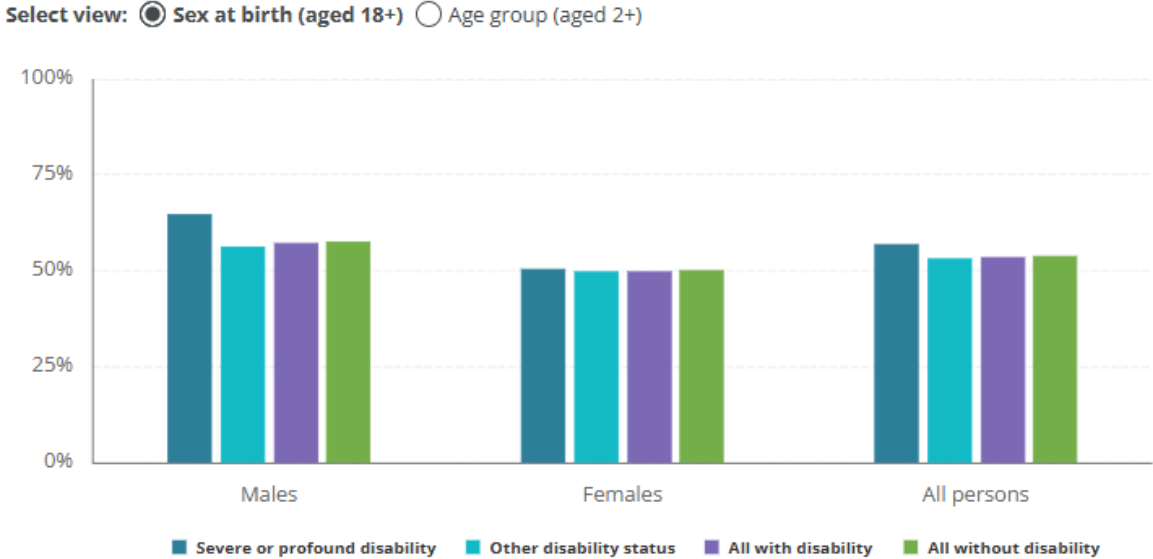
meet the vegetable consumption guideline. Among adults with disability, 44% ate enough fruit while only 6.8% ate enough vegetables. The numbers were 44% and 6.3%, respectively, for adults without disability (AIHW analysis of ABS 2024a).

Around half (53%) of adults with disability did not meet either fruit or vegetable consumption guideline (were eating less than the recommended serves of fruit and less than the recommended serves of vegetables each day). Similarly, 54% of adults without disability did not meet either guideline (Figure RISK.2).

Among children aged 2–17, those with disability were more likely to have inadequate fruit and vegetable intake than those without disability. Around half (47%) of children with disability did not meet either fruit or vegetable guideline, compared with 1 in 3 (34%) children without disability (Figure RISK.2).

The proportion of adults aged 18 and over who did not meet either guideline increased slightly from 2014–15 to 2022 for both people with and without disability. It rose from 49% to 53% for adults with disability, and from 48% to 54% for adults without disability (AIHW analysis of ABS 2024a).

**Figure RISK.2: Proportion not meeting fruit and vegetable consumption guidelines, by disability status, sex, and age group, 2022**



\* Proportion has a high margin of error and should be used with caution.

Notes:

1. Restricted to people living in households.
2. Based on 2013 National Health and Medical Research Council (NHMRC) Australian Dietary Guidelines.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. [Data tables:](#) Health risk factors and behaviours, Tables RISK2, RISK3.

**Key takeaways from Figure RISK.2**

1. Proportion of people not meeting fruit and vegetable consumption guidelines is higher for men (aged 18+) with severe or profound disability, and for people aged 65 and over with severe or profound disability.
2. Among children and young people (aged 2–17), those with disability are less likely to meet fruit and vegetable intake consumption guidelines than those without disability.

For adults (aged 18 and over) with disability, consumption of fruit and vegetables varies by sex and age:

- Men (57%) are more likely than women (50%) to not eat enough fruit and vegetables each day.
- The inadequate intake of fruit and vegetables is highest for the 18–64 age group at 59%, compared with 43% for people aged 65 and over (Figure RISK.2).

Other demographic and socio-economic factors also play a role:

- Adults with disability from CALD backgrounds (47%) are less likely to have inadequate fruit and vegetable intake than those from non-CALD backgrounds (55%).

- Adults with disability who have a partner (51%) are less likely to have inadequate fruit and vegetable intake than those who do not have a partner (57%).
- Among adults aged 18–64 with disability who have completed a Bachelor degree or higher, 52% have inadequate fruit and vegetable intake, compared with 66% of those whose highest level of education is Year 10 or Year 11 (AIHW analysis of ABS 2024a).

## Weight

Maintaining a healthy weight is important for good health. Not maintaining a healthy weight – such as being underweight, overweight, or obese – is a risk factor for lower life expectancy and the development of chronic conditions, such as:

- cardiovascular disease
- type 2 diabetes
- some musculoskeletal conditions
- some cancers.

### What is healthy weight?

Healthy weight can be measured in several ways, including waist circumference and body mass index (BMI). These are valuable tools at broader population level, but they have some limitations for measuring healthy weight for certain groups of people, including some people with disability. For example, these measures do not account for the effects of medications taken by, or the long-term health conditions of, some people with disability that may contribute to weight gain or increased waist circumference.

More information on healthy weight can be found in [AIHW overweight and obesity](#).

## Waist circumference

### Waist circumference

Waist circumference is a commonly used measure to assess the risk of developing obesity-related chronic conditions. It is an indicator of the amount of fat carried around the middle of the body. In general, a higher waist measurement is associated with an increased risk to health. Waist circumference may not be an accurate predictor of health risk in some situations, such as if a person has a medical condition involving enlargement of the abdomen.

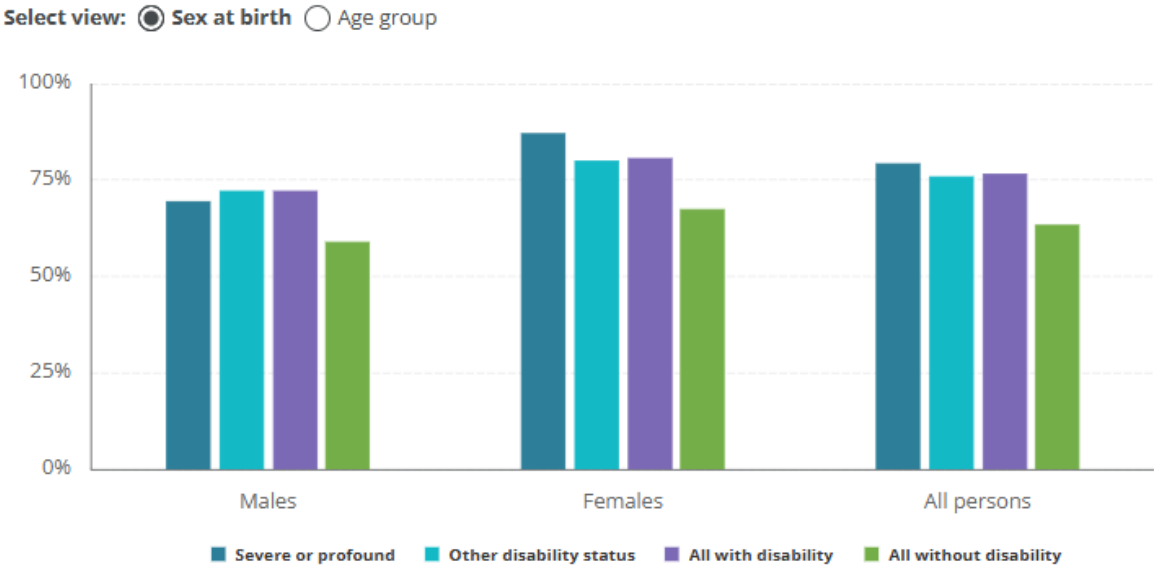
In the ABS NHS, waist circumference is measured for people aged 2 and over, however this report and the accompanying supplementary data tables only look at results for adults aged 18 and over. Physical measurement of waist circumference is voluntary in the NHS. In 2022, 39% of adult respondents did not have their waist circumference measured. For these participants, waist circumference was estimated through imputation (ABS 2023).

Based on waist circumference, people are considered to be in one of 3 groups: at lowered risk, at increased risk, or at substantially increased risk of developing obesity-related chronic

conditions. Different measurement cut-offs are used for men and women. In this report, those with increased risk and substantially increased risk are reported on as one group and referred to as 'at higher risk'.

Based on waist circumference, adults with disability (76%) are more likely than those without disability (63%) to be at higher risk of developing chronic conditions (Figure RISK.3).

**Figure RISK.3: Proportion at increased or substantially increased risk of developing chronic conditions based on waist circumference, by disability status, sex, and age group, 2022**



Notes:

1. Restricted to people aged 18 and over living in households.
2. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. [Data tables:](#) Health risk factors and behaviours, Table RISK9.

**Key takeaways from Figure RISK.3**

1. Women (aged 18+) with disability, especially those with severe or profound disability, are more likely to have a waist circumference that indicates a higher risk of developing chronic conditions.
2. Younger people (aged 18–64) with disability are more likely to have a higher-risk waist circumference than those without disability. Among people aged 65 and over, there are no substantial differences in waist circumference by disability status.

Women with disability (81%) are more likely than men with disability (72%) to be at higher risk of developing chronic conditions, based on waist circumference. This pattern is also observed for people without disability (Figure RISK.3).

Older people (aged 65 and over) with disability are more likely (84%) than younger people (aged 18–64) with disability (72%) to be at higher risk based on waist circumference (Figure RISK.3).

Similarly to patterns by BMI, adults with disability who are from CALD backgrounds (69%), are not partnered (72%), or have a learning or understanding disability (66%) are less likely to be at higher risk than the overall adult disability population (76%) (AIHW analysis of ABS 2024a).

## Body mass index

### Body mass index

BMI is an internationally recognised standard for classifying weight in adults (healthy weight range, underweight, overweight, or obese). It is calculated by dividing a person's weight in kilograms by the square of their height in metres.

However, because BMI does not distinguish between the proportion of weight due to fat or muscle, it may inaccurately assess healthy weight in some individuals. For example, some people with disability may experience muscle loss. A person with muscle loss and increased body fat may be incorrectly classified as within the healthy weight range.

In the ABS NHS, BMI is calculated for people aged 2 and over. Different cut-offs for BMI categories are used for adults and children. Physical measurement of height and weight is voluntary in the NHS. In 2022, 51% of adult participants and 57% of children aged 2–17 in the NHS did not have their height and/or weight measured. For these participants, imputed data were used. Imputation is a way of filling in missing information based on available data, such as self-reported height and weight, in combination with responses from survey participants with similar characteristics (ABS 2023).

The results presented in this report and accompanying supplementary data tables are in most cases limited to adults aged 18 and over.

Adults (aged 18 and over) with disability are more likely to have a BMI in the overweight or obese range (73%) than those without disability (62%). This comprises:

- 39% of adults with disability have a BMI in the obese range, compared with 28% of adults without disability
- 34% of adults both with and without disability are overweight but not obese.

In contrast, children aged 2–17 with disability are about as likely to be overweight or obese (25%) as those without disability (26%) (AIHW analysis of ABS 2024a).

While the proportion of adults who are overweight remained similar between 2011–12 and 2022, the proportion of those who are obese increased both for adults with and without disability. In 2022, 39% of adults with disability were obese, up from 35% in

2011–12. For those without disability, 28% in 2022 were obese, up from 24% in 2011–12 (AIHW analysis of ABS 2024a).

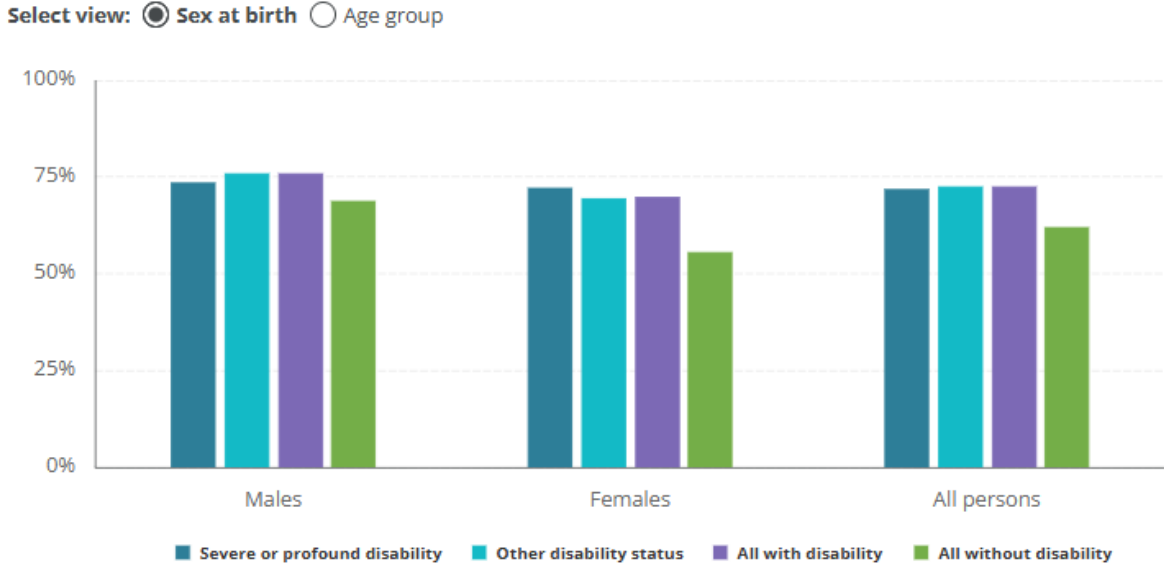
The proportion of people with disability who are overweight or obese varies between men and women, by age, cultural and linguistic diversity (CALD) status, and partnered status:

- Sex at birth: Men aged 18 and over with disability (76%) are more likely than women (69%) to be overweight or obese (Figure RISK.3).
- Age group: Older people (aged 65 and over) with disability (75%) and adults (aged 18–64) (71%) are more likely to be overweight or obese than children (aged 2–17) (25%).
- CALD status: Adults aged 18 and over from CALD background with disability are less likely to be overweight or obese (62%) compared with those from non-CALD backgrounds (75%).
- Partnered status: Adults aged 18 and over with disability who have a partner are more likely to be overweight or obese (76%) than those without a partner (67%) (AIHW analysis of ABS 2024a).

The above patterns are also observed among people without disability.

Adults aged 18 and over with learning and understanding disability are less likely to be overweight or obese (60%) than those with psychosocial disability (69%), sensory or speech disability (73%) or physical restriction (75%). Rates are similar for adults with severe or profound disability (72%) and adults with other disability status (73%) (AIHW analysis of ABS 2024a).

**Figure RISK.4: Proportion with BMI in the overweight or obese range, by disability status, sex, and age group, 2022**



Notes:

1. Restricted to people aged 18 and over living in households.
2. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. [Data tables:](#) Health risk factors and behaviours, Table RISK6.

**Key takeaways from Figure RISK.4**

1. Adults (aged 18+) with disability are more likely to have BMI in the overweight or obese range than adults without disability.
2. Among adults with disability, men are more likely than women to have BMI in the overweight or obese range.

## Physical activity

Getting enough exercise is an important factor in maintaining good physical and mental health and wellbeing.

### What is physical activity?

Physical activity includes just about any movement resulting in energy expenditure, such as:

- taking part in a deliberate exercise or sport, like playing tennis or swimming
- muscle strengthening activity, like weight training
- incidental movement, like mowing the lawn
- work-related activity, like lifting.

[Physical activity and exercise guidelines for all Australians \(DHDA 2021\)](#) define sufficient physical activity for adults as:

- adults aged 18–64: 150 to 300 minutes of moderate physical activity or 75 to 150 minutes of vigorous physical activity (or an equivalent combination) over 5 or more days per week, and muscle strengthening activities on at least two days per week
- adults aged 65 and over: at least 30 minutes of physical activity per day.

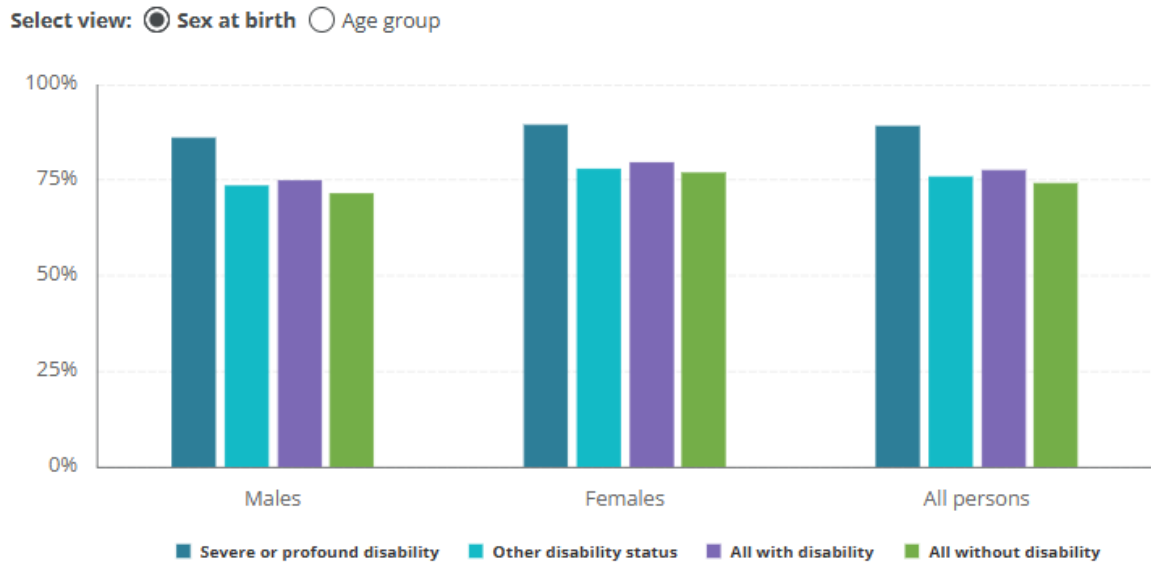
These guidelines are aimed at everyone irrespective of cultural background, gender, or ability. However, they may not be appropriate for people with some forms of disability and may not fully take into account that, for some groups of people with disability, such as those with mobility issues, getting enough exercise can be particularly challenging. Physical activity for people with disability or chronic or acute medical conditions is still important, but the type and amount should be appropriate to a person's ability and based on advice from health care practitioners. The availability of inclusive gyms and exercise spaces can play an important role for some people with disability to participate in physical activity.

In the ABS NHS, people aged 15 and over are asked to report the intensity, duration and number of sessions spent on physical activity during the week before the survey (including at work). The results presented in this report and accompanying supplementary data tables are in most cases limited to adults aged 18 and over.

More information on physical activity can be found in [AIHW physical activity](#).

Many people, including those with disability, are not getting enough exercise. Based on self-reported data, more than three-quarters (77%) of adults aged 18 and over with disability in 2022 did not do enough physical activity (including at work) for their age. This was slightly higher than for adults without disability (74%) (Figure RISK.5).

**Figure RISK.5: Proportion not meeting physical activity guidelines, by disability status, sex, and age group, 2022**



Notes:

1. Restricted to people aged 18 and over living in households.
2. Based on Australia's Physical Activity and Sedentary Behaviour Guidelines 2014–15.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. **Data tables:** Health risk factors and behaviours, Table RISK15.

**Key takeaways from Figure RISK.5**

Adults (aged 18+) with severe or profound disability are much more likely to have insufficient physical activity than other people with disability, or people without disability.

People aged 65 and over, both with and without disability, are more likely to meet physical activity guidelines than people aged 18–64, most likely due to differences in the guidelines for the two age groups:

- 28% of people aged 65 and over with disability (42% without disability) had enough physical activity, compared with 20% of people aged 18–64 with disability (24% without disability) (AIHW analysis of ABS 2024a).

Among adults aged 18–64 with disability, the proportion getting adequate physical activity was lower for:

- adults with severe or profound disability (of whom 11% had enough physical activity), compared with adults with other disability status (21%)
- adults with disability aged 45–54 (17%) and aged 55–64 (14%), compared with those aged 18–24 (27%), 25–34 (25%), or 35–44 (23%)

- those with lower levels of education – 12% of those with Year 10/11 as their highest level of education met physical activity guidelines, compared with 25% of those who completed a Bachelor degree
- lone parents with children under 15 (13% met guidelines) compared with those in couple families with children under 15 (22%), or those in couples without children (21%) (AIHW analysis of ABS 2024a).

Among older adults aged 65 and over with disability, the proportion getting adequate physical activity was lower for:

- older adults with severe or profound disability (of whom 10% had enough physical activity), compared with adults with other disability status (31%)
- those aged 75 and over (23%) compared with those aged 65–74 (33%)
- older adults with psychosocial disability (15%), compared with those with physical restriction (24%), or sensory or speech disability (28%)
- women with disability (24%), compared with men (32%)
- those in major cities (27%), compared with inner regional areas (34%) (AIHW analysis of ABS 2024a).

## Blood pressure

High blood pressure – also known as hypertension – is a major risk factor for some chronic conditions including stroke, coronary heart disease, heart failure, and chronic kidney disease.

Risk factors for high blood pressure include:

- poor diet (particularly a high salt intake)
- obesity
- excessive alcohol consumption
- insufficient physical activity.

### What is hypertension (high blood pressure)?

Blood pressure is the force exerted by the blood on the walls of the arteries. It is written as systolic/diastolic (for example, 120/80 mmHg, stated as '120 over 80').

In the ABS NHS, blood pressure is measured for people aged 18 and over (adults) at the time of their interview. High blood pressure (hypertension) is defined when any of the following occur:

- systolic blood pressure is greater than or equal to 140 mmHg
- diastolic blood pressure is greater than or equal to 90 mmHg
- the person is receiving medication for high blood pressure.

Uncontrolled high blood pressure means having a systolic reading of 140 mmHg or higher, or diastolic reading of 90 mmHg or higher, irrespective of the use of blood pressure medication. It increases the risk of serious health problems.

Controlled high blood pressure means having a normal blood pressure reading while on medication.

Physical measurement of blood pressure is voluntary in the NHS. In 2022, 39% of adult participants in the NHS did not have their blood pressure measured. For these participants, blood pressure information was estimated through imputation (ABS 2023).

In 2022, among adults with disability:

- 43% (more than 2 in 5) have hypertension (Figure RISK.6), comprising
  - 29% with uncontrolled high blood pressure
  - 14% with controlled high blood pressure (AIHW analysis of ABS 2024a).

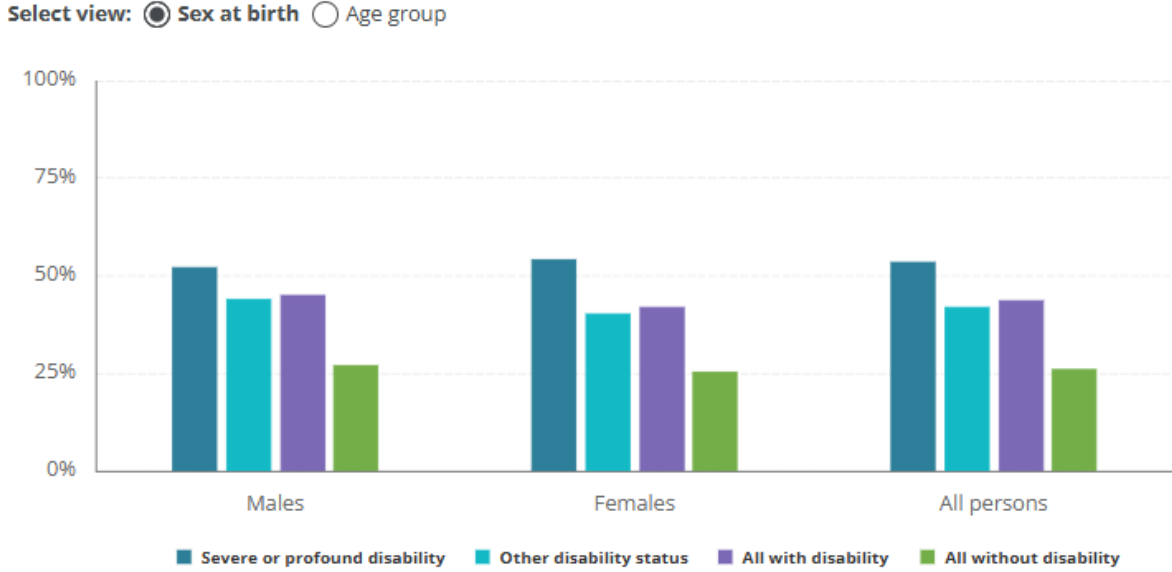
This is far higher than for adults without disability, of whom:

- 26% have hypertension (Figure RISK.6), comprising
  - 20% with uncontrolled high blood pressure
  - 5.9% with controlled high blood pressure (AIHW analysis of ABS 2024a).

The prevalence of high blood pressure varies by age group and disability severity:

- both controlled and uncontrolled high blood pressure increase with age – adults with disability aged 65 and over are almost twice as likely (41%) to have uncontrolled high blood pressure compared with those aged 18–64 (22%), and more than 3 times as likely to have controlled high blood pressure (26% compared with 7.9%) – similar to patterns among people without disability
- adults with severe or profound disability are about as likely (30%) to have uncontrolled high blood pressure as those with other disability status (29%), but are more likely to have controlled high blood pressure (24% compared with 13%)
- there was little difference between men and women (AIHW analysis of ABS 2024a).

**Figure RISK.6: Proportion of people with hypertension, by disability status, sex, and age group, 2022**



Notes:

1. Restricted to people aged 18 and over living in households.
2. Hypertension includes uncontrolled and controlled high blood pressure.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. [Data tables:](#) Health risk factors and behaviours, Table RISK12.

**Key takeaways from Figure RISK.6**

1. Adults (aged 18+) with disability are more likely than those without disability to have high blood pressure, and adults with severe and profound disability even more so.
2. Older people (aged 65+) are much more likely to have high blood pressure, regardless of disability status.

**Tobacco smoking**

Tobacco smoking is an important cause of preventable ill health and death in Australia. It is a leading risk factor for the development of many chronic conditions and premature death.

Health conditions often affected by tobacco smoking include many types of cancer, respiratory disease, and heart disease.

## What is tobacco smoking?

Tobacco smoking is the smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, cigars, and pipes.

In the ABS NHS, people aged 15 and over are asked:

- if they currently smoke
- if they were ex-smokers or had never smoked
- about frequency and quantity of their smoking.

Because daily smoking presents the greatest health risk, the results presented in this section relate to people who were daily smokers at the time of the survey. The results presented in this report and accompanying supplementary data tables are limited to adults aged 18 and over.

More information can be found in [AIHW smoking and e-cigarettes](#).

About 1 in 7 (14%) adults aged 18 and over with disability smoke daily (based on self-reported data). They are more likely to do so than adults without disability (8.7%).

Younger adults (aged 18–64) with disability are twice as likely (18%) to smoke daily as those without disability (9.0%). This is not the case for older adults (aged 65 and over). The proportion of daily smokers is 6.4% for both older adults with and without disability (Figure RISK.7).

Men aged 18 and over with disability are slightly more likely (16%) to smoke daily than women (12%) (Figure RISK.7), and women aged 18 and over with disability are more likely to have never smoked (56%) than men (42%) (AIHW analysis of ABS 2024a).

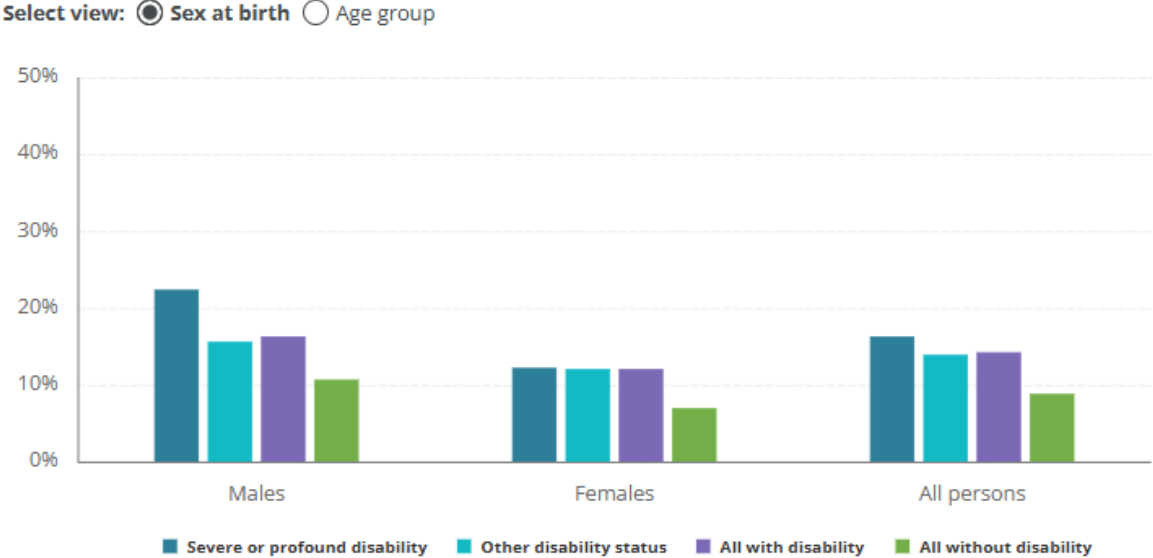
Adults aged 18 and over with disability are less likely to smoke daily if:

- their highest level of education is a Bachelor degree or higher (5.3%), compared with none or below Year 10 (16%), or Year 10/11 (19%)
- they have a partner (11%) compared with those who do not (18%).

Among younger adults aged 18–64 with disability, those in major cities (16%) were less likely to be daily smokers than those in inner regional areas (23%) or outer regional and remote areas (27%). This is consistent with patterns in adults without disability (AIHW analysis of ABS 2024a).

While the proportion of daily smokers has decreased for adults both with and without disability over the past decade, the gap has widened slightly. In 2011–12, 18% of adults with disability and 15% of adults without disability smoked daily, compared with 14% of adults with disability and 8.7% of adults without disability in 2022 (AIHW analysis of ABS 2024a).

**Figure RISK.7: Proportion of daily tobacco smokers, by disability status, sex, and age group, 2022**



Notes:

1. Restricted to people aged 18 and over living in households.
2. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. **Data tables:** Health risk factors and behaviours, Table RISK19.

**Key takeaways from Figure RISK.7**

1. Adults (aged 18+) with disability are more likely to smoke daily than adults without disability.
2. Among adults with disability, men are more likely than women to be smoke daily, especially men with severe or profound disability.
3. Older adults with disability (aged 65+) are much less likely to smoke daily than those aged 18–64.

**E-cigarette use and vaping**

While e-cigarettes and vaping devices do not produce the tar produced by conventional cigarettes, they can include a number of other known cancer-causing agents. Possible health risks associated with using e-cigarettes include lung disease, heart disease, and cancer. Evidence shows a strong association between vaping and future smoking behaviours. Research indicates that young people who vape, but have never smoked, are more likely to take up tobacco smoking compared to young people who have never vaped (Department of Health, Disability and Ageing 2025).

## What are e-cigarettes and vaping devices?

An e-cigarette is a device that heats a liquid to produce vapours that users inhale. This may contain nicotine and other toxic chemicals. E-cigarette use is also commonly referred to as vaping. In this report, e-cigarette use includes the use of vaping devices and/or e-cigarettes.

In the ABS NHS 2022, people aged 15 and over were asked:

- if they currently use an e-cigarette or vaping device
- if they had ever used an e-cigarette or vaping device
- about frequency of their e-cigarette use or vaping.

The results presented in this report and accompanying supplementary data tables are limited to adults aged 18 and over.

Based on self-reported data from the ABS NHS 2022, the use of e-cigarettes and vaping devices is more common among younger adults and declines with age:

- 1 in 5 (21%) adults aged 18–64 with disability are current or past e-cigarette users, slightly higher than those without disability (16%) (AIHW analysis of ABS 2024a)
- adults aged 18–34 with disability are more likely (8.2%) to be daily e-cigarette users than those aged 35–64 (3.2%) (AIHW analysis of ABS 2024b)
- most older adults aged 65 and older have never used an e-cigarette or vaping device (98% of those with disability and 99% of those without disability) (AIHW analysis of ABS 2024a).

Daily e-cigarette use is less common than daily tobacco smoking. Less than 1 in 20 adults aged 18–64 use e-cigarettes daily (4.6% of those with disability and 3.4% of those without disability), while almost 1 in 5 (18%) adults with disability aged 18–64 and 1 in 10 (9.0%) of those without disability are daily tobacco smokers (AIHW analysis of ABS 2024a).

## Alcohol consumption

Harmful levels of alcohol consumption are a major health issue and are associated with increased risk of chronic conditions and injury.

### What is risky alcohol consumption?

Alcohol consumption refers to the consumption of drinks containing ethanol, commonly referred to as alcohol. The quantity, frequency, or regularity with which alcohol is drunk provides a measure of the level of alcohol consumption.

*Australian guidelines to reduce health risks from drinking alcohol (NHMRC 2020)* provide advice on reducing the risk of harm from alcohol-related disease or injury. Based on the guideline for adults, the ABS NHS 2022 defines excessive alcohol consumption as:

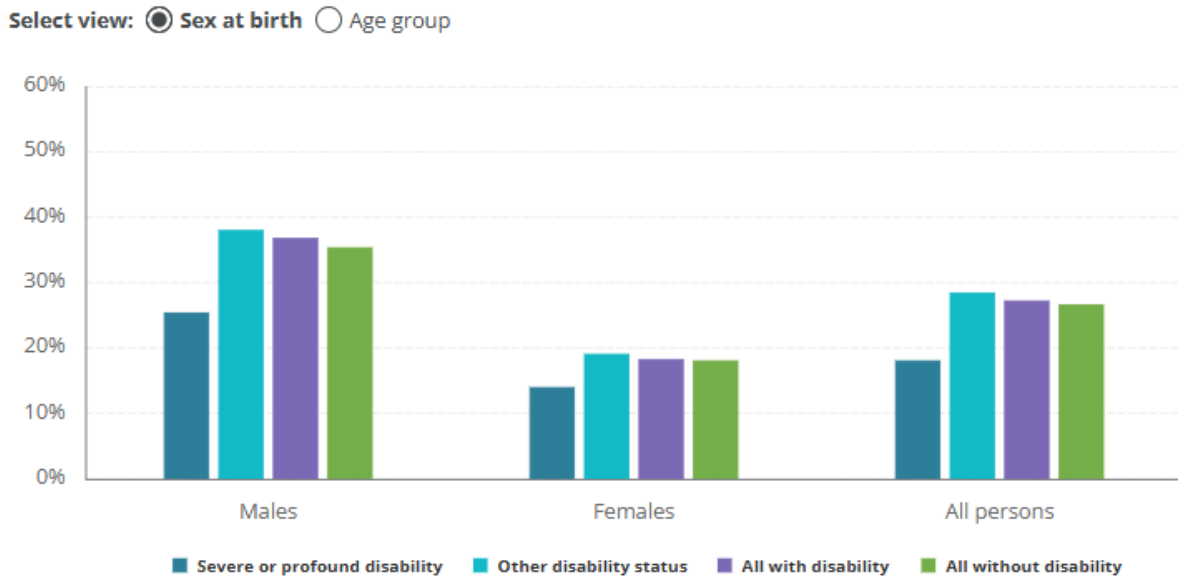
- consuming more than 10 standard drinks of alcohol per week, and/or
- consuming 5 or more standard drinks of alcohol in one day at least monthly over the last 12 months.

In 2022, the NHS collected information about alcohol consumption for people aged 15 and over. It should be noted that the above definition of risky alcohol consumption is for people aged 18 and over, and that the current guidelines state that children and young people under 18 years of age should not be drinking alcohol. The results presented in this report and accompanying supplementary data tables are limited to adults aged 18 and over.

More information can be found in [AIHW alcohol](#).

Based on self-reported data, more than 1 in 4 (27%) adults (aged 18 and over), both with and without disability, exceed the 2020 recommended alcohol consumption guideline (Figure RISK.8).

**Figure RISK.8: Whether exceeded recommended alcohol consumption guideline, by disability status, sex, and age group, 2022**



Notes:

1. Restricted to people aged 18 and over living in households.
2. Based on the alcohol consumption guideline for adults from the National Health and Medical Research Council (NHMRC) released in 2020.
3. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a and 2024b. **Data tables:** Health risk factors and behaviours, Table RISK23.

**Key takeaways from Figure RISK.8**

1. There were almost no differences in alcohol consumption between adults (aged 18+) with and without disability.
2. However, adults with severe or profound disability are much less likely to exceed alcohol consumption guidelines than other people with disability.
3. Men, both with and without disability, are much more likely to exceed alcohol consumption guidelines than women. Younger people (aged 18–64) are more likely than those aged 65+.

Both single-day and weekly excessive alcohol consumption levels were similar for adults with and without disability:

- 20% of adults with disability drink 5 or more standard drinks in one day at least monthly, and 21% of adults without disability
- 20% of adults with disability drink more than 10 standard drinks per week, and 18% of adults without disability (AIHW analysis of ABS 2024a).

The alcohol consumption of people with disability varies by sex, age group, and disability severity (Figure RISK.6).

Males aged 18 and over with disability are far more likely than their female counterparts to drink at risky levels:

- 37% of males exceed the 2020 alcohol consumption guideline compared with 18% of females
- 27% consume more than 10 standard drinks of alcohol per week, compared with 13%
- 28% consume 5 or more standard drinks of alcohol on a single occasion each month, compared with 12% (AIHW analysis of ABS 2024a).

Younger adults (aged 18–64) with disability are more likely (30%) to exceed the alcohol consumption guideline than older adults (aged 65 and over) (22%) (Figure RISK6).

Younger adults with disability are:

- more than twice as likely (25%) to consume 5 or more standard drinks in a single occasion at least monthly as older adults with disability (11%).
- about as likely to consume more than 10 standard drinks per week as older adults with disability (20% compared with 19%) (AIHW analysis of ABS 2024a).

Adults with disability from CALD backgrounds (11%) are less likely to exceed the alcohol consumption guideline than those from non-CALD backgrounds (31%).

There is similar variation of alcohol consumption patterns by sex, age group, and CALD status among people without disability (AIHW analysis of ABS 2024a).

Adults with severe or profound disability are less likely (18%) to exceed the alcohol consumption guideline than those with other disability status (28%) (Figure RISK.5; AIHW analysis of ABS 2024a).

## Where can I find out more?

- [Data tables](#) for this report.
- Health risk factors and behaviours for the general Australian population – [Behaviours & risk factors](#).
- ABS key statistics and information about [Dietary behaviour](#), [Waist circumference and BMI](#), [Physical activity](#), [Hypertension and high measured blood pressure](#), [Smoking and vaping](#), and [Alcohol consumption](#).
- Dietary guidelines – [National Health and Medical Research Council \(NHMRC\)](#).
- Physical activity and exercise guidelines – [Department of Health, Disability and Ageing](#).
- Guidelines to reduce health risks from drinking alcohol – [National Health and Medical Research Council \(NHMRC\)](#).

## References

ABS (2023) *National Health Survey methodology, 2022*, ABS, accessed 19 November 2025.

ABS (2024a) *Microdata and TableBuilder: National Health Survey*, ABS, AIHW analysis of detailed microdata in DataLab, accessed 20 November 2024 and 20 February 2026.

ABS (2024b) *Microdata and TableBuilder: National Health Survey*, ABS, AIHW analysis of TableBuilder data, accessed 6 January 2026.

Department of Health, Disability and Ageing (2021) *24-hour movement guidelines for all Australians*, Department of Health, Disability and Ageing, Australian Government, accessed 19 May 2026.

Department of Health, Disability and Ageing (2025) *About vaping and e-cigarettes*, Department of Health, Disability and Ageing, Australian Government, accessed 19 November 2025.

NHMRC (National Health and Medical Research Council) (2013) *Australian Dietary Guidelines*, NHMRC, accessed 19 May 2026.

NHMRC (2020) *Australian guidelines to reduce health risks from drinking alcohol*, NHMRC, accessed 19 May 2026.

# Chronic conditions and disability

## Key findings

- **Chronic conditions and disability:** Having a chronic health condition is often associated with disability. In 2022, 58% of people with arthritis as their main condition had disability.
- **Core activity limitation:** 90% of people with dementia as their main condition had severe or profound core activity limitation in 2022, compared with 31% of people with chronic obstructive pulmonary disease (COPD).
- **Age as a factor for disability and chronic conditions:** Half (48%) of people aged 65 and over with asthma as their main condition had disability, compared with 12% of those aged under 65 (in 2022).

Chronic health conditions are the leading cause of illness, disability and death in Australia. They are often associated with some level of disability. Chronic health conditions are diseases or disorders that have lasted or are likely to last for 6 months or more. People who are restricted or limited in their ability to do activities because of chronic health conditions are identified as having disability (ABS 2022).

This section explores how many people with certain chronic conditions as their main condition have disability, and how severe this disability is. The 12 chronic conditions covered in this section are:

- heart disease (including angina, heart attack, Ischaemic heart disease, heart failure, and other heart disease)
- stroke
- diabetes (excluding gestational diabetes)
- arthritis (including rheumatoid arthritis, osteoarthritis, and other types of arthritis)
- back problems (including dorsopathies)
- osteoporosis
- asthma
- chronic obstructive pulmonary disease (COPD; including emphysema, bronchitis, or bronchiolitis chronic, and chronic airflow limitation)
- cancer
- kidney or urinary disease
- dementia (including frontotemporal dementia, dementia with Lewy bodies, and Alzheimer's disease)
- mental and behavioural conditions (excluding dementia).

The *People with disability in Australia 2024* report covered 8 of the above 12 conditions. Cancer, kidney or urinary disease, dementia, and mental and behavioural conditions

excluding dementia were added to the list for the first time in this update. The approach used to analyse the link between chronic conditions and disability is consistent with earlier reports.

These 12 chronic conditions were selected because they are common, pose significant health problems, and, in many instances, action can be taken to prevent their occurrence. More information can be found in [AIHW chronic disease](#).

It cannot be assumed that disability is a consequence of a chronic health condition. As such, this section describes only the associations between disability and the selected chronic conditions and does not describe a causal relationship.

### **What is the relationship between chronic health conditions and disability?**

There is a 2-way relationship between chronic health conditions and disability. People with a chronic health condition are more likely to develop disability, and people with disability are more likely to develop a chronic health condition.

Not everyone with a chronic health condition will develop disability, and people with the same chronic health condition who have disability may also experience different forms of disability. More information about the relationship between chronic health conditions and disability can be found in [‘Defining disability’](#).

## Data note

Data in this section are sourced from the Australian Bureau of Statistics (ABS) **2022 Survey of Disability, Ageing and Carers (SDAC)**. More information about the SDAC, including the concepts of disability, disability groups, and remoteness categories used by the SDAC, can be found in '[Data sources](#)'.

The SDAC collects data on chronic health conditions. For people who report more than one long-term condition, the condition causing the most problems is identified as the **main condition**. As this is based on self-reported data, reporting relies on survey participants being aware of and accurately reporting their health conditions.

Unless otherwise indicated, all findings in this section refer to 2022.

**Living arrangements:** Reporting on chronic conditions covers people living in cared accommodation (such as aged care facilities) and in households (in private dwellings in the community).

## Main condition

About 8.6 million people in Australia are affected by at least one of the 12 chronic health conditions covered in this section. For more than 3 in 4 of them (78% or 6.7 million), the condition is reported as their main health condition (the condition causing the most problems) (AIHW analysis of ABS 2024a).

Some of the selected chronic conditions are more common than others. According to the ABS National Health Survey, in 2022, 26.1% of Australians had a mental or behavioural condition, 14.5% had arthritis and 10.8% had asthma. Kidney disease (1.0%), cancer (1.8%), and COPD (2.5%) were relatively less common (ABS 2023). Smaller numbers for the less common conditions may make it harder to interpret results, or to confirm observed differences statistically.

Certain chronic conditions are more likely to be the main condition, while others more commonly occur alongside another main condition. For example:

- 60% (or 2.2 million) of people with a mental or behavioural condition have this as their main condition
- 55% (or 125,000) of people with dementia have dementia as their main condition
- 47% (or 931,000) of people with asthma have this as their main condition
- 22% (or 95,000) of people with stroke have this as their main condition
- 20% (or 111,000) of people with osteoporosis have this as their main condition (AIHW analysis of ABS 2024b).

## **Disability among people with selected chronic conditions**

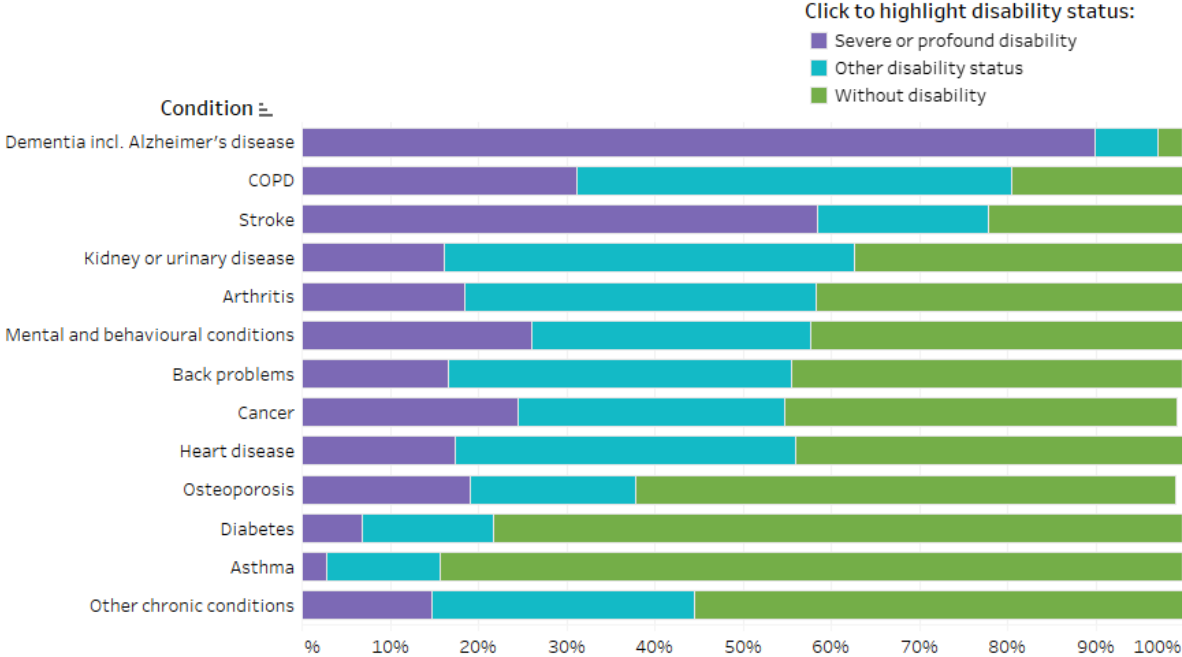
Chronic conditions often coexist with some form of disability:

- over half (54% or 4.7 million) of people with at least one of the selected chronic conditions also have disability
- 50% (or 3.4 million) of people who have one of the selected chronic conditions as their main condition also have disability (AIHW analysis of ABS 2024a).

Some chronic conditions are more likely than others to be linked with disability (Figure CHRONIC.1). Among selected chronic conditions, people with asthma as their main condition are the least likely to have disability (16% or 147,000). People with dementia (97% or 121,000) or COPD (80% or 90,000) as their main condition are the most likely to have disability.

Asthma as the main condition is also associated with the lowest proportion of severe or profound disability (Figure CHRONIC.1), with 1 in 35 (2.8% or 26,000) people with asthma as their main condition having severe or profound disability. On the other hand, dementia is associated with the highest likelihood of severe or profound disability, with 90% (or 112,000) of people whose main condition is dementia having severe or profound disability (Figure CHRONIC.1).

**Figure CHRONIC.1: Disability status among people with selected chronic conditions as their main condition, 2022**



\* Proportion has a high margin of error and should be used with caution.  
 COPD = Chronic Obstructive Pulmonary Disease.  
 Note: Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.  
 Source: AIHW analysis of ABS 2024b. Data tables: Chronic conditions and disability, Table CHRN3.  
<https://www.aihw.gov.au/>

\* Proportion has a high margin of error and should be used with caution.  
 Note: Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024b. [Data tables:](#) Chronic conditions and disability, Table CHRN3.

**Key takeaways from Figure CHRONIC.1**

1. The relationship between chronic conditions and disability differs by condition.
2. Dementia has the strongest association with disability. Almost all people who have dementia as their main condition also have disability.
3. Diabetes and asthma have a weaker association with disability. Most people who have one of these conditions as their main condition do not have disability.

Chronic conditions and disability both become more common with age (more information on this can be found in 'How many people have disability?', and [AIHW chronic disease](#)). For most of the 12 conditions, people aged 65 and over who have one of these conditions as their main condition are more likely than those aged under 65 to have disability. For example:

- among people with asthma as their main condition, 12% (or 102,000) of those aged under 65 and 48% (or 44,000) of those 65 and over have disability

- for people who have back problems as their main condition, 46% (or 345,000) aged under 65 and 73% (or 307,000) aged 65 and over have disability (AIHW analysis of ABS 2024b).

Differences in the disability rate by age are smallest among people with mental and behavioural conditions as their main condition. Around 3 in 5 of people with this main condition have disability, 57% (or 1.2 million) of those aged under 65, and 65% (or 111,000) of those aged 65 and over (AIHW analysis of ABS 2024b).

For osteoporosis and dementia, no comparison between age groups could be made due to small numbers of people aged under 65 who have these conditions.

For most of the 12 chronic conditions, there is less variation by sex than by age group in how likely a person is to have disability. The largest difference between males and females occurs for mental and behavioural conditions and arthritis. Males with a mental and behavioural condition as their main condition are more likely than females to have disability, while for arthritis, females with this main condition are more likely to have disability than males:

- 65% (or 687,000) of males with a mental and behavioural condition as their main condition have disability, compared with 51% (or 589,000) of females
- 62% (or 454,000) of females with arthritis as their main condition have disability, compared with 52% (or 195,000) of males (AIHW analysis of ABS 2024b).

Heart disease, cancer, and kidney or urinary disease appear to be associated with higher occurrence of disability in males than females. At the same time, stroke, dementia, COPD, diabetes, and asthma appear to be associated with higher rates of disability in females than in males. However, due to relatively small numbers of people who have these conditions as their main condition, findings were estimated with a high degree of error, and the differences could not be confirmed statistically (AIHW analysis of ABS 2024b).

Back problems as the main condition were associated with similar rates of disability in males (55%) and females (56%). Findings for osteoporosis could not be compared by sex, due to small numbers of males who have this condition as their main condition (AIHW analysis of ABS 2024b).

To more fully support the evidence base about the interrelationship between sex, age, chronic conditions and disability, further analysis is needed. This could include age standardisation, analysis of multimorbidity, and better linkage between chronic health, disability support, mainstream health services, NDIS access and non-NDIS support pathways.

## Where can I find out more?

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022](#).
- [AIHW Chronic disease overview page](#).

## References

ABS (Australian Bureau of Statistics) (2022) *Disability, Ageing and Carers, Australia: Summary of Findings, 2022*, ABS Website, accessed 4 February 2026.

ABS (2023) *National Health Survey, 2022*, ABS, accessed 29 May 2026.

ABS (2024a) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022*, ABS, AIHW analysis of TableBuilder, accessed 21 November 2025.

ABS (2024b) *Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022*, ABS, AIHW analysis of detailed microdata in DataLab, accessed 19 May 2025.

AHMAC (Australian Health Ministers' Advisory Council) (2017) *National Strategic Framework for Chronic Conditions*, AHMAC, Australian Government, accessed 4 August 2021.

## Access to health services

### Key findings

- **Cost as barrier to health care:** In 2022, 46% of people with disability who did not see a dental professional when needed said cost was the main reason.
- **Waiting times:** In 2022, 43% of people with disability who had unmet need for GP care said waiting time or service availability was the main reason.
- **Coordination of care:** In 2022, 47% of people with severe or profound disability saw 3 or more health professionals for the same condition.

Like everyone, people with disability have health care needs, access health services to meet them, and have varying health-related experiences. They use a range of mainstream health services, such as general practitioners (GPs), medical specialists, dentists, and hospitals. Their care may require coordination between different health professionals.

People with disability may also rely on informal care, such as that provided by family and friends, to meet or supplement their health care needs.

### Data note

Data in this section are largely sourced from the Australian Bureau of Statistics (ABS) **2022 Survey of Disability, Ageing and Carers (SDAC)**. More information about the SDAC, including the concepts of disability, disability groups, and remoteness categories used by the SDAC, can be found in '[Data sources](#)'.

The patient experience information collected in the SDAC does not include health professionals other than GPs, medical specialists, and dental professionals. Hence, it is not possible to examine from this survey whether needs for non-hospital health services were met by other health professionals, such as nurses, pharmacists, or other allied health professionals.

Unless otherwise indicated, all findings in this section refer to 2022.

**Living arrangements:** Reporting on access to health services is restricted to people living in households (in private dwellings in the community).

## **Assistance with health care activities**

About 30% (an estimated 1.6 million) of people with disability living in households need assistance with health care activities. Of those:

- 56% (or an estimated 877,000) receive assistance from formal services
- 44% (or 689,000) receive informal assistance
- 18% (or 275,000) do not receive any assistance (ABS 2022).

Older people with disability are more likely to need assistance with health care activities. Among those aged 65 and over, 42% (or 898,000) needed assistance with health care activities, compared with 21% (or 669,000) of those aged under 65 (ABS 2022).

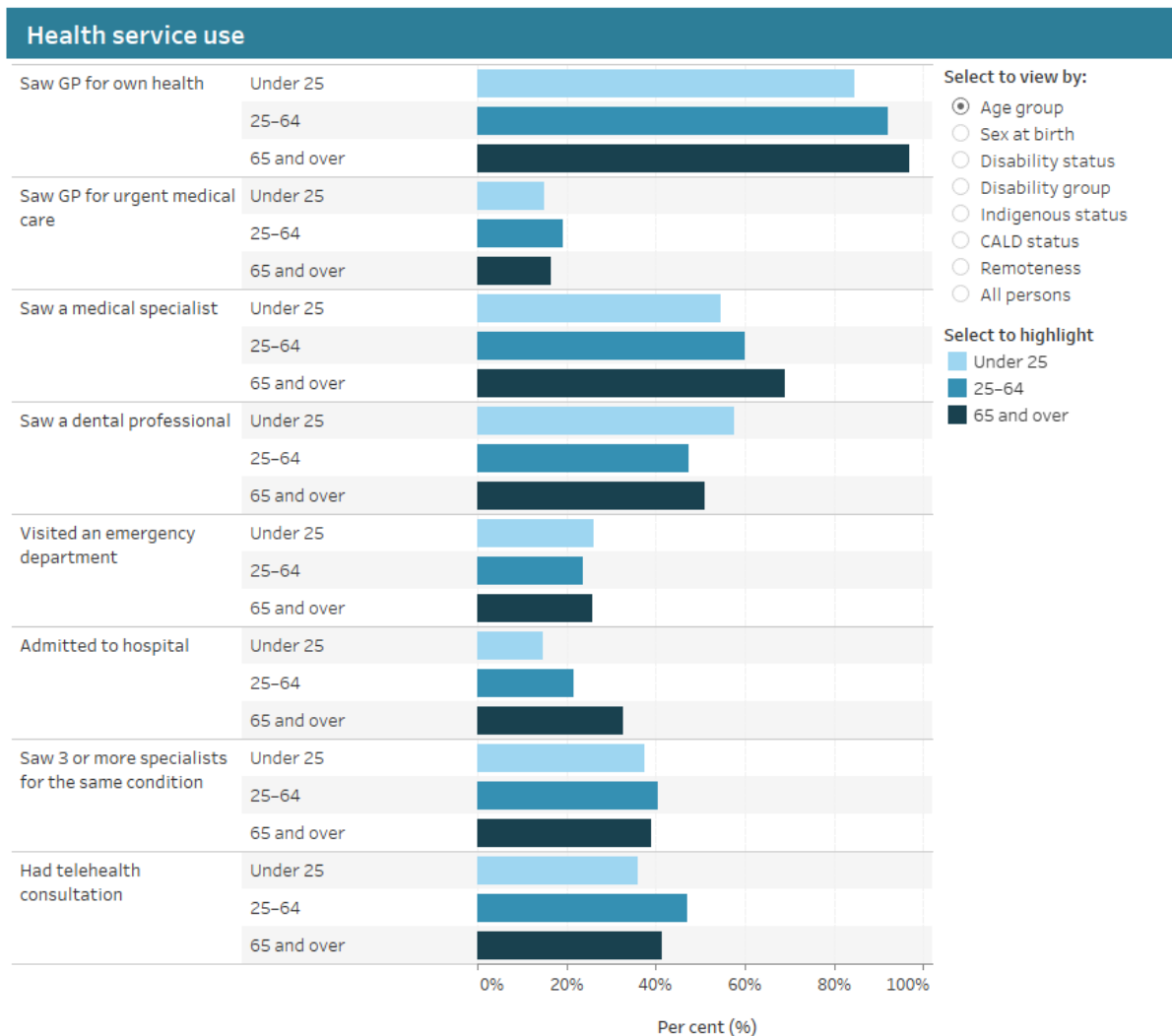
For 6.5% (or 347,000) people with disability, their needs for assistance with health care activities were not fully met (ABS 2022).

## **Use of mainstream health services**

In 2022, most people with disability living in households reported using health services in the last 12 months:

- most (93% or 4.9 million) saw a GP for their own health
- 1 in 6 (17% or 916,000) saw a GP for urgent medical care
- 2 in 3 (63% or 3.3 million) saw a medical specialist
- half (51% or 2.7 million) saw a dental professional
- 1 in 4 (25% or 1.3 million) visited a hospital emergency department
- 1 in 4 (25% or 1.3 million) were admitted to hospital
- 2 in 5 (39% or 2.1 million) saw 3 or more health professionals for the same condition
- 2 in 5 (43% or 2.3 million) had a telehealth consultation (Figure ACCESS.1).

**Figure ACCESS.1: Use of selected health services by people with disability, by population groups, 2022**



CALD = culturally and linguistically diverse; ABI = acquired brain injury.  
 Source: AIHW analysis of ABS 2024a. Data tables: Access to health services, Table ACCE1b.  
<https://www.aihw.gov.au>

**Notes:**

1. Data are restricted to use of selected health services for own health in the last 12 months by people with disability living in households.
2. Numbers are rounded and randomly adjusted to protect confidentiality. Because of this, components may not add up to totals.

**Source:** AIHW analysis of ABS 2024a. [Data tables:](#) Access to health services, Table ACCE1b.

**Key takeaways from Figure ACCESS.1**

1. Use of health services by people with disability varies by demographic and disability characteristics.
2. Older people (aged 65+) with disability are more likely to visit a GP or a medical specialist, or be admitted to hospital. However, visiting a dental professional is more common for those aged under 25, and telehealth consultations are more common for people aged 25-64.

3. Females and males have mostly similar patterns of health service use, however females are more likely to have telehealth consultations, or visit a dental professional.
4. People with severe or profound disability are more likely to use health services than other people with disability.
5. First Nations people with disability are generally less likely to use health services than non-Indigenous people with disability, but are more likely to visit an emergency department. Similar patterns are observed for people with disability living in *Outer regional and Remote* areas.

The use of health services by people with disability varied by age. People aged 65 and over were more likely to:

- see a GP (97% or 2.1 million) within the last year, compared with those aged under 25 (85% or 801,000), or those aged 25–64 (92% or 2.1 million)
- see a medical specialist (69% or 1.5 million), compared with those aged under 25 (55% or 517,000), or those aged 25–64 (60% or 1.3 million)
- be admitted to hospital (33% or 690,000), compared with those aged under 25 (15% or 140,000), or those aged 25–64 (22% or 484,000) (Figure ACCESS.1).

Use of dental health services and telehealth is higher in the younger age groups. People aged under 25 with disability were most likely to see a dental professional within the last year (58% or 546,000). This compares with 47% (or 1.1 million) among those aged 25–64, or 51% (or 1.1 million) among those aged 65 and over. People aged 25–64 with disability were the most likely to have a telehealth consultation (47% or 1.1 million). This compares with 36% (or 342,000) for those aged under 25 and 41% (or 877,000) among those aged 65 and over (Figure ACCESS.1).

Females tend to have higher rates of GP, dental professional, and telehealth use compared with males. The largest difference occurs in the use of telehealth consultations. Half (49% or 1.3 million) of females with disability had a telehealth consultation in the last 12 months, compared with just over 1 in 3 (36% or 935,000) males (Figure ACCESS.1).

People with severe or profound disability have higher rates of health services use. In 2022, people with severe or profound disability were more likely than those with other disability status to:

- visit a medical specialist (68% or 1.3 million compared with 59% or 2.0 million)
- see a GP for urgent medical care (23% or 420,000 compared with 14% or 497,000)
- visit a hospital emergency department (31% or 574,000 compared with 22% or 756,000)
- be admitted to hospital (30% or 561,000 compared with 22% or 752,000)
- see 3 or more health professionals for the same condition (47% or 875,000) than those with other disability status (35% or 1.2 million) (Figure ACCESS.1).

However, people with severe or profound disability were slightly less likely than others to see a dental professional (47% or 873,000 compared with 53% or 1.8 million) (Figure ACCESS.1).

There are also some differences in the use of health services by disability group. People with head injury, stroke or acquired brain injury were more likely to see a GP for urgent medical care or visit a hospital emergency department, and less likely to use dental services than people with disability overall:

- 29% (or 94,000) of those with head injury, stroke or acquired brain injury saw a GP for urgent medical care (17% or 916,000 of all people with disability)
- 37% (or 120,000) visited a hospital emergency department (25% or 1.3 million of all people with disability)
- 43% (or 139,000) visited a dental professional (51% or 2.7 million of all people with disability) (Figure ACCESS.1).

People with physical disability, psychosocial disability, or head injury, stroke or acquired brain injury were more likely to see 3 or more specialists for the same condition:

- among people with these disabilities, 44% saw 3 or more health professionals for the same condition, compared with 39% for all people with disability (Figure ACCESS.1).

People with sensory or speech disability, and those with learning and understanding disability were less likely to have had a telehealth consultation:

- 39% (or 701,000) of people with sensory disability and 38% (or 395,000) of those with learning and understanding disability had a telehealth consultation in the past year. This compares with 43% (or 2.3 million) of all people with disability (Figure ACCESS.1).

People with disability living in *Major cities* were more likely to see a medical specialist, visit a dentist or have a telehealth consultation:

- 64% (or 2.2 million) of people in *Major cities* saw a medical specialist in the last year, compared with 60% (or 711,000) in *Inner regional* areas and 57% (or 377,000) in *Outer regional and remote* areas
- 52% (or 1.8 million) of people in *Major cities* saw a dentist in the last year, compared with 49% (583,000) in *Inner regional* areas and 44% (290,000) in *Outer regional and remote* areas
- 45% (or 1.6 million) of people in *Major cities* had a telehealth consultation, compared with 40% (or 472,000) in *Inner regional* areas and 36% (or 236,000) in *Outer regional and remote* areas (Figure ACCESS.1).

At the same time, people with disability living in *Outer regional and remote* areas were more likely to visit a hospital emergency department:

- 30% (or 200,000) of people in *Outer regional and remote* areas had visited a hospital emergency department in the last year, compared with 24% (or 840,000) in *Major cities* and 25% (or 291,000) in *Inner regional* areas (Figure ACCESS.1).

These patterns suggest that people in *Outer regional and remote* areas have a higher reliance on the hospital system to have their health needs met (AIHW 2025a).

Use of health services differed for First Nations (Aboriginal and Torres Strait Islander) and non-Indigenous people with disability (Figure ACCESS.1). First Nations people with disability were less likely to see medical specialists, dental health professionals, and use telehealth, and more likely to visit hospital emergency departments. These patterns mirror findings based on remoteness. However, the numbers in Figure ACCESS.1 do not include First Nations people living in very remote areas, or in discrete communities. The '[Aboriginal and Torres Strait Islander \(First Nations\) people](#)' section below provides information about health services use for First Nations Australians based on a more complete geographic coverage.

## **How does the use of mainstream health services compare for people with and without disability?**

The patient experience information in the SDAC is collected only from people with disability and primary carers (living in households). It is not therefore possible to compare with people without disability.

However, the AIHW analysis of self-reported information from the HILDA Survey suggests that, in 2021, people with disability aged 15 and over had higher rates of use of:

- GPs or family doctors (94% compared with 78% of those without disability)
- mental health professionals (18% compared with 8.4%)
- specialist doctors (48% compared with 23%)
- hospital doctors as an outpatient or casualty (30% compared with 12%)
- hospital overnight stays (22% compared with 7.6%)
- hospital admission as day patient (18% compared with 10%) (DSS and MIAESR 2022).

In contrast to this, people with disability aged 15 and over were slightly less likely to visit a dentist (51%) than people without disability (57%) (DSS and MIAESR 2022).

## **How many people have a regular GP?**

People aged 15 and over with disability were more likely to see a particular GP or clinic when they were sick or needed advice about their own health than those without disability (95% compared with 86% in 2021). Of people with disability:

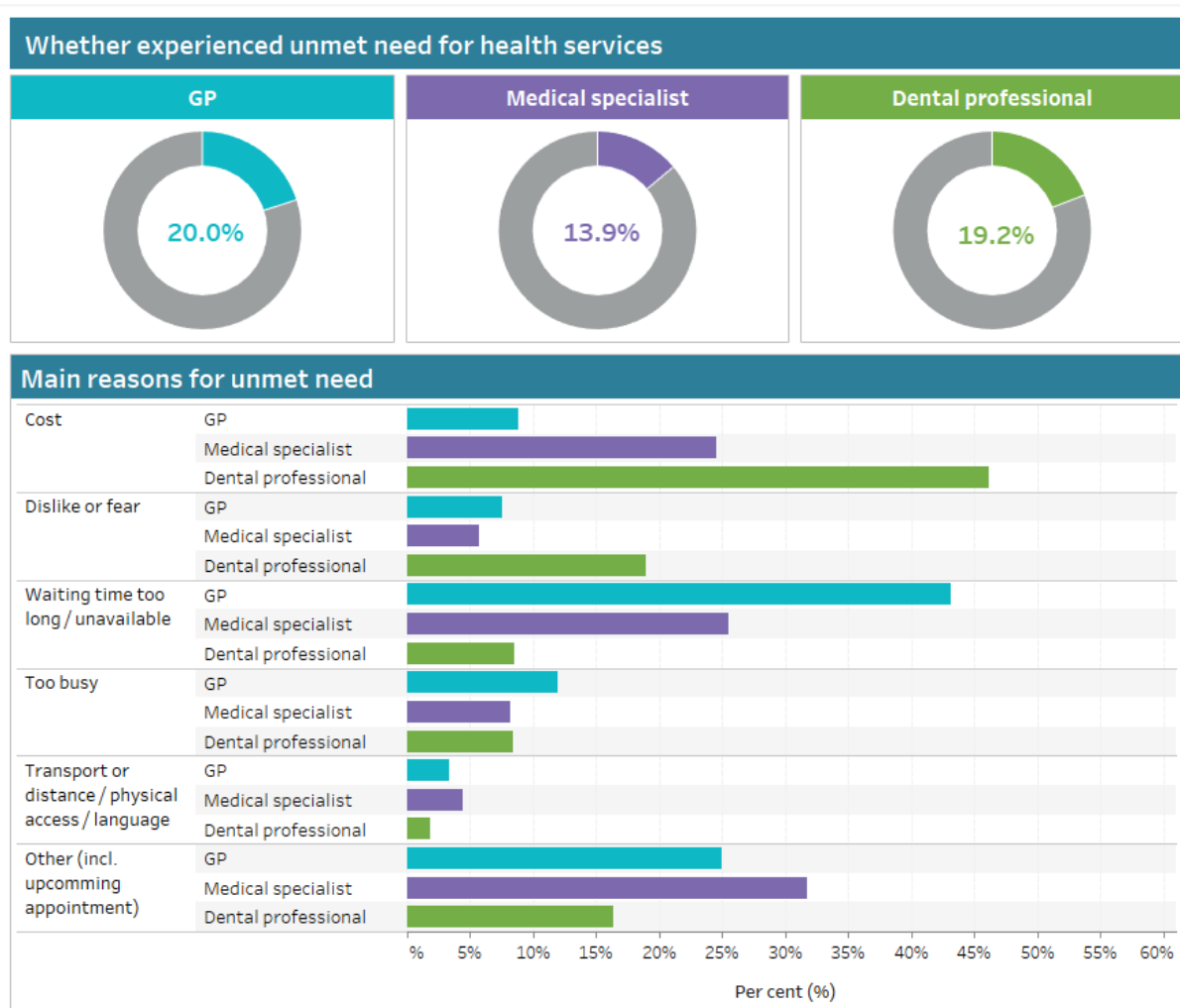
- people aged 65 and over were more likely (99%) to see a particular GP or clinic than people aged 15–64 (93%)
- females (94%) aged 15–64 were about as likely as males (92%) (DSS and MIAESR 2022).

## Difficulties accessing health services

Access to services depends on many factors. Some people with disability face barriers to accessing health care or receiving quality care. These barriers include:

- long waiting times or service not being available
- cost
- inaccessible buildings
- discrimination by health professionals.

**Figure ACCESS.2: Unmet need for health services and main reason for unmet need among people with disability, 2022**



Source: AIHW analysis of ABS 2024a. Data tables: Access to health services, Tables ACCE2a, ACCE3, ACCE6a, ACCE7, ACCE8a, ACCE9. <https://www.aihw.gov.au>

**Note:** Restricted to patient experience in the last 12 months for people with disability living in households.

**Source:** AIHW analysis of ABS 2024a. **Data tables:** Access to health services, Tables ACCE2a, ACCE3, ACCE6a, ACCE7, ACCE8a, ACCE9.

### Key takeaways from Figure ACCESS.2

1. Between 14% and 20% of people with disability who needed to use the services of a GP, medical specialist, or dental professional were unable to do so for various reasons.
2. Main reasons to miss out were different depending on type of medical professional. For GPs, the most common reason was long waiting time. For dental professionals, the most common reason was cost. For medical specialists, both cost and long waiting time were equally common.

Many people with disability experience unmet need for health services – needing to see a medical professional or to use a health service but not being able to do so. In 2022:

- 1 in 5 (20% or 1.1 million) people with disability (living in households) at least once needed to see a GP in the past 12 months but did not
- 1 in 7 (14% or 736,000) at least once needed to see a medical specialist but did not
- 1 in 5 (19% or 1.0 million) at least once needed to see a dental professional but did not
- 3.7% (or 198,000) at least once needed to go to hospital but did not go (Figure ACCESS.2, AIHW analysis of ABS 2024a).

Cost is a major factor in accessing health care. It was the main reason of unmet need for:

- 8.8% (or 93,000) of those who did not see a GP when needed
- 24% (or 180,000) of those who did not see a medical specialist when needed
- 46% (or 468,000) of those who did not see a dental professional when needed (Figure ACCESS.2).

Long waiting times or lack of service availability also often prevented timely access to health care:

- More than 2 in 5 (43% or 457,000) people with disability who did not see a GP when needed said the main reason was waiting time or service unavailability. This was also the main reason for 1 in 4 (26% or 188,000) people who had unmet need for medical specialist services, and 1 in 12 (8.5% or 86,000) people with unmet need for dental services (Figure ACCESS.2).
- Two in 5 (40% or 371,000) people who needed to see a GP for urgent medical care waited one or more days after making an appointment to be seen (AIHW analysis of ABS 2024a).

For people who need to see multiple specialists for the same condition, coordination of care can help achieve better health outcomes:

- Of people with disability who saw 3 or more specialists for the same condition, 64% (or 1.3 million) had a health professional help coordinate their care.
- Among those who received help with coordination of care, 53% (or 711,000) said it helped to a large extent, 41% (or 546,000) said it helped somewhat, and 3.6% (or 48,000) said it did not help at all (AIHW analysis of ABS 2024a).

People's experience of health services is also affected by accessibility of services and attitudes of healthcare workers:

- 2.3% (or 94,000) of people with disability aged 15 and over experienced discrimination by health staff (GP, nurse, hospital staff) (AIHW analysis of ABS 2024b)
- 4.6% (or 186,000) of people with disability aged 15 and over avoided visiting medical facilities (GP, dentist, hospital) due to their disability (AIHW analysis of ABS 2024b)
- more than 1 in 10 (11% or 242,000) people with disability aged 5 and over who need assistance or have difficulty with communication or mobility had difficulty accessing medical facilities (GP, dentist, hospital) (AIHW analysis of ABS 2024b)
- while more than 9 in 10 people with disability aged 18 and over who had used health services in the past 12 months said they were treated with respect and that things were explained clearly to them, 5.2% felt they were not respected by health workers, and 8.0% did not receive clear explanations (AIHW 2025b)
- 15% of people with disability aged 18 and over who had used health services in the past 12 months felt they would have been treated better by health workers if they did not have disability (AIHW 2025b)
- half (50%) of healthcare workers say they often or very often advised, assisted, or treated a person with disability as part of their job in the last 12 months (AIHW 2025b)
- most (92%) healthcare workers feel confident they respond in a positive way to people with disability (AIHW 2025b).

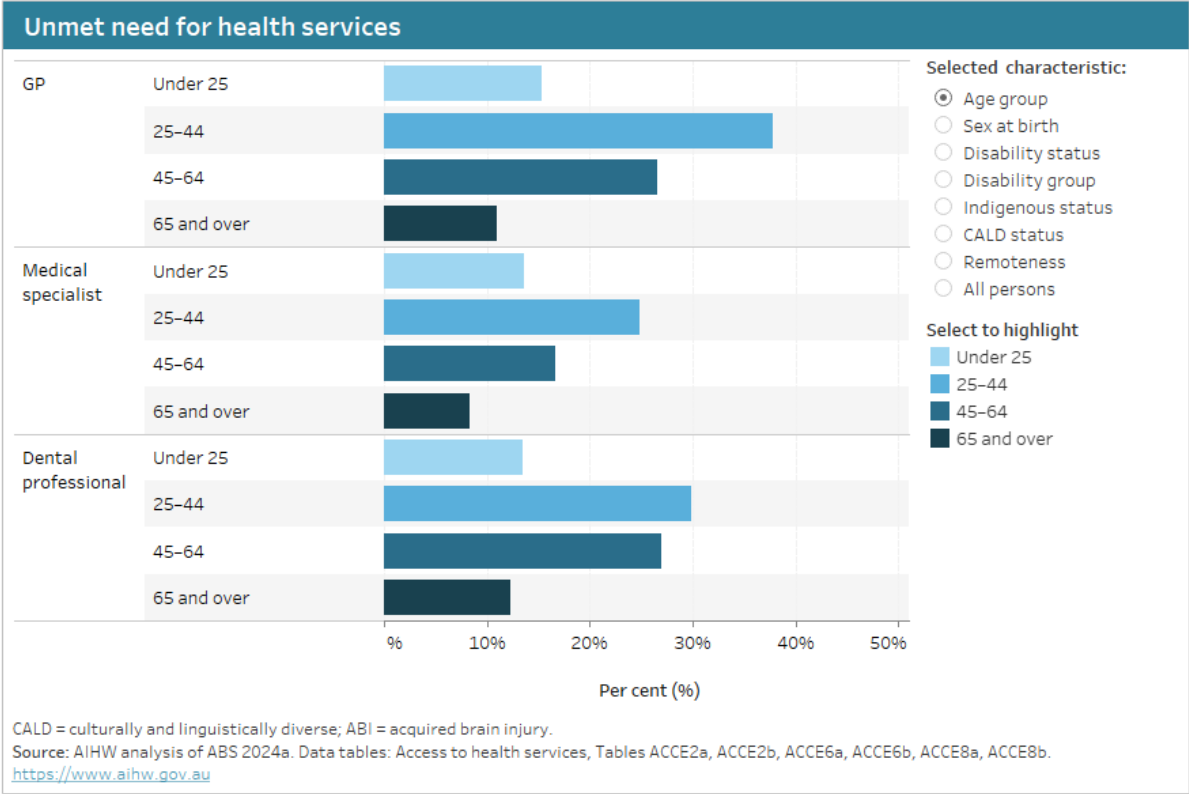
### **Unmet need for health services for sub-groups of people with disability**

Unmet need for health services is highest among people with disability aged 25–44 and lowest for the 65 and over age group. Females are more likely than males to miss out on health services when needed (AIHW analysis of ABS 2024a).

Groups with higher unmet need are more likely to report cost as the main reason for missing out (AIHW analysis of ABS 2024a).

Unmet need for health services among people with disability living in households varies by age, sex, disability characteristics, and other personal factors (Figure ACCESS.3).

**Figure ACCESS.3: Unmet need for health services among people with disability, by selected characteristics, 2022**



**Note:** Restricted to patient experience in the last 12 months of people with disability living in households.

**Source:** AIHW analysis of ABS 2024a. [Data tables:](#) Access to health services, Tables ACCE2a, ACCE2b, ACCE6a, ACCE6b, ACCE8a, ACCE8b.

**Key takeaways from Figure ACCESS.3**

1. Unmet need for health services among people with disability varies by person’s characteristics.
2. People aged 25–44 have the highest rates of unmet need, followed by those aged 45–64. People aged under 25 or 65 and over have the lowest rates of unmet need for health services.
3. Females have higher rates of unmet need than males.
4. Among different disability groups, people with psychosocial disability have the highest rates of unmet need, while people with sensory or speech disability have the lowest.

Unmet need for health services is highest among people with disability aged 25–44 and lowest for the 65 and over age group. Almost 2 in 5 (38% or 297,000) people aged 25–44 with disability reported unmet need for GP services in the last 12 months. This compares with 26% (or 385,000) of those aged 45–64, 15% (or 145,000) of those aged under 25, and 11% (or 232,000) of those aged 65 and over (Figure ACCESS.3).

Females have higher rates of unmet need for health services than males. Almost 1 in 4 (23% or 633,000) females with disability had unmet need for GP services compared with 16% (or 424,000) of males (Figure ACCESS.3).

People with severe or profound disability have similar rates of unmet need to people with other disability status, except when it comes to medical specialists. One in 6 (17% or 319,000) of people with severe or profound disability did not see a medical specialist when needed, compared with 12% (or 419,000) of people with other disability status (Figure ACCESS.3).

The rates of unmet need are lowest for people with sensory or speech disability, and highest for people with psychosocial disability. For example:

- 26% (or 395,000) of people with psychosocial disability had unmet need for GP services, compared with 16% (or 287,000) of people with sensory or speech disability
- 20% (or 306,000) of people with psychosocial disability had an unmet need for medical specialist services (12% or 211,000 for people with sensory or speech disability)
- 25% (or 379,000) of people with psychosocial disability had an unmet need for dental services (16% or 286,000 for people with sensory or speech disability) (Figure ACCESS.3).

Moreover, 7.0% (or 106,000) of people with psychosocial disability had, at least once in the preceding 12 months, needed to go to a hospital but did not go, compared with 3.7% (or 198,000) of all people with disability (AIHW analysis of ABS 2024a).

There are also some differences in unmet need depending on Indigenous or CALD status and remoteness, however these are less pronounced.

The groups that have higher rates of unmet need are more likely to name cost as the main reason for not using the health services (medical specialists or dental professionals) when needed:

- 40% (or 78,000) of people aged 25–44 with unmet need for medical specialist services said cost was the main reason, compared with 15% (or 26,000) of those aged 65 and over
- 29% (or 124,000) of females with unmet need for medical specialist services report cost as the main reason compared with 18% (or 56,000) of males
- 59% (or 137,000) of those aged 25–44 who did not see dental professional when needed report cost as the main reason, compared with 36% (or 92,000) of those aged 65 and over
- 49% (or 281,000) of females with unmet need for dental services report cost as the main reason, compared with 42% (or 183,000) of males (AIHW analysis of ABS 2024a).

## Use of medicines

Medicines can help manage health conditions, ease pain, reduce symptoms and support daily activities. They can also help prevent complications from existing conditions, improve quality of life or delay onset of disease (for more information, go to [Medicines in the health system](#)).

### Data note

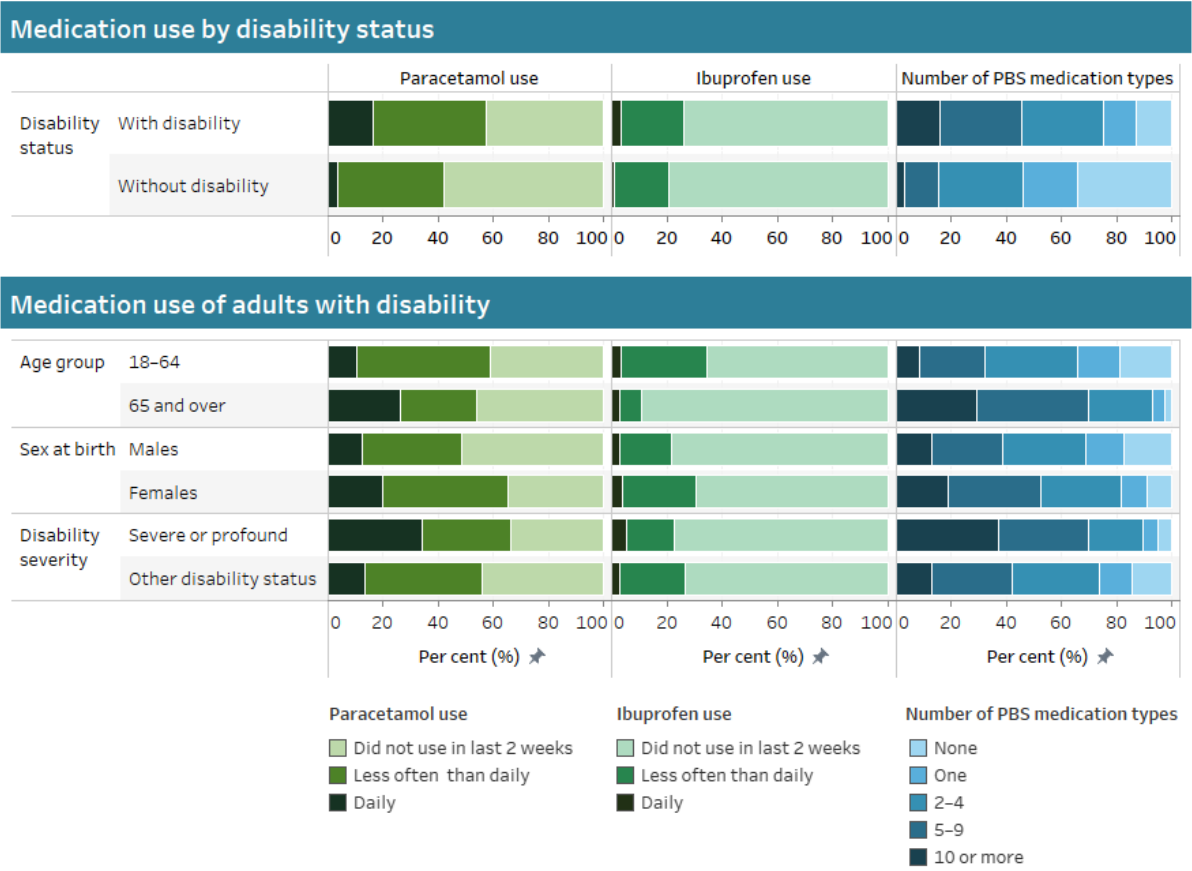
Data in this section are sourced from the Australian Bureau of Statistics (ABS) **National Health Survey (NHS) 2022**. More information about the NHS, including the concepts of disability, disability groups, and remoteness categories used by the NHS, can be found in '[Data sources](#)'.

The 2022 NHS collected data on use of over-the-counter medicines (paracetamol and ibuprofen) in the 2 weeks before the survey interview. It also linked data from the Pharmaceutical Benefits Scheme (PBS) about PBS medications dispensed to NHS survey participants in the 6 months before or after their interview. It should be noted that PBS data only shows if a medicine was dispensed, not whether it was taken or used as prescribed.

**Living arrangements:** Reporting on the use of medicines is restricted to people living in households (in private dwellings in the community).

The 2022 NHS data show that people with disability are more likely to use paracetamol and ibuprofen than people without disability. This may reflect higher levels of pain among people with disability.

**Figure ACCESS.4: Use of medicines, by disability status and characteristics of people with disability, 2022**



Source: AIHW analysis of ABS 2024c. Data tables: Access to health services, Tables ACCE16, ACCE18, ACCE20. <https://www.aihw.gov.au>

Notes: Restricted to adults (aged 18 and over) living in households.

Source: AIHW analysis of ABS 2024c. Data tables: Access to health services, Tables ACCE16, ACCE18, ACCE20.

**Key takeaways from Figure ACCESS.4**

1. Use of paracetamol is higher for adults (aged 18+) with disability than for those without disability. Likewise, adults with disability are dispensed a greater number of different PBS medications than those without disability.
2. Among adults with disability, people aged 65 and over, women, and people with severe or profound disability have higher rates of paracetamol use and are dispensed more PBS medications.

In the 2 weeks before their 2022 NHS interview:

- 16% of adults aged 18 and over with disability (living in the households) used paracetamol daily, compared with 3.3% of adults without disability; 57% of adults with disability and 42% of those without disability used paracetamol at least once

- 26% of adults with disability used ibuprofen at least once, and 3.4% used it daily, compared with 21% and 1.2%, respectively, for those without disability (AIHW analysis of ABS 2024c).

Older adults aged 65 and over with disability are more likely to use paracetamol daily, while younger adults aged 18–64 are more likely to use ibuprofen:

- 26% of people aged 65 and over with disability used paracetamol daily, compared with 10% of those aged 18–64
- 34% of people aged 18–64 with disability used ibuprofen in the last 2 weeks, compared with 11% of those aged 65 and over (AIHW analysis of ABS 2024c).

Women with disability are more likely to use paracetamol and ibuprofen than men:

- 20% of women aged 18 and over used paracetamol daily, compared with 12% of men
- 51% of men did not use any paracetamol in the last 2 weeks, compared with 35% women
- 30% of women used ibuprofen in the last 2 weeks, compared with 22% of men (AIHW analysis of ABS 2024c).

Adults with disability are more likely to be dispensed PBS medications and often receive a higher number of different PBS medication types than those without disability:

- almost 9 in 10 (87%) adults aged 18 and over with disability were dispensed at least one PBS medication in the 6 months before or after their NHS interview, compared with 2 in 3 (66%) adults without disability
- 46% of adults with disability were dispensed 5 or more types of PBS medications, compared with 15% of adults without disability (AIHW analysis of ABS 2024c).

Older adults (aged 65 and over) with disability were dispensed more PBS medication types than younger adults (aged 18–64):

- almost all (98%) older adults were dispensed with at least one PBS medication, compared with 4 in 5 (81%) younger adults
- older adults with disability were more than twice as likely (70%) to be dispensed 5 or more types of PBS medications than younger adults (32%) (AIHW analysis of ABS 2024c).

Women with disability were dispensed more PBS medicine types than men:

- more than half (52%) of women with disability were dispensed 5 or more types of PBS medication compared with 2 in 5 (38%) men
- men were twice as likely to not be dispensed any PBS medications (17%) than women (8.7%) (AIHW analysis of ABS 2024c).

In 2022, the most commonly dispensed PBS medication types among adults with disability were:

- medicines for the cardiovascular system, such as blood pressure and cholesterol-lowering medicines (49% of adults with disability were dispensed this type of medication)

- medicines for the nervous system, such as pain relief and medications used for mental health (48%)
- anti-infectives for systemic use, such as bacterial antibiotics and antivirals (47%)
- medicines for the alimentary tract and metabolism, such as anti-nausea and diabetic medications (38%)
- medicines for the musculoskeletal system, such as non-steroid based anti-inflammatory medications (27%) (AIHW analysis of ABS 2024c).

Older adults aged 65 and over had higher dispensing rates for all types of PBS medication. This was the case for people with disability and for those without disability. For example, for people with disability:

- 83% of older adults were dispensed medicines for the cardiovascular medicine, compared with 30% of those aged 18–64
- 57% of older adults were dispensed medicines for the alimentary tract and metabolism, compared with 27%
- 30% of older adults were dispensed medicines for the blood and blood forming organs, compared with 8.5% (AIHW analysis of ABS 2024c).

## Aboriginal and Torres Strait Islander (First Nations) people

### Data note

Data in this section are sourced from the Australian Bureau of Statistics (ABS) **2022–23 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)**. More information about the NATSIHS, including the concepts of disability, disability groups, and remoteness categories used by the NATSIHS, can be found in '[Data sources](#)'.

In 2022–23, 9 in 10 (90%) First Nations people with disability saw a GP or specialist in the last 12 months, almost half (45%) of those aged 2 and over saw a dentist or dental professional, and around 1 in 5 (22%) were admitted to hospital (AIHW analysis of ABS 2025).

Not all First Nations people with disability were able to access health services when needed. In 2022–23:

- 1 in 4 (25%) had at least one occasion in the last 12 months when they needed to see a GP but did not. The most common reasons were long waiting time or service not being available when needed (45%), or being too busy with work, personal and family responsibilities (24%) (more than one reason could be given).
- Around 3 in 10 (29%) at least once did not see a dentist or dental professional when needed, of those 47% report cost as a reason and 28% dislike of dental services
- 1 in 10 (10%) were not admitted to hospital when needed (AIHW analysis of ABS 2025).

Transport, distance, or health service not being available in area can be barriers to accessing health services for First Nations people with disability:

- 20% of those with unmet need for GP services report transport, distance, or health service not being available in area as a reason for not receiving care when needed
- 17% of those with unmet need for dental services
- 23% of those with unmet need for hospital admission (AIHW analysis of ABS 2025).

## Health expenses

### Data note

Data in this section are sourced from the **2021 Household, Income and Labour Dynamics in Australia (HILDA) Survey**. More information about HILDA, including the concepts of disability, disability groups, and remoteness categories used by HILDA, can be found in '[Data sources](#)'.

### What are out-of-pocket expenses?

Out-of-pocket expenses occur when services are not bulk-billed and are also known as gap payments.

In 2021, people aged 15–64 with disability were less likely (34%) to pay out-of-pocket for GP consultations than those without disability (40%). Older people with disability (aged 65 and over) were less likely (24%) to pay out-of-pocket than younger people (aged 15–64) (34%) (AIHW analysis of DSS and MIAESR 2022). Of those aged 15–64 with disability:

- people with severe or profound disability were less likely (20%) to have had out-of-pocket expenses than those with other disability status (35%)
- females (34%) were about as likely to have had out-of-pocket expenses as males (33%)
- those living in *Major cities* were less likely (31%) than those living in *Inner regional areas* (40%)
- people with physical disability (31%), sensory (30%), or psychosocial disability (30%) were more likely than those with intellectual disability (22%) (AIHW analysis of DSS and MIAESR 2022).

## What is private health insurance?

Private health insurance is a voluntary form of insurance that covers a wider range of health care options than the public system. Depending on the type of cover, private health insurance can fully or partly cover the costs of hospital services and/or the costs of other general treatments (PHIO 2023).

### Types of private health insurance

Private health insurance can include hospital cover only, extras cover only (such as dental care, physiotherapy, chiropractic services, and podiatry), or both hospital and extras cover.

In 2021, people with disability aged 15–64 were less likely (42%) to have private health insurance than those without disability (56%). Older people with disability aged 65 and over were more likely (53%) to have private health insurance than those aged 15–64 (42%). Of people aged 15–64 with disability:

- those with severe or profound disability were less likely (34%) to have private health insurance than those with other disability status (43%)
- females were more likely (46%) than males (38%)
- those living in *Major cities* were more likely (46%) than those living in *Inner regional areas* (34%)
- those with physical disability (40%), sensory disability (39%), or psychosocial disability (37%) were more likely than those with intellectual disability (28%) (AIHW analysis of DSS and MIAESR 2022).

Most (79%) people with disability aged 15–64 who have private health insurance have both hospital and extras cover. This is similar to those without disability (81%). Older people aged 65 and over with disability are more likely (14%) to have hospital cover only than those aged 15–64 (10%) (AIHW analysis of DSS and MIAESR 2022).

## Health outcomes for recipients of government disability payments and services

To date, reporting on outcomes for people with disability using non-disability specific services has been patchy. This was mainly due to inconsistent identification of disability across administrative (government) data sources. Recently, there have been significant efforts to link different administrative data to identify records of disability service users in systems such as health care. Much of this effort has occurred as part of the [National Disability Data Asset](#) initiative.

In 2025, as part of reporting against Australia's Disability Strategy 2021–2031, some health outcomes for people using disability-related government payments and services were able to be reported for the first time. In 2021–22:

- people using disability-related government payments and services were 7 times as likely as others to experience a [potentially avoidable death in hospital](#)

- there were 1,841 [involuntary hospital admissions](#) per 100,000 people using disability services
- there were 17,608 [GP-type emergency presentations](#) per 100,000 disability service users.

## Where can I find out more?

- [Data tables](#) for this report.
- [ABS Disability, Ageing and Carers, Australia: Summary of Findings, 2022](#).
- [The Household, Income and Labour Dynamics in Australia Survey](#).

## References

ABS (Australian Bureau of Statistics) (2022-23) [Patient experiences, 2022–23](#), ABS, accessed 21 November 2025.

ABS (2022) [Disability, Ageing and Carers, Australia: Summary of Findings, 2022](#), ABS website, accessed 20 February 2026.

ABS (2024a) [Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022](#), ABS, AIHW analysis of detailed microdata in DataLab, accessed 11 November 2025.

ABS (2024b) [Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022](#), ABS, AIHW analysis of TableBuilder, accessed 21 November 2025 and 12 February 2026.

ABS (2024c) [Microdata and TableBuilder: National Health Survey, 2022](#), ABS, AIHW analysis of detailed microdata in DataLab, accessed 20 November 2024.

ABS (2025) [Microdata and TableBuilder: National Aboriginal and Torres Strait Islander Health, Australia, 2022–23](#), ABS, AIHW analysis of TableBuilder data, accessed 5 January 2026.

AIHW (2025a) [Rural and remote health](#), AIHW, Australian Government, accessed 12 February 2026.

AIHW (2025b) [Australia's Disability Strategy Survey: Wave 2 Report](#), Australian Department of Health, Disability and Ageing, Canberra, Australia, accessed 11 February 2026.

DSS (Department of Social Services) and MIAESR (Melbourne Institute of Applied Economic Social Research) (2022) [The Household, Income and Labour Dynamics in Australia \(HILDA\) Survey, General Release 21 \(wave 21\)](#), doi:10.26193/KXNEBO, ADA Dataverse, V3, AIHW analysis of unit record data, accessed 7 December 2022.

PHIO (Private Health Insurance Ombudsman) (2023) [How health insurance works](#), PrivateHealth.gov.au website, accessed 5 May 2026.

# Key data gaps

Although much is known about how people with disability experience life in Australia, critical data gaps remain. These limit the ability to present a comprehensive and insightful picture, including about pathways through and across multiple service systems and the extent to which these contribute to positive outcomes.

This section presents key gaps in data about people with disability. It also looks at opportunities to improve available information through:

- maximising the use of existing data sources
- improving the quality and comparability of data sources
- adding to data sources.

The gaps and opportunities presented in this section are not exhaustive. Rather, they are intended to form a basis for discussion. The Australian Institute of Health and Welfare (AIHW) continues to work with other statistical agencies and data custodians to maximise, streamline and improve the collection of data about people with disability.

## Existing data sources and challenges

There are many data sources that contain information about people with disability. These have varying degrees of accessibility, quality and usefulness. For example, some sources are not widely available for use, and some are useful only if linked to another source.

This report draws on a range of data sources, including survey and administrative data, to shed light on the experiences of people with disability in Australia. Although these sources offer a comprehensive overview, important data gaps remain, and there are still questions that need to be answered or explored.

### Administrative and survey data

Information about people with disability comes from 2 major types of data sources:

- administrative – collected when running a service or program (such as income support, taxation, or health care)
- survey – collected for a sample of individuals or households on a given topic.

Each has advantages and disadvantages.

#### Administrative data

Many administrative datasets have data about people with disability. Some of these datasets contain ‘disability flags’ – a set of questions to identify records of people with disability within the data collection. Other datasets do not contain such flags.

The AIHW Specialist Homelessness Services Collection is a good example of an administrative dataset that has a question set to identify disability. This data collection uses a version of the [standardised disability flag](#) developed by the AIHW.

Administrative data are collected as a by-product of service delivery. Therefore, they:

- only contain data on people receiving these services
- only contain information directly relevant to the service provision. They are unlikely to include data on client outcomes outside of the service, or on client satisfaction with the service (although some service providers do separately survey consumers of their services).

#### Survey data

Population surveys can be used for:

- estimating the prevalence of disability in the population, including changes over time
- collecting information about people’s experiences across different life areas.

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers is the best example of a population survey that collects data about people with disability.

However, survey data have some limitations:

- as a dedicated data collection exercise, surveys are costly to run, and there may be a gap of several years between data collections

- surveys usually collect information from a sample of the population, and the results may be biased by who is selected to participate in a survey
- the information collected is restricted by the questions asked, and the available response options may be too prescriptive.

The quality of the survey data is also affected by how well the respondent understands the questions and how much the respondent trusts the survey.

## **Key data sources about people with disability**

### **Survey/census data**

- Australia's Disability Strategy Survey, Department of Health, Disability and Ageing (DHDA)
- Census of Population and Housing, Australian Bureau of Statistics (ABS)
- Children and Young People with Disability Australia (CYDA) surveys (various)
- General Social Survey (GSS), ABS
- Graduate Outcomes Survey (GOS), Quality Indicators for Learning and Teaching (QILT)
- Household, Income and Labour Dynamics in Australia (HILDA) Survey, Department of Social Services (DSS) and Melbourne Institute of Applied Economic and Social Research
- National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), ABS
- National Aboriginal and Torres Strait Islander Social Survey (NATSISS), ABS
- National Health Survey (NHS), ABS
- National Social Housing Survey, Australian Institute of Health and Welfare (AIHW)
- Personal Safety Survey (PSS), ABS
- Student Experience Survey, QILT
- Survey of Disability, Ageing and Carers (SDAC), ABS
- Youth Survey, Mission Australia

### **Administrative data**

- Australian Government Housing Data Set, DSS
- Australian Human Rights Commission (AHRC) Complaint statistics, AHRC
- Higher Education Student Data Collection, Department of Education (DoE)
- Nationally Consistent Collection of Data on School Students with Disability, DoE
- National Disability Insurance Scheme (NDIS) data, National Disability Insurance Agency (NDIA)
- National Housing Assistance Data Repository, AIHW

- NDIS Quality and Safeguards Commission data
- Report on Government Services, Productivity Commission
- Services Australia income support data, collated and published by DSS
- Specialist Homelessness Services Collection, AIHW
- Total Vocational Education and Training (TVET) Students and Courses Collection, National Centre for Vocational Education Research (NCVER)
- TVET Student Outcomes Collection, NCVER.

## What are the key challenges with existing data sources?

Key data challenges with existing data sources include:

- inconsistent ways in which data collections capture information about a person's disability
- poor adoption of a disability flag to identify people with disability in mainstream data sources
- inability to reliably report on specific disability population sub-groups (refer to **Box 1**)
- fragmented, dispersed and incomplete data about services used by people with disability (specialist and mainstream)
- data being collected but not made available for analysis and reporting
- limited integration of data across services (specialised and mainstream) and life domains.

### Box 1. Examples of disability population sub-groups for whom information is limited

#### Aboriginal and Torres Strait Islander (First Nations) people

Data about First Nations people collected in population surveys can be affected by small sample size and geographic constraints (ABS 2019). For example, the Survey of Disability, Ageing and Carers (SDAC) does not collect data from people living in very remote areas or in discrete Aboriginal and Torres Strait Islander communities (ABS 2024a).

As a result, information about First Nations people with disability is usually sourced from the:

- Australian Census
- National Aboriginal and Torres Strait Islander Health Survey
- National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey.

However, these surveys do not identify disability as well as the more detailed set of questions used in the SDAC (ABS 2025a). Survey questions about disability may also not easily translate into concepts relevant to First Nations people (Avery 2018, ABS 2025b).

## **LGBTIQ+ people**

The LGBTIQ+ community includes individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer or otherwise diverse in gender, sex or sexuality.

LGBTIQ+ people can face harassment and discrimination based on their identity. They may also experience poorer health outcomes than other Australians.

Recently, there have been developments in national data collections to capture information about people's gender characteristics and sexual orientation. For example, the ABS introduced a revised set of questions to collect information on gender, sex, and sexual orientation (ABS 2020).

However, the quality of data about this group of people with disability in survey collections is often affected by small sample size. This means there is still very limited reporting on the intersection of LGBTIQ+ and disability.

## **People who experienced violence, abuse, and neglect**

Several ABS surveys collect data about crime-related experiences of people with disability. These include the Survey of Disability, Ageing and Carers (SDAC), Personal Safety Survey, Personal Fraud Survey and Crime Victimization Survey (ABS 2025c).

However, these data have some limitations:

- they are only collected for people who live in the community (in private dwellings) and therefore exclude those in cared accommodation
- they are only collected by personal interview and therefore exclude some people with communication difficulties
- disability status is collected as at the time of the survey, not at the time the violence or abuse occurred
- different surveys use different approaches to identify disability. Shorter question sets used by surveys other than SDAC tend to overestimate the presence of disability (ABS 2025a). This could lead to understating the differences in outcomes of those with and without disability.

## **People who experienced discrimination**

While the SDAC collects data on discrimination against people with disability, it does not collect these data for people without disability. This means experiences of discrimination cannot be compared for people with and without disability.

Some information about experiences of discrimination can be drawn from the ABS General Social Survey (GSS). GSS collects data on various forms of discrimination including age and sex discrimination. However, GSS uses a shorter disability question set, which tends to overestimate the presence of disability (ABS 2025a). This could lead to understating the differences in experiences of discrimination between people with and without disability.

It is also difficult to estimate the direct effect of discrimination on people with disability. Data show that people with disability who have experienced discrimination tend to have lower rates of employment, income, and social participation, as well as poorer health outcomes than other people with disability. However, it cannot be assumed that poorer outcomes were caused by the experience of discrimination.

## People who are homeless

Very few population surveys include a measure of homelessness. Those that do measure homelessness (such as the ABS Census of Population and Housing) may not capture disability as comprehensively as the SDAC, or not capture it at all.

The AIHW's [Specialist Homeless Services Collection](#) collates data about people who have sought assistance from a homelessness agency. This collection includes a version of the AIHW's standardised disability flag. However, due to differences in how disability questions are interpreted, data for young children may not be comparable with older age groups.

A key initiative in this space is the proposed linkage of housing and homelessness data, to improve understanding of service pathways.

## What main questions cannot be answered?

While data exist on many aspects of what life is like for people with disability in Australia, critical gaps make it difficult to comprehensively answer some questions.

For example, there is a lack of data on:

- what services people with disability use (across mainstream and specialist areas), and how coordinated, timely, appropriate and effective they are
- unmet need for services (both within and outside the NDIS)
- the use of restrictive practices (such as seclusion and physical or chemical restraints)
- people with disability in closed and segregated settings (such as specialist schools or group homes)
- supported decision-making for people with disability, such as whether people with disability feel supported to make their own choices and remain in control of their lives
- transition pathways of people with disability at key life points, such as from school to further education or employment
- how much contact people with disability have with the justice and child protection systems, as victims and as offenders
- the quality and sustainability of the disability workforce
- causes of death of people with disability – such as potentially avoidable deaths.

These limitations were highlighted by the COVID-19 pandemic and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Royal Commission).

The Royal Commission made a range of recommendations to address existing data gaps. These related to realising the human rights of people with disability, enabling autonomy, access to services and participation in all aspects of life, and achieving inclusive systems such as education, employment, and housing.

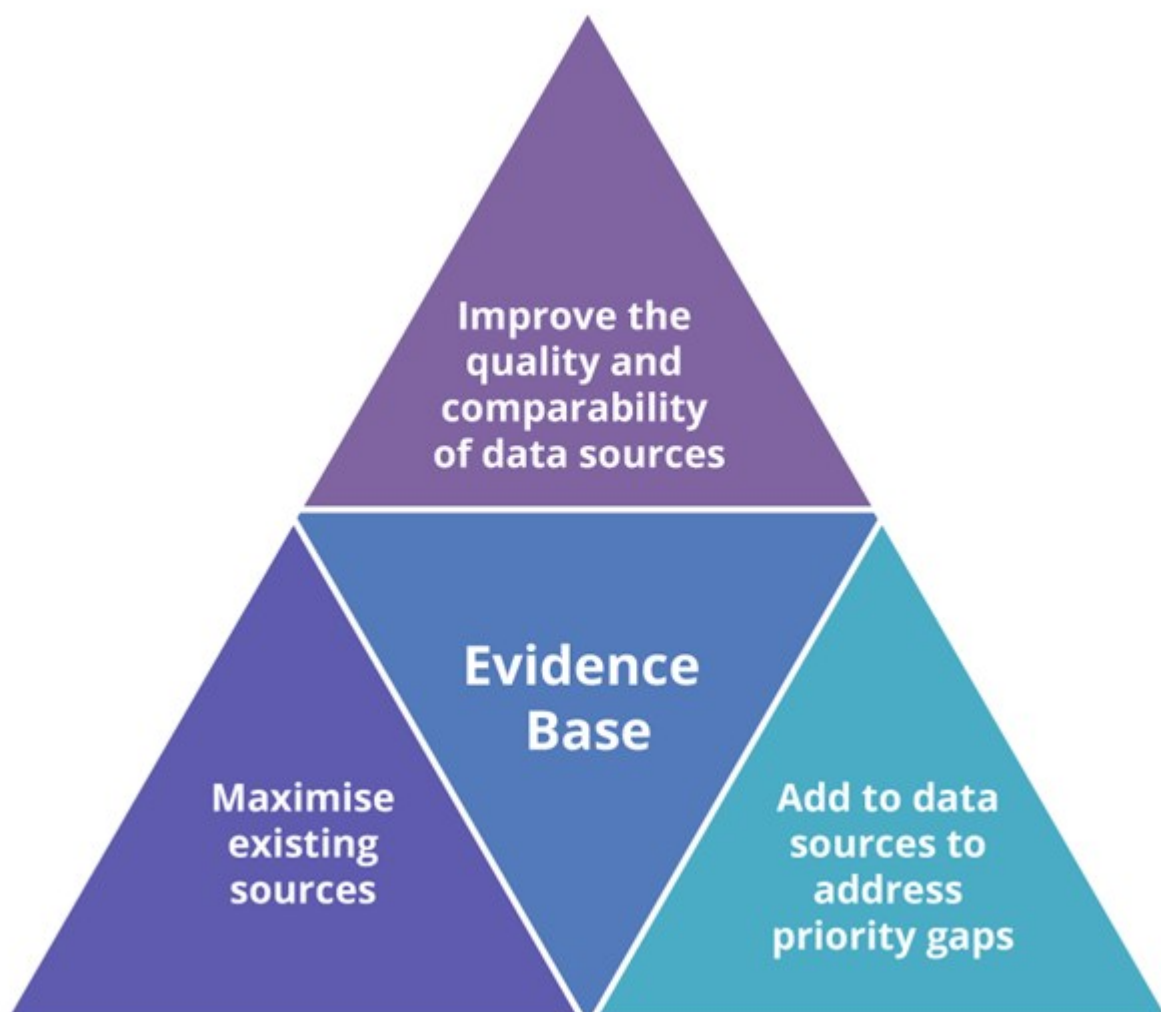
# What can be done to improve the evidence?

## Priority themes to improve the evidence base

A useful framework for improving data is presented in Figure DATA.1. It involves making improvements in 3 key areas:

- maximising the use of existing data sources
- improving the quality and comparability of data across data sources
- adding to data sources, including by developing new data sources in priority areas and through data linkage.

**Figure DATA.1: Priority themes to improve the evidence base for people with disability**



**Source:** Adapted from Diagram 8 in ABS 2013.

Importantly, data gaps or issues should not prohibit reporting on what is available. Instead, data limitations should be acknowledged, and data agencies should work together to continually improve data availability and quality.

## **Maximise the use of existing data sources**

Bringing together information from multiple data sources helps support a person-centred, whole-of-system view of the experiences of people with disability in Australia. This provides a more comprehensive picture than is possible by relying on any one data source.

Examples of national reporting and associated frameworks that draw on multiple sources to understand the experiences of people with disability are:

- this report
- reporting against the Australia's Disability Strategy 2021–2031 Outcomes Framework
- the Report on Government Services (SCRGSP 2026)
- the disability and wellbeing monitoring framework and indicators developed by the Centre of Research Excellence in Disability and Health (Fortune et al. 2020).

Such national reports complement the large body of research on the experiences of people with disability in Australia and reporting at state and territory levels. However, much greater gains in understanding can come from sharing existing data sources, particularly through data linkage.

## **Improve the quality and comparability of data sources**

Many different agencies and sectors collect information about people with disability, including:

- AIHW
- Australian Bureau of Statistics (ABS)
- Department of Health, Disability and Ageing (DHDA)
- Department of Social Services (DSS)
- National Disability Insurance Agency (NDIA)
- NDIS Quality and Safeguards Commission.

Each data collection may have its own approach to defining disability, reflecting the role of the collecting agency and the purpose of the collection. These differences can make it difficult to compare data from different collections.

Mainstream services – which cater to all people regardless of their disability status, such as schools, hospitals, and housing – also collect valuable information about their customers or clients. However, it is not always possible to identify records of people with disability in these data collections.

The quality and comparability of existing data sources could be improved by:

- harmonising how disability is captured in different data collections
- adding a disability flag in mainstream data collections – a standard set of questions to identify people with disability and the level of their disability.

These 2 options come with issues to consider. These include privacy implications, the role of (and the burden on) service providers, and the associated costs of data collection.

Given these issues, there is a growing view that data sharing and linkage, which could accommodate different definitions of disability and develop more consistent disability flags, is a practical way forward. Section ‘Safely share and link data to better understand pathways and outcomes’ below has more information on this, especially in relation to the National Disability Data Asset.

### **Harmonising definitions of disability across data sources**

The definition of disability in a data source depends on the source’s purpose and how the data is collected. These considerations shape the questions used to determine if a respondent or a service user has disability. As a result, definitions of disability vary across population surveys and administrative data.

It is not always possible to perfectly align existing definitions of disability across data sources. With careful analysis and reporting, it may be possible to manage these differences. However, strategies to improve the consistency of definition and coverage between sources of data should also be considered. The World Health Organization’s [International Classification of Functioning, Disability and Health \(ICF\)](#) is an international standard framework and classification system, and provides a valuable basis for disability data development.

### **Adding a disability flag in mainstream data sources**

The inclusion of a disability flag in a data collection enables researchers to know which records within the collection belong to people with disability. This can reduce the need for new data sources.

An example of such flag is the [AIHW’s standardised disability flag](#). This flag represents a set of questions about whether a person has difficulty or needs support with various everyday activities. These questions are based on the ICF and are broadly consistent with the ABS Short Disability Module (ABS 2025a). Versions of the flag have been implemented in the AIHW’s Specialist Homelessness Services Collection (SHSC), the National Social Housing Survey, and National Prisoner Health Data Collection.

Another useful flag is the National Disability Insurance Scheme (NDIS) participation indicator, such as used within the SHSC. This flag can be used to look at the use of mainstream and other services by NDIS participants. Together with the standardised disability flag, it could be used to examine differences in the use of mainstream services between NDIS participants and other people with disability.

In its final report, the Royal Commission recommended that disability flags are included in data collections for key mainstream services (DRC 2023).

## **Add to data sources to address priority gap areas**

Data gaps can also be addressed by:

- enhancing existing data sources by improving coverage and refining or adding data items
- enabling safe data sharing and linkage
- creating new data sources to fill priority gaps.

### **Enhance existing data sources**

Existing data sources could be improved to better capture diversity and intersectionality in the disability population.

One way to improve a data source is to make it more accessible by introducing hybrid modes of data collection. Hybrid modes of data collection – such as combining face-to-face, telephone, and online methods – are more flexible and user-friendly and can help reduce respondent burden. One example of this is the Survey of Disability, Ageing and Carers which introduced the option of online questionnaire for the first time in 2022.

Existing data collections can also be improved by standardising how they capture diverse groups within the disability population. As highlighted above, key data gaps exist for people with disability who are Aboriginal and/or Torres Strait Islander, come from culturally and linguistically diverse backgrounds, or identify as LGBTIQ+. Having consistent agreed methods of identifying these groups in data collections can help ensure high data quality, improve comparability, and provide a more accurate picture of the needs of these groups.

Examples of standardised items that are being introduced in various survey and administrative data collections include the ABS data standards, such as:

- the Indigenous Status Standard (ABS 2014)
- the standards for statistics on cultural and linguistic diversity (ABS 2022)
- the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables (ABS 2020).

The new Occupation Standard Classification for Australia (OSCA) (ABS 2024b) will allow more accurate reporting on disability workforce.

### **Safely share and link data to better understand pathways and outcomes**

Safely sharing data for statistical purposes, including for data linkage, could lead to major improvements in understanding the experience of people with disability in Australia.

Many government agencies and organisations already have arrangements in place to share and release data in ways that support privacy and confidentiality of information. However, some data collected about people with disability are not widely available for use or sharing. These include, but are not limited to, data collected by non-government organisations but not collated for national analysis.

Improving the ability to access these data sources would assist in expanding the evidence base, particularly in understanding other services people with disability use.

Some benefits of data sharing cannot be realised without data linkage. For example, without data linkage it is difficult to see how different specialist disability support systems interact, such as how the NDIS interacts with other specialist disability services. It is also difficult to understand how these specialist disability services interact with mainstream supports.

## What is data linkage?

Data linkage (also called data matching, data integration or record matching) combines information from multiple data sources while preserving privacy. This tells a much more powerful story than is possible from individual data sources in isolation.

## Examples of improving the evidence base through data linkage

Data linkage can be used in many ways to improve the evidence base about people with disability, for example linking:

- disability support services and payments data to national hospital data, the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme – to provide insights into how people with disability use mainstream health services, and how these services complement specialist disability supports
- disability support services data to aged care and mental health data – to help improve understanding of how these sectors interact
- employment services data (including specialist disability employment services) with income support payments data – to provide information about the relationship between seeking employment and income support.

## Linked data assets supporting disability research

Some examples of linked data assets that are being used for disability research include:

- [Person Level Integrated Data Asset \(PLIDA\)](#) – which combines information on health, education, government payments, income and taxation, employment, and population demographics (including the Census) over time.
- [National Health Data Hub \(NHDH\)](#) – which brings together a wealth of health-related information, including hospital and emergency department services, data on medications, use of health services, aged care, deaths, and immunisation.

The disability-related research using these data assets is carried out under disability and community co-governance provisions.

While data linkage is a powerful tool, it still has its challenges. These include lack of consistent linkage information across administrative systems in Australia, and complexities in data sharing and access arrangements. Data sources often need extensive 'data cleaning' before linkage, for example when different data 'rules' have been applied to seemingly similar data items in different sources. Finally, findings from

the analysis of linked data need to be carefully reviewed to ensure privacy is protected. All these can make the data linkage complex, time-consuming, and costly.

The Australian and state and territory governments are working together with people with disability and the wider disability community on the [National Disability Data Asset](#) (NDDA). The NDDA brings together de-identified information from different government agencies about all Australians. These data will help us better understand experiences of people with disability and give us more information about programs and services used by people with disability.

The first step to achieving this purpose is through the development of disability indicators, or flags. These flags are constructed within the NDDA using disability-relevant information from various data sources. The flags have been developed in consultation with people with disability and their representatives, and will continue to be improved throughout the lifetime of the NDDA. More information about the disability flags can be found in [Measuring disability factsheet | NDDA](#).

Insights from the National Disability Data Asset are shared in accessible formats on the data asset's website (available at [Insights | NDDA](#)).

### **Create new data sources where no data currently exist**

When no data exist on a particular topic, or about a specific population, new data collections may need to be developed.

One area where new data collection is needed is disability services provided outside the NDIS. Before the NDIS, data about specialist disability services was collated in the AIHW's Disability Services National Minimum Data Set (DS NMDS). The DS NMDS was last collated in 2018–19. After this, no national data have been available on services outside the NDIS, apart from disability employment services.

While the NDIS is a large scheme, it cannot provide all specialist disability supports to all people with disability. The Australian and state and territory governments are planning to introduce [Foundational Supports](#) to provide specific supports to people with disability outside the NDIS. The first phase of Foundational Supports, known as 'Thriving Kids', will start providing services from 1 October 2026. It is expected that the program will be supported by a data collection to evaluate and monitor its roll-out.

An example of a recent new survey data collection is the Australia's Disability Strategy Survey (ADS Survey). The ADS Survey reports on community attitudes towards disability. The survey is part of *Australia's Disability Strategy 2021–2031* and is run by the Department of Health, Disability and Ageing. The aim of the survey is to collect data about disability awareness and attitudes in key service sectors (such as education and health care) and in the broad community. The survey also asks people with disability about their experiences when interacting with the services and being in the community. Reports on the survey can be found at [Australia's Disability Strategy Hub – Data and Research](#).

## References

- ABS (Australian Bureau of Statistics) (2013) *Bridging the data gaps for family, domestic and sexual violence 2013*, ABS, accessed 27 May 2026.
- ABS (2014) *Indigenous Status Standard*, version 1.5, ABS, accessed 5 February 2026.
- ABS (2019) *Sources of data for Aboriginal and Torres Strait Islander peoples with disability, 2012–2016*, ABS, accessed 5 February 2026.
- ABS (2020) *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables*, ABS, accessed 19 January 2026.
- ABS (2022) *Standards for Statistics on Cultural and Language Diversity*, ABS, accessed 5 February 2026.
- ABS (2024a) *Disability, Ageing and Carers, Australia: Summary of Findings methodology*, ABS, accessed 5 February 2026.
- ABS (2024b) *OSCA – Occupation Standard Classification for Australia*, version 1.0, ABS, accessed 5 February 2026.
- ABS (2025a) *ABS Sources of Disability Statistics, 2018–2023*, ABS, accessed 4 February 2026.
- ABS (2025b) *Aboriginal and Torres Strait Islander peoples with disability, 2022*, ABS, accessed 5 February 2026.
- ABS (2025c) *Disability and Crime*, ABS, accessed 5 February 2026.
- Avery S (2018) *Culture is Inclusion: A narrative of Aboriginal and Torres Strait Islander people with disability*, First Peoples Disability Network (Australia), Sydney, accessed 4 February 2026.
- DRC (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability) (2023) *Final report*, accessed 5 February 2026.
- Fortune N, Badland H, Clifton S, Emerson E, Rachele J, Stancliffe RJ, Zhou Q and Llewellyn G (2020) *The Disability and Wellbeing Monitoring Framework and Indicators, technical report*, Centre of Research Excellence in Disability and Health, Melbourne, accessed 27 May 2026.
- SCRGSP (Steering Committee for the Review of Government Service Provision) (2026) *Report on government services 2026*, Productivity Commission, accessed 5 February 2026.

# Technical notes

This section contains more detailed information about abbreviations and the survey data sources used in this report.

## Abbreviations

Abbreviation	Explanation
ABS	Australian Bureau of Statistics
ADS	Australia's Disability Strategy 2021–2031
DHDA	Department of Health, Disability and Ageing
DSS	Department of Social Services
HILDA	Household, Labour and Income Dynamics in Australia Survey. See also ' <a href="#">Data sources</a> '.
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey. See also ' <a href="#">Data sources</a> '.
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NHS	National Health Survey. See also ' <a href="#">Data sources</a> '.
SDAC	Survey of Disability, Ageing and Carers. See also ' <a href="#">Data sources</a> '.

## Data sources

This section briefly describes key survey data sources used in this report and provides definitions of disability and other relevant concepts used by these sources.

Some of these surveys were conducted during the COVID-19 pandemic and may have been affected by the pandemic and the associated government restrictions. This section summarises impacts of COVID-19 on these data sources, where relevant.

Data source	Notes
<b>HILDA – The Household, Income and Labour Dynamics in Australia Survey</b>	<p>The Household, Income and Labour Dynamics in Australia (HILDA) Survey is a nationally representative, household-based longitudinal study of Australian households and individuals conducted in annual waves since 2001. Members of selected households who are Australian residents and aged 15 or older are invited to participate in a personal interview. This report uses data from the 21st wave of the HILDA Survey (2021). In 2021, 16,500 people from around 9,000 households participated in the HILDA Survey.</p> <p><b>Impact of COVID-19 on HILDA 2021 data collection:</b> The HILDA 2021 data collection was affected by lockdowns and restrictions put in place due to the COVID-19 pandemic. As a result, the interviews were primarily conducted over the telephone rather than face-to-face (76% of the individual interviews were completed by telephone in wave 21, compared with 96% in wave 20 and less than 10% in earlier waves). Overall, the 2021 data was found to be of similar quality to the previous waves despite the changes to data collection (Watson et al. 2022).</p> <p><b>Self-Completion Questionnaire:</b> In addition to personal interviews, survey participants are asked to complete a self-completion questionnaire. The questionnaire covers sensitive questions some people may not feel entirely comfortable answering in an interview.</p> <p><b>Disability:</b> The HILDA Survey defines disability as an impairment, long-term health condition or disability that restricts everyday activities and has lasted, or is likely to last, for a period of 6 months or more. This is similar to the definition of disability used by the ABS Short Disability Module.</p> <p><b>Disability severity:</b> Disability is further classified by whether a person has limitation or restriction in 3 core activities – self-care, mobility, and communication. People who always or sometimes need help with one or more core activities are referred to in this report as ‘people with severe or profound disability’. People who have disability but do not need help or supervision with core activities are referred to as people with ‘other disability status’.</p> <p>The HILDA Survey does not collect information on severity of disability in every wave. The most recent collection was in the 21st wave (2021) (Summerfield et al. 2021; Wilkins et al. 2023).</p> <p><b>Disability group:</b> Disability group is a broad categorisation of disability. It is based on underlying health conditions and on impairments, activity limitations and participation restrictions. It is not a diagnostic grouping, nor is there a one-to-one correspondence between a health condition and a disability group.</p> <p>The HILDA Survey collects information on 17 disability types, which can be combined into the following 6 disability groups:</p> <ul style="list-style-type: none"> <li>• sensory or speech: includes sight, hearing, and speech problems</li> <li>• learning and understanding disability – difficulty learning or understanding things</li> <li>• physical: includes difficulty breathing, blackouts, chronic pain, limited use of arms or fingers, difficulty gripping things, limited use of feet or legs, physical restrictions, and disfigurement or deformity</li> <li>• psychosocial: includes nervous or emotional conditions, and mental illness</li> <li>• head injury, stroke or other brain damage</li> <li>• other: includes long-term conditions that are restrictive despite treatment or medication, and other long-term conditions.</li> </ul> <p><b>Remoteness:</b> The remoteness categories used in HILDA are based on the Australian Statistical Geography Standard Remoteness Area (Summerfield et al. 2021). People living in remote and sparsely populated areas are not included in the HILDA sample (Watson and Wooden 2002).</p>

Data source	Notes
<b>NATSIHS – National Aboriginal and Torres Strait Islander Health Survey</b>	<p>This report uses data from the Australian Bureau of Statistics (ABS) 2022–23 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). The NATSIHS was designed to collect information about the health and wellbeing of Aboriginal and Torres Strait Islander people of all ages in non-remote and remote areas of Australia, including discrete Aboriginal and Torres Strait Islander communities.</p> <p><b>Disability:</b> In the NATSIHS a person is considered to have disability if they have one or more conditions (including long-term health conditions) which have lasted, or are likely to last, for at least 6 months and restrict everyday activities.</p> <p>The NATSIHS uses the ABS Short Disability Module (SDM) to identify disability. While this module provides useful information about the characteristics of people with disability relative to those without, it is not recommended for use in measuring disability prevalence – in particular, it overestimates the number of people with less severe forms of disability (ABS 2025). The SDM produces an estimate of disability known as ‘disability or long-term health condition’. In the analyses based on the NATSIHS data in this report, people with disability or long-term health condition are referred to as ‘people with disability’.</p> <p><b>Disability severity:</b> Disability is further classified by whether a person has limitation or restriction in 3 core activities – self-care, mobility, and communication. People who always or sometimes need help with one or more core activities are referred to in this report as ‘people with severe or profound disability’. People who have disability but do not need help or supervision with core activities are referred to as people with ‘other disability status’.</p>
<b>NHS – National Health Survey</b>	<p>This report uses data from the Australian Bureau of Statistics (ABS) National Health Survey (NHS) 2022. The NHS collects information on prevalence of long-term health conditions, general and mental health, and health risk factors such as smoking, alcohol consumption, diet, and physical activity (ABS 2023).</p> <p><b>Comparison with historic NHS data:</b> the 2022 NHS is comparable with the 2017–18 NHS and previous cycles. The 2022 NHS should not be compared with the 2020–21 survey. The 2020–21 NHS data was collected during the COVID-19 pandemic which resulted in significant changes to data collection (ABS 2023).</p> <p><b>Coverage:</b> The NHS collects information from people living in households (private dwellings) only. People living in cared accommodation are out of scope for this survey. See also ‘<b>Remoteness</b>’.</p> <p><b>Proxy responses:</b> In some cases, the 2022 NHS survey questions were not answered by the selected person directly, but by a parent, guardian or proxy respondent instead.</p> <ul style="list-style-type: none"> <li>• For children aged 0–14, survey questions were always answered by a parent or guardian on the child’s behalf.</li> <li>• For people aged 15–17, parental or guardian consent was sought for the selected person to answer the questions. Where consent was not given a parent or guardian answered the questions on the selected person’s behalf. For people aged 15–17 with disability, 58% of responses were by parent or guardian, and 61% for those without disability (AIHW analysis of ABS 2024a).</li> <li>• For adults aged 18 and over, proxy responses were collected for 7.6% of adults with disability and 7.3% of adults without disability (AIHW analysis of ABS 2024a).</li> </ul> <p><b>Disability:</b> In the NHS a person is considered to have disability if they have one or more health conditions which have lasted, or are likely to last, for at least 6 months and restrict everyday activities.</p> <p>The NHS uses the ABS Short Disability Module (SDM) to identify disability. While this module provides useful information about the characteristics of people with disability relative to those without, it is not recommended for use in measuring disability prevalence – in particular, it overestimates the number of people with less severe forms of disability (ABS 2025). The SDM produces an estimate of disability known as ‘disability or long-term health condition’. In the analyses based on the NHS data in this report, people with disability or long-term health condition are referred to as ‘people with disability’. See also <b>Disability severity</b> for more information on how the definition of disability in this report differs from the report’s previous versions.</p>

Data source	Notes
	<p><b>Disability severity:</b> Disability is further classified by whether a person has a limitation or restriction in 3 core activities (self-care, mobility, and communication), and/or in schooling or employment. People who always or sometimes need help with one or more core activities are referred to as 'people with severe or profound disability'. In this report, 'other disability status' includes those who have:</p> <ul style="list-style-type: none"> <li>• mild or moderate core activity limitations (have difficulties with core activities or use aids to perform those activities but do not need assistance)</li> <li>• a schooling or employment restriction only</li> <li>• disability or long-term health condition but no core activity limitations or schooling or employment restrictions.</li> </ul> <p>In the pre-2024 versions of <i>People with disability in Australia</i> report, people with disability or long-term condition but without core activity limitations or schooling or employment restrictions were included in the 'without disability or restrictive long-term health condition' category. Therefore, <b>findings in this report and the 2024 version are not comparable with pre-2024 versions.</b></p> <p>The NHS collects data from people in private dwellings and does not include people living in institutional settings, such as aged care facilities. Therefore, it may underestimate disability for some groups, such as people aged 65 and over, and those with severe or profound disability.</p> <p><b>Disability group:</b> Disability group is a broad categorisation of disability. It is based on underlying health conditions and on impairments, activity limitations and participation restrictions. It is not a diagnostic grouping, nor is there a one-to-one correspondence between a health condition and a disability group. Disability groups are not exclusive, and people may have disabilities from more than one disability group.</p> <p>The NHS identifies 6 disability groups:</p> <ul style="list-style-type: none"> <li>• sensory or speech</li> <li>• learning and understanding</li> <li>• physical restriction</li> <li>• psychosocial</li> <li>• head injury, stroke or acquired brain injury</li> <li>• other (ABS 2023).</li> </ul> <p><b>Remoteness:</b> The remoteness categories used in the ABS NHS are defined by the Australian Statistical Geography Standard Remoteness Structure (ABS 2016). Remoteness Areas divide Australia into 5 classes of remoteness based on a measure of relative access to services. Very remote areas are out of scope for the NHS.</p>
<p><b>SDAC – Survey of Disability, Ageing and Carers</b></p>	<p>This report uses data from Australian Bureau of Statistics' (ABS) 2022 Survey of Disability, Ageing and Carers (SDAC). The SDAC is the most detailed and comprehensive source of data on disability prevalence in Australia.</p> <p><b>Proxy responses:</b> In some cases, SDAC 2022 survey questions were not answered by the selected person directly, but by a parent, guardian or proxy respondent instead.</p> <ul style="list-style-type: none"> <li>• For people living in cared accommodation (such as aged care facilities), staff member(s) of the facility answered questions about each respondent.</li> <li>• For children aged 0–14 and living in households, survey questions were always answered by a parent or guardian on the child's behalf.</li> <li>• For people aged 15–17 living in households, parental or guardian consent was sought for the selected person to answer the questions. Where consent was not given a parent or guardian answered the questions on the selected person's behalf. For people aged 15–17 with disability living in households, 75% had responses provided by parent or guardian (AIHW analysis of ABS 2024b).</li> <li>• For adults aged 18 and over living in households, proxy responses were collected if the selected person was unable to answer themselves due to illness, impairment, injury or language problems. For adults with disability living in households, 13% had responses provided by a proxy (AIHW analysis of ABS 2024b).</li> </ul>

Data source	Notes
	<p><b>Disability:</b> the SDAC considers that a person has disability if they have at least one of a list of limitations, restrictions or impairments, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities.</p> <p>The limitations are grouped into 10 activities associated with daily living – self-care, mobility, communication, cognitive or emotional tasks, health care, reading or writing tasks, transport, household chores, property maintenance, and meal preparation. The SDAC also identifies 2 other life areas in which people may experience restriction or difficulty as a result of disability – schooling and employment.</p> <p><b>Disability severity:</b> Disability is further classified by whether a person has a limitation or restriction in 3 core activities (self-care, mobility, and communication), and/or in schooling or employment. People who always or sometimes need help with one or more core activities, have difficulty understanding or being understood by family or friends, or can communicate more easily using sign language or other non-spoken forms of communication are referred to in this report as ‘people with severe or profound disability’. People who have disability but do not need help or supervision with core activities are referred to as people with ‘other disability status’.</p> <p><b>Disability group:</b> Disability group is a broad categorisation of disability. It is based on underlying health conditions and on impairments, activity limitations and participation restrictions. It is not a diagnostic grouping, nor is there a one-to-one correspondence between a health condition and a disability group.</p> <p>The SDAC broadly groups disabilities depending on whether they relate to functioning of the mind or the senses, or to anatomy or physiology. Each disability group may refer to a single disability or be composed of a number of broadly similar disabilities. The SDAC identifies 6 disability groups based on particular types of disability:</p> <ul style="list-style-type: none"> <li>• sensory or speech disability group (includes loss of sight, loss of hearing, and speech difficulties disability types)</li> <li>• learning and understanding disability group (refers to difficulty learning or understanding things). In earlier rounds of SDAC, this group was referred to as ‘Intellectual disability group’.</li> <li>• physical disability group (includes disability arising from shortness of breath or breathing difficulties, blackouts, seizures or loss of consciousness; chronic or recurrent pain or discomfort, incomplete use of arms or fingers, difficulty gripping or holding things, incomplete use of feet or legs, restriction in physical activities or physical work, and disfigurement or deformity)</li> <li>• psychosocial (includes disability arising from nervous or emotional conditions, mental illness, memory problems, and social or behavioural difficulties)</li> <li>• head injury, stroke or acquired brain injury</li> <li>• other (restrictions in everyday activities due to other long-term conditions or ailments) (ABS 2024c).</li> </ul> <p><b>Remoteness:</b> The remoteness categories used in the SDAC are defined by the Australian Statistical Geography Standard Remoteness Structure (ABS 2016). Remoteness Areas divide Australia into 5 classes of remoteness on the basis of a measure of relative access to services. Very remote areas are out of scope for the SDAC.</p>

## References

- ABS (Australian Bureau of Statistics) (2016) [Australian Statistical Geography Standard \(ASGS\): Volume 5 – remoteness structure, July 2016](#), ABS cat. no. 1270.0.55.005, accessed 4 August 2021.
- ABS (2023) [National Health Survey methodology, 2022](#), ABS, accessed 18 December 2025.
- ABS (2024a) [Microdata and TableBuilder: National Health Survey, 2022](#), ABS, AIHW analysis of microdata in TableBuilder, accessed 7 January 2026.
- ABS (2024b) [Microdata and TableBuilder: Disability, Ageing and Carers, Australia, 2022](#), ABS, AIHW analysis of microdata in TableBuilder, accessed 7 January 2026.

ABS (2024c) *Disability, Ageing and Carers, Australia: Summary of Findings methodology, 2022*, ABS, accessed 7 January 2026.

ABS (2025) *ABS Sources of Disability Statistics, 2018–2023*, ABS, accessed 16 May 2023.

Summerfield M, Garrard B, Nesa MK, Kamath R, Macalalad N, Watson N, Wilkins R and Wooden M (2021) *HILDA user manual – Release 21*, Melbourne Institute: Applied Economic and Social Research, University of Melbourne, accessed 4 May 2023.

Watson N, Nesa MK and Summerfield M (2022) 'Wave 21 data quality', *HILDA Discussion Paper Series*, Melbourne Institute: Applied Economic and Social Research, University of Melbourne, accessed 24 May 2023.

Watson N and Wooden M (2002) *The Household, Income and Labour Dynamics in Australia (HILDA) Survey: Wave 1 Survey Methodology*, HILDA Technical Paper Series No. 1/02, May 2002 [revised October 2002], accessed 9 February 2024.

Wilkins R, Vera-Toscano E and Botha F (2023) *The Household, Income and Labour Dynamics in Australia Survey: selected findings from Waves 1 to 21*, Melbourne Institute: Applied Economic & Social Research, University of Melbourne, accessed 23 February 2023.

# Acknowledgements

This online report, *People with disability in Australia 2026*, was prepared by Thi Thao Nguyen, Anastasia Sartbayeva, and Carla Willrodt of the Disability Unit at the Australian Institute of Health and Welfare (AIHW). The AIHW's Disability Analysis and Reporting Advisory Group, Louise York (Head, Community Services Group), Penny Siu, Sam Chambers and Kirsten Morgan provided valuable comments on the draft report.

## Disclaimer notices

This report uses unit record data from Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted by the Australian Government Department of Social Services (DSS). The findings and views reported in this report, however, are those of the authors and should not be attributed to the Australian Government, DSS, or any of DSS' contractors or partners. DOI: 10.26193/KXNEBO

This report uses data from the National Disability Insurance Scheme (NDIS). The results and views reported in this report, however, are those of the authors and should not be attributed to the National Disability Insurance Agency (NDIA). The work in this report has not been prepared in collaboration or partnership with the NDIA.



*People with disability in Australia 2026* brings together information from a range of national data sources to contribute to a greater understanding of disability in Australia.

[aihw.gov.au](http://aihw.gov.au)



**AIHW**

Stronger evidence,  
better decisions,  
improved health and welfare

