

Child and Youth Social Health Atlas of Australia

Notes on the data

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General information

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Introductory information

The indicator information and data sources are presented below in the general order used by PHIDU in their products by the themes of [Demographic and social indicators](#), [Health status, disability, carers and deaths](#) and [Use and provision of health and welfare services](#).

Geographical structures

Data are presented for areas designated as 'PHAs' - Population Health Areas, 'LGAs' - Local Government Areas, 'PHNs' - Primary Health Networks, 'Quintiles' - Quintiles of Socioeconomic Disadvantage of Area; 'Remoteness' - Remoteness Areas of Australia; and 'GCCSA' - Greater Capital Cities Statistical Areas. The PHA data sheets include totals at the Statistical Areas Level 3 (SA3).

For further information regarding the geographies available, refer to the [geographical structures](#) information.

Statistical information

Except where otherwise stated, all age-standardised rates and ratios presented in the maps, data or graphs are indirectly standardised rates, based on the Australian standard. For further information on the statistics presented, refer to the [statistical information](#) available from the PHIDU website.

Calculation of measures for quintiles

Percentages and rates were calculated by allocating events (e.g., dwellings with no vehicle, deaths) to one of five groups of areas (quintiles) based on the 2021 Index of Relative Socio-Economic Disadvantage (IRSD¹ [1]). To produce quintiles of socioeconomic disadvantage, the smallest geographic areas for which the data were available were ranked by their IRSD score and categorised into five population-equivalent groups, each comprising areas with 20% of the total population (of all-ages, not just children and young people). The percentage or rate for the event was then calculated for each quintile, with quintile 1 containing the highest socioeconomic status areas (Least Disadvantaged) and quintile 5 comprised of the lowest socioeconomic status areas (Most Disadvantaged). Note that this approach (as used in the social sciences) is different from that used by economists and in data released by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare, where quintile 1 comprises the Most Disadvantaged areas and quintile 5 comprises the Least Disadvantaged areas.

Calculation of measures for Remoteness Areas

Percentages and rates were calculated using either the ABS Remoteness Structure, 2016 or 2021 [2].

References

1. Australian Bureau of Statistics (ABS). Socio-Economic Indexes for Areas (SEIFA), Australia, 2021. Available from <https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release>, accessed 3 May 2023.
2. Australian Bureau of Statistics (ABS). 1270.0.55.005 - Australian Statistical Geography Standard (ASGS): Edition 3 - Remoteness Structure, July 2021. Available from <https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure>, accessed 31 July 2023.

¹ The IRSD is one of the Socio-Economic Indexes for Areas (SEIFA), produced by the Australian Bureau of Statistics (see reference [1], above).

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Demographic and social indicators

Age distribution: total population

Estimated resident population (ERP) by sex, by 5-year age group (0-4 years to 20-24 years), and broad age groups (0-14, 15-24), 2024

– by PHA, LGA, PHN, Remoteness (broad age groups only for Remoteness Areas)

Policy context: The estimated resident population (ERP) is the official measure of Australia's population based on the concept of usual residence. It refers to all people, regardless of nationality or citizenship, who usually live in Australia, with the exception of foreign diplomatic personnel and their families. It includes usual residents who are overseas for less than 12 months. It excludes overseas visitors who are in Australia for less than 12 months. The ERP is based on the results of the Census of Population and Housing, adjusted for net undercount and Australian usual residents temporarily overseas on census night. The ERP is compiled as of 30 June of each year and updated quarterly for Australia, states and territories and annually for smaller areas [1].

Reference

1. Australian Bureau of Statistics (ABS). Population FAQs, accessed 21 September 2021. Available from: <https://www.abs.gov.au/websitedbs/D3310114.nsf/home/Population+FAQs>.

Indicator detail: The ERP in June 2024 was derived by the Australian Bureau of Statistics (ABS) by applying the following adjustments to the usual residence Census counts:

- removing overseas visitors who were in Australia on Census night from the Census counts
- adjusting the Census counts for undercounting using results of the Post Enumeration Survey
- including Australian residents who were temporarily absent overseas on Census night
- backcasting the resulting estimates which relate to the earlier 9 August 2021 to 30 June 2024 using births, deaths and migration data.

In August each year the ABS issue an updated ERP by age and sex by Statistical Area Level 2 and Local Government Area, at 30 June of that year. These data are aggregated within PHIDU to Population Health Areas, Primary Health Networks and Remoteness Areas.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network and Remoteness Area.

Numerator: Male, female and total estimated resident population in 2023 by 5-year age group: 0-4 years to 20-24 years and/or broad age group: 0-14, 15-24, 25-44 years.

Denominator: Total males, females or persons, estimated resident population in 2024.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on ABS 3235.0 Population by Age and Sex, Regions of Australia, 30 June 2024.

Age distribution: Aboriginal population

Aboriginal estimated resident population by sex, by broad age group (0-14, 15-24 years); for Remoteness Areas only, by broad age group (0-4, 5-14, 15-24 years), 2021 – by PHA, LGA, PHN, Remoteness

Policy context: The proportions of the total estimated resident population in 2021 who were Aboriginal and/or Torres Strait Islander people (in this atlas collectively referred to as Aboriginal) varies greatly by location, from 30.7% in the Northern Territory to 1.2% in Victoria. Aboriginal people represent the largest proportion of the populations in Greater Darwin (13.2%) and in the remainder of the Northern Territory (56.9%). The next largest proportion was in Western Australia, at 11.4% outside of Perth [1].

However, the largest numbers of Aboriginal people in 2021 were in New South Wales (339,710, with 111,075 in Greater Sydney, 36,745 in Illawarra, Newcastle and Lake Macquarie and 191,890 in the remainder of New South Wales); and in Queensland (273,119, with 87,940 in Greater Brisbane, 40,284 in Gold Coast and Townsville, and 144,895 in the remainder of Queensland). The estimated resident populations in Darwin and in the remainder of the Northern Territory were 19,464 and 57,023, respectively [1].

The Aboriginal and Torres Strait Islander population is considerably younger than the non-Indigenous population. In 2021, the median age for this population was 24 years, 14.9 years less than the national median age of 38.9 years for the non-Indigenous population [2]. One in three (33.1%) Aboriginal people were estimated to be aged less than 15 years, while just 5.4% were aged 65 years and over (and although very low, this is higher than in 2011 or 2016, when the proportions were 3.8% and 5.1%, respectively) [2].

References

1. Australian Bureau of Statistics (ABS) estimated resident population (produced as a consultancy for PHIDU), 30 June 2021.
2. Australian Bureau of Statistics, Estimates of Aboriginal and Torres Strait Islander Australians: Final 2021 Census-based estimated resident population of Aboriginal and Torres Strait Islander and non-Indigenous Australians for various geographies, accessed 29 November 2023. Available from: <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release>.

Indicator detail: The age group as a percentage of the total Aboriginal population for males, for females and for persons.

PHIDU publishes Aboriginal population by age and sex for Population Health Areas (PHAs), Local Government Areas (LGAs) and Indigenous Areas (IAREs), and also uses these populations as a denominator when calculating percentages and rates for a large number of indicators for PHAs and IAREs.

As the Australian Bureau of Statistics (ABS) does not publish ERP by age and sex for the Aboriginal population, or by Indigenous status, for PHAs, LGAs or IAREs, PHIDU entered into a contract with the ABS to produce these data.

Due to small populations in some areas, the ABS could only estimate the population by age and sex for Aboriginal people and by Indigenous status for the following age groups:

- PHA and LGA: 0-14, 15-24, 25-34, 35-44, 45-54 and 55+ years
- IARE: 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64 and 65+ years.

The 'all-age' totals for LGAs and IAREs are consistent with those published by the ABS.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Aboriginal male, female and total estimated resident population (ERP) by broad age group: 0-14, 15-24 years; or Remoteness Areas broad age group: 0-4, 5-14, 15-24 years.

Denominator: Total Aboriginal males, females or persons, ERP.

Detail of analysis: The age group as a percentage of the total Aboriginal population for males, for females and for persons.

Source: ABS estimated resident population (produced as a consultancy for PHIDU), 30 June 2021.

Aboriginal population by age as a proportion of the total population

Aboriginal estimated resident population, by broad age group (0-14, 15-24); and by 5-year age group (0-4 years to 20-24 years) for Remoteness Areas only, as a proportion of the total estimated resident population (ERP), 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness Area

Policy context: The proportions of the total estimated resident population in 2021 who were Aboriginal and/or Torres Strait Islander people (in this atlas collectively referred to as Aboriginal) varies greatly by location, from 30.7% in the Northern Territory to 1.2% in Victoria. Aboriginal people represent the largest proportion of the populations in Greater Darwin (13.2%) and in the remainder of the Northern Territory (56.9%). The next largest proportion was in Western Australia, at 11.4% outside of Perth [1].

However, the largest numbers of Aboriginal people in 2021 were in New South Wales (339,710, with 111,075 in Greater Sydney, 36,745 in Illawarra, Newcastle and Lake Macquarie and 191,890 in the remainder of New South Wales); and in Queensland (273,119, with 87,940 in Greater Brisbane, 40,284 in Gold Coast and Townsville, and 144,895 in the remainder of Queensland). The estimated resident populations in Darwin and in the remainder of the Northern Territory were 19,464 and 57,023, respectively [1].

The Aboriginal and Torres Strait Islander population is considerably younger than the non-Indigenous population. In 2021, the median age for this population was 24 years, 14.9 years less than the national median age of 38.9 years for the non-Indigenous population [2]. One in three (33.1%) Aboriginal people were estimated to be aged less than 15 years, while just 5.4% were aged 65 years and over (and although very low, this is higher than in 2011 or 2016, when the proportions were 3.8% and 5.1%, respectively) [2].

References

1. Australian Bureau of Statistics (ABS) estimated resident population (produced as a consultancy for PHIDU), 30 June 2021.
2. Australian Bureau of Statistics, Estimates of Aboriginal and Torres Strait Islander Australians: Final 2021 Census-based estimated resident population of Aboriginal and Torres Strait Islander and non-Indigenous Australians for various geographies, accessed 29 November 2023. Available from: <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release>.

Indicator detail: Aboriginal population as a percentage of the total population.

PHIDU publishes Aboriginal population by age and sex for Population Health Areas (PHAs), Local Government Areas (LGAs) and Indigenous Areas (IAREs), and also uses these populations as a denominator when calculating percentages and rates for a large number of indicators for PHAs and IAREs.

As the Australian Bureau of Statistics (ABS) does not publish ERP by age and sex for the Aboriginal population, or by Indigenous status, for PHAs, LGAs or IAREs, PHIDU entered into a contract with the ABS to produce these data.

Due to small populations in some areas, the ABS could only estimate the population by age and sex and Indigenous status for the following age groups:

- PHA and LGA: 0-14, 15-24, 25-34, 35-44, 45-54 and 55+ years
- IARE: 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64 and 65+ years
- The all-age totals for LGAs and IAREs are consistent with those published by the ABS.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Total Aboriginal estimated resident population by broad age groups: 0-14, 15-24 years or by 5-year age group (Remoteness Areas only): 0-4 years to 20-24 years.

Denominator: Total Aboriginal estimated resident population ERP by broad age group: 0-14, 15-24 years or by 5-year age group (Remoteness Areas only): 0-4 years to 20-24 years.

Detail of analysis: Aboriginal population in each age group as a percentage of the total population.

Source: ABS estimated resident population (produced as a consultancy for PHIDU), 30 June 2021.

Birthplace & non-English-speaking residents

Australian-born population, by 5-year age group (0-4 years to 20-24 years), 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: At the Census in 2021, two thirds (65.3%) of the population gave Australia as their country of birth, consistent with the proportion in 2016, but down from almost three quarters (74%) at the 2011 Census. However, at recent Censuses, over a million Australians have not stated their birthplace. Therefore, their generation cannot be identified from Census data. In 2021 the 1.4 million people for whom the birthplace was not stated represented 5.3% of the population [1].

Reference

1. Data for 2021 Census from the Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022. For earlier Censuses, data from PHIDU workbooks, available from: <https://data.from.PHIDU.workbooks.torrens.edu.au/social-health-atlases/data-archive>.

Indicator detail: In the data workbooks, the numerator excludes 5.3% of the population (this percentage varies across States/Territories) who did not provide their country of birth: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People born in Australia, by 5-year age group (0-4 years to 20-24 years).

Denominator: Total population, by 5-year age group (0-4 years to 20-24 years).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

People born in predominantly non-English-speaking (NES) countries, by 5-year age group (0-4 years to 20-24 years), 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Although this indicator is far from precise, even in defining countries from which people coming to live in Australia will face a language barrier, it is included in the absence of a better measure. Other measures of relevance in this atlas are of the year in which people arrived (shown as recent or longer-term arrivals), language spoken at home and details of those arriving under Australia's Humanitarian Program, or the Migration Program for skilled and family entrants.

In the 2021 Census, 5,016,314 people (19.7% of the total population) were born in countries referred to as 'predominantly non-English-speaking' [1]. Country of birth groups which increased the most between 2011 and 2021 were India (up 373,300 people) and China (208,200). Notably, the number of people born in China decreased by 52,000 people during the pandemic; there was a small decrease, of 13,000, of those born in India.

Two countries with relatively large increases over this ten-year period were Philippines (up by 117,600) and Nepal (by 102,100) [1].

In 2021, just over half (51.2%) of all Australians were either born overseas or had at least one parent who was born overseas:

- More than a quarter (29.3%) of the Australian population were first generation Australians (born overseas)
- 22.2% of the population were second generation Australians (born in Australia, but had one or both parents born overseas)
- Almost half (48.5%) of the population were at least third generation Australians (born in Australia, as were both of their parents) [1].

Reference

1. Data from PHIDU workbooks available at: <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: The data comprise people born in 'predominantly non-English-speaking countries' which comprise all but the following overseas countries, designated as 'English-speaking': Canada, Ireland, New Zealand, South Africa, United Kingdom and the United States of America.

In the data workbooks, the numerator excludes the 5.3% of the population (this percentage varies across States/Territories) who did not provide their country of birth: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People born in predominantly non-English speaking countries, by 5-year age group (0-4 years to 20-24 years).

Denominator: Total population, by 5-year age group (0-4 years to 20-24 years).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

People born in NES countries resident in Australia for five years or more, by 5-year age group (0-4 years to 20-24 years), 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Although this indicator is far from precise, even in defining countries from which people coming to live in Australia will face a language barrier, it is included in the absence of a better measure. Other measures of relevance in this atlas are of the year in which people arrived (shown as recent or longer-term arrivals), language spoken at home and details of those arriving under Australia's Humanitarian Program, or the Migration Program for skilled and family entrants.

In 2021, some 83% of Australia's population who were born in a predominantly non-English-speaking country had been in Australia for five years or more [1]. In the post-war period (in particular from the 1950s), the majority of immigrants from non-English-speaking countries came from Europe; in recent years the proportion of these immigrants from Europe has declined, with increasing numbers coming, in particular, from across Asia (South East Asia, North East Asia and Southern and Central Asia).

Reflecting this trend, the proportions arriving from countries in North-West Europe and Southern and Eastern Europe have, whereas those from Philippines, Nepal, Pakistan, Vietnam, Sri Lanka and Iraq, among others, have increased [2].

References

1. Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022.
2. Australian Bureau of Statistics (ABS). Australia's Population by Country of Birth, 2021. Available from: <https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/latest-release>; accessed 25 August 2022.

Indicator detail: The data comprise people born in predominantly non-English-speaking countries arriving before 2012. 'Predominantly non-English-speaking countries' comprise all but the following overseas countries, designated here as 'English-speaking': Canada, Ireland, New Zealand, South Africa, United Kingdom and the United States of America.

In the data workbooks, the numerator excludes the 5.3% of the population (this percentage varies across States/Territories) who did not provide their country of birth, as well as the 2.4% of the population born overseas who did not state their year of arrival: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People born in predominantly non-English speaking countries, and resident in Australia for five years or more, by 5-year age group (0-4 years to 20-24 years).

Denominator: Total population, by 5-year age group (0-4 years to 20-24 years).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

People born in NES countries resident in Australia for less than five years, by 5-year age group (0-4 years to 20-24 years), 2021
– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Although this indicator is far from precise, even in defining countries from which people coming to live in Australia will face a language barrier, it is included in the absence of a better measure. Other measures of relevance in this atlas are of the year in which people arrived (shown as recent or longer-term arrivals), language spoken at home and details of those arriving under Australia's Humanitarian Program, or the Migration Program for skilled and family entrants.

In 2021, 16.9% of Australia's population who were born in a predominantly non-English-speaking country had been in Australia for less than five years [1]. People born in this population group face a number of difficulties. For many who arrive without proficiency in English, the combination of economic struggle with adjustment to a new language and a new cultural milieu can be expected to give rise to considerable stresses. Although a relatively small group, they also pose special challenges for deliverers of health, welfare and other community services [2]. This community is also not a homogeneous group, even though there are common experiences including those relating to migration and dislocation. There is great diversity in language, culture, religion, socioeconomic status, education and age structure [3]. Reflecting this trend, the most rapidly growing non-English-speaking groups are now from Asia, with their proportion in the population increasing from 24% of the overseas-born population in 2001, to 32.9% in 2011 and to 39.7% in 2016 [3,4].

References

1. Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022.
2. Australian Institute of Health & Welfare (AIHW). Australia's welfare, 2011. (AIHW Cat. no. AUS 142). Canberra: AIHW; 2011.
3. Australian Bureau of Statistics (ABS). Cultural diversity in Australia - Reflecting a Nation: Stories from the 2011 Census, 2012-2013. (ABS Cat. no. 2071.0). Canberra: ABS; 2012.
4. Australian Bureau of Statistics (ABS). Cultural diversity in Australia - Reflecting Australia: Stories from the Census, 2016. (ABS Cat. no. 2071.0). Canberra: ABS; 2017 [accessed 10 August 2017]. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Cultural%20Diversity%20Article~60>.

Indicator detail: The data comprise people born in predominantly non-English-speaking countries arriving from 2017 to 2021. The year 2021 is the period 1 January 2021 to 10 August 2021 (Census Night), therefore, the data presented represent a total time of approximately 4 years and 7 months.

Resident in Australia for less than five years: Data comprise NES residents arriving from 2017 to 2021. The year 2016 is the period 1 January 2021 to 10 August 2021 (Census Night), therefore, the data presented represent a total time of approximately 4 years and 7 months.

'Predominantly non-English-speaking countries' comprise all but the following overseas countries, designated as 'English-speaking': Canada, Ireland, New Zealand, South Africa, United Kingdom and the United States of America.

In the data workbook, the numerator excludes the 5.3% of the population (this percentage varies across States/Territories) who did not provide their country of birth, as well as the 2.4% of the population born overseas who did not state their year of arrival: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People born in predominantly non-English speaking countries, and resident in Australia for less than five years, by 5-year age group (0-4 years to 20-24 years).

Denominator: Total population, by 5-year age group (0-4 years to 20-24 years).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

**People aged 5 years and over who were born overseas and reported poor proficiency in English, by 5-year age group (5-9 years to 20-24 years), 2021
– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness**

Policy context: For migrants born in predominantly non-English-speaking countries, the rate at which they adapt to live in the host country is directly related to the rate at which they achieve proficiency in English. Their proficiency in English has profound implications for the ease with which they are able to access labour markets, develop social networks, become aware of and utilise services, and participate in many aspects of Australian society. Those people who are not proficient in spoken English are less likely to be in full-time employment and more likely not to be in the labour force [1]. From a health service viewpoint, the location of this population group is most relevant in the provision of health services for women, and for older people, who may not have developed English language skills (especially females), or have returned to using the language of their birthplace as they have aged (both females and males).

In Australia, there were over 350 separately identified languages spoken at home in 2021. While English remained the main language spoken, Census data showed that more than one-fifth (21.7%) of Australians spoke a language other than English at home. The most commonly spoken languages were Mandarin (2.7% of the total population), Arabic (1.4 per cent), Vietnamese (1.3 per cent), Cantonese (1.2 per cent) and Punjabi (0.9 per cent) [2].

Of the overseas-born people who had arrived in in 2005, or later, 10.9% either did not speak English well, or at all in 2021. For earlier migrants (those arriving before 2005) this number was lower, at 9.0%. Of those aged 65 years and over, the proportion was higher, at 17.1%, increasing from 15.3% at ages 65 to 74 years, to 17.1% at ages 75 to 84 years and to 25.0% at ages 85 years and over [3].

References

1. Australian Bureau of Statistics (ABS). Perspectives on migrants, 2007. (ABS Cat. no. 3416.0). Canberra: ABS; 2008.
2. Australian Bureau of Statistics (ABS). Cultural diversity: Census 2021. Available from: <https://www.abs.gov.au/statistics/people/people-and-communities/cultural-diversity-census/latest-release>; accessed 25 August 2022.
3. Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022.

Indicator detail: The data comprise people born overseas who reported speaking English 'not well' or 'not at all'. In the data workbooks, the numerator excludes the 0.8% of the population (this percentage varies across States/Territories) aged five years and over born overseas who did not state their language (other than English) spoken, or their proficiency in English: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People aged 5 years and over who were born overseas and reported speaking English 'not well' or 'not at all', by 5-year age group (5-9 years to 20-24 years).

Denominator: Population aged 5 years and over, by 5-year age group (5-9 years to 20-24 years)..

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Non-English-speaking countries of birth

Top six birthplaces of people aged 0 to 24 years born in non-English-speaking countries, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: In the post-war period (in particular from the 1950s) the majority of immigrants from non-English speaking countries came to Australia from Europe; in recent years, the proportion of these immigrants from Europe has declined [1]. The largest non-English speaking groups at the time of the 2021 Census were from India (710,400), China (595,600), Philippines (310,600), Vietnam (268,200), Malaysia (172,300), Italy (171,500), Sri Lanka (145,800), Nepal (129,900), Germany (170,900) and South Korea (106,600) [2].

Country of birth groups which increased the most between 2011 and 2021 were India (up 373,300 people), and China (208,200). Notably, the number of people born in China decreased by 52,000 people during the pandemic; there was a small decrease, of 13,000, of those born in India. Two countries with relatively large increases over this ten-year period were Philippines (up by 117,600) and Nepal (up by 102,100) [2].

References

1. Australian Bureau of Statistics (ABS). Cultural diversity in Australia - Reflecting a Nation: Stories from the 2011 Census, 2012-2013. (ABS Cat. no. 2071.0). Canberra: ABS; 2012.
2. Australia's Population by Country of Birth, 2021. Available from: <https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/latest-release>; accessed 25 August 2022.

Indicator detail: The data comprise residents of Australia who were born overseas in one of the predominantly non-English speaking countries which are in the top ten for Australia in terms of high numbers of migrants. These are, from highest to lowest: India, China (excluding Special Administrative Regions of Hong Kong & Macau, and Taiwan), Philippines, Vietnam, Malaysia, Italy, Sri Lanka, Nepal, Germany and South Korea.

The numerator excludes the 5.3% of the population (this percentage varies across States/Territories) who did not state their country of birth: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People aged 0 to 24 years born in the top six non-English speaking countries: India, China (excluding Special Administrative Regions of Hong Kong & Macau, and Taiwan), Philippines, Vietnam, Malaysia, and Italy, Sri Lanka, Nepal, Korea, Republic of (South).

Denominator: Total population aged 0 to 24 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Fertility

Total fertility rate, 2023

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Fertility is an important component of population change (particularly population age-structure), and low fertility has implications for a population's ability to sustain itself [1]. Fertility levels vary between areas with different socioeconomic conditions, between metropolitan and regional areas, and among the States and Territories. Differences may exist for a variety of reasons, such as culture, social norms, employment, the economy, and socioeconomic status [1].

Fertility is measured by the total fertility rate (TFR) which represents the average number of children that a woman could expect to bear during her reproductive lifetime: it is calculated from details of the age of the female population, the number of births and the age of the mother at birth. Since 1974, Australia's TFR has been below the replacement level of 2.1 babies per woman. In 2023, Australia's TFR was 1.50 babies per woman, lower than in 2022 (1.63) but remaining lower than in 2011 (1.92) [2]. Sustained periods of fertility below the replacement level are major drivers of population ageing. Given the potential economic impacts of an ageing population, fertility is of particular interest to policymakers.

References

1. Australian Bureau of Statistics (ABS). Year Book Australia, 2008. (ABS cat. no. 1301.0). Canberra: ABS; 2008.
2. Australian Bureau of Statistics (ABS). Births, Australia, 2023. Available at <https://www.abs.gov.au/statistics/people/population/births-australia/latest-release>; accessed 30 October 2023.

Indicator detail: Fertility is measured by the total fertility rate (TFR) which represents the average number of children that a woman could expect to bear during her reproductive lifetime: it is calculated from details of the age of the female population, the number of births and the age of the mother at birth.

Total fertility rates are not shown for areas recording fewer than 5 births.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Live births.

Detail of analysis: Total fertility rate per woman, calculated from age-specific fertility rates.

Source: Compiled by PHIDU based on ABS data from Table 2: Births, Summary, Statistical Area Level 2 - 2011 to 2023, [Births, Australia 2023](#).

Education

Children aged 4 years old, 5 years old, and 4 and 5 years old enrolled in a preschool program and children attending a preschool, 2023.

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Research has shown that positive educational and life outcomes for children, particularly those from more disadvantaged backgrounds are linked to participation in a quality preschool program [1].

Participation in high quality preschool supports school readiness as children were found to perform better at school with these benefits persisting over time. Children who attended preschool were found to outperform those who did not across all elements of national assessment results for Year 3 students, including numeracy, reading, spelling, writing and grammar [2].

References

1. Rosier K. & McDonald, M. Promoting positive education and care transitions for children. Child Family Community Australia Resource Sheet, November 2011. Australian Institute of Family Studies accessed 9 April 2018. Available from: <https://aifs.gov.au/cfca/publications/promoting-positive-education-and-care-transitions-children>.
2. Department of Education and Training. How is the Government supporting access to preschool education? Factsheet, July 2017, accessed 9 April 2018. Available from: https://docs.education.gov.au/system/files/doc/other/14._how_is_the_government_supporting_access_to_preschool_education.pdf.

Indicator detail: The data comprise children aged 4 years old, 5 years old, and 4 and 5 years old: enrolled in a preschool program; and attending a preschool program in both cases as a proportion of the estimated resident population (ERP) of children at those ages in 2022.

The data for 2023 have been limited to 'Preschool' under the 'Sector' category that ABS provide in the Preschool TableBuilder dataset: data published by PHIDU in previous years included children in a 'Preschool program within centre-based day care' and 'Children across more than one provider type'. In the 2023 Preschool Census there were 164,671 in centre-based day care program and 51,804 children across more than one provider type.

These data are generally not published as percentages, as the age at which children commence preschool and leave preschool to enter primary school varies between jurisdictions and includes children at age three and age six. As we cannot replicate the results published by the ABS to produce a denominator that reflects these different ages across the states and territories at which children are enrolled in preschool, we have calculated the percentage of children at age four in preschool against the percentage of children in the population at this age. Unfortunately, this results in some proportions of over 100% and also occurs with those aged five, although it occurs less frequently with the total of children aged four and five years, for which data are also published. The instances over 100% occur, in part, because of the difficulty in estimating the population in small geographic areas by single-year ages. However, in order to provide an understanding of variations between geographic areas, we have calculated and published percentages. More information, including details of the ABS [calculation](https://www.abs.gov.au/statistics/people/education/preschool-education/latest-release), can be found at <https://www.abs.gov.au/statistics/people/education/preschool-education/latest-release>, accessed 3rd December 2024.

As ERPs are not available by single year at the PHA level, the numbers of children at ages four and five were estimated by applying the proportion of children at these ages in the 0 to 4 and 5 to 9-year age groups at the 2021 Census to the 2023 ERP in the 0 to 4 and 5 to 9-year age groups.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: The indicators presented are:

- Children aged 4 years, 5 years and 4 and 5-years enrolled in a preschool program
- Children aged 4 years, 5 years and 4 and 5-years attending a preschool program.

Denominator: Children aged 4 years, 5 years or 4 and 5 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the Australian Bureau of Statistics Preschool Education, Australia, 2023; data extracted from TableBuilder.

Full-time participation in secondary school education at age 16, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Education increases opportunities for choice of occupation and for income and job security and equips people with the skills and ability to control many aspects of their lives - key factors that influence wellbeing throughout the life course. Young people completing Year 12 are more likely to make a successful initial transition to further education, training and work than early leavers. There is greater risk of poor transitions or mixed outcomes for those who have disabilities, lower levels of literacy or numeracy, or come from a family with a lower socioeconomic status [1]. Participation in schooling is also a major protective factor across a range of risk factors, including substance misuse, unemployment and homelessness.

A majority (85.3%) of the population aged 16 years at the time of the 2021 Census were reported as being in full-time secondary education; this was an increase from 79.1% at the 2016 Census [2]. The intention of this variable is to show the extent of variation in participation geographically and between population groups.

As data covering all sectors (government, non-government, Catholic and independent) are not available at the small area level from State and Territory education authorities, the data used in this analysis are from the 2021 Australian Bureau of Statistics (ABS) Population Census. As such they are not official estimates of participation at age 16 in full-time secondary education. However, they are useful in showing the extent of variations between areas, by socioeconomic status and by remoteness.

References

1. Dale R. Early school leaving - lessons from research for policy makers. (Report on behalf of the Network of Experts in Social Sciences and Education (NESSE)). Paris, France: European Commission; 2010.
2. 2021 data from PHIDU workbooks, data release November 2022, available from <https://phidu.torrens.edu.au/social-health-atlases/data>; 2016 data from PHIDU workbooks, data release December 2017, available from the [Data archive](#).

Indicator detail: As data covering all sectors (government, non-government, Catholic and independent) are not available at the small area level from State and Territory education authorities, the data used in this analysis are from the 2021 ABS Population Census. As such they are not official estimates of participation at age 16 in full-time secondary education. However, they are useful in showing the extent of variations between areas, by socioeconomic status and by remoteness.

Note that: the extent to which those who have left school at this age to enter the labour force is not accounted for in these data - see Learning or Earning at ages 15 to 24; the numerator excludes the small proportion of the population aged 16 whose participation in secondary school education, or full-time/part-time status, was not stated: however, these records are included in the denominator; and percentages may be more than 100% due to the ABS' randomisation of both the numerator and denominator for confidentiality purposes.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: 16-year-olds in full-time secondary school education.

Denominator: Population aged 16 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

School leavers enrolled in higher education, 2023 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Education increases opportunities for choice of occupation and for income and job security and also equips people with the skills and ability to control many aspects of their lives – key factors that influence wellbeing throughout the life course. Young people who complete Year 12 are more likely to make a successful initial transition to further education, training and work than early leavers [1].

The acquisition of a non-school qualification increases work and employment opportunities and increases the likelihood of a financially secure future. Despite the Global Financial Crisis and the end of the mining boom impacting on the earning of early career graduates, bachelor's degree holders continue to enjoy a significant income premium over Year 12 holders [2].

References

1. McMillan J, Marks GN. School leavers in Australia: profiles and pathways. (Research report no. 31). Camberwell, Victoria: Australian Council for Educational Research, 2003.
2. Norton A, Cherastidtham, I and Mackey W. Mapping Higher Education 2018. Grattan Institute, 2018 [accessed 19 February 2019]. Available from: <https://grattan.edu.au/wp-content/uploads/2018/09/907-Mapping-Australian-higher-education-2018.pdf>.

Indicator detail: The data comprise school leavers who are identified as enrolled at an Australian university at 31 March 2023. 'School leavers' are students who attained an Australian Year 12 qualification in 2022 in any State/ Territory through the completion of one or more Year 12 courses; may include (unless noted otherwise below) adult students, part time students and students doing one or more subjects to improve their overall score (repeating students).

The estimated resident population is the population aged 17 years in 2022, as this is the age of the majority of Year 12 students at 30 June 2022. As age data at the small geographical area level are not available by single years, the number at age 17 was estimated from the number in the five-year age group 15 to 19 years. Data have been provided by individual State and Territory tertiary admission centres. As these data were collected from each State and Territory, they may exclude people who live in one State/Territory and were enrolled in another.

The data show areas as having proportions in excess of 100%; these are clearly not accurate. The reason for this is not clear, although it may be the result of the address of the school leaver data being a postcode which is not allocated to the correct Population Health Area or Local Government Area by the correspondence files available; it may also reflect inaccuracies in the denominator (the population aged 17 year), as the population is an estimate, based on a proportion of the those at age 17 years in the five-year age group 15 to 19 years from the Population Census.

Direct enrolments to universities were not included in the data collected: in 2022, these represented a small proportion of total enrolments, other than in the ACT.

Variations in data between States

Definitions vary across the States and Territories; however, the impact of any difference is considered to be small.

South Australian data represent the number of school leavers that have received and accepted an offer to a university in South Australia and the Northern Territory; however, this is not necessarily indicative of the enrolment status as they may not have enrolled at the institution by 31 March 2023.

The University of Notre Dame (NSW and WA) did not provide data for the 2023 time period and were not included in the final data published.

For more information, please consult the relevant admissions centre as listed in the Source below.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: School leavers who are identified as enrolled at an Australian university at 31 March 2023.

Denominator: Estimated resident population aged 17 years at 30 June 2022 (population data at June 2023 not available at time of publication).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from the:

1. Universities Admissions Centre (NSW & ACT), Victorian Tertiary Admissions Centre (Vic.), Queensland Tertiary Admissions Centre (Qld), South Australian Tertiary Admission Centre (SA & NT), Tertiary Institutions Service Centre (WA), The University of Notre Dame Australia (WA & NSW), and the University of Tasmania (Tas.).
2. ABS estimated resident population, 30 June 2022.

Early childhood development

Australian Early Development Census (AEDC) Indicators, 2024 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The Australian Early Development Census (AEDC) is a population census measuring the development of children in Australia in their first year of full-time school. It provides a picture of early childhood development outcomes and was first conducted nationwide in 2009, as the Australian Early Development Index. The AEDC has been conducted nationally every three years since then (2012, 2015, 2018, 2021 and 2024), with 95 per cent of children in their first year of full-time school participating in 2024² [1, 2].

The results from the AEDC provide communities, schools, government and non-government agencies and policy makers with information about how children have developed by the time they start school, measured across five areas of early childhood development: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge. The AEDC domains have been shown to predict later health, wellbeing, and academic success [1].

In 2024, 52.9% of children assessed were considered to be on track on all five domains of the AEDC and 23.5% developmentally vulnerable on one or more domains of the AEDC [3].

The 2024 AEDC shows clear equity gaps in children's development, both by remoteness and socio-economic disadvantage [3].

- Children in Very Remote areas are 40% less likely to be on track compared with those in Major Cities.
- Twice as many children in Very Remote areas are developmentally vulnerable compared with those in Major Cities.
- Children in the most disadvantaged areas are 30% less likely to be on track, and almost twice as likely to be vulnerable compared with those in the least disadvantaged areas.

References

1. Australian Early Development Census (AEDC). AEDC National Report 2015 (A snapshot of early childhood development in Australia). Canberra: Department of Education and Training; 2016.
2. Australian Early Development Census (AEDC). AEDC National Report 2024 ISSN 2206-284X (Online).
3. Data from PHIDU workbooks, data release December 2025, available from: <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: The AEDC results report on the number of children scoring in the following percentile ranges: below the 10th percentile (developmentally vulnerable), 10th to 25th percentile (developmentally at risk) and above the 25th percentile (developmentally on track).

The PHIDU data are presented for children who were assessed as being:

- Developmentally vulnerable (below 10th percentile) on one or more domains
- Developmentally vulnerable (below 10th percentile) on two or more domains
- Developmentally on track (above the 25th percentile) on all five domains.

² Children are those from in-scope schools. PHIDU estimate that 91.3% of all children (attending in-scope and out-of-scope schools) participated.

Also reported are data for children who were assessed as being developmentally vulnerable (below the 10th percentile), at risk (10th to 25th percentile), and on track (above the 25th percentile) in the following domains:

- Physical health and wellbeing domain
- Social competence domain
- Emotional maturity domain
- Language and cognitive skills (school-based) domain
- Communication skills and general knowledge domain.

Summary measures are reported for children who were assessed as being developmentally vulnerable (below the 10th percentile) in the following areas:

- Physical readiness for school day
- Physical independence
- Gross and fine motor skills.

The following suppression rules have been applied to the data to preserve confidentiality:

- AEDC data are not reported for locations in which three or fewer children had been assessed
- Suppression of AEDC data also occurs when one or more of the following have not been met:
 - less than fifteen children had valid AEDC scores
 - less than two teachers had completed the AEDC instrument for children in that location
 - the AEDC instrument was completed for less than 80% of all non special needs children
 - the number of vulnerable children represented at least 90% of valid AEDC scores
- additional minor suppressions have occurred where necessary to preserve confidentiality of related suppressed cells (consequential suppression).

Notes

- Unless specified (footnoted) in the data workbooks, the data do not include external territories
- The quintiles in the Social Health Atlas differ from those published by the AEDC. PHIDU publishes quintiles with areas allocated to quintiles (on the basis of their level of disadvantage) to achieve approximately equal proportions of the population, whereas AEDC publishes quintiles with equal numbers of areas. In addition, PHIDU follows the traditional approach used in the social sciences, with quintiles published from Least disadvantaged (Quintile 1) to Most disadvantaged (Quintile 5).
- AEDC scores are invalid for children who are less than 4 years old, with special needs, where teachers have completed less than 75% of the items in any given domain and where the teacher has known the child for less than one month and feels as though they do not know the child well enough to complete the instrument.
- Children with special needs are not included within domain indicators/categories because of the already identified substantial developmental needs of this group.
- Definition of “on track” on 0-5 domains:
 - that the base includes children with missing data,
 - children not on track on five domains may not be ‘vulnerable’ on any domain i.e., they could be at risk on that domain or could be missing a domain score. For example: “*The percentage of children not on track on five domains includes children developmentally vulnerable, at risk or missing a domain score due to the teacher not being able to answer at least 75% of items in any domain*”.
- The Social Health Atlas of Australia uses data from the Australian Early Development Census (AEDC). The AEDC is funded by the Australian Government Department of Education. The findings and views reported are those of PHIDU and should not be attributed to the Department or the Australian Government.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children who were assessed as being developmentally vulnerable on one or more/ two or more domains; and children in each domain/ subdomain who were assessed as being developmentally vulnerable, developmentally at risk or developmentally on track.

Denominator: Children assessed in AEDC, with valid results.

Detail of analysis: Percent.

Source: Compiled by PHIDU based on data from the 2024 Australian Early Development Census (an Australian Government Initiative), provided by the Social Research Centre, who host and manage the AEDC data on behalf of the Australian Government Department of Education.

Learning or Earning

Learning or Earning at ages 15 to 24, 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Young people who fail to engage in school, work or further education/ training run a significant risk of school failure, unemployment, risky health behaviours and mental health problems, social exclusion, and economic and social disadvantage over the longer term [1]. The data comprise the number of 15 to 24-year-old people who, at the time of the Census, were engaged in school, work or further education/ training, expressed as a proportion of the population aged 15 to 24 years. At the 2021 Census, the proportion was 85.4% [2].

References

1. Taylor J. Stories of early school leaving: pointers for policy and practice. Fitzroy: Brotherhood of St Laurence; 2009.
2. Data from PHIDU workbooks, data release November 2022, available from <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: The data comprise the number of 15- to 24-year-old people who were engaged in school, work or further education/ training, expressed as a proportion of all those aged 15 to 24 years. Note that the data published by PHIDU for this indicator from the 2011 Census was for the 15 to 19-year age group.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: 15- to 24-year-olds engaged in school, work or further education/ training.

Denominator: 15- to 24-year-olds.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Families

Single parent families with children aged less than 15 years, 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: In the 2021 Census, of the families in Australia, 43.7% were couple families with children, 38.8% were couple families without children and 15.9% (1,068,268 families) were one parent families: 79.8% of single parents were female and 20.2% were male [1,2]. Compared with other family types, one parent families are considered to be at a higher risk of disadvantage, with respect to income, housing, employment and social participation [2].

The number of single parent families (increased by over 100,000 between 2016 and 2021, compared with an increase of 50,000 more families in 2016 when compared with 2011). As a result, many children spend at least some of their childhood with a lone parent; and many women and some men experience sole parenting, often in difficult financial circumstances. The economic and social wellbeing of one-parent families is a focus of social policy, as many single parent families also experience poorer health, and are major users of publicly funded services [3]. Details of their location are, therefore, relevant to policy makers and those providing health, education, welfare and housing and transport services.

Indicator detail: Single parent families with children under 15 years, as a proportion of all families with children under 15.

References

1. Labour Force Status of Families. Available from: <https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-status-families/latest-release>; accessed 7 September 2022.
2. Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022.
3. ABS. Australian Social Trends, 2007 - Article: One-parent families. (ABS Cat. no. 4102). Canberra: ABS; 2007 [cited 2013 Oct 18]. Available from: [http://www.abs.gov.au/ausstats/subscriber.nsf/0/3A8D1AA0F3AB7D66CA25732F001C94E6/\\$File/41020_One-parent%20families_2007.pdf](http://www.abs.gov.au/ausstats/subscriber.nsf/0/3A8D1AA0F3AB7D66CA25732F001C94E6/$File/41020_One-parent%20families_2007.pdf).

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Single parent families with children under 15 years.

Denominator: All families with children under 15 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Jobless families with children aged less than 15 years, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Families with no employed parent ('jobless families') not only experience substantial economic disadvantage but may also have reduced social opportunities that affect their wellbeing and health. Children who live without an employed parent may be at higher risk of experiencing financial hardship and other disadvantage in the short to medium term. They may not have a role model of employment to follow, and so the joblessness of the parent(s) may mean that such children are more likely to have outcomes such as welfare dependency in the long-term. In some families, the reason the parent is without a job may be to care for children or to undertake study to try to improve the future economic prospects of the household. However, most of the children living without an employed parent live in lone-parent households with limited resources [1].

At the 2021 Census, 11.4% of families with children under 15 years of age met this definition [2].

References

1. Australian Bureau of Statistics (ABS). Children without an employed parent [Internet]. In: Measures of Australia's Progress, 2010. (ABS Cat. no. 1370.0). Canberra: ABS; 2010 [cited 2013 Oct 18]. Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Children%20without%20an%20employed%20parent%20%284.5.2%29>.
2. Data from PHIDU workbooks, data release November 2022, available from <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: Families with children under 15 years in which no parent is employed, as a proportion of all families with children under 15.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Families with children under 15 years in which no parent is employed.

Denominator: Total families with children under 15 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU, Torrens University Australia based on the ABS Census of Population and Housing, August 2021.

Children aged less than 15 years in jobless families, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Families with no employed parent ('jobless families') not only experience substantial economic disadvantage but may also have reduced social opportunities that affect their wellbeing and health.

Children who live without an employed parent may be at higher risk of experiencing financial hardship and other disadvantage in the short to medium term. They may not have a role model of employment to follow, and so the joblessness of the parent(s) may mean that such children are more likely to have outcomes such as welfare dependency in the long-term [1]. In some families, the reason the parent is without a job may be to care for children or to undertake study to try to improve the future economic prospects of the household. However, most of the children living without an employed parent live in lone-parent households with limited resources [2].

In August 2021 there were 196,009 children aged 0–14 years in jobless couple families and a further 327,197 children at these ages in jobless one parent families [3].

References

1. Hancock K, Edwards B, Zubrick S. Echoes of disadvantage across the generations? The influence of long-term joblessness and separation of grandparents on grandchildren. Melbourne, Victoria: Australian Institute of Family Studies, 2013.
2. Australian Bureau of Statistics (ABS). Labour Force, Australia: labour force status and other characteristics of families, June 2011. (ABS Cat. no. 6224.0.55.001). Canberra: ABS, 2011.
3. Australian Bureau of Statistics (ABS). Labour Force, Australia: labour force status and other characteristics of families, June 2017. (ABS Cat. no. 6224.0.55.001). Canberra: ABS, 2017.

Indicator detail: Children aged less than 15 years in jobless families.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children under 15 years in families in which no parent is employed.

Denominator: Total children under 15 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021 (unpublished data).

Children in families where the mother has low educational attainment, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Strong relationships between education and health outcomes exist in many countries, favouring the survival and health of children born to educated parents, especially mothers; but the pathways are culturally and historically complex and vary between and within countries [1,2,3]. A lack of successful educational experiences of parents may lead to low aspirations for their children; and may be related to parents' attitudes, their ability to manage the complex relationships which surround a child's health and education, and their capacity to control areas of their own lives [4,5,6,7].

In August 2021, some 14.1% of children aged under 15 years were in such a family, 196,009 children in jobless couple families and a large number (327,197 children) at these ages in jobless one parent families. This was well down on the proportion in 2011 (23.5%) and also below that in 2016 (17.0%).

Although, under this measure, one in seven children remains at risk from a poorer outcome, the reduction over the past ten years is heartening.

References

1. Cleland JG. Maternal education and child survival: further evidence and explanations. In: Caldwell J et al. (Eds.), What we know about the health transition (Vol. 1). Canberra: Health Transition Centre, Australian National University; 1990.
2. Ewald D, Boughton B. Maternal education and child health: an exploratory investigation in a Central Australian Aboriginal Community. (Occasional paper series, no. 7). Casuarina, NT: Cooperative Research Centre for Aboriginal and Tropical Health; 2002.
3. Hobcraft J. Women's education, child welfare and child survival: a review of the evidence. *Health Transition Review* 1993; 3(2):159-73.
4. Graetz B. Socio-economic status in education research and policy. In: Ainley J et al. (Eds.), Socio-economic status and school education. Canberra: Department of Education, Employment and Training (DEET) and Australian Council for Educational Research (ACER); 1995.
5. Williams T, Long M, Carpenter P, Hayden M. Year 12 in the 1980's: report of a study supported by the Commonwealth EIP program. Canberra: AGPS; 1993.
6. Considine G, Zappala G. Factors influencing the educational performance of students from disadvantaged backgrounds. In: Eardley T, Bradbury B (Eds.), *Competing visions: refereed Proceedings of the National Social Policy Conference 2001*. (SPRC Report 1/02). Sydney: Social Policy Research Centre, University of New South Wales; 2002.
7. Ryan C, Sartbayeva S. Young Australians and social inclusion. Canberra: Social Policy Evaluation, Analysis, and Research (SPEAR) Centre, Australian National University; 2011.

Indicator detail: The data presented are of children aged less than 15 years living in families where the female parent's highest level of schooling was year 10 or below, or where the female parent did not attend school, expressed as a proportion of all children aged less than 15 years.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children in families where the mother has low educational attainment.

Denominator: Total children under 15 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021 (unpublished data).

Housing

Couple families with children aged less than 15 years living in privately-owned rental dwellings; Single parent families with children aged less than 15 years living in privately-owned rental dwellings, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The size and nature of the private rental market has grown and evolved over the last three decades. In 2021, over one-quarter (26.7%) of all households, or 2.5 million people rented privately [1]. Further, more than one million low-income households rented privately in 2018 – a figure which had doubled in the previous 20 years. Once considered a short-term housing choice for young people, many are now renting for longer periods with the ratio renting in the private market increasing across all age groups, families with and without children and low and middle incomes [2].

In 2011, over half of Aboriginal people (56.0 per cent) and migrants arriving in Australia in the last ten years from predominantly non-English-speaking countries (58.2 per cent) lived in a rented home; these proportions were close to twice that for the population overall (30.6 per cent). The proportion of the population living in rental housing was lowest among older people, at 11.9 per cent. Nationally, some 45.3 per cent of single parent families lived in a rented house. While this was 66 per cent higher than the proportion for all families (29.8 per cent), it was below the proportion in 2016, when more than half (58.6 per cent) of single parent families were renting [3].

References

1. Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022.
2. Productivity Commission. Vulnerable Private Renters: Evidence and Options, Commission Research Paper, Canberra, 2019, accessed 30 September 2019. Available from: <https://www.pc.gov.au/research/completed/renters>.
3. Public Health Information Development Unit (PHIDU). Housing experiences and suitability as determinants of health: population patterns of housing experiences and correlated health risk factors and outcomes, Adelaide: PHIDU, 2019, accessed 30 September 2019. Available from: <https://phidu.torrens.edu.au/pdf/2015-onwards/housing-atlas/housing-atlas-report.pdf>.

Indicator detail: This indicator is comprised of couple/ single parent families with children aged less than 15 years living in private dwellings rented from a real estate agent, person not in the same household, other landlord type and landlord type 'not stated'. The data include households in occupied private dwellings only.

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

The numerator excludes the 2.7% of dwellings or 2.2% of persons living in dwellings for which tenure type was not stated: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs and Remoteness Area.

Numerator: Couple/ single parent families with children aged less than 15 years living in privately-owned private dwellings that are rented.

Denominator: Total couple/ single parent families with children aged less than 15 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Children aged less than 15 years in couple families living in privately-owned rental dwellings; Children aged less than 15 years in single parent families living in privately-owned rental dwellings, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The size and nature of the private rental market has grown and evolved over the last three decades. In 2021, over one-quarter (26.7%) of all households, or 2.5 million people rented privately [1]. Further, more than one million low-income households rented privately in 2018 – a figure which had doubled in the previous 20 years. Once considered a short-term housing choice for young people, many are now renting for longer periods with the ratio renting in the private market increasing across all age groups, families with and without children and low and middle incomes [2].

In 2011, over half of Aboriginal people (56.0 per cent) and migrants arriving in Australia in the last ten years from predominantly non-English-speaking countries (58.2 per cent) lived in a rented home; these proportions were close to twice that for the population overall (30.6 per cent). The proportion of the population living in rental housing was lowest among older people, at 11.9 per cent. Nationally, some 45.3 per cent of single parent families lived in a rented house. While this was 66 per cent higher than the proportion for all families (29.8 per cent), it was below the proportion in 2016, when more than half (58.6 per cent) of single parent families were renting [3].

References

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Indicator detail: This indicator is comprised of children aged less than 15 years in couple/ single parent families living in private dwellings rented from a real estate agent, person not in the same household, other landlord type and landlord type 'not stated'. The data include households in occupied private dwellings only.

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

The numerator excludes the 2.7% of dwellings or 2.2% of persons living in dwellings for which tenure type was not stated: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs and Remoteness Area.

Numerator: Children aged less than 15 years in couple/ single parent families living in privately-owned private dwellings that are rented.

Denominator: Children aged less than 15 years living in couple/ single parent families.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

**Couple families with children aged less than 15 years living in rented social housing; Single parent families with children aged less than 15 years living in rented social housing, 2021
– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness**

Policy context: Social housing includes all rental housing owned and managed by government or non-government organisations (including non-profit); social housing rents in general are set below market levels and determined by household income [1]. The social housing services system seeks to provide low income people with access to social housing assistance; supporting their wellbeing and contributing to their social and economic participation by providing services that are timely and affordable, safe, appropriate (meeting the needs of individual households), high quality and sustainable [2]. The distribution of public rental housing remains an indicator of socioeconomic disadvantage. Public housing tenants are increasingly welfare-dependent (especially single parents; those who are unemployed, aged or with a disability; and Aboriginal and Torres Strait Islander peoples) and public housing stocks have declined substantially since 1996.

There is a clear link between cold homes and ill-health, where existing conditions such as respiratory illnesses or mental health conditions are exacerbated [3].

The AIHW reported that:

- At June 2021, there were 417,800 households in the four main social housing programs, increasing from 378,600 in June 2008
- The number of households living in public housing decreased from 331,100 in 2008 to 288,300 in 2021
- The proportion of households living in social housing in Australia decreased from 4.8% in 2011 to 4.2%, in 2021
- In 2021, over 4 in 10 (44%) households in public housing had been in their tenancies for 10 years or more [4].

At June 2021, the number of households on the waiting list (excluding transfers) were: 163,500 households on a waiting list for public housing (up from 154,600 at June 2014). 12,100 households on a waiting list for State owned and managed Indigenous housing dwellings (up from 8,000 at June 2014) [4].

Of those applicants on the waiting list at June 2021:

- There were 67,700 greatest need households on the waiting list for public housing; an increase from 43,200 at June 2014
- There were over 6,500 greatest need households waiting for State owned and managed Indigenous housing dwellings, up from 3,800 at June 2014 [4].

Moreover, housing affordability has declined in Australia as increases in median income has not kept pace with growth in median mortgage and rental payments. From 2001-2011, median mortgage and rental payments increased by 100 Per cent whereas median household income increased by only 60 Per cent in the same period [5]. At the 2021 Census of Population and Housing, the largest number of social housing rentals were rented from a State or Territory housing authority (274,535 dwellings), with a further 73,483 rented from a community housing provider (e.g., a housing co-operative, community or church group), or 12.2% of all rented dwellings [6]. Notably there were some 25,000 fewer of these dwellings rented from a State or Territory housing authority in 2021, when compared with 2016 – and over 22,000 more rented from a community housing provider [7].

References

1. Australian Institute of Health and Welfare (AIHW) (2017) Housing Assistance in Australia 2017, accessed 5 December 2017. Available from: <https://www.aihw.gov.au/reports/housing-assistance/housing-assistance-in-australia-2017/contents/social-housing-tenants>.
2. Productivity Commission (2017) Housing and Homelessness in 2017 Report on Government Services, accessed 5 December 2017. Available from: <https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/housing-and-homelessness/housing>.
3. Public Health England (2014) Local action on health inequalities: Fuel poverty and cold home-related health problems.

4. Australian Institute of Health and Welfare (AIHW) (2022) Housing assistance in Australia. Households and waiting lists, accessed 9 September 2022. Available from: <https://www.aihw.gov.au/reports/housing-assistance/housing-assistance-in-australia/contents/households-and-waiting-lists>.
5. Muir, K. et al. (2017) The opportunities, risks and possibilities of social impact investments for housing and homelessness, AHURI Final Report No.288. Melbourne: Australian Housing and Urban Research Institute.
6. Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing General community profile Australia Canberra ABS 2022. Available from: <https://www.abs.gov.au/census/guide-census-data/about-census-tools/community-profiles>; accessed 25 August 2022.
7. ABS. 2016 Census Community Profiles. Canberra: ABS; 2017 Mar, accessed 8 August 2017. Available from: http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/communityprofile/036?opendocument.

Indicator detail: The data include households in occupied private dwellings only.

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

Social housing: Occupied private dwellings rented from the government housing authority, or community housing provider (housing co-operative, community or church group).

The numerator excludes the 1.5% of dwellings for which tenure type was not stated: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Couple/ single parent families with children aged less than 15 years living in rented social housing dwellings.

Denominator: Total couple/ single parent families with children aged less than 15 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Children aged less than 15 years in couple families living in rented social housing; Children aged less than 15 years in single parent families living in rented social housing, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Social housing includes all rental housing owned and managed by government or non-government organisations (including non-profit); social housing rents in general are set below market levels and determined by household income [1]. The social housing services system seeks to provide low income people with access to social housing assistance; supporting their wellbeing and contributing to their social and economic participation by providing services that are timely and affordable, safe, appropriate (meeting the needs of individual households), high quality and sustainable [2]. The distribution of public rental housing remains an indicator of socioeconomic disadvantage. Public housing tenants are increasingly welfare-dependent (especially single parents; those who are unemployed, aged or with a disability; and Aboriginal and Torres Strait Islander peoples) and public housing stocks have declined substantially since 1996.

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References

8. Australian Institute of Health and Welfare (AIHW) (2017) Housing Assistance in Australia 2017, accessed 5 December 2017. Available from: <https://www.aihw.gov.au/reports/housing-assistance/housing-assistance-in-australia-2017/contents/social-housing-tenants>.
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Indicator detail: The data include households in occupied private dwellings only.

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

Social housing: Occupied private dwellings rented from the government housing authority, or community housing provider (housing co-operative, community or church group).

The numerator excludes the 1.5% of dwellings for which tenure type was not stated: however, these records are included in the denominator.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children aged less than 15 years in couple/ single parent families living in rented social housing dwellings.

Denominator: Children aged less than 15 years living in couple/ single parent families.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Couple families with children aged less than 15 years living in crowded dwellings; Couple families with children aged less than 15 years living in 'severely' crowded dwellings, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: For Australian agencies such as State/Territory housing authorities and the Australian Bureau of Statistics (ABS), household crowding is defined according to the Canadian National Occupancy Standard (CNOS), a widely-used guideline for assessing whether a household has a sufficient number of bedrooms for household members. The CNOS is based on measuring the number of people per bedroom in each dwelling in the context of the 'norms' of sleeping and living associated with the culture of a western nuclear family. Rather than a simple 'crowding' definition based on how many people are living in each bedroom, it is based on a nuanced understanding of the social and family relationships of those in the dwelling, including the number of usual residents, their relationships, age and sex [1]. At the 2021 Census, 6.6% of the population were assessed as living in a crowded dwelling (17.2% of the Aboriginal population, compared with 6.2% of the non-Indigenous population) [4].

A 'severely' crowded dwelling requires four or more extra bedrooms to adequately accommodate its usual residents according to the principles of the CNOS. The ABS categorises people living in 'severely' crowded dwellings in one of six ABS homeless groups [2]. People living in severe overcrowding are considered to lack control of and access to space for social relations (one of the key elements of the ABS definition of homelessness) and are considered not to have accommodation alternatives when remaining in such extreme living arrangements [3]. At the 2021 Census, 20.4 people per 10,000 population were assessed as living in a severely crowded dwelling (197.6 Aboriginal people per 10,000 Aboriginal population compared with 14.4 per 10,000 non-Indigenous people for the non-Indigenous population [4]. The health and safety of occupants may not be compromised in instances of slight overcrowding or short-term overcrowding; severe and sustained overcrowding can however put their health and safety at risk [3].

People living in 'severely' crowded dwellings have been the largest homeless group in each of the last four Censuses. Although the number of people in this group fell slightly between 2001 and 2006, increases of 31% and 23% of people living in 'severely' crowded dwellings in 2011 and 2016, respectively accounted for the majority of the rise in homelessness in these periods. Moreover, New South Wales contributed to most of the increase in 2016 with a 74% increase to 16,821 people from 9,655 people in 2011 [3].

References

1. Australian Housing and Urban Research Initiative (AHURI). When is a dwelling considered 'crowded' and 'severely crowded', AHURI Brief, 2019 (May). Available from: <https://www.ahuri.edu.au/policy/ahuri-briefs/when-is-a-dwelling-considered-crowded-and-severely-crowded>, accessed 8 August 2019.

2. Australian Bureau of Statistics (ABS). Information Paper - Methodology for Estimating Homelessness from the Census of Population and Housing 2012. Cat no. 2049.0.55.001. Available from: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2049.0.55.0012012?OpenDocument>, accessed 8 August 2019.
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4. Data from PHIDU workbooks, data release November 2022, available from: <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: The Canadian National Occupancy Standard assesses the bedroom requirements of a household, accounting for both household size and composition, specifying that:

- there should be no more than two people per bedroom
- children less than five years of age of different sexes may reasonably share a bedroom
- children less than 18 years of age and of the same sex may reasonably share a bedroom
- single household members 18 years and over should have a separate bedroom, as should parents or couples and a lone person household may reasonably occupy a bed-sitter.

'Severely' crowded dwellings are those assessed as needing four or more additional bedrooms to accommodate all people currently living in the household, according to the Canadian National Occupancy Standard (see People living in crowded dwellings above).

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Couple families with children aged less than 15 years living in private dwellings requiring extra bedrooms.

Denominator: Total couple families with children aged less than 15 years.

Detail of analysis:

- Crowded dwellings: Rate per 10,000
- Severely crowded dwellings: Rate per 10,000.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Single parent families with children aged less than 15 years living in crowded dwellings; Single parent families with children aged less than 15 years living in 'severely' crowded dwellings, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: For Australian agencies such as State/Territory housing authorities and the Australian Bureau of Statistics (ABS), household crowding is defined according to the Canadian National Occupancy Standard (CNOS), a widely-used guideline for assessing whether a household has a sufficient number of bedrooms for household members. The CNOS is based on measuring the number of people per bedroom in each dwelling in the context of the 'norms' of sleeping and living associated with the culture of a western nuclear family. Rather than a simple 'crowding' definition based on how many people are living in each bedroom, it is based on a nuanced understanding of the social and family relationships of those in the dwelling, including the number of usual residents, their relationships, age and sex [1]. At the 2021 Census, 6.6% of the population were assessed as living in a crowded dwelling (17.2% of the Aboriginal population, compared with 6.2% of the non-Indigenous population) [4].

A 'severely' crowded dwelling requires four or more extra bedrooms to adequately accommodate its usual residents according to the principles of the CNOS. The ABS categorises people living in 'severely' crowded dwellings in one of six ABS homeless groups [2]. People living in severe overcrowding are considered to lack control of and access to space for social relations (one of the key elements of the ABS definition of homelessness) and are considered not to have accommodation alternatives when remaining in such extreme living arrangements [3]. At the 2021 Census, 20.4 people per 10,000 population were assessed as living in a severely crowded dwelling (197.6 Aboriginal people per 10,000 Aboriginal population compared with 14.4 per 10,000 non-Indigenous people for the non-Indigenous population [4]). The health and safety of occupants may not be compromised in instances of slight overcrowding or short-term overcrowding; severe and sustained overcrowding can however put their health and safety at risk [3].

People living in 'severely' crowded dwellings have been the largest homeless group in each of the last four Censuses. Although the number of people in this group fell slightly between 2001 and 2006, increases of 31% and 23% of people living in 'severely' crowded dwellings in 2011 and 2016, respectively accounted for the majority of the rise in homelessness in these periods. Moreover, New South Wales contributed to most of the increase in 2016 with a 74% increase to 16,821 people from 9,655 people in 2011 [3].

References

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3. Australian Bureau of Statistics (ABS). Census of Population and Housing: Estimating Homelessness, 2016. Cat no. 2049.0, available from <https://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588/54e0338cb1f6c896ca257a7500148dfe!OpenDocument>, accessed 8 August 2019.
4. Data from PHIDU workbooks, data release November 2022, available from: <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: The Canadian National Occupancy Standard assesses the bedroom requirements of a household, accounting for both household size and composition, specifying that:

- there should be no more than two people per bedroom
- children less than five years of age of different sexes may reasonably share a bedroom
- children less than 18 years of age and of the same sex may reasonably share a bedroom
- single household members 18 years and over should have a separate bedroom, as should parents or couples and a lone person household may reasonably occupy a bed-sitter.

'Severely' crowded dwellings are those assessed as needing four or more additional bedrooms to accommodate all people currently living in the household, according to the Canadian National Occupancy Standard (see People living in crowded dwellings above).

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Single parent families with children aged less than 15 years living in private dwellings requiring extra bedrooms.

Denominator: Total single parent families with children aged less than 15 years.

Detail of analysis:

- Crowded dwellings: Rate per 10,000
- Severely crowded dwellings: Rate per 10,000.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Children aged less than 15 years in couple families living in crowded dwellings; Children aged less than 15 years in couple families with living in 'severely' crowded dwellings, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: For Australian agencies such as State/Territory housing authorities and the Australian Bureau of Statistics (ABS), household crowding is defined according to the Canadian National Occupancy Standard (CNOS), a widely-used guideline for assessing whether a household has a sufficient number of bedrooms for household members. The CNOS is based on measuring the number of people per bedroom in each dwelling in the context of the 'norms' of sleeping and living associated with the culture of a western nuclear family. Rather than a simple 'crowding' definition based on how many people are living in each bedroom, it is based on a nuanced understanding of the social and family relationships of those in the dwelling, including the number of usual residents, their relationships, age and sex [1]. At the 2021 Census, 6.6% of the population were assessed as living in a crowded dwelling (17.2% of the Aboriginal population, compared with 6.2% of the non-Indigenous population) [4].

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References

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- children less than five years of age of different sexes may reasonably share a bedroom
- children less than 18 years of age and of the same sex may reasonably share a bedroom
- single household members 18 years and over should have a separate bedroom, as should parents or couples and a lone person household may reasonably occupy a bed-sitter.

'Severely' crowded dwellings are those assessed as needing four or more additional bedrooms to accommodate all people currently living in the household, according to the Canadian National Occupancy Standard (see People living in crowded dwellings above).

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children aged less than 15 years in couple families living in private dwellings requiring extra bedrooms.

Denominator: Children aged less than 15 years living in couple families.

Detail of analysis:

- Crowded dwellings: Rate per 10,000
- Severely crowded dwellings: Rate per 10,000.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Children aged less than 15 years in single parent families living in crowded dwellings; Children aged less than 15 years in single parent families living in 'severely' crowded dwellings, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: For Australian agencies such as State/Territory housing authorities and the Australian Bureau of Statistics (ABS), household crowding is defined according to the Canadian National Occupancy Standard (CNOS), a widely-used guideline for assessing whether a household has a sufficient number of bedrooms for household members. The CNOS is based on measuring the number of people per bedroom in each dwelling in the context of the 'norms' of sleeping and living associated with the culture of a western nuclear family. Rather than a simple 'crowding' definition based on how many people are living in each bedroom, it is based on a nuanced understanding of the social and family relationships of those in the dwelling, including the number of usual residents, their relationships, age and sex [1]. At the 2021 Census, 6.6% of the population were assessed as living in a crowded dwelling (17.2% of the Aboriginal population, compared with 6.2% of the non-Indigenous population) [4].

A 'severely' crowded dwelling requires four or more extra bedrooms to adequately accommodate its usual residents according to the principles of the CNOS. The ABS categorises people living in 'severely' crowded dwellings in one of six ABS homeless groups [2]. People living in severe overcrowding are considered to lack control of and access to space for social relations (one of the key elements of the ABS definition of homelessness) and are considered not to have accommodation alternatives when remaining in such extreme living arrangements [3]. At the 2021 Census, 20.4 people per 10,000 population were assessed as living in a severely crowded dwelling (197.6 Aboriginal people per 10,000 Aboriginal population compared with 14.4 per 10,000 non-Indigenous people for the non-Indigenous population) [4]. The health and safety of occupants may not be compromised in instances of slight overcrowding or short-term overcrowding; severe and sustained overcrowding can however put their health and safety at risk [3].

People living in 'severely' crowded dwellings have been the largest homeless group in each of the last four Censuses. Although the number of people in this group fell slightly between 2001 and 2006, increases of 31% and 23% of people living in 'severely' crowded dwellings in 2011 and 2016, respectively accounted for the majority of the rise in homelessness in these periods. Moreover, New South Wales contributed to most of the increase in 2016 with an 74% increase to 16,821 people from 9,655 people in 2011 [3].

References

1. Australian Housing and Urban Research Initiative (AHURI). When is a dwelling considered 'crowded' and 'severely crowded', AHURI Brief, 2019 (May). Available from: <https://www.ahuri.edu.au/policy/ahuri-briefs/when-is-a-dwelling-considered-crowded-and-severely-crowded>, accessed 8 August 2019.
2. Australian Bureau of Statistics (ABS). Information Paper - Methodology for Estimating Homelessness from the Census of Population and Housing 2012. Cat no. 2049.0.55.001. Available from: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2049.0.55.0012012?OpenDocument>, accessed 8 August 2019.
3. Australian Bureau of Statistics (ABS). Census of Population and Housing: Estimating Homelessness, 2016. Cat no. 2049.0, available from <https://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588/54e0338cb1f6c896ca257a7500148dfe!OpenDocument>, accessed 8 August 2019.
4. Data from PHIDU workbooks, data release November 2022, available from: <https://phidu.torrens.edu.au/social-health-atlases/data>.

Indicator detail: The Canadian National Occupancy Standard assesses the bedroom requirements of a household, accounting for both household size and composition, specifying that:

- there should be no more than two people per bedroom
- children less than five years of age of different sexes may reasonably share a bedroom
- children less than 18 years of age and of the same sex may reasonably share a bedroom
- single household members 18 years and over should have a separate bedroom, as should parents or couples and a lone person household may reasonably occupy a bed-sitter.

'Severely' crowded dwellings are those assessed as needing four or more additional bedrooms to accommodate all people currently living in the household, according to the Canadian National Occupancy Standard (see People living in crowded dwellings above).

Private dwelling: A private dwelling can be a house, flat or even a room. It can also be a caravan, houseboat, tent, or a house attached to an office, or rooms above a shop.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children aged less than 15 years in single parent families living in private dwellings requiring extra bedrooms.

Denominator: Children aged less than 15 years living in single parent families.

Detail of analysis:

- Crowded dwellings: Rate per 10,000
- Severely crowded dwellings: Rate per 10,000.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Income support recipients

Young people receiving an unemployment benefit, June 2023 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Unemployment and its accompanying health effects are not distributed evenly through the population. The experience of unemployment harms a young person's financial and psychological wellbeing, and these effects are felt more severely by those who experience long-term unemployment [1]. Furthermore, those who experience unemployment while young are more likely to be unemployed, have poor health and have lower educational attainment when they are older, than those who are not affected by unemployment while young [1].

Reference

1. Brotherhood of St Laurence (BSL). On the treadmill: young and long-term unemployed in Australia. Melbourne: BSL; 2014.

Indicator detail: People receiving an 'unemployment benefit' those receiving the Youth Allowance (other) paid by Centrelink are shown as proportion of the population aged 16 to 21 years. Youth Allowance (other) is comprised of unemployed people aged 16 to 21 years who are looking for full-time work, studying part-time and looking for work, or temporarily unable to work. It excludes full-time students and those undertaking an apprenticeship/traineeship.

A very small number of Local Government Areas (LGAs) have proportions in excess of 100%: these are clearly not accurate. The reason for this is not clear, although it may be the result of the address of the beneficiary not being allocated to the correct small geographical area by the correspondence files available; it may also reflect inaccuracies in the denominator (the population), as population estimates at the small area level for age groups can be unreliable, in particular for areas with proportionately high numbers of Aboriginal and Torres Strait Islander people (as is the case for this income support payment). It also indicates that it is possible that percentages of less than 100% may also be overstated.

Population Health Area (PHA) data were derived from already suppressed Statistical Area Level 2 (SA2) data. Therefore, if a PHA includes an SA2 with suppressed data, there could be an undercount in the PHA. As State and territory totals were also provided, data in the 'Unknown' data row in the Excel data workbooks are calculated from the difference between the sum of the PHA or LGA data and the State/Territory totals; these figures therefore include the sum of the suppressed SA2 cells.

Data cells with counts of less than five were suppressed (confidentialised).

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: People aged 16 to 21 years in receipt of the Youth Allowance (other).

Denominator: People aged 16 to 21 years at 30 June 2022 (population data at June 2022 not available at time of publication).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from DSS Payment Demographic Data, June 2023, available from <https://data.gov.au/data/dataset/dss-payment-demographic-data>, accessed 20 December 2023 for PHAs and data supplied by the Department of Social Services, June 2023 for LGA data; and Australian Bureau of Statistics estimated resident population, 30 June 2022 (population data at June 2023 not available at time of publication).

Low income, welfare-dependent families (with children), June 2023 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Families either solely or largely dependent on government for their income have the least access to income and other resources and are more likely to have lower achievements in education, experience housing stress, and have poorer physical and mental health [1]. For children living in such families, there is an increased likelihood of limited opportunity and poorer outcomes in terms of wellbeing and learning [2].

For this indicator, to present the distribution of families on the lowest incomes, the data are for families:

- with two children under 16 years of age
- with the household head not in the workforce
- with incomes under \$31,297 p.a.
- in receipt of the Family Tax Benefit part A.

These families would all receive the Family Tax Benefit part A at the maximum level. For further details see under 'Notes', below.

References

1. Barnett M. Economic disadvantage in complex family systems: expansion of family stress models. *Clin Child Fam Psych Rev.* 2008;11(3):145-61.
2. Smart D, Sanson A, Baxter J, Edwards B, Hayes A. Home-to-school transitions for financially disadvantaged children. Sydney: The Smith Family; 2008.

Indicator detail: The level of income used for these data was based on Poverty Lines: Australia, June Quarter 2023, which contains a weekly income for a single parent with two children, excluding housing costs. Poverty Lines: Australia is a quarterly newsletter that updates the Henderson Poverty Line as defined in the 1973 Commonwealth Commission of Inquiry into Poverty. Poverty lines are presented for a range of family sizes, in order to avoid the situation of poverty. The updated Poverty Lines takes account of changes in the average income level of all Australians, reflecting the idea that poverty is relative.

Data cells with less than 5 counts were suppressed (confidentialised).

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Low income families receiving welfare payments from Centrelink: families included are those with children under 16 years of age and with incomes under \$30,596 p.a. in receipt of the Family Tax Benefit part A.

Denominator: Total families, 2021 (as data on families only available at the Census).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data supplied by Department of Social Services, June 2023; and Australian Bureau of Statistics Census of Population and Housing (families), 2022 (population data at June 2023 not available at time of publication).

Children in low income, welfare-dependent families, June 2023 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Children living in families either solely or largely dependent on government for their income have the least access to financial and other resources and are more likely to have lower achievements in education and poorer health outcomes than their more advantaged peers [1]. They also face an increased likelihood of limited opportunity and poorer outcomes in terms of wellbeing and learning [2]. In particular, extreme stressful events, such as homelessness, victimisation or abuse, can have long-term effects on children's outcomes [1].

For this indicator, to present the distribution of families on the lowest incomes, the data are for children in families:

- with two children under 16 years of age
- with the household head not in the workforce
- with incomes under \$31,297 p.a.
- in receipt of the Family Tax Benefit part A.

The families these children are living in would all receive the Family Tax Benefit part A at the maximum level. For further details see under 'Notes', below.

References

1. Jones E, Gutman L, Platt L. Family stressors and children's outcomes. (Report for UK Department for Education). London, UK: Childhood Wellbeing Research Centre; 2013.
2. Smart D, Sanson A, Baxter J, Edwards B, Hayes A. Home-to-school transitions for financially disadvantaged children. Sydney: The Smith Family; 2008.

Indicator detail: Families included are those with children under 16 years of age, with the household head not in the workforce, and with incomes under \$31,297 p.a. in receipt of the Family Tax Benefit part A (whether receiving income support payments or not). These families would all receive the Family Tax Benefit part A at the maximum level. The level of income used for these data was based on [Poverty Lines: Australia](#), June Quarter 2023, which contains a weekly income for a single parent with two children, including housing costs. Poverty Lines: Australia is a quarterly newsletter that updates the Henderson Poverty Line as defined in the 1973 Commonwealth Commission of Inquiry into Poverty. Poverty lines are presented for a range of family sizes, in order to avoid the situation of poverty. The updated Poverty Lines takes account of changes in the average income level of all Australians, reflecting the idea that poverty is relative.

A very small number of Local Government Areas (LGAs) have proportions in excess of 100% for the indicator of children in low income, welfare-dependent families: these are clearly not accurate. The reason for this is not clear, although it may be the result of the address of the beneficiary not being allocated to the correct small geographical area by the correspondence files available; it may also reflect inaccuracies in the denominator (the population), as population estimates at the small area level for age groups can be unreliable, in particular for areas with proportionately high numbers of Aboriginal and Torres Strait Islander people (as is the case for this income support payment). It also indicates that it is possible that percentages of less than 100% may also be overstated.

Data cells with counts of less than five were suppressed (confidentialised).

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children under 16 years of age in low income families receiving welfare payments from Centrelink: families included are those with incomes under \$30,596 p.a. in receipt of the Family Tax Benefit part A.

Denominator: All children under 16 years of age at 30 June 2022 (population data at June 2023 not available at time of publication).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from the Department of Social Services, June 2023; Australian Bureau of Statistics (ABS) Census of Population and Housing, August 2021 (families), and ABS estimated resident population 30 June 2022 (children under 16 years, population data at June 2023 not available at time of publication).

Summary measure of disadvantage

Index of Relative Socio-Economic Disadvantage (IRSD), 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The Index of Relative Socio-economic Disadvantage (IRSD) is one of four Socio-Economic Indexes for Areas (SEIFAs) compiled by the Australian Bureau of Statistics (ABS) after the Census of Population and Housing. The aim is to represent the socioeconomic status (SES) of Australian communities and identify areas of advantage and disadvantage. The IRSD scores each area by summarising attributes of the population, such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. It reflects an area's relative disadvantage and lack of disadvantage. Being an average, the score is likely to reduce apparent differences between individuals in an area, and between areas: this is of particular importance for areas with larger populations.

The IRSD is a useful summary measure. However, if you are studying a particular population, then there may be more appropriate indicators. For example, if interested in children in disadvantaged families, you can use the indicator of the number of children in families where no parent has a job ('jobless' families); or the number of children in families where the mother is receiving welfare benefits at the maximum level, due to having no other income.

Note: The index is calculated on the whole population, not just on children and young people.

Indicator detail: The Index has a base of 1000 for Australia: scores above 1000 indicate relative lack of disadvantage and those below 1000 indicate relatively greater disadvantage.

For further information see the information provided by the Australian Bureau of Statistics (ABS) at: <http://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa> or download the ABS Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2011 (Cat. no. 2033.0.55.001) technical paper at: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001>.

The LGA data were re-produced from the ABS originals. Data for other geographic levels were constructed using population weighted averages, based on the published ABS SA2 data.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Index of Relative Socio-economic Disadvantage, derived by ABS from 2021 Census data.

Note: The Local Government Area (LGA) data were re-produced from the ABS originals. Data for other geographic areas were constructed using population weighted averages, based on the published ABS Statistical Areas Level 2 (SA2) data.

Denominator: Not applicable.

Detail of analysis: The Index has a base of 1000 for Australia: scores above 1000 indicate relative lack of disadvantage (referred to as least disadvantaged) and those below indicate relatively greater disadvantage (referred to as most disadvantaged).

Source: Compiled by PHIDU based on the ABS Socio-Economic Indexes for Areas (SEIFA), 2021 data.

Mothers and babies

Low birthweight babies, 2019 to 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The weight of a baby at delivery (birthweight) is widely accepted as a key indicator of infant health and can be affected by several factors, including the age, size, health and nutritional status of the mother, pre-term birth, and tobacco smoking during pregnancy [1]. A baby is defined as having a low birthweight if they are born weighing less than 2,500 grams. Low birthweight is generally associated with poorer health outcomes, including increased risk of illness and death, longer periods of hospitalisation after birth, and increased risk of developing significant disabilities [2]. The country of birth of the mother may also be an important risk factor for outcomes such as low birthweight and perinatal mortality [3].

References

1. Laws PJ, Grayson N, Sullivan EA. Australia's mothers and babies, 2004. (AIHW Cat. no. PER 34). Sydney: Australian Institute of Health and Welfare (AIHW), 2006.
2. Australian Institute of Health and Welfare (AIHW). A picture of Australia's children, 2012. Canberra: AIHW, 2012.
3. Li Z, McNally L, Hilder L, Sullivan EA. Australia's mothers and babies 2009. (Perinatal statistics series no. 25, AIHW Cat. no. PER 52). Sydney: Australian Institute of Health and Welfare (AIHW), 2011.

Indicator detail: The data comprise all live born babies weighing less than 2500 grams at birth, expressed as a proportion of all live births (data over 3 years).

Data are not shown for areas where there were fewer than 20 births.

Data published prior to 2015 to 2017 were collected from each State and Territory health agency and are likely to have excluded people who live in one State/Territory and used a service in another. This data release uses data, provided to the Australian Institute of Health and Welfare by each State and Territory, in which residents of another jurisdiction were generally coded to their correct usual address. This change will affect the time series published for quintiles and Remoteness Areas.

Data for many remote areas, particularly in Western Australia and Northern Territory, should be treated with caution, as the Australian Bureau of Statistics rate the quality of the population correspondence from SA2 to LGA in some LGAs as 'Poor'.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: All liveborn babies weighing less than 2,500 grams at birth (data over 3 years).

Denominator: Total live births (data over 3 years).

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from the Australian Institute of Health and Welfare, on behalf of the States and Territories.

Women who reported smoking at any time during pregnancy, 2019 to 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Maternal smoking during pregnancy is a major risk factor that can adversely affect infant health, increasing the likelihood of low birth weight, pre-term birth, fetal and neonatal death, and SIDS [1]. In 2016–18 in Australia, one in ten women (9.6%) smoked during pregnancy, with rates over four times as high among Aboriginal and Torres Strait Islander women (43.4%) and those living in remote areas (34.6%, compared with 7.2% for those living in Major Cities) and over six times as high as those living in socioeconomically disadvantaged areas (17.7% in the most disadvantaged areas, compared with 2.8% in the least disadvantaged areas).

Reference

1. Laws PJ, Grayson N, Sullivan EA. Smoking and pregnancy. (AIHW Cat. no. PER 33). Sydney: Australian Institute of Health and Welfare (AIHW), 2006.

Indicator detail: The data comprise the women who reported that they smoked during a pregnancy, expressed as a proportion of the total women who gave birth in the time period (data over 3 years), whether resulting in a live or stillbirth, if the birthweight is at least 400 grams or the gestational age is 20 weeks or more. Includes women with not stated or missing number of antenatal visits and 'Unknown number of visits'.

Data published prior to 2015 to 2017 were collected from each State and Territory health agency and are likely to have excluded people who live in one State/Territory and used a service in another. This data release uses data, provided to the Australian Institute of Health and Welfare by each State and Territory, in which residents of another jurisdiction were generally coded to their correct usual address. This change will affect the time series published for quintiles and Remoteness Areas.

Note that as the data are aggregated over three years, they may include women who gave birth more than once during the time period.

Data for many remote areas, particularly in Western Australia and Northern Territory, should be treated with caution, as the Australian Bureau of Statistics rate the quality of the population correspondence from SA2 to LGA in some areas as 'Poor'.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Women who reported that they smoked during pregnancy (data over 3 years).

Denominator: Total women who gave birth in the time period (data over 3 years), whether resulting in a live or stillbirth, if the birthweight is at least 400 grams or the gestational age is 20 weeks or more. Includes women with not stated or missing number of antenatal visits and 'Unknown number of visits'.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from the Australian Institute of Health and Welfare, on behalf of the States and Territories.

Women who gave birth and did not attend antenatal care within the first 10 weeks, 2019 to 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Antenatal care is associated with positive child and maternal health outcomes, with regular antenatal care visits in the first trimester (before 14 weeks' gestational age), leading to fewer interventions in late pregnancy and positive outcomes for child health [1]. The Australian Antenatal Guidelines recommend that the first antenatal visit occur within the first 10 weeks of pregnancy and that first-time mothers with an uncomplicated pregnancy attend 10 visits [2]. Although almost all mothers (99.9%) who gave birth in 2015 had at least one antenatal visit, fewer than half (47%) of mothers did so in the first 10 weeks of pregnancy and 10% did not start antenatal care until after 20 weeks' gestation [1].

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16, 4.12 Antenatal risk factors.
2. AHMAC 2012. Quoted in AIHW, Australia's health 2018, 4.12 Antenatal risk factors.

Indicator detail: The data comprise the number of women who gave birth and who did not attend their first antenatal visit before 10 weeks gestation, expressed as a proportion of total women who gave birth in the time period (data over 3 years), whether resulting in a live or stillbirth, if the birthweight is at least 400 grams or the gestational age is 20 weeks or more. Includes women with not stated or missing number of antenatal visits and 'Unknown number of visits'.

Note that as the data are aggregated over three years, they may include women who gave birth more than once during the time period.

Data for many remote areas, particularly in Western Australia and Northern Territory, should be treated with caution, as the Australian Bureau of Statistics rate the quality of the population correspondence from SA2 to LGA in some areas as 'Poor'.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: The number of women who gave birth and who did not attend their first antenatal visit before 10 weeks gestation (data over 3 years).

Denominator: Total women who gave birth in the time period (data over 3 years), whether resulting in a live or stillbirth, if the birthweight is at least 400 grams or the gestational age is 20 weeks or more. Includes women with not stated or missing number of antenatal visits and 'Unknown number of visits'.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from the Australian Institute of Health and Welfare, on behalf of the States and Territories.

Child and youth health

Children fully immunised at 1 year of age, 2 years of age and 5 years of age, 2023 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Immunisation coverage among Australian children is a significant public health issue. If a sufficiently large proportion of children are immunised against a particular infectious disease, then the potential for that disease to spread in the community is greatly reduced. Another important implication of immunisation is the decrease in human suffering, disability and cost of health care through preventing an infectious disease and its consequences.

Australia has an aspirational target of 95% childhood immunisation coverage due to measles needing 92% to 94% of children to be immunised to achieve herd immunity [1].

Reference:

1. Department of Health (DoH) 2016. Immunisation coverage targets. Canberra: DoH. Available from: <https://www.health.gov.au/news/immunisation-coverage-targets>, accessed 15 May 2023.

Indicator detail: The data presented are of children on the Australian Childhood Immunisation Register (ACIR) who are fully immunised at 1 year of age (a child aged 12 months to less than 15 months), 2 years of age (a child aged 24 to less than 27 months) and 5 years of age (a child aged 60 to less than 63 months).

The definitions of fully immunised are shown on the National Immunisation Program Schedule, which is available at <https://www.health.gov.au/resources/publications/national-immunisation-program-schedule>.

Data are not shown for areas where there were 0 to 9 children immunised.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Children fully immunised at 1 year of age, 2 years of age and 5 years of age.

Denominator: Children on the Australian Childhood Immunisation Register (ACIR) at 1 year of age, 2 years of age and 5 years of age.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on data from the Australian Childhood Immunisation Register, 2023 calendar year.

**Human Papillomavirus (HPV) vaccine coverage: females/ males aged 15 years as at mid June 2023, who received 1 dose or more of the vaccine, 2023
– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness**

Policy context: Australia was the first country to introduce a fully funded, population-based HPV vaccination program, the National Human Papillomavirus (HPV) Vaccination Program, aiming to prevent HPV infection and HPV-related diseases.

The National Immunisation Program (NIP) introduced the HPV vaccination in 2007. Between 2007 and 2009, all females aged 12 to 26 years were offered vaccination against HPV through schools and a community-based program. In 2013, the program was extended to include males.

As of February 2023, the routine 2-dose HPV vaccine schedule provided to young people aged 12 to 13 years became a single dose schedule using the Gardasil®9 vaccine [1].

Reference:

1. Preventing HPV infection and HPV-related diseases: News. Available from: <https://www.cdc.gov.au/newsroom/news-and-articles/preventing-hpv-infection-and-hpv-related-diseases>; accessed 3 February 2025.

Indicator detail: The data presented are for females and males who were aged 15 years as at 30 June 2023, and who had received one dose or more of the HPV vaccination, as reported on the Australia Immunisation Register for HPV as at 4 October 2024.

The data include only vaccinations administered to consumers whose residential address is located in Australia, including unknown postcodes, and excludes consumers who do not wish their details to be recorded on the Australia Immunisation Register for HPV.

Where there were 0-9 participants or residents in an area, the data are not shown. Services Australia have advised that information held by the National HPV Vaccination Program Register is provided to the Register from immunisation providers. The accuracy of the information is dependent on the quality and timeliness of the data provided. Every effort is made to ensure that the information recorded on the Register is up to date and correct.

Population Health Area (PHA) data were derived from data already suppressed Statistical Area Level 2 (SA2). Therefore, if a PHA includes an SA2 with suppressed data, there could be an undercount in the PHA. As State and territory totals were also provided, data in the 'Unknown' data row in the Excel data workbooks are calculated from the difference between the sum of the PHA or LGA data and the State/Territory totals; these figures therefore include the sum of the suppressed SA2 cells.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Number of females/ males aged 15 years as at 30 June 2023, who had received 1 dose or more of the HPV vaccine.

Denominator: Number of females/ males aged 15 years at mid-year 2023 on the Australia Immunisation Register.

Detail of analysis: Per cent.

Source: Compiled by PHIDU using data supplied by Services Australia from the Australia Immunisation Register for HPV, 4 October 2024.

Infant mortality, 2018 to 2022 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The survival of infants in their first year of life is viewed as an indicator of general health and wellbeing of a population. Infant mortality refers to deaths of infants under one year of age and is measured by the infant mortality rate (IMR), the rate of infant deaths per 1000 births in a calendar year. The IMR for Indigenous infants is significantly higher than that for non-Indigenous infants, indicating their overall poorer health and wellbeing and the levels of socioeconomic disadvantage of their families, much of which represent the legacy of colonisation, cultural dispossession, discriminatory policies and social exclusion. Australia has one of the lowest IMR in the world: in 2022 it was 3.2 infant deaths per 1,000 live births, compared with 4.1 deaths per 1,000 live births in 2010 [1].

However, the five state/territory (New South Wales, Queensland, South Australia, Western Australia and the Northern Territory) IMR for Aboriginal and Torres Strait Islander Australians was 63 per cent above the rate for non-Indigenous Australians (5.2 and 3.2 per 1,000 live births, respectively) [2].

References

1. 3302.0 - Infant deaths. Deaths, Australia, 2018. Available from: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/3302.0Main%20Features52018>: accessed 2 December 2019.
2. Australian Bureau of Statistics (ABS) Deaths, Australia, 2022. Available from: <https://www.abs.gov.au/statistics/people/population/deaths-australia/latest-release#aboriginal-and-torres-strait-islander-people>: accessed 29 November 2023.

Indicator detail: The data presented are of deaths that occurred before 12 months of age, as a rate per 1,000 live births. Data are not shown for areas where there were fewer than 20 births.

For detailed data released since 2007, the Australian Bureau of Statistics (ABS) has applied a staged approach to the coding of cause of death which affects the number of records available for release at any date. In general, the latest year's data are designated preliminary, the second latest as revised and the data for the remaining years as final. For further information about the ABS revisions process see the following and related sites: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Explanatory%20Notes12015?OpenDocument>.

Data published here are from the following releases: 2018, 2019 and 2020 final; 2021 and 2022, preliminary.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Deaths that occurred before 12 months of age.

Denominator: Live births.

Detail of analysis: Infant mortality rate; infant deaths per 1,000 live births.

Source: Data compiled by PHIDU from deaths data based on the 2017 to 2021 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System. The births data for 2017 to 2021 were compiled from the [ABS Births, Australia 2020 \(ABS Cat. no. 3301.0\)](#).

**Youth mortality: total deaths, persons aged 15 to 24 years, 2018 to 2022
– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness**

Policy context: In 2022 the leading cause of deaths for 15-24 years of age was suicide, followed by land transport accidents [1]. For Aboriginal and Torres Strait Islander youth, significantly higher rates of suicide are experienced compared to non-Indigenous youth [1]. Risk factors for youth suicide include social determinants of health such as educational disadvantage, exposure to adverse life events, social and cultural disadvantage [1].

The number of suicides should be interpreted with caution, as they are likely to increase as the ABS revisions process is applied (see 'Notes', below).

Additional information: Although it is not possible to present data for deaths at these ages by specific causes, the following information may be of interest. In 2021, just over one third (34.0%) of male deaths and over one third (35.6%) of female deaths between 15 and 24 years of age were from intentional self-harm (suicide). The proportion for males was lower than the 37.8% in 2021; and for females it was higher than the 32.3% in 2021. The next highest proportion for females was deaths as an occupant of a car injured in a transport accident (15.8%), with a higher proportion for males (23.8%). The number of suicides should be interpreted with caution, as they will increase when the ABS revisions process is applied (see 'Notes', below) [1].

Reference

1. Australian Institute of Health and Welfare. Deaths in Australia. Available at: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/summary>; accessed 5th of September 2024.

Indicator detail: The data presented are the average annual indirectly age-standardised rates per 100,000 population (aged 15 to 24 years); and/or indirectly age-standardised ratios, based on the Australian standard.

For detailed data files released since 2007, the ABS has applied a staged approach to the coding of cause of death which affects the number of records available for release at any date. In general, the latest year's data are designated preliminary, the second latest as revised and the data for the remaining years as final. For further information about the Australian Bureau of Statistics (ABS) revisions process see the following and related sites: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0Explanatory+Notes12012>.

Data published here are from the following releases: 2018, 2019 and 2020 final; 2021 and 2022, preliminary. Some causes of death, including drug-induced deaths, suicide and assault, are more sensitive to the revisions process than others: as a result, data in the files designated as preliminary should be treated with caution.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: All deaths of people aged 15 to 24 years.

Denominator: Total population aged 15 to 24 years.

Detail of analysis: Average annual indirectly age-standardised rate per 100,000 population (aged 15 to 24 years); and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Data compiled by PHIDU from deaths data based on the 2018 to 2022 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information system. The population is the average of the ABS estimated resident population (ERP) for Australia, 30 June 2018 to 30 June 2022.

Prevalence of selected long-term health conditions, by age (ABS Census)

Long-term health conditions, by age, 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The rationale for including the long-term health conditions topic in the 2021 Census was to:

- allow for cross-classification with other Census topics
- enable output for sub-populations (e.g., culturally and linguistically diverse or Aboriginal and Torres Strait Islander populations)
- enable data outputs at finer geographies than what can be achieved through existing health collections.

Apart from this new question in the Census, the ABS have multiple instruments to collect information about health conditions. These are in the form of the National Health Survey, National Aboriginal and Torres Strait Islander Health Survey and the Patient Experience Survey. Each instrument can be used to estimate rate of long-term health conditions across the Australian population. To understand the methodological differences in the creation of these estimates, the ABS have created a web document “Comparing ABS long-term health conditions data sources: Exploring the purpose, collection and concept of health data”, available at: <https://www.abs.gov.au/statistics/detailed-methodology-information/information-papers/comparing-abs-long-term-health-conditions-data-sources>.

The document compares the purposes, the collection methods, and advantages and disadvantages of each of the instruments in defining estimates and provides a comparison of the derived Australian estimates for each long-term health conditions from their various collections. They highlight that the key point of difference is that the 2021 Census asks only a single long-term health conditions question while their targeted health surveys provide more detailed data about the health status of the populations under investigation. The ABS states that the “long-term health conditions data from the Census is not intended to provide prevalence estimates” and recommends that their health survey instruments should be used for national and state/territory level long-term health condition prevalence rates.

The benefit of asking the long-term health conditions question in the Australian Census context, as quoted by the ABS, is “that it allows for the analysis of long-term health conditions data at more detailed geographic and sub-population levels than ABS health surveys can support, and across a range of socio-economic and demographic dimensions”. Given PHIDU’s remit to publish small area statistics for monitoring inequality in health and wellbeing and for supporting opportunities to improve population health outcomes.

PHIDU have published the reported responses (albeit as standardised rates per 100 population) at the small area level as they can highlight variations across Australia from the national and state/ territory rates, a major purpose of the Social Health Atlas. However, given the comments above, the rates of long-term health conditions reported here at the national and state/ territory level should be used with caution, and the other caveats in the linked ABS document should also be borne in mind.

Definition of a long-term health condition:

Long-term health conditions are those conditions diagnosed by a doctor or nurse, last six months or longer and include health conditions that:

- May recur from time to time, or
- Are controlled by medication, or
- Are in remission.

This variable records the type of selected long-term health condition(s) a person has reported. Respondents can record multiple long-term health conditions including:

- arthritis
- asthma
- cancer (including remission)
- dementia (including Alzheimer's)
- diabetes (excluding gestational diabetes)
- heart disease (including heart attack or angina)
- kidney disease
- lung condition (including COPD) or emphysema)
- mental health condition (including depression or anxiety)
- stroke
- and other long-term health conditions.

As respondents can select multiple conditions, the count of components for this variable will not equal the total number of people.

Multiple variables are created from multiple responses from one or more long-term health conditions questions. Therefore, some variables do not have a non-response rate calculated. The non-response rate derived for the "Count of long-term health conditions (CLTHP)" in the 2021 Census was 8.1%.

Indicator detail: Long-term health conditions, by age (Children and young people aged 0 to 14 years); People who reported they had:

- one long-term health condition, 2021
- two long-term health conditions, 2021
- one or more long-term health conditions, 2021
- no long-term health condition, 2021.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Remoteness Area.

Numerator: Number of children and young people aged 0 to 14 years or 15 to 24 years who had no long-term health conditions/ one condition/ two conditions or one or more conditions on the list above, or any other long-term health conditions, by age.

Denominator: Children and young people aged 0 to 14 years or 15 to 24 years.

Detail of analysis: Indirectly age-standardised rate per 100 population; and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Prevalence of selected long-term health conditions, by condition (ABS Census)

Long-term health conditions, by condition and age, 2021

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The rationale for including the long-term health conditions topic in the 2021 Census was to:

- allow for cross-classification with other Census topics
- enable output for sub-populations (e.g., culturally and linguistically diverse or Aboriginal and Torres Strait Islander populations)
- enable data outputs at finer geographies than what can be achieved through existing health collections.

Apart from this new question in the Census, the ABS have multiple instruments to collect information about health conditions. These are in the form of the National Health Survey, National Aboriginal and Torres Strait Islander Health Survey and the Patient Experience Survey. Each instrument can be used to estimate rate of long-term health conditions across the Australian population. To understand the methodological differences in the creation of these estimates, the ABS have created a web document “Comparing ABS long-term health conditions data sources: Exploring the purpose, collection and concept of health data”, available at: <https://www.abs.gov.au/statistics/detailed-methodology-information/information-papers/comparing-abs-long-term-health-conditions-data-sources>.

The document compares the purposes, the collection methods, and advantages and disadvantages of each of the instruments in defining estimates and provides a comparison of the derived Australian estimates for each long-term health conditions from their various collections. They highlight that the key point of difference is that the 2021 Census asks only a single long-term health conditions question while their targeted health surveys provide more detailed data about the health status of the populations under investigation. The ABS states that the “long-term health conditions data from the Census is not intended to provide prevalence estimates” and recommends that their health survey instruments should be used for national and state/territory level long-term health condition prevalence rates.

The benefit of asking the long-term health conditions question in the Australian Census context, as quoted by the ABS, is “that it allows for the analysis of long-term health conditions data at more detailed geographic and sub-population levels than ABS health surveys can support, and across a range of socio-economic and demographic dimensions.” Given PHIDU’s remit to publish small area statistics for monitoring inequality in health and wellbeing and for supporting opportunities to improve population health outcomes.

PHIDU have published the reported responses (albeit as standardised rates per 100 population) at the small area level as they can highlight variations across Australia from the national and state/ territory rates, a major purpose of the Social Health Atlas. However, given the comments above, the rates of long-term health conditions reported here at the national and state/ territory level should be used with caution, and the other caveats in the linked ABS document should also be borne in mind.

Definition of a long-term health condition

Long-term health conditions are those conditions diagnosed by a doctor or nurse, last six months or longer and include health conditions that:

- May recur from time to time, or
- Are controlled by medication, or
- Are in remission.

This variable records the type of selected long-term health condition(s) a person has reported. Respondents can record multiple long-term health conditions including:

- arthritis
- asthma
- cancer (including remission)
- dementia (including Alzheimer’s)
- diabetes (excluding gestational diabetes)
- heart disease (including heart attack or angina)
- kidney disease
- lung condition (including COPD) or emphysema)
- mental health condition (including depression or anxiety)
- stroke
- and other long-term health conditions.

As respondents can select multiple conditions, the count of components for this variable will not equal the total number of people. Multiple variables are created from multiple responses from one or more long-term health conditions questions. Therefore, some variables do not have a non-response rate calculated. The non-response rate derived for the “Count of long-term health conditions (CLTHP)” in the 2021 Census was 8.1%.

Indicator detail: Long-term health conditions, by condition and age (Children and young people aged 0 to 14 years).

People who reported they had:

- asthma
- mental health condition (including depression or anxiety)
- and other long-term health conditions.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Number of children and young people aged 0 to 14 years or 15 to 24 years who been told by a doctor or nurse that they have one of the conditions listed above.

Denominator: Children and young people aged 0 to 14 years or 15 to 24 years. The variables are derived from responses to the long-term health conditions question and count the number of people who marked a condition listed on the Census form, or who reported a long-term health condition in addition to those listed.

Detail of analysis: Indirectly age-standardised rate per 100 population; and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2021.

Prevalence of selected health risk factors (estimates)

Modelled estimates and direct estimates:

In the absence of data from administrative data sets, modelled estimates are provided at the [Population Health Area \(PHA\)](#) level for selected indicators from the 2022 National Health Survey (NHS), conducted by the Australian Bureau of Statistics (ABS). The modelled estimates were produced by the ABS as a consultancy.

Estimates at the Local Government Area (LGA) and Primary Health Network (PHN) level were derived from the PHA estimates. Estimates for quintile of socioeconomic disadvantage of area and Remoteness Area are, however, direct estimates, extracted using the ABS TableBuilder.

Users of these modelled estimates should note that they do not represent data collected in administrative or other data sets. As such, they should be used with caution and treated as indicative of the likely social dimensions present in an area with these demographic and socioeconomic characteristics.

The numbers are estimates for an area, not measured events as are, for example, death statistics. As such, they should be viewed as a tool that, when used in conjunction with local area knowledge and taking into consideration the prediction reliability, can provide useful information that can assist with decision making for small geographic regions. Of particular note is that the true value of the published estimates is also likely to vary within a range of values as shown by the upper and lower limits published in the data (xlsx) and viewable in the column chart in the single map atlases.

What the modelled estimates do achieve, however, is to summarise the various demographic, socioeconomic and administrative information available for an area in a way that indicates the expected level of each health indicator for an area with those characteristics. In the absence of accurate, localised information about the health indicator, such predictions can usefully contribute to policy and program development, service planning and other decision-making processes that require an indication of the geographic distribution of the health indicator.

The relatively high survey response rate in the NHS provides a high level of coverage across the population; however, the response rate among some groups is lower than among other groups, e.g., those living in the most disadvantaged areas have a lower response rate than those living in less disadvantaged areas. Although the sample includes the majority of people living in households in private dwellings, it excludes those living in the Very Remote areas of Australia and discrete Aboriginal and Torres Strait Islander communities; whereas these areas comprise less than 3% of the total population, Aboriginal people comprise up to one third of the population. The survey does not include persons usually resident in non-private dwellings (hospitals, gaols, nursing homes - and also excludes members of the armed forces serving in Australia).

This and other limitations of the method mean that estimates have not been published for PHAs with populations under 1,000 and for PHAs with more than 20% of their population residing in SA1s classified as very remote or as discrete Aboriginal and Torres Strait Islander Communities.

The ABS used a number of methods to measure the quality of the estimates, one of which is the relative root mean squared error (RRMSE) of the modelled estimates. The RRMSEs are included with the data. Users are advised that:

- estimates with RRMSEs less than 25% are considered reliable for most purposes;
- estimates with RRMSEs from 0.25 and to 0.50 have been marked (~) to indicate that they should be used with caution; and
- those greater than 0.50 but less than 1 are marked (~~) to indicate that the estimate is considered too unreliable for general use.

Differences from data published by the Australian Bureau of Statistics (ABS):

Data by quintile of socioeconomic disadvantage and Remoteness will differ to the extent that data extracted from Survey TableBuilder have been randomised, whereas those published by the ABS are not. In addition, rates published by the ABS for modelled estimates are generally crude rates; rates published by PHIDU are age-standardised.

Estimated number of males, females and persons aged 2-17 years who were overweight (but not obese), or obese, 2022 – by PHA, LGA, PHN, Quintiles, Remoteness

Policy context: Overweight and obesity in childhood and adolescence can cause a range of physical and emotional health problems; and obesity increases the risk of chronic disease and premature death in adulthood.

In 2022, over a quarter (27.7%) of children and young people aged 2-17 years were overweight or obese, comprised of 19.5% overweight and 8.2% obese [1]. This represents an increase in the proportion of overweight children from 16.7% in 2017–18 [2].

References

1. Australian Bureau of Statistics (ABS). Waist circumference and BMI: Children and Body Mass Index (BMI). Available from <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/waist-circumference-and-bmi/2022>; accessed 11 November 2024.
2. Australian Bureau of Statistics (ABS). Table 16: Children's Body Mass Index, waist circumference, height and weight. National Health Survey: First Results, 2017–18. Canberra: ABS; 2018. Available from: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012017-18?OpenDocument>; accessed 13 December 2019.

Indicator detail: Body Mass Index (BMI) (or Quetelet's index) is a measure of relative weight based on an individual's mass and height. The height (cm) and weight (kg) of respondents, as measured during the NHS interview, were used to calculate the BMI.

Note that the modelled estimates are based on the 43.2% of children and young people aged 2 to 17 years in the sample who had their height and weight measured: this is markedly below the level in 2017–18 when it was 56.1%. For respondents who did not have their height and weight measured, imputation was used to obtain height, weight and BMI scores.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, quintile of socioeconomic disadvantage of area and Remoteness Area.

Numerator: Estimated number of males, females or persons aged 2 to 17 years who were assessed as being overweight (not obese) or obese, based on their measured height and weight.

Denominator: Male, female or total population aged 2 to 17 years.

Detail of analysis: Indirectly age-standardised rate per 100 males, females or persons (aged 2 to 17 years); and/or indirectly age-standardised ratio, based on the Australian standard.

Source: PHA, LGA & PHN: Age-standardised rates are based on Australian Bureau of Statistics data, produced as a consultancy for PHIDU, from the 2022 National Health Survey. Quintiles & Remoteness: Compiled by PHIDU based on direct estimates from the 2022 National Health Survey, ABS TableBuilder.

Disability: Need for assistance

The information in the Child and Youth Social Health Atlas of people living with disability and their carers comprises:

- Data from the 2021 Census of the number of children and young people who have a need for assistance with core activities (immediately below).
- Participants in the National Disability Insurance Scheme, December 2024 (located [here](#)).
- Participants in the National Disability Insurance Scheme with a principal diagnosis of autism, June 2025 (located [here](#)).

Has need for assistance with core activities, by 5-year age groups, 0-4 years to 20-24 years, 2021 – by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: The likelihood of disability generally increases with age, but can also reflect people's life cycle, their changing environments and the risks they encounter [1]. Focusing on the age-specific prevalence rates of a severe or profound limitation, the peak in early childhood and school years may reflect the effects of early intervention services and the school environment on the identification of disability [1]. Young adulthood may see the onset of psychiatric disabilities. From age 35, disability prevalence rates increase with age, as risk of injury, including work-related injuries, becomes relatively high. Late working age years may also see the onset of musculoskeletal and other conditions such as arthritis and heart disease associated with physical disabilities. For people at older ages, limitations in functioning are more likely to be associated with diseases and long-term conditions such as cardiovascular diseases, cancers, dementia, arthritis, and hearing and vision impairments [1].

The 'Core Activity Need for Assistance' variable was developed by the Australian Bureau of Statistics (ABS) for use in the five-yearly population Census to measure the number of people with a profound or severe disability, and to show their geographic distribution. A person with profound or severe limitation needs help or supervision always (profound) or sometimes (severe) to perform activities that most people undertake at least daily, that is, the core activities of self-care, mobility and/or communication, as the result of a disability, long-term health condition (lasting six months or more), and/or older age. Fewer people are reported under this measure as having a profound or severe disability as are measured in the ABS Survey of Disability, Ageing and Carers (SDAC).

The reasons for this are definitional (the SDAC approach, which uses a filtering approach to determine whether the respondent has a disability, and the severity) as compared to the self-report approach in the Census; and the large not-stated category in the Census data, with more people not responding to this set of questions than are reported as having a profound or severe disability. While the SDAC figures should be used as the measure for this concept, the Census data are appropriate for getting an understanding of the geographic distribution of this population group.

Reference

1. Australian Institute of Health and Welfare (AIHW). Australia's welfare 2007. (AIHW Cat. no. AUS 93). Canberra: AIHW; 2007.

Indicator detail: The ABS published figures are of people who have a need for assistance with core activities, by 5-year age groups, 0-4 to 20-24 years.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Number of people who have a need for assistance with core activities, by 5-year age group: 0-4 years to 20-24 years

Denominator: Total population, by 5-year age group, 0-4 years to 20-24 years.

Detail of analysis: Per cent.

Source: Compiled by PHIDU based on the ABS Census of Population and Housing data, August 2021.

Potential years of life lost, by age and sex

Potential years of life lost from deaths of males, females and persons by broad age groups: 0 to 14 and 15 to 24 years, 2018 to 2022

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Potential years of life lost (PYLL) is a measure of the sum of the potential years of life lost from deaths at 15 years (59 years), 25 years (49 years) and so on, assuming they had all lived to 74 years of age.

The Australian Institute of Health and Welfare note that, on this measure, a particular PYLL value will be higher if mortality among children or young people is high; chronic diseases causing death among older people, on the other hand, have little effect on these values [1].

In 2022, there were 944,599 PYLLs in Australia, a 90% drop from 382 per 1,000 people (in 1907) to 39 per 1,000 people (in 2022) [1]. Males are more likely to experience premature death, however over time the difference between the sexes is narrowing as:

- In 1980, there were 109 PYLLs per 1,000 males and 58 PYLLs per 1,000 females (a difference of 51 PYLL per 1,000, or down by 53.2%);
- In 2022, there were 49 PYLLs per 1,000 males and 30 PYLLs per 1,000 females (a difference of 19 PYLLs per 1,000, or down by 61.2%).

Some notable variations in the data sex by age and for the five years 2018 to 2022 [2] are:

- rates for males were above those for females in all age groups studied
- all of the states had rates for males around 70% above those for females, with a smaller gap in the Australian Capital Territory (where the male rate was 55% above the female rate and the Northern Territory (where the male rate was 44% above the female rate).

References

1. Australian Institute of Health and Welfare (AIHW), Deaths in Australia: Life expectancy and deaths. Available from: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/about>; accessed 5 September 2024.
2. PHIDU (www.phidu.torrens.edu.au), based on Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System; 2018 to 2022.

Indicator detail: For detailed data files released since 2007, the Australian Bureau of Statistics (ABS) has applied a staged approach to the coding of cause of death which affects the number of records available for release at any date. In general, the latest year's data are preliminary, the second latest are revised and the data for the earlier years are final. In this way, the majority of records are released earlier than would be the case than were no data released until files had been returned from Coroners' offices. For further information about the ABS revisions process see the following and related sites: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0Explanatory+Notes12012>.

Data published here are from the following releases: 2018, 2019 and 2020, final; and 2021 and 2022, preliminary.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: The sum of the number of years between the actual age at death and 75 years of age for all deaths of each of males, females or persons aged 0 to 14 and 15 to 24 years over the years 2018 to 2022.

Denominator: Males, females or persons aged 0 to 14 and 15 to 24 years.

Detail of analysis: Average annual indirectly age-standardised rate of potential years of life lost per 1,000 population (aged 0 to 14 and 15 to 24 years); and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Data compiled by PHIDU from deaths data based on the 2018 to 2022 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System. The population is the average of the ABS estimated resident population (ERP) for Australia, 30 June 2018 to 30 June 2022.

Use and provision of health and welfare services

National Disability Insurance Scheme participants

See also data from the 2021 Census of the number of children and young people who have a need for assistance with core activities (located [here](#)).

National Disability Insurance Scheme participants by broad age groups, December 2024 – by PHA, PHN, Quintiles, Remoteness

Policy context: The National Disability Insurance Scheme (NDIS) takes a lifetime approach, investing early in people with disability and children with developmental delay to improve their outcomes later in life. Every person living with a disability has different needs and the NDIS provides funds to provide participants with the supports needed for their disability and help working towards their goals [1].

The NDIS, with over 692,000 active participants at 31 December 2024, also connects anyone with disability to services in their community. This includes connections to doctors, community groups, sporting clubs, support groups, libraries and schools, as well as providing information about what support is provided by each state and territory government [1].

More detail as to the types of funding and support are available from <https://www.ndis.gov.au/participants/creating-your-plan/plan-budget-and-rules>.

The rate of participation in the NDIS rises steeply from birth and peaks approximately at the age of 6. At 31 December 2024, there were 159,356 children younger than 9 with a NDIS plan, and a further 23,679 accessing early connections [2]. The number of NDIS participants then declines steadily by age 35, before rising gradually by age 55 [2]. Overall, over half of all NDIS participants were aged 18 years or under [2].

References

1. National Disability Insurance Agency (NDIA). National Disability Insurance Scheme [Internet]. URL: <https://www.ndis.gov.au/>; accessed 9 September 2025.
2. National Disability Insurance Agency (NDIA). National Disability Insurance Scheme [Internet]. URL: <https://www.ndis.gov.au/publications/quarterly-reports/archived-quarterly-reports-2024-25>; accessed on 9 September 2025.

Indicator detail: The data presented are of the number of NDIS participants active as at 31 December 2024 by broad age group. Population Health Area (PHA), Primary Health Network (PHN), Quintiles and Remoteness Areas were derived from NDIS participants' data coded to the Statistical Area Level 2 (SA2).

Data are not shown for areas with fewer than 11 NDIS participants.

Geography: Data available by Population Health Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Number of active NDIS participants by age groups – 0 to 8 years, 9 to 14 years, 15 to 18 years and 19-24 years.

Denominator: Estimated resident population.

Detail of analysis: Indirectly age-standardised rate per 100 population; and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Compiled by PHIDU based on data from the National Disability Insurance Agency, December 2024 and ABS estimated resident population, 30 June 2024.

National Disability Insurance Scheme participants with autism as a primary disability, aged 0 to 24 years, June 2025
– by PHA, PHN, Quintiles, Remoteness

Policy context: Autism, also known as autism spectrum disorder (ASD), is a lifelong neurodevelopmental condition characterised by differences or difficulties in how individuals interact, communicate, and perceive the world. People diagnosed with autism can exhibit different approaches to social engagement alongside restricted, repetitive behaviours and intense interests [1].

Autism can be diagnosed in people of all ages, cultural backgrounds, and economic statuses. An estimated 1 in 40 people are on the autism spectrum [1]. Data from the National Disability Insurance Scheme (NDIS), established with the goal of supporting Australians with a significant and permanent disability, indicates that of the 739,414 participants in the NDIS, 294,960 (40%) have autism as a primary disability [2].

In Australia, the (age-standardised) rates of participation in NDIS with autism as a primary disability range from 19.0 per 1,000 at ages 0 to 8 years, to 26.5 per 1,000 at 15 to 24 years and to 56.9 per 1,000 for children aged 9 to 14 years [3]. Across the three age groups, rates of NDIS participants with autism from the most disadvantaged communities are approximately 1.6 times those from the least disadvantaged communities. For example, among NDIS participants aged 0 to 8 years, those with autism from the most disadvantaged communities have an age-standardised rate of 22.7 per 1,000, or 64 % greater than compared to those with autism from the least disadvantaged communities, of 15.8 per 1,000 [3]. Notably, age-standardised rates for NDIS participants with autism from the Very Remote areas are only around 40% of those from Major Cities [3].

Among NDIS participants in capital cities and non-metropolitan areas, there are frequently strong correlations between the rate of participation and people reporting one or more long-term health conditions [4].

In addition, NDIS participants with autism living in Greater Adelaide show some of the strongest correlations of all capital cities whether being a low income, welfare-dependent family with children under 15 years, or being classed as developmentally vulnerable on one or more AEDC early childhood development domains (physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge) [5].

Note: Similar correlations can be seen for these and other variables and for all capital cities and non-metropolitan areas using the link in footnote [5] and by changing the geography ('Filter to an area') or the indicators ('Select data for Map' in each map window).

References

1. Autism Spectrum Australia (ASPECT). Available from: <https://www.aspect.org.au/>, accessed 27 January 2026.
2. The National Disability Insurance Agency (NDIA). National Disability Insurance Scheme [Internet]. Available from: <https://www.ndis.gov.au/>, accessed 27 January 2026.
3. Public Health Information Development Unit (PHIDU). Available from www.phidu.torrens.edu.au, accessed 2 March 2026.
4. Public Health Information Development Unit (PHIDU). Available from: <https://phidu.torrens.edu.au/current/maps/sha-aust/pha-double-map/aust/atlas.html>.
5. Public Health Information Development Unit (PHIDU). Available from: https://phidu.torrens.edu.au/current/maps/sha-topics/child_youth/pha-double-map/atlas.html, accessed 2 March 2026. NOTE: Under 'Filter to an area', choose 'Capital City', then 'Adelaide'.

Changes of note

Change in number of participants

Since the reference date for these data, of 30 June 2025, there has been an increase of 9.9% in the number of participants with a primary disability of autism (29,246 participants) to December 2025: this contrasts with an overall increase in participants of 3.0%.

Other than in the 0 to 8 year age group (with a decline of 3.9%), the number of participants with autism increased in all age groups over this six-month period. The largest increases were in the 19 to 24 year, 65 years and over, and 15 to 19 year age groups, with increases of 8.2%, 7.9% and 6.9%, respectively.

Source: NDIS, Explore data. Available from: <https://dataresearch.ndis.gov.au/explore-data>; accessed 2 March 2026.

Forthcoming change to the model of care for children with autism with low to moderate support needs

A new program, to be called Thriving Kids, will be introduced from 1 October 2026 across the country for children with developmental delay and/or autism with low to moderate support needs. This will impact on future reporting of NDIS participants with autism on the NDIS. Further details are available at

<https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/press-conference-with-minister-butler-canberra-3-february-2026?language=en>.

Indicator detail: The data presented are of the number of NDIS participants with autism as the primary disability active on 30 June 2025 by broad age group. Primary Health Network (PHN), Quintiles and Remoteness Areas were derived from NDIS participants' data supplied by Population Health Area (PHA).

Data are not shown for areas with fewer than 11 NDIS participants.

Geography: Data available by Population Health Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Number of active NDIS participants with autism as a primary disability by broad age groups – 0 to 8 years, 9 to 14 years, 15 to 24 years.

Denominator: Total estimated resident population.

Detail of analysis: Indirectly age-standardised rate per 1,000 population; and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Compiled by PHIDU based on data from the National Disability Insurance Agency, June 2025 and ABS estimated resident population, 30 June 2024 (population for June 2025 not available at time of publication).

Hospital admissions (excluding same-day renal dialysis)

Admissions in 2022/23 by broad age group and sex; principal diagnosis; procedure; and principal diagnosis of injury or poisoning, by external cause.

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Admission to hospital is a formal process, and follows a decision made by an accredited medical practitioner at that hospital that a patient needs to be admitted for appropriate management or treatment of their condition, or for appropriate care or assessment of needs [1]. Patients are usually admitted to hospital either as an emergency or as a booked admission. Emergency admission patients are usually admitted through the Accident and Emergency Department: these are seriously injured or ill patients who need immediate treatment. Most patients receive hospital-based services as a booked (elective) admission, either as a same-day patient or an inpatient.

However, admission to hospital per se carries at risk of adverse events, in addition to those related to any medical treatment undertaken. These include a risk of cross-infection, injury, or rarely, death [2].

References

1. Australian Institute of Health and Welfare (AIHW). Australian hospital statistics 2012-13. Health services series no. 54. (Cat. no. HSE 145.) Canberra: AIHW; 2014.
2. Australian Institute of Health and Welfare (AIHW). Hospital safety and quality. Available from: <https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-safety-and-quality>; accessed 7 December 2023.

Indicator detail: The data presented are of the number of separations, or completions of the episode of care of a patient in hospital, where the completion can be the discharge, death or transfer of the patient, or a change in the type of care (e.g., from acute to rehabilitation). In this atlas the term 'admission' is used in place of the more technical 'separation'. As these data relate to short-term episodes of care, and not to long-stay episodes, the number of admissions is similar to the number of separations in any year.

Note that the data are based on the count of all admissions. As such, repeat admissions for one person are counted as separate admissions. In addition, patients admitted to one hospital and transferred to another hospital are also counted as separate admissions. The impact of these hospital transfers is likely to result in a higher rate of admissions of people living in regional areas compared to the capital cities, as well as for certain conditions which are more likely to result in transfers.

In some instances results are not comparable between jurisdictions due to the variations in scope of hospitals for individual states and territories.

Impact of COVID-19 on hospitalisations in 2022/23:

The Australian Institute of Health and Welfare advised that there were 11.8 million hospitalisations (of people of all ages) in Australia in 2020-21, up from 11.1 million in 2019-20, although not all states and territories experienced an increase at this level [1].

Reference

1. Australian Institute of Health and Welfare (AIHW). AIHW media releases. Available from: <https://www.aihw.gov.au/news-media/media-releases/2021/june/hospital-admissions-rose-as-covid-19-restrictions>; accessed 7 December 2023.

Exclusions

The national data published by the Australian Institute of Health and Welfare exclude well babies (i.e., babies not admitted for acute care) who are nine days older or less, other than the second or subsequent live born infant of a multiple birth whose mother is currently an admitted patient. This publication also excludes same-day admissions for renal dialysis.

Details of data presented

Data are presented for acute hospitals for the following categories:

1. Admissions by age and sex (excluding same-day admissions for renal dialysis - Z491 to Z492):
 - Male total admissions - Public hospitals, 0-14 years and 15-24 years
 - Female total admissions - Public hospitals, 0-14 years and 15-24 years
 - Total admissions - Public, 0-14 years and 15-24 years

2. Admissions by age, sex and principal diagnosis:

Note: Bracketed numbers below refer to codes in the [International Classification of Diseases \(ICD-10-AM\) chapters](#).

- Infectious and parasitic diseases (A00-B99), males/ females, 0-14 years and 15-24 years - Public hospitals
- All cancers (C00-D48), males/ females, 0-14 years and 15-24 years - Public hospitals
- Endocrine, nutritional and metabolic diseases (E00-E90), males/ females, 0-14 years and 15-24 years - Public hospitals
- Mental health related conditions (F00-F99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Nervous system diseases (G00-G99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Ear and mastoid process diseases (H60-H95), males/ females, 0-14 years and 15-24 years - Public hospitals
- Respiratory system diseases (J00-J99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Asthma (J45-J46), males/ females, 0-14 years and 15-24 years - Public hospitals
- Digestive system diseases (K00-K93), males/ females, 0-14 years and 15-24 years - Public hospitals
- Skin and subcutaneous tissue diseases (L00-L99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Musculoskeletal system and connective tissue diseases (M00-M99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Genitourinary system diseases (N00-N99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Injury, poisoning and certain other consequences of external causes (S00-T98), males/ females, 0-14 years and 15-24 years - Public hospitals.

3. Admissions by principal diagnosis of injury or poisoning, by external cause:

Note: Bracketed numbers below refer to codes in the [International Classification of Diseases \(ICD-10-AM\) chapters](#).

- Transport crash Injury (V00-V99), males/ females, 0-14 years and 15-24 years - Public hospitals
- Falls (W00-W19), males/ females, 0-14 years and 15-24 years - Public hospitals
- Injury due to exposure to inanimate mechanical forces (W20-W49), males/ females, 0-14 years and 15-24 years - Public hospitals
- All diagnosis of injury or poisoning, by external cause, males/ females, 0-14 years and 15-24 years - Public hospitals.

4. Admissions by procedure:

Note: Bracketed numbers below refer to codes in the [International Classification of Diseases \(ICD-10-AM\)/ Australian Classification of Health Interventions \(ACHI\)](#) for all procedures except hip fracture codes that are from the [International Classification of Diseases \(ICD-10-AM\)](#).

- Tonsillectomy, (41789-00, 41789-01, 41787-01 and/or 41786-01), 0-14 years - Public hospitals
- Myringotomy, children aged 0 to 9 years (41632-02 (Insertion of myringotomy tube, unilateral), 41632-03 (Insertion of myringotomy tube, bilateral), 41626-00 (Myringotomy, unilateral) and/or 41626-01 (Myringotomy, bilateral)) - Public/ Private/ All hospitals

Confidentiality of data

Counts of less than six admissions have been suppressed. The Population Health Areas of 30057 Brisbane Inner - North - Central and 30051 Fortitude Valley/Spring Hill have been combined at the request of Queensland Health; data displayed is the combination of values and rates for these areas.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Admissions for the above categories.

Denominator:

- Admissions by hospital type and sex (excluding same-day admissions for renal dialysis): Total population, or total males/ females, aged 0-14 years or 15-24 years, where appropriate
- Admissions by principal diagnosis of injury or poisoning, by external cause: The denominator is the total population, aged 0-14 years or 15-24 years
- Admissions by procedure: For myringotomy, is children aged 0 to 9 years; for tonsillectomy, is children aged 0 to 14 years.

Detail of analysis: Indirectly age-standardised rate per 100,000 (respective population); and/or indirectly age-standardised ratio, based on the Australian standard.

Source: Compiled by PHIDU using data from the Australian Institute of Health and Welfare, supplied on behalf of State and Territory health departments for 2022/23; and the ABS estimated resident population, average of 30 June 2022 and 30 June 2023.

Potentially preventable hospitalisations

Admissions to public (acute) hospitalisations for potentially preventable conditions, by broad age group (all conditions and acute conditions), 2020/21

– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Potentially preventable hospitalisations are admissions from a specified range of conditions where hospitalisation could have been potentially prevented through the provision of appropriate individualised preventative health interventions and early disease management, usually delivered in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals).

Data definitions for potentially preventable hospitalisations are in the National Healthcare Agreement: PI 18- Selected potentially preventable hospitalisations available through METeOR ([METeOR ID: 630028](#)). The indicator potentially preventable hospitalisations is described as a 'progress measure' under the National Healthcare Agreement: PI 18-Selected potentially preventable hospitalisations, 2021 available through METeOR ([METeOR: 725793](#)).

Indicator detail: The data presented are of the number of separations, or completions of the episode of care of a patient in hospital. Where the completion can be the discharge, death or transfer of the patient, or a change in the type of care (e.g., from acute to rehabilitation). In this atlas the term 'admission' is used in place of the more technical 'separation'. As these data relate to short-term episodes of care, and not to long-stay episodes, the number of admissions is similar to the number of separations in any year.

Note that the data are based on the count of all admissions. As such, repeat admissions for one person are counted as separate admissions. In addition, patients admitted to one hospital and transferred to another hospital are also counted as separate admissions. The impact of these hospital transfers is likely to result in a higher rate of admissions of people living in regional areas compared to the capital cities, as well as for certain conditions which are more likely to result in transfers.

The impact of the COVID-19 pandemic on the rates of potentially preventable hospitalisations is not known.

Admissions for potentially preventable conditions:

- Potentially preventable conditions, people aged 0 to 14 years or 15 to 24 years - Public hospitals
- Acute convulsions and epilepsy, people aged 0 to 14 years or 15 to 24 years - Public hospitals
- Acute dental conditions, people aged 0 to 14 years or 15 to 24 years - Public hospitals
- Acute ear, nose and throat infections, people aged 0 to 14 years or 15 to 24 years - Public hospitals
- Acute urinary tract infections, people aged 0 to 14 years or 15 to 24 years - Public hospitals
- Total acute conditions, people aged 0 to 14 years or 15 to 24 years - Public hospitals

Confidentiality of data

Counts of less than six admissions have been suppressed. The Population Health Areas of 30057 Brisbane Inner - North - Central and 30051 Fortitude Valley/Spring Hill have been combined at the request of Queensland Health; data displayed is the combination of values and rates for these areas.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Number of admissions for the above categories, people aged 0 to 14 years or 15 to 24 years - Public hospitals.

Denominator: The total population aged 0 to 14 years or 15 to 24 years.

Detail of analysis: Indirectly age-standardised rate per 100,000 population; and/or indirectly age-standardised ratio, based on the Australian standard. A standardised ratio (SR) provides a comparison to the Australian rate which is assigned a value of 100. Ratios below 100 are proportionally less than the national rate, while ratios above 100 are proportionally higher than the national rate. The SR is the ratio of the observed value to the expected value (the expected value is age-standardised).

Source: Compiled by PHIDU using data from the Australian Institute of Health and Welfare, supplied on behalf of State and Territory health departments for 2020/21; and the ABS estimated resident population, average of 30 June 2020 and 30 June 2021.

Emergency department presentations

Emergency department presentations, broad age group by sex and by principal diagnosis; and by age and sex for selected principal diagnoses, 2022/23
– by PHA, LGA, PHN, Quintiles, Quintiles within PHNs, Remoteness

Policy context: Public hospital emergency departments (ED) are accessible 24 hours a day, seven days a week, to provide acute and emergency care to patients arriving either by ambulance or by other means. While some people require immediate attention for life threatening conditions or trauma, most require less urgent care.

Timely access to care is a high priority for patients, health care providers and the public at large. Although there needs to be an appropriate balance between primary and acute care, EDs play an important role as a safety net in the health system, providing care to people who are unable to access services elsewhere (especially after hours) including care from general practitioners [1]. Young children and people aged 65 years and over are over-represented among those accessing EDs, as are people who are homeless or transient.

The Australian Institute of Health and Wellbeing report that in 2023 there were 293 public hospitals that have purpose-built emergency departments which responded to 8.8 million presentations [2].

An ED service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the ED [3]. The data include both presentations at formal EDs and emergency occasions of service provided through other arrangements, particularly in smaller hospitals located in regional and remote areas.

References

1. Ford G. The role of the Emergency Department as a 'safety net'. *Health Issues* 2002;73:29-32.
2. Australian Institute of Health and Welfare (AIHW). Australia's hospitals at a glance Available from: <https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/hospital-activity>; accessed 7 December 2023.
3. Australian Institute of Health and Welfare (AIHW). Australian hospital statistics 2011-12. Health services series no. 50. (Cat. no. HSE 134.) Canberra: AIHW; 2013.

Indicator detail: The data include presentations to emergency departments (EDs) between 1 July 2022 and 30 June 2023. The data presented are sourced from the AIHW's National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), which is based on the Non-admitted Patient Emergency Department Care (NAPEDC) National Minimum Data Set/National Best Endeavours Data Set (NMDS/NBEDS). The NNAPEDCD provides information on the care provided for non-admitted patients registered for care in EDs in public hospitals where the ED meets the following criteria:

- a purposely designed and equipped area with designated assessment, treatment, and resuscitation areas
- the ability to provide resuscitation, stabilisation, and initial management of all emergencies
- availability of medical staff in the hospital 24 hours a day
- designated emergency department nursing staff 24 hours per day 7 days per week, and a designated emergency department nursing unit manager.

The coverage of the NNAPEDCD was considered complete for public hospitals which meet the above criteria. The collection does not include all emergency services provided in Australia; for example, emergency service activity provided by private hospitals, or by public hospitals which do not have an ED that meets the above criteria are excluded (however, data may have been provided for some of these services by some States and Territories). This should be taken into account, particularly when comparing data between urban and regional areas, or by Remoteness Area. States and Territories provided ED diagnosis information in several classifications, including SNOMED CT-AU, International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM); and various editions of ICD-10-AM. For the purpose of reporting principal diagnoses, the AIHW mapped the provided information to ICD-10-AM 10th edition codes, where necessary.

The provision of these services varies between the States and Territories, with the greatest geographical coverage in New South Wales. This can be seen in the maps of these data, by clicking on the button, in the map legend, labelled 'Public hospital emergency departments'.

Impact of COVID-19 on hospitalisations in 2022-23: The Australian Institute of Health and Welfare provides comment as to the impact of COVID-19 on presentations to public hospital EDs. For example, see <https://www.aihw.gov.au/news-media/media-releases/2021-1/december/covid-19-continues-to-impact-public-hospital-emerg>. In particular, two new codes were introduced to capture data about COVID-19 presentations – one where COVID 19 has been confirmed by laboratory testing and another when COVID-19 has been clinically diagnosed, but laboratory testing is inconclusive, not available or unspecified. The Australian Institute of Health and Welfare provides comment as to the impact of COVID-19 on presentations to public acute hospital EDs: see Impact of COVID-19 on emergency department activity at <https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed>.

In the PHIDU data workbooks and maps emergency department presentation data is presented by the following principal diagnosis:

Chapter ICD-10-AM definitions:

Any of the reported principal diagnosis as per the below:

- A00–B99 (Certain infectious and parasitic diseases)
- F00–F99 (Mental and behavioural disorders)
- I00–I99 (Diseases of the circulatory system)
- J00–J99 (Diseases of the respiratory system)
- K00–K93 (Diseases of the digestive system)
- M00–M99 (Diseases of the musculoskeletal system and connective tissue)
- N00–N99 (Diseases of the genitourinary system)
- S00–T98 (Injury, poisoning and certain other consequences of external causes)
- Z00–Z99 (Factors influencing health status and contact with health services).

Confidentiality of data: Counts of less than six presentations have been suppressed. The Population Health Areas of 30057 Brisbane Inner - North - Central and 30051 Fortitude Valley/Spring Hill have been combined at the request of Queensland Health; data displayed is the combination of values and rates for these areas.

Geography: Data available by Population Health Area, Local Government Area, Primary Health Network, Quintile of socioeconomic disadvantage of area and Quintiles within PHNs, and Remoteness Area.

Numerator: Presentations to emergency departments by ICD-10-AM Chapter, Triage, and ICD-10-AM Chapter by sex and selected age-group categories (where available).

Denominator: Male, female or total populations where applicable.

Detail of analysis: Indirectly age-standardised rate per 100,000 population; and/or indirectly age-standardised ratio, based on the Australian standard. A standardised ratio (SR) provides a comparison to the Australian rate which is assigned a value of 100. Ratios below 100 are proportionally less than the national rate, while ratios above 100 are proportionally higher than the national rate. The SR is the ratio of the observed value to the expected value (the expected value is age-standardised).

Source: Compiled by PHIDU using data from the Australian Institute of Health and Welfare, supplied on behalf of State and Territory health departments for 2022/23; and ABS estimated resident population, average of 30 June 2022 and 2023.