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Eye health measures for Aboriginal and Torres Strait Islander people 2025

in-brief



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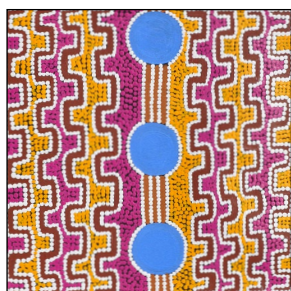
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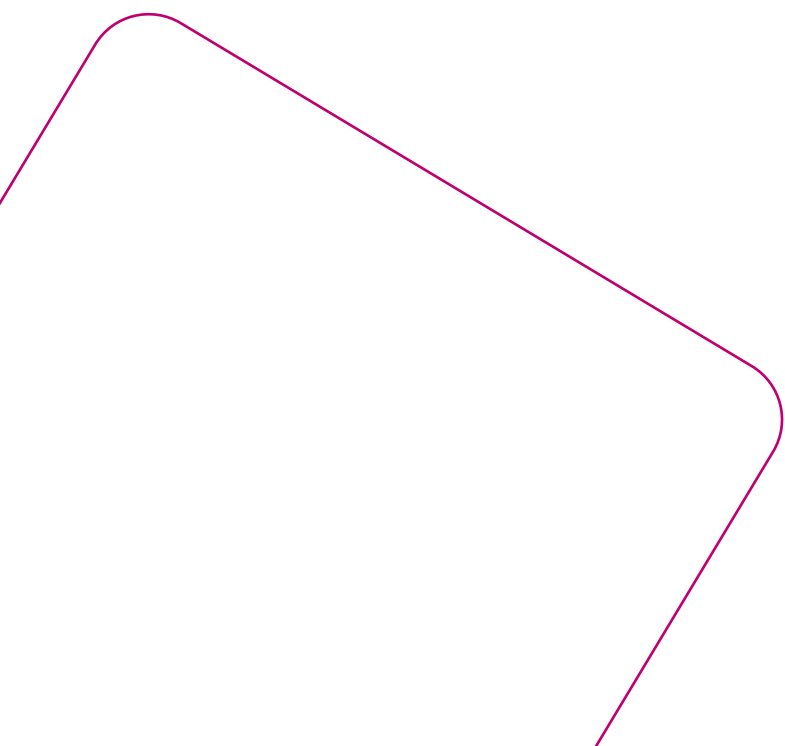
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Ngurlu Jukurrpa (Native Seed Dreaming) by Gloria Napangardi Gill.

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

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Introduction

This in-brief summarises the findings from the *Eye health measures for Aboriginal and Torres Strait Islander people 2025* report and the accompanying web report.

These reports bring together the latest available data on the 22 eye health measures for Aboriginal and Torres Strait Islander (First Nations) people with ongoing data collections (see the following table: 'Eye health measures for Aboriginal and Torres Strait Islander people'). The data for these measures provide information on:

- the prevalence and causes of vision loss and blindness
- detection and screening of eye diseases and vision problems
- eye health treatment services
- the eye health workforce and outreach and other programs.

During the reporting years, there have been notable improvements in:

- trachoma prevalence in at-risk First Nations communities
- annual health assessments for First Nations people and health assessments for First Nations people with an initial eye examination
- eye examinations by an eye health professional
- rates of screening for diabetic retinopathy
- hospitalisations for cataract surgery
- the number and full-time equivalent (FTE) rates of optometrists
- occasions of service provided under the Visiting Optometrist Scheme and the Medical Outreach Indigenous Chronic Disease Program.

Waiting times for elective cataract surgery appear to have worsened as waiting times have increased.

The full report, web report and online tables are available at: <https://www.aihw.gov.au/reports/indigenous-australians/eye-health-measures-2025>



Population rates

Three types of population rates are used to present data in this report:

- *Crude rates*: the number of events divided by the total population. Crude rates are used to show differences within a population, such as the First Nations population. These rates can be misleading, however, when comparing populations with different age structures, such as First Nations people and non-Indigenous Australians. It is important to take these differences into account, particularly when looking at age related conditions, such as refractive error and cataracts.
- *Age-specific rates*: the number of events for a specified age group divided by the population in that age group. Age-specific rates allow populations with different age structures to be compared. These rates provide information on the measures of interest for different age groups but are difficult to summarise and present.
- *Age-standardised rates (ASR)*: the crude rates for different groups, such as First Nations people and non-Indigenous Australians, applied to a standard population to produce a summary rate. Age-standardised rates control for the effects of age and provide a summary rate for each of the populations of interest. The resulting rates, however, are not the 'real' or reported rates that occur in the population.

The statistics presented in this release are based on the Australian Bureau of Statistics 2021 Census-based population estimates and projections, unless stated otherwise. The crude or age standardised rate of prevalence within a survey sample uses the denominator of the sample to calculate the rate. However, for these statistics the ABS population estimates have also been used to make age adjustments to the proportions.

Where the denominator uses these estimates and projections, trends are limited to 2016 onwards due to a large non-demographic increase in Census counts of Aboriginal and Torres Strait Islander people between 2016 and 2021. As a results, the rates for Aboriginal and Torres Strait Islander people in this report are generally lower than those in previous reports and are not directly comparable.

Eye health measures for Aboriginal and Torres Strait Islander people

Measures
<i>Prevalence</i>
1.1 Prevalence of vision impairment and blindness
1.2 Main causes of vision impairment and blindness
1.3 Prevalence of trachoma and trichiasis
<i>Diagnosis and screening services</i>
2.1 Annual health assessments
2.2 Eye examinations undertaken by an eye care professional
2.3 Target population screened for diabetic retinopathy
2.4 Trachoma and trichiasis screening coverage
2.5 Undiagnosed eye conditions
2.6 Eye health problems managed by GPs (discontinued)
<i>Treatment services</i>
3.1 Hospitalisations for diseases of the eye
3.2 Hospitalisations for injuries to the eye
3.3 Hospitalisations for eye procedures
3.4 Cataract surgery rate
3.5 Cataract surgical coverage rate
3.6 Waiting times for elective cataract surgery
3.7 Target population treated for diabetic retinopathy
3.8 Trachoma and trichiasis treatment coverage
3.9 Treatment of refractive error
3.10 Spectacles dispensed under state schemes
<i>Workforce and outreach services</i>
4.1 Number and rate of optometrists
4.2 Number and rate of ophthalmologists
4.3 Number and rate of allied ophthalmic personnel
4.4 Occasions of eye health services provided under outreach and other programs

GPs = general practitioners.



1

Eye health problems affect First Nations people

Aboriginal and Torres Strait Islander (First Nations) children begin life with some of the best eyesight in the world, yet by adulthood, their rates of vision loss are significantly higher than those of non-Indigenous Australians. Research shared in *Minum Barreng: The Story of the Indigenous Eye Health Unit* highlights that although First Nations children may start with excellent vision, by age 40, they are almost six times more likely to suffer blindness from preventable conditions compared to non-Indigenous counterparts – a disparity rooted in limited access to care, service gaps, and the impacts of colonisation (Ryan & Senior 2022).

Eye diseases and vision problems are the most common long-term health conditions reported by Aboriginal and Torres Strait Islander (First Nations) people. Based on the latest available Australian Eye and Ear Health Survey (AEEHS) 2025 data (Kha et al. 2025), it was 11% of First Nations people over the age of 50 suffered from vision loss. After adjusting for age and sex, First Nations people over the age of 50 had almost 3 times the rate of bilateral vision impairment of non-Indigenous Australians.

Most of the blindness and vision impairment experienced by First Nations people is caused by conditions that are preventable or amenable to treatment – that is, vision

loss due to refractive error, cataract and diabetic retinopathy. For example, use of glasses (spectacles) and cataract surgery are 2 relatively low-cost effective interventions for treating the main causes of vision loss (Foreman et al. 2016).

Monitoring the size and causes of vision impairment in the population over time can help governments and service providers to develop more effective eye health policies and programs.

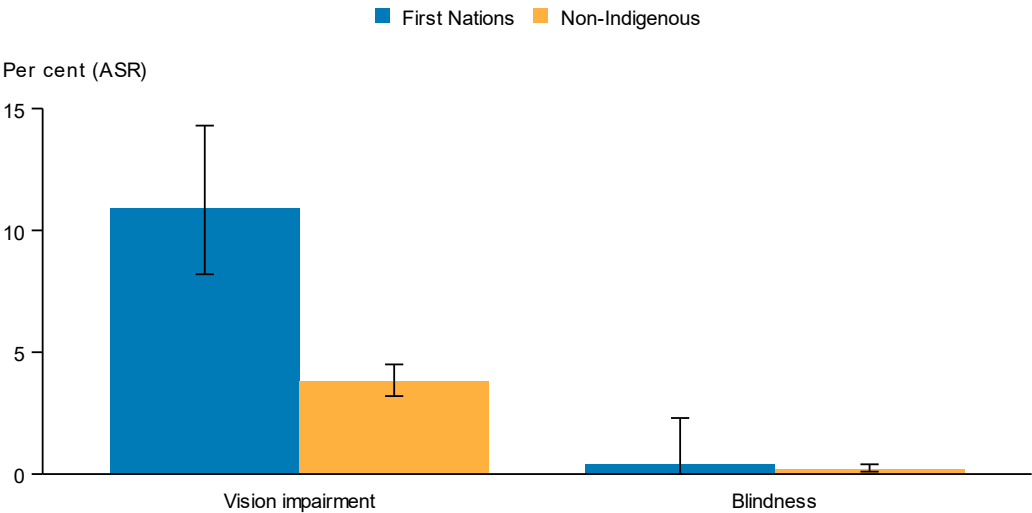
The 2025 AEEHS is the main source of data on the prevalence of eye health problems among First Nations people. The survey used eye examinations to assess vision loss and blindness. The key results from this survey are presented in this section.

Vision impairment and blindness

Based on the available AEEHS data, in 2022–25, an estimated 1 in 10 (11%) First Nations participants aged 50 and over were visually impaired in both eyes and 1 in 500 (0.2%) were blind in both eyes.

First Nations participants of this age were 2.9 times as likely as non-Indigenous participants aged 50 and over to suffer vision impairment (10.9%, confidence interval (CI) 8.2–14.3 and 3.8%, CI 3.2–4.5, respectively).

Vision loss (vision impairment and blindness), by Indigenous status, 2022 to 2025



Notes:

- 1. Error bars show 95% CIs
- 2. The rates presented are based on sample data. The 2021 Australian Census population is used as the standard population for age-standardised (or adjusted) data.
- 3. Data for these figures are available in the online data tables.

Source: Australian Eye and Ear Health Survey 2025.

The 3 main causes of vision loss (vision impairment and blindness combined) for First Nations people aged 50 and over in 2022–25 were:

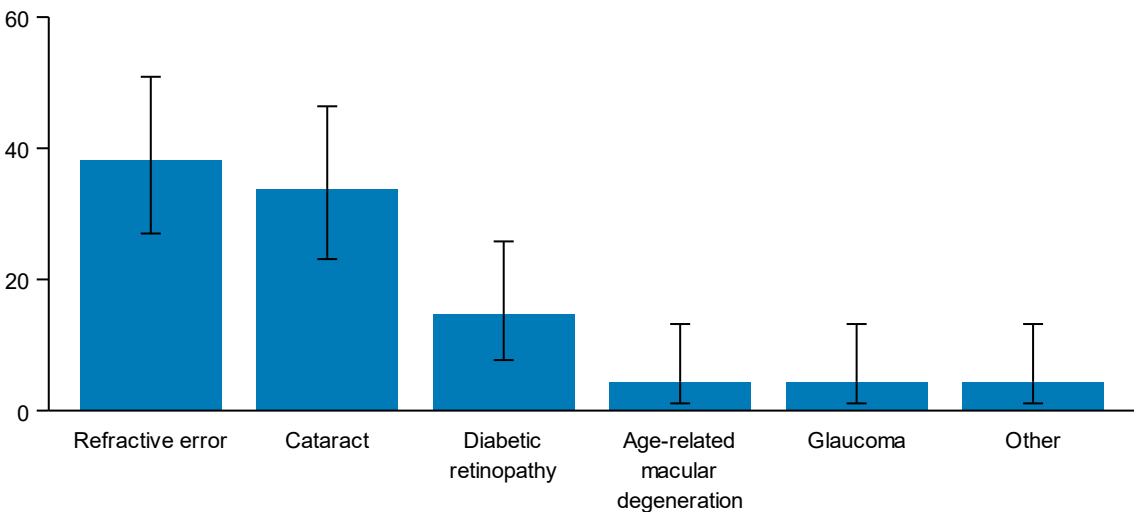
- refractive error (38%)
- cataract (34%)
- diabetic retinopathy (15%).

For non-Indigenous Australians, the main causes were:

- refractive error (42%)
- cataract (29%)
- age-related macular degeneration (17%).

Main causes of vision loss, First Nations participants, 2022 to 2025

Per cent (crude)



Notes:

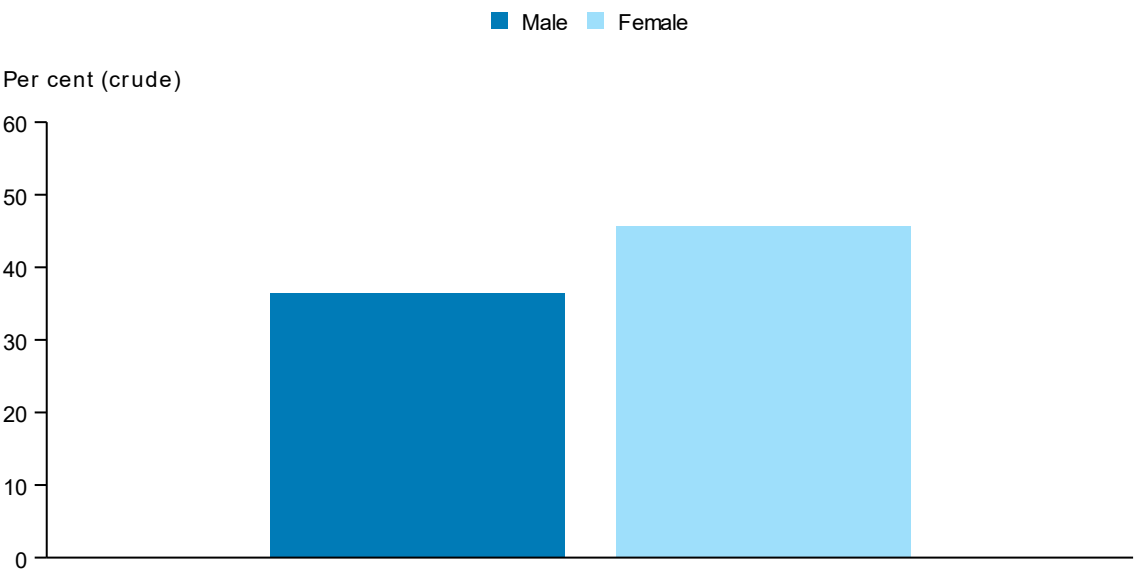
1. Error bars show 95% confidence intervals.
2. The rates presented are based on sample data
3. Data for these figures are available in the online data tables

Source: Australian Eye and Ear Health Survey data 2025.

Self-reported eye or sight problems

According to the 2022–23 National Aboriginal and Torres Strait Islander Health Survey, 4 in 10 First Nations people (41%, or 408,800 people) reported long-term eye or sight problems. The prevalence of self-reported eye or sight problems was higher for First Nations females than First Nations males.

Proportion of First Nations people with self-reported eye/sight problems, by sex, 2022–23



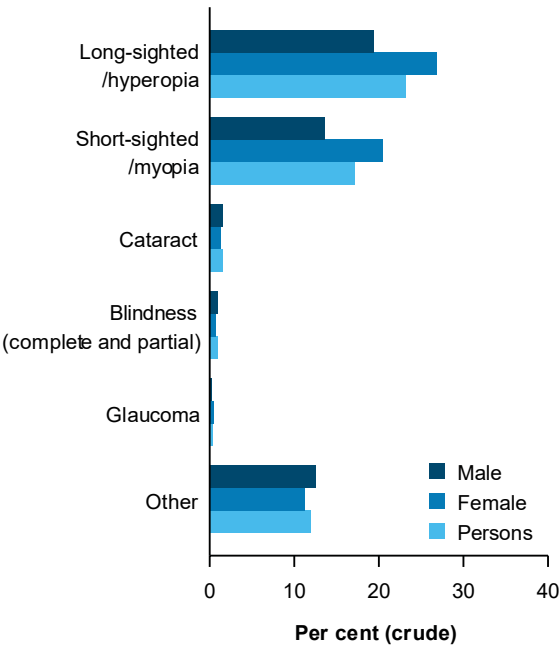
Source: ABS 2022–23 National Aboriginal and Torres Strait Islander Health Survey.

The main causes of sight problems reported by First Nations people were long sightedness (19%), short-sightedness (14%) and cataract (1.6%).

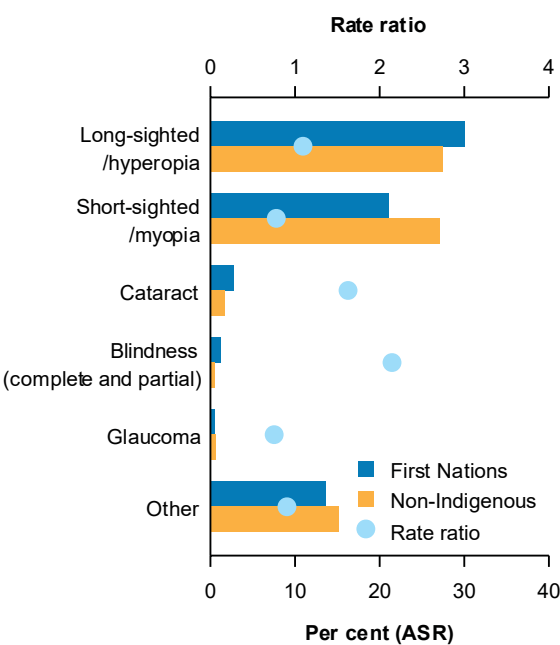
Adjusting for age, First Nations people were more likely than non-Indigenous Australians to report blindness (2.1 times as likely) or having a cataract (1.6 times as likely) as a cause of sight problems.

Prevalence of eye/sight problems, by main cause, 2022–23

First Nations people, by sex



By Indigenous status



ASR = age-standardised rate.

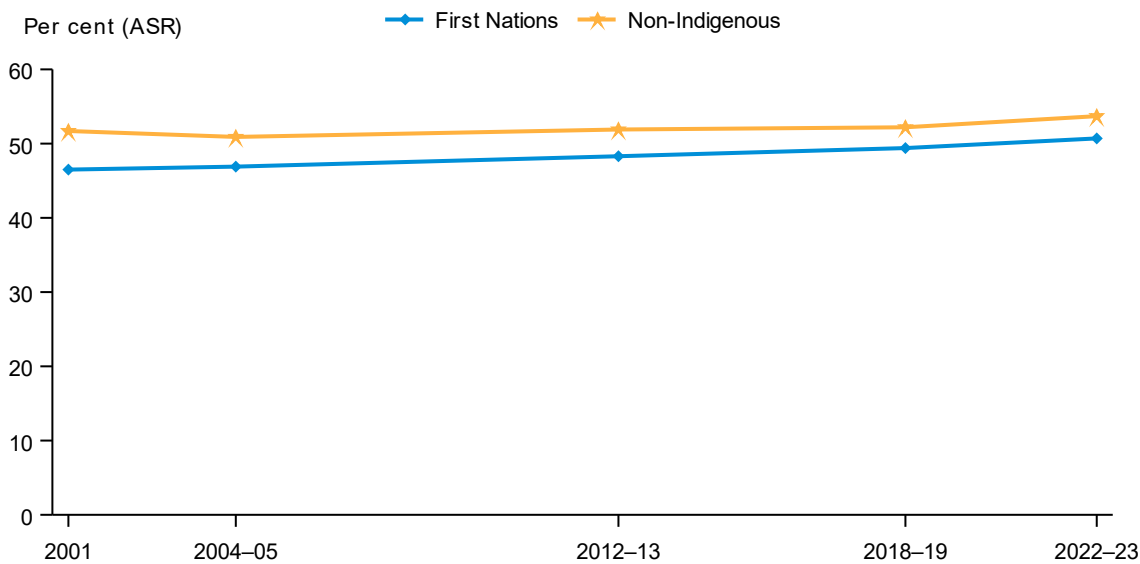
Note: The estimate for glaucoma and blindness for First Nations males, females and persons have a relative standard error between 25% and 50% and should be used with caution. Multiple responses are allowed for these questions, so proportions may add to more than 100%.

Sources: AIHW analysis of ABS 2022–23 National Aboriginal and Torres Strait Islander Health Survey and 2022 National Health Survey

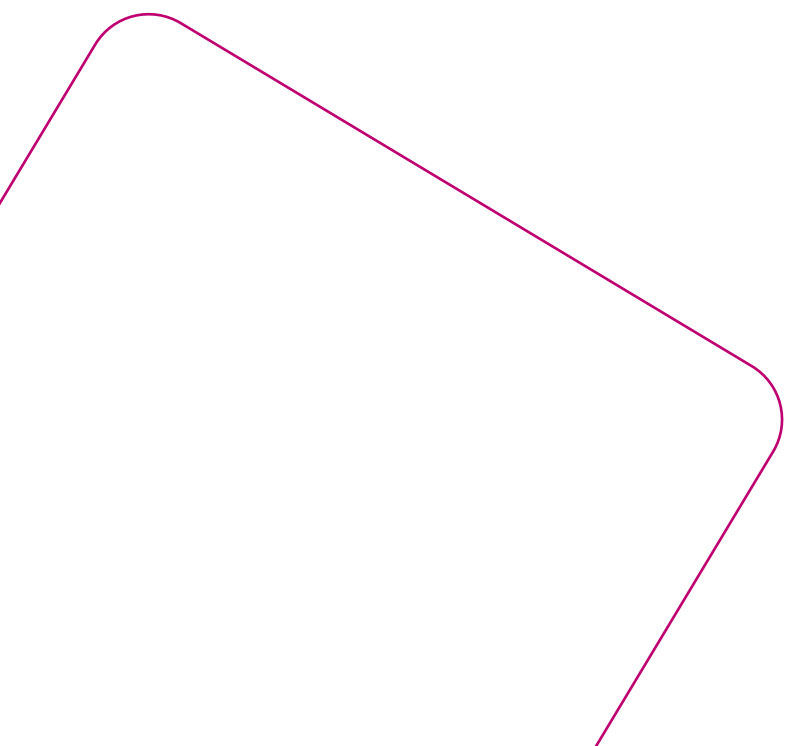
Between 2001 and 2022–23, the age-standardised proportion of those with an eye or sight problem:

- Increased 4 percentage points (from 47% to 51%) for First Nations people
- increased 2 percentage points (from 52% to 54%) for non-Indigenous Australians.

Australians with self-reported eye/sight problems, by Indigenous status, 2001 to 2022–23



ASR = age-standardised rate.
Source: AIHW analysis of National Health Surveys and National Aboriginal and Torres Strait Islander Health Surveys.





2

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Eye health diagnosis and screening

This section provides Medicare Benefits Schedule (MBS) data on health checks undertaken by general practitioners, eye examinations provided by eye care specialists (optometrists and ophthalmologists), and on screening for diabetic retinopathy.

MBS items related to health assessments for First Nations people

Health assessments relate to MBS items 715 and 228 for health checks undertaken in the community, including health assessments provided via videoconference or teleconference (MBS items 92004, 92011, 92016, 92023).

Note that the MBS items 92016 and 92023 were removed from the MBS as of 1 July 2021.

Voluntary Indigenous Identifier

The AIHW, in consultation with the Department of Health and Aged Care (now the Department of Health, Disability and Ageing, hereafter referred to as 'the Department'), has developed a scale-up methodology for estimating use of Medicare services by First Nations people (ABS 2011, 2012). The methodology compensates for the incompleteness of Voluntary Indigenous Identifier (VII) coverage by adjusting VII data based on the level of coverage compared with the total estimated First Nations population (Department of Health and Ageing 2012).

Before the current edition of this report, the Department calculated the scale-up factors. The AIHW calculated them for this report; however, the estimates obtained are consistent with those produced by the Department. The VII scale-up factors were applied to estimate MBS service use for the following measure and sub measures:

- Eye examinations undertaken by an eye care professional
- Eye examinations among those treated for diabetes
- Treated for diabetic retinopathy among those screened for diabetic retinopathy
- Treated for diabetic retinopathy among those tested for diabetes.

Health assessments for First Nations people

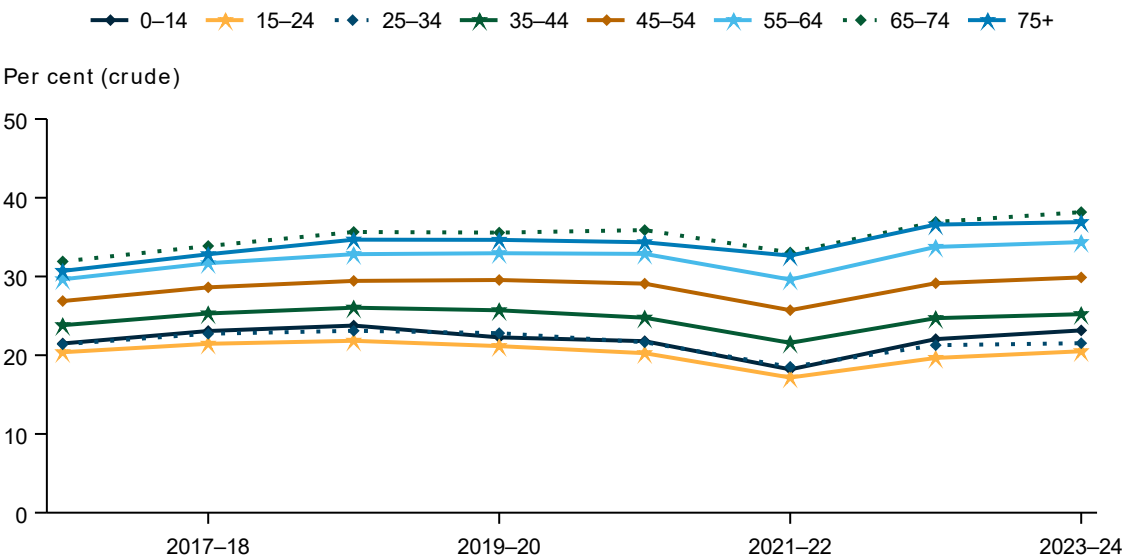
While eye health checks are meant to be a mandatory component of health assessments for First Nations people undertaken by general practitioners, these checks are not always conducted. Hence, specific data on the provision of eye health checks as part of health assessments are not available.

One-quarter (25% or 259,941) of First Nations people had a health assessment in 2023–24. This included about 2,700 (1%) health assessments provided via videoconference or teleconference.

Between 2016–17 and 2023–24, the age-standardised proportion of First Nations people who received a health assessment (including via telehealth) increased from 24% in 2016–17 to 27% in 2018–19. It then declined slightly over the following three years, before rising again to 26% in 2022–23 and returning to 27% in 2023–24.

The proportion of First Nations people who had a health assessment was highest in age groups 65 years and over and lowest in the age group 15 to 24 years.

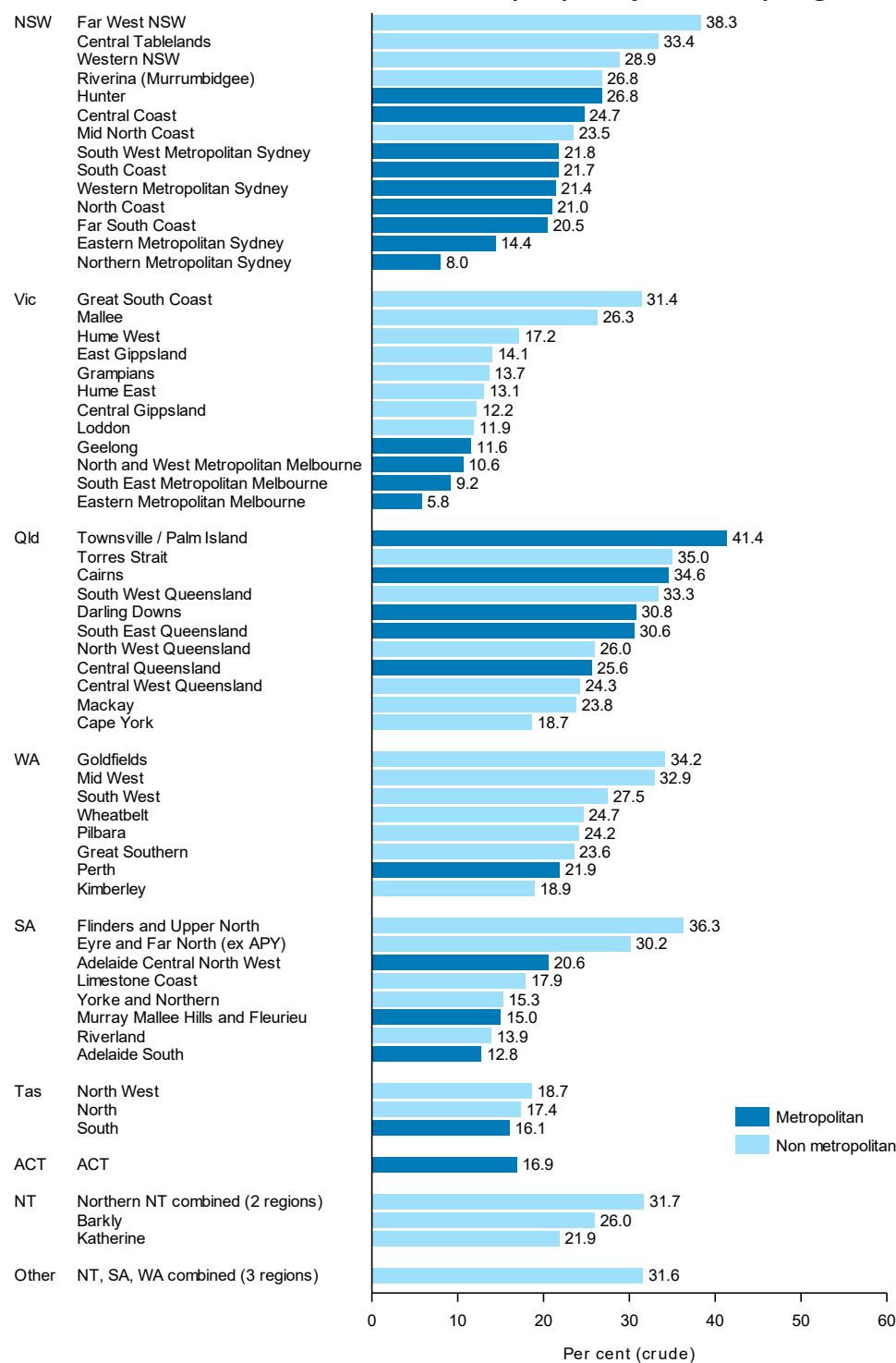
MBS health assessments, First Nations people, by age group



Source: AIHW analysis of Medicare Benefits Schedule data.

The proportion of the First Nations population who had a health assessment varied across Australia: in 2023–24, the Roadmap region with the highest proportion was Townsville/Palm Island in Queensland (41%) and Far West NSW (38%) was the highest amongst non-metropolitan areas.

MBS health assessments, First Nations people, by Roadmap region, 2023–24



APY = Anangu Pitjantjatjara Yankunytjatjara, NT, SA, WA combined includes Central Australia (NT), Ngaanyatjarra Lands (WA) and APY Lands (SA), Northern NT combined includes Greater Darwin and East Arnhem

Source: AIHW analysis of Medicare Benefits Schedule data.

Health assessments for First Nations people and initial eye examination by an optometrist

To provide an indication of eye health follow-up services, this sub-measure presents the number of First Nations people who have a health assessment and an initial eye examination in a 12-month period. The sub-measure includes cases where the initial eye examination arises out of the health assessment as well as cases where it is independent of the assessment.

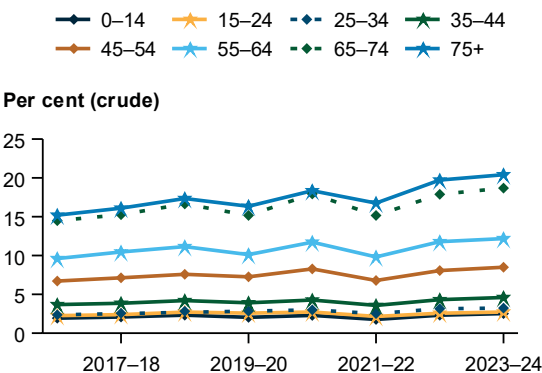
Just over 1 in 20 (5.2% or 54,028) First Nations people had a health assessment and an initial eye examination by an optometrist in 2023–24.

Between 2016–17 and 2023–24, the age-standardised proportion of First Nations people who had a health assessment (including a telehealth assessment) and an initial eye examination by an optometrist increased from 5.3% in 2016–17 to 6.8% in 2023–24.

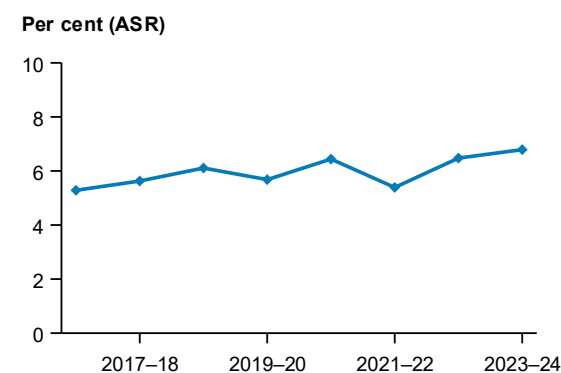
The proportion of First Nations people who had a health assessment and an initial eye examination by an optometrist was highest in the age group 75 years and over. In 2023–24, the Roadmap regions with the highest proportions of First Nations people who had a health assessment and an initial examination by an optometrist were Far West NSW (9.2%) and Great South Coast in Victoria (7.4%).

MBS health assessments and initial eye examinations, First Nations people

By age group (years)



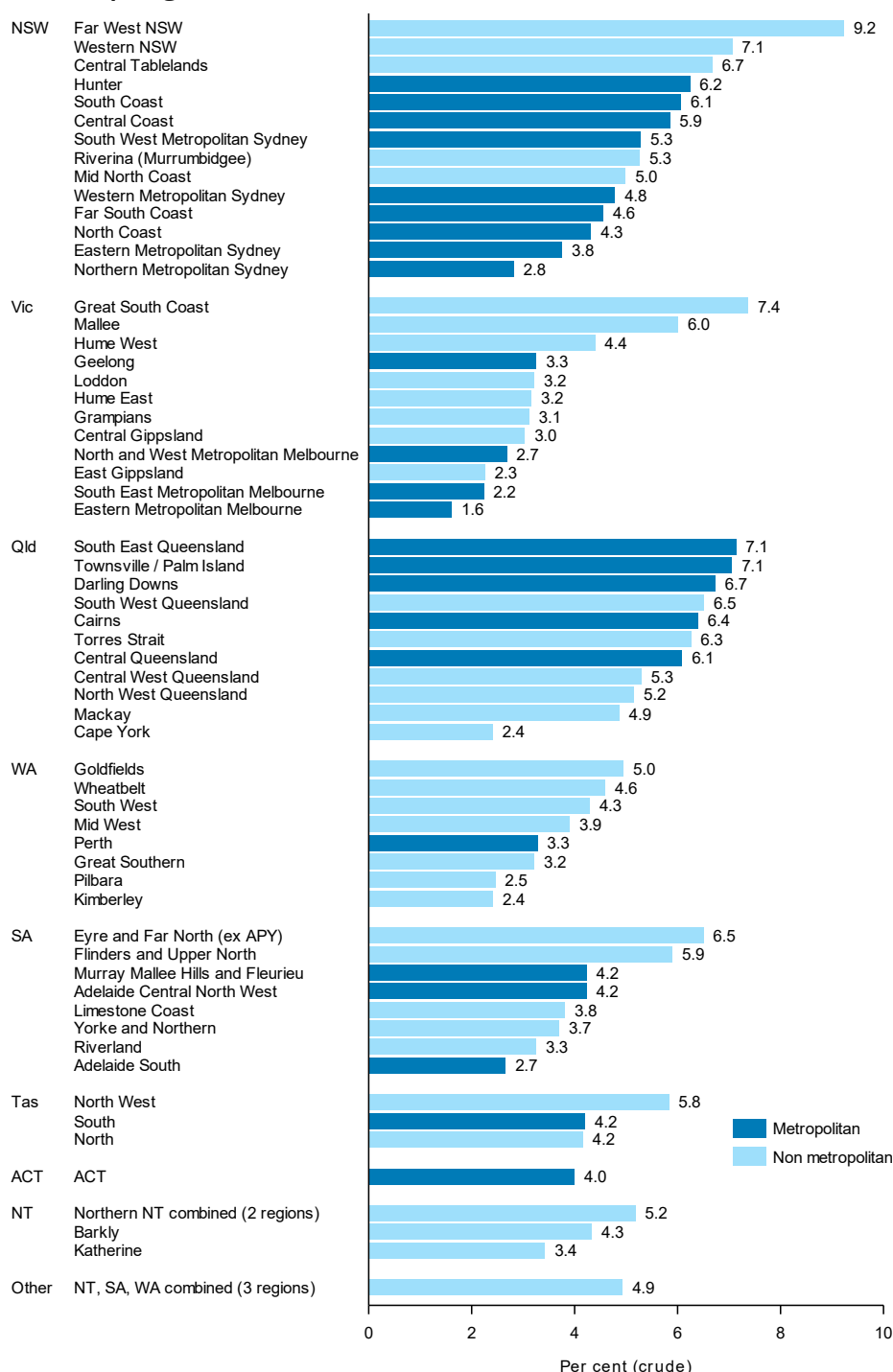
Total (ASR)



ASR = age standardised rate.

Source: AIHW analysis of Medical Benefits Schedule data.

MBS health assessments with initial eye examination, First Nations people, by Roadmap region, 2023–24



APY = Anangu Pitjantjatjara Yankunytjatjara, NT, SA, WA combined includes Central Australia (NT), Ngaanyatjarra Lands (WA) and APY Lands (SA), Northern NT combined includes Greater Darwin and East Arnhem.

Source: AIHW analysis of Medicare Benefits Schedule data.

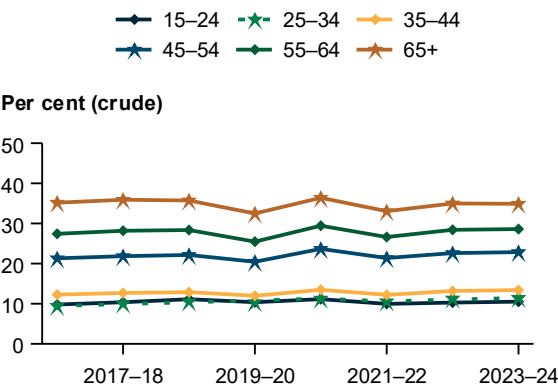
Eye examinations

In 2023–24, 147,436 (14%) First Nations people had had an initial eye examination by an optometrist or ophthalmologist in the previous 12 months. Overall, older age groups consistently had higher percentages compared to younger group. The 65+ group showed the highest rates, while younger groups like 15–24 and 25–34 had the lowest. Most age groups experienced slight increases over the period, with no notable shifts.

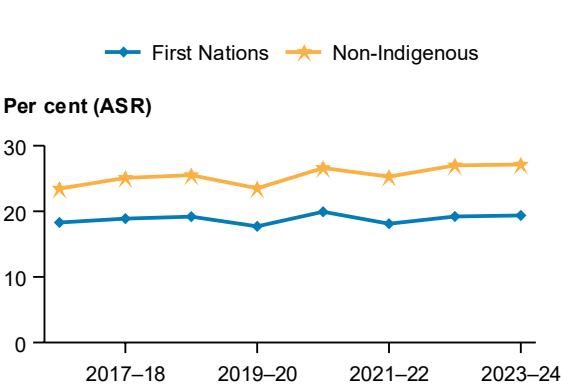
In the period from 2016–17 to 2023–24, the age-standardised proportion of the First Nations population who had an eye examination was stable, at around 18% to 19%. Over the same period, the age-standardised proportion for non-Indigenous Australians increased from 24% to 27%.

Eye examinations

First Nations people, by age group (years)



by Indigenous status



ASR = age standardised rate.

Source: AIHW analysis of Medical Benefits Schedule data.

Eye examinations among target population

Current guidelines recommend an annual eye examination for First Nations people with diabetes to screen for diabetic retinopathy – an eye condition that can cause vision impairment and blindness in people with diabetes.

The rate of eye examinations among those tested for diabetes was analysed as a proxy for access to retinopathy screening. While the number of First Nations people tested provides insight into screening coverage, it does not reflect the true prevalence of diabetes. Some individuals tested may not have diabetes, while others with diabetes

may not have been tested. Accordingly, this indicator should be interpreted as a proxy, with the actual prevalence of diabetes likely higher.

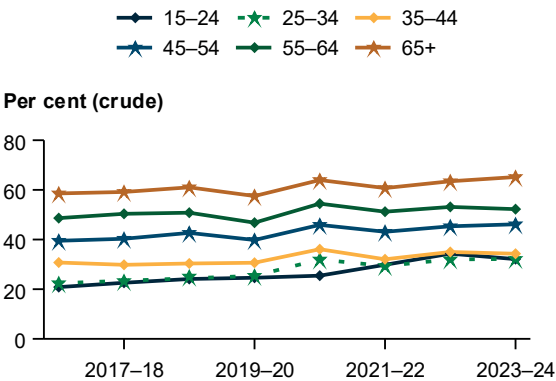
In 2023–24, among those who had a diabetes test in the test previous 2 years, 50% or 15,973 First Nations people also had an eye examination.

In 2023–24, the proportion of First Nations people who had a diabetes test who also had an eye examination increased with age – from over 32% of those aged 15–34 to over 65% of those aged 65 and over.

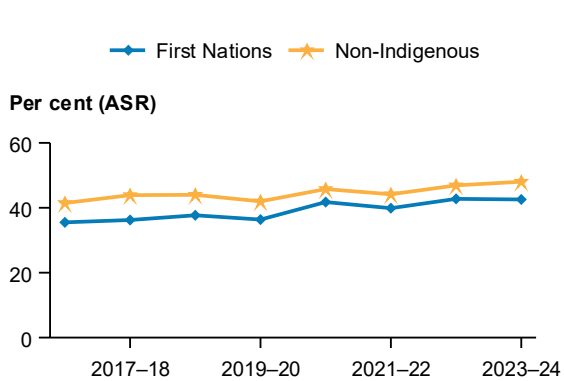
Between 2016–17 and 2023–24, the total age-standardised proportion of First Nations people tested for diabetes who had an eye examination increased from 36% to 43%; for non-Indigenous Australians, it rose from 42% to 48%.

Population who had an eye examination among those tested for diabetes

First Nations people, by age group (years)



by Indigenous status



ASR = age standardised rate.

Source: AIHW analysis of Medical Benefits Schedule data.



Did you know?

In 2016, an estimated 387 million people worldwide were diagnosed with diabetes; this figure is predicted to rise to 592 million by 2035. Ninety-three million people are globally affected by diabetic retinopathy. The prevalence of diabetic retinopathy is 77.3% in type 1 diabetes patients and 25.1% in type 2 diabetes patients (Shukla and Tripathy 2022).



3

Eye health treatment

Different eye problems require different treatments. For example, surgery is required to remove cataracts, while refractive error is treated by using visual aids, such as glasses and contact lenses.

This section includes data on hospitalisations for eye diseases and injuries, and for cataract surgery and the treatment of diabetic retinopathy. Information on subsidised glasses comes from state or territory government data.



Did you know?

A new World Health Organization (WHO) guide titled '[Eye care in health systems: guide for action](#)' was launched on 24 May 2022. It aims to help countries tackle the global eye care crisis.

The guide provides:

- an evidence-based framework to help countries assess their eye health services
- tools to support countries in achieving the WHO's global eye health targets (including recommended national eye care indicators and planning tools for budgeting and human resources).

Hospitalisations for diseases and injuries of the eye

In the 2-year period 2022–24, there were 15,461 (7.6 per 1,000 population) hospitalisations of First Nations people for eye diseases and 2,107 (1.0 per 1,000 population) for eye injuries.

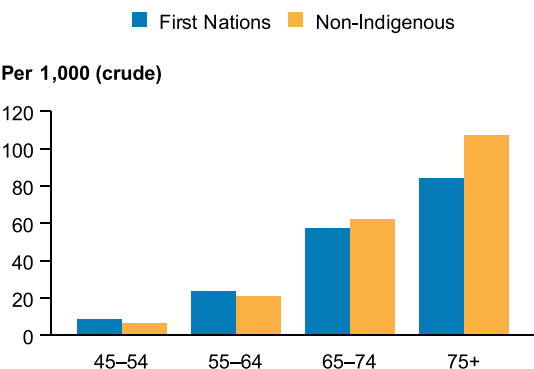
Hospitalisation rates for eye diseases increased with age, peaking at age 75 and over, while rates for eye injuries peaked in the middle years (ages 35–44).

Between 2016–17 and 2023–24, the age-standardised hospitalisation rate for diseases of the eye for First Nations people rose from 9.3 to 13.1 per 1,000 population. For non-Indigenous Australians, the rate also rose slightly from 13.9 to 14.1, indicating a narrowing of the gap.

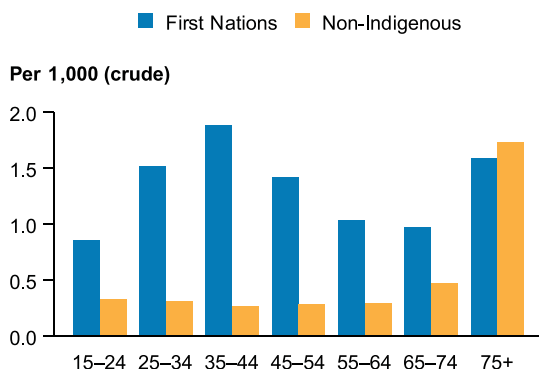
The age-standardised hospitalisation rate for injuries of the eye for First Nations people and for non-Indigenous Australians was fairly constant over the same period.

Hospitalisations for diseases of the eye and injuries to the eye

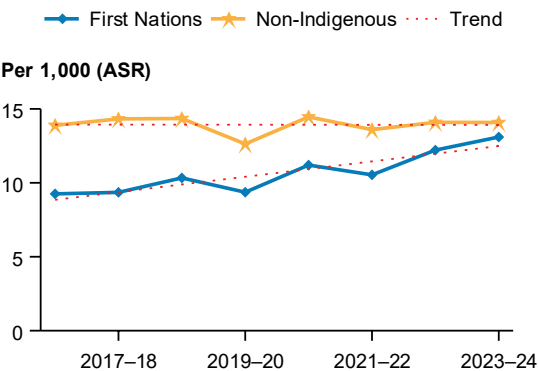
Eye diseases, by age group, 2022–24



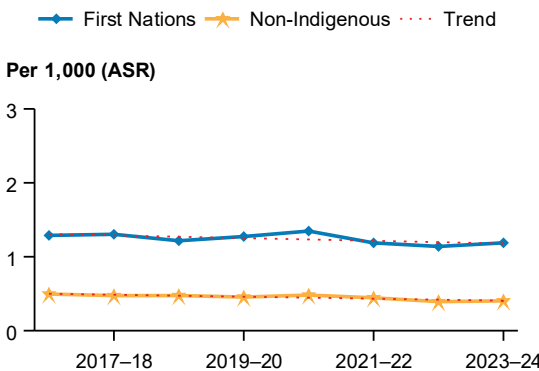
Eye injuries, by age group, 2022–24



Eye diseases, time trend, 2016–17 to 2023–24



Eye injuries, time trend, 2016–17 to 2023–24



ASR = age standardised rate.

Source: AIHW analysis of National Hospital Morbidity Database.

Hospitalisations for eye procedures

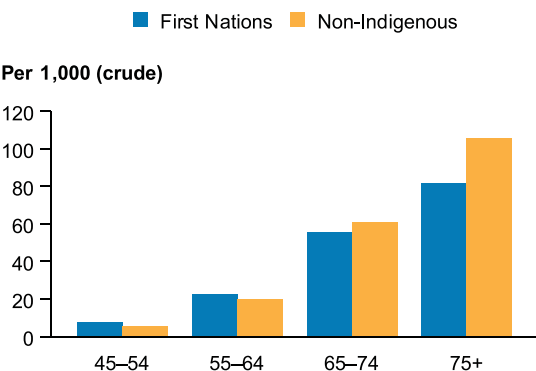
In the 2-year period 2022–24, there were 14,920 hospitalisations of First Nations people for eye procedures – a crude rate of 7.3 per 1,000 population.

The rate of hospitalisations for eye procedures for First Nations people and non-Indigenous Australians increased with age, peaking at age 75 and over.

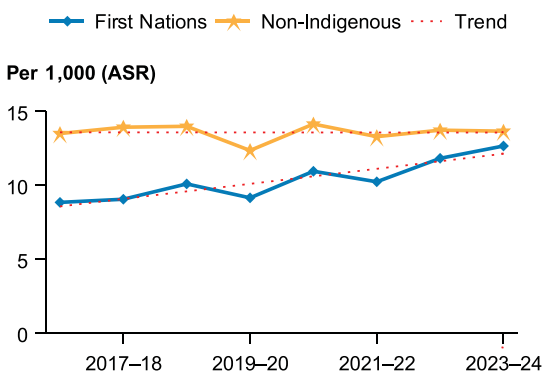
Between 2016–17 and 2023–24, the age-standardised hospitalisation rate for eye procedures for First Nations people rose from 8.8 to 12.7 per 1,000 population while the rate for non-Indigenous Australians remained fairly constant at around 14. The trend line shows a slight rise in the age standardised hospitalisation rate for First Nations people over this period, indicating a narrowing of the gap.

Hospitalisations for eye procedures, by Indigenous status

By age group, 2022–24



Time trend, 2016–17 to 2023–24



ASR = age standardised rate.

Source: AIHW analysis of National Hospital Morbidity Database.



Did you know?

According to a study of hospitalisation records in Sweden, low socioeconomic status is associated with increases in a number of age-related eye diseases – suggesting the importance of community-level factors in preventing hospitalisations for eye disease (Hamano et al. 2015).

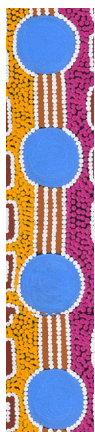
Cataract surgery

Based on AEEHS 2025, cataract surgical coverage was 94% overall, 87% for First Nations participants and 95% for non-Indigenous participants. Effective coverage was 85% overall, with lower rates for First Nations participants (71%) compared with non-Indigenous participants (87%).

In 2022–24, there were 9,671 hospitalisations of First Nations people for cataract surgery. The number of hospitalisations over the 2 year period was below the estimated number of First Nations people needing cataract surgery (over 19,000).

Hospitalisation rates for cataract surgery for First Nations people were higher in regional Roadmap regions than in metropolitan areas.

The estimated need for cataract surgery provides a target for the provision of eye care services for First Nations people and facilitates the planning of services but is not a limit on the need for services. In 2022–24, three Roadmap regions, Mid West, Kimberley and Goldfields in Western Australia, exceeded the estimated need for cataract surgery. These regions had hospitalisation rates greater than 10,100 per 1,000,000 population.

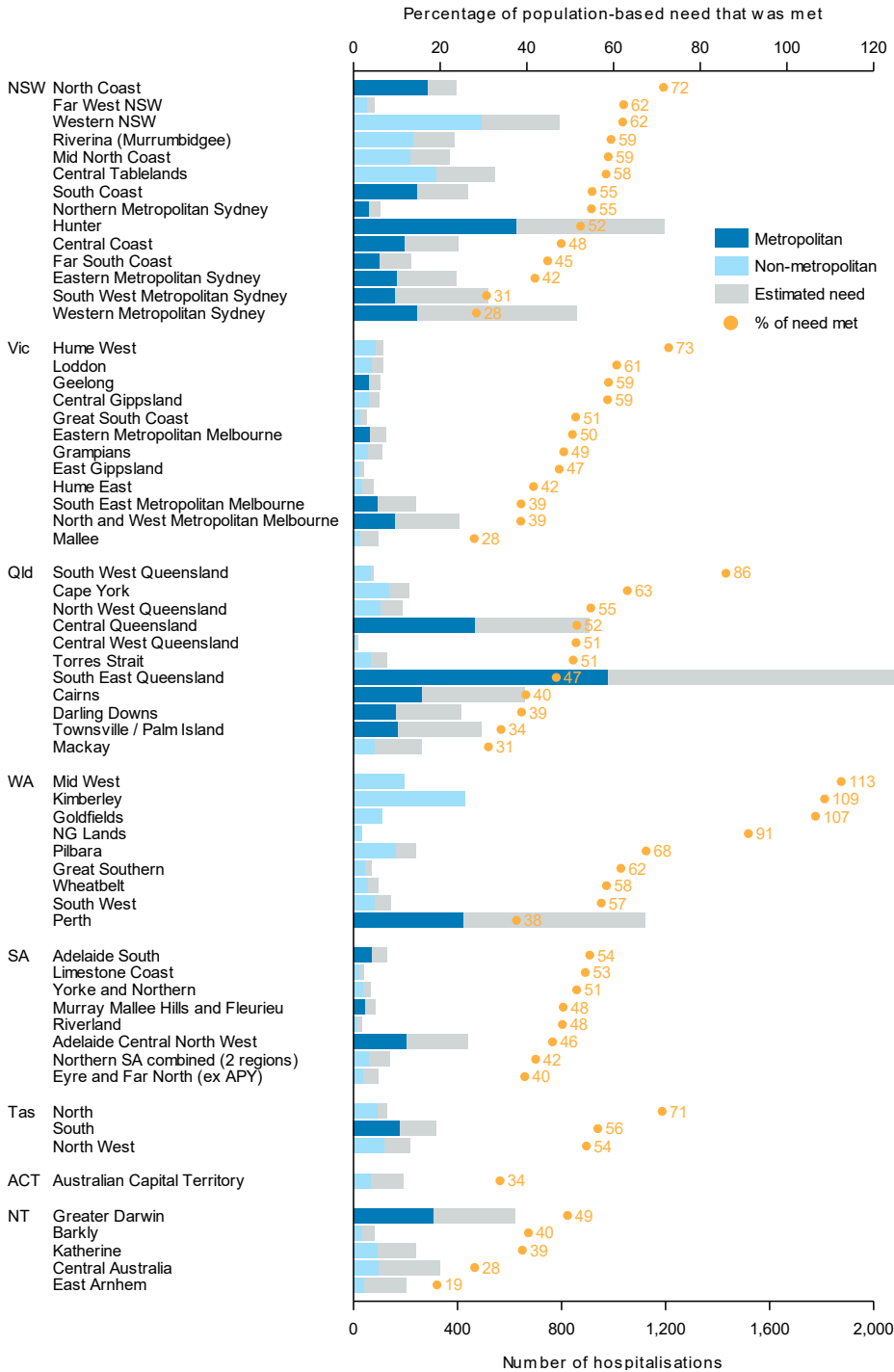


Did you know?

It is estimated that the Australian public hospital system provides around 29% of cataract surgeries for non-Indigenous Australians (ACSQHC 2017) and 80% of cataract surgeries for First Nations people (Randall et al. 2014). Hence, delays or interruptions to the public health service provision disproportionately affect First Nations people with cataracts.

A likely contributing factor is the lower proportion of Indigenous adults with private health insurance (estimated at 20% compared with 57% of all Australian adults living in non-remote areas in 2012–13) (AIHW 2015).

Hospitalisations and estimated need for cataract surgery, First Nations people, by Roadmap region, 2022–24



APY = Anangu Pitjantjatjara Yankunytjatjara, Northern SA combined (2 regions) = Anangu Pitjantjatjara Yankunytjatjara (APY) Lands and Flinders and Upper North, NG Lands = Ngaanyatjarra Lands.

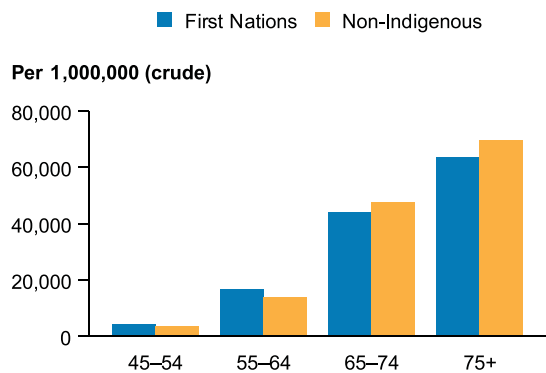
Source: AIHW analysis of National Hospital Morbidity Database and of the calculator for the delivery and coordination of eye care services (Indigenous Eye Health Unit (IEHU) – see References).

In 2022–24, the rate of hospitalisations was higher for First Nations people aged 45–54 and 55–64 than for non-Indigenous Australians of the same age. However, at older ages, rates for First Nations people were slightly lower than for non-Indigenous Australians.

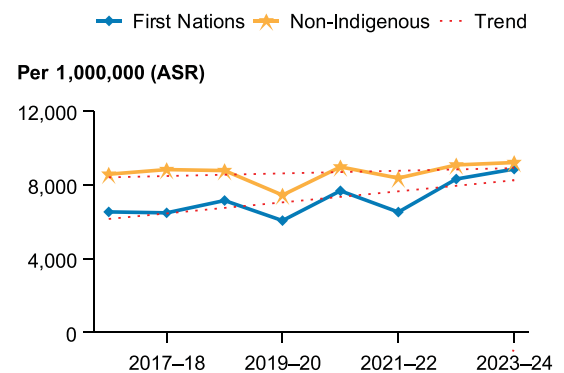
The gap in age-standardised cataract surgery rates between First Nations people and non-Indigenous Australians has narrowed over the last 10 years, mostly due to the rise in rates for First Nations people.

Cataract surgery, by Indigenous status

By age group, 2022–24



Time trend, 2016–17 to 2023–24



ASR = age standardised rate.
Source: AIHW analysis of National Hospital Morbidity Database

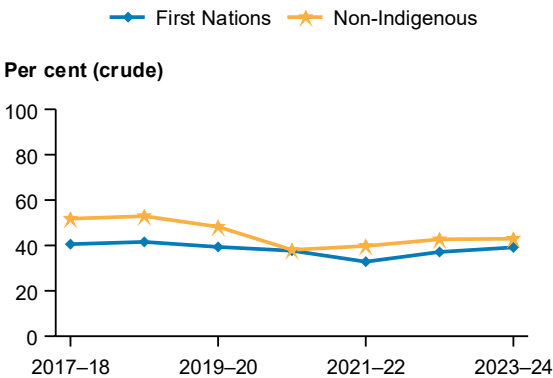
In 2023–24, First Nations people waited longer for cataract surgery (a median number of 138 days) than non-Indigenous Australians (114 days).

The proportion of First Nations people who waited more than 365 days for cataract surgery (7.8%) was slightly higher than the proportion of non-Indigenous Australians who waited this long (6.5%).

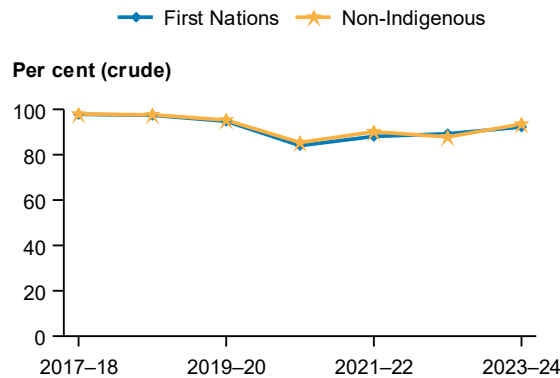
Between 2017–18 and 2023–24, the proportion of First Nations people who were treated within 90 days for elective cataract surgery fluctuated but remained relatively stable. The proportion of non-Indigenous Australians dropped over this period (from 52% to 43%). The proportion of First Nations people and non-Indigenous Australians treated within 365 days dropped over this period (from 98% to 92% and from 98% to 94%, respectively).

Waiting times for elective cataract surgery, 2017–18 to 2023–24

Time trend, treated within 90 days



Time trend, treated within 365 days



Source: AIHW analysis of National Hospital Morbidity Database

Treatment for diabetic retinopathy

Treated for diabetic retinopathy among those screened for diabetic retinopathy

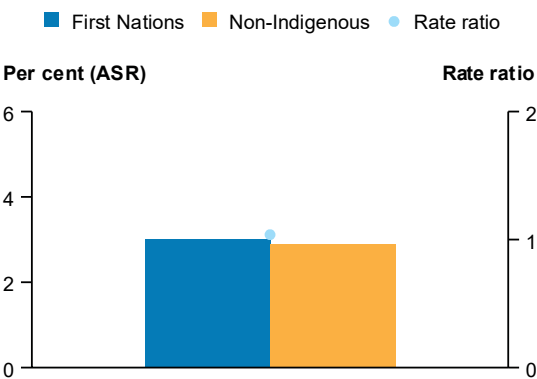
In 2023–24, 581 First Nations people who were screened for diabetic retinopathy underwent treatment (representing 3.6% of those screened for diabetic retinopathy).

The rate ratio of the age-standardised proportion of First Nations people and non-Indigenous Australians who were treated was 1.0.

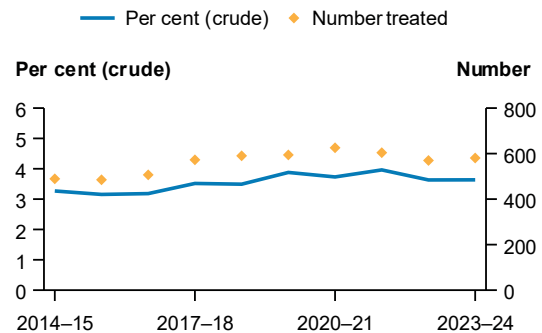
Between 2014–15 and 2023–24, the number of First Nations people who were screened for diabetic retinopathy underwent treatment increased from 489 in 2014–15 to 581 in 2023–24.

Population treated for diabetic retinopathy among those screened for diabetic retinopathy

By Indigenous status, 2023–24



First Nations people, 2014–15 to 2023–24



ASR = age standardised rate.
Source: AIHW analysis of Medical Benefits Schedule (MBS) data.



Did you know?

The timely treatment of diabetic retinopathy can prevent vision loss. Treatment generally involves injections into the eye or laser therapy. Recent development involving newer retinal diagnostics are proving beneficial in optimising both initiation and maintenance of therapy. Recent advances in novel pharmaceutical agents and ocular drug delivery methods show promise in better controlling the disease as well reducing the burden treatment (Mansour et al. 2020).

Treated for diabetic retinopathy among those tested for diabetes

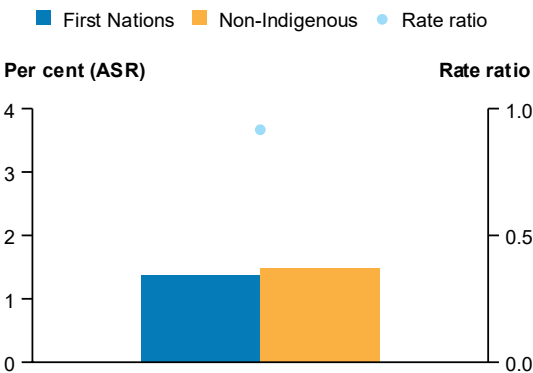
In 2023–24, 581 First Nations people who were screened for diabetes underwent treatment for diabetic retinopathy (representing 1.8% of those screened for diabetes).

The rate ratio of the age-standardised proportion of First Nations people and non-Indigenous Australians who were treated was 0.9.

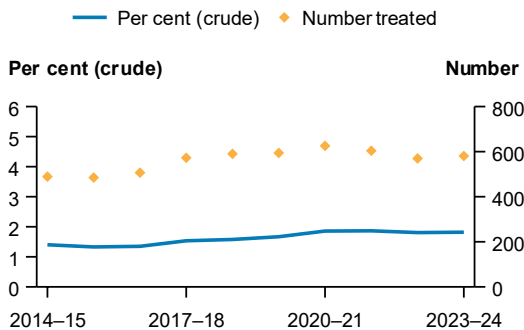
Between 2014–15 and 2023–24, the crude per cent of First Nations people who were screened for diabetes underwent treatment for diabetic retinopathy increased from 1.4% (489 from 34,917) in 2014–15 to 1.8% (581 from 31,927) in 2023–24.

Population treated for diabetic retinopathy among those screened for diabetes

By Indigenous status, 2023–24



First Nations people, 2014–15 to 2023–24



ASR = age standardised rate.

Source: AIHW analysis of Medical Benefits Schedule (MBS) data.

Subsidised spectacles

Based on AEEHS 2025, refractive error coverage was 96% overall, 90% for First Nations participants and 97% for non-Indigenous participants. Effective coverage was 94% overall, with lower rates for First Nations participants (87%) compared with non-Indigenous participants (95%).

To support access, all states and territories have schemes that provide visual aids, including glasses, to eligible people at low or no cost. Only 4 states, however, could provide data on the number of spectacles dispensed to First Nations people.

In 2023–24, the number of spectacles dispensed to First Nations people under state schemes was:

- 9,214 in New South Wales (26 per 1,000)
- 7,266 in Queensland (26 per 1,000)
- 3,742 in Victoria (46 per 1,000)
- 1,277 in South Australia (24 per 1,000)
- 478 in Tasmania (14 per 1,000).

The number of spectacles dispensed in Victoria was closest to meeting the estimated number of First Nations people aged over 40 who needed them – with an estimated 71% having their needs met.

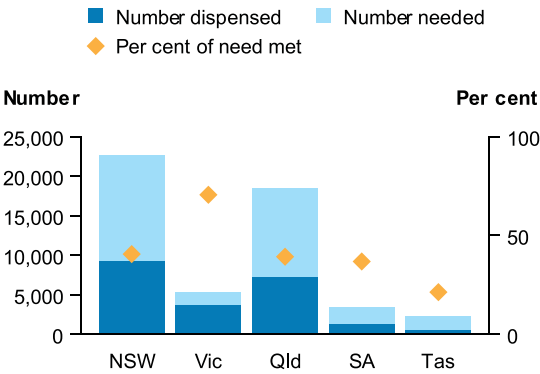


Did you know?

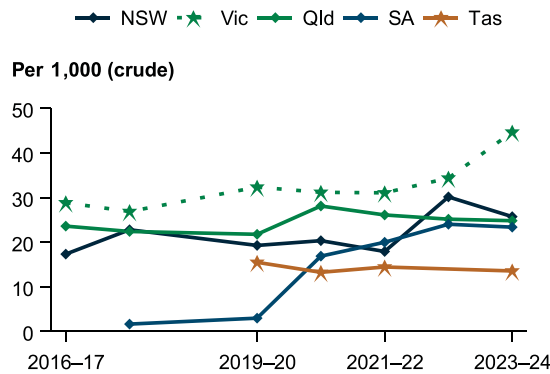
The provision of spectacles is a low-cost measure that can alleviate refractive error, the main cause of vision loss for First Nations people.

State spectacles schemes, First Nations people

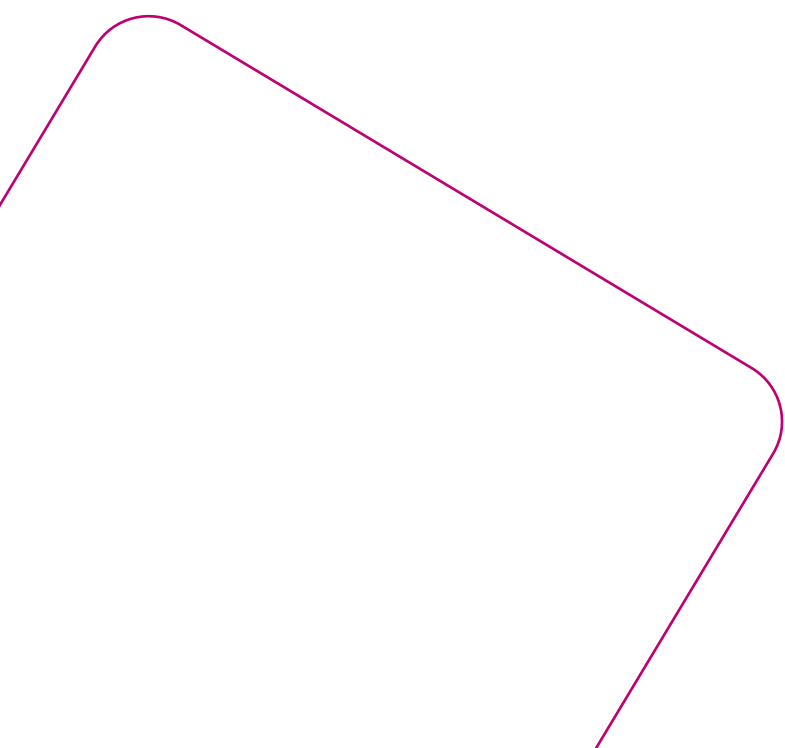
Spectacles dispensed and estimated need by jurisdiction, 2023–24



Spectacles dispensed by jurisdiction, 2016–17 to 2023–24



Sources: AIHW analysis of New South Wales Department of Family and Community Services data (unpublished), Australian College of Optometry Victorian data (unpublished), Queensland Health data (unpublished), South Australia Department of Human Services data (unpublished); Tasmanian Health Service data (unpublished); and the calculator for the delivery and coordination of eye care services (Indigenous Eye Health Unit (IEHU) – see References).





4

Trachoma and trichiasis

Trachoma is an infectious disease of the eye caused by the bacteria *Chlamydia trachomatis*. Active trachoma is characterised by the presence of multiple follicles or lumps (trachomatous inflammation – follicular) on the upper tarsal conjunctiva (upper inner eyelid) or pronounced thickening obscuring more than half the normal deep tarsal vessels (trachomatous inflammation – intense). Repeated infections can result in scarring, in-turned eyelashes (trachomatous trichiasis, referred to as trichiasis in this report) and blindness. Trachoma is linked to poor living conditions, including inadequate housing, water and sanitation facilities to support hygiene practices. Australia has adopted the World Health Organization’s recommended package of interventions for trachoma control known as the SAFE strategy: Surgery to correct trichiasis, Antibiotics to treat chlamydial infection, Facial cleanliness to reduce transmission and prevent reinfection and Environmental improvements to increase access to water, sanitation and hygiene facilities (Kuper et al., 2003; Solomon et al., 2020).

Trachoma is a preventable disease that is rarely found in high-income countries; however, it remains a significant public health issue in some remote First Nations communities in Western Australia and the Northern Territory. Following the receipt of 2024

surveillance data, the National Trachoma Surveillance and Control Reference Group agreed in June 2025 to endorse South Australia's reclassification as free of endemic trachoma. This places SA alongside Queensland and New South Wales, which no longer require screening for active trachoma under current public health guidelines.

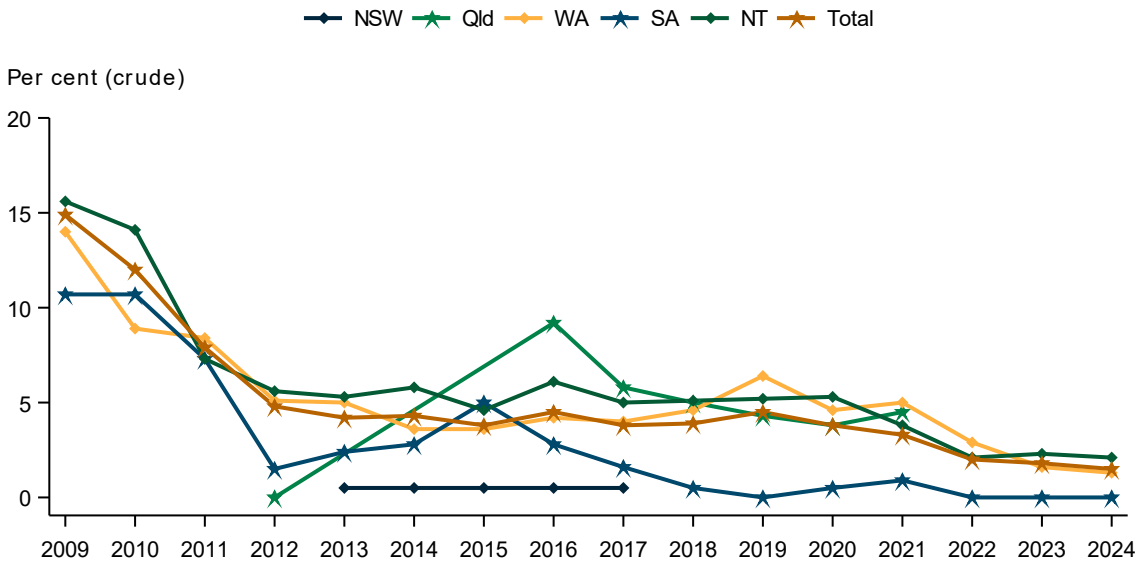
The Australian Government funds the National Trachoma Surveillance and Reporting Unit at the Kirby Institute, UNSW Sydney, to collect, analyse, and report national trachoma data. These efforts are documented in the Australian Trachoma Surveillance Reports.

Prevalence of trachoma

In 2024, trachoma screening was undertaken among children aged 5–9 years in 86 at-risk communities across Western Australia, South Australia, and the Northern Territory.

Overall, trachoma prevalence among children aged 5–9 years fell from 15% in 2009 to 1.5% in 2024.

Overall trachoma prevalence among First Nations children aged 5–9 years in all current and former at-risk communities



Note: Overall prevalence was calculated using the most recent data for all at-risk communities screened in 2024, as well as the most recent data carried forward from at-risk communities that did not screen and communities removed from the at-risk register. National overall prevalence calculations do not include data from NSW and Qld as these jurisdictions undertook mapping exercises rather than a sustained screening program.

Sources: Australian Trachoma Surveillance Report 2010 to 2024 (Kirby Institute)

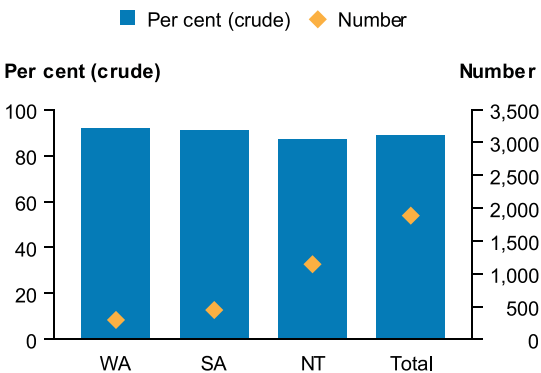
Trachoma screening and treatment

In 2024, 1,885 First Nations children aged 5–9 years were screened for trachoma in 86 communities. There was 89% screening coverage for this group. The proportions of children aged 5–9 years screened for trachoma in at-risk communities were 92% in Western Australia (295 children screened), 91% in South Australia (446 children screened) and 87% in the Northern Territory (1,144 children screened). Screening for trachoma is no longer required in Queensland and New South Wales, which were endorsed as non-endemic for trachoma in 2017 and 2022 respectively.

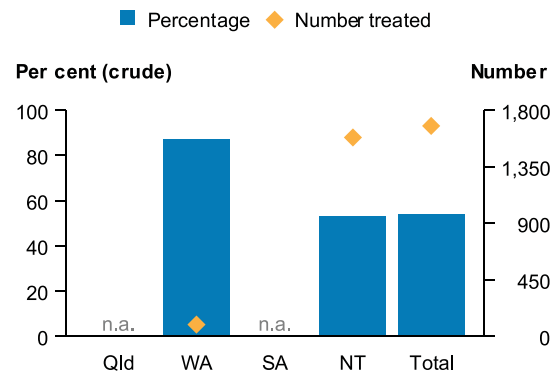
In 2024, in communities where active trachoma (trachomatous inflammation – follicular and/or intense) was identified, a total of 1,674 community members (active cases and household/community contacts) received treatment out of an estimated 3,104 who required treatment, a rate of 54%. The proportion of cases, household and community contacts who received required treatment was 87% in Western Australia (92 persons treated) and 53% in the Northern Territory (1,582 persons treated). No active trachoma cases were identified in South Australia.

Trachoma screening and treatment in at-risk communities, by jurisdiction, 2024

Trachoma screening coverage in at-risk communities screened, children aged 5–9 years



Community members (cases and household/community contacts) treated in communities where active trachoma was identified



Notes:

- 1. Screening data cover the 86 communities screened in 2024 (26 communities in WA, 15 communities in SA, and 45 communities in the NT). In 2024 NT and SA undertook additional screening as part of evidence confirmation for final-year dossier validation surveillance. For the purposes of simplicity, results from these communities that would not normally require screening in 2024 are counted as at-risk communities and included in results.
- 2. Includes data from the 25 communities that received treatment in 2024.
- 3. Estimated as a proportion of those requiring treatment according to national guidelines.

Source: Australian Trachoma Surveillance Report 2024 (Kirby Institute, UNSW Sydney, 2025).

Trachoma-related trichiasis

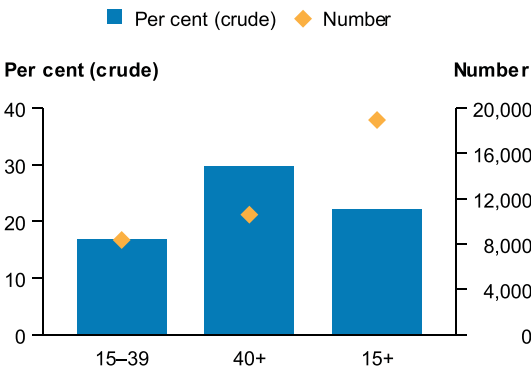
Screening for trichiasis is undertaken through a range of strategies, including during adult health assessments.

In 2024, trichiasis screening data was reported for 165 communities in current and formally trachoma endemic regions in 4 jurisdictions (Queensland, Western Australia, South Australia and the Northern Territory):

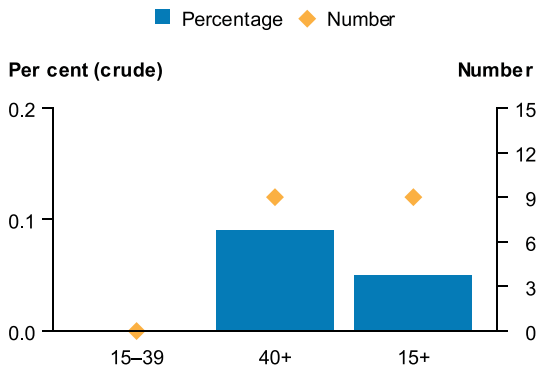
- 8,348 First Nations adults aged 15–39 years, and 10,583 First Nations adults aged 40 years and over, were screened for trichiasis.
- 9 cases of trichiasis were identified, a prevalence rate of 0.05% amongst screened persons.

Trichiasis screening coverage and prevalence in at-risk communities, by age group, 2024

Trichiasis screening



Prevalence of trichiasis



1. Prevalence of trichiasis as a proportion of persons reported as examined for trichiasis in 2024. This number may not account for all adults who may be examined in routine adult health checks and may also include multiple patient screenings. Screening is linked to trachoma endemic regions and does not consider changing endemic regions over time and transiency between regions.
2. Screening coverage estimates are derived from ABS census data and is linked to current and former trachoma endemic regions identified during implementation of the National Trachoma Management Program from 2006. Estimates do not consider changing endemic regions over time and transiency between regions.

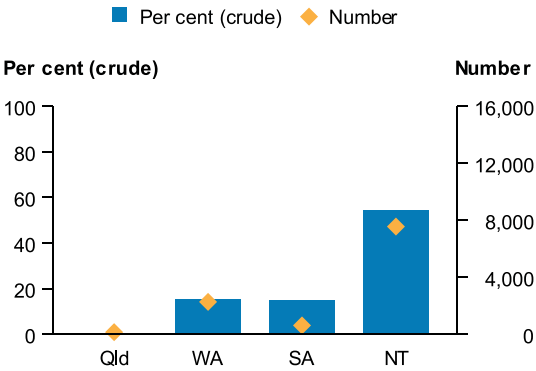
Source: Australian Trachoma Surveillance Report 2024 (Kirby Institute, UNSW Sydney, 2025)

In 2024, the estimated proportion of First Nations people aged 40 years and over who were screened for trichiasis in current and former trachoma endemic regions was 30% overall (16% in Western Australia, 15% in South Australia and 54% in the Northern Territory). The estimated population coverage for those aged 15 years and over was 22%.

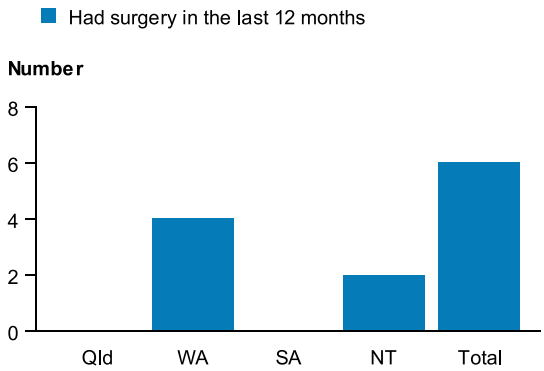
Surgery to correct trichiasis was undertaken for six persons aged 40 years and over in 2024. Four of the six surgeries took place in Western Australia.

Trichiasis screening and treatment coverage, First Nations people, aged 40 years and over, by jurisdiction, 2024

Trichiasis screening



Trichiasis treatment



Notes:

- 1. Screening coverage estimates are derived from ABS census data and is linked to current and former trachoma endemic regions identified during implementation of the National Trachoma Management Program from 2006. Estimates do not consider changing endemic regions over time and transiency between regions. Population coverage for Queensland is not supplied due to screening results only reported from one community.
- 2. The treatment referred to in this section is surgery, which is only one form of trichiasis treatment. Surgery cases may include cases identified in previous years.

Source: Australian Trachoma Surveillance Report 2024 (Kirby Institute, UNSW Sydney, 2025).



5

Eye health workforce

Optometrists and ophthalmologists play an important role in the eye health of First Nations people.

Optometrists are eye care professionals who perform comprehensive eye examinations and vision tests to determine the presence of visual, ocular, and other abnormalities; ocular diseases; and systemic diseases with ocular manifestations. They also prescribe lenses, other optical aids, therapy and medication to correct and manage vision problems and eye diseases.

Ophthalmologists are medical eye specialists who provide diagnostic, treatment and preventive medical services related to diseases, injuries and deficiencies of the human eye and associated structures.

Data on the size and location of the eye health workforce can indicate the availability of specialised services in different regions. Annual data on the number of registered optometrists and ophthalmologists are available from the National Health Workforce Dataset.

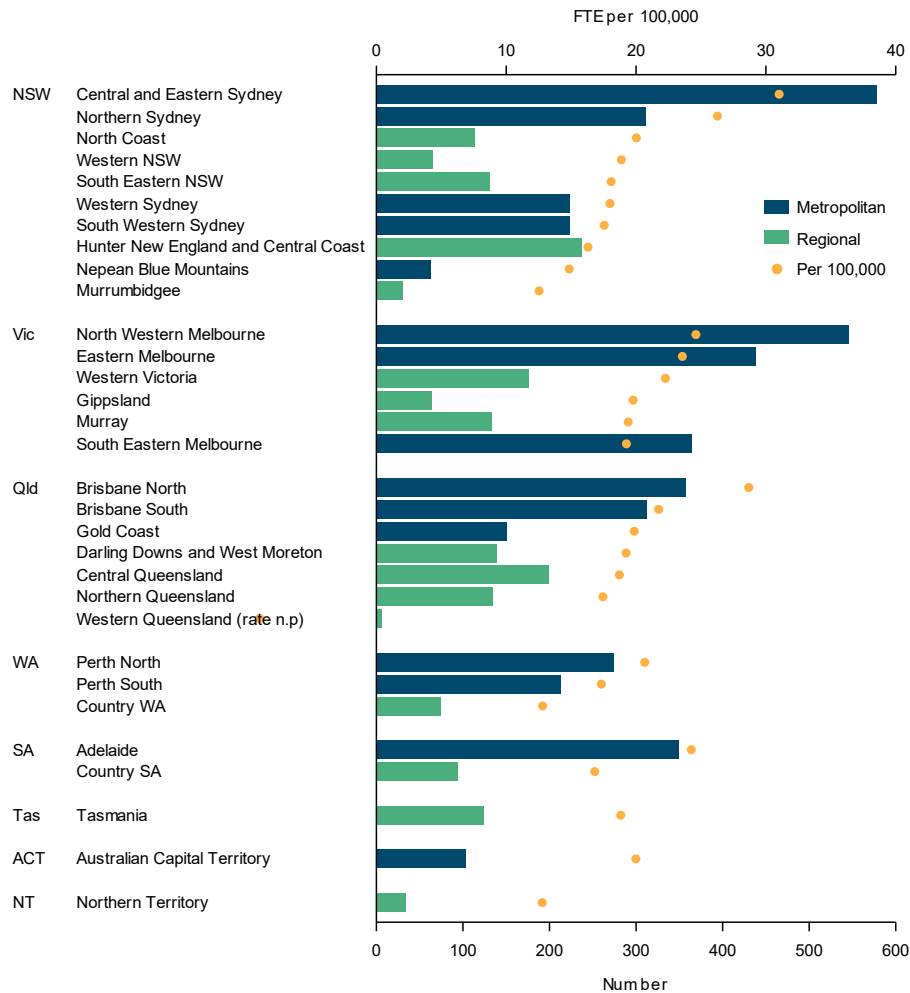
Full-time equivalent rate

The full-time equivalent rate (FTE) is a measure used to present data on the eye health workforce. This is calculated by dividing the total hours worked by employees in an occupation, by the standard hours worked.

Optometrists

In 2023, 6,275 optometrists were employed in Australia (21 FTE per 100,000), an increase of 2,056 optometrists since 2013 (4,219 optometrists were employed in 2013). The number and rate of optometrists were higher in metropolitan areas. The Central and Eastern Sydney primary health network had the highest rate of optometrists (578 and 31 FTE per 100,000).

Optometrists, by Primary Health Network, 2023



Notes:

- 1. Rates have not been published (n.p.) where fewer than 10 people employed for any occupation was fewer than 10 people.
- 2. FTE per 100,000 based on a 38-hour work week.

Source: AIHW analysis of National Health Workforce Dataset.



Did you know?

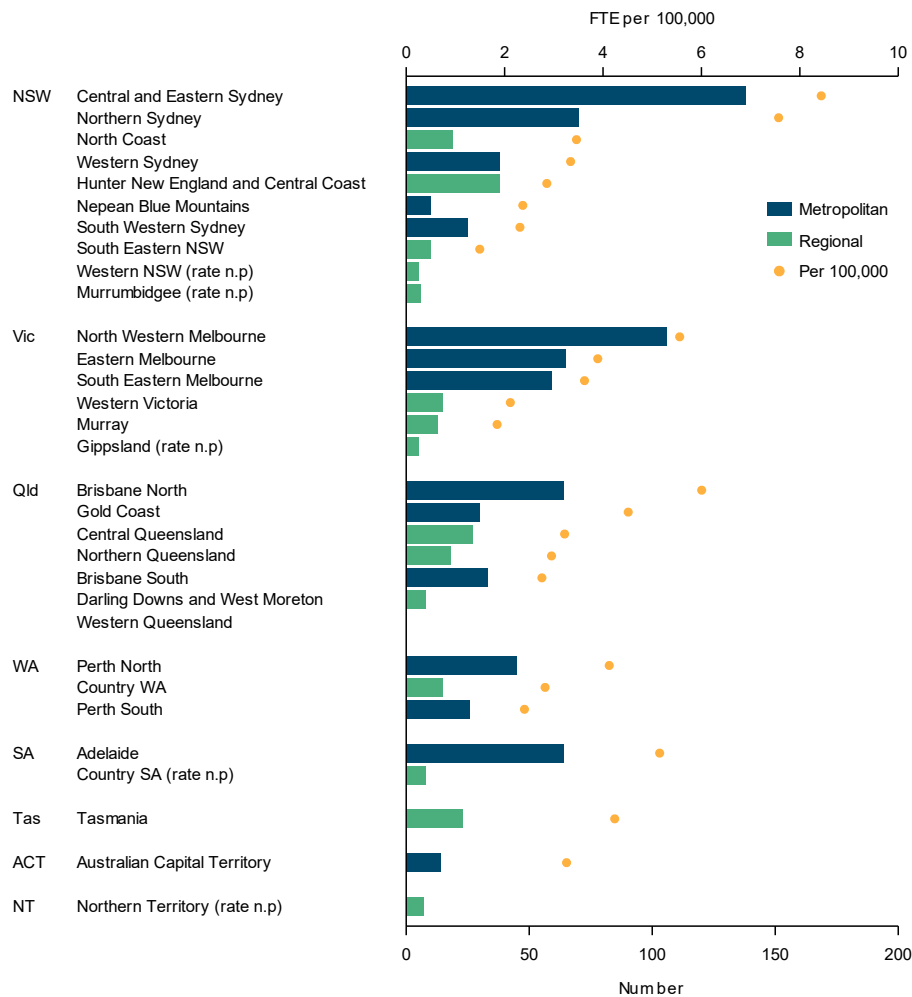
An optometrist is often the first port of call for any problems with eyes or vision. Being a primary health provider, they play a key role in providing accessible eye care to their communities.

Ophthalmologists

The ophthalmologist workforce is smaller than the optometrist workforce with 1,004 ophthalmologists employed in Australia (3.9 FTE per 100,000) in 2023.

Ophthalmologists were primarily located in metropolitan areas, with the highest rate in the Central and Eastern Sydney Primary Health Network (138 and 8.7 FTE per 100,000).

Ophthalmologists, by Primary Health Network, 2023



Notes:

1. Rates have not been published (n.p.) where fewer than 10 people employed for any occupation was fewer than 10 people.
2. FTE per 100,000 based on a 40-hour work week.

Source: AIHW analysis of National Health Workforce Dataset.



Did you know?

An ophthalmologist is a medical specialist, also known as an eye doctor or eye surgeon. Most people come across an ophthalmologist through referral for an eye disease or visual disorder.



6

Eye health services provided under outreach and other programs

Australian Government outreach programs are designed to deal with the uneven distribution of the health workforce and to improve access to eye health services across Australia.

The programs provide specialist eye health services, primarily in regional and remote areas of Australia include:

- the Visiting Optometrists Scheme (VOS): Australian Government program that funds optometrists to deliver eye care services in regional, rural, and remote communities, improving access to essential eye health services, especially for First Nations peoples.
- the Rural Health Outreach Fund (RHOF): Australian Government program that supports outreach services by medical specialists, GPs, and allied health professionals to improve access to healthcare in rural and remote communities, focusing on key areas like eye health, mental health, maternity, and chronic disease management.
- the Medical Outreach Indigenous Chronic Disease

Program (MOICDP): An Australian Government program that specifically supports outreach health services for First Nations people with chronic conditions. It funds travel and service delivery costs for health professionals providing culturally appropriate care in rural, remote, and selected urban areas.

- The Eye and Ear Surgical Support (EESS) Program is an Australian Government initiative that provides timely access to eye and ear surgeries for First Nations people, particularly in rural and remote areas. It supports culturally safe care pathways, including travel, accommodation, and access to bulk-billing surgeons, with a focus on reducing avoidable vision and hearing loss.

In 2023–24, 48,185 occasions of service for First Nations patients were provided by eye health professionals under combined outreach services (VOS, RHOF and MOICDP).

Services provided

In 2023–24, the numbers of occasions of service for outreach programs delivered to First Nations patients for eye health care were:

- 31,534 provided through the VOS
- 1,394 provided under the RHOF
- 15,257 provided under the MOICDP
- 648 First Nations patients were supported under the Eye and Ear Surgical Support Program.

Between 2013–14 and 2023–24, VOS occasions of service for First Nations patients increased almost 1.6-fold, rising from 20,151 to 31,534.

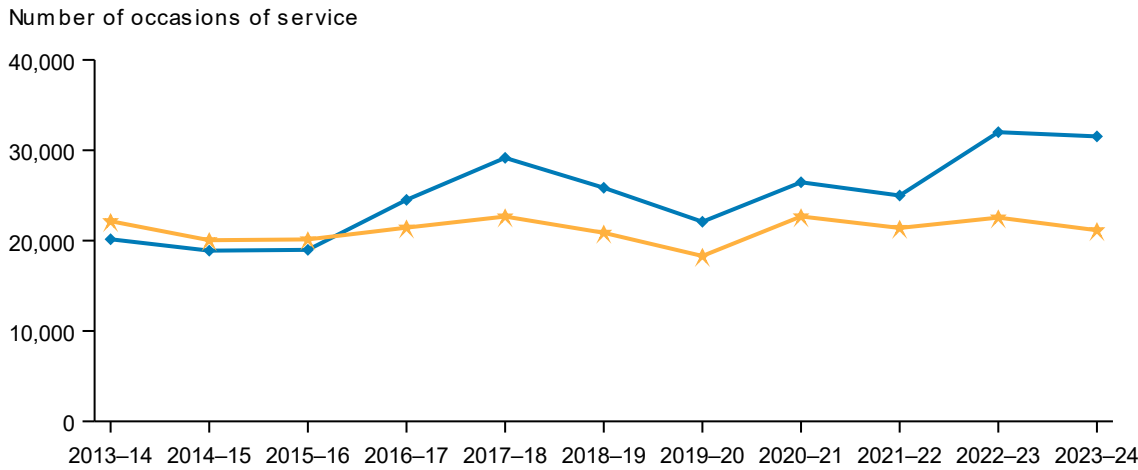
Services provided to First Nations patients have exceeded those provided to other patients (that is, to non-Indigenous Australians and to people of unknown Indigenous status) since 2016–17.



Did you know?

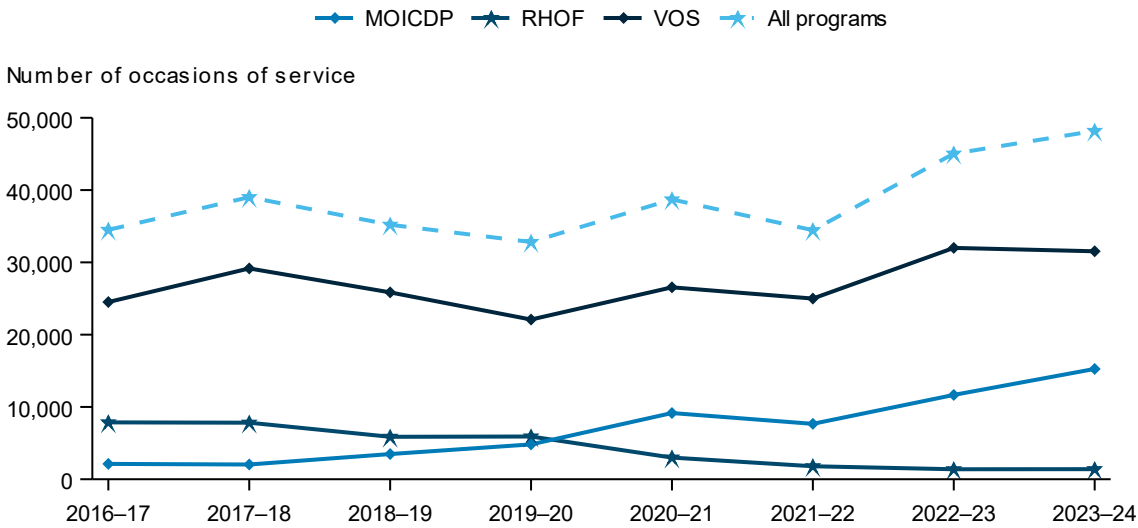
Eye health is one of the 4 main priorities of the RHOF – along with chronic disease management, maternity and paediatric health, and mental health.

VOS occasions of service, by Indigenous status



Source: AIHW analysis of Department of Health and Aged Care data (unpublished).

Outreach programs occasions of service for eye health care, First Nations people, 2016-17 to 2023-24



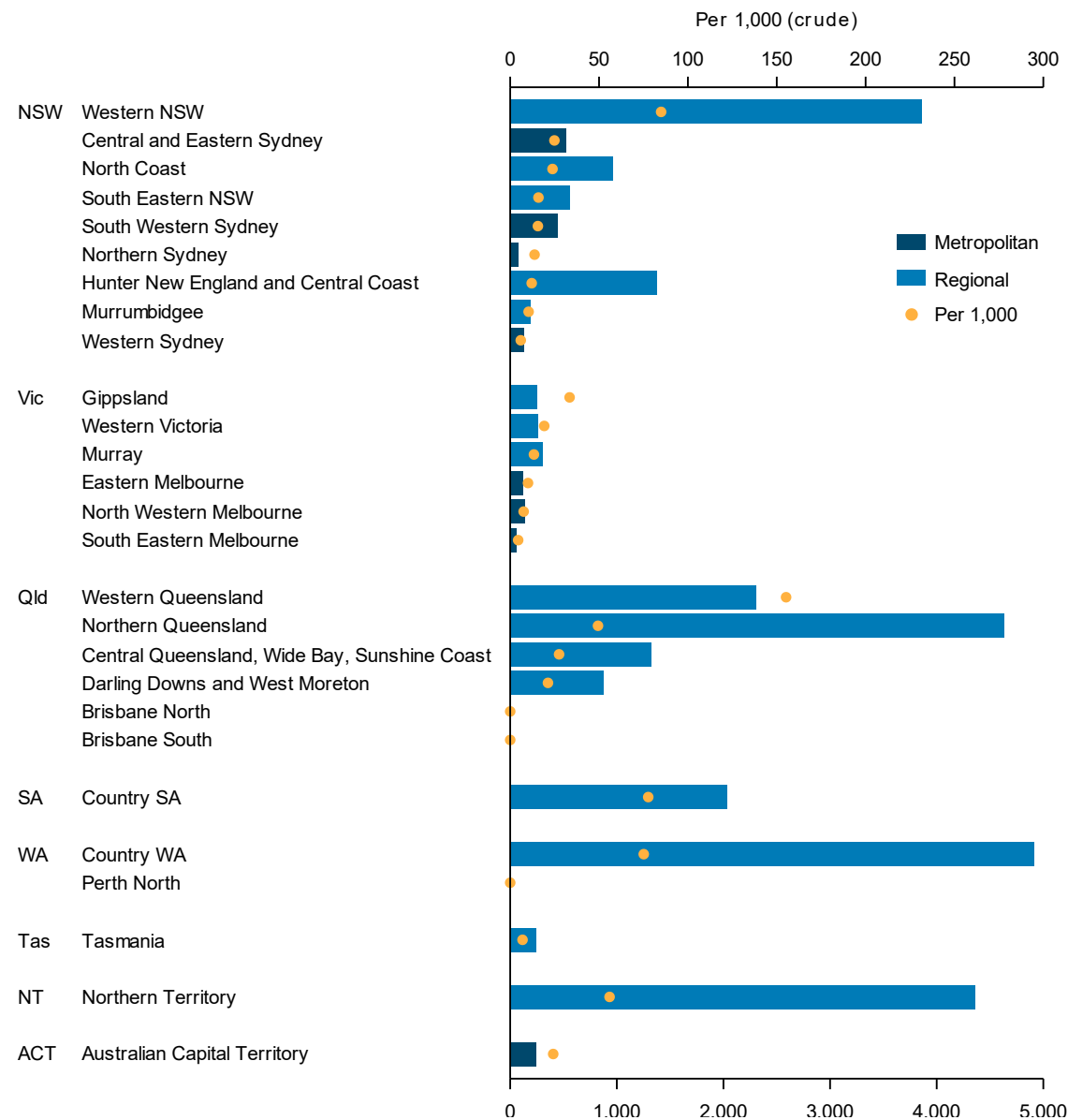
Source: AIHW analysis of Department of Health and Aged Care data (unpublished).

Areas outreach services provided

Outreach services generally cover areas where there are low numbers of registered optometrists and ophthalmologists.

The highest number of occasions of service for VOS, for example, were provided in Country WA, Northern Queensland and in the Northern Territory.

VOS occasions of service, First Nations people, by Primary Health Network, 2023–24



Source: AIHW analysis of Department of Health and Aged Care data (unpublished).

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This report provides an overview of the latest Aboriginal and Torres Strait Islander people eye health data. It includes information on the prevalence of eye health conditions, diagnosis and treatment services, the eye health workforce and outreach services. Eye health measures for Aboriginal and Torres Strait Islander people 2025 is a companion to this report.

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