

Australia: Poor communities hit by largest diphtheria outbreak on record

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7 June 2026

Since October, Australia has been experiencing its largest recorded outbreak of diphtheria, exacerbated by an inadequate public health response.

Nearly 260 cases of the potentially deadly disease have been reported. At least 60 of those infected have been hospitalised, with several requiring intensive care. One person has died—the first confirmed diphtheria death in Australia since 2018.

Most cases have occurred in the Northern Territory (NT) and Western Australia, with infections also recorded in Queensland and South Australia. Aboriginal and Torres Strait Islander people, among the most oppressed layers of the population, account for 95 percent of infections.

With case numbers escalating since February, the outbreak is far from contained. The delayed responses of local and federal authorities, which essentially amounted to covering up the outbreak in its initial stages, have been denounced by health workers.

Diphtheria is an infectious disease caused by the bacterium *Corynebacterium diphtheriae*. It spreads primarily through airborne respiratory droplets, although transmission through skin lesions or contaminated objects is possible. The bacteria attack the skin and mucosal tissues, particularly in the respiratory tract.

While *Corynebacterium diphtheriae* can infect people of all ages, diphtheria is more common and dangerous in young children. It is a disease of poverty, with overcrowded housing and inadequate healthcare contributing significantly to transmission.

The illness has two principal forms: the more common but generally less severe “cutaneous diphtheria,” which causes skin infections, and “respiratory diphtheria,” the more dangerous form that infects the respiratory tract. In severe respiratory cases, thick grey membranes can form in the throat and airways, causing breathing difficulties and potentially death.

Even with antibiotic treatment, respiratory diphtheria can be fatal in around 10 percent of cases, with higher mortality among children. In the current outbreak, roughly one-third of all cases have been of the deadlier respiratory diphtheria, consistent with historical outbreaks.

Diphtheria vaccinations were introduced internationally during the 1920s and 1930s. According to the World Health

Organization, worldwide diphtheria cases have fallen by 85 percent, and deaths by 75 percent, since 1990.

The introduction of vaccination in Australia in 1932 led to the near-elimination of the disease. Over the past three decades, annual case numbers have generally remained in the single digits. Between 1999 and 2019, only eight cases of respiratory diphtheria were reported nationally. The current outbreak is the largest recorded since national reporting began in 1991.

The first cases were reported last October in rural settlements in the NT, where 160 cases have now been identified.

Despite its mining and agricultural wealth, the NT contains some of the most impoverished sections of the Australian working class, especially in remote Aboriginal communities. The Territory has the country’s highest homelessness and overcrowding rates.

Decades of inadequate housing investment by Labor and Country Liberal Party (CLP) governments have left many remote communities severely overcrowded. In some settlements, overcrowding rates exceed 50 percent. Many homes lack adequate cooling, reliable electricity and consistent running water, despite temperatures frequently exceeding 40 degrees Celsius.

The Territory’s Department of Children and Families warned in 2020 that 12,000 additional homes were needed by 2025 to meet existing demand in the NT. However, under a 2024 deal between the federal Labor government and the Territory’s CLP government, less than 300 new public homes are planned per year for the next decade.

These social conditions have provided an ideal environment for the spread of diphtheria.

Compounding the problem has been a decline in diphtheria vaccinations since the COVID-19 pandemic. Public health experts generally estimate that vaccination coverage of around 95 percent is needed to prevent sustained transmission. However, vaccination rates in the Territory have fallen below that level in several age groups since 2020.

The situation among adolescents and adults is particularly concerning. Immunity from diphtheria vaccination weakens over time, requiring booster doses that are increasingly being missed. Health authorities and clinicians have warned that low booster uptake of diphtheria in remote communities has

increased vulnerability to the disease, with only 67 percent of adolescents (aged 13–18), and just 30 percent of adults adequately vaccinated. In the current outbreak, a large proportion of infections have occurred among adults aged 25–44, unusually high for a disease that historically affects children most severely.

While anti-vaccine misinformation may have contributed to declining vaccination rates, responsibility primarily lies with decades of underfunding of public health infrastructure by successive federal, state and territory governments.

The NT, like other states and territories, faces chronic healthcare workforce shortages, which have been exacerbated by the COVID pandemic. The Medical Journal of Australia estimated in 2024 that the Territory would need to expand its workforce by more than 20 percent simply to meet existing demand.

These shortages are even worse in rural communities, where shortfalls in funding mean that clinics and other health services either cannot operate, or are limited in the services they can provide. This has included providing sufficient vaccinations, and providing awareness and education of the need for them.

Freezes to Medicare funding for GPs have resulted in the closure of GP clinics throughout the NT, with rural towns, often dependent on just 1 or 2 clinics, especially impacted. Heavy workloads have contributed to burnout, with staff turnover rates as high as 148 percent for nurses in remote NT towns.

The parlous state of healthcare has contributed to rural Aboriginal communities in the NT having a life expectancy 13 years below the national average. In terms of infectious diseases, it often means that early signs of illness are missed, creating conditions for outbreaks.

The experience of the pandemic has not led to any substantial improvements in public health management of infectious diseases, or any other aspect of health care, either in the NT or Australia-wide.

While poor housing and inadequate healthcare have provided the conditions for diphtheria, it is the government’s response that has enabled it to reach epidemic proportions.

Health workers, Aboriginal medical organisations and local residents have criticised authorities for suppressing knowledge of diphtheria, and delaying action to halt its spread. Dr John Boffa, chief medical officer of the Central Australian Aboriginal Congress, told the *Guardian* that health services were not adequately informed about the extent of the outbreak until months after cases had begun appearing in Darwin and remote communities.

“Once we started going out to town camps to immunise, we realised there wasn’t enough information out there in the community either,” he said. This included information about the severity of diphtheria and the need for urgent vaccinations and booster shots.

Boffa reported that it took nearly two months for sufficient

supplies of diphtheria vaccine to be made available, by which time 15–20 new cases were being diagnosed each week. He reported that there is only one laboratory in the NT to test diphtheria cases, with results taking up to one week to come back, contributing to delays in diagnosis.

Eugene Penhall, a resident of Yuendumu, a remote Aboriginal community of 700 in the NT, told the *Guardian* that no efforts to alert the population about diphtheria had been made. “[T]he thing about this outbreak is that we’ve never been told what it is,” he said. Penhall added, “How we live as Aboriginal people, we have 10 people in one house. They could be carrying this thing that we don’t even know about and it’s really, really bad.”

These concerns of delay have been substantiated by leaked internal government statistics, collected by the NT Health department. The ABC reported that NT Health was aware of the increased spread of diphtheria cases, one month before a public health alert was issued in late March.

The NT government did not take further action and even now refuses to provide statistics regarding the diphtheria outbreak, with the ABC reporting that their request for a breakdown of case numbers had been rejected. Undoubtedly, the federal Labor government would have been made aware of the situation months ago, but also refused to take emergency action.

After months of criticism from health workers and community organisations, the federal Labor government announced an additional \$7.2 million in outbreak funding at the end of May, largely directed toward vaccination programs and emergency staffing. No extra money was made available to increase testing, boost the healthcare system or improve housing.

The re-emergence of diphtheria in Australia is another stark expression of deepening social inequality under capitalism. Diseases long considered eliminated are returning because the essential social determinants of health—adequate housing, accessible healthcare and comprehensive public health infrastructure—have been eroded by decades of bipartisan attacks on public health.



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