Children's Headline Indicators

Web report | Last updated: **18 Sep 2018** | Topic: <u>Children & youth</u>

About

The Children's Headline Indicators (CHI) are a set of 19 indicators endorsed by the Australian Health Ministers' Conference, Community and Disability Services Ministers' Conference and the Australian Education, Early Childhood Development and Youth Affairs Senior Officials Committee in 2008 (first reported in 2009). They are high level, measureable indicators that identify the immediate environments as particularly important to children's health, development and wellbeing. The CHI are presented from 2006 to 2016 and are grouped into 3 broad topic areas – Health, Early learning and care and Family and community.

Cat. no: CWS 64

Findings from this report:

- 3.1 infants per 1,000 live births died in 2016, decreasing from 4.7 deaths per 1,000 live births in 2006

- 11 births per 1,000 were to teenage mothers in 2015, decreasing from 13 per 1,000 females in 2014

- 10 per cent of women smoked in the first 20 weeks of pregnancy in 2015, declining steadily from 13 per cent in 2011

- 22 per cent of children were living in households with housing stress in 2016, decreasing from 26 per cent in 2011

Overview

Data visualisations are available for the 19 Children's Headline Indicators that currently have suitable data.

Children's Headline Indicators by domain

Health	Early learning and care	Family and community
1. Smoking during pregnancy updated	9. Early childhood education updated	14. Teenage births updated
2. Infant mortality updated	10. Transition to primary school	15. Family social network
3. Low birthweight updated	11. Attendance at primary school	16. Family economic situation updated
4. Breastfeeding	12. Literacy updated	17. Child abuse and neglect updated
5. Immunisation	13. Numeracy updated	18. Social and emotional wellbeing
6. Overweight and obesity		19. Shelter updated
7. Dental health[a]		
8. Injury deaths updated		

a. Most recent data is 2010.

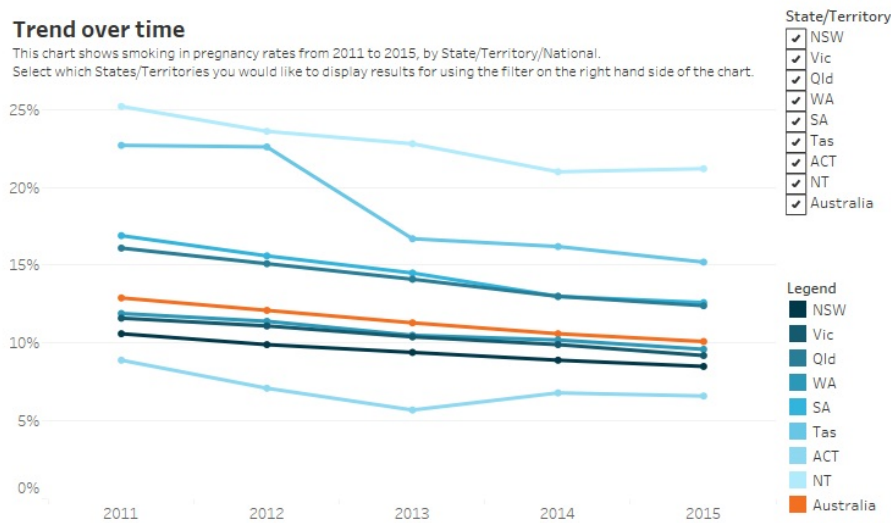## Visualisation not available for printing

1. Smoking during pregnancy

Smoking in pregnancy

Headline Indicator: Proportion of women who smoked during the first 20 weeks of pregnancy

Trend over time

This chart shows smoking in pregnancy rates from 2011 to 2015, by State/Territory/National.
Select which States/Territories you would like to display results for using the filter on the right hand side of the chart.

State/Territory
- ✔ NSW
- ✔ Vic
- ✔ Qld
- ✔ WA
- ✔ SA
- ✔ Tas
- ✔ ACT
- ✔ NT
- ✔ Australia

Legend
- NSW
- Vic
- Qld
- WA
- SA
- Tas
- ACT
- NT
- Australia

Smoking in pregnancy rates for a specific year

Select a year to view using the filter on the right hand side of the chart.

Year
- 2011
- 2012
- 2013
- 2014
- ● 2015

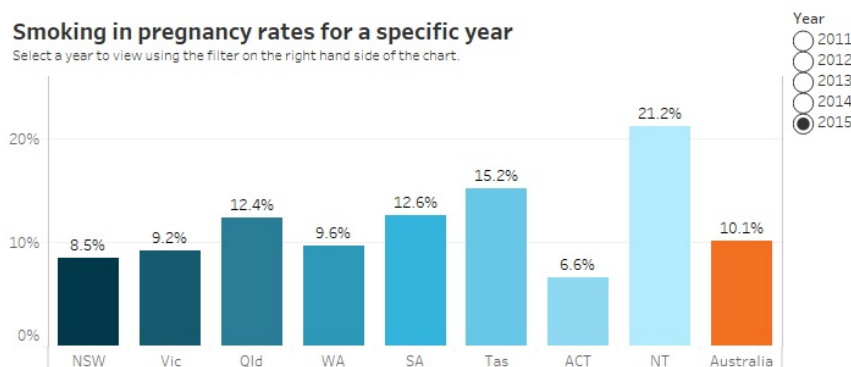| NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
8.5%	9.2%	12.4%	9.6%	12.6%	15.2%	6.6%	21.2%	10.1%

Chart: AIHW. Source: AIHW National Perinatal Data Collection

Why are smoking in pregnancy rates important?

Smoking in pregnancy is an important modifiable risk factor for low birthweight, pre-term birth, placental complications and perinatal mortality. Tobacco smoke reduces the flow of oxygen to the placenta and exposes the fetus to a number of toxins (Knopik et al. 2012; Milner et al. 2007).

Smoking during pregnancy can also impact the infant or developing child, with children whose mothers smoked during pregnancy more likely to be affected by sudden infant death syndrome (SIDS), childhood cancers, high blood pressure, asthma, obesity and lowered cognitive development (Julvez et al. 2007; Ng & Zelikoff 2006).

Poorer child health outcomes are associated with a higher number of cigarettes smoked during pregnancy. There were positive changes in smoking behaviour during the antenatal period, with around one-fifth (22%) of women who smoked quitting during the first 20 weeks of pregnancy (AIHW 2015). Quitting smoking, particularly within the first 20 weeks of pregnancy, may help to reduce some of the effects of smoking (Chan & Sullivan 2008). The AIHW's perinatal dynamic data display also provides comparison of rates of smoking in the first 20 weeks of pregnancy compared to the second 20 weeks of pregnancy.

National Core Maternity Indicator 1 also reports on smoking in pregnancy, for those who reported smoking in the first 20 weeks and among those who reported smoking, the proportion who reported smoking after 20 weeks of pregnancy. This NCMI indicator includes disaggregations by hospital sector, remoteness, Indigenous status of the mother and disadvantage quintile. This information may be used alongside the children's headline indicator to provide a more detailed picture of smoking in pregnancy in Australia.

Does smoking in pregnancy vary across population groups?

In 2015, around 1 in 10 (10.1%) mothers across Australia smoked during the first 20 weeks of pregnancy. The proportion of women who smoked during the first 20 weeks was highest among teenage mothers, with almost one third (32.3%) of mothers under the age of 20 reporting smoking during this period. The proportion decreased with increasing maternal age: 6.4%, 6.3% and 6.8% for mothers aged 30-34, 35-39, and 40 and over, respectively.

Age-standardised rates have been used for this indicator to present the data by Indigenous status to take into account differences in the age distribution of the two groups. The proportion of Indigenous women smoking during the first 20 weeks of pregnancy was 3.7 times as high (43.8%) as that for non-Indigenous women (11.7%). Mothers born in Australia (13.4) were 3.8 times as likely to smoke during the first 20 weeks of pregnancy when compared to overseas born mothers (3.5%). Smoking rates were around 3.4 times as high for those mothers living in Remote or very remote areas (26.0%) compared to women living in Major cities (7.7%).

Has there been a change over time?

Smoking during the first 20 weeks of pregnancy was reported in Children's Headline Indicators for the first time in 2011. The overall rate of women smoking during the first 20 weeks of pregnancy in 2015 (10.1%) is slightly lower compared to the rate in 2011 (12.9%). In fact, for every national disaggregation reported in the portal the proportion of women who smoked in the first 20 weeks has decreased each year, though sometimes by a small amount. The rate for women under the age of 20 has decreased slightly between 2011 and 2015, from 35.7% to 32.3%. The rate for Indigenous women was also slightly lower across the five years (43.8% in 2015 compared with 47.0% in 2011), as was the rate for women living in Remote and very remote areas (26.0% in 2015 compared with 29.4% in 2011), and in the lowest socioeconomic areas (17.9% in 2015 compared with 20.5% in 2012).

Notes

Smoking status in pregnancy is self-reported by the mother and is based on the first 20 weeks of pregnancy.

For Indigenous status of the mother, Indigenous and non-Indigenous proportions are directly age-standardised using the 2001 Australian female Estimated Resident Population (ERP) population as the standard population.

Age-standardisation is a method of removing the influence of age when comparing populations with different age structures. The age structures of the different populations are converted to the same 'standard' structure, and then the disease rates that would have occurred with that structure are calculated and compared.

References

AIHW (Australian Institute of Health and Welfare) 2015. Australia's mothers and babies 2013 —in brief. Perinatal statistics series no. 31. Cat. no. PER 72. Canberra: AIHW.

Chan DL & Sullivan EA 2008. Teenage smoking in pregnancy and birthweight: a population study, 2001–2004. Medical Journal of Australia 188(7):392-6.

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2. Infant mortality

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Why is infant mortality important?

Measures of infant mortality provide insight into the socio-demographic and lifestyle factors into which Australian children are born and how these affect both life and death chances. Child mortality also provides a key measure of the effectiveness of the health system in maternal and perinatal health including insight into how well the system is working and how it can be improved.

Social and economic factors are key determinants of infant and child mortality in both developed and developing countries (Collison et al. 2007; Marmot 2006). Infant and child mortality have been shown to be associated with indicators of parental disadvantage such as low income or joblessness, teenage motherhood, mother's education and Indigenous status (Gracey & King 2009).

Australia has shown significant progress in reducing infant deaths with death rates halving between 1986 and 2010 (ABS 2013; ABS 2011a; AIHW 2012). Programs and resources directed at intensive care units, increased community awareness of the risk factors for sudden unexpected deaths in infancy (SUDI), and reductions in vaccine-preventable diseases through national childhood immunisation programs have been particularly successful.

Improvements in both access and quality of antenatal and maternal care should help to further reduce the infant mortality rate, especially for Indigenous babies. Issues currently targeted include maternal nutrition and reduction in risk behaviours such as drinking and smoking in pregnancy (AIHW 2012; Gracey & King 2009).

The Indigenous infant mortality rate has more than halved from 13.5 per 1,000 live births in 1998 to 6.0 per 1,000 in 2016, and the gap has narrowed significantly (by 84 per cent) over this period (Commonwealth Australia 2017). Further gains will be achieved by addressing the leading causes of Indigenous child death including conditions originating in the perinatal period (42 per cent of Indigenous child deaths), such as birth trauma, foetal growth disorders, complications of pregnancy, and respiratory and cardiovascular disorders (Commonwealth Australia 2017).

Do infant mortality rates vary across population groups?

The overall infant mortality rate for 2016 was 3.1 per 1,000 live births. The male infant mortality rate (3.4 per 1,000 live births) is slightly higher than the female infant death rate (2.8 per 1,000 live births). The Indigenous infant death rate (6.0 per 1,000 live births), was twice as high as the non-Indigenous infant death rate (3.0 per 1,000 live births).

In 2016, infant deaths were over twice as high in Remote and very remote areas (6.0 per 1,000 live births) compared with Major cities (2.9 per 1,000 live births). Infant deaths were also higher in the lowest socioeconomic areas compared to the highest socioeconomic areas (4.6 compared with 2.5 per 1,000 live births, respectively).

Has there been a change over time?

Over the period 2006 to 2016, the overall infant mortality rate has shown a downward trend (with some variability) from a high of 4.7 per 1,000 live births in 2006 to 3.1 per 1,000 live births in 2016. The difference between the male and female infant mortality rates has decreased over time: in 2006, the male rate was 1.3 times as high as the female rate (5.2 compared with 4.1 per 1,000 live births); in 2016, the rate for males was 1.2 times as high as that for females (3.4 compared with 2.8 per 1,000 live births).

The difference between the Indigenous and non-Indigenous infant mortality rates has also decreased, from 10.0 and 4.4 per 1,000 live births respectively in 2006, to 6.0 and 3.0 per 1,000 live births respectively in 2016. In part, the Indigenous infant mortality trend has changed due to an improvement in the quality of Indigenous identification (Commonwealth Australia 2017). Data on remoteness and socioeconomic position have not been available across all years from 2006 to 2016; however, the rates across all populations appear to be declining over time.

Notes

Infant mortality is measured as the number of deaths of infants less than 1 year of age in a given year, expressed per 1,000 live births in the same year.

Sudden infant death syndrome (SIDS) refers to the sudden and unexpected death of an infant aged less than 1 year during sleep that remains unexpected after a thorough investigation.

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3. Low birthweight

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Why are low birthweight rates important?

Babies who are born with low birthweight are at greater risk of poor health, disability and death than other babies.

Birthweight is a key indicator of infant health and a principal determinant of a baby's chance of survival and good health. A baby may be small due to being born early (pre-term) or may be small for gestational age (suggesting possible intrauterine growth restriction).

Low birthweight is a risk factor for neurological and physical disabilities, with the risk of adverse outcomes increasing with decreasing birthweight (Goldenberg & Culhane 2007). The health effects of low birthweight can continue into adulthood. Research has found an increased risk of Type 2 diabetes, high blood pressure as well as metabolic and cardiovascular diseases (Phillips 2006; Verrips & Van der Pal 2014).

Factors that contribute to low birthweight include extremes of maternal age, illness during pregnancy, low socioeconomic position, multiple pregnancy, maternal history of spontaneous abortion, harmful behaviours such as smoking or excessive alcohol consumption, poor nutrition during pregnancy and poor antenatal care (AIHW 2015; AIHW 2014; Goldenberg & Culhane 2007). A number of these risk factors are modifiable and amenable to intervention.

Recent studies have demonstrated associations between aggressions suffered during individual phases of somatic development and amplified risk of chronic diseases throughout life, such as obesity, diabetes and cardiovascular diseases (Silveira, Portella, Goldani, Barbieri 2007).

National Core Maternity Indicator 10 reports on the proportion of babies born at or after 40 weeks gestation who weighed less than 2,750 grams at birth. This may be used alongside this Children's Headline Indicator on low birthweight to provide a picture of factors affecting low birthweight (noting that the two cut-off weights are slightly different).

More data on birthweight can be found on the Perinatal data portal, which reports on 3 birthweight groups: low (less than 2,500 grams), normal (2,500 to 4,449 grams) and high (4,500 grams and over).

Does low birthweight vary across population groups?

According to the 2015 AIHW National Perinatal Data Collection, 6.5% of liveborn babies in Australia were of low birthweight. Baby girls were more likely to be of low birthweight than boys (7.0% compared with 6.0%). Twice as many babies of Indigenous mothers were of low birthweight (11.9%) compared to babies of non-Indigenous mothers (6.2%). The proportion of low birthweight babies born to overseas-born mothers was marginally lower than the rate for Australian-born mothers (6.5% and 6.4%, respectively). Babies born to mothers in Remote and very remote areas were more likely to be of low birthweight as those born to mothers in Major cities (8.6% compared with 6.4%). Babies born to mothers in the lowest socioeconomic areas were more likely to be of low birthweight as those born to mothers in the highest socioeconomic areas (7.6% compared with 5.5%).

Has there been a change over time?

There has been little change in the proportion of low birthweight babies over the 10 years to 2015 which remained between 6.1% and 6.5%. The rate for Indigenous babies also remained fairly constant, ranging between 11.8% and 12.6%. Similarly, the rate of low birthweight babies among overseas-born mothers remained relatively constant, ranging between 5.9% and 6.4%. Between 2006 and 2015, the low birthweight rate for mothers living in Remote and very remote areas ranged from 7.8% to 9.0%. The 2015 value of 8.6% is in the middle of this range. Between 2012 and 2015, the proportion of low birthweight babies born to mothers living in the lowest socioeconomic areas increased slightly (from 7.4% to 7.6%). The proportion of low birthweight babies born to mothers from highest socioeconomic areas showed similar change between 2012 and 2015, increasing slightly from 5.3% to 5.5%.

Notes

Low birthweight is defined as less than 2500 grams for the purpose of this indicator (AIHW 2014a).

The low birthweight indicator reported here does not currently distinguish between pre-term babies who are appropriate weight for gestational age and full-term babies who are small for gestational age.

The proportion of low birthweights for babies born in the ACT to Indigenous mothers has not been reported due to a low overall number of births recorded for Indigenous mothers in the ACT in that year.

References

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4. Breastfeeding

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Why is breastfeeding important?

Breastfeeding promotes the healthy growth and development of infants and young children. In Australia, the National Health and Medical Research Council publishes infant feeding guidelines which state 'it is recommended that infants are exclusively breastfed until around 6 months of age when solid foods are introduced, and that breastfeeding is continued until 12 months of age and beyond, for as long as the mother and child desire' (NHMRC 2012). 'Exclusive breastfeeding' means that the infant receives only breast milk (including expressed milk) and medicines (including oral rehydration solutions, vitamins and minerals), but no infant formula or non-human milk (AHMAC 2009). Breast milk contains all the requirements necessary for a baby's development for the first 6 months and remains the most important part of the baby's diet, with the addition of family foods, until around 12 months. Breast milk continues to provide a valuable source of nutrition and immunological protection for 2 years and beyond (ABA 2013).

Exclusive breastfeeding is recommended as evidence suggests it has health, nutritional and developmental benefits, including:

* protection for the infant against infectious diseases, including gastrointestinal illness, respiratory tract infections and middle ear infections (Duijts, Ramadhani, Moll 2009; Eidelman 2012);
* lower incidence of high cholesterol, high blood pressure, obesity and diabetes later in life, with improved cognitive development (Horta & Victoria 2013; Kramer et al. 2008);
* reduced risk of SIDS, type 1 diabetes and leukaemia (Eidelman 2012); and
* improved mother-infant bonding and secure attachment (Allen & Hector 2005; Bryanton et al. 2009).

Do breastfeeding rates vary across population groups?

In the 2014–15 National Health Survey, the national proportion of infants exclusively breastfed to around 4 months of age was almost 58%. Babies born to a mother who was born overseas were more likely to be exclusively breastfed to around 4 months (almost 76%) than those babies born to mothers born in Australia (51%). There was no statistically significant difference between the proportion of infants exclusively breastfed to around 4 months in couple families (60%) and one-parent families (61%). Nor were there statistically significant differences across remoteness areas or areas of highest and lowest socioeconomic disadvantage.

Notes

CALD refers to Culturally and Linguistically Diverse background.

Data from the three periods 2010, 2011–12 and 2014–15 are not comparable; data in 2010 were from the Australian National Infant Feeding Survey, while data from 2011–12 and 2014–15 were from the National Health Survey. Data from 2011–12 is derived using people aged 4 months to 47 months of age. Data from 2014–15 is derived using people aged 4 months to 24 months of age. Due to a change in question sequencing between these two surveys, 2014–15 data is not comparable to 2011–12 data.

For more detailed information on the data refer to the data source tables.

References

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5. Immunisation

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Why is immunisation important?

Immunisation coverage reflects the capacity of the health-care system to provide vaccinations to children.

Immunisation uses the body's natural defence mechanism—the immune response—to build resistance to specific infections. A large part of the reduction in mortality and morbidity among children over the past century was due to immunisation (Plotkin & Plotkin 2008). Immunisation resulted in the worldwide eradication of smallpox, the widespread elimination of poliomyelitis and can protect children against a multitude of other communicable diseases. Children who do not receive complete and timely immunisations remain at risk of contracting vaccine-preventable diseases, and the short- and long-term health consequences associated with these.

Immunisation also plays a role in protecting individuals who are not immunised, through 'herd immunity' (Department of Health 2013a). Generally, immunisation coverage needs to exceed 90% in order to achieve and maintain the level of herd immunity needed to interrupt the spread of the vaccine-preventable diseases (Lister et al. 1999). Australia has an excellent record in childhood immunisation coverage, achieving at or above 90% average coverage for children at 12 months, 24 months and 60 months of age.

In the 2018 Australian Childhood Immunisation Register, 90.5% of children on the Australian Childhood Immunisation Register were fully immunised at 2 years of age (Department of Health 2018). In 2015, more than 1.3% (equivalent to around 30,000 children aged under 7 were not vaccinated because their parents were vaccine objectors (Department of Health 2016). This equates to an increase of more than 30,000 children over the last 10 years. In order to protect children and the community from preventable diseases, the Australian Government has removed 'conscientious objection' as an exemption category for child care payments on 1 January 2016. Maintaining and improving these high immunisation rates will continue to be important in the future (Department of Health 2013b; Hull et al. 2016).

Do immunisation rates vary across population groups?

At the national level, in 2016 there were slight differences in immunisation rates between different population groups, with rates varying between around 90% to 92% irrespective of sex, socioeconomic position, or remoteness. National immunisation rates for Indigenous and non-Indigenous children are similar despite coverage for vaccines recommended only for Aboriginal and Torres Strait Islander children remaining substantially lower than that for universal vaccines (DoH 2013c).

Has there been a change over time?

Over the period 2008 to 2014, immunisation rates in Australia at a national level have remained largely stable, between 92 and 93%. However, marginal differences occur between 2008 and 2014 across gender, different socioeconomic position and remoteness areas. There was a slight improvement in immunisation rates for Indigenous children at 2 years of age rising from 91% in 2008 to 93% in 2014.

From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) were included in the definition of fully immunised for the 24-27 month cohort. This new definition has been used to produce the 2015 and 2016 fully immunised at 2 years of age rate, and consequently the 2015 data should not be compared to previous years due to a break in the time series (see Notes section for further details).

The immunisation rates for children who were fully immunised at 2 years of age in Australia has increased slightly from 2015, rising by 0.8 percentage points from 90% in 2015 to 90.8% in 2016. Similar patterns were seen among boys and girls, with boys increasing from 90.1% in 2015 to 90.9% in 2016, and girls increasing from 89.9% in 2015 to 90.7% in 2016. For Indigenous children, the immunisation rates increased 2.6 percentage points from 87.1% in 2015 to 89.7% in 2016. For socioeconomic status, there was a slight increase in national immunisation rates (by 0.4 percentage points) in both the lowest and highest socioeconomic status areas. By remoteness, the national immunisation rates also increased in Major cities and Inner regional areas (by 0.7 and 0.8 percentage points, respectively), while Outer regional, remote and very remote areas increased by 2 percentage points, from 90.1% in 2015 to 92.1% in 2016.

Notes

Data from the Australian Childhood Immunisation Register prior to 2015 include children who have received the scheduled doses of vaccines for diphtheria; tetanus and pertussis; poliomyelitis; hepatitis B; Haemophilus influenza type B (Hib); and measles, mumps and rubella. The data exclude other scheduled vaccines for children aged up to 2 years (rotavirus, chicken pox, meningococcal C and pneumococcal conjugate).

The inclusion of these immunisations to the coverage calculation means that for 2015 data, a considerable drop in the 24-27 month coverage rates was observed. The coverage rate has dropped because the criteria to assess fully immunised now includes more vaccines. The more vaccines included in the assessment, the higher the likelihood of reduced coverage rates. This usually resolves over time as the changes become more routine.

Age is calculated as at 30 June.

The data presented for the Total Persons (per cent and number) differ marginally from similar immunisation coverage data published by ACIR due to slight variations in the programs used to calculate the coverage estimates. Any differences observed will not be large enough to affect any interpretation of the data.

It should be noted that data used in this report is for the September quarter (collected over a three month window) in each year; this includes the total number of children. The number of children fully immunised at 24 months is therefore about 4 times the number fully immunised in each September quarter.

References

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6. Overweight & obesity

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Why are rates of overweight and obesity in children important?

Overweight and obesity increases a child's risk of poor physical health and is a risk factor for morbidity and mortality in adulthood. Obese children have a greater risk of developing asthma, Type 2 diabetes, cardiovascular conditions and certain cancers, than non-obese children (Summerbell et al. 2005). In addition to physical health problems, overweight and obese children frequently experience discrimination, victimisation, and teasing by their peers. This may contribute to poor peer relationships, school experiences and psychological wellbeing, particularly among older overweight or obese children (Griffiths et al. 2006; Sawyer et al. 2006). Early childhood is therefore an ideal period for intervention, particularly as childhood obesity is closely linked to food preferences and dietary habits, which are firmly established in the early years of life (Daniels et al. 2009).

Research from Growing up in Australia: the Longitudinal Study of Australian Children (LSAC) has shown that obesity becomes more entrenched throughout early childhood and possibly less reversible by the middle school years. Persistent overweight/obesity is more common among the most disadvantaged children, according to measures of family economic position and neighbourhood disadvantage (Wake & Maguire 2012).

Do rates of overweight and obesity among children vary across population groups?

In the ABS Australian Health Survey 2014-15, there were around 750,000 children aged 5-14 years whose body mass index (BMI) score was above the international cut-off points for 'overweight' or 'obese' for their age and sex. This represents around 26% of children within this age group. There were no significant differences in levels of overweight/obesity for children of different sexes but older children aged 10–14 years were more likely to be overweight or obese than younger children aged 5–9 years (30% compared to 23%). Children from single parent families (about 28%) had slightly higher rates of overweight and obesity than children from families with two parents (almost 25%).

Has there been a change over time?

The Australian Health Survey 2014–15 showed that in the 3 years since the last survey there was no significant difference in the overall proportion of overweight or obese 5-14 year olds (around 26%). There was a notable change in the proportion of overweight and obese children for country of birth. In 2011-12, children born in Australia were more likely to be overweight or obese (27%) than those born overseas (20%) but the opposite was observed in 2014-15, where fewer Australian-born children (26%) than overseas-born children (31%) were overweight or obese. There were fewer overweight or obese children with lone parents with children aged under 15 years in 2014-15 (28%) than in 2011-12 (35%). There was no change over this period of couples with children aged under 15 years (24% and 25%, respectively).

Notes

Error bars represent 95% confidence intervals. Caution should be taken if comparisons between values are made. Please refer to the Data Quality Statement (DQS) tab for further information.

Body mass index (BMI) is used to indirectly measure overweight and obesity in the child population. It is calculated as the ratio of weight in kilograms divided by height in metres squared (kg/m^2).

At the population level, international cut-off points are used to determine the number of children either overweight or obese based on their age and sex (Cole et al. 2000). In children, BMI changes substantially with age and can differ between boys and girls, rising steeply in infancy, falling during the preschool years and increasing through to adolescence and into adulthood (DoHA 2009).

The ABS 2011-12 Australian Health Survey collected physical measurements of the height and weight of around 85% of the children aged 5-14 sampled for the survey. Therefore, the estimate of the number of overweight and obese children presented assumes that the pattern of overweight/obesity amongst those children who were not measured is the same as for those who were.

CALD refers to Culturally and Linguistically Diverse background.

For more detailed information on the data refer to the data source tables.

References

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7. Dental health

Visualisation not available for printing

Why is dental health in children important?

Good oral health in childhood contributes to better wellbeing and improved dental outcomes in adulthood – less decay and the loss of fewer natural teeth.

Changes caused by dental decay (dental caries), either because of pain or aesthetic changes, affect children's quality of life, and a healthy smile has considerable bearing on social interactions and self-esteem (Bonecker et al. 2012; Rodd et al. 2011).

Negative impacts of dental decay on children's lives include: symptoms and functional alterations, such as chewing and speech impairment; schooling factors, such as school absenteeism and decline in academic performance; and, psychological issues, such as trouble sleeping, and irritability (Brennan, Spencer, Roberts-Thomson 2008; Jackson et al. 2011; Bonecker et al. 2012; Rodd et al. 2011).

Dental decay (dental caries) results from a complex interplay of genetic and biological factors, the social and physical environment, health behaviours, and dental and medical care (Fisher-Owens et al. 2007). Untreated dental decay can adversely affect children's growth, facilitating infection and the systemic spread of disease (Berg & Coniglio 2006). Decay in deciduous (baby) teeth is a risk factor for decay in permanent teeth (Skeie, Raadal, Stand, Espelid 2006).

Most dental diseases are largely preventable, however there are risks associated with dental disease. Early preventive strategies include parental counselling about diet, establishing sound oral hygiene practice, appropriate use of fluorides and the avoidance of transmission of bacteria from parents to children (Berg & Coniglio 2006).

Do mean DMFT vary across population groups?

In the 2010 Child Dental Health Survey, the national mean number of decayed, missing or filled permanent teeth (DMFT) among children aged 12 was 1.3. The mean DMFT was significantly higher in *inner regional* areas (1.8) compared with *major cities* (1.3), *outer regional* (1.3) and *remote and very remote* areas (1.4). Children aged 12 living in the lowest socioeconomic status (SES) areas experienced significantly higher DMFT than those in the highest SES area (1.6 compared with 1.0). Differences for children aged 12 by sex and Indigenous status were not statistically significant.

Has there been a change over time?

Nationally, the mean number of DMFT among 12 year olds was significantly higher in 2010 (1.3) than in 2002 (1.0). Similarly, over the same time period, the mean DMFT among 12 year olds living in areas with the lowest socioeconomic status (SES) areas was significantly higher in 2010 (1.6) than in 2002 (1.2).

Differences for 12 year olds by sex, remoteness and Indigenous status were not statistically significant.

Notes

Data were not available for New South Wales for 2001 to 2006 and 2008 to 2010 and for Victoria from 2005. National data by Indigenous status are not available from 2003–04 to 2007.

This indicator is based on survey data and 95% confidence intervals have been calculated. The confidence intervals are used to provide an approximate indication of the true difference between rates. If the 95% confidence intervals do not overlap, the difference can be said to be statistically significant.

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8. Injury deaths

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Why are child injury death rates important?

Injury is a leading cause of death for children aged 0–14 in Australia, and is also a major cause of hospitalisation (AIHW: Pointer 2014).

Children are particularly vulnerable to certain types of injuries, depending on their age which has often been considered to reflect development (Flavin et al. 2006; MacInnes & Stone 2008). As children develop and their mobility increases, the hazards they are exposed to change. Before children have the ability to properly assess the risks involved in new activities and avoid potential dangers, they are particularly vulnerable to injury (AIHW: Pointer 2014).

Emotional turmoil is common, sometimes leading to self-injurious behaviour, as is an increase in risk-taking behaviours, particularly among boys (Martin et al. 2010; Spear 2000). Over time, a child's ability to make decisions about their safety increases. Injuries sustained among older children are increasingly influenced by behaviour in addition to their physical and social environment.

Injuries sustained during childhood can have profound and lifelong effects on health and development, by causing permanent physical disabilities or long-term cognitive or psychological damage (for example, traumatic brain injury) (Gabbe et al. 2014).

Almost all life lost in infancy and early childhood was due to infant-related diseases, such as birth trauma and asphyxia, pre-term/low birthweight complications, sudden infant death syndrome and other disorders of infancy (AIHW 2016). From ages 5–14, the predominant causes of life lost were injuries and cancer. Injuries to motor vehicle occupants from road traffic injuries, other road traffic injuries and other cancers were the main causes of life lost for males (AIHW 2016). For females, brain cancer and road traffic injuries to motor vehicle occupants were leading causes of life lost in this age group (AIHW 2016).

Childhood deaths and hospitalisations as a result of injury are preventable and can be effectively reduced through the implementation of prevention strategies. Some of the strategies for preventing childhood injury include child-resistant containers, seatbelts and fencing around pools (Harvey 2009).

Do child injury death rates vary across population groups?

In 2014–16, injuries contributed to 547 deaths of children aged 0-14—a rate of 4.1 per 100,000 children. Overall, boys were 1.1 times more likely to die from injury than girls (5.7 compared to 5.1 per 100,000 population), although there was some variation by age group. Children (0–4 year olds) had the highest rate of injury death (6.8 per 100,000 children) compared to older children (5–9 years and 10–14 years accounting for 3.2 and 6.4 per 100,000 of children injury death, respectively).

For the period 2012-16, injury death rate among Indigenous children was 5.7 times as high as the rate for non-Indigenous children (24.4 compared to 4.3 per 100,000). During the same period, the injury death rate in Outer regional, remote and very remote areas (18.5 per 100,000 children) was 4.1 times higher than in Major cities and 2.8 times higher than in Inner regional areas (4.5 and 6.6 per 100,000 children, respectively). Children in the lowest socioeconomic areas also experienced higher injury death rates than those in the highest socioeconomic areas (11.2 injury deaths compared to 2.6 per 100,000 children, respectively).

Has there been a change over time?

The rate of injury deaths has gradually decreased between 2004-06 and 2014-16 from 6.2 per 100,000 children to 4.1 per 100,000 children. The injury death rate for boys was around 1.5 times as high as the rate for girls in 2004-06; however, this has declined to around 1.1 times the rate for girls in 2014-16. Children aged 0-4 years had consistently higher rates than the other age groups over this period but the rate has been gradually declining from 11 per 100,000 children in 2004-06 to 6.8 per 100,000 in 2014-16.

The injury death rate for Indigenous children has risen slightly from 15.3 per 100,000 children in 2005-09 to 24.4 per 100,000 children in 2012-16. Injury death rates for children living in Outer regional, remote and very remote areas were similar for the two periods reported: 2009-13 and 2012-16 (18.4 and 18.5 per 100,000 respectively).

Notes

Data by Indigenous status, remoteness and socioeconomic position are calculated using data for a five-year period for data quality reasons (small numbers). This aligns with the reporting for sex and age (which use a three-year period) as follows:

Sex and age	Indigenous status, Remoteness, Socioeconomic position
2004–2006	2002–2006
2005–2007	2003–2007
2006–2008	2004–2008

2007–2009	2005–2009
2008–2010	2006–2010
2009–2011	2007–2011
2010–2012	2008–2012
2011–2013	2009–2013
2012–2014	2010–2014
2013–2015	2011–2015
2014–2016	2012–2016

Causes of death are classified according to the International Classification of Diseases and Related Health Problems, 10th revision (ICD-10). Injury deaths include ICD-10 multiple cause of death (S00-T75 or T79) or underlying cause of death (V01-Y36, Y85-Y87 or Y89).

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9. Early childhood education

Why is early childhood education important?

Early childhood is a critical period for child neurological and behavioural development. Early childhood education has been found to improve school readiness, communication and behaviour (Silburn et al. 2011), particularly in those from disadvantaged backgrounds (AIHW 2012). Those who attended early childhood education are found to have higher academic outcomes later in life, including higher vocabulary and cognitive scores (Harrison et al. 2009).

In Australia, early childhood education services are provided by government and non-government organisations, through kindergartens, preschools and early learning centres (ABS 2014a).

Early childhood education prepares a child for school and provides a solid foundation for learning and achieving at school and beyond. Evidence shows that participation in preschool has a significant positive impact on vocabulary for Indigenous students in the following two years (Arcos Holzinger & Biddle 2015). Three to five years after preschool enrolment, positive impacts included developmental outcomes as well as reading and maths achievements. Importantly, evidence shows 15-year-old students who had attended at least a year of preschool outperformed students who had not, even for socioeconomic background (OECD 2014).

In recent years, the Australian Government and state and territory governments have committed to increase participation in high-quality early childhood education and care. A particular focus has been on increasing participation rates of Indigenous children and children from a disadvantaged background. As part of this commitment, the Australian Government undertook a review of child care and early childhood learning between 2014 and 2015. The final report from the review was released in February 2015 (Productivity Commission 2014).

Does enrolment vary across population groups?

In 2017, over 292,000 children aged 4 or 5 years were enrolled in an early childhood education program in the year before starting primary school. There were almost 154,000 boys and 139,000 girls enrolled in early childhood education programs, equating to roughly 15,000 more boys than girls. There were 15,500 Indigenous children enrolled in early childhood education programs.

Has there been a change over time?

The presentation of the proportion of children enrolled in an early childhood education program in the year before starting primary school for 2016 and 2017 represents a break in series. As such, comparisons with previous years are not made. There is not yet enough data for a time series comparison of enrolment rates.

The number of children attending an early childhood education program increased by approximately 16,400 children from 2013 to 2014 (around 281,000 and 297,400, respectively). This number further increased by approximately 14,600 to just over 312,000 in 2015.

The number of Indigenous children attending an early childhood education program remained relatively steady between 2013 and 2014 (at around 12,250), but increased to over 14,000 in 2015. The number of children living in the lowest socioeconomic areas attending such a program increased by about 2,000 between 2013 and 2014, with an even larger increase of over 3,000 between 2014 and 2015 to 54,680. The number of 4 and 5 year olds attending an early childhood education program in Remote areas, was relatively stable at around 4,400 over the three years, with the same observed stability in Very remote areas, at around 2,500. Changes between 2014 and 2015 are due in part to an expanded service and child identification and imputation strategy introduced for the 2015 collection of data from long day care centres.

Notes

For 2012 to 2015 data, numbers of children attending early childhood education are presented for this indicator rather than proportions due to difficulties with using different sources for numerator and denominator data. For 2016 and 2017 data, proportions of children enrolled in early childhood education are reported. The inclusion of enrolment data aligns the indicator with the reporting practices of other bodies that publish data on preschool participation, such as the Productivity Commission's Report on Government Services, and the Australian Bureau of Statistics' Preschool Education publication.

In order to have a nationally comparable preschool participation rate for children in the year before full-time schooling begins (the 'universal access' target cohort), proportions have previously calculated using the total population of 4 year olds as an approximate measure for the 'year before school' target cohort as the denominator. However, as there are a small number of children aged 5 who attend an early education program in the year before beginning primary school, the numerator includes children aged 4 and 5 which results in some attendance rates of greater than 100%.

In addition, some children attend early childhood education programs in a different geographical area to which they reside (such as state/territory, remoteness area, socioeconomic status area). There are also issues affecting the availability and quality of ABS Indigenous population data at fine levels of disaggregation by jurisdiction (ABS2014b).

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10. Transition to primary school

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Why is measuring the transition to primary school important?

Starting school is key milestone in any child and family's life. Many elements influence a child's ability to make this transition successfully, including community, family and individual factors such as parental socioeconomic position, parental education and mental health, child health, home and community environment and participation in a quality preschool program (Elliot 2006). Evidence suggests that children who have a positive start to school are likely to engage well and to experience academic and social success (Farrer et al 2007). The starting age for the first year of school varies between 5 and 6 across states and territories.

The Australian Early Development Census (AEDC) is a national measure of children's development, as they enter their first year of full-time school. The AEDC highlights what is working well and what needs to be improved or developed to support children and their families, and helps communities know how their children are progressing. (Australian Government Department of Education and Training 2016).

Do rates vary across population groups?

In 2015, over 1 in 5 (22%) Australian children were developmentally vulnerable on 1 or more domains of the AEDC. Girls were less likely to be developmentally vulnerable on this measure (around 16%) than boys (around 29%).

Indigenous children were twice as likely to be developmentally vulnerable on 1 or more domains as non-Indigenous children (around 42% compared with around 21%, respectively).

Overall, children with a language background other than English (LBOTE) were more likely to be developmentally vulnerable on 1 or more domains than children who only spoke English (around 28% compared with around 20%). However, children from both LBOTE and English-only backgrounds can be either proficient or not proficient in English. Results published by the Australian Government in 2016 have found that children who were proficient in English and have LBOTE status were less likely to be developmentally vulnerable on 1 or more domains of the Australian Early Development Census (around 19%) than children who had a LBOTE status and were not proficient in English (around 94%) (Australian Government Department of Education and Training 2016).

Children living in Very remote areas were more than twice as likely to be developmentally vulnerable on 1 or more domains compared with children living in Major cities (47% compared with 21%). Children living in the lowest socioeconomic areas were also more likely to be developmentally vulnerable on 1 or more domains than children living in the highest socioeconomic areas (around 33% compared with around 16%).

Has there been a change over time?

The proportion of children who were developmentally vulnerable on 1 or more domains at the national level has been constant between 2012 and 2015 (at 22%), but is lower than in 2009 (around 24%). For both boys and girls, the rate decreased between 2009 and 2012 (boys decreased from 30% to 29% and girls decreased from 17% to 16%), but has remained relatively stable between 2012 and 2015. The rate of Indigenous children found to be developmentally vulnerable on 1 or more domains has decreased over the three censuses, from 47% in 2009 to 43% in 2012 and 42% in 2015.

The proportion of children living in *Very remote* areas who were developmentally vulnerable on 1 or more domains has increased from around 45% in 2009 to 47% in 2015. The proportion of children who were developmentally vulnerable on 1 or more domains living in the lowest socioeconomic areas remained stable, at around 33% for all the years reported. Slightly more variability was observed in the highest socioeconomic areas (17% in 2009; 14% in 2012; 16% in 2015).

Notes

The Australian Early Development Census (AEDC), known as the Australian Early Development Index (AEDI) until 1 July 2014, was introduced in 2009 as a population measure of children's health and development in different communities across Australia.

The AEDC measure is based on the scores from a teacher-completed Instrument about children in their first year of full-time school. The average age of children at the time the Australian version of the Early Development Instruments were completed is 5 years and 7 months (Australian Government Department of Education and Training 2016). Domains covered include physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), communication skills and general knowledge. For each of the five AEDC domains, children receive a score between zero and ten, where zero is most developmentally vulnerable. The AEDC results are then reported as percentage of children who are considered to be 'developmentally on track', 'developmentally at risk' and 'developmentally vulnerable' on each domain.

In the first data collection cycle a series of cut-off scores was established for each of the five domains:

- children falling below the 10th percentile were categorised as 'developmentally vulnerable'
- children falling between the 10th and 25th percentile were categorised as 'developmentally at risk'

- all other children were categorised as 'developmentally on track'.

The cut-off scores set in 2009 provide a reference point against which later AEDC results can be compared. These have remained the same across the three collection cycles.

Children are considered 'LBOTE' if they speak a language other than English at home, or if they speak English at home but are still considered to have English as a second language (ESL) status. Indigenous children who have LBOTE status are part of the LBOTE group. For example, it is possible for children to be both Indigenous and have LBOTE status.

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11. Attendance at primary school

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Why are primary school attendance rates important?

Attendance at school, in particular primary school, exposes children to opportunities to develop the basic building blocks for learning and educational attainment, as well as social skills such as friendship building, teamwork, communication skills and healthy self-esteem. Attendance patterns have been found to be established early in school life, and disparities in attendance tend to be carried into, and become greater in secondary school. (Hancock et al. 2013). Children who are regularly absent from school are at risk of missing out on these critical stages of educational development and may experience long-term difficulties with their learning, resulting in fewer educational and employment opportunities. Absenteeism can also exacerbate issues of low self-esteem, social isolation and dissatisfaction (Vic DHS 2008). Attendance rates generally fall in secondary school and thus it is important that initiatives that are aimed at improving attendance start early (Hancock et al. 2013). Prolonged non-attendance in adolescents is also associated with increased substance use, high-risk sexual behaviour and teenage pregnancy, violence, suicide attempts and unintentional injury. Absenteeism is also associated with mental health issues over the longer-term (Hawkrigg and Payne 2014).

Indigenous students have higher rates of absenteeism and suspension, and lower rates of school completion than non-Indigenous students, which limit their future life choices and ability to achieve their full potential (Helme & Lamb 2011). Increasing attendance at primary school for disadvantaged populations, particularly for Indigenous children, is expected to help reduce the considerable gap that currently exists in academic achievement between different socio-economic population groups within Australia.

A recent study by the Productivity Commission (2016) found that lower average school attendance rates were associated with poorer Indigenous literacy and numeracy results in primary school (Productivity Commission 2016). School attendance is affected by a range of underlying issues such as housing, health care, mental health issues, family violence and intergenerational unemployment (Mission Australia 2016).

Research shows that students from low socioeconomic status background have significantly lower attendance rates, especially in secondary school, than other students (Hancock et al. 2013). ACWP survey data shows that mobility of young people, in terms of moving home or school several times in a short period, is associated with lower attendance rates at school (Redmond et al. 2016).

Do primary school attendance rates vary across population groups?

In 2016, the Australian Curriculum, Assessment and Reporting Authority (ACARA) reported that the national attendance rate of children in Year 5 was around 94%, with girls having similar attendance rates to boys (around 94% and 93%, respectively). Major cities had the highest attendance rate (around 94%), with attendance decreasing with remoteness (to around 77% in Very remote areas).

At the same time, the attendance rates for Indigenous children (around 86%) were lower than for non-Indigenous children (94%); with the largest difference observed in the Northern Territory (around 73% for Indigenous, compared to around 93% for non-Indigenous children) and the smallest difference observed in Tasmania (around 92% for Indigenous, compared to around 94% for non-Indigenous children).

Attendance rates did not vary significantly between school sectors (Catholic, Independent, and Non-government schools —reported 94%, 95% and 94% Year 5 attendance rates, respectively), but were slightly lower for Government schools (93%) (see Notes section for definitions of 'school sector').

The proportion of students who attend school 90% or more of possible days nationally for 2016 was 80.8%, with higher proportions observed in New South Wales and Victoria (84.2% and 82.8%, respectively), compared with Northern Territory (56.2%) (see Notes section for definition).

Has there been a change over time?

Attendance rates for Year 5 students have changed little within the population groups presented, by state and territory between 2014, 2015 and 2016.

Notes

ACARA developed the National Standards for Student Attendance Data Reporting (national standards) to standardise reporting across Australia for comparability purposes. Government and non-government providers of attendance data are obliged to draw on them when providing data for national reporting purposes (ACARA 2015).

In the AIHW published report 'Headline indicators for children's health, development and wellbeing 2011', substantial differences were highlighted in the different ways that data were collected in jurisdictions and across sectors resulting in poor comparability of attendance figures (AIHW 2011). In the intervening period, the non-government sectors (Catholic and independent schools) complied with the standards from 2013 onwards; government schools in all jurisdictions except New South Wales, from 2014 (ACARA 2015). Consequently, only data for 2014, 2015 and 2016 are reported.

New South Wales government schools are working towards being fully compliant with the National Standards.

Beginning in 2016, NAPLAN results are reported using the ABS Australian Statistical Geography Standard (ASGS) to classify each school's geographical location (geolocation). As a result, the geolocation results obtained from the National Standards for Student Attendance Data Reporting 2016 are not directly comparable to those of previous cycles.

The National Report on Schooling in Australia uses the term 'school sector' to distinguish between government and non-government schools. Government schools are established and administered by State and Territory governments through their education departments or authorities. Non-government schools, usually with some religious affiliation, are established and operated under conditions determined by State and Territory Governments through their registration authorities. School sector is also used to distinguish between non-government schools as Catholic or independent. Catholic schools are affiliated with the Catholic Church and make up the largest group of non-government schools. Independent schools may be associated with other religions, other denominations, particular educational philosophies or operate as single entities (see ACARA glossary for more details).

References

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12. Literacy

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Why are literacy rates important?

Literacy skills enable children to engage in learning and ultimately to fully participate in society and lead productive lives.

Literacy is often thought to involve reading, writing and understanding the conventions of language (DECD 2013). While these aspects are very important, they do not cover the entire field of literacy. A broader definition of literacy is defined by OECD as the ability to understand, use and reflect on written texts in order to achieve one's goals, to develop one's knowledge and potential, and to participate effectively in society (Schneider, Keseler, Morlock 2010).

Research shows that highly developed numeracy and literacy capabilities strongly contribute to the social, economic and physical wellbeing of individuals (DECD 2013). The building blocks for literacy start very early in life and a child's early literacy skills are a predictor of later literacy and academic achievement (Neuman & Dickinson 2010). Literacy levels will also affect children's opportunities in life for education, employment, income and wellbeing later in life (Goldfeld et al. 2011; Goldfeld et al. 2012).

A number of factors affect successful educational outcomes during the school years, such as young person's home environment (including whether books are available at home and whether parents read aloud to their children), their engagement with the school, the quality of their educational experience and their attitudes to school and learning (Walsh & Black 2009). Several other factors have also been shown to have an impact, such as resources, parental level of education and socioeconomic position (Walsemann et al. 2008).

Do literacy rates vary across population groups?

In 2017 NAPLAN, the majority of Year 5 students (94%) met the national minimum standard of reading. Girls were more likely to perform better than boys in reading, 96% met the minimum standards compared to 92%. This may be attributed to a tendency for boys to be less interested and engaged in reading activities (AIHW 2012). It is also thought that boys are less likely to be encouraged to read and more likely to experience anxiety about reading (Malloy & Botzakis 2005). Non-Indigenous students were more likely to achieve at or above the national minimum standard than Indigenous students (95% and 76%, respectively).

Students from English-speaking backgrounds were slightly more likely to achieve at or above the national minimum standard in reading than those with language background other than English (LBOTE) (95% and 92%, respectively). Year 5 students in Major cities were more likely to achieve at or above the national minimum standard in reading than those in Remote or Very remote areas (95% compared with 84% and 53%, respectively). The national minimum standard of reading was higher in Year 5 students whose parents had a Bachelor or Diploma (98% and 96%, respectively), compared with Year 12 and Year 11 education (92% and 82%, respectively).

Has there been a change over time?

The proportion of students achieving at or above the national minimum standard for reading has increased slightly since 2008, rising 5.1 percentage points from 91% in 2008 to around 96% in 2013. The proportion has remained relatively stable at around 93% between 2014 and 2016, increasing slightly to 94% in 2017. Similar patterns were seen among boys and girls, with the proportion of boys achieving at or above the national minimum standard increasing 2.9 percentage points from about 89% in 2008 to about 92% in 2017 and the proportion of girls achieving at or above the national minimum standard increasing 2.9 percentage points from almost 93% in 2008 to almost 96% in 2017. Both boys and girls remained stable at around 91-92% and 95-96%, respectively, between 2014 and 2017. The proportion of Indigenous students achieving at or above the national minimum standard for reading increased 12.1 percentage points from just above 63% in 2008 to just below 76% in 2017. For students with a LBOTE, the proportion of students achieving at or above the national minimum standard increased 4.5 percentage points from almost 88% to 92%, between 2008 and 2017.

Notes

The National Assessment Program – Literacy and Numeracy (NAPLAN) tests are the only Australian assessments that provide nationally comparable data on the performance of students in the vital areas of literacy and numeracy. Year 5 reading data is being used for this indicator. Estimated percentage meeting the national minimum standards is based on assessed students. Year 5 corresponds to different average duration of formal schooling and average student age across the states and territories. Refer to source for details.

For Indigenous status, students for whom this was not stated are excluded from the Indigenous status analysis.

LBOTE refers to Language Background Other Than English.

Beginning in 2016, NAPLAN results are reported using the ABS Australian Statistical Geography Standard (ASGS) to classify each school's geographical location (geolocation). As a result, the geolocation results obtained from the 2016 and 2017 NAPLAN are not directly comparable to those of previous cycles.

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13. Numeracy

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Why are numeracy rates important?

Numeracy skills enable children to engage in learning and ultimately to fully participate in society and lead productive lives.

Numeracy skills are a building block for further educational attainment, social development and employment. Numeracy is central to many areas of education, and life outside school. The OECD defines numeracy as the ability to access, use, interpret and communicate mathematical information and ideas, in order to engage in and manage the mathematical demands of a range of situations in adult life (Dumont 2012).

Numeracy is not limited to the ability to use numbers, to add, subtract, multiply and divide. Numeracy encompasses the ability to use mathematical understanding and skills to solve problems and meet the demands of day-to-day living in complex social settings (Dumont 2012). Children who are able to apply mathematical understanding and communicate effectively in a range of contexts – economic, technical, scientific and social – are best placed to succeed in education and in life (DECD 2013).

The national science, technology, engineering and mathematics (STEM) education strategy is focused on action that lifts foundation skills in STEM learning areas, develop mathematical, scientific and technological literacy, and promotes the development of the 21 st century skills of problem solving, critical analysis and creative thinking (Education Council 2015. International research shows that building STEM capacity across the population is critical in helping to support innovation and productivity regardless of occupation or industry (Education Council 2015).

Do numeracy rates vary across population groups?

In 2017 NAPLAN, the majority of Year 5 students (95%) met the national minimum standard for numeracy. Girls were slightly more likely to achieve at or above the national minimum standard than boys, with 96% of girls meeting the national minimum standard for numeracy compared to 95% of boys. Students from non-Indigenous backgrounds were more likely to achieve at or above the national minimum standard than Indigenous students (96% and 80%, respectively).

Students from a language background other than English (LBOTE) were slightly less likely to achieve at or above the national minimum standard in numeracy than their non-LBOTE counterparts (94% and 96%, respectively). Year 5 students in Remote or Very remote areas were less likely to achieve at or above the national minimum standard in numeracy than those in Major cities (87% and 61% of students respectively, compared with 96% of students in Major cities). The national minimum standard of numeracy was higher in Year 5 students whose parents had a Bachelor or Diploma (99% and 97%, respectively), compared with Year 12 and Year 11 education (94% and 86%, respectively).

Has there been a change over time?

The proportion of students achieving at or above the national minimum standard for numeracy has increased slightly since 2008, rising 2.7 percentage points from around 93% in 2008 to over 95% in 2017. Similar patterns were seen among boys and girls, with the proportion of boys achieving at or above the national minimum standard increasing 2.0 percentage points from almost 93% in 2008 to almost 95% in 2017, and the proportion of girls increasing 3.4 percentage points from around 93% in 2008 to almost 96% in 2017. The proportion of Indigenous students achieving at or above the national minimum standard for numeracy increased 11.0 percentage points from just over 69% in 2008 to just over 80% in 2017. For students with a LBOTE, the proportion of students achieving at or above the national minimum standard increased 3.4 percentage points from almost 91% to just over 94% between 2008 and 2017.

Notes

The National Assessment Program – Literacy and Numeracy (NAPLAN) tests are the only Australian assessments that provide nationally comparable data on the performance of students in the vital areas of literacy and numeracy. Year 5 numeracy data is being used for this indicator. Estimated percentage meeting the national minimum standards is based on assessed students. Year 5 corresponds to different average duration of formal schooling and average student age across the states and territories. Refer to source for details.

For Indigenous status, students for whom this was not stated are excluded from the Indigenous status analysis.

LBOTE refers to Language Background Other Than English.

Beginning in 2016, NAPLAN results are reported using the ABS Australian Statistical Geography Standard (ASGS) to classify each school's geographical location (geolocation). As a result, the geolocation results obtained from the 2016 and 2017 NAPLAN are not directly comparable to those of previous cycles.

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14. Teenage births

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Note break in series from 2011 for Birthplace (mother) and Remoteness, for more details seethe data source tables for this indicator.

Why are teenage birth rates important?

Teenage motherhood poses significant long-term risks for both mother and child, including poorer health, educational and economic outcomes. Babies born to teenage mothers have an increased risk of pre-term birth, low birthweight and associated complications (Gupta et al. 2008). Children born to teenage mothers may also be more likely to have poorer emotional, cognitive and behavioural outcomes and to be born into and continue to live in disadvantaged socioeconomic situations (Paranjothy et al. 2009; Chittleborough et al. 2011).

A number of factors have been associated with teenage birth, with the most widely cited being a family history of teenage pregnancy, socioeconomic disadvantage, one-parent family structure and family breakdown (Gaudie et al. 2010). While not all teenage births result in negative outcomes for mother and child, the factors that often contribute to teenage birth mean that many young mothers do not receive the support they need during pregnancy and after the birth.

Do teenage birth rates vary across population groups?

In 2015, teenage mothers gave births to over 8,000 live-born babies, a rate of about 11 live births per 1,000 females aged 15-19. The teenage birth rate for Indigenous women was about 5.8 times the rate for non-Indigenous teenage women (52 per 1,000 females, compared to 9 per 1,000 females). The teenage birth rate for overseas-born teenage women was lower (8 per 1,000 females) than among Australian-born teenage mothers (12 per 1,000 females).

The teenage birth rate was 9 times as high among teenage women from the lowest socioeconomic areas (over 24 per 1,000 females), as that for teenage women from the highest socioeconomic areas (nearly 3 per 1,000 females). Similarly, those living in Remote and very remote areas (47 per 1,000 females) were 5.9 times more likely to have a teenage birth than mothers born in Major cities (8 per 1,000 females).

Has there been a change over time?

The teenage birth rate has declined slightly in the 10 years to 2015 from around 18 per 1,000 females in 2006 to about 11 per 1,000 in 2015. The Indigenous teenage birth rate has also declined during this period from 70 to 52 per 1,000 females.

Between 2013 and 2015, the rate for live births among overseas-born teenage women decreased from 10 per 1,000 to about 8 per 1,000 females. Over the same period, the rate among teenage women living in the lowest socioeconomic areas decreased by almost 5 per 1,000 females from 29 per 1,000 females. The teenage birth rate for teenage women living in Remote and very remote areas also decreased from 53 per 1,000 females in 2013 to 47 per 1,000 females in 2015.

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15. Family social network

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Why is the family social network important?

Family social network broadly refers to a child's social network comprising their immediate family, as well as the family's broader social network. The quality of the relationships and interactions in a child's social environment affects a child's health, development and wellbeing. Families with rich social networks have been found to have increased access to information, material resources, and friends and neighbours to assist them in managing their daily lives and problems. Support provided by social institutions and from formal and informal social networks is important to healthy development and overall child wellbeing (Ferguson 2006; Runyan et al. 1998; Sheldon 2002; Waters et al. 2002; Wise 2003; Zubrick et al. 2008).

Social support and sharing experiences with other parents can support better parenting and result in improved outcomes for children, including decreasing the likelihood that children drop out of school or commit delinquent acts, improving outcomes for youth in finishing school and gaining employment, improving positive behavioural outcomes for at-risk preschool children and lowering levels of depression in at-risk teens (Ferguson 2006).

Strong family relationships and supportive neighbourhoods can also act as a protective factor against socioeconomic disadvantage and buffer the effects of other risk factors (Zwi & Henry 2005). Conversely, living in isolation from extended family networks and support services is associated with less effective parenting behaviours and practices and poorer parental mental health, which are associated with poorer health, development and wellbeing outcomes for children (Wise 2003; Zubrick et al. 2008).

Does the use of the family social network vary across population groups?

In the ABS General Social Survey 2014, the proportion of parents or guardians who 'somewhat agreed' or 'strongly agreed' with being able to get help when needed (i.e. the rate of use of the family social network) was slightly higher for those with younger children (88% for children 0-4 years of age) relative to older children (87% for 5-14 years of age). The data also showed that more Australian-born parents/guardians (88%) felt that they could get help when needed compared with parents/guardians born overseas (85%).

Family social networks are affected by socioeconomic position, with lowest two quintiles reporting that 85% agreed or strongly agreed with being able to get help when needed, compared to 88% of the top three quintiles. The largest observed difference in the rate of those who felt that they could get help when needed is associated with family type — one-parent, one-family households were less likely to agree that they could get help when needed (81%), compared with 88% of couples in a one-family household. However, this pattern is not consistent across the states and territories — one-parent, one-family households felt that they could get help when needed at a higher rate than couples in a one-family household in South Australia, Tasmania and the Northern Territory.

Has there been a change over time?

No trend data are available.

Notes

In consultation with experts and through a literature review, 9 potential indicators were identified by the AIHW for the *Family social network* priority area. More information on the consultation outcomes can be found in the AIHW's paper on this issue (AIHW 2010). Subsequent consultation produced agreement that 'the proportion of children aged 0-12 years whose parent or guardian was usually able to get help when needed' is the most suitable indicator. Since the publication of the *Headline Indicators for children's health, development and wellbeing 2011* (AIHW 2011) report, a new question has been added to the General Social Survey by the ABS.

In the new question in the General Social Survey, there are five response codes in a Likert scale, ranging from 'Strongly agree' to 'Strongly disagree'. The first two categories can both be considered affirmative responses to the question and are used in the measure.

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16. Family economic situation

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Why is family economic situation important?

Low family income can adversely affect the health, education and self-esteem of children. Decades of research have provided evidence that low family income unfavourably affects children's outcomes (Duncan et al. 2013). For most families, regular adequate income is the single most important determinant of their economic situation. Children living in households without sufficient income are at a greater risk of poor health and educational outcomes, both in the short and long term (Ryan et al. 2012). Low income affects a child's diet and access to medical care, the safety of their environment, level of stress in the family, quality and stability of their care and provision of appropriate housing, heating and clothing (AIHW 2011; AIHW 2012).

In addition, studies have shown that children from low-income families are more prone to psychological or social difficulties, behaviour problems, lower self-regulation and elevated physiological markers of stress (Barnett 2008).

Does family economic situation vary across population groups?

In the 2015-16 ABS Survey of Income and Housing, there were an estimated 481,200 low income households with dependent children aged 0–14 years receiving an average real equivalised disposable income of $542. Equivalised disposable income is income left after tax that has been adjusted to account for the number of people living in the house and number of household incomes so that comparisons across households can be made. Further detail about this methodology is provided in the notes section.

The largest observed differences are in relation to family type; couple family households had a higher disposable income ($540 per week) compared to one-parent family households ($523).

There was little difference in income for households with the eldest dependent child in the 0–4 age group, relative to households with a child in the 5–14 year old age group ($541 compared with $542). Similarly, there was little difference reported between families with dependent children born in Australia ($539) relative to those with children born overseas ($534).

There was no obvious association between remoteness and equivalised household income, with households in Major cities having slightly higher income ($539) than households in Inner regional areas ($528), which in turn have lower income than households in Outer regional and remote areas ($544).

Has there been a change over time?

Over six survey periods between 2005-06 and 2015-16, the national mean equivalised disposable household income for households with dependent children aged 0-14 years in the second and third income deciles has increased year-on-year, in real 2015-16 dollars, from $449 in 2005-06 to $542 in 2015-16. This same trend has been observed for most of the population groups presented, with more pronounced variability observed for multiple family households and Inner regional areas, both experiencing a decrease in real household income between 2007-08 and 2009-10.

Notes

Equivalised household income is total household income adjusted by applying an equivalence scale. This makes it possible to compare income levels between households with different sizes and compositions. It reflects the need for larger households to have a higher level of income to achieve the same standard of living as a smaller household.

The equivalence scale allocates 1.0 point for the first adult (aged 15 years and over) in a household; 0.5 for each additional adult; and 0.3 for each child. Equivalised household income is derived by dividing total household income by the sum of the equivalence points allocated to household members. For example, if a household received combined gross income of $2,100 per week and comprised two adults and two children (combined household equivalence points of 2.1), the equivalised gross household income would be calculated as $1,000 per week (ABS 2013)

Low income households were defined as those in the second and third income deciles. The lowest decile is excluded because household income is not always a good measure of the total economic resources available to many people with an income close to nil or negative (some may own their homes and thus have low housing costs, some may be between jobs, or on holiday without pay and some may report negative returns on investments).

Deciles are formed using equivalised disposable household income of all households. Income is usually received by individuals but shared among family members. Household size and composition can therefore have a large impact on the standard of living that a given income can support. For this reason, income deciles are formed using equivalised disposable household income of all households, whereby an equivalence scale is used to adjust household income for household size and composition.

Data for all years are expressed in 2015-16 dollars.

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17. Child abuse & neglect

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Different policies and practices in jurisdictions influence the collection of administrative data. Differences in policy, practice, legislation and data systems must be taken into consideration when interpreting all child protection data. See Child protection Australia 2016-17 for further information.

Why is reporting child abuse and neglect rates important?

While most children in Australia grow up in safe family environments, some are subject to maltreatment in the form of abuse and/or neglect.

Abuse and neglect can cause significant long-term harm. Adverse effects of child abuse and neglect have been found to be significant and diverse in nature and may include: reduced social skills; poor school performance; impaired language ability; a higher likelihood of criminal offending; and mental health issues such as eating disorders, substance abuse and depression (Chartier et al. 2007; Gupta 2008).

In response to the complex nature of child abuse and neglect, the then Community and Disability Services Ministers' Advisory Committee (CDSMAC) developed the National Framework for Protecting Australia's Children 2009-2020. The National Framework focuses on improving child safety and wellbeing through prevention, early intervention and best practice strategies, with an overarching goal of a substantial and sustained reduction in child abuse and neglect over time (COAG 2009).

Do child abuse rates vary across population groups?

In the 2016–17 AIHW Child Protection Data Collection, the national rate of children aged 0–12 who were the subject of a child protection substantiation was 10.0 per 1,000 children, with a slight difference between boys and girls (9.9 per 1,000 and 9.8 per 1,000, respectively). Infants (children aged under 1) were most likely to be the subject of a substantiation (16.4 per 1,000 children) compared with children aged 1–4 (9.4 per 1,000 children) and children aged 5–12 (8.8 per 1,000 children). The high substantiation rate for infants is partly due to an increased focus on early interventions for infants, a group recognised as requiring extra care and protection due to their vulnerability (AIHW 2016).

Indigenous children were around 7.1 times as likely as non-Indigenous children to be the subject of substantiated abuse or neglect (52.4 per 1,000 compared with 7.4 per 1,000). The reasons for the over-representation of Indigenous children in child protection substantiations are complex: the legacy of past policies of forced removal; intergenerational effects of previous separations from family and culture; lower socioeconomic status; and perceptions arising from cultural differences in child-rearing practices are all underlying causes for their over-representation in the child welfare system (HREOC 1997).

Has there been a change over time?

While the national substantiation rate decreased from 7.5 per 1,000 children in 2007–08 to 7.0 per 1,000 in 2010–11, the rate has increased to 10.0 per 1,000 in 2016-17. For Indigenous children, the rate was relatively constant at around 34 per 1,000 children over the period 2007-08 to 2010-11. Since this time, the rate has increased steadily to 52.4 per 1,000 children in 2016-17. Although a real change in the incidence of abuse and neglect may contribute to the observed fluctuation, increased community awareness and changes to policy, practice and legislation in jurisdictions are also contributing factors (AIHW 2016).

For data on the rate of children aged 0–17 years who are in out-of-home care see the AIHW's website on the National framework for protecting Australia's children (Indicator 0.2).

Notes

Different policies and practices in jurisdictions influence the collection of administrative data. Limited specificity in the technical specifications and different interpretation and application in data collection and reporting impact on national comparability. See Child protection Australia 2016-17 for further information.

Substantiations of notifications occur when an investigation has concluded and there is reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed (AIHW 2017).

The AIHW collects and reports national data on child protection notifications, investigations, substantiations and other components of the child protection system. While the child protection systems and processes are broadly similar in each jurisdiction, child protection legislation, policies and practices vary. Therefore, caution needs to be taken when comparing child protection data across jurisdictions, or over time. See Child Family Community Australia resource sheet for a table of mandatory reporting requirements across Australia.

For data disaggregated by Indigenous status, 'Other children' includes non-Indigenous children and children for whom Indigenous status was unknown. In 2014-15, Indigenous status was unknown for 2.5% of children.

All rates for child abuse and neglect have been calculated using revised population estimates based on the 2011 Census. This includes updates to rates previously reported in this data portal.

From 2012–13, the Child Protection data collection reports unit record level data, which replaces the aggregate data previously used for national reporting. NSW and Queensland data for 2012–13 and 2013–14, and NSW data for 2014–15 were provided at aggregate level. Unit record level data were not available for NSW in 2015–16; aggregate data have been reported.

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18. Social & emotional wellbeing

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Why is social and emotional wellbeing important?

Social and emotional wellbeing focuses on the individual social and emotional strengths of children, rather than simply the absence of mental ill health. A key feature is the focus on the strengths of families, schools and communities and the influence that these environments have on children's social and emotional wellbeing (Hamilton & Redmond 2010).

Viewing social and emotional wellbeing through an ecological frame can help identify individual internal and relational characteristics of social and emotional wellbeing. These influences include proximal environments (such as the home, early childhood education and care settings and school), as well as more distal one (such as the wider community and society at large). Social and emotional wellbeing involves interactions between these multiple environments (home, school and community), as well as the individual and relational characteristics of the child.

Social and emotional wellbeing emphasises the experience of positive behaviours and emotions, as well as how the individual adapts and copes with daily challenges (through resilience and coping skills) while leading a fulfilling life. These skills are dynamic in that they form the social and emotional foundations of future behaviours, emotions, and abilities to adapt.

Does social and emotional wellbeing vary across population groups?

The second Australian Child and Adolescent Survey of Mental Health and Wellbeing (also known as the 'Young Mind Matter Survey'), found that in 2013-14, the proportion of individuals classified in the 'abnormal' range on the SDQ (Strengths and Difficulties Questionanaire) scale increased with age, with 7.3% of 4-6 year olds classified as 'abnormal' compared with 12% of 10-12 year olds. The survey also reported that girls have a substantially lower 'abnormal' classification rate (7.7%) than boys (13%). Overseas-born children also have a lower rate of 'abnormal' classification (6.2%) relative to those born in Australia (11%).

Socioeconomic position is strongly associated with the rate of 'abnormal' classification: those in the most disadvantaged quintile have a rate of 16%, while the least disadvantaged have a rate of 7.2%. The family composition of the child's household is also related to the rate of 'abnormal' classifications with a higher rate observed for step-families, blended families, and families with one parent or carer (16%, 18% and 18%, respectively) relative to families with two parents or carers, and original families (8.6% and 7.3%, respectively).

Has there been a change over time?

No trend data is available. The results of the second Australian Child and Adolescent Survey of Mental Health and Wellbeing are not comparable to the first Australian Child and Adolescent Survey of Mental Health and Wellbeing as different instruments were used.

Notes

In 2011-12, the AIHW were funded by the then Australian Government Department of Families, Housing, Community Services and Indigenous Affairs to develop a Children's Headline Indicator for Social and Emotional wellbeing. The process undertaken involved:

- conceptualising social and emotional wellbeing — defining its scope, theoretical basis, and main elements
- reviewing the literature on social and emotional wellbeing and children's outcomes
- identifying possible indicators by reviewing indicator frameworks and reports
- consulting key experts and stakeholders.

The process was supported by the Headline Indicator Data Development Expert Working Group, with a Social and Emotional Wellbeing Workshop convened to engage as many key stakeholders as possible to guide the development process.

An information paper was produced by AIHW, in consultation with experts and key stakeholders, which strongly supported the use of the Strengths and Difficulties Questionnaire (SDQ) as the most appropriate tool for measuring social and emotional wellbeing in children (AIHW 2012). This instrument has been extensively validated and is used widely as a population measure, both internationally and in Australia. The Children's Headline Indicator for social and emotional wellbeing is defined as the proportion of children scoring 'of concern' (also known as 'abnormal') on the SDQ.

The Strengths and Difficulties Questionnaire (SDQ) consists of a brief behavioural screening questionnaire comprising five subscales of five items each. Items in four of these subscales — emotional problems, conduct problems, hyperactivity and peer problems — are combined to generate a total difficulties score. Scores are assigned a category of 'normal', 'borderline' and 'abnormal' which are reported here. Scores in the 'abnormal' range indicate substantial risk of clinically significant problems. The SDQ was designed so that approximately 10% of children and adolescents will fall into the 'abnormal' range on the total difficulties score.

The Young Minds Matter Survey SDQ component used for this indicator consists of two questionnaires — one completed by the child (child-report) and one by the parent/carer (parent-report) (Lawrence et al. 2015). The parent-report is used for this CHI analysis, as it was completed for a larger age range (4-17 relative to 12-17), with 3,607 parent-report SDQs for children aged 4-12. Furthermore, several

important psychometric properties of the parent-report are as good as or better than the youth-report version, including for retest stability, correlation with teacher reports, and internal reliability (Goodman 2001).

The survey was designed to be nationally representative — the number of respondents from each state reflects the population of that state. The number of respondents from small states and territories is therefore quite low, and so precludes disaggregation by jurisdiction. Indigenous status is not available due to the size and geographic extent of the sample, as *Very remote* areas were not included in the survey — the sample was not designed to provide a separate estimate for Indigenous children.

The intention of this indicator is as a measure of positive social and emotional wellbeing. The SDQ measures something akin but not identical to this concept; nonetheless it is used as there is no other robust national data source closer aligned to this concept.

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19. Shelter

Why is shelter important?

A child's access to stable, adequate shelter is recognised as a basic human need. Having adequate housing enables people and children to engage with the wider community – socially, recreationally, and economically, and can influence both their physical and mental health (Wise 2003).

Shelter broadly refers to about having a safe place of one's own in which the routines of daily life can be established, privacy can be negotiated, and where there is a secure base from which to engage in social interactions based on trust which enable self-esteem to be enhanced and self-identity to be maintained (Hulse & Saugeres 2008).

For children, the home environment, including both physical and social dimensions, provides a sense of identity and security that is fundamental to their development. Shelter is closely linked to the social and emotional aspects of a child's health and wellbeing, and not merely to the structural features of the built environment. This approach to shelter is consistent with the view that children's interactions with their immediate environment, and the relationship between children's immediate environments and larger social contexts, are critical to their development (Ziol-Guest & McKenna 2014).

There are a number of components of shelter that affect child development and wellbeing, including home ownership, affordability, mobility, homelessness, overcrowding and characteristics of the dwelling.
Housing costs are usually the largest and least flexible item in a family budget. High housing costs can adversely affect child wellbeing through the experience of financial or material hardships (Herbers et al. 2012); impact on parental wellbeing and family stress and the quality, size and type of housing a family can afford (Leventhal & Newman 2010).

Housing mobility, overcrowding and homelessness are associated with an increase in social, emotional and behavioural problems, and a decrease in children's short-term academic achievement, in particular school age children and adolescents (Cole et al 2013; Herbers et al. 2012). Frequent family moves are linked with increased grade repetitions, school suspensions and expulsions and other psychological issues. The magnitude of the effect of frequent moves increases with additional risk factors such as poverty, minority race, single-parent family structure, low levels of parental education and young maternal age (Cooper 2001). In addition, the adverse effects of overcrowding and homelessness on children can persist throughout life, ultimately affecting future socioeconomic status and adult wellbeing; children are also at a greater risk of finding themselves in similar situations as their parents, leading to the intergenerational transmission of social inequality (Solari & Mare 2007).

How is shelter reported?

This indicator has been developed to incorporate three mutually exclusive measures from ABS Census: homeless, overcrowding and housing stress.

- The denominator is every child in the ABS Census aged 0–14.
- The numerator is children aged 0–14 who were homeless (including those living in a residence requiring 4 or more additional bedrooms according to the Canadian national standard), living in an overcrowded household or living in a household experiencing housing stress (including those living in a residence requiring 1–3 additional bedrooms) on ABS Census night.
- The disaggregation is by jurisdiction and sex, household composition, Indigenous status, cultural and linguistic diversity, remoteness areas, socioeconomic status areas.

References

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19. Shelter

According to the Australian Bureau of Statistics (ABS), a person is considered to be homeless if they are: living in an improvised dwelling, tent or sleeping out; in supported accommodation for the homeless; staying temporarily with another household; or staying in a boarding house or other temporary lodging. The ABS definition of homelessness also includes people living in a severely overcrowded situation (i.e. those living in a residence requiring 4 or more additional bedrooms according to the Canadian National Occupancy Standard) because they do not have control of, or access to, space for social relations (ABS 2016).

In the ABS Census 2016, the national proportion of homelessness among children aged 0–14 years was 0.4%. There were negligible differences in the rates of homelessness between boys and girls (both 0.4%), children born in Australia and those born overseas (0.4% and 0.6% respectively), and between younger (0–4 years) and older children (5–14 years; 0.5% and 0.4% respectively). Indigenous children aged 0–14 years were 11 times as likely to be homeless (3.3%) than non-Indigenous children (0.3%).

The rates of homelessness of children aged 0–14 years varied across different types of households, remoteness and socioeconomic status (SES) areas. In 2016, 2.4% of children aged 0–14 years who lived in multiple family households were homeless, compared with 0.6% of children in one-parent family households and 0.1% of children in couple family households. The national proportion of homelessness for children aged 0–14 years was higher in Remote and very remote areas (5.2%) compared with Major cities (0.3%), Inner regional (0.3%) and Outer regional (0.4%) areas. Children aged 0–14 years living in the lowest SES areas were also more likely to be homeless (1.3%) than those in the highest SES areas (0.1%).

Has there been a change over time?

Between 2006 and 2016 there has been a very small decrease in the rate of homessness of children aged 0-14 years, from 0.5% to 0.4%.

The proportion of Indigenous children classified as homeless has decreased by 2.0 percentage points, from 5.3% in 2006 to 3.3% in 2016. Over the same period, the proportion of non-Indigenous children classified as homeless has remained stable at 0.3%. The proportion of homelessness for children living in multiple family households has also decreased, from 3.6% in 2006 to 2.4% in 2016, while the proportions in couple families and one-parent families have remained stable.

The proportion of homelessness for children in Remote and very remote areas has increased from 3.6% in 2006 to 5.2% in 2016, while the proportions in all other Remoteness categories have remained stable over time.

Notes

According to ABS, there was underestimation of youth homelessness (sometimes referred to as ages 12-18 years or 12-24 years) due to 'usual address' reporting. A usual address may be reported for 'couch surfers' either because the young person doesn't want to disclose to the people they are staying with that they are unable to go home, or the person who fills out the Census form on behalf of the young person staying with them assumes that the youth will return to their home (ABS 2012).

References

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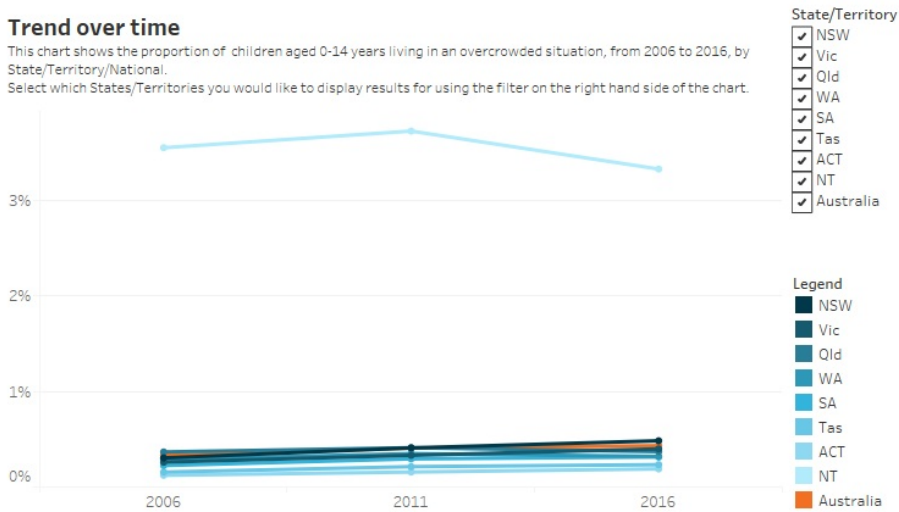
19. Shelter

Shelter: Overcrowding
Headline Indicator: Proportion of children aged 0-14 years living in an overcrowded situation

Trend over time
This chart shows the proportion of children aged 0-14 years living in an overcrowded situation, from 2006 to 2016, by State/Territory/National.
Select which States/Territories you would like to display results for using the filter on the right hand side of the chart.

State/Territory
☑ NSW
☑ Vic
☑ Qld
☑ WA
☑ SA
☑ Tas
☑ ACT
☑ NT
☑ Australia

Legend
■ NSW
■ Vic
■ Qld
■ WA
■ SA
■ Tas
■ ACT
■ NT
■ Australia

Overcrowding rates for a specific year
Select a year to view using the filter on the right hand side of the chart.

Year
○ 2006
○ 2011
● 2016

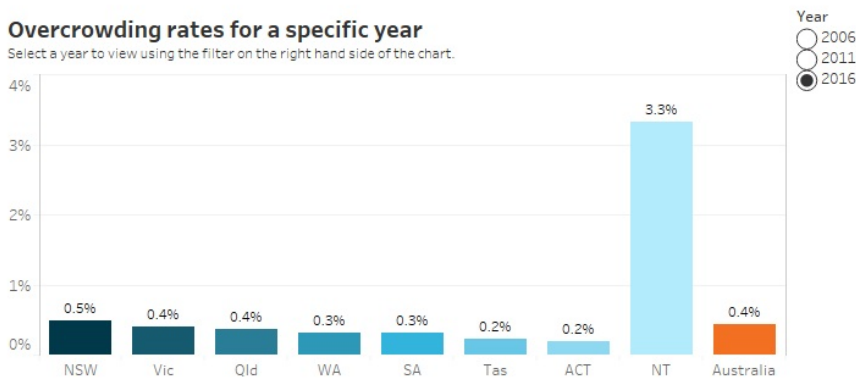| NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
0.5%	0.4%	0.4%	0.3%	0.3%	0.2%	0.2%	3.3%	0.4%

Chart: AIHW. Source: ABS Census of Population and Housing

The Australian Bureau of Statistics (ABS) collects data on specific key groups of people who are considered to be marginally housed but are not classified as homeless. Persons living in other crowded dwellings other than severely crowded dwellings are considered a marginal housing group. These households are considered overcrowded as they are estimated to require three extra bedrooms according to the Canadian National Occupancy Standard (ABS 2016).

Nationally, nearly 19,000 children aged 0-14 years were recorded as living in other crowded dwellings in the 2016 ABS Census of Population and Housing, a national proportion of 0.4%. There were no differences in the rates of overcrowded living for boys and girls, or between younger children aged 0-4 years and older children aged 5-14 years (all 0.4%). Indigenous children were 4.5 times as likely to be living in an overcrowded situation than non-Indigenous children (1.8% compared to 0.4%). Children born overseas were more than twice as likely to be living in an overcrowded situation than children born in Australia (0.9% compared to 0.4%).

Children from households with multiple families were more likely to be living in an overcrowded situation (1.6) than children of one-parent families (0.5) and couple families (0.2). More children were living in an overcrowded situation in Remote and very remote areas (2.4) than in Outer regional areas (0.4), Major cities (0.4) and Inner regional (0.2) areas. The proportion was 12 times as high in the lowest socioeconomic (SES) areas (1.2%) as in the highest SES areas (0.1%).

Has there been a change over time?

Nationally, there was a slight increase in the proportion of children living in an overcrowded situation, from 0.3% in 2006 to 0.4% in 2016. The same increase occurred in rates of overcrowding for boys, girls, younger children (0-4 years) and older children (5-14 years).

The proportion of Indigenous children living in an overcrowded situation decreased from 2.5% in 2006 to 1.8% in 2016, while there was a slight increase for non-Indigenous children (0.2% in 2006 to 0.4% in 2016). The rates of overcrowding have increased between 2006 and 2016 for children born in Australia (from 0.3% to 0.4%) and those born overseas from (0.8% to 0.9%).

The proportion of children in multiple family households who were living in an overcrowded situation has increased slightly from 1.4% in 2006 to 1.6% in 2016. Similarly, the proportion of children in one-parent families increased from 0.4% in 2006 to 0.5% in 2016, whilst the proportion for couple families has remained steady at 0.2% since 2006.

The proportion of children from Remote and very remote areas living in an overcrowded situation increased from 1.4% in 2006 to 2.4% in 2016, while the proportion of those living in Major cities and Outer regional areas only increased slightly from 0.3% to 0.4% from 2006 to 2016. The rate of children living in overcrowded situations in Inner regional areas remained steady at 0.2% over the same period. The rate of overcrowding for children in the lowest SES areas increased from 0.9% to 1.2% between 2006 and 2016 while the rate in the highest SES areas remained stable at 0.1%.

Notes

According to ABS Census 2011 data, 18,000 children under 12 are homeless (ABS 2012). But data provided on 9,000 homeless young children aged 0-14 years.

According to ABS, there was under estimation of youth homeless (sometimes referred to as 12-18 years or 12-24 years) due to 'usual address' reporting. A usual address may be reported for 'couch surfers' either because the young person doesn't want to disclose to the people they are staying with that they are unable to go home, or the person who fills out the Census form on behalf of the young person staying with them assumes that the youth will return to their home (ABS 2012).

References

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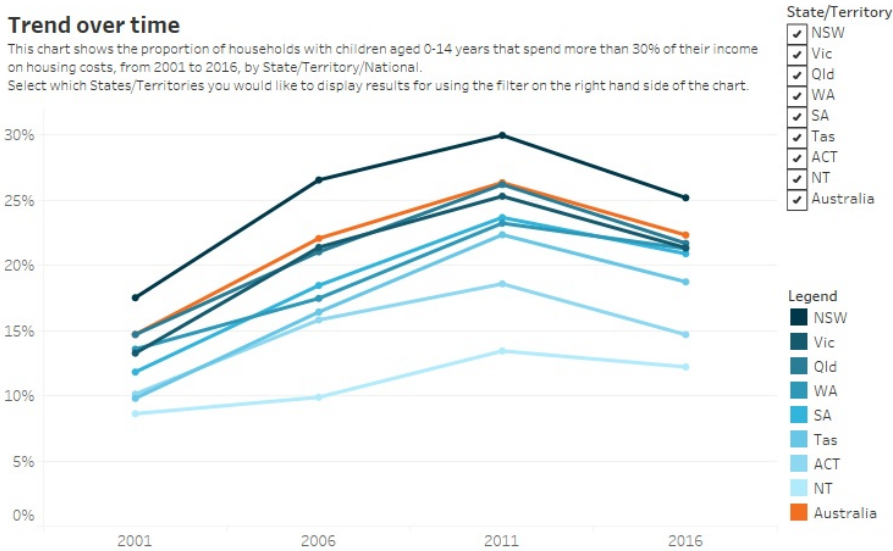
19. Shelter

Shelter: Housing Stress

Headline Indicator: Proportion of children aged 0-14 years living in households with housing stress
(households that spend more than 30% of their income on housing costs)

Trend over time

This chart shows the proportion of households with children aged 0-14 years that spend more than 30% of their income
on housing costs, from 2001 to 2016, by State/Territory/National.
Select which States/Territories you would like to display results for using the filter on the right hand side of the chart.

Housing stress rates for a specific year

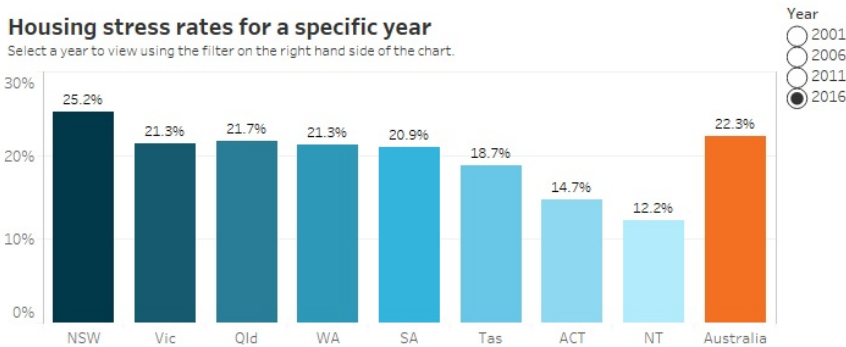Select a year to view using the filter on the right hand side of the chart.

Chart: AIHW. Source: ABS Census of Population and Housing

Nationally, 22.3% of children aged 0-14 years were listed as living in households experiencing housing stress (households that spend more than 30% of their income on housing costs) in the 2016 Census of Population and Housing. This proportion has decreased since 2011 (26.4%). There was very little difference in the rate of boys and girls living in households with housing stress (22.3% and 22.4% respectively). Younger children (0-4 years) were more likely to be living in households with housing stress than older children aged 5-14 years (23.2% compared to 21.9%).

Indigenous children were more likely to be living in households experiencing housing stress than non-Indigenous children (27.1% compared to 23.1%), and more children born overseas lived with housing stress (29.1%) than children born in Australia (22.7%). More than half of children from one-parent families were living in households with housing stress (52.2%). This was nearly three times the proportion of children from couple families (18.1%) and over five times the proportion of those from multiple family households (9.9%). Children living in Major cities were most likely to be living in households with housing stress, and children in Remote and very remote areas were least likely (23.9% and 9.4%, respectively). The proportion of children living in households with housing stress was higher in the lowest socioeconomic (SES) areas (29.1%) than the highest SES areas (16.9%).

Has there been a change over time?

The national rate of children living in households with housing stress has fluctuated over time between 2001 and 2016, increasing from 14.7% in 2001 to 22.1% in 2006 and 26.4% in 2011, then decreasing to 22.3% in 2016. This spike in 2011 was seen across all demographic groups except for Indigenous children, children in one-parent families and children in multiple family households. The proportion of Indigenous children living in households experiencing housing stress has increased with each Census collection, from 13.5% in 2001 to 27.1% in 2016. Similarly, the proportion of children living in one-parent families experiencing housing stress increased steadily from 35% in 2001 to 52.2% in 2016. In contrast, the proportion of children in multiple family households with housing stress was highest in 2001 (10.8%), decreasing slightly to 9.9% in 2016.

Notes

Amendments

Indicators were updated with the most recent data available in the latest (2016) release unless otherwise stated. Data are subject to minor revisions over time.

15 Oct 2018 - Correction to Indigenous infant mortality rates for Northern Territory, 2013 to 2016.

25 Sep 2018 - Additional reference to the 3-year period in the footnotes of the Infant mortality data table.

20 Jan 2020 - Breastfeeding data for 2014-15 have been updated following the recalculation of rates by the ABS due to a processing issue which resulted in an over-estimation.

28 Oct 2020 - Numbers in infant mortality rates were updated.

Data