Making progress

The health, development and wellbeing of Australia’s children and young people
Foreword

The health and wellbeing of Australia’s children and young people is at the centre of policy making in Australia today. Policy initiatives in the areas of health, productivity and social inclusion draw on the principles of early intervention and prevention. The effectiveness of these initiatives depends on the ability to track progress and provide regular feedback to inform the developing reform agendas. This has been recognised as a high priority by all Australian Government departments, and is a primary goal of the Australian Institute of Health and Welfare (AIHW).

This report builds on work undertaken by the AIHW over the last decade on the development and reporting of key national indicators of child and youth health, development and wellbeing, and more recently work undertaken on the Ministerial endorsed Headline Indicators. This report is distinct from previous AIHW reports, as it presents measures of progress for children and young people in a summary, indicator-based format. This report focuses on issues of importance for children and adolescents, including indicators of mental health, risk factors for chronic disease, hospitalisation, mortality, educational achievement in primary and high school, homelessness, jobless families and family economic situation.

The analysis in this report shows that, while many children and adolescents in Australia are doing well, some experience significant physical, social, educational and economic disadvantage, and numerous indicators do not compare favourably with other developed countries.

This report reveals that while much progress has been made, a great deal remains to be done to ensure that all children have the best possible start in life.

The AIHW gratefully acknowledges the valuable input, advice and comments provided by the Australian Bureau of Statistics (ABS), the Australian Institute of Family Studies (AIFS), the Australian Government Departments of Health and Ageing (DoHA), Education, Employment and Workplace Relations (DEEWR), and Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), and Professor George Patton (VicHealth Professor of Adolescent Health Research, University of Melbourne).

Penny Allbon
Director, AIHW
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How are Australia’s children and young people faring?

This report shows that, while many Australian children and adolescents are faring well, some experience considerably worse health, poorer developmental and learning outcomes and generally reduced wellbeing than others in the population, and there are many areas where further gains in health and wellbeing could be achieved. The table below summarises these key areas of concern, as well as some recent achievements, in the areas of health, education and wellbeing for different stages of development—early childhood, childhood, adolescence, and for the overall 0–19 year age group. It also identifies where data gaps exist in the national monitoring of child and youth health and wellbeing in Australia.

In response to the Council of Australian Governments’ (COAG) ‘Closing the gap’ agenda, particular focus is given to Aboriginal and Torres Strait Islander children and youth. Indigenous children and youth continue to be disadvantaged across a broad range of health and socioeconomic indicators, and have not shared the same improvements in health, education and wellbeing as those observed for Australian children and youth generally. This report shows that while Indigenous students are gradually catching up in retention to Year 12, there has been no measurable progress in recent years in closing the gap in the Year 5 writing and numeracy benchmark results. Immunisation coverage of Indigenous 2 year olds is similar to the national average, but Indigenous children are still twice as likely as other children to be of low birthweight, to be hospitalised for chronic conditions and to die before the age of 20. Similarly, children and young people living in regional and remote areas and the most socioeconomically disadvantaged areas also have worse health and education outcomes for many of the indicators where data are available.

The report also shows that Australia does not compare favourably with other developed countries for many of the indicators presented, where comparable data are available. For example, Australia has the second highest percentage of children living in jobless families in the OECD and ranks in the bottom third in the under-5 mortality rate.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Achievements</th>
<th>Areas of concern</th>
<th>What don’t we know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Across the age span (0–19 years)</td>
<td>Mortality rates falling in all age groups</td>
<td>Poor outcomes for Indigenous children and youth in multiple areas (both health and wellbeing)</td>
<td>Prevalence of child abuse and neglect, and whether rate has changed over time</td>
</tr>
<tr>
<td></td>
<td>Fewer children living in jobless families</td>
<td>High unmet requests for SAAP accommodation for children and youth</td>
<td>Prevalence of disability among Indigenous children and other disadvantaged populations</td>
</tr>
<tr>
<td>Early childhood</td>
<td>Immunisation coverage for 1 and 2 year olds is over 90%</td>
<td>Infant mortality and teenage fertility compare unfavourably with other OECD countries</td>
<td>Proportion of women exclusively breastfeeding to 4 and 6 months of age</td>
</tr>
<tr>
<td></td>
<td>Gap in Indigenous infant mortality rates narrowing</td>
<td>High unmet demand for child care due to accessibility barriers, particularly availability of places</td>
<td>Number of children attending early childhood education programs delivered by university-qualified teacher in the year before school</td>
</tr>
<tr>
<td>Childhood</td>
<td>Good dental health compared with other OECD countries</td>
<td>Gap in literacy and numeracy for Indigenous students remains high</td>
<td>How many children are physically active according to National Physical Activity Guidelines</td>
</tr>
<tr>
<td></td>
<td>Drop in asthma hospitalisation rate</td>
<td>Increase in hospitalisation rates for diabetes</td>
<td></td>
</tr>
<tr>
<td>Adolescence</td>
<td>Reduction in rates of smoking, risky alcohol intake, illicit drug use</td>
<td>High youth unemployment and underemployment</td>
<td>Rates of physical and sexual assault, and whether rate has changed over time</td>
</tr>
<tr>
<td></td>
<td>Increase in Year 12 retention rate for Indigenous students</td>
<td>Indigenous youth over-represented in juvenile justice supervision, and no change in rates in 6 years</td>
<td>How Australia compares internationally on many of the health and crime indicators</td>
</tr>
</tbody>
</table>
The table **How does Australia compare...** summarises information about Australia’s international performance and the level of inequality between three population groups of interest within Australia—Aboriginal and Torres Strait Islander people, people living in regional or remote areas, and those living in socioeconomically disadvantaged areas. Comparisons are made internally, that is, between population groups within Australia, and externally with other developed countries. For the groups of interest in the internal comparison, rates for various indicators are compared with those of the remaining population group. Each comparison is expressed as a rate ratio: the rate for the group of interest over the rate for the rest of the population. For indicators relating to childhood immunisation, breastfeeding, and education, rate ratios of less than 1 indicate disadvantage for the group of interest. The lower the ratio, the greater the disadvantage for the group of interest. For all remaining indicators, a rate ratio of greater than 1 indicates that the group of interest is at a disadvantage—in these cases, the higher the rate ratio, the greater the disadvantage.

International data and data for population groups of interest were not available for each indicator presented in this report.

### How does Australia compare... who fares worse than others? ...externally: how do we compare with like countries?

<table>
<thead>
<tr>
<th>Indicator</th>
<th>OECD rankings (total number of countries)(b)</th>
<th>See page</th>
<th>Indigenous to non-Indigenous Australians</th>
<th>Remote/very remote areas to major cities</th>
<th>Most disadvantaged to least disadvantaged areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>24 (30)</td>
<td>7</td>
<td>2.0–3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teenage births</td>
<td>16 (24)</td>
<td>15</td>
<td>5.2</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td>Low birthweight</td>
<td>13 (30)</td>
<td>16</td>
<td>2.2</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Childhood immunisation (12, 24 months)</td>
<td>14 (20)</td>
<td>18</td>
<td>0.9, 1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding (NSW)</td>
<td></td>
<td>17</td>
<td>1.1</td>
<td></td>
<td>0.4</td>
</tr>
<tr>
<td>Dental decay (6 years, 12 years)</td>
<td>8 (30)</td>
<td>24</td>
<td>2.5, 1.8</td>
<td>1.7, 1.4</td>
<td>2.2, 1.5</td>
</tr>
<tr>
<td>Chronic disease</td>
<td></td>
<td>23</td>
<td>2.1–2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity (6–11 years, 15–19 years)</td>
<td></td>
<td>26, 32</td>
<td>1.4, 2.6</td>
<td></td>
<td>2.0(c)</td>
</tr>
<tr>
<td>Physical activity/screen time</td>
<td></td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td></td>
<td>22, 30</td>
<td>1.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td>31</td>
<td>1.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance use</td>
<td></td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WELLBEING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care accessibility</td>
<td></td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood education (preschool: 3, 4 years)</td>
<td>8 &amp; 16(25)(e)</td>
<td>20</td>
<td>0.4, 1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literacy and numeracy</td>
<td></td>
<td>27</td>
<td>0.8, 0.9</td>
<td>0.6, 0.9</td>
<td></td>
</tr>
<tr>
<td>Year 12 retention and completion</td>
<td></td>
<td>34</td>
<td>0.6, 0.5</td>
<td>0.4–0.7</td>
<td></td>
</tr>
<tr>
<td>Youth participation (unemployment rate)</td>
<td></td>
<td>35</td>
<td>2.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jobless families</td>
<td></td>
<td>9</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family economic situation</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child abuse and neglect</td>
<td></td>
<td>11</td>
<td>5.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homelessness</td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime</td>
<td></td>
<td>28, 36</td>
<td>13–49</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† For these indicators, rate ratios of less than 1 indicate disadvantage for the population group of interest. For all other indicators, disadvantage is indicated by rate ratios of greater than 1.
(a) The comparison groups included in the table column headings may not apply to all the indicators. For some of the indicators, the comparison is between Indigenous and other Australians, while for others it is Indigenous and all Australians. Different comparison groups also apply for regional and disadvantaged areas. For precise comparison groups, see the relevant sections.
(b) Green shading indicates a ranking in the top third, yellow in the middle third and red in the bottom third.
(c) 6–11 years only, based on school socioeconomic status.
(d) Australia ranked 8th in science and 16th in maths. Includes some non-OECD countries.
(e) Percentage of 15–19 year olds neither working nor studying.
Introduction

Ensuring children get the best possible start in life is central to the health, social inclusion and productivity agendas of the Australian Government. Meeting this goal will involve reforms in the areas of education, early childhood development, preventive health care and housing, as well as strategies to address economic and social disadvantage. The benefits of investing in children and young people flow through to the entire population with outcomes as diverse as greater productivity, lower burden of disease, stronger families, and safer and more connected communities. Promoting the physical, social, emotional, and cognitive development of Australia’s children and young people is therefore a matter of national priority.

Australia’s children and young people are growing up in an environment of rapid social, economic and technological change. The world in which children and young people live plays an important role in shaping their health, development and wellbeing, both in the short-term and into adulthood. It follows that any reflection on their progress needs to take account of these environmental factors. The indicator framework developed for this report aims to do this, by presenting a range of indicators in the areas of health, development and wellbeing while taking into account the broad social, community and economic factors.

Purpose of this report

Good information is at the heart of good policy development. A great deal of detailed information exists about children and young people in Australia today. The AIHW, in consultation with an expert advisory group and funding assistance from the Australian Government Department of Health and Ageing, has produced six comprehensive, national, statistical reports on the health, development and wellbeing of Australian children and young people over the last decade.1,2 The next of these reports, focusing on children, will be released in May 2009. The AIHW has also been contracted by three Ministerial Councils (Australian Health Ministers’ Advisory Council, the Community and Disability Services Ministers’ Advisory Council and the Australian Education Systems Officials Committee) to report on the 19 Headline Indicators of children’s health, development and wellbeing endorsed by the Australian Health Ministers’ Conference and the Community and Disability Services Ministers’ Conference in 2006.3 However, given current policy priorities there is an increasing need to also have a timely, targeted indicator-based report drawing together key summary statistics integral to child and youth health and wellbeing in order to inform the COAG and social inclusion agendas. This report aims to meet this need, and in doing so, the following questions have been central:

- What aspects of health and wellbeing have changed for Australia’s children and young people in recent years—for better or for worse?
- Where is there a clear need for improvement?
- How do we compare with countries like ours?
- And crucially, in the context of the social inclusion agenda which addresses multiple difficulties or levels of disadvantage, in what areas do some subpopulations within Australia fall behind their peers?

Changing lives: children and young people in Australia

Children and young people in Australia today are growing up in a very different environment from 20, and even 10, years ago. Major social changes that have directly affected families include a rise in the number of blended and lone-parent families, a trend towards having fewer children and children later in life, increased workforce participation of women with children and the accompanying growth in the use of child care.4 For infants and young children, research about the importance of the first years of life has led to an increased focus on antenatal care, early learning and development, and early intervention for children at risk of health, educational or social problems. Among older children and adolescents, advances in information technology have changed the way they learn and interact with their friends and society at large. Changes in the labour market, alongside increasing participation in post-secondary education, has seen a rise in the proportion of young people combining study with work, and many remain in the family home well into their 20s.4 In the area of health, far fewer children than in generations past die before
the age of 20; most grow up free from infectious diseases such as measles and polio, and more survive serious illnesses such as cancer or live longer with genetic conditions such as cystic fibrosis.\textsuperscript{1,2} However, these conditions have been replaced with rising concerns about obesity, chronic disease and mental and behavioural problems, and their associated disabilities.

The size and composition of the child and youth population has important implications for planning and policy development, and these, too, are changing. In 2006, there were 1.3 million children aged under 5 years (comprising 6% of the population), 2.1 million children aged 5–12 years (11%), and 1.9 million teenagers (10%)—in total, 5.3 million Australians aged under 20, comprising more than one-quarter (27%) of the population. By 2020 the number of children and youth is projected to be similar, but they will represent only 22% of the population. Some population groups have experienced greater growth than average—the proportion of Australians aged under 20 years who were Indigenous increased from 3.7% to 4.1% between 1996 and 2006, while those born outside Australia rose from 8.2% to 8.8%. Understanding these changing demographic trends contributes to good policy decisions about the provision, delivery and accessibility of services required by children and young people, including child care, schools, and health and welfare services.

### Framework

The indicators selected for this report take into account these different social, community and economic environments that children and young people are growing up in today. Each of the indicators presented relate to one or more high-level objectives of the Social Inclusion and COAG Reform agendas, and have been chosen on that basis. A mapping of the indicators included in this report to these high-level objectives is shown in Appendix A.

This report focuses on children and young people aged 0–19 years, and is divided into four sections reflecting different stages of development. The first section presents six indicators covering the broad 0–19 year age range. The chosen indicators represent topics of relevance to children and young people aged less than 20 years in the areas of health, development and wellbeing. Each of these indicators signify an issue that can have profound impact on the lives of children, young people, their families and society at large, and interact with many of the indicators covered in the later sections. The remaining three sections are dedicated to specific stages of growing up: infancy and early childhood, ‘school age’ childhood, and adolescence. These sections include indicators of particular significance and relevance to the age group concerned in the areas of health, development and wellbeing.
This section presents data on six indicator topics for the broad age group 0–19 years. The indicators included here represent issues that affect children and young people of all ages in the areas of health (mortality and disability), family socioeconomic status (jobless families and family economic situation), and safety/social breakdown (homelessness, and child abuse and neglect).

The following table shows how children and young people fare against various measures of the six indicator topics. Measures and trends are reported for the broad age group as well as each of the specific age groups on which this report is focused. Where time series data has been referred to on an indicator page, the direction of the recent trend is shown in the table.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Value</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Deaths per 100,000 persons aged 1–19 years</td>
<td>20</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Deaths per 100,000 persons aged 1–4 years</td>
<td>21</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Deaths per 100,000 persons aged 5–12 years</td>
<td>10</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Deaths per 100,000 persons aged 13–19 years</td>
<td>31</td>
<td>✓</td>
</tr>
<tr>
<td>Disability</td>
<td>Percentage of 0–19 year olds with disability</td>
<td>8</td>
<td>✗</td>
</tr>
<tr>
<td></td>
<td>Percentage of 0–4 year olds with disability</td>
<td>4</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 5–12 year olds with disability</td>
<td>10</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 13–19 year olds with disability</td>
<td>10</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 0–19 year olds with severe or profound core activity limitation</td>
<td>4</td>
<td>✗</td>
</tr>
<tr>
<td></td>
<td>Percentage of 0–4 year olds with severe or profound core activity limitation</td>
<td>3</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 5–12 year olds with severe or profound core activity limitation</td>
<td>5</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 13–19 year olds with severe or profound core activity limitation</td>
<td>3</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 5–19 year olds with schooling restriction</td>
<td>6</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 5–12 year olds with schooling restriction</td>
<td>7</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of 13–19 year olds with schooling restriction</td>
<td>5</td>
<td>..</td>
</tr>
<tr>
<td>Jobless families</td>
<td>Percentage of children aged 0–14 years living in jobless families</td>
<td>15</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of children aged 0–4 years living in jobless families</td>
<td>16</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of children aged 5–12 years living in jobless families</td>
<td>15</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of children aged 13–14 years living in jobless families</td>
<td>15</td>
<td>✓</td>
</tr>
<tr>
<td>Family economic situation</td>
<td>Mean equivalised disposable household income of all low-income households with children aged 0–19 years</td>
<td>$346</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>. . . where eldest child was aged 0–4 years</td>
<td>$353</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>. . . where eldest child was aged 5–12 years</td>
<td>$347</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>. . . where eldest child was aged 13–19 years</td>
<td>$342</td>
<td>✓</td>
</tr>
<tr>
<td>Child abuse and neglect</td>
<td>Child protection substantiations per 1,000 children aged 0–17 years</td>
<td>7</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Child protection substantiations per 1,000 infants aged less than 1 year</td>
<td>17</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Child protection substantiations per 1,000 1–4 year olds</td>
<td>8</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Child protection substantiations per 1,000 5–12 year olds</td>
<td>6</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>Child protection substantiations per 1,000 13–17 year olds</td>
<td>4</td>
<td>?</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Average daily number of 0–19 year olds with unmet requests for SAAP accommodation</td>
<td>415</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Average daily number of children aged 0–11 years with unmet requests for SAAP accommodation</td>
<td>221</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Average daily number of young people aged 12–19 years with unmet requests for SAAP accommodation</td>
<td>167</td>
<td>..</td>
</tr>
</tbody>
</table>

Key: ✓ = favourable trend; ✗ = unfavourable trend; .. = no trend data presented; ? = Rate has been increasing, but as data are reflection of Departmental Child Protection activity it is unknown whether an increase indicates an unfavourable or favourable trend.
Mortality

Measure: Number of deaths of children and youth aged 1–19 years, per 100,000 population

Mortality rates and causes of mortality are key indicators of the health of a population and, as many deaths are potentially preventable, provide crucial information for public health policy and planning. They not only reflect circumstances around the time of death, but also provide insight into changes in social and environmental conditions, medical interventions, lifestyles and trends in underlying risk factors.

High rates of child mortality are strongly associated with social and economic disadvantage, including maternal age, health and parity, exposure to environmental contaminants, nutrition, risk of injury, personal preventive measures and access to medical treatment. For older children and adolescents these factors are exacerbated by the increased independence that comes with adolescence, the period where new skills are developed, such as driving and job skills, and increased exposure to alcohol and other drugs. Injuries from traffic accidents, psychological problems and the harmful effects of alcohol and other drug use are prominent hazards for young people.

As more than half of all deaths before the age of 20 occur in the first year of life, and the causes of mortality in infants are quite different from mortality in children and adolescents, infant mortality is addressed in a separate indicator (p.14), and is not included under this indicator.

COAG has committed to halving the mortality gap for Indigenous children under five within a decade. Improvements in Indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services, and integrated child and family services.

Australia’s under-5 mortality rate is in the best fifth of the world, but the worst third of the OECD (24th out of 30 countries). Overall mortality rates are decreasing, but among 1–19 year olds the Indigenous rate is still twice as high as the non-Indigenous rate. Many of the leading causes of death in children and young people are potentially preventable: half of all deaths of 1–19 year olds were caused by injuries, and half of these were transport accidents.
Measure: Percentage of children and young people with disability, severe or profound core activity limitations, or schooling restrictions

Disability is a characteristic that goes beyond the presence or absence of particular health conditions; it relates to the way in which an individual functions in society and is strongly influenced by environmental factors. Disability is measured in terms of impairments, activity limitations and participation restrictions, covering the range of activities that people perform in everyday life. People who sometimes or always need assistance with one or more of the core activities of daily living (self-care, mobility or communication tasks) are referred to as having severe or profound core activity limitation.

People with disability may also experience restrictions in other aspects of their lives. For example, children and adolescents with disability may experience schooling restrictions that result in needing special assistance, arrangements or equipment at school, attending special classes or a special school, needing frequent time off school or having difficulty with aspects of schoolwork or the school environment.

Overall, people with disability achieve lower educational qualifications than people without disability, and often have poorer labour market outcomes. However, because the experience of disability stems from the interaction of individual and external factors, it is possible to reduce the impact of disability on the person’s participation in all aspects of life through early intervention, and environmental and societal modifications.

The new National Disability Reform Agenda aims to place people with disabilities, their families and carers at the centre of services across Australia and to improve the availability, flexibility and consistency of services across all jurisdictions.

In 2003, 440,300 young people (8%) aged 0–19 years had a disability, including almost 200,000 (4%) with severe or profound core activity limitations and more than 250,000 (6% of 5–19 year olds) with schooling restrictions.

Boys aged 5–12 years were twice as likely as girls to have schooling restrictions or severe or profound core activity limitations.

Almost one in four children with disability had asthma.

All children aged 5–12 years with autism had schooling restrictions, and 91% had severe or profound core activity limitations.

77% of children and youth aged 5 years or over with ADHD and 85% with intellectual disability experienced schooling restrictions, and half had severe or profound core activity limitations.

Key messages

- 8% of Australians aged 0–19 years had a disability in 2003; rates were higher for boys than girls.
- Reported rates of disability and severe/profound core activity limitations in children aged under 15 years have increased since the 1980s.
- More than 90% of children with autism had severe or profound core activity limitations and all had schooling restrictions.
Jobless families

Measure: The number of children with no co-resident employed parent, as a percentage of all children

One of the notable results of labour market trends over the past generation has been what is termed ‘employment polarisation’. As the unemployment rate of individuals has fallen and an increasing number of families have two working parents, joblessness has become more concentrated within some households. Jobless households are disproportionately likely to be reliant on welfare, have low incomes and experience financial stress, and members of these households report worse physical and mental health and lower life satisfaction than members of households where someone is employed.

Studies on the effects of unemployment on other family members have identified relationships between parental joblessness and family conflict, family breakdown and child abuse. Secure employment provides financial stability, self-confidence and social contact for parents, with positive effects flowing onto their children. Paternal employment in particular was associated with adolescent psychological wellbeing, sociability, satisfaction and happiness. Reducing jobless families would not only be a major improvement for society at the time, but could also have positive inter-generational effects, as the likelihood of a young person completing secondary school and finding secure employment is affected by their parent’s socioeconomic status.

The Australian Government has identified addressing the incidence and needs of jobless families with children as an early priority for Australia’s Social Inclusion Agenda.

Key messages

- Australia had the second highest percentage of working-age jobless families out of 24 OECD countries in 2000, largely due to the relatively high rate of one-parent households in Australia and the high rate of joblessness among this group.
- Indigenous children are 3 times as likely as other children to live in jobless families.
- The proportion of children living in jobless families has decreased over the last decade, but half of all children in one-parent families still live with a jobless parent.
Overarching indicators (0–19 years)

**Family economic situation**

**Measure: Mean equivalised disposable household income of low-income households with dependent children aged 0–19 years**

Children living in families without regular adequate income are at increased risk of poor health and educational outcomes, both in the short and long-term. Living on a low income can affect a child's nutrition, access to medical care, environmental safety, quality and stability of their care, and the provision of appropriate housing, heating and clothing. A primary concern for economically disadvantaged children is being excluded from activities that other children take for granted.

Income disadvantage is also a relative concept, as some Australian families may have higher absolute incomes than people in the past, or in other countries, and still experience relative income disadvantage.

Equivalised disposable household income is the after-tax total of all income sources, adjusted for the size and composition of the household. A household's equivalised income shows how much income a person living alone would need to enjoy the same level of economic wellbeing as a household comprising more than one person.

The average real equivalised disposable household income for households with children aged 0–12 years in the 2nd and 3rd income deciles has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator for children's health, development and wellbeing.

The Australian Government has identified addressing the incidence and needs of jobless families with children and secure employment as early priorities for Australia's Social Inclusion Agenda.

**Key messages**

- The mean equivalised income of low-income households with dependent children aged 0–19 years (more than half a million households) was $346 per week in 2005–06.
- The income of low-income households with children and dependent youth has not grown as fast as that of all households with children and youth generally.
- Australia ranked 13th of 24 OECD countries in terms of the percentage of children living in relative income poverty in 1999.
Child abuse and neglect

Measure: Number of children aged 0–17 years who were the subject of a child protection substantiation in a given year, per 1,000 population

‘Children everywhere have the right to survival... to protection from harmful influences, abuse and exploitation’.

There is a demonstrated relationship between the health and wellbeing of children and the environment in which they grow up. Children who are raised in supportive, nurturing environments are more likely to have better social, behavioural and health outcomes. The reverse is also true: children who have been abused or neglected often have poor developmental outcomes, such as lower social competence, poor school performance and a higher likelihood of criminal offending later in life.

In Australia, statutory child protection systems are the responsibility of the state and territory governments. Child protection substantiation refers to the determination, after investigation, that a child has been, is being or is likely to be abused or neglected or otherwise harmed. Child abuse may include physical, sexual or emotional abuse or neglect. Due to variation in child protection legislation, policy and practice between jurisdictions and over time, the comparison of substantiation rates across time and across jurisdictions is problematic.

Child abuse and neglect has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator for children’s health, development and wellbeing.

The Australian Government has committed to developing a National Child Protection Framework which will focus on preventing abuse through early intervention and better integration of family services. COAG has also committed to identify joint reforms and implementation timetables for basic protective security from violence for Indigenous parents and children.

Key messages

- Indigenous children are over-represented in child protection substantiations.
- Substantiation rates are highest for infants, due partly to an increased focus on early intervention.
- At the state and territory level, substantiation rates are not directly comparable due to differences in jurisdictional child protection policy, legislation and practice.
Homelessness

Measure: Average daily number of 0–19 year olds with unmet requests for accommodation from the Supported Accommodation Assistance Program (SAAP)

Children who are homeless, whether as part of a family unit or on their own, experience significant negative social and health consequences. Homelessness is associated with increased prevalence of a number of health conditions including gastroenteritis, bronchitis, asthma, depression and schizophrenia. Young people who become homeless face increased risk of exposure to physical and sexual assault, poor diet and inadequate shelter, and are more likely than other youth to engage in risky behaviours such as smoking, drug and alcohol abuse, and unsafe sex.

The factors contributing to homelessness are complex, and may be the result of domestic violence, family or relationship breakdown, poverty or financial crisis, mental illness or lack of affordable housing. Responding to homelessness requires a multi-sectoral approach.

The major government response to homeless people or people at risk of homelessness is SAAP. SAAP provides a range of assistance including emergency accommodation, meals and showers, counselling and advocacy. Children and young people may access SAAP services individually as a SAAP client, or they may accompany a parent or guardian who is a SAAP client.

The Australian government has identified addressing the incidence of homelessness as an early priority for Australia’s social inclusion agenda. As part of the new National Housing Affordability Agreement COAG has committed to service delivery improvements to reduce homelessness.

The Australian Government will also be releasing a White Paper (policy paper) on homelessness in late 2008 articulating the future policy approach for reducing homelessness in Australia.

Key messages

- More than 400 young people aged under 20 years have a valid unmet request for SAAP accommodation on an average day.
- Domestic violence and family breakdown are major drivers of children and families seeking SAAP assistance.
- Indigenous accompanying children are over-represented in SAAP and account for over a quarter of all accompanying children under 18 years (77 per 1,000 compared to 14).
- 34,100 children and adolescents were homeless on Census night in 2006 (one-third of the homeless population). Children accounted for a higher proportion of the homeless population in 2006 than in 2001 (22% increase), while the proportion of adolescents has declined.
This section focuses on infants and young children (0–4 year olds). COAG, supported by a growing body of research into the importance of the early years of life, has initiated a series of reforms to maternal and child health care and early childhood education. With the principle of early intervention for children at risk of poor outcomes underpinning policy development in this area, many initiatives have particular focus on disadvantaged population groups. Improving maternal and child health services and early learning opportunities for Aboriginal and Torres Strait Islander children are important steps on the pathway to closing the gap in Indigenous disadvantage.

The following table presents national data for each of the measures of the five indicator topics relating to infant and child health, and for the indicators related to child care accessibility and early learning. Where time series data has been referred to on an indicator page, the direction of the recent trend is shown in the table.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Value</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>Deaths per 1,000 live born infants</td>
<td>5</td>
<td>✓</td>
</tr>
<tr>
<td>Teenage births</td>
<td>Live births per 1,000 females aged 15–19 years</td>
<td>17</td>
<td>✓</td>
</tr>
<tr>
<td>Low birthweight infants</td>
<td>Percentage of live born infants with low birthweight</td>
<td>6</td>
<td>..</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Percentage of infants fully breastfed at 4 months of age</td>
<td>46</td>
<td>..</td>
</tr>
<tr>
<td></td>
<td>Percentage of infants fully breastfed at 6 months of age</td>
<td>14</td>
<td>..</td>
</tr>
<tr>
<td>Childhood immunisation</td>
<td>Percentage of 1 year olds on the ACIR fully immunised</td>
<td>92</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 2 year olds on the ACIR fully immunised</td>
<td>93</td>
<td>✓</td>
</tr>
<tr>
<td>Access to child care</td>
<td>Number of 0–4 year olds with unmet demand for formal child care</td>
<td>110,000</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Number of 0–4 year olds with unmet demand for formal child care mainly due to cost</td>
<td>17,000</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Number of 0–4 year olds with unmet demand for formal child care mainly due to lack of places</td>
<td>49,500</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Number of 0–4 year olds with unmet demand for formal child care mainly due to lack of services locally</td>
<td>5,100</td>
<td>✓</td>
</tr>
<tr>
<td>Early childhood education</td>
<td>Percentage of 3–4 year olds attending pre-school or long day care</td>
<td>68</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 3 year olds attending preschool or long day care</td>
<td>56</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 4 year olds attending preschool or long day care</td>
<td>80</td>
<td>✓</td>
</tr>
</tbody>
</table>

Key: ✓ = favourable trend; X = unfavourable trend; ~ = no change or clear trend; . . = no trend data presented.
Early childhood (0–4 years)

**Infant mortality**

**Measure: Number of deaths of infants aged less than 1 year per 1,000 live births**

A child’s risk of death is greatest in the first year of life, and the first month in particular. The infant mortality rate reflects the effect of structural factors on population health, such as the prevailing health and hygiene conditions, and accessibility and effectiveness of the health system in maternal and perinatal health. The infant mortality rate is used internationally as a key measure of population and child health.

Infant deaths have fallen substantially over the last two decades, and are a result of the work of neonatal intensive care units, increased community awareness of the risk factors for SIDS and the importance of early and exclusive breastfeeding, and reductions in vaccine-preventable diseases through the national childhood immunisation program.

Infant mortality has been chosen as the mortality indicator to report on for early childhood, as the vast majority of deaths (85%) in this age group occur within the first year of life, and the causes of mortality in infants are quite different from mortality in young children. See Mortality (p. 7) for child mortality rates for 1–4 year olds.

Infant mortality has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator for children’s health, development and wellbeing.

COAG has committed to halving the mortality gap for Indigenous children under five within a decade. Improvements in Indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services, and integrated child and family services.

**Key messages**

- Indigenous infants were 3 times as likely as non-Indigenous infants to die in their first year of life, but the gap is closing.
- Australia’s infant mortality rate ranks 20th out of 30 OECD countries. Excluding the high Indigenous rate, Australia still ranks in the middle of the OECD (14th).
- 80% of infant deaths are caused by perinatal conditions (such as SIDS) and congenital abnormalities. Mortality rates for Indigenous infants were particularly high for respiratory and parasitic or infectious diseases, compared to non-Indigenous infants.
**Teenage births**

**Measure: Number of live births to teenage mothers, per 1,000 females aged 15–19 years**

Teenage motherhood, particularly at younger ages, can pose significant long-term risks to both mother and child. Teenage mothers often delay having their pregnancy confirmed and/or seeking antenatal care, and are more likely to engage in risky behaviour, including smoking and drinking alcohol during pregnancy. Consequently, teenage mothers face increased risk of miscarriage, preterm delivery, low birthweight and other complications, and perinatal mortality.40

Parenthood during the teenage years often results in interrupted schooling, a high risk of single parenthood, greater dependence on government assistance, increased problems in engaging with the labour market, and poverty.41 All of these factors can affect the health, education and economic futures of children born to teenage parents. While not all teenage pregnancies result in negative outcomes for mother and child, the circumstances that often contribute to teenage pregnancy mean that many young mothers do not receive the support they need before and after birth.

Factors thought to contribute to teenage fertility include family history of teenage pregnancy, violence and sexual abuse in childhood, unstable housing arrangements, poor school attendance and performance, socioeconomic disadvantage, and absence of a father figure.40

The teenage fertility rate has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator of children’s health, development and wellbeing.3

**Key messages**

- Australia’s teenage fertility rate ranked 16th out of 24 OECD countries in 2003.21
- Rates are substantially higher for Indigenous Australians and those living outside major cities.
Early childhood (0–4 years)

Birthweight

Measure: Percentage of live born infants with a birthweight of less than 2,500 grams

Birthweight is an important indicator of a baby’s chance of survival and good health. Low birthweight increases the probability of lengthy hospitalisation after birth, the need for resuscitation, or death, and is a risk factor for neurological and physical disabilities. In 2005, 70% of high-risk infants admitted to level III neonatal intensive care units in Australia were of low birthweight.

A baby may be small for its gestational age (intrauterine growth retardation) or due to being born early (preterm). Factors that contribute to low birthweight include maternal age, illness during pregnancy, low socioeconomic status, multiple fertility, maternal history of spontaneous abortion, harmful behaviours such as smoking or excessive alcohol consumption, poor nutrition during pregnancy and poor prenatal care.

Mothers aged less than 20 years, or 40 years or over, are at heightened risk of delivering a low birthweight infant. The increasing number of infants born to older mothers in Australia, and the disproportionate risk faced by certain population groups, including Indigenous women, makes this an important indicator of antenatal care and neonatal health.

The proportion of live born infants of low birthweight has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator for child health, development and wellbeing.

6.4% of live born infants were of low birthweight in 2005 (17,241 infants), including 1.1% of very low or extremely low birthweight.

The rate was double for Indigenous mothers (13.2%), and the gap between Indigenous and non-Indigenous mothers grew between 1991 and 2004.

The percentage of low birthweight infants was also higher in remote and very remote areas (8.7%) and the most socioeconomically disadvantaged areas (7.2%).

Australia ranked 13th out of 30 OECD countries in the proportion of low birthweight infants in 2005.

Key messages

- Australia ranked in the middle of the OECD in 2005 (13th out of 30 countries).
- Indigenous mothers are twice as likely as non-Indigenous mothers to have a low birthweight infant, and the gap is widening.
- Infants born in remote areas or areas of high socioeconomic disadvantage were 30–40% more likely to be of low birthweight.
Breastfeeding

Measure: Percentage of infants fully or exclusively breastfed at 4 and 6 months of age

Breastfeeding is extremely important in promoting healthy development in children. Breast milk provides the best nutritional start for infants and helps to protect against infectious disease. Breastfeeding is also associated with long-term benefits, including improved cognitive development and protection against immune-related diseases such as Type 1 diabetes, celiac disease, inflammatory bowel disease and possibly some forms of cancer. Breastfeeding has many positive health effects for mothers, as well as encouraging bonding between mother and child.

‘Exclusive’ breastfeeding is defined as the infant receiving only breast milk and no other food or drink, including water, while ‘fully’ breastfeeding infants can receive other fluids such as juice or water. The Australian dietary guidelines for children and adolescents recommend exclusive breastfeeding of infants until around 6 months of age to achieve optimal growth, development and health.

Currently, Australia has no reliable national data collection to effectively monitor infant feeding practices, and the inconsistent use of definitions and terms makes it difficult to compare studies of the rates of breastfeeding.

The proportion of infants exclusively breastfed at 4 months of age has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator of children’s health, development and wellbeing.

According to state surveys, 18% of children in NSW (2005–06) and 15% in Victoria (2006) had been exclusively breastfed up to 6 months of age.

Exclusive breastfeeding rates in NSW were substantially lower for infants with mothers younger than 25, mothers without tertiary qualifications and those living in areas of the greatest socioeconomic disadvantage.

Key messages

- Rates of breastfeeding decline substantially within the first 6 months after birth.
- One in seven infants were fully breastfed at 6 months of age, and there is currently no national data available on exclusive breastfeeding.
- Rates of exclusive breastfeeding in NSW were half as high among younger and less educated women, and women living in the most disadvantaged areas.
Early childhood (0–4 years)

Childhood immunisation

Measure: Percentage of children on the Australian Childhood Immunisation Register (ACIR) who are fully immunised at 1 and 2 years of age

Immunisation against childhood diseases is one of the most cost effective public health interventions in preventing childhood mortality and morbidity. Increased immunisation coverage has been one of the most important public health successes of the past three decades, and has resulted in significant declines in infant and child mortality.

Australian children are protected against a number of communicable diseases through routine immunisation as part of the Immunise Australia Program. Large-scale immunisation programs exist for a wide variety of communicable diseases including diphtheria, tetanus, pertussis (whooping cough), rotavirus, poliomyelitis, measles—mumps—rubella (MMR), *Haemophilus influenzae* type b (Hib), hepatitis B, varicella (chickenpox), meningococcal C and pneumococcal disease.

The ACIR, administered by Medicare Australia, records information on the immunisation status of approximately 99% of children aged less than 7 years.

Immunisation coverage at 2 years of age of children on the ACIR has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator for children’s health, development and wellbeing. Immunisation coverage goals for Australia, recommended by the National Health and Medical Research Council (NHMRC) in 1993, called for higher than 90% coverage of children at two years of age, and near 100% coverage of children at school entry age. The coverage target for 2 year olds was achieved in 2003.

92–93% of 1 and 2 year olds on the ACIR were fully immunised in 2007, meeting the 90% national coverage target.

Immunisation coverage has increased over the past decade, particularly among 2 year olds (almost a 50% increase since 1997).

In 2005, coverage for Indigenous children (84%) was lower than for other children (90%) at 1 year of age, largely due to lower coverage of diphtheria—tetanus—pertussis and poliomyelitis vaccines.

Among 2 year olds, immunisation rates were similar for Indigenous and other children, meeting the 90% target.

Key messages

- Immunisation coverage of 1 and 2 year olds is the highest on record and meets the NHMRC 90% coverage target. However, coverage at 6 years (89%) is well below the target of nearly 100%.
- There is potential for further increases in immunisation coverage—Australia’s average coverage for 1 and 2 year olds ranked 14th out of 20 selected countries in 2006.
**Access to child care**

**Measure: Number of 0–4 year olds who required formal child care or additional formal child care, and did not receive it because of accessibility barriers**

Access to affordable, high-quality child care services is a major concern for both parents and governments. Child care services are increasingly being recognised as being of vital importance to society as they help parents participate in work or study, offer families an opportunity to be involved in the community, help create social networks and provide children with opportunities to develop their social and intellectual skills. Child care services also give parents respite from caring for children with behavioural difficulties, and provide early intervention for developmentally and socioeconomically disadvantaged children.

In recent years there has been an expanding demand for child care services, reflecting trends in social factors such as family structure, employment patterns and population mobility.

Unmet demand for child care is an important indicator of accessibility, and this information is available from the ABS Child Care Surveys, where parents were asked whether their formal child care requirements were met.

COAG has committed to improving the quality and availability of child care. This includes establishing children and family centres as part of a broader early childhood development agenda. The Australian Government is also committed to improving child care affordability for Australian families by increasing the Child Care Tax Rebate from 30% to 50%, and improving accessibility by establishing new long day care centres.

**Key messages**

- Lack of available places (services booked out) was the main reason for unmet demand for child care in 2005, and reporting of this as a barrier to accessing child care has doubled since 1999.

- Children living outside major cities are more likely to have difficulty accessing formal child care or preschool due to cost or lack of services in the area (see also Early childhood education, p.20).
Early childhood education

Measure: Percentage of children aged 3 or 4 years attending preschool or long day care centres

Attendance at high-quality early educational programs before the first year of compulsory schooling is considered to have a number of benefits that can help prepare children for successful transition to school, achieve at school and participate in society as adults. These include improved intellectual development and social, language and cognitive skills. Quality Early Childhood Education programs are especially beneficial for children from disadvantaged backgrounds.18,19

It is difficult to estimate the actual number of children participating in quality early childhood education programs in the year before primary school, due to the varied nature of children’s services throughout Australia and differences in data collection between states and territories. Early education programs may be delivered in preschool or long day care facilities; however, the proportion of children receiving high-quality programs through these settings is uncertain, in particular whether the program is delivered by a university-qualified teacher. Participation in early childhood education programs is usually for children in the year before school (generally 4 year olds) although it is open to 3 year olds in some jurisdictions. Attendance at an early educational program in the 2 years before beginning primary school has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator for children’s health, development and wellbeing.13

COAG has committed to providing universal access to 15 hours of early childhood education programs a week, for a minimum of 40 weeks a year, delivered by degree-qualified teachers. In particular, COAG has committed to providing access to a quality early childhood education program for all Indigenous 4 year olds in remote Indigenous communities within 5 years.60

Key messages

Australia’s preschool attendance rate for 4 year olds ranked in the bottom third of OECD countries in 2005, the lower rate likely to be a considerable underestimate due to the large number of privately-operated child care facilities in Australia.61

Attendance of 4 year olds at preschool and long day care centres is increasing.

Attendance at preschool and long day care centres declines with increasing remoteness for 3 year olds, while it increases for 4 year olds in preschool (see also Access to child care, p.19).
This section focuses on ‘school age’ childhood (5–12 year olds). For many children this is the first major transition in life from the family home and into other environments, such as full-time compulsory schooling. This brings about challenges and risks. Both their behaviour and the physical and social environment increase the risk of adverse events such as injuries, the development of chronic conditions, mental and behavioural problems, and risk factors that persist into adolescence and adulthood. This is a crucial time for learning, social and emotional development and social participation, and the acquisition of literacy and numeracy skills. It is also a critical time for establishing good health and social behaviours.

The following table presents national data for each of the measures of the five indicator topics for health and key health risk factors, and for each of the indicators for education and crime. Where time series data has been referred to on an indicator page, the direction of the recent trend is shown in the table.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Value</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injury and poisoning</strong></td>
<td>Total hospitalisations due to injury and poisoning per 100,000 5–12 year olds</td>
<td>1,366</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to transport accidents per 100,000 5–12 year olds</td>
<td>232</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to falls per 100,000 5–12 year olds</td>
<td>652</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to burns and scalds per 100,000 5–12 year olds</td>
<td>16</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to accidental poisoning per 100,000 5–12 year olds</td>
<td>10</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to accidental drowning per 100,000 5–12 year olds</td>
<td>3</td>
<td>~</td>
</tr>
<tr>
<td><strong>Chronic disease and mental health</strong></td>
<td>Hospitalisations for asthma per 100,000 5–12 year olds</td>
<td>331</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations for mental health and behavioural disorders per 100,000 5–12 year olds</td>
<td>178</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations for diabetes per 100,000 5–12 year olds</td>
<td>85</td>
<td>×</td>
</tr>
<tr>
<td><strong>Dental health</strong></td>
<td>Average number of decayed, missing or filled teeth in 6 year olds</td>
<td>2</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Average number of decayed, missing or filled teeth in 12 year olds</td>
<td>1</td>
<td>~</td>
</tr>
<tr>
<td><strong>Physical activity/screen time</strong></td>
<td>Percentage of children aged 5–12 years who did not participate in any organised sport or dancing in 2 weeks</td>
<td>42</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Percentage of children aged 5–12 years with 40 hours or more ‘screen time’ in 2 weeks</td>
<td>16</td>
<td>. .</td>
</tr>
<tr>
<td><strong>Overweight and obesity</strong></td>
<td>Percentage of 6–11 year olds who were obese</td>
<td>6</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Percentage of 6–11 year olds who were overweight but not obese</td>
<td>17</td>
<td>. .</td>
</tr>
<tr>
<td><strong>Literacy and numeracy benchmarks</strong></td>
<td>Percentage of Year 5 children meeting national reading benchmarks</td>
<td>88</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Percentage of Year 5 children meeting national writing benchmarks</td>
<td>94</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Percentage of Year 5 children meeting national numeracy benchmarks</td>
<td>90</td>
<td>~</td>
</tr>
<tr>
<td><strong>Crime</strong></td>
<td>Children aged 0–9 years who were victims of robbery, per 100,000</td>
<td>2</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Children aged 10–14 years who were victims of robbery, per 100,000</td>
<td>61</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Children aged 0–9 years who were victims of kidnapping or abduction, per 100,000</td>
<td>4</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Children aged 10–14 years who were victims of kidnapping or abduction, per 100,000</td>
<td>11</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Children aged 10–12 years under juvenile justice supervision, per 100,000</td>
<td>44</td>
<td>✓</td>
</tr>
</tbody>
</table>

Key: ✓ = favourable trend; × = unfavourable trend; ~ = no change or clear trend; . . = no trend data presented.
Injury and poisoning

Measure: Injury hospitalisations for 5–12 year olds due to selected causes, per 100,000 population

Injuries (including poisoning) are a major cause of acute care utilisation, long-term disability and mortality among children. They are the leading cause of death of children aged 1–14 years in every industrialised country, including Australia. Among 5–12 year olds injuries and poisoning accounted for one-third of all deaths in 2006 and almost 30,000 hospitalisations in 2006–07 (see also Mortality, p. 7). Injuries can also result in permanent disability. In 2003, more than 120,000 Australians had a disability where their main disabling condition was caused by an injury that occurred before the age of 20. Therefore, injuries, which are largely preventable, are responsible for a great deal of personal suffering and cost to the health system and wider community.

Children are exposed to a range of settings where there is potential for injury or poisoning to occur, including school, sporting environments, streets and neighbourhoods. Injuries sustained among older children are increasingly influenced by behaviour in addition to their physical and social environment. The compulsory use of bicycle helmets and seat-belts, safe playgrounds, and reduced speed limits and traffic-calming devices in school zones are examples of injury prevention initiatives relating to individual behaviour and physical and social environments.

Injury prevention and control has been a National Health Priority Area since 1986. A key priority of the National Injury Prevention and Safety Promotion Plan 2004–2014 is to create a positive safety culture and a safe environment, particularly for children.

Key messages

- Around 30,000 children aged 5–12 years are hospitalised for injuries each year—there has been little change in the rate over the past decade.
- Boys 60% more likely than girls to be hospitalised for injuries; Indigenous children 30% more likely than other children.
- Hospitalisation rate due to burns and scalds has increased by 20% in a decade.
Chronic disease and mental health

Measure: Hospitalisations for 5–12 year olds for selected chronic health conditions, per 100,000 population

Despite substantial health gains due to reductions in rates of communicable disease and death, chronic disease remains a significant challenge to the health and wellbeing of Australian children. This section presents data on three chronic health conditions that are National Health Priority Areas. Asthma is the most common long-term health condition among children. Diabetes is less common but can have severe consequences in the short and long term, including diabetic coma, kidney failure, loss of limbs and premature death. Mental and behavioural disorders are also included as many of these are chronic conditions and may have health and social consequences for affected children later in life (see also Mental health, p.31).

Broad measures of chronic conditions in children may be based on surveys (such as National Health Surveys), or diagnosed or treated populations (such as the National Diabetes Register). Hospitalisations due to specific conditions represent the extent to which chronic diseases require acute care and are presented here. Differences in hospitalisation rates between types of conditions or population groups, or over time, reflect a range of factors including prevalence, severity, access to and effectiveness of early intervention, and access to and effectiveness of management and treatment in the community.

Asthma, diabetes and mental health are all National Health Priority Areas. COAG has committed to establishing a Preventative Health Care Partnership, including addressing the major risk factors contributing to increasing rates of diabetes and poor mental health. Australian Health Ministers have established a National Asthma Strategy 2006–2008, which provides a framework for a collaborative approach towards improving asthma care in Australia. The Australian Government has also formulated a National Primary Health Care Strategy to improve management of chronic disease.

Key messages

- Children’s hospitalisation rates have fallen considerably for asthma, but have risen for diabetes (mostly Type 1 diabetes).
- Boys and Indigenous children are at increased risk of hospitalisation due to asthma, and mental and behavioural disorders. Indigenous children are also more than twice as likely as other children to be hospitalised for diabetes.
Dental health

Measure: Mean number of decayed, missing or filled teeth among 6 year olds and 12 year olds

Poor dental health adversely affects children’s health and overall wellbeing. Untreated dental caries facilitate abscess formation, cellulitis and systemic disease. Oral disease can lead to failure to thrive and school absences, negatively affecting educational performance. Poor nutrition or an unbalanced diet high in sugar may place children at an increased risk of developing dental health problems such as gum disease and dental caries.

The number of teeth decayed, extracted due to decay, or teeth with fillings is an indicator of oral disease in the population. Good oral health in childhood contributes to better dental outcomes in adulthood—less decay and the loss of fewer natural teeth. It also enhances children’s confidence, self-esteem, appearance, chewing ability and participation in social activities.

The dental health of Australia’s children has improved substantially since the mid-1970s. This trend can be attributed to a number of factors, including increased access to fluoridated toothpaste and drinking water, improved dental hygiene, and provision of clinical preventive services and ongoing monitoring through the School Dental Scheme. However, since the mid-1990s the decline in dental decay has been arrested or reversed.

The mean number of decayed, missing or filled teeth among 12 year olds has been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator of children’s health, development and wellbeing.

COAG has committed to provide additional dental health services, delivering up to one million consultations and services over 3 years under the Commonwealth Dental Health Program, including 48,000 services over 4 years to Indigenous Australians.

Australia compares favourably with other OECD countries, ranking 8th out of 30 countries in mean decay experience among 12 year olds in 2002. Indigenous children and children living outside major cities or in areas of high socioeconomic disadvantage are at increased risk of dental health problems, with the gap between population groups higher for 6 year olds than 12 year olds.

Key messages
Physical activity/screen time

Measure 1: Percentage of children aged 5–12 years who did not participate in any organised sport or dancing in a 2 week period

Measure 2: Percentage of children aged 5–12 years who spent 40 or more hours participating in screen activities over a 2 week period

Regular physical activity has many benefits to health and wellbeing of children and is an important factor in maintaining good health. It reduces the risk of being overweight or obese; having high blood pressure, Type 2 diabetes and cardiovascular disease; protects against some forms of cancer; and strengthens the musculoskeletal system. Physical activity also has psychosocial benefits, reducing symptoms of depression, stress and anxiety, and improving self-confidence, self-esteem, energy levels, sleep quality and the ability to concentrate. Physical activity includes any activity that requires children to expend energy, including sports, domestic duties or simply playing. It is important to consider children’s physical activity alongside information on the amount of screen time they engage in, as various studies have found a positive correlation between hours of television viewing and overweight.

The National Physical Activity Guidelines for Australian children aged 5–18 years recommend at least 60 minutes of moderate to vigorous physical activity and no more than 2 hours of screen time (for example, watching television or using a computer) per day.

Key messages

- More than half of all 5–12 year olds were involved in organised sport or dancing outside school hours in 2006.
- One in six children spent 40 hours or more on screen activities in a fortnight; the rate was higher for boys than girls.
**Overweight and obesity**

**Measure: Percentage of 6–11 year olds who are overweight or obese**

Children who are overweight or obese are at increased risk of developing physical and mental health problems. In the short to medium term they may experience serious conditions such as gallstones, hepatitis, sleep apnoea, asthma, cardiovascular conditions and Type 2 diabetes. In the long term, consequences of childhood weight problems include adult obesity, increased rates of coronary heart disease, diabetes, certain cancers, gall bladder disease, osteoarthritis and endocrine disorders. In addition, overweight and obese children frequently experience discrimination, victimisation and teasing by their peers and are more likely to have mental health problems than children with other chronic health conditions.

Many interacting factors lead to increased body weight. All children naturally gain body weight as they grow and develop; however, for excess weight gain to occur, an imbalance must exist between the amounts of energy children are consuming and the energy they expend over an extended period of time. While genetics plays a role, it is clear that cultural, environmental, economic, familial and individual behavioural factors also influence the likelihood of this imbalance occurring.

Rates of overweight and obesity among children have been endorsed by Health, Community and Disability Services Ministers as a Headline Indicator of children's health, development and wellbeing. Australian Health Ministers made obesity a National Health Priority Area in 2008. The Australian Government has also established the Preventative Health Taskforce, aimed at reducing the burden of chronic disease caused by obesity, tobacco and the excessive consumption of alcohol. This Taskforce is responsible for the development of a National Obesity Strategy.

**Key messages**

- 6% of primary school-aged children (6–11 year olds) were obese, and 17% were overweight but not obese in 2006.
- Overweight and obesity rates in children increased with socioeconomic disadvantage.
Literacy and numeracy

Measure: Percentage of Year 5 students who achieve the national benchmarks for reading, writing and numeracy

The acquisition of literacy skills in the schooling years is the basis for further educational attainment, social development and employment. The concepts of literacy and numeracy encompass the skills required to identify, understand, interpret, create, communicate and compute using written and printed materials in various contexts, including information and communication technologies.

People with limited literacy and numeracy tend to experience greater difficulty in finding employment. In terms of business and the economy, low levels of functional literacy and numeracy are a recognised major barrier to growth. Educational outcomes measured through test scores during the school years, including literacy and numeracy scores, are predictive of social exclusion and there is a strong connection between health and socioeconomic gradients related to education, employment and income.

Ministers for Health, Disability and Community Services have endorsed literacy and numeracy benchmarking results for Year 5 students as a Headline Indicator of children’s health, development and wellbeing.

COAG has committed to the development of a broad national strategy for early childhood development and reforms in schools. COAG has also committed to the development and implementation of a national curriculum in key learning areas by 2010. For Indigenous young people, COAG has committed to halve the gap in reading, writing and numeracy achievements within a decade.

Key messages

- Most Year 5 students met national literacy (reading and writing) and numeracy benchmarks.
- There is a significant gap between Indigenous students and the national average for literacy and numeracy. It is not limited to Indigenous students living in remote parts of Australia.
- Australian Year 4 students ranked 8th in science and 16th in mathematics out of 25 participating countries in an international benchmarking study in 2003.
### Crime

**Measure 1:** Number of children aged 0–14 years who were victims of selected crimes, per 100,000 population

**Measure 2:** Number of children aged 10–12 years who are under juvenile justice supervision, per 100,000 population

Being a victim of crime can be detrimental to a child’s health, wellbeing, sense of security, safety and feelings about the future. For some children, being victimised may lead to diminished educational attainment and social participation in early adulthood, or result in physical injury, disability and even death. Experience of crime is central to issues of community safety in general, and even more so for children as the most vulnerable members of society. For many children, their personal experience of crime is as victims of child abuse and neglect (see also Child abuse and neglect, p. 11).

Some children are themselves perpetrators of crime, and children who have been victimised are at greater risk of later offending. For most children engaged in criminal activities, the nature of the offence is relatively minor and the behaviour is short lived. However, for a small number of children this behaviour becomes more serious or persistent and results in contact with the juvenile justice system. Children whose first juvenile justice supervision order occurs before the age of 13 comprise less than 10% of all young people under supervision, and represent a particularly disadvantaged and high-risk group of the Australian population.

The Australian Government has committed to developing a National Child Protection Framework which will focus on preventing abuse through early intervention and better integration of family services. COAG has also committed to identify joint reforms and implementation timetables for basic protective security from violence for Indigenous parents and children.

**Key messages**

- Children aged 10–14 years are more likely to be victims of robbery or kidnapping/abduction than younger children (0–9 year-olds).
- Boys are 5 times as likely as girls to be victims of robbery, and 6 times as likely to be under juvenile justice supervision.
- Indigenous children are over-represented in juvenile justice supervision, 49 times as likely as other 10–12 year olds to be under supervision.
This section focuses on adolescents (13–19 year olds). Teenagers are in transition between childhood and adulthood, and their increasing independence brings about new challenges and risks. This results in marked differences in patterns of morbidity and mortality for adolescents compared with younger children. They are more likely to engage in risky behaviours (such as substance use, dangerous driving and unsafe sexual practices), leading to high rates of violence and injury among young people. Long-term health conditions and associated risk factors (such as mental health disorders, chronic and communicable diseases, and overweight and obesity) also emerge during this period and may persist into adulthood.

Secondary and post-school education, a good transition from school to work, no or limited exposure to or participation in criminal activities, preparation for parenthood, and economic and social participation are key factors contributing to the wellbeing of young adults.

The following table presents national data for each of the measures of the four indicator topics relating to health and key health risk factors and for each of the three indicators related to wellbeing (including education). Where time series data has been referred to on an indicator page, the direction of the recent trend is shown in the table.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Value</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury and poisoning</td>
<td>Total hospitalisations due to injury and poisoning per 100,000 13–19 year olds</td>
<td>2,221</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to transport accidents, per 100,000 13–19 year olds</td>
<td>490</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to falls, per 100,000 13–19 year olds</td>
<td>386</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to intentional self-harm, per 100,000 13–19 year olds</td>
<td>197</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Hospitalisations due to assault, per 100,000 13–19 year olds</td>
<td>180</td>
<td>×</td>
</tr>
<tr>
<td>Mental health</td>
<td>Percentage of 13–19 year olds reporting mental or behavioural problems</td>
<td>10</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Total hospital bed days, per 100,000 population for mental and behavioural problems</td>
<td>5,819</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Hospital bed days, per 100,000 population for schizophrenia and related disorders</td>
<td>1,224</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Hospital bed days, per 100,000 population for substance use-related disorders</td>
<td>515</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Hospital bed days, per 100,000 population for mood disorders</td>
<td>1,503</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Hospital bed days, per 100,000 population for behavioural syndromes</td>
<td>1,299</td>
<td>×</td>
</tr>
<tr>
<td>Overweight and obesity</td>
<td>Percentage of 15–19 year olds who were obese</td>
<td>5</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Percentage of 15–19 year olds who were overweight but not obese</td>
<td>18</td>
<td>×</td>
</tr>
<tr>
<td>Substance use</td>
<td>Percentage of 14–19 year olds who are current smokers</td>
<td>10</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds at risk of long-term harm to their health from alcohol</td>
<td>9</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds at risk of short-term harm to their health from alcohol</td>
<td>26</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds who had used illicit drugs in the past 12 months</td>
<td>17</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds who had been the victim of alcohol-related verbal abuse in the past 12 months</td>
<td>28</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds who had been the victim of alcohol-related physical abuse in the past 12 months</td>
<td>7</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds who had been the victim of other drug-related verbal abuse in the past 12 months</td>
<td>10</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Percentage of 14–19 year olds who had been the victim of other drug-related physical abuse in the past 12 months</td>
<td>3</td>
<td>. .</td>
</tr>
<tr>
<td>Year 12 retention &amp; completion</td>
<td>Apparent retention rate to Year 12 (%)</td>
<td>74</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Percentage of 19 year olds who have completed Year 12</td>
<td>74</td>
<td>~</td>
</tr>
<tr>
<td>Youth participation</td>
<td>Percentage of 15–19 year olds who are not engaged in education or employment</td>
<td>7</td>
<td>~</td>
</tr>
<tr>
<td></td>
<td>Percentage of 15–19 year olds in the labour force who were unemployed</td>
<td>13</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Percentage of 15–19 year olds in the labour force who were underemployed</td>
<td>10</td>
<td>✓</td>
</tr>
<tr>
<td>Crime</td>
<td>Persons aged 15–19 years who were victims of robbery, per 100,000 population</td>
<td>270</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Persons aged 15–19 years who were victims of kidnapping or abduction, per 100,000 population</td>
<td>10</td>
<td>. .</td>
</tr>
<tr>
<td></td>
<td>Percentage of young people aged 13–19 years under juvenile justice supervision</td>
<td>0.6</td>
<td>✓</td>
</tr>
</tbody>
</table>

Key: ✓ = favourable trend; × = unfavourable trend; ~ = no change or clear trend; . . = no trend data presented.
Injury and poisoning

Measure: Injury hospitalisations for 13–19 year olds due to selected causes, per 100,000 population

Increasing responsibility for decision making in adolescence creates more opportunities to engage in risky behaviours. This independence occurs simultaneously with exposure to alcohol and other drugs, and the development of new skills, such as driving and job skills, at a time when peer acceptance is important. Young people may experiment with illicit substances and alcohol, which can make them more prone to certain types of injuries, such as falls, transport accidents, accidental poisoning and assault.88

Injury (including poisoning) accounts for 18% of the burden of disease among 15–24 year olds—the second highest contributor after mental disorders89. It is the leading cause of death (see also Mortality, p.7) and the third leading cause of hospitalisation in this age group84 and can result in significant disability. In 2003, more than 120,000 Australians had a disability where their main disabling condition was caused by an injury that occurred before the age of 20.41 Reducing the number and severity of injuries among adolescents and young adults is therefore key to preventive health initiatives.

Injuries may be caused by a diverse range of factors, including transport accidents, falls from heights or during sport, assault and intentional self-harm. Consequently, injury prevention strategies intersect with initiatives in the areas of community safety, violence reduction and mental health care.

Injury prevention and control has been a National Health Priority Area since 1986. A key priority of the National Injury Prevention and Safety Promotion Plan 2004–2014 is to create a positive safety culture and a safe environment, particularly for children and youth.90

Hospitalisations of 13–19 year olds for selected injuries, per 100,000 population

Notes: See Berry & Harrison 200764 for details of injury classifications from hospital morbidity data.
Source: AIHW National Hospital Morbidity Database.

Young males were 3–4 times as likely as young females to be hospitalised for transport accidents, falls and assault, while females were 3 times as likely to be hospitalised for intentional self-harm.

Overall hospitalisation rate for Indigenous teenagers was 30% higher than for other teenagers, largely due to the assault hospitalisation rate being 5 times as high among Indigenous teenagers.

Key messages

- Males had higher rates of hospitalisations than females due to transport accidents, falls and assault, while females had higher rates of hospitalisations due to intentional self-harm.
- Hospitalisation rates are increasing for assault and intentional self-harm.
- Injury hospitalisation rates are higher for Indigenous youth, young people living in remote or very remote areas and those living in areas of the greatest socioeconomic disadvantage, particularly for assault and intentional self-harm.88
Mental health

Measure 1: Percentage of 15–19 year olds who report having a mental or behavioural problem

Measure 2: Hospital bed days per 100,000 population for mental and behavioural disorders among 13–19 year olds

Mental health disorders are the leading cause of disability among young Australians aged 15–24 years and account for almost 50% of the burden of disease in this age group. More specifically, anxiety and depression contribute 17% of the male disease burden and 32% of the female disease burden.89

Young people with a mental health disorder are more likely to have lower educational attainment, experience joblessness and have poor physical health.89 It is not possible to determine causality from these associations, and experiencing adverse situations, especially during youth, may in fact contribute to the development of a mental disorder. The reasons why some people develop mental disorders are complex, but a range of possible influences include individual attributes, family and social factors, school context, life events and situations, and community and cultural factors.

Many people living with mental health problems are undiagnosed or do not access specialist services; others manage their condition largely through primary health care. Measures of the extent to which people with mental disorders receive treatment as hospital inpatients and the duration of their hospital stay (bed days) therefore represent the acute care-treated prevalence of mental illness.

Mental health is a National Health Priority Area. The COAG National Action Plan on Mental Health 2006–2011 aims to reduce the prevalence and severity of mental illness and its risk factors.92

Key messages

- 1 in 10 Australians aged 15–19 years reported a mental or behavioural problem.
- Reported prevalence and hospital bed day rate for mental and behavioural problems are each 40% higher among Indigenous than non-Indigenous teenagers.
- Male hospital bed day rate for mental and behavioural disorders fell by 28%, but female rate rose by 7% between 1998–99 and 2006–07.
Adolescence (13–19 years)

Overweight and obesity

Measure: Percentage of adolescents aged 15–19 years who were overweight or obese

Overweight and obesity in young people are linked to a range of immediate and long-term health problems. In the short term, overweight and obesity affects young people’s psychological wellbeing and increases their risk of developing cardiovascular conditions, asthma and Type 2 diabetes. Long-term consequences include adult obesity, increased risk of coronary heart disease, diabetes, some cancers, gall bladder disease, osteoarthritis and endocrine disorders. Negative social consequences of teenage obesity include social isolation and lower educational and income attainment throughout life.

Risk factors associated with obesity in childhood and adolescence include genetic makeup, ethnicity, television viewing, extent and types of physical activity, dietary intake and eating patterns, artificial feeding as infants, and presence of other health conditions.

While overweight and obesity accounted for less than 1% of the burden of disease in youth, it contributed 7.5% to the total disease burden in 2003. Young people who are overweight or obese are more likely to be obese as adults, therefore reducing youth overweight and obesity is key to early intervention and prevention of chronic disease.

The overweight and obesity data in this section is based on self-reported height and weight, which is less accurate than measured height and weight. For younger children, the overweight and obesity data presented in this report is based on measured height and weight (see p.26), and hence it is not accurate to compare the prevalence of overweight and obesity between these different age groups.

Australian Health Ministers made obesity a National Health Priority Area in 2008. The Australian Government has also established the Preventative Health Taskforce, aimed at reducing the burden of chronic disease caused by obesity, tobacco and the excessive consumption of alcohol. This Taskforce is responsible for the development of a National Obesity Strategy.

Key messages

- 1 in 20 Australians aged 15–19 years were obese in 2004–05.
- 18% of 15–19 years olds were overweight but not obese, up from 15% in 1995.
- Indigenous teenagers were more than twice as likely to be obese as non-Indigenous teenagers in 2004–05.
Substance use

Measure 1: Percentage of 14–19 year olds who consume alcohol at risky or high risk levels for short and long term harm, who smoke tobacco, and who have used an illicit drug recently

Measure 2: Percentage of 14–19 year olds who have been the victim of an alcohol or other drug-related incident

Misuse of alcohol and use of other drugs (including tobacco) by young people can cause immediate and long-term health and social problems. In the short term, it may result in hospitalisations due to acute intoxication and related injuries, dependence, withdrawal symptoms, psychotic disorders and amnesia. In the long term, alcohol and other drug use can lead to depression, infections with blood-borne diseases, damage to the liver, heart and brain, and increased risk of cancers and other serious health conditions.98,99 Drug abuse has also been associated with family and relationship conflict, and legal and financial problems.100

Many factors can put young people at risk of problematic drug use. Some of these occur before they reach adolescence, such as maternal drug use during pregnancy, early behavioural and emotional problems and early exposure to drugs.95,100 Other factors include peer antisocial behaviour, poor parental control and supervision, poor family bonding, drug use among family members, low self-esteem, academic failure, leaving school early and poor connection with family, school and community.100

COAG has identified reducing alcohol and substance abuse and its impact on families, safety and community wellbeing as a priority area for the 2008 forward work-plan.9 COAG has also acknowledged the importance of tackling alcohol misuse and binge drinking among young people and commissioned the Ministerial Council on Drug Strategy to investigate options to reduce binge drinking.30

Key messages

- Adolescent smoking rates have halved and risky alcohol intake and illicit drug use have also declined since 2001.
- One in four teenagers regularly risk short-term harm to their health from alcohol consumption; 1 in 10 are at risk of long-term harm.
- Almost 300,000 teenagers have felt or experienced threats to their safety through the alcohol use of others.
Overall retention rate more than doubled throughout the 1980s, but has remained steady at 74–75% for the past 5 years.

Retention to Year 12 is consistently higher for females than for males (80% compared with 69% in 2007).

Indigenous students are almost half as likely to stay in school until Year 12 (43% retention rate), but the gap is closing.

**Year 12 retention and completion**

**Measure 1:** Number of full-time students who continued to Year 12 as a percentage of those who commenced secondary schooling (apparent retention rate)

**Measure 2:** Percentage of 19 year olds who have completed Year 12 (completion rate)

As the number of low-skilled jobs in the employment market decreases, the importance of educational qualifications increases. Early school leavers often have trouble finding stable, full-time employment and tend to work in a narrow range of jobs.101 In Australia, individuals with higher levels of education report fewer illnesses and have better mental health than those with lower levels of education.102 Educational attainment may directly affect health by providing young people with greater knowledge and understanding about health, particularly awareness of health risk and protective factors, or indirectly through its association with typically safe, secure and generally better paid and rewarding employment. These benefits positively influence health-related factors such as stress level, injury risk, diet and ability to acquire medical care.

While the apparent retention rate provides information about the proportion of young people who stay in school, it is not a measure of successful completion of Year 12. Young people who did not finish high school have fewer post-school education, training and employment options, and are more likely to experience unemployment than those who completed Year 12 (see also *Youth participation*, p.35).103

COAG has requested Commonwealth and State implementation plans for lifting the Year 12 or the equivalent retention rate to 90 per cent by 2020.9 For Indigenous youth, COAG has committed to at least halve the gap for Year 12 attainment or equivalent attainment rates by 2020.60

Australia ranked 18th out of 29 OECD countries in high school completion rates for 25–34 year olds in 2006.105 Retention rate to Year 12 is much lower for Indigenous students, but the gap has narrowed over the past decade.

Year 12 completion rates are lower for 19 year olds in regional and remote areas, and Indigenous young people throughout Australia.

**Key messages**

- Australia ranked 18th out of 29 OECD countries in high school completion rates for 25–34 year olds in 2006.105
- Retention rate to Year 12 is much lower for Indigenous students, but the gap has narrowed over the past decade.
- Year 12 completion rates are lower for 19 year olds in regional and remote areas, and Indigenous young people throughout Australia.
### Youth participation

**Measure 1: Percentage of 15–19 year olds not engaged in education or employment**

**Measure 2: Unemployment and underemployment rates for 15–19 year olds**

Young people not involved in school or employment may have decreased opportunities to fully participate in society and are considered at risk of social exclusion. Youth inactivity is linked to dependency on parents or social welfare, family problems, substance abuse, physical and sexual abuse, violence and crime.\(^{106,107}\)

Secure and satisfactory employment offers young people not only financial independence but also a sense of self-control, self-confidence and social contact. In contrast, unemployment, insecure employment and unfavourable working conditions have all been associated with low self-esteem and poor physical and mental health.\(^{108,109}\)

Underemployed workers, or those with inadequate wages or insufficient number of working hours, may also be at risk of low self-esteem, alcohol abuse and depression.\(^{110}\)

Underemployment is also a concern from social and economic perspectives, as it can have a significant detrimental effect on the financial, personal and social lives of young people.

COAG has requested Commonwealth and State implementation plans for improving and expanding vocational and technical education, creating an additional 450,000 training places over the next four years.\(^9\) A further 50,000 vocational education and training places for national priority health occupations will be available through the COAG Productivity Places Program.\(^{10}\) COAG has also committed to lifting the Year 12 or equivalent retention rates (see Year 12 retention and completion, p.34) and halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.\(^{60}\)

### Key messages

- **7% of 15–19 year olds were neither working nor studying (96,500 adolescents) in 2007. This proportion has not changed significantly since 2001.**
- **One in three had more than a full-time load, either full-time study with additional work or full-time work with additional study.**

### Participation in education and employment by 15–19 year olds (per cent)

<table>
<thead>
<tr>
<th>Participation Type</th>
<th>May 2001</th>
<th>May 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time work and full-time study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time work only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time study only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time work and part-time study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time study and part-time work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time work only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time study only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time work only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neither work nor study</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: ABS 2001 and 2007 Education and work (Cat. no. 6227.0).

- **In September 2007, the unemployment rate of 15–19 year olds was 13.3%—3 times that of all people aged 15 years and over (4.2%).**
- **The youth underemployment rate (10.0%) was more than twice that for the overall labour force (4.7%).**
- **Youth unemployment and underemployment rates have fallen by a quarter since 2001.**

### Unemployment and underemployment rates (per cent of the labour force)

<table>
<thead>
<tr>
<th>Year</th>
<th>Unemployment rate 15–19 year olds</th>
<th>Underemployment rate 15–19 year olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>2002</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>2003</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>2004</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>2005</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>2006</td>
<td>15.0</td>
<td>10.0</td>
</tr>
<tr>
<td>2007</td>
<td>15.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Notes:
1. Data are original series (unadjusted) at September each year.
2. The underemployment rate is the number of employed persons who want, and are available for, more hours of work than they currently have, as a percentage of the labour force.

Source: Australian Labour Market Statistics July 2008 (ABS Cat. no. 6105.0).

- **Australia ranked 16th (out of 25 OECD countries) in the percentage of 15–19 year olds not engaged in education or employment in 2006, and 12th (out of 30 OECD countries) in the unemployment rate for 15–19 year olds in 2007.**\(^{105,111}\)
- **7% of 15–19 year olds are neither working nor studying, while a third have more than a full-time load.**
- **15–19 year olds in the labour force are 3 times as likely to be unemployed and twice as likely to be underemployed as the overall labour force population.**
- **The unemployment rate for Indigenous youth aged 15–24 years was more than twice as high as for other young people in 2006 (22.4%) compared to 9.9%).**
Crime

Measure 1: Number of persons aged 15–19 years who were victims of selected crimes, per 100,000 persons aged 15–19 years

3,900 15–19 year olds were victims of robbery in 2007, representing one-quarter of all robbery victims.

The rate for teenage males being robbery victims was 4 times as high as males generally; for teenage females it was 3 times as high.

The rate of kidnapping/abduction was 3 times as high for young females (15 per 100,000) as young males (6 per 100,000).

Victims of selected crimes per 100,000 population, 2007

- Males 15–19 years
- Females 15–19 years
- All males
- All females

Source: ABS Recorded Crime—Victims, Australia 2007 (Cat. no. 4510.0).

Measure 2: Percentage of persons aged 13–19 years who were under juvenile justice supervision

11,900 teenagers (13–19 years) were under juvenile justice supervision in 2006–07 (0.6% of all teenagers).

The supervision rate for Indigenous teenagers was 13 times that of other teenagers.

No change in the Indigenous supervision rate in 6 years, but the rate for other Australian youth fell by 20%.

Percentage of 13–19 year olds under juvenile justice supervision

- Indigenous youth
- Males
- Females
- Other youth

Notes:
1. No data were available for the ACT from 2000–01 to 2002–03, therefore national rates across all years exclude the ACT.
2. Legislation governing the age of persons under the jurisdiction of the juvenile justice system varies between states and territories.

Source: AIHW Juvenile Justice National Minimum Data Set.

Key messages

- Teenagers, particularly males, experience high rates of being victims of robbery.
- No national data are available on rates of physical or sexual assault for young people.
- Indigenous teenagers are over-represented in juvenile justice supervision, and there has been no change in the Indigenous supervision rate as observed for other Australian teenagers in recent years.
Appendix A: Mapping the indicators to Government priorities and reform

The following high-level objectives, set by government, underpin current reforms that will impact on the health and wellbeing of children and adolescents, as well as the broader society. While COAG has established seven Working Groups to drive the reform work program, only four of these relate directly to children and youth, and have been described below.

To improve health outcomes for all Australians and the sustainability of the Australian health system
—COAG Working Group on Health and Ageing

To pursue substantial reform in the areas of education, skills and early childhood development, to deliver significant improvements in human capital outcomes for all Australians.
To strengthen Australia’s economic and social foundations through this reform workplan
—COAG Working Group on the Productivity Agenda (Education, Skills, Training & Early Childhood Development)

To develop service delivery improvements to reduce homelessness (one of the 5 objectives of this Working Group)
—COAG Housing Working Group

To close the gap on Indigenous disadvantage and in particular close the life expectancy gap within a generation; halve the gap in mortality rates for Indigenous children under 5 within a decade; and halve the gap in reading, writing and numeracy achievements within a decade—in partnership between all levels of government and Indigenous communities. The pathway to closing the gap is inextricably linked to economic development and improved education outcomes
—COAG Working Group on Indigenous Reform

All Australians need to be able to play a full role in all aspects of Australian life.
—The Social Inclusion Agenda

The following table shows how the indicators presented in this report relate to each of these high level objectives. A number of indicators are of relevance to more than one area of reform.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>COAG Working Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health &amp; Ageing</td>
</tr>
<tr>
<td>Mortality</td>
<td>✓</td>
</tr>
<tr>
<td>Disability</td>
<td>✓</td>
</tr>
<tr>
<td>Jobless families</td>
<td></td>
</tr>
<tr>
<td>Family economic situation</td>
<td></td>
</tr>
<tr>
<td>Child abuse &amp; neglect</td>
<td></td>
</tr>
<tr>
<td>Homelessness</td>
<td>✓</td>
</tr>
<tr>
<td>Teenage births</td>
<td>✓</td>
</tr>
<tr>
<td>Birthweight</td>
<td>✓</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>✓</td>
</tr>
<tr>
<td>Childhood immunisation</td>
<td>✓</td>
</tr>
<tr>
<td>Access to child care</td>
<td></td>
</tr>
<tr>
<td>Early childhood education</td>
<td>✓</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>✓</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>✓</td>
</tr>
<tr>
<td>Mental health</td>
<td>✓</td>
</tr>
<tr>
<td>Dental health</td>
<td>✓</td>
</tr>
<tr>
<td>Physical activity</td>
<td>✓</td>
</tr>
<tr>
<td>Overweight &amp; obesity</td>
<td>✓</td>
</tr>
<tr>
<td>Literacy &amp; numeracy</td>
<td>✓</td>
</tr>
<tr>
<td>Crime</td>
<td>✓</td>
</tr>
<tr>
<td>Substance use</td>
<td>✓</td>
</tr>
<tr>
<td>Year 12 retention &amp; completion</td>
<td>✓</td>
</tr>
<tr>
<td>Youth participation</td>
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</tr>
</tbody>
</table>
Appendix B: About the data

The data and analysis included in this report builds on previous work that the AIHW has undertaken in the areas of child and youth health, development and wellbeing. Over the last decade the AIHW has produced six comprehensive national statistical reports on patterns and trends in child and youth health, development and wellbeing. The indicators included in these reports cover a broad range of areas including health and health risk factors, learning and development, family and community environments, and safety and security (further information on these reports can be found at www.aihw.gov.au/publications/index.cfm). This report builds on the work of these detailed reference documents by drawing together key summary statistics on selected indicators integral to child and youth health and wellbeing.

Data sources

Various data sources were used to compile this report, including administrative data (for example, hospital and mortality data), survey data, longitudinal data and published data. In all cases, the data used in this report have been the most recently available at the time of writing. For many of the selected indicators more than one data source was available to report on the specific indicator, and the data source chosen for a particular indicator was dependent on the availability of data for the selected age groups and for the subpopulations examined in this report.

Table 1 provides information on the data sources used, in terms of data availability and where further information can be found for each of these data sources.

Data analysis

Various statistical methods have been used in the analysis and presentation of data in this report. The majority of the rates presented are age-specific or crude rates, either presented as a percentage or as a rate indexed to 1,000 or 100,000 (see the AIHW report Australia’s health 2008 for definitions of these methods).

The ABS estimated resident population (ERP) data were used to calculate most rates presented in this report, except for rates by Indigenous status. The ABS experimental projections, based on the 2001 Census, were the most recent available population data for the Aboriginal and Torres Strait Islander population.

Measures presented by geographical remoteness (such as major cities versus remote and very remote areas) use the Accessibility-Remoteness Index of Australia Plus (ARIA+), except for breastfeeding data, which was based on the classification of area health services in NSW, and literacy and numeracy data which uses the MCEETYA Schools Geographic Location Classification Scale.

Trend data has been presented where available, and has been calculated by examining the percentage change between the two time-periods.

The mortality classification for coding causes of death used in Australia, and in this report, is the International Statistical Classification of Diseases and Related Health Problems (ICD-10). This international classification has been modified for morbidity coding in health services in Australia, and the ICD-10-AM has been used as the classification for hospital data in the National Hospital Morbidity Database. Specific ICD and ICD-AM codes used throughout the report can be supplied on request.
<table>
<thead>
<tr>
<th>Data source</th>
<th>Data availability</th>
<th>Further information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIHW and collaborating units data sources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Dental Health Survey</td>
<td>Annual from 1990</td>
<td>AIHW DSRU: Armfield et al. 2007</td>
</tr>
<tr>
<td><strong>ABS data sources</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Other data sources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OECD Education Database</td>
<td>Varies by indicator</td>
<td><a href="http://www.oecd.org/education/database">www.oecd.org/education/database</a></td>
</tr>
<tr>
<td>OECD Family Database</td>
<td>Varies by indicator</td>
<td><a href="http://www.oecd.org/els/social/family/database">www.oecd.org/els/social/family/database</a></td>
</tr>
<tr>
<td>OECD Health Data</td>
<td>Selected indicators from 1960 onwards</td>
<td><a href="http://www.oecd.org/health/healthdata">www.oecd.org/health/healthdata</a></td>
</tr>
</tbody>
</table>
Abbreviations

ABS Australian Bureau of Statistics
ACER Australian Council for Educational Research
ACIR Australian Childhood Immunisation Register
AESOC Australian Education Systems Officials Committee
AHMAC Australian Health Ministers’ Advisory Council
AHMC Australian Health Ministers’ Conference
AIFS Australian Institute of Family Studies
AIHW Australian Institute of Health and Welfare
CDSMAC Community and Disability Services Ministers’ Advisory Council
CDSMC Community and Disability Services Ministers’ Conference
COAG Council of Australian Governments
DoHA Australian Government Department of Health and Ageing
FaHCSIA Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
MCEETYA Ministerial Council on Education, Employment, Training and Youth Affairs
NHMRC National Health and Medical Research Council
OECD Organisation for Economic Co-operation and Development
SAAP Supported Accommodation Assistance Program
SES socioeconomic status
UN United Nations
UNESCO United Nations Educational, Scientific and Cultural Organization
UNICEF United Nations International Children’s Emergency Fund
WHO World Health Organization

Acknowledgments

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72. Berry J & Harrison JE 2006. Hospital separations due to 64.

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Ensuring that children get the best possible start in life is a key priority for the Australian Government. This report delivers the latest and most reliable information on how, as a nation, we are faring according to key statistical indicators of child and youth health, development and wellbeing.

The report covers children and young people aged 0–19 years, and includes indicators for the entire 0–19 year age range as well as indicators for three different stages of development:

1. infancy and early childhood;
2. school age childhood; and
3. adolescence.

Information is presented on important issues such as mental health, disability, risk factors for chronic disease, mortality, education, homelessness, crime, jobless families and family economic situation. Particular attention is given to Aboriginal and Torres Strait Islander children and youth, and to how Australia compares internationally.

This is an essential resource for policy makers, researchers, practitioners and anyone interested in the progress of Australia’s children and youth.