5.3 How healthy are Australia’s children?

Good health is a critical element in a child’s quality of life and can influence participation in many aspects of life, including learning, recreation and relationships, not only in childhood but throughout life.

Children’s health and developmental outcomes are closely related to the social environment in which they live—differences in socioeconomic position translate into inequalities in child development. These social determinants of health include socioeconomic, political, cultural context and daily living conditions. Disparities between children based on differences in social and economic circumstances can be evident from birth, and grow larger as children get older (CSDH 2008; Moore et al. 2015; Woolfenden et al. 2013). See also ‘Chapter 4.1 Social determinants of health’ and ‘Chapter 4.2 Social determinants of Indigenous health’.

In recognition of the importance of ensuring that children have the best possible start in life, the Council of Australian Governments Health Council recently endorsed Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health. The framework identifies the five strategic priorities in Australia for the next 10 years (COAG 2015):

• equip children and young people with the foundations for a healthy life
• support children and young people to become strong and resilient
• support children and young people to live in healthy and safe homes, communities and environments
• ensure that children and young people have equitable access to health care services and equitable health outcomes
• improve systems to optimise the health outcomes of children and young people.

These strategic priorities comprise 27 objectives and 64 actions. Four of the 27 objectives have actions relating to child health which are measurable using existing data:

1. Children and young people are active, healthy and thriving.
2. Children and young people are immunised against preventable illnesses.
3. Children and young people have lower rates of preventable injury and mortality.
4. Children and young people experience lower rates and impact of chronic disease.

This snapshot examines how Australia’s 4.4 million children aged 0–14 (19% of the Australian population) are faring against these four objectives.
How children are faring

Objective 1: Children are active, healthy and thriving

In 2014–15, only 2.5% of children aged 5–14 ate enough fruit and vegetables as recommended in the Australian Dietary Guidelines (NHRMC 2013): 70% ate the recommended 2 daily serves of fruit (or 1.5 serves for 4–8 year olds), but only 2.9% ate the recommended serves of vegetables daily (4.5 serves for 4–8 year olds; 5 serves for 9–11 year olds and for girls aged 12–14; and 5.5 for boys aged 12–14) (ABS 2015a).

At the same time, just over one-quarter (26%) of children aged 5–14 were classified as overweight or obese (19% as overweight and 7.1% as obese). Two-thirds (68%) were in the normal weight range with a body mass index of 18.50–24.99 (ABS 2015b).

In 2011–12, less than one-quarter (23%) of Australian children aged 5–14 met the national physical activity recommendations every day. About half collectively met the recommendations on 5–6 days (32%) or on 3–4 days (22%) a week, while the remainder met the guidelines even less frequently (ABS 2013; Department of Health 2014).

Objective 2: Children are immunised against preventable illnesses

As at December 2015, 92.6% of Australian children were fully immunised by the time they started school. Rates among Indigenous children were slightly higher at 93.9% (Department of Health 2016a, 2016b).

While vaccination rates have increased since the Australian Childhood Immunisation Register was established in 1996, vaccine objection rates for children under the age of 7 have also increased steadily, especially under the ‘conscientious objector’ category.

However, between 2014 and 2015, for the first time since 1999, national vaccine objection rates have decreased (from 1.8% to 1.3%) (Department of Health 2016c).

In 2015, more than 1.3% (equivalent to 30,000) children aged under 7 were not vaccinated because their parents were vaccine objectors (Figure 5.3.1). This equates to an increase of more than 13,000 children over 10 years. In order to protect children and the community from preventable diseases, the Australian Government will remove ‘conscientious objection’ as an exemption category for child care payments from 1 January 2016. See ‘Chapter 6.1 Prevention and health promotion’ and ‘Chapter 7.1 Indicators of Australia’s health’.

Figure 5.3.1: Proportion of Australian children with conscientious objection recorded, 1999–2015

Source: Department of Health 2016c.
Objective 3: Children have lower rates of preventable injury and mortality

In 2013–14, there were over 74,000 hospitalisations (1,686 per 100,000) due to injury and poisoning for children aged 0–14. Rates have changed little since 1993–94.

Hospitalisations tend to increase with age—in 2013–14, 80,000 (2,572 per 100,000) young people aged 15–24 were hospitalised with a principal diagnosis of injury and poisoning. Boys aged 0–14 were almost 1.5 times as likely to be hospitalised for injury and poisoning as girls (2,006 compared with 1,347 per 100,000).

Falls (700 per 100,000) were the most common cause of injury/poisoning hospitalisations for children in 2013–14, with rates 4.4 times as high as for transport accidents (160 per 100,000). Boys were more likely to be hospitalised than girls across all causes of injury and poisoning (Figure 5.3.2).

**Figure 5.3.2: Hospitalisations for the top five principal diagnoses of injury and poisoning, by cause and sex, children aged 0–14, 2013–14**

<table>
<thead>
<tr>
<th>Cause of injury/poisoning</th>
<th>Hospitalisations per 100,000 children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>660</td>
</tr>
<tr>
<td>Exposure to inanimate mechanical forces</td>
<td>400</td>
</tr>
<tr>
<td>Complications of medical and surgical care</td>
<td>200</td>
</tr>
<tr>
<td>Transport accidents</td>
<td>200</td>
</tr>
<tr>
<td>Other accidental exposures(a)</td>
<td>200</td>
</tr>
</tbody>
</table>

(a) This category comprises accidental drowning and submersion; accidental threats to breathing; overexertion; travel and privation; and accidental exposure to other and unspecified factors.

Source: AIHW Morbidity Database.

During 2011–2013, there were 3,265 infant deaths, a rate of 361 deaths per 100,000 infants aged under 1. During the same period, there were 1,441 child deaths, a rate of 12 deaths per 100,000 children (aged 1–14).

The leading causes of death for infants were conditions originating in the perinatal period and congenital conditions (76% of all infant deaths, or 272 per 100,000); sudden infant death syndrome (6.0% of all infant deaths, or 22 per 100,000); other ill-defined causes (5.0% of all infant deaths, or 18 per 100,000); and accidental threats to breathing (1.2% of all infant deaths, or 4 per 100,000).
The leading causes of death for children aged 1–14 were land transport accidents (14%, or 1.7 per 100,000), conditions originating in the perinatal period (8.9%, or 1.1 per 100,000), brain cancer (6.5%, or 0.8 per 100,000) and accidental drowning (6.0%, or 0.7 per 100,000).

On average, 7 pedestrians aged 0–14 were killed each year (in the 10-year period 2001–02 to 2009–2010) and 60 were seriously injured (in the 8-year period 2002–2003 to 2009–2010) due to being hit by a four-wheeled motor vehicle moving around a home (commonly known as ‘driveway run-overs’) (BITRE 2012).

**Objective 4: Children experience lower rates and impact of chronic disease**

The most common reported long-term conditions in children were asthma, and hayfever and allergic rhinitis.

In 2014–15, just over 1 in 10 (11%) children were diagnosed with asthma. See ‘Chapter 3.10 Chronic respiratory conditions’.

In 2014–15, the prevalence of allergic rhinitis (hay fever) was also 11%. Food allergies were reported for the first time in the 2014–15 National Health Survey, with 6.3% of children having a food allergy (ABS 2015b).

In 2014, 1,088 new cases of type 1 diabetes were diagnosed in children (equivalent to rate of 25 cases per 100,000). Rates for this age group have remained relatively stable since 2000, and were similar for males and females.

**What is missing from the picture?**

Data are not collected for the majority of the priorities in the Strategic Framework. Data development work to scope and benchmark these priorities, objectives and actions needs to be progressed so that the success of targeted policies, resources and initiatives can be measured.

Key topics of public interest relating to child health and wellbeing include obesity, sleep disorders and the effects of screen-time use. Recent and regularly updated data on physical activity and screen-time use for children would be useful to help understand the factors affecting levels of childhood obesity.

**Where do I go for more information?**

References


NHMRC (National Health and Medical Research Council) 2013. Australian dietary guidelines (2013). Canberra: NHMRC.
