

## **PART 3: THE WELLBEING OF AUSTRALIA'S CHILDREN 0-8**

### **Introduction**

The following snapshot of child health and wellbeing uses as a framework the indicators of child health and wellbeing identified by NSW, Queensland and Victoria (NSW Commission for Children and Young People, 2003; Commission for Children and Young People (Qld), 2002; Waters, Goldfeld & Hopkins, 2001) but it is not restricted to these sources. Only the national data that are readily available in published reports (and identified within the available time) are presented. Trend data are also presented where they are available.

This snapshot is not exhaustive of all possible indicators of child wellbeing or of all available data relating to child wellbeing. It is indicative of the types of data that are available for measuring child wellbeing and for monitoring trends in the health and wellbeing of children 0-8 years old.

Conclusions about trend data must be made with care. Trends can be the result of a myriad of factors, including the changing demographic profile of the country, policy changes, changes in social attitudes (for example, towards working mothers) and changes in how data are collected.

### **1. Health**

#### **Parental health**

- **Maternal age:**

In recent years, the average age of women giving birth in Australia has gradually increased from 27.9 years in 1991 to 29.0 years in 2000 (AIHW National Perinatal Statistics Unit, 2003). In line with this trend, the birth rate among teenage mothers has decreased from 55.5 births per 1,000 women in 1971 to a present low of 17.4 in 2000 (AIHW, 2002b). However, a similar number of teenage women underwent abortions producing an abortion/delivery ratio that is much higher (1.18 in 1996) than in those European countries, such as the Netherlands (0.28 in 1996), that have social policies promoting the early use of contraception in sexually active teenagers (United Nations Children's Fund [UNICEF], 2001).

- **Reported wellbeing:**

Throughout the 1990s, the proportion of adults who have reported good health has increased (Table 2). However, reported wellbeing varied with socio-economic status, with 22% of persons in the most disadvantaged quintile reporting fair or poor health, compared with 12% of persons in the least disadvantaged quintile (AIHW, 2002b).

**Table 2: Adults who report 'good', 'very good' or 'excellent' health 1989-90 to 1997**

| <u>Gender</u> | <u>1989-90</u> | <u>1995</u> | <u>1997</u> |
|---------------|----------------|-------------|-------------|
| Men           | 79.5%          | 82.7%       | 84.4%       |
| Women         | 78.9%          | 83.4%       | 86.5%       |

Note: From *Australia's Health 2002* (p.14), by AIHW, 2002, Canberra: AIHW.

## Child nutrition

- **Breastfeeding:**

In 1992-95, most (82%) babies were exclusively breastfed at discharge from hospital. This declined to 57% at three months and to 19% at six months of age (Al-Yaman, Bryant & Sargeant, 2002).

- **Adults' diet:**

Data on the eating patterns of adults in Australia (not necessarily parents) suggests that many adults are eating a poor diet. For example, a 1995 survey of adult Australians identified that:

- only 1% of women aged 15-49 years consumed the recommended level of folate.
- 42% did not eat any fruit on the day of the survey and only 17% met the daily recommendation of 300g of fruit (two serves, excluding fruit juice).
- 16% did not eat any vegetables (including potatoes) on the day of the survey and 32% had over 300g of vegetables (four serves), the lower end of the range recommended by the National Health and Medical Research Council (AIHW, 2002b).

- **Child's Body Mass Index:**

There have been significant increases in childhood obesity in recent years. The prevalence of obese children aged 7-15 years increased from 1985 to 1995:

- from 1.2% to 5.5% among girls.
- from 1.4% to 4.7% among boys (AIHW, 2002b).

- **Food security:**

"From the 1995 Australian Bureau of Statistics [ABS] National Nutrition Survey, an estimated 8% of households with dependent children under 15 years ran out of food and had no money to buy more, at least once in the previous 12 months (ABS, unpublished data)" (Al-Yaman et al., 2002, p. 260).

## **Play and physical activity**

Among children aged 5-8 years in the 12 months to April 2000:

- 51% had engaged in at least one organised sport (59% of boys and 42% of girls).
- 24% had participated in selected organised cultural activities outside of school hours (approximately 17% of boys and 37% of girls) (ABS, 2003a, p. 191).

Children's participation in organised sport and cultural activities varied with their family situation: it was highest if living with employed parents and lowest with unemployed parents. However, participation in leisure activities varied less with family situation (ABS, 2003a).

## **Child welfare – abuse and neglect**

National data on the number of child protection investigations, substantiations and notifications reflect variations in different practices among the jurisdictions in child protection matters (Johnstone, Al-Yaman, Moyle, Kelly & Aydinli, 2002). Given this caveat, data suggest that there have been a number of increases in this area:

- 50% increase in notifications from 91,700 in 1995-96 to 137,900 in 2001-02. However, substantiations during this period slightly decreased.
- 55% increase in the number of investigations between 1990-91 and 1994-95, which then fell each year to 1999-2000. These trends varied by jurisdiction (Johnstone et al., 2002).
- An increase in the number of children on care and protection orders from 12,680 in 1991 to 20,600 in 2002 (Johnstone et al., 2002; ABS, 2003a).
- 35% increase in the number of children in out-of-home care between June 1996 and June 2002 (ABS, 2003a).

## **Child morbidity**

Around two-thirds of children were reported to have had a recent or long-term condition in 1995. Recent conditions were more prevalent than long-term conditions for all ages and genders.

**Table 3: Proportion of children aged 0-14 years with reported recent and long-term conditions, 1995**

| Age         | <u>Recent conditions</u> |           | <u>Long-term conditions</u> |           | <u>Recent or long-term conditions</u> |           |
|-------------|--------------------------|-----------|-----------------------------|-----------|---------------------------------------|-----------|
|             | M                        | F         | M                           | F         | M                                     | F         |
| <1          | 69                       | 68        | 17                          | 16        | 71                                    | 71        |
| 1-4         | 57                       | 54        | 39                          | 29        | 66                                    | 61        |
| 5-9         | 53                       | 55        | 48                          | 47        | 67                                    | 67        |
| 10-14       | 53                       | 56        | 52                          | 53        | 70                                    | 72        |
| <b>0-14</b> | <b>55</b>                | <b>56</b> | <b>45</b>                   | <b>42</b> | <b>68</b>                             | <b>67</b> |

Note: From *Australia's Children, Their Health and Wellbeing* (p. 37), by F. Al-Yaman, M. Bryant & H. Sargeant, 2002. Canberra: AIHW.

Asthma was the most frequently reported long-term condition, reported for 16% of all children. Asthma, hay fever, other allergies and eczema, all of which are related to allergic reactions, made up nearly one-third of all reported long-term conditions.

“The most commonly reported recent condition was the common cold, reported for 10% of children... Asthma was the second most frequently reported condition (9% of children), with other common conditions being dental problems (7%) and cough or sore throat (5%)” (Al-Yaman et al., 2002, p. 38).

#### ***Hospitalisations in 1999-2000:***

- The main reasons for hospitalisation of infants were conditions originating in the perinatal period and diseases of the respiratory system.
- The main reasons for hospitalisation of children aged 1-14 years were diseases of the respiratory system (including asthma) and injury. Respiratory problems were also the most common problems managed by general practitioners in 2000-01 (Al-Yaman et al., 2002).

Asthma and Type 1 diabetes are serious childhood illnesses, both of which increased over the decade 1991-2000. The prevalence of asthma in children in 1995 increased with age up to 19% among children aged 5-9 years (Table 4), while the incidence of Type 1 diabetes was about 20 per 100,000 children by age 5-9 years (Table 5).

Australia ranks among the highest prevalence rates in the world for asthma and both diseases increased over the decade 1991-2000.

**Table 4: Parental report of child asthma, 1995 (percentages)**

| <u>Age</u> | <u>Recent</u> | <u>Long-term</u> |
|------------|---------------|------------------|
| <1         | 2             | 3                |
| 1-4        | 6             | 12               |
| 5-9        | 10            | 19               |

Note: From *Australia's Children, Their Health and Wellbeing* (p. 158), by F. Al-Yaman, M. Bryant & H. Sargeant, 2002. Canberra: AIHW.

**Table 5: Diabetes (mostly Type 1) 1995 (rate per 100,000)**

| <u>Age</u> | <u>Males</u> | <u>Females</u> |
|------------|--------------|----------------|
| 0-4        | 13.0         | 12.2           |
| 5-9        | 20.2         | 20.5           |

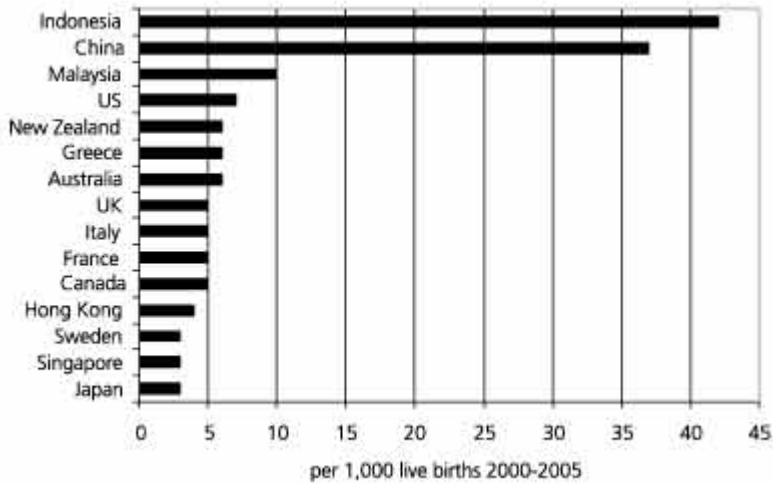
Note: From *Australia's Children, Their Health and Wellbeing* (p. 166), by F. Al-Yaman, M. Bryant & H. Sargeant, 2002. Canberra: AIHW.

## **Child mortality**

"In 2000 in Australia, 1,931 children aged 0-14 years died, accounting for 1.5% of all deaths in that year. Of these child deaths, 1,290 (66.8%) were infants.

"Despite the decline in the infant mortality rate over the last two decades, Australia's infant mortality rate (5.2 per 1,000 live births) is high compared with other developed countries and, in 1999, ranked 19th among Organisation for Economic Cooperation and Development (OECD) countries" (AIHW 2002b, p. 181).

**Figure 5: Infant mortality rates 2000-2005, international comparison**



Note: From *Australian Social Trends 2003* (p. 203), ABS, (Cat. No. 4102.0). Canberra: Author.

As seen in Table 6, child death rates were highest in remote areas and lowest in metropolitan areas.

**Table 6: Child death rates by region, 1998-00**

| <u>Age</u> | <u>Metropolitan</u> | <u>Rural</u> | <u>Remote</u> |
|------------|---------------------|--------------|---------------|
| 1-4        | 28                  | 31           | 40            |
| 5-8        | 10                  | 11           | 25            |

**Infants** (AIHW National Perinatal Statistics Unit, 2003; Al-Yaman et al., 2002):

- Infant death rates fell during the decade 1991-2000, with rates for boys decreasing by 26% and rates for girls by 23%. Foetal, neonatal and perinatal death rates all decreased over the same period.
- The main causes of death among infants were conditions originating in the perinatal period, congenital malformations and sudden infant death syndrome (SIDS).
- Between 1991 and 2000, SIDS death rates decreased for boys by 65% and for girls by 63%.

**Children 1-14 years** (AIHW National Perinatal Statistics Unit, 2003; Al-Yaman et al., 2002):

- The death rates for children aged 1-14 years fell by 22% during the decade 1991-2000.
- The main causes of death in children aged 1-14 years were injury and poisoning, neoplasms (including cancer) and diseases of the nervous system.
- The most common reason for injury hospitalisations was falls, followed by pedal cyclist injuries and accidental poisoning. Deaths from injuries, including motor vehicle accidents and accidental drowning, declined over the decade.
- “In 2000, injury was the leading cause of death for people aged 12-24 years, with 68.1% (1,222) of all deaths attributed to some form of injury. The majority of injury cases (93.4%) were related to motor vehicle accidents. Self-harm was the second leading cause of death, representing 19.2% of all deaths in this age group. However, when specific causes of death were considered, suicide by hanging, strangulation and suffocation was the main leading cause of death for those aged 12-24 years (198 deaths, 154 males and 44 females). Vehicle driver killed in collision with a stationary object (99 deaths) and death from taking opioids (drug dependence, 72 deaths) were also leading specific causes of death in this age group” (AIHW Australia's Health, 2002, p. 186).

## **Child disabilities**

In 1998, an estimated 296,000 Australian children were reported to have a disability. Of these, 144,000 had a profound/severe core activity restriction where they needed help with self-care, mobility, communication and schooling. The most common disabling conditions were intellectual and other mental disorders and respiratory diseases. The majority of children with a disability attended school (97%), with most of these being enrolled in a mainstream school. Notification rates for congenital malformations have been declining, especially for neural tube defects. “Neural tube defects (spina bifida, anencephalus and encephalocele) affected 146 infants in 1997. Such defects have decreased by about half since 1987 (5.7 compared with 11.9 per 10,000 births)” (Al-Yaman et al., 2002, p. 103). The reasons for this reduction in congenital malformations are not known. Al Yaman et al., noted that neural tube defects could be reduced by giving folic acid to women before and during pregnancy. De Looper & Bhatia (1998) attributed decreased rates of some malformations to increased rates of screening and termination of pregnancy following diagnosis of a congenital malformation.

## Child emotional wellbeing

In 1998, the Child Behaviour Checklist was administered to children aged 4-12 years in the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing. Results indicated that 15.0% of boys and 14.4% of girls had emotional and/or behavioural problems and many children manifested several of these problems. Among the children aged 4-12 years to whom the Checklist was administered, the specific problems most frequently identified were somatic complaints (7.2% of boys and 5.6% of girls), delinquent behaviour (7.4% of boys and 7.8% of girls) and attention problems (7.4% of boys and 6.2% of girls) (Al-Yaman et al., 2002).

Research has indicated that children have had a greater likelihood of having mental health problems if they live in one-parent, step/blended or low-income families or families in which one or both parents are unemployed (Al-Yaman et al., 2002).

Hospitalisation rates for children aged 1-8 years for mental and behavioural disorders are presented for 1999-2000 in Table 7. Rates were generally higher for boys than girls.

**Table 7: Hospitalisation rates for children aged 1-8 years for mental and behavioural disorders, 1999-2000 (per 100,000 children)**

|                | <u>Age</u> | <u>Rate</u> |
|----------------|------------|-------------|
| <u>Males</u>   | 1-4        | 126.6       |
|                | 5-9        | 283.7       |
| <u>Females</u> | 1-4        | 41.1        |
|                | 5-9        | 67.2        |

Note: From *Australia's Children, Their Health and Wellbeing* (p. 198), by F. Al-Yaman, M. Bryant & H. Sargeant, 2002. Canberra: AIHW.

Time trends in hospitalisation rates for children for mental and behavioural disorders are not presented because they are likely to have been influenced by the introduction of the ICD-10-AM coding system in 1988-99. However, hospitalisation for intentional self-inflicted injuries has been associated with mental health problems and disorders, such as depression. Trends in these rates provide an indication of trends in mental health. In 1999-2000, 547 children aged 0-14 years were hospitalised for intentional self-inflicted injuries, nearly all of whom (97%) were aged between 10-14 years (Al-Yaman et al., 2002).

Rates of self-inflicted injuries have been increasing since 1993-94. For both girls and boys, hospitalisations for self-inflicted injuries were at their highest point in 1999-2000 (64.2 and 17.1 per 100,000, respectively (Al-Yaman et al., 2002).

## **2. Education and work**

Data in this area suggest an apparent deterioration in performance of Australian children with age. It is not clear whether this is a cohort effect or an actual deterioration. While we have very high literacy and mathematics standards in primary school, our retention rates in Year 12 are relatively low by OECD standards and our post-school qualifications are even worse.

### **School retention**

The apparent retention rate of students to Year 12 has decreased since 1992:

- Among males, from 72.5% in 1992 to 69.8% in 2002.
- Among females, from 82.0% in 1992 to 80.7% in 2002.

However, the most recent rates represent an increase in school retention, since it reached a low of around 66% for males and 77% for females in the mid 1990s.

Females have consistently been retained to Year 12 at a higher rate than males during this period.

### **Child literacy**

- **Benchmark for reading:**

Most Year 3 and Year 5 students reached the benchmarks for reading in 1999 and 2000. The overall results are summarised in Table 8 (Ministerial Council on Education, Training and Youth Affairs [MCETYA], 2001). The year 2000 is only the second year for which reading benchmark data have been available, so there is insufficient evidence to indicate any clear trend.

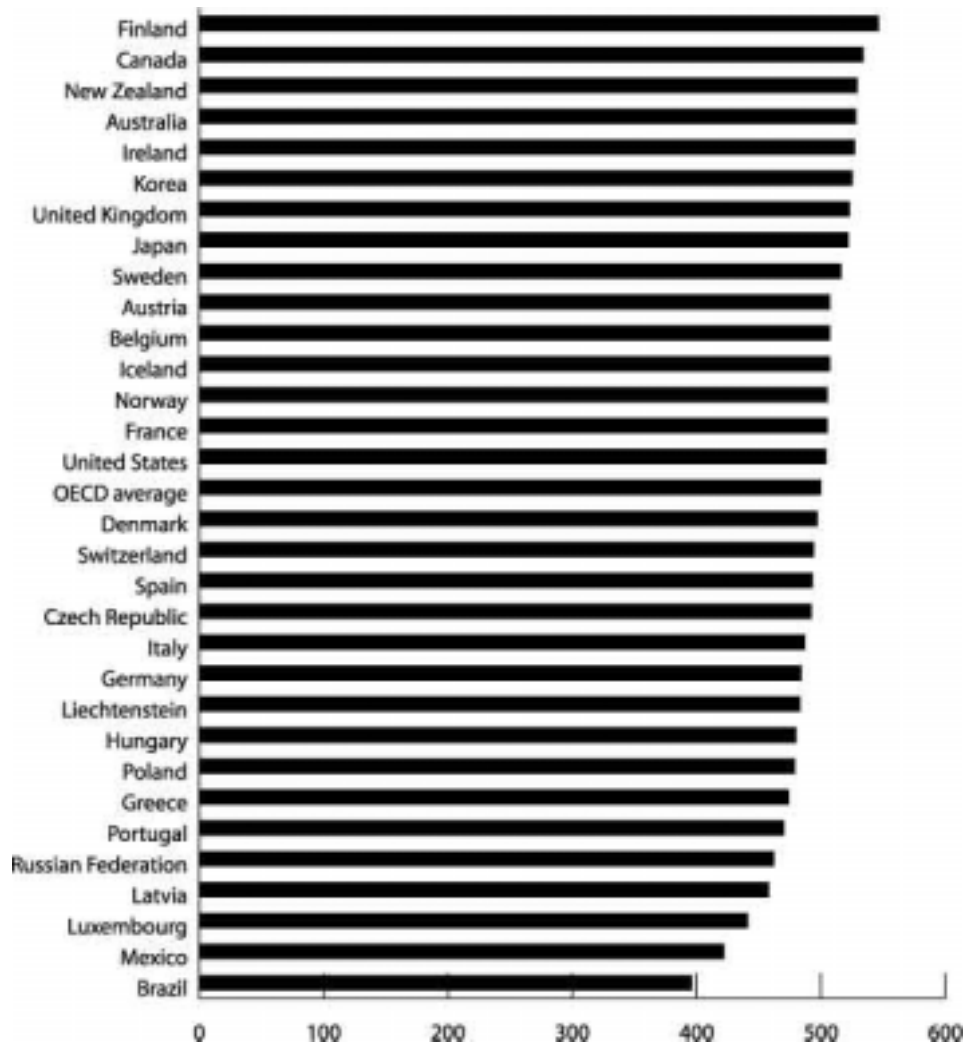
**Table 8: Percentage of students achieving the reading benchmark, Australia, Years 3 and 5, 1999 and 2000**

| <u>Grade</u> | <u>Year</u> | <u>Per cent achieving reading benchmark</u> |
|--------------|-------------|---|
| Year 3       | 1999        | 89.7±2.5                                    |
|              | 2000        | 92.5±2.2                                    |
| Year 5       | 1999        | 85.6±2.0                                    |
|              | 2000        | 87.4±2.1                                    |

Note: From *National report on schooling in Australia* (p. 9), by MCETYA, 2001. Preliminary Paper, National Benchmark Results, Reading and Numeracy, Years 3 & 5. Canberra: Department of Education, Training and Youth Affairs [DETYA].

Australian students aged 15 years ranked fourth (after Finland, Canada and New Zealand) in the reading literacy score of the OECD international Knowledge and skills for life test in 2000 (Figure 6).

**Figure 6: Country comparisons on reading literacy at age 15, 2000 (N=265,000)**



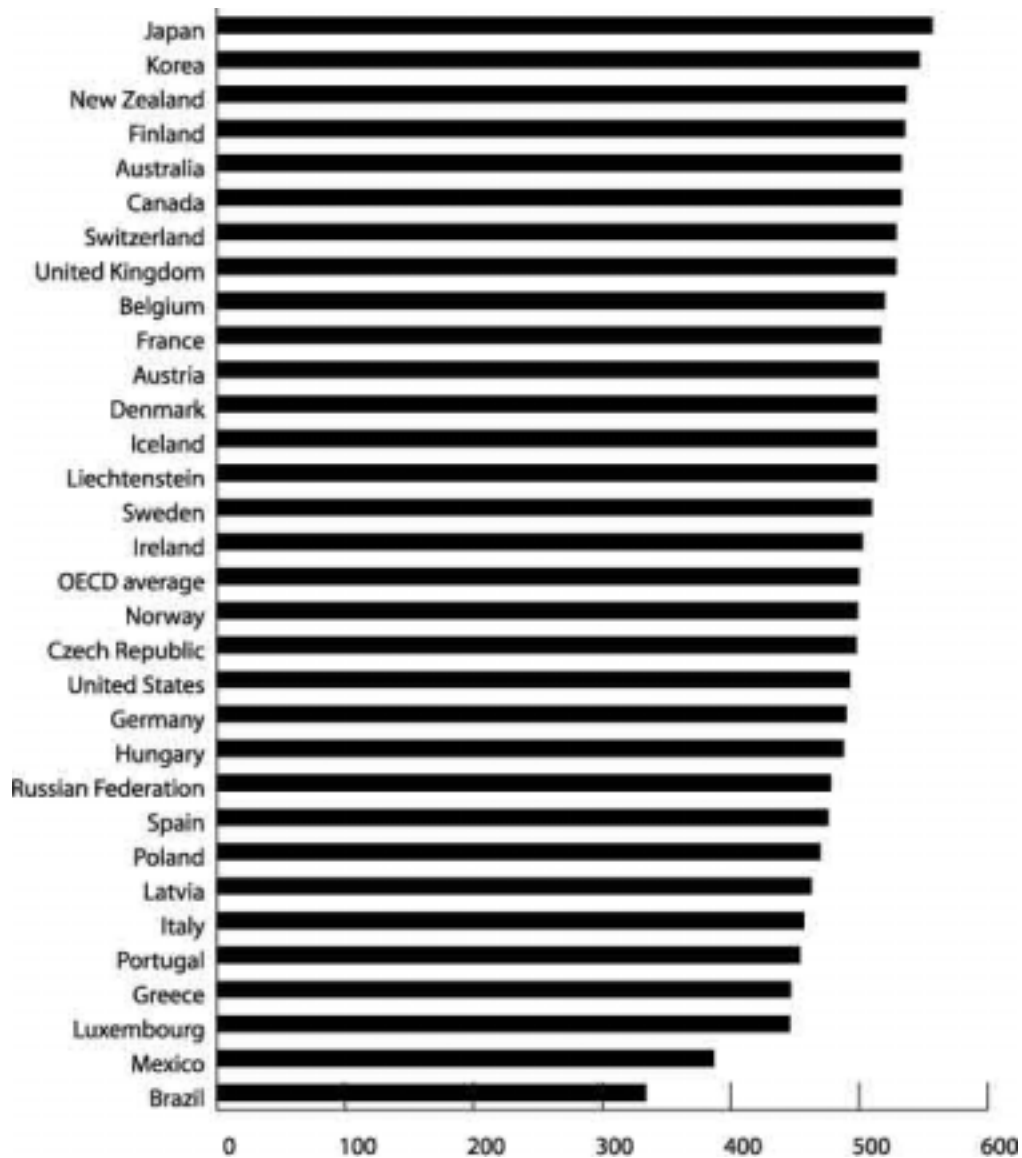
Note: From *Knowledge and Skills for Life First Results from PISA 2000* (p. 8), by OECD, 2001. Paris: OECD. Retrieved October 5, 2003, from <http://www.pisa.oecd.org>.

## Child numeracy

Most students in Years 3 (92.7%±2.0) and 5 (89.7%±1.7) achieved numeracy benchmarks in 2000. This was the first year in which student performance was measured against numeracy benchmarks, so trend data is not yet available (MCETYA, 2001).

Australian students aged 15 years ranked fourth (after Korea, New Zealand and Finland) in the mathematical literacy score of the OECD international Knowledge and skills for life test in 2000 (Figure 7).

**Figure 7: Country comparisons on mathematical literacy at age 15, 2000 (N=265,000)**



Note: From *Knowledge and Skills for Life First Results from PISA 2000* (p. 10), by OECD, 2001. Paris: OECD. Retrieved October 5, 2003, from <http://www.pisa.oecd.org>.

## Parental employment

- Children are increasingly being raised by working parents:
  - In two-parent families, 51.7% of both parents worked in 1992. This percentage increased to 57.1% in 2002.

- In one-parent families, 40.6% of parents worked in 1992. This percentage increased to 46.2% in 2002 (ABS, 2003a).
- Employed lone parents tended to work fewer hours than employed parents who had partners (ABS, 2003a).
- Women with children aged less than five years are increasingly in the workforce, suggesting that mothers are returning to work earlier after giving birth than in the past (ABS, 2003a).
- In 1996-97, children were slightly more likely to live in families ranked at the lower end of the income distribution. When ranked on income adjusted for the differing needs of different sized families (that is, equivalent income), 70% of children in one-parent families and 41% of children in couple families were in the lowest 40% of the income distribution (ABS, 1999a).

### **3. Child environment**

#### **Family structure**

The number of sole-parent households increased by 53% between 1986 and 2001, while the number of two-parent households increased by only 3% during this time. Among households with dependent children aged under 15 years, the percentage headed by sole parents increased from 14.4% in 1992 to 20.5% in 2002 (ABS, 2003a).

#### **Safety**

- **Domestic violence:**

A national survey of women conducted in 1996 identified that:

- about 6,300 Australian women experienced actual or threatened physical and sexual violence.
- 7.1% of the adult female population experienced violence. 6.2% of women experienced violence perpetrated by a male, and 1.6% experienced violence perpetrated by a female.
- 2.6% of women who were married or in a de facto relationship had experienced violence perpetrated by their current partner.
- 4.8% of unmarried women had experienced violence by their previous partner in the previous 12 months (ABS, 1996).

In the same national study, a survey of 5,000 Australian teenagers found that one quarter had witnessed domestic violence against a female parent.

- **Parents feeling safe in community:**

While most reported crimes have decreased in recent years, the assault victimisation rate increased by 44% from 563 to 810 per 100,000 population between 1995 and 2002. In addition, the sexual assault victimisation rate increased from 69 to 91 per 100,000 population between 1993 and 2002. This was its highest level since the collection began in 1993 (ABS, 1999b).

## **Housing status**

- **Home tenure:**

By international standards, Australia in 1999 was characterised by high levels of home ownership (70%) and a relatively small public and community-housing sector (5%). Most of the remainder (20%) rented privately (AIHW, 2002a).

There was little change in tenure types over the five years between 1994 and 1999. "In the rental sector, there has been a decline in public housing and an increase in private rental. In contrast to the population census analysis, owners have stayed relatively steady at around 70% of the population. There has been a decline in owners without a mortgage, while the population with a mortgage has increased" (AIHW, 2002a, p. 56).

"In 1996, 76% of all couple families with children owned or were purchasing the home in which they lived, compared with 39% of one-parent families. Home ownership was less common among low income families, families which had young children only and Indigenous families" (ABS, 1999a).

- **Housing occupancy:**

Insufficient bedrooms appear to be almost entirely limited to households with children. The proportion of households with insufficient bedrooms in 2001 was:

- 1% for childless couples, male partner < 35 years.
- 45.4% for couples with dependent children.
- 22.7% for sole parents with dependent children (ABS, 2003a).

- **Young clients of the Supported Accommodation Assistance Program (SAAP):**

SAAP provides housing and other supports for people who are, or are at risk of becoming, homeless, including women and/or children escaping domestic

violence. In 1999-2000, 25% of SAAP clients had children (84% of these clients were women); 1,675 clients were children without parents/guardians aged less than 15 years (AIHW, 2002a).

**Table 9: Supported Accommodation Assistance Program: clients by age, 1999-2000 (per cent)**

| Age       | Young people | All    |
|-----------|--------------|--------|
| Under 15  | 5.0          | 1.9    |
| 15-17     | 28.7         | 10.7   |
| 18-19     | 23.3         | 8.7    |
| 20-24     | 42.9         | 16.1   |
| 25+       | -            | 62.6   |
| Total (N) | 33,500       | 89,600 |
| Total (%) | 100.0        | 100.0  |

Note: From *Australia's welfare 2001* (p. 342), by AIHW, 2002b. Canberra: AIHW.

## **4. Service delivery**

### **Child care**

The ABS has conducted the Child Care Survey in Australia since 1969. Information from the most recent report is provided below (ABS, 2003b). It was estimated that in the week of the survey in June 2002, 49% of children aged 0-11 years in Australia (n=1,510,500) were in child care. Details of this care are summarised below.

**Formal or informal:** Informal care, either alone or in combination with formal care, was used by 33% (1,019,200) of children under 12 years. This was a reduction from 37% of children in 1999. Formal care (alone or in combination) was used by 25% (787,400) of children, an increase from 23% in 1999 and continuing the upward trend observed throughout the 1990s.

**Type of formal care:** The most commonly used types of formal care were long day care (10%) and preschool (8%). These were followed by before and after school care programs (6%), family day care (3%), and occasional care (1%). Among children attending formal care, the proportion attending long day care and before and after school care has increased steadily since 1993.

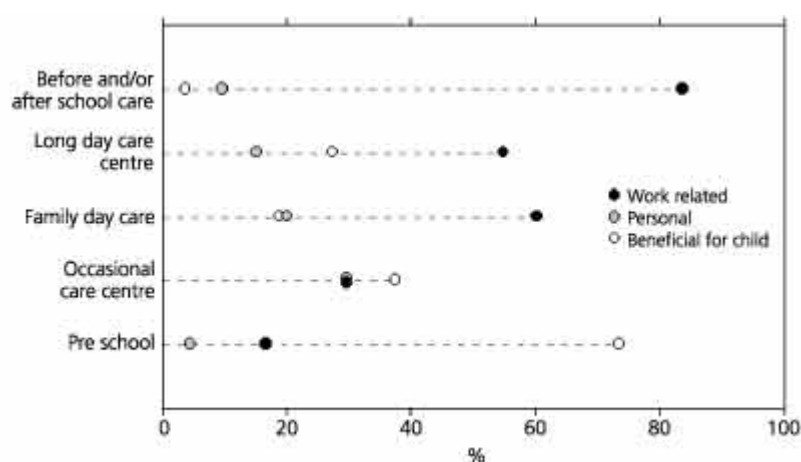
**Type of informal care:** Grandparents provided much of the informal care (19% of children). Siblings looked after 2% of children, other relatives 7%. Other (unrelated) people provided care to 7% of children.

**Age of children in care:** Child care use varied with age and type of care. The rate of use of formal care increased with age, from 7% of children under one year to 83% of children aged four years. After children commenced school, the use of formal care declined and was mostly in the form of before and after school care: 28% of five year old children and 7% of 9-11 year old children were in formal care. Age-specific rates of the use of formal care varied less than rates for formal care. Overall, 37% of children under five years used informal care compared to 30% of children aged 5-11 years.

**Hours in care:** Most children who used any type of child care used it for less than 20 hours per week: 45% used it for less than 10 hours per week, 27% used it for 10-19 hours per week; 6% attended for 45 hours or more per week.

**Reasons for child care:** varied with the type of child care (Figure 8). Parents who used each type of care were asked to nominate the primary reason for their use of that type of care. The sum of the values of the three points on each line in Figure 8 is therefore 100%.

**Figure 8: Reasons for use of child care 2002**



Note: From *Child Care* (p. 5), by ABS, 2003b, (Cat. No. 4402.0), Canberra: Author.

**Demand for care:** Parents reported that 323,100 children had increased their use of formal care in the previous 12 months and 125,300 had decreased their use. The most common reason for change was parental work. In general, as family income increased, the proportion of children who used care increased: 45% of children in families with weekly income less than \$400 attended some type of child care, compared to 67% of children in families with weekly income \$2,000 or more.

Parents were asked if their child care requirements were met. Most (94%) said they needed no additional formal care. The main types of additional formal care reported as required were before and after school care (47,800 children), long day care (46,300) and occasional care (37,600).

Parental work was the single largest reason for requiring additional formal care (for 72,300 children).

## Early detection and intervention

- **Immunisation:**
- During the 1990s, notification rates for many vaccine-preventable diseases decreased, and there was an increase in the proportion of children immunised against these diseases (Al-Yaman et al., 2002).
- In 2001, 90.4% of children aged one year, and 88.0% of children aged two years, were fully immunised (Al-Yaman et al., 2002).
- “Between 1993 and 2000, more than 37,000 children suffered a vaccine-preventable disease and more than 6,000 hospitalisations occurred as a result of contracting one of these diseases. Pertussis (whooping cough), measles and rubella were the most commonly occurring vaccine-preventable diseases in Australian children...
- Over the same period, the vaccine-preventable disease responsible for the most deaths of children in Australia was Haemophilus influenzae Type B disease (Hib), which caused 16 deaths” (Al-Yaman et al., 2002, p. 117).
- **Dental treatment:**

Most Australian children have good dental health and this has improved in recent years (Al-Yaman et al., 2002). Between 1990 and 1997:

- The mean number of decayed teeth in children aged six years decreased from 2.1 to 1.5.
- The proportions of children aged six years free from decay experience rose from 49% to 59%.

Most Australian children (78.5% of children aged 5-9 years) have visited a dentist in the previous 12 months, many of them using school dental services. In the 4-8 year age group, the proportion of children needing immediate treatment in the 1997 study was around 11% (Table 10).

**Table 10: Percentage of children needing immediate dental treatment, Australia, 1997**

| Age (years) | Percent |
|-------------|---------|
| 4           | 12.0    |
| 5           | 10.5    |
| 6           | 10.5    |
| 7           | 10.6    |
| 8           | 9.4     |

Note: From *Australia's Children, Their Health and Wellbeing* (p. 218), by F. Al-Yaman, M. Bryant & H. Sargeant, 2002. Canberra: AIHW.

## **5. Criminality**

### **Youth offences**

The following data on juvenile offending is taken from an Australian Institute of Criminology (AIC) report which is based on police data from three States. Only police statistics on alleged offenders from Victoria, Queensland and South Australian were available (AIC, 2002). These figures can give an idea of national trends, but a more complete data set could provide quite a different picture.

In 2000-01, juveniles<sup>1</sup> accounted for about one-quarter of the total offender population. Compared to adults, juveniles were three times more likely to be identified as offenders.

In 2000-01, the 15-19 year age group had the highest rate per 100,000 persons relative to older offenders for assault, motor vehicle theft, robbery, unlawful entry with intent (UEWI) and other theft. The rate of homicide offences was greatest among 15-19 year olds in 1995-96, but in 2000-01 the homicide rate was highest among 20-24 year olds relative to other age groups.

During the period 1995-96 to 2000-01, the offender rate per 100,000 persons among juveniles declined from 4,545 to 4,165. This was during a period in which the adult rate increased. There was, however, an increase in the percentage of female juvenile offenders during this period, from 21% to 25% (AIC, 2002).

Between 1995-96 and 2000-01, there was no clear pattern in trends in the rates of specific offences per 100,000 persons within the 15-19 year age group. The rate of robbery and UEWI increased among the males. The rates of assaults, motor

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<sup>1</sup> The term 'juvenile offender' includes alleged offenders aged 10 to 16 years.

vehicle theft (among males), UEWI (among females) and other theft remained fairly stable. The rates of motor vehicle theft (among females) decreased during this time (AIC, 2002).

## Youth justice orders / detention

National data was found on youth detention (AIC, 2002; Cahill & Marshall, 2002) but not on youth justice orders. The AIC reported that, between 1981 and 2001, the overall incarceration rate for persons in juvenile corrective institutions declined from 65 to 28 per 100,000. This amounted to a decline at an average annual rate of 3% (males) and 6% (females) (AIC, 2002). This reduction is likely to be related to the increase in restorative justice programs<sup>2</sup>.

## Drug use

- **Drug use among the general population:** From 1991 to 2001 there were decreases in the prevalence of smokers and daily drinkers the general population. Illicit drug use in the general population has fluctuated, with peaks in 1991 and 1998 (Table 11).

**Table 11: Drug use in past 12 months by general population 1991-2001**

| Drug                      | 1991 | 1993 | 1995 | 1998 | 2001 |
|---------------------------|------|------|------|------|------|
| Tobacco (Current smoker)  | 32.5 | 32.6 | 29.6 | 27.8 | 25.6 |
| Alcohol (Current drinker) | 81.6 | 77.9 | 78.3 | 80.5 | 82.4 |
| Alcohol (Daily drinker)   | 10.2 | 8.5  | 8.8  | 8.5  | 8.3  |
| Cannabis                  | 13.7 | 12.7 | 13.1 | 17.9 | 12.9 |
| Heroin                    | 0.4  | 0.2  | 0.4  | 0.8  | 0.2  |
| Amphetamines              | 2.6  | 2.0  | 2.1  | 3.7  | 3.4  |
| Cocaine                   | 0.7  | 0.5  | 1.0  | 1.4  | 1.3  |
| Hallucinogens             | 1.6  | 1.3  | 1.8  | 3.0  | 1.1  |
| Ecstasy/designer drugs    | 1.1  | 1.2  | 0.9  | 2.4  | 2.9  |
| Any illicit               | 22.8 | 14.0 | 17.0 | 22.0 | 16.9 |

Note: From *Statistics on drug use in Australia 2002* (pp. 5, 11 & 19), by AIHW, 2003. Canberra: Author.

<sup>2</sup> See Strang, H. (2001). *Restorative Justice Programs in Australia. A report to the Criminology Research Council*. Canberra: Australian Institute of Criminology.

The AIHW summarised Australia's drug use in comparison to other countries as follows:

- Decline in smoking rates in Australia over the period 1971 to 2001 leaves Australia ranked third lowest in the world in 2001 behind Sweden and the US in prevalence of daily smoking.
- In 2000, Australia ranked 19th highest in the world in per capita consumption of alcohol.
- Illicit drug use patterns vary between countries. Among the English-speaking countries selected for comparison (Table 12), Australia ranked second highest in cannabis use and amphetamine use after New Zealand and equal highest for ecstasy use with New Zealand. Opiate use was rare in each country (AIHW, 2003b).

**Table 12: Population prevalence of use of selected illicit drugs, 2000-01**

| Substance    | Australia | Canada | NZ   | UK  | US  |
|--------------|-----------|--------|------|-----|-----|
| Cannabis     | 15.0      | 8.9    | 20.0 | 9.4 | 9.3 |
| Amphetamines | 4.0       | na     | 5.0  | 1.9 | 1.1 |
| Ecstasy      | 3.4       | 1.5    | 3.4  | 1.6 | 1.4 |
| Opiates      | 0.6       | 0.3    | 1.0  | 0.6 | 0.5 |

Note: From *Statistics on drug use in Australia 2002* (p. 32), by AIHW, 2003. Canberra: Author.

- **Youth drug use:**

“Most Australian children do not consume alcohol, smoke tobacco or take illicit drugs. However, in the 1999 Australian Secondary Students Alcohol and Drug Survey, 13% of children aged 12-14 years reported smoking tobacco and 24% reported consuming alcohol in the week prior to the survey. Of children aged 12-15 years, 29% of boys and 23% of girls reported having taken an illicit drug at least once” (Al-Yaman et al., 2002).

Studies of Australian secondary student drug use have been conducted in 1984, 1987, 1990, 1993 and 1999. An analysis of trend data relating to alcohol consumption found that a greater proportion of 12-15 year olds were current drinkers in 1999 than in 1996, 1993 and 1990. Furthermore, more current drinkers in this age group drank at hazardous levels in 1999 than in 1987 or 1984 (White, 2001). The mean ages at which Australians first used licit and any illicit drug remained relatively stable between 1993 and 2001 (AIHW, 2003b).

## **6. Aboriginal and Torres Strait Islander children**

There are a number of groups for which child health and wellbeing is worse than for the rest of Australia. These include children of sole parents, children in low-income families, children in rural and remote regions, and Aboriginal and Torres Strait Islander children.

What follows is a comparative description of the health and wellbeing of Aboriginal and Torres Strait Islander children.

### **Health**

Al-Yaman and colleagues found that Aboriginal and Torres Strait Islander children were in a worse position than other Australian children on most measures of health (Al-Yaman et al., 2002). These are some of the examples they cite:

- The proportion of babies of Aboriginal and Torres Strait Islander mothers that were low birth weight was 13.6% compared to 6.6% of babies of other Australian mothers (AIHW National Perinatal Statistics Unit, 2003).
- Aboriginal and Torres Strait Islander children have been over-represented in the child protection system. For example, in 1999-2000, their rates in substantiations were four times higher than those for other children in NSW and seven times higher in Western Australia (Johnstone et al., 2002).
- “In 2000, death rates for Aboriginal and Torres Strait Islander infants were three times higher than those for other Australian infants. Deaths among Indigenous children aged 1-14 years were 2.5 times those for other Australian children” (Al-Yaman et al., 2002, p. 24).

### **Education**

A gap between the performance of Aboriginal and Torres Strait Islander students and all students in reading ability in Years 3 and 5 was identified in 1999 and continued to 2000 (Table 13).

**Table 13: Percentage of Aboriginal and Torres Strait Islander (ATSI) and all students achieving the reading benchmark, Australia, Years 3 and 5, 1999 and 2000**

| <u>Grade</u> | <u>Year</u> | <u>ATSI</u> | <u>All</u> |
|--------------|-------------|-------------|------------|
| Year 3       | 1999        | 73.4±6.2    | 89.7±2.5   |
|              | 2000        | 76.9±6.5    | 92.5±2.2   |
| Year 5       | 1999        | 58.7±4.2    | 85.6±2.0   |
|              | 2000        | 62.0±4.8    | 87.4±2.1   |

Note: From *National Report on Schooling in Australia*, Preliminary Paper, National Benchmark Results, Reading and Numeracy, Years 3 & 5 (p. 10), by MCETYA, 2001. Canberra: DETYA.

There were substantial differences between the achievement of numeracy benchmarks by Indigenous students and all students in Years 3 and 5 in 2000 (Table 14).

**Table 14: Percentage of Aboriginal and Torres Strait Islander (ATSI) and all students achieving the numeracy benchmark, Australia, Years 3 and 5, 2000**

| <u>Cohort</u> | <u>ATSI</u> | <u>All</u> |
|---------------|-------------|------------|
| Year 3        | 73.7±7.1    | 92.7±2.0   |
| Year 5        | 62.8±4.5    | 89.7±1.7   |

Note: From *National Report on Schooling in Australia*, Preliminary Paper, National Benchmark Results, Reading and Numeracy, Years 3 & 5 (pp. 13-14), by MCETYA, 2001. Canberra: DETYA.

The gaps between Aboriginal and Torres Strait Islander students and all students in literacy and numeracy appear to have increased from Year 3 to Year 5.

## **Child environment**

Aboriginal and Torres Strait Islander children have been over-represented in the child protection system (AIHW 2003a). Rates of Aboriginal and Torres Strait Islander children in substantiations are six times higher than the rates of other Australian children, while the rates of Indigenous children in out-of-home care are nine times higher than those of other children (AIHW, 2002a).

Home ownership was less common among Indigenous families. In 1996, while 70% of the general population owned or were purchasing their own home, 26% of Indigenous families owned or were purchasing the home in which they lived (ABS, 1999a).

“Results from the 1999 Australian Housing Survey showed that 13% of Indigenous households in urban areas and major regional centres did not have enough bedrooms to meet their needs, compared with 4% of other Australian households” (AIHW, 2002b p. 209).

## **Service delivery**

- **Early detection and intervention:**

A 1992 study identified that Aboriginal and Torres Strait Islander children had significantly more decayed teeth and higher aggregate decay experience in both baby and adult teeth than other Australian children (Al-Yaman et al., 2002).

- **Service availability:**

In 2001, proportionally more Aboriginal and Torres Strait Islander people (26%) lived in remote and very remote areas than non-Aboriginal and Torres Strait Islander Australians (2%) (ABS, 2003a). People living in remote areas have less access to services than others. For example, in 2001 a survey of Aboriginal and Torres Strait Islander communities with a population of 50 or more people located 10kms or more from the nearest hospital found that 36% of communities had no access to a dentist and 47% had no access to a mental health professional. Much of the access that was available occurred only four times a year or less (ABS, 2003a).

## **Criminality and drug use**

The total number of Indigenous persons in juvenile corrective institutions on 30 June 2001 was 269. This represented 45% of the total number of persons detained in juvenile corrective institutions. This incarceration rate was 17 times higher than the rate for non-Indigenous juveniles.

“Since 1998, the rate of Indigenous detention has declined much faster than the rate for non- Indigenous persons” (AIC, 2002 p. 71).

“In 2001, Aboriginal and Torres Strait Islander people were twice as likely to smoke, drink at levels that significantly increase the risk of harm in the short and long-term, and use illicit drugs than were non-Indigenous Australians” (AIHW, 2003b p. xvi).

## HUMAN DEVELOPMENT: INTERNATIONAL COMPARISON

The United Nations Development Programme (UNDP) report on human development provides an account of global progress in democracy and participation, economic justice, health and development, peace and personal security (UNDP, 2002). Out of the 173 countries UN-member countries for which data was available, Australia was ranked:

- 10th on the subjective indicators of governance relating to democracy (eg civil liberties, political rights), rule of law and government effectiveness (eg political stability, law and order) and corruption.
- 5th on objective indicators of governance relating to participation (eg voter turnout), civil society (eg trade union membership) and ratification of rights instruments (eg International Convention on Civil and Political Rights).
- 5th on the human development index (HDI), which summarises three dimensions of the concept of human development: living a long and healthy life, being educated and having a decent standard of living. It combines measures of life expectancy, school enrolment, literacy and income to allow a broad view of a country's development. Australia's HDI score has increased steadily from 0.844 in 1975 to 0.939 in 2000.
- 14th on the human poverty index (HPI).

A number of international comparisons were provided. Comparisons with the top six countries in the HDI are presented in Table 15.

**Table 15: International comparisons in human development**

| Indicator   | Norway | Sweden | Canada | Belgium | Australia   | USA  |
|---|--------|--------|--------|---------|-------------|------|
| <b>HDI rank</b>   | 1      | 2      | 3      | 4       | <b>5</b>    | 6    |
| People aged 16-65 lacking functional literacy skills 1994-95        | 8.5    | 7.5    | 16.6   | 18.4    | <b>17.0</b> | 20.7 |
| Long-term unemployment as a % of labour force, 2000                 | 0.2    | 1.4    | 0.8    | 4.0     | <b>1.8</b>  | 0.2  |
| Population below income poverty line (50% of median income 1987-98) | 6.9    | 6.6    | 12.8   | 8.2     | <b>14.3</b> | 16.9 |

| Indicator  | Norway | Sweden | Canada | Belgium | Australia   | USA  |
|--|--------|--------|--------|---------|-------------|------|
| Public health expenditure (as % of GDP) 1998           | 7.0    | 6.6    | 6.6    | 6.3     | <b>6.0</b>  | 5.7  |
| Infants with low birth weight (%) 1995-2000            | 5      | 4      | 6      | 8       | <b>7</b>    | 8    |
| Infant mortality (per 1,000 live births) 2000          | 4      | 3      | 6      | 6       | <b>6</b>    | 7    |
| Under-5 mortality rate (per 1,000 live births) 2000    | 4      | 4      | 6      | 6       | <b>6</b>    | 8    |
| Public education expenditure (as % of GNP) 1995-7      | 7.7    | 8.3    | 6.9    | 3.1     | <b>5.5</b>  | 5.4  |
| Inequality: Gini index                                 | 25.8   | 25.0   | 31.5   | 28.7    | <b>35.2</b> | 40.8 |
| Youth unemployment (% of labour force aged 15-24) 2000 | 10.2   | 11.9   | 12.6   | 15.2    | <b>12.3</b> | 9.3  |
| Victims of crime 1999 (% of total population)          | -      | 24.7   | 23.8   | 21.4    | <b>30.1</b> | 21.1 |

Note: From *Human Development Report, Deepening democracy in a fragmented world* (pp. 160-220), by United Nations Development Programme, 2002. New York: Oxford University Press.

## Conclusion

This snapshot of children's health and wellbeing in Australia yields mixed results. Some indicators are positive. For example:

- Infant mortality has declined.
- Youth suicides have begun to decline.
- Juvenile offending and incarceration rates have generally decreased.
- Australian home ownership is quite high.
- Childhood immunisation has increased and vaccine-preventable diseases have decreased.

- Most children have good dental health and this has improved in recent years.
- Most children do not smoke tobacco, drink alcohol or use illegal drugs.

However, there are some areas that suggest the need for attention. These include:

- Parental diets are reportedly poor, suggesting that they might provide poor sources of encouragement for a healthy diet among children.
- There is an increase in the number and percentage of children in the child welfare system.
- Childhood asthma remains a significant health problem for children.
- While child literacy and numeracy levels appear quite high, Australia ranks quite low in the population prevalence of attainment of upper secondary (Year 12) and post-secondary non-tertiary (skilled vocational level) training for persons aged 25-64.
- One survey has identified that one quarter of Australian adolescents has witnessed violence against a female parent.
- 1,675 children under 15 years without parents/guardians sought accommodation assistance in 1999-2000.
- Increased child hospitalisation rates for intentional self-inflicted injuries, which have been associated with mental health problems and disorders, such as depression.
- An increasing number of children are using formal child care. However, the quality and availability of care has been an issue of concern. For example, in 1999, less than half of the workers in long-day-care centres, 79% of family day care providers, and about 60% of workers in before-and-after school and vacation care services had no relevant qualifications (AIHW, 2002a).
- The use of alcohol and illicit drugs has increased in the general population, youth drinking appears to have increased, and about a quarter of young teenagers had used an illicit drug at least once in 1999.
- There are some significant health and wellbeing disparities. For example, health and wellbeing tended to be poorer for children from Aboriginal and Torres Strait Islander families.