

5 Health

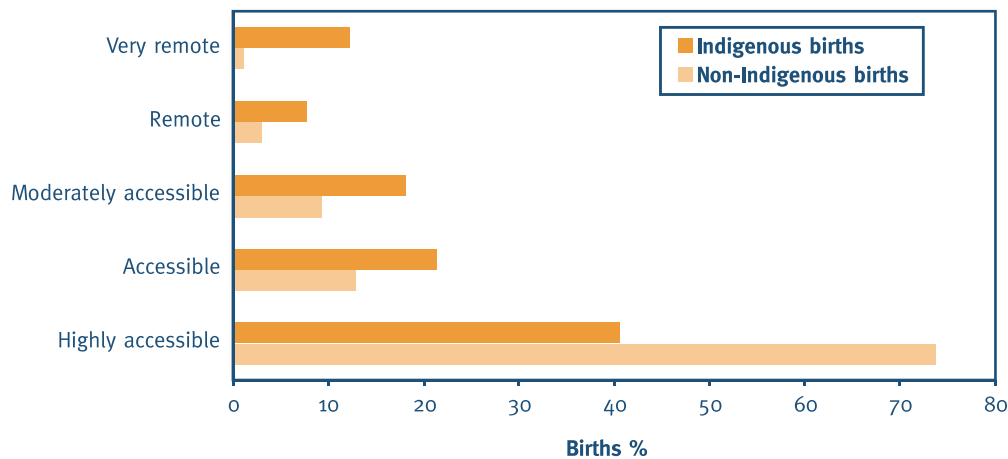
This chapter provides an overview of statistics on some of the significant indicators of the health of Queensland's children and young people.

Remote births

Difficulty accessing medical facilities can be a risk factor for mothers and babies delivered in remote or very remote areas, particularly if problems develop during delivery. The majority of Queensland babies are born in accessible or highly accessible areas (Figure 5.1).

However, in 2003, 20% of Indigenous babies were born in remote or very remote areas compared to only 4% of non-Indigenous babies.

Figure 5.1 Births by remoteness by Indigenous status, Queensland, 2003



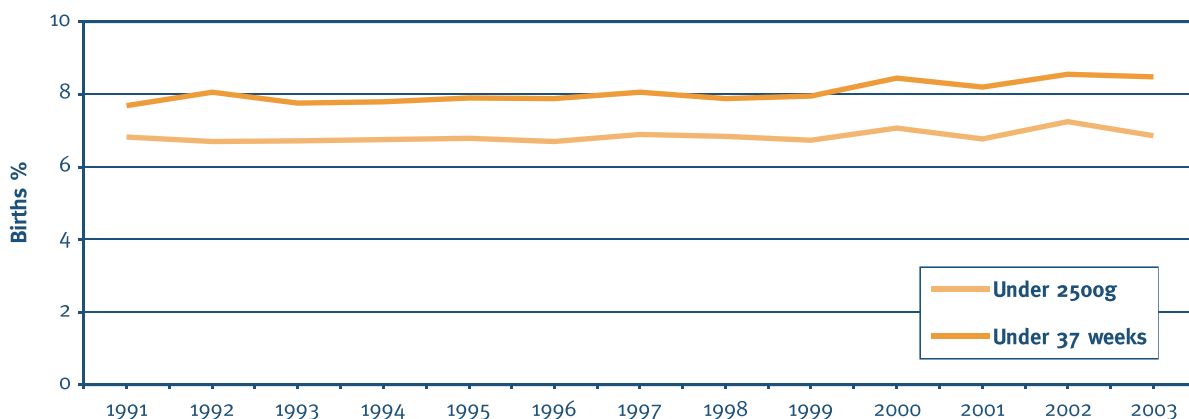
Source: ABS, Registered Births; Commonwealth Department of Health and Ageing, Accessibility/Remoteness Index of Australia

Premature births

Babies with low birthweight or shorter gestation may have significant short and long term health problems (Al-Yaman, Bryant & Sargeant, 2002). Contributing factors can include multiple births, the mother's age (older or younger), cigarette smoking, alcohol consumption and inadequate nutrition.

In Queensland in 2003, 6.9% of babies had a low birthweight (under 2500g), and 8.5% were born before 37 weeks gestation (Figure 5.2). There has been a slight upward trend in the proportion of babies born with low birthweight.

Figure 5.2 Births by birthweight and gestation, Queensland, 1991 to 2003

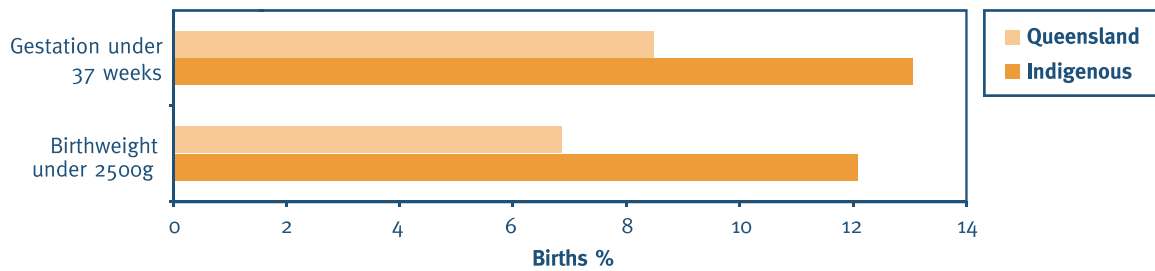


Source: Queensland Health, Perinatal Statistics

Babies born to Indigenous mothers were more likely to have a low birthweight and/or a shorter gestation period (Figure 5.3).

- Approximately one in eight Indigenous babies (12.1%) had a birthweight under 2500g in 2003 compared to the Queensland rate of one in 14 babies (6.9%).
- Around one in eight Indigenous babies (13.0%) was born before 37 weeks gestation compared to the Queensland rate of one in 12 babies (8.5%).

Figure 5.3 Birthweight and gestation by Indigenous status^a, Queensland, 2003



a. Indigenous status of mother.

Source: Queensland Health, Perinatal Statistics

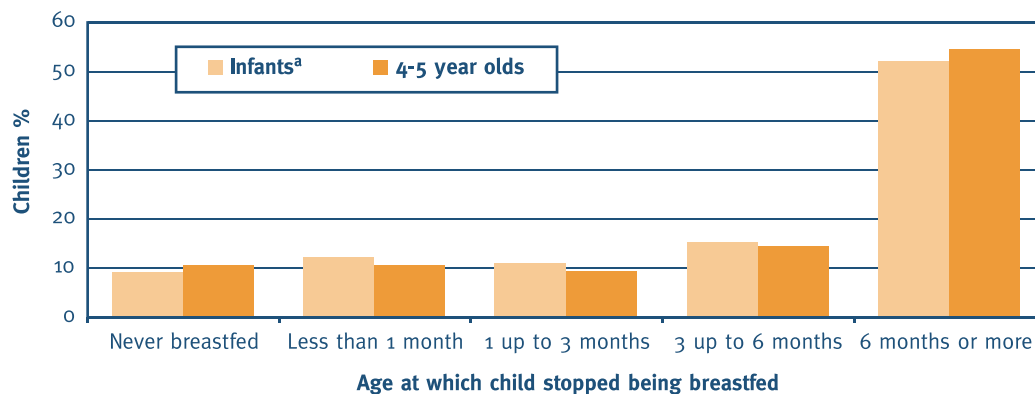
Breastfeeding

Various studies have shown that breastfeeding babies can reduce the risk of them developing a range of conditions throughout infancy and childhood, including diabetes mellitus, otitis media (ear infection), diarrhoea and respiratory infections such as asthma and eczema (Al-Yaman et al., 2002; National Health and Medical Research Council, 2003). Queensland Health recommends that babies be breastfed exclusively for the first six months of life, with solid foods introduced at this age in addition to continued breastfeeding to at least 12 months, and after for as long as mutually desired.

According to the Queensland Perinatal Data Collection, 83% of babies in 2003 were fed only breastmilk at the time of discharge from hospital (Queensland Health, 2004). However, babies with younger mothers were less likely to be breastfed, with only 75% of babies with mothers aged under 20 exclusively breastfed at the time of discharge.

The 2004 Longitudinal Study of Australian Children (AIFS, 2005) found that, nationally, just over half of all young children were breastfed for at least six months (52.1% of infants and 54.7% of 4 to 5 year olds) (Figure 5.4). However, the survey also found that the majority were not *exclusively* breastfed for the recommended period, with 91% of infants introduced to eating solids before the recommended age of six months (usually at around four months).

Figure 5.4 Age at which child stopped being breastfed, Australia, 2004



a. Infants who were at least 6 months old at the time of the interview.

Source: AIFS, *Growing Up in Australia: The Longitudinal Study of Australian Children: 2004 Annual Report*

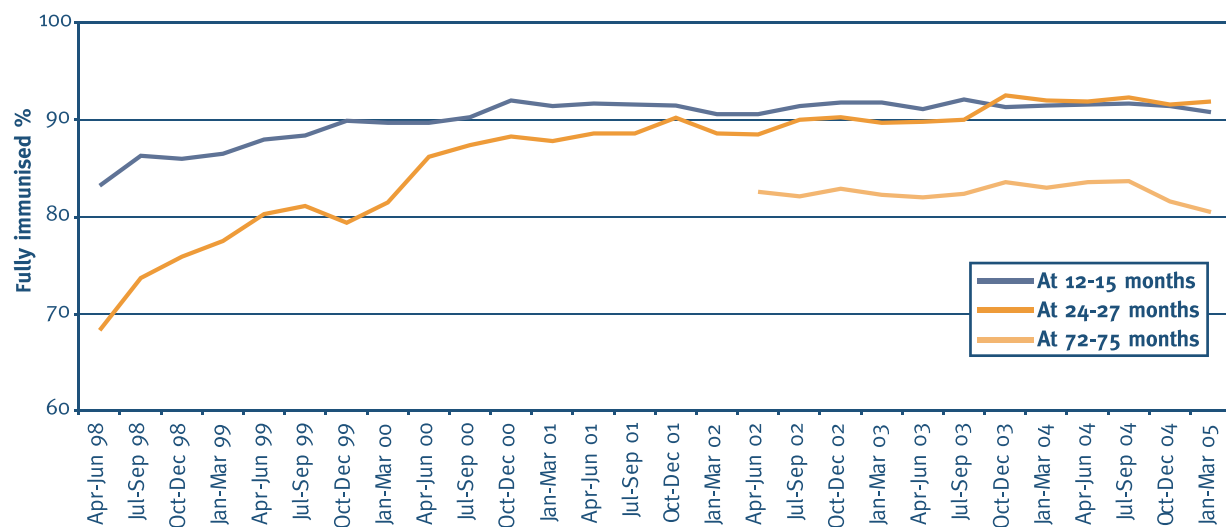
The recommended period for exclusive breastfeeding was changed from four to six months in 2002, and it may take several years for this new health message to be taken up by more mothers.

Family members and peers, whose experience may have predated the change, often have more influence than health care professionals on decisions about cessation of breastfeeding and the introduction of solid foods (Binns & Scott, 2002).

Immunisation

Overall, trends for immunisation in the first two years of life show an increase over time, with rates remaining relatively stable for the past few years (Figure 5.5). The national target is currently 95%, with Queensland performing on par with other states and territories against nationally defined milestones.

Figure 5.5 Age-appropriate immunisation coverage rates, Queensland, April–June 1998 to January–March 2005



Note: In the September 2002 quarter the DTPa dose for children 18 months old was dropped from the schedule.

Source: Queensland Health, Communicable Diseases Unit; Australian Childhood Immunisation Register, www.hic.gov.au/providers/health_statistics/statistical_reporting/acir.htm

From the Australian Childhood Immunisation Register, the vaccination coverage rates for Queensland children on 31 March 2005 were:

- 90.8% of children fully vaccinated by 15 months of age
- 91.9% fully vaccinated by 27 months of age, and
- 93.6% of children having received a first dose of MMR (measles, mumps, rubella) by 27 months of age.

Immunisation coverage for children at six years of age remains lower than optimum. The statewide coverage for this milestone at 31 March 2005 was 80.5%.

Immunisation levels for Indigenous children were found to be lower than the general population, with 85% fully vaccinated by 15 months of age (Australian Childhood Immunisation Register, unpublished data).

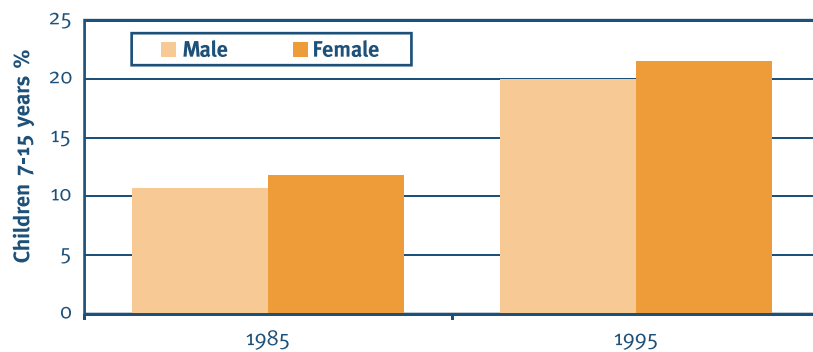
A report on morbidity and mortality from vaccine-preventable diseases and vaccine coverage in Australia found that total notifications for the eight diseases covered by the routine childhood vaccination schedule continued to decline in 2001 and 2002 (National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases, 2005). However, reductions - particularly in measles, mumps and rubella - were offset by increases in pertussis notifications (whooping cough), which caused six deaths of infants nationally in 2001 and 2002.

While much of the effort in immunisation over the last decade has resulted in increased coverage rates, a significant number of children in all cohorts remain incompletely vaccinated. There is general agreement on the factors associated with the incomplete vaccination status of children. These include failure to get primary vaccinations, high mobility, low socio-economic status, being from a single parent family, parental unemployment, coming from a culturally or linguistically diverse background or being of Aboriginal or Torres Strait Islander descent. There are also parents who make a conscientious decision against immunisation due to the risks involved.

Weight

Evidence from national surveys suggests that the proportion of children with unhealthy weight to height ratios has increased markedly in recent decades. There is no current reliable information on the weight indicators in Queensland, but it is estimated that the proportion of overweight and obese children in Australia almost doubled from around 11% in 1985 to 21% in 1995 (Figure 5.6).

Figure 5.6 Children 7–15 years who were overweight or obese, Australia, 1985 and 1995



Source: AIHW, *Australia's Children: Their health and wellbeing 2002*

More recently, the Longitudinal Study of Australian Children found that in 2004, 15% of 4 to 5 year olds would be classified as overweight and 6% obese (AIFS, 2005). However, parents did not necessarily perceive their child to be overweight. The majority of parents of overweight children (86%) and half of parents of obese children (50%) were not concerned about their child's weight.

A number of lifestyle changes have contributed to the increasing level of overweight and obesity in children. For example:

- families increasingly rely on fast foods and 'prepared' foods high in fat and/or sugar
- levels of physical activity have decreased as children may spend more time playing electronic games and watching television
- parental concerns about neighbourhood safety and the increase in both parents working mean that children are more likely to be driven to school, and older children have less freedom to roam and play unsupervised after school, and
- greater marketing and advertising of foods high in fat and/or sugar, particularly during peak viewing times for children.

Long term health conditions

The most common long term health conditions affecting children and young people in Queensland in 2001 were:

- asthma – which affected 12% of 0 to 6 year olds and 14% of 0 to 17 year olds, and
- hay fever and allergic rhinitis, which affected 3% of 0 to 6 year olds and 8% of 0 to 17 year olds (Table 5.1).

In the same year, mental health and behavioural problems were experienced by 7% of 0 to 17 year olds. Around 4% of 0 to 17 year olds were long sighted, 4% short sighted and 2% of children had some degree of deafness.

Table 5.1 Long term conditions by age, Queensland, 2001

	0-6 years	0-17 years
	Per cent	
Asthma	11.8	14.0
Hayfever & allergic rhinitis	2.9	8.4
Mental health & behavioural problems	2.2	6.3
Deafness (complete/partial)	1.8	2.0
Long sightedness	0.4	4.1
Short sightedness	0.4	3.9
Back pain/problems & disc disorders	a	2.7

a. Not published.

Source: ABS, National Health Survey 2001, cat. no. 4364.0 (companion data)

The AIHW report *Australia's children: their health and wellbeing 2002* (Al-Yaman et al., 2002) states that the incidence of Type 1 (juvenile onset or insulin dependant) diabetes is rising nationally, but also indicates that data on its incidence is patchy. More reliance can be placed on the number of new cases of Type 1 diabetes recorded on the National Diabetes Register (AIHW, 2003b), which indicated there were 160 new cases among 0 to 14 year olds in Queensland in 2001, up from 150 in 2000 and 135 in 1999.

However, the report notes that children living in Indigenous communities and children in remote areas may use health and pharmacy services which are not included on the register, possibly resulting in an under-reporting of Type 1 diabetes for children in these areas.

The incidence of new cases of Type 1 diabetes increased with increasing age. For the years 2000 and 2001, the average annual rates were:

- 15.3 for males aged 0 to 4 years per 100,000 population and 13.3 for females aged 0 to 4 years
- 21.5 for males aged 5 to 9 years per 100,000 population and 19.2 for females aged 5 to 9 years
- 27.3 for males aged 10 to 14 years per 100,000 population and 23.4 for females aged 10 to 14 years.