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Purpose

The National Child and Youth Strategic Framework for Health (the Framework) aims to identify the key strategic priorities for child and youth health in Australia. The Framework will guide the collective efforts of governments and professionals towards a shared national vision to improve child and youth health outcomes.

The aim of the Framework is not to duplicate the work of other frameworks, strategies or plans, but to provide an overarching framework. The Framework draws together a range of policy initiatives that seek to improve the health and wellbeing of children and youth, but are currently fragmented.

The Framework will inform and guide future national efforts and support the development and implementation of policies and measures by the Australian, state, territory and local governments, health service and education providers and relevant community groups. In this broad policy context, it will encourage a coordinated, holistic and multi-agency approach to target key child and youth health priority areas.

Going forward, a coordinated and collaborative approach will be essential to generate collective impact for future child and youth health efforts across Australia to best support and influence health care opportunities and health outcomes for Australia’s children and youth.

Scope

The Framework establishes a national vision for child and youth health that recognises the collective impact that can be achieved through collaboration from a range of stakeholders including governments, clinicians, program managers, policy makers, funders, consumers, peak bodies and non-government organisations. In identifying the key strategic priorities for the best health outcomes for children and young people, the Framework addresses health for children and youth from preconception to 24 years of age. As the indicators currently available cover a variety of age ranges, there is no strict delineation in the defined age range between child and youth. However as a guide, the Australian Bureau of Statistics commonly uses the age groups 0-14 years for children and 15-24 years for youth.

To ensure there is continuity, the Framework will build upon and update the work set out in the 1992 Health Goals and Targets for Australian Children and Youth. A review of progress since the 1992 document was undertaken; where data appears in the Framework without footnotes, it is sourced from that review. Significant progress has been made in the majority of areas, and further work is required as new issues have emerged.

Within the broader health system, the Australian Government and state and territory governments have different but complementary roles in contributing to child and youth health services and health outcomes and in setting priorities at local and national levels. Action requires coordination, collaboration and strategic partnerships between sectors to be successful. It is clear that the major achievements over the last 20 years reflect the investment by all levels of government.

Many other plans and strategies exist, or are being developed, that will support improvements in child and youth health. The National Child and Youth Strategic Framework for Health will draw from
these kinds of documents, as well as other forms of evidence, to draw attention to the health and wellbeing needs of children and young people and guide efforts to improve achievement of optimal child and youth health outcomes.

**Implementation**

Action on child and youth health is a multi-agency and multi-government responsibility. For national action to be effective, it must be supported by all levels of government. Under the Framework, the Australian and state and territory governments will work together and through their jurisdictions to ensure the strategic priorities are implemented.

One of the key areas in which the landscape has changed since the *1992 Health Goals and Targets for Australian Children and Youth* was written is the development of national indicators. Whilst there has been a number of regular reports, in 2014 the Australian Institute of Health and Welfare (AIHW) published the *Mapping of Children and Youth Indicator Reporting Framework*, drawing together existing indicators to measure progress. This Framework references the work of the AIHW to facilitate the use of existing, established child and youth indicators, ensuring that the Framework is robust and measurable.

**Policy Context**

The development of the new Framework builds on the previous work under the *1992 Health Goals and Targets for Australian Children and Youth*, as well as the wealth of new information about continuing and emerging health issues, and the most effective ways to achieve population-level health improvements for children and youth. It will assist to establish national, evidence-based and measurable priorities to improve health outcomes for children and young people.

Other plans and strategies exist, or are being developed, that will support improvements in child and youth health. The Framework will support implementation of the broad, high level strategies that support better health for all Australians, and which aim to improve Australia’s health system. These include the *National Primary Health Care Strategic Framework*, and the *National Mental Health Strategy*. The Framework will draw from these documents and other sources, to focus attention on the health and wellbeing needs of children and young people and guide efforts to improve achievement of optimal child and youth health outcomes.

There are also a number of international policy drivers to which Australia is a signatory that provide standards or guides on the health, development and wellbeing of children and young people. These include the United Nations *Convention on the Rights of the Child*, the Organisation for Economic Co-operation and Development’s comparative reports on child wellbeing and World Health Organization policy statements.

Close consideration has been given to elements relevant to the work of the health sector from the diverse strategic initiatives including the Council of Australian Governments’ *Early Development Agenda, Closing the Gap, National Security and Community Safety Reform Agenda*, the *Roadmap for National Mental Health Reform 2012-2022*, and a host of others.

The Framework aims to distil the elements of those plans that relate to children and young people’s health into a coordinated strategic guide for action for the child, youth and family health sector. It
also aims to demonstrate the connections between the different issue-focused policies it covers and
the achievement of improved outcomes for children and young people.

These policies currently include the *National Framework for Universal Child and Family Health
Services*, the development of the *National Framework for Secondary and Tertiary Child Health
Services*, the *National Framework for Protecting Australia’s Children*, and the *National Aboriginal and
Torres Strait Islander Health Plan*, amongst others listed in Appendix Three.

It is envisioned that new and developing policies will be strengthened by using the Framework as a
guide and a point of connection with other policy initiatives.

**Next Steps**
The Strategic Framework is an Australian Health Ministers’ Advisory Council funded project and is
being progressed through its Community Care and Population Health Principal Committee. Work on
the project is led by NSW Kids and Families, a pillar of NSW Health.

Stakeholders' views are now sought on the draft Strategic Framework, its priorities and objectives.
Feedback from this consultation will be taken into consideration prior to finalisation of the new
National Strategic Framework for Child and Youth Health. It is anticipated the new National Child
and Youth Strategic Framework for Health will be finalised for release by early 2015. More
information can be found at [tinyurl.com/strategicframework](http://tinyurl.com/strategicframework).

Feedback can be provided through the online survey at [www.surveymonkey.com/s/NationalCYH](http://www.surveymonkey.com/s/NationalCYH).

Submissions can also be made via email to NationalCYH@doh.health.nsw.gov.au.

The consultation is open until **21 November 2014**.
Consultation Questions

Consultation Question 1

Does the vision capture the broad health outcomes for all Australian children and youth?

Consultation Question 2

Does the draft Framework identify the right key Strategic Priorities in child and youth health?

Consultation Question 3

Strategic Priority One: Providing the best foundations for healthy children and youth. Do we have the right objectives? Are any objectives missing?

Questions relating to Strategic Objectives

Strategic Objective 1.1: What needs to be done next to further improve the health of babies and their mothers at birth?

Current indicators that could be used to monitor progress:

- Increasing the proportion of mothers who use antenatal services at all (mothers who attended at least one antenatal care session)
- Increasing the proportion of mothers who attended 5 or more antenatal visits
- Increasing the proportion of babies born at term
- Increasing the proportion of babies born at a healthy birth weight
- Decreasing the proportion of women who smoked in the first 20 weeks of pregnancy
- Decreasing the proportion of women who consumed alcohol in pregnancy
- Decreasing the proportion of women who used illicit drugs or substances during pregnancy

Strategic Objective 1.2: What needs to be done next to further reduce the child and youth mortality rate?

Current indicators that could be used to monitor progress:

- Reducing the infant mortality rate
- Reducing the rate of sudden infant death
- Increasing the proportion of children who are fully immunised
- Reducing the proportion of households with children/young people where adults/household members smoke inside.
- Causes of death by age, including monitoring the leading causes of death for infants up to 12 months, children aged 1-14 and young people aged 15-24.

Strategic Objective 1.3: What needs to be done next to reduce hospitalisations for children and young people?

Current indicators that could be used to monitor progress:

- Reduce hospitalisations for illness
  - Reduce rate of avoidable hospitalisations for respiratory disease 0-24
  - Encourage appropriate use of antibiotics (Indicator collected is proportion of upper respiratory tract infections managed for which oral antibiotics were prescribed)
• **Reduce hospitalisations for injury**
  - Reduce age-specific death rates from all injuries for children 0–14
  - Reduce the injury and poisoning death rate for young people 12–24
  - Reduce road transport accident death rate 0–14 and 12–24
  - Reduce the accidental drowning rate for children 0–14
  - Reduce the injury and poisoning hospitalisation rate 0–14, 12–24
  - Reduce the suicide rate for young people
• **Reduce rates of serious injury and poisoning resulting in hospitalisation for children and young people including:**
  - Age-specific serious injuries for land transport 0–14
  - Assault hospitalisation rate for children 0–14
  - Intentional self-harm hospitalisation rate for children 10–14
• **Reduce hospitalisations for vaccine preventable diseases**
• **Increase the proportion of:**
  - Children on the Australian Childhood Immunisation Register who are fully immunised at 2 years
  - Indigenous children who are fully vaccinated 12–15 months, 24–27 months, 60–63 months
  - Australian children fully vaccinated resident in agreed areas of low immunisation coverage 12–15 months, 60–63 months
  - Children who are fully vaccinated 60–63 months
  - Children attending the Children and Family Centres who have had all age-appropriate health checks and vaccinations
• **Reducing the proportion of households with children/young people where adults/household members smoke inside.**

**Strategic Objective 1.4** What needs to be done next to increase the proportion of children who start school developmentally on track?

Current indicators can be used to monitor the progress of increasing the proportion of Australian children who are developmentally ‘on track’ in each domain measured in the Australian Early Development Census.

**Strategic Objective 1.5** What needs to be done next to improve the oral health of children and young people?

Current indicators can be used to monitor progress in increasing the proportion of Australian children and young people who are decay free at 6, 12 and 15 years, decreasing the number of decayed, missing and/or filled teeth and decreasing hospitalisation for dental problems.

**Strategic Objective 1.6** What needs to be done next to improve the cleanliness and safety of physical environments for children and young people? How can we measure progress?

Current indicators can be used to track progress in increasing the proportion of Australian young people using sun protection or avoiding the sun on a regular basis.
Strategic Objective 1.7  What needs to be done next to promote healthy lifestyles for children and young people?

Current indicators track progress in efforts to:

- Increase the proportion of infants exclusively breastfed to around 4 months of age
- Increase the proportion of children/young people at a healthy weight in each age category.
- Increase the proportion of children meeting the National Physical Activity Guidelines and not exceeding the screen time guidelines
- Increase the proportion of children meeting the national guidelines for fruit and vegetable consumption
- Increase the proportion of young people (aged 12–24) meeting Australian Dietary Guidelines

Consultation Question 4

Strategic Priority Two: Improving the social and emotional wellbeing of children and youth. Do we have the right objectives? Are any objectives missing?

Questions relating to Strategic Objectives

Strategic Objective 2.1:  What needs to be done next to support and strengthen the capability of parents? How can this be measured?

Current indicators do not include indicators of parenting capability or quality that would measure this objective.

Strategic Objective 2.2:  What needs to be done next to ensure the provision of safe, nurturing family environments for children and young people, free from abuse and neglect?

Current indicators track progress in efforts to:

- Monitor the rate of children who were the subject of a child protection substantiation in a given year (ages 1-12 and 12-17) compared to previous years
- Monitor the rate of children (and also specifically Indigenous children) who were the subject of care and protection orders (0–12 and 12–17)
- Reduce the rates of children/young people who have been the victims of physical assault or sexual assault (0–12 and 15–24)
- Reduce alcohol- and drug-related victimisation rate for young people 12–24
- Reduce the assault (homicide) death rate for: Children 0–14; 0–17; Young people 12–24; and Indigenous children/young people.
- Reduce the number of incidents where adults experienced current partner violence and their children saw or heard the violence in the previous 12 months

Strategic Objective 2.3  What needs to be done next to improve the social and emotional wellbeing of children and young people? How can this be measured?

Current indicators monitor the:

- Proportion of children with mental health problems (age 4–14)
• Proportion of children with mental health disorders (attention deficit hyperactivity disorder, depressive disorder, conduct disorder) (age 6-14)
• Prevalence of mental disorders among young people
• Proportion of young people having high/very high levels of psychological distress as measured by the Kessler 10 (K10) scale (age 16–24)
• Proportion of people reporting high or very high levels of psychological distress; - by level of psychological distress and also by whether they saw a health professional because of psychological distress (age 18–24)
• Mental health-related mortality rates (age 15–24)
• Intentional self-harm mortality rates (age 15–24)
• Age-specific hospitalisation rates for mental health-related conditions (age 0–24)
• People receiving clinical mental health services (age 0–24)
• Community mental-health care service contacts (age 0–24)
• Proportion of children who have engaged in risky drinking on any one occasion (age 12–14)
• Proportion of young people who drink at risky or high-risk levels in the short term or long term (age 12-24)
• Adults at risk of long-term harm from alcohol (age 18-24)
• Alcohol risk levels, Indigenous persons (age 18–24)

Strategic Objective 2.4 What needs to be done next to reduce the prevalence of children experiencing early adverse events and to improve family functioning? How can this be measured?

Current indicators track progress in efforts to:
- Increase the proportion of children whose parent/guardian was usually able to get help when needed
- Decrease the proportion of parents who used any illicit drug in the previous 12 months
- Decrease the proportion of parents who drank alcohol at risky levels

Strategic Objective 2.5 What needs to be done next to support children and young people living with chronic illness?

Current indicators track progress in efforts to:
- Decrease the prevalence of long term conditions (age 12-24 years)
- Decrease the prevalence of asthma (age 0-14; 12-24)
- Decrease the prevalence of cancer (age 0-14; 12-24)
- Decrease the prevalence of diabetes (age 0-14; 15-24)
- Decrease the prevalence of mental health problems (age 4-14)

Strategic Objective 2.6 What needs to be done next to support children and young people living with a disability?

Current indicators track the number of children/young people living with a disability (severe or profound core activity limitation) for 0-14 years and 15-24 years.
The current indicator for neonatal hearing screening:

- Proportion of children identified as requiring a hearing aid who are then fitted with a hearing aid by 6 and/or 12 months of age.

**Consultation Question 5**

Strategic Priority Three: Improving health outcomes for vulnerable populations. Do we have the right objectives? Are any objectives missing?

**Questions relating to Strategic Objectives**

Strategic Objective 3.1: What needs to be done next? How do we identify the most vulnerable populations? How do we decide which groups are prioritised? How can we measure progress?

Current indicators do not specifically address the effectiveness of systems used to identify vulnerable populations for prevention and early intervention.

Strategic Objective 3.2: What needs to be done next to reduce disadvantage as a result of the social determinants of health? How can we measure progress?

Current indicators do not specifically address innovative system responses to improve access and effectiveness of services for vulnerable communities and groups. There appear to be limited systems dedicated to promotion and dissemination of effective models of care for vulnerable and disadvantaged children and their families.

Strategic Objective 3.3: What needs to be done next to enable fairer access to primary health care services? How can we measure progress?

Current indicators do not specifically address workforce issues for the health workforce providing health services to children and their families.

**Consultation Question 6**

Strategic Priority Four: Provide coordinated systems focused on the health needs of children, young people and their families. Do we have the right objectives? Are any objectives missing?

**Questions relating to Strategic Objectives**

Strategic Objective 4.1 What needs to be done next to improve health literacy? How can we measure progress? Are there measures or other strategies that could usefully be included in this section?

Strategic Objective 4.2 What needs to be done to improve the delivery and use of health information? How can we measure progress? Are there measures or other strategies that could usefully be included in this section?
Strategic Objective 4.3 What needs to be done to encourage cross sector and intergovernmental collaboration and coordination? How can we measure progress? Are there measures or other strategies that could usefully be included in this section?

Strategic Objective 4.4 What needs to be done to support evidence based policies and programs? How can we measure progress? Are there measures or other strategies that could usefully be included in this section?

Consultation Question 7

Are there any key child and youth health priorities missing from the Framework? If so, are there nationally collected indicators? Are there indicators missing?

Consultation Question 8

Does the Framework strike an appropriate balance between a wellness approach and a disease focus?

Consultation Question 9

What are the enablers and barriers to implementation of the Framework?
National Vision for Child and Youth Health

Australian children and young people are healthy, nurtured, on track in their development and living in safe, healthy and family inclusive communities and environments.

The child, youth, and family health sector has a major role in contributing to the achievement of improved outcomes for children and young people. Although the primary responsibility for raising children lies with their parents, carers and families, there is still a critical role for communities, non-government organisations and governments in shaping children’s early life experiences and their health and development.

From supporting and caring for families during the preconception period and from the moment a pregnancy is confirmed, throughout the early years, through school and adolescence into adulthood, services in the health sector work towards maintaining and improving health and wellbeing outcomes for children, youth and their families – outcomes that make a difference to their health and wellbeing for the rest of their lives.

The physical health of children and young people has always been a key concern, but over the last 20 years research has made clearer the connection between physical health, social and emotional wellbeing, environment and experience. For efforts to be effective, all these aspects must be addressed. We know more about the interaction between genetics and experience, about the lifetime effects of early deprivation and trauma. We know more about what contributes to vulnerability, but also more about what contributes to strength, resilience and optimal outcomes.

For that reason, the national vision for the future encompasses not only a reduction in vulnerability and risk factors and the numbers or proportion of children and youth with poor outcomes, but goes further to a vision of the best possible outcomes for all. A future where children and young people are nurtured to be as healthy as they can be, on track in their development and live in an environment that supports their health and engagement with their community.
Principles for selecting Strategic Priorities

This Framework adopts the eight principles for selecting strategic priorities from the 1992 Health Goals and Targets for Australian Children and Youth. The principles remain effective and appropriate to guide the identification of strategic priorities and the strategic objectives.

The eight Principles include:

1. **Credible** - address important public health issues that are likely to remain current
2. **Clear** – easily appraised by and relevant to a wide general audience
3. **Selective** – the choice of topic should be used to highlight areas that are a priority for action
4. **Compatible** – with current public health strategies
5. **Achievable** – interventions should be available or potentially available
6. **Balanced** – monitor progress through a mixture of process and outcome measures
7. **Quantifiable** – national data is required. If necessary proxy indicators should be used or a specific recommendation made for the collection of data
8. **Ethical** – respect the autonomy of individuals and avoid unnecessary value judgements.

The Australian, state and territory governments will work together towards achieving the priorities and strategic objectives of the Framework, to provide Australian children and youth the best life chance, opportunities and health outcomes.

<table>
<thead>
<tr>
<th>Strategic Priority One</th>
<th>Provide all children and young people with the best foundations for a healthy life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Priority Two</td>
<td>Improve social and emotional wellbeing for all children and young people</td>
</tr>
<tr>
<td>Strategic Priority Three</td>
<td>Strengthen and improve health outcomes for vulnerable populations</td>
</tr>
<tr>
<td>Strategic Priority Four</td>
<td>Provide more coordinated systems focused on the health needs of children, young people and their families</td>
</tr>
</tbody>
</table>
The National Child and Youth Strategic Framework for Health: The Vision, Strategic Priorities and the Strategic Objectives

Table: National Child and Youth Strategic Framework for Health
Strategic Priority One: Provide all children and young people with the best foundations for a healthy life

Provide the best foundations for healthy young people by investing in early intervention, promoting healthy lifestyles, providing safe and clean environments, investing in early interventions and reducing preventable illnesses.

1.1 MAINTAIN AND IMPROVE GOOD HEALTH OF BABIES AND THEIR MOTHERS AT BIRTH
1.2 FURTHER REDUCE THE MORTALITY RATE
1.3 REDUCE HOSPITALISATIONS FOR:
   1.3.1 ILLNESS
   1.3.2 INJURY
   1.3.3 VACCINE PREVENTABLE DISEASES
1.4 INCREASE THE PROPORTION OF CHILDREN WHO START SCHOOL DEVELOPMENTALLY ON TRACK
1.5 REDUCE THE RATES OF ORAL HEALTH ISSUES
1.6 PROVIDE CLEAN AND SAFE PHYSICAL ENVIRONMENTS
1.7 PROMOTE HEALTHY LIFESTYLES

Rationale

Investment in the early years of child development provides an opportunity for significant health gains across the lifespan. There are well established links between low birth weight and increased risk of coronary heart disease, diabetes, hypertension and stroke in adulthood. It is clear from the evidence that the intrauterine environment and the caregiving that a child receives in their first years of life are critical foundations for a healthy life. These factors also play a role in moderating how social factors such as socioeconomic disadvantage interact with genetic and physical factors to determine a child’s health and developmental outcomes. The relationships between birth weight and other factors present at and before, birth are modified by patterns of postnatal nutrition, development and growth. There are also clear links demonstrated between a range of adverse experiences early in life, and later chronic disease.

If a reduction in hospitalisations for illness, injury and preventable disease is to be achieved, prevention and early intervention is key to reducing the future burden on the health system. Evidence shows that intervening early in the life course to either prevent events that increase risk or addressing issues early to reduce their impact are most effective in preventing or reducing later health issues. Benefits of early life intervention include cumulative improvement to health outcomes in the long term. This is particularly so for children from disadvantaged backgrounds; the earlier the intervention, the more effective it is likely to be. Sustained intervention that addresses multiple environmental risk factors simultaneously is most effective.
Strategic Objectives

1.1 MAINTAIN AND IMPROVE GOOD HEALTH OF BABIES AND THEIR MOTHERS AT BIRTH

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Under the 1992 Health Goals and Targets for Australian Children and Youth significant gains were made in improving the health of mothers and babies. The 2014 analysis of progress against the 1992 benchmarks demonstrated that the two decades had seen the development of consistent clinical standards for antenatal care in Australia, and that by 2011, 94.4% of women were having five or more antenatal visits. The change in the rate of neural tube defects in infants born to mothers who had an affected child exceeded the targets, dropping from 3.6% in 1991 to 0.1% or less by 2006-2008. The rate of babies born of low birth weight decreased slightly from 7.1% in 1989 to 6.3% in 2011; however the rate remained fairly steady in the decade from 2000 to 2011.

The progress against the 1992 Health Goals and Targets for Australian Children and Youth also demonstrated areas where there was more work to do. Breastfeeding is associated with improved general health, growth and development of infants and protection against a number of acute and possibly chronic diseases. In 1992, the target was to increase levels of breastfeeding at 6 months from the 1984 rate of 45% to 75% by 2000. However, current data shows that while most infants (96%) commence breastfeeding, only 39% are exclusively breastfed to three months, and at 6 months 2.1% of babies are exclusively breastfed. At six months of age 60.1% of babies are still receiving some breast milk – well below the target of 75%.

Current Status:

High quality antenatal care is associated with improved outcomes at birth, and over the last 20 years has been instrumental in the health improvements for children and young people. Implementation of the National Primary Maternity Services Framework and the National Clinical Practice Guidelines: Antenatal Care will assist in ensuring that high quality and consistent antenatal care is available to all mothers expecting a baby across Australia.

Smoking during pregnancy is the most common preventable risk factor for complications in pregnancy and is associated with poorer outcomes for babies such as low birth weight, perinatal death and increased risk of sudden infant death syndrome (SIDS). Indicators for reduced smoking in pregnancy are discussed elsewhere. The currently collected and reported indicators relevant to reducing infant mortality can be found in Appendices 1 and 2.

Fetal Alcohol Spectrum Disorders (FASD) describes a range of outcomes that can occur in an individual who had prenatal exposure to alcohol. People with FASD have observable abnormalities in the structure and size of their brain as a result of exposure, which lead to changes in function. It is the largest cause of non-genetic, at-birth brain damage in Australia. Functional changes related to FASD can include learning difficulties, memory problems, behavioural and anger management problems, speech and muscle coordination problems, and physical abnormalities in a range of organs. Although some children suffer severe disability as a result of FASD and are identified, children who are at the milder end of the spectrum of functional effects may not be identified as having FASD. The true prevalence is largely unknown. In response to the recommendations of the 2012 Parliamentary Inquiry into Fetal Alcohol Spectrum Disorders, the Australian Government has
identified five areas of action under the *Action Plan to Reduce the Impact of Fetal Alcohol Spectrum Disorders 2013-14 to 2016-17* to address the harmful effects of FASD on children and families.

1.2 FURTHER REDUCE THE MORTALITY RATE

**Achievements from analysis of progress against the 1992 Health Goals and Targets:**

Under the *1992 Health Goals and Targets for Australian Children and Youth* significant gains were made in addressing preventable mortality in infants. The target to reduce the Aboriginal and Torres Strait Islander infant mortality rate by at least a third, and to 10 per 1000 live births by 2000, has been met nationally and exceeded in many states and territories. Only the Northern Territory remained higher than the target in 2012. The target to reduce the rate of SIDS by one half, and to one per 1000 live births by 2000 has been exceeded. The rate of SIDS in 2010 was 0.29 per 1000.

Overall, the death rate has more than halved for Australian infants and children between 1986 and 2010 (from 8.8 to 4.2 deaths per 1,000 live births) and has continued to fall. The work of neonatal intensive care units, increased community awareness of the risk factors for SIDS, and reductions in vaccine-preventable diseases through national childhood immunisation programs, have all significantly contributed to this trend.

For some population groups, infant mortality rates remain significantly higher than the general rate. In the period 2006-2010, the mortality rate for Indigenous infants was twice the non-Indigenous rate (8 per 1,000 live births compared with 4 per 1,000 live births) despite the gains made in reducing the Aboriginal and Torres Strait Islander infant mortality rate. Aboriginal and Torres Strait Islander infant mortality rates also vary across jurisdictions, from 6 per 1,000 in SA, to 13 per 1,000 in the NT.

**Current Status:**

Child mortality is a long-established measure of general child health, the overall health of the population, and the effectiveness of the health system. The overall infant mortality rate in Australia is low, and is still decreasing. The Australian Bureau of Statistics reports regularly on infant mortality rates. Infant and child death rates provide insight into the social and environmental conditions in which children grow and develop.

Despite the improvements over the last two decades, Australia is currently ranked 14 of 30 OECD countries for which infant mortality rates were reported for 2012. Australia’s infant mortality rate (3.3 deaths per 1,000 live births) was three times higher than that of the best-performing country, Iceland (1.1 deaths per 1,000 live births), and twice that of Slovenia (1.6 deaths per 1,000 live births).

More than two-thirds (69%) of infant deaths were in the neonatal period (first 28 days after birth), of which almost half (48%) were on the day of birth. More than half (60%) of all infant deaths were boys. The three leading causes of infant death are perinatal conditions (such as maternal...
complications during pregnancy); congenital anomalies; and those categorised as ‘symptoms, signs and abnormal findings’ (which includes SIDS). Child death review processes document that in the vast majority of SIDS incidents there is at least one modifiable risk factor present. Commonly, exposure to tobacco smoke is among these risk factors.

In 2008, the Council of Australian Governments committed to halving the gap in infant mortality rates for Aboriginal and Torres Strait Islander children under five by 2018, and there has been a significant increase in investment and effort to implement evidence-based programs known to improve infant mortality since then. SIDS has been reduced to low levels in Australia; however further health gains are possible, particularly for Indigenous children, through maintaining awareness and reducing exposure to modifiable risk factors.

The most common causes of death vary across age groups. An analysis of the leading underlying causes of death in Australia by sex and age group for 2009–11 revealed that for children and young people the five leading causes of death were:

<table>
<thead>
<tr>
<th>Age</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>Maternal and Perinatal Congenital</td>
<td>SIDS</td>
<td>Ill defined causes</td>
<td>Spinal muscular atrophy &amp; related</td>
<td>Selected metabolic disorders</td>
</tr>
<tr>
<td>1-14</td>
<td>Land Transport accidents</td>
<td>Maternal and Perinatal Congenital</td>
<td>Accidental drowning and submersion</td>
<td>Brain Cancer</td>
<td>Cerebral palsy and related</td>
</tr>
<tr>
<td>15-24</td>
<td>Land Transport accidents</td>
<td>Suicide</td>
<td>Accidental poisoning</td>
<td>Event of undetermined intent</td>
<td>Assault</td>
</tr>
</tbody>
</table>

Injury prevention (including transport accidents), assault and suicide prevention are all referred to under other objectives, although reducing the mortality from these causes is not addressed separately to preventing injury. Cancer is considered under chronic disease, and skin cancer is specifically considered under the sections dealing with sun exposure.

1.3 REDUCE HOSPITALISATIONS FOR:
   1.3.1 ILLNESS
   1.3.2 INJURY
   1.3.3 VACCINE PREVENTABLE DISEASES

Achievements from analysis of progress against the 1992 Health Goals and Targets:

The leading causes of hospitalisation for children and young people in Australia are not routinely reported at a national level. Although a number of jurisdictions publish the leading causes of hospitalisation by age, the last time such information was published nationally was in the ABS report

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Asthma can impact significantly on a person’s quality of life, and people with asthma are more likely to suffer comorbidity, and also to experience more complications with their asthma due to comorbidity. There was a significant decline in the prevalence of asthma in children, aged 0-14, between 2001 and 2011-12, with a reduction from 13.5% to 9.3% of this cohort. Despite this decline, asthma remains a significant health problem in Australia by international comparison.

Reducing the morbidity, mortality and disability cause by injury to children and young people was the first goal of the 1992 Health Goals and Targets for Australian Children and Youth, and the targets for reductions in all injury mortality, traffic related injury deaths, drowning rates in the 1-4 year age group and episodes of poisoning in 0-4 year olds requiring hospitalisation were all exceeded. The target for reducing burns and scalds in 0-4 year olds requiring hospitalisation was not met (although significant progress was made).

Significant progress was made against the targets for increasing vaccination rates, but at 91.9% population coverage for Diptheria, Pertussis, Tetanus, Measles, Mumps and Rubella vaccination for five year olds in 2014, progress fell short of reaching the 95% target by 2000. Additional progress against the 1992 goal of reducing the impact of vaccine preventable disease has included:

- Rotavirus vaccination, introduced in 2007, resulting in subsequent reductions in hospital presentations for gastroenteritis.
- Human Papilloma Virus (HPV) Vaccination Program was introduced in 2007, and the data from sexual health clinic samples indicates a significant decrease in HPV associated genital warts.

Indigenous children are significantly more likely than non-Indigenous children to experience vaccination delay, which reduces the benefit of vaccination.

Current Status:

1.3.1 REDUCE HOSPITALISATIONS FOR ILLNESS

Asthma

In 2010–11 the overall rate of hospital separation for asthma was 175 per 100,000 population. This rate was much higher among children aged 0–14 (495 per 100,000 population) than the rate among people aged 15 and over (92 per 100,000 population), and was highest for children aged 0-4 years (958 per 100,000 population).

Rotavirus

Worldwide, diarrhoea is the second most common cause of fatal childhood disease, estimated to cause approximately 1.34 million deaths among children aged 5 years. Rotavirus is the leading cause of severe diarrhoea in young children and is responsible for approximately one-third of all diarrheal deaths.
Rotavirus vaccination was introduced to the National Immunisation Program in 2006. An Australian study has shown that vaccination with the RV1 and RV5 vaccines saw a 68%-93% reduction in the number of infant (12 months or younger) rotavirus related hospital admissions. Large declines in all-cause diarrhoea hospitalisations indicate that rotavirus may be a more important cause of childhood diarrhoea than previously estimated. However, diarrhoea remains a common cause of hospitalisation of children.

**Allergies**
There has been a rapid increase over the past 30 years in the prevalence of allergic conditions such as eczema and food allergy, and the causes remain unknown. Food allergy prevalence in particular, has increased dramatically over the past decade. Food allergy is a problem that affects mainly children.

The disease burden of childhood allergic conditions is substantial. The prevalence of childhood food allergies, however, is less certain. Australian population-based research has shown that up to 10% of infants have confirmed food allergies. Although there is uncertainty about the exact prevalence of food allergies, research suggests that it is increasing. In Australia, a 350% increase in hospital admissions for food allergies and anaphylaxis was reported in the period 1994-95 to 2004-05.

### 1.3.2 REDUCE HOSPITALISATIONS FOR INJURY

Injury remains a major reason for hospitalisation of children, and injury prevention and control remains a national health priority. Among very young children (aged 0-4 years), the leading cause for injury hospitalisation was a fall (42%). For older children (5-14 years), 46% of injury hospitalisations were the result of a fall and 16% were transport-related. The most common causes of injury hospitalisation for young adults aged 15-24 years were transport-related injuries (19%), falls (14%), assault (11%) and intentional self-harm (10%).

Road transport accidents are the most common external cause of injury death among children. Accidental drowning remains a leading cause of childhood death, especially among 1–4 year olds. Hospitalisations for assault are an important indicator as they capture serious incidents of intentional harm inflicted upon children and youth, including physical assault, domestic violence and child abuse. Intentional self-harm is a significant public health problem and can be related to suicidal behaviour.

### 1.3.3 REDUCE HOSPITALISATIONS FOR VACCINE PREVENTABLE DISEASES

Nationally, the percentage of children fully immunised is just above 90%. Although Australian immunisation rates are high, maintenance of those rates is important to ensure that the gains made in protecting children from childhood diseases are sustained. Immunisation is a simple, safe and effective way of protecting people against harmful diseases before they come into contact with

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them in the community. Immunisation not only protects individuals, but also others in the community, by reducing the spread of disease.

Immunisation of babies and their close contacts against vaccine preventable disease is central to protecting this vulnerable group. While data is available on childhood vaccination rates, there is no national data on adult vaccination coverage, and research indicates that mothers (and other close family members) are the most likely source of whooping cough infection in young babies. The full benefits of immunisation are only realised through sustained high participation rates. Further research is needed to ensure that data is collected on new vaccines that have become available, rates of immunisation and effectiveness.

In 2013, the *National Immunisation Strategy for Australia 2013-2018* was released which notes that although our national immunisation coverage rate is over 90%, meeting the WHO international target, many other countries report coverage rates around 95%.

### 1.4 INCREASE THE PROPORTION OF CHILDREN WHO START SCHOOL DEVELOPMENTALLY ON TRACK

**Achievements from analysis of progress against the 1992 Health Goals and Targets:**

While the importance of promoting education and development was recognised under the fifth 1992 goal, there was little available in 1992 to inform development of indicators and baselines. The main target set in this area was to increase the proportion of children making adequate progress for school. There was no baseline, and only proxy measures could be used in relation to development.

**Current Status:**

Evidence amassed over the last 20 years tells us that an individual’s life successes, health and emotional wellbeing have their roots in early childhood. Children whose health and development is on track in their early years, are given the best chance of being on a trajectory that sees them thrive throughout school and their adult lives.

In recent years, evidence on neurological development and epigenetics has provided a wealth of knowledge about the impact of negative environmental influences and experiences on development and on lifelong health outcomes, and also the impact of positive environmental factors and experiences as opportunities to build strength and resilience for a healthy life.

The quality of a child’s earliest environments and the availability of appropriate experiences at the right stages of development are crucial determinants of the way a child’s brain architecture develops\(^8\). Studies examining the impact of early life trauma and adverse experiences also show a link between those (largely preventable) factors and poor physical and mental health in later life. Adult health and behavioural factors correlated with early adverse experiences include smoking, chronic obstructive pulmonary disease, intravenous drug use, depression, anxiety, suicidality, and more. The more adverse events experienced, the stronger the effect.

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Caring and supportive environments that promote optimal early childhood development greatly increase children’s chances of a successful transition to school. This, in turn, promotes children’s chances of achieving better learning outcomes while at school and better education, employment and health after they have finished school. Australia now has a robust set of measures in place for tracking children’s developmental status at school entry, the Australian Early Development Census (AEDC). This census measures the development of almost all Australian children on five domains in their first year of school and is repeated every three years.

In both 2009 and 2012, the majority of Australian children were doing well on each of the five AEDC developmental domains of:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge

In 2012, approximately one in five Australian children (22%) were developmentally vulnerable on one or more domains, an improvement compared with 23.6% in 2009. In 2012, 10.8% children were developmentally vulnerable on two or more domains, an improvement compared with 11.8% in 2009.

Data from the 2009 and 2012 collections show that the majority of Australian Indigenous children were developmentally on track on each of the five AEDC developmental domains but were more likely to be developmentally vulnerable than non-Indigenous children.

1.5 REDUCE THE RATES OF ORAL HEALTH ISSUES

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Oral health was not a priority under the 1992 Health Goals and Targets for Australian Children and Youth.

Current status:

There is now significant evidence demonstrating that oral health is integral to general health. Good oral health throughout infancy and early childhood contributes to better dental health in adulthood, resulting in less decay and reduced loss of natural teeth. Tooth loss is directly associated with poor diet and compromised nutrition, which can impair general health and exacerbate existing health conditions. Further, the mouth is often an entry point for infections, which may spread to other parts of the body. International research indicates there are associations between chronic oral infections and heart and lung diseases, stroke, low birth weight and premature births. Associations between periodontal disease and diabetes have also been noted in international literature.

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11 Ibid.
1.6 PROVIDE CLEAN AND SAFE PHYSICAL ENVIRONMENTS

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Significant progress was made in enhancing air quality, enhancing water quality, improving the availability of appropriate recreation facilities for children and young people, increasing child-friendliness of the urban environment, and improving the availability of safe transport to school. There was not sufficient progress against the two remaining targets for noise pollution and availability of public transport.

Significant gains were made through the introduction of the SunSmart program at early childhood education and care environments and schools across Australia. However, over 75% of adolescents are still not using adequate sun protection while outdoors, and melanoma is the most common cancer in young Australians aged 15-29, making up 25% of all cancer cases in this age group.

Current Situation:

Having a clean and safe environment that is conducive to learning, play and growth is beneficial to the development of motor and social skills, such as child friendly neighbourhoods with adequate play areas, safe pathways, public transport, and good air and water quality. Though some aspects are outside of the scope of the Framework, the environment is a critical contributor to child and youth health. Partnerships and interagency collaboration are key to achieving the best health outcomes for children and youth.

Research has identified that population health and the state of the environment are closely linked. The natural and built environment has been identified as a major determinant of health, and a major influence on health related behaviours. Environmental factors influence our health through exposure to physical, chemical and biological risk factors or by triggering behavioural changes. Individuals, organisations and government, through their intervention in the environment, play a vital role in exacerbating or mitigating health risks.

In 2006, the World Health Organization estimated that 24% of the global burden of disease was due to modifiable environmental factors. In 2011, the AIHW released a review of the evidence on the relationship between health and the environment in Australia. In general, the results of that review demonstrate that:

- The influence of the environment on health occurs through a variety of channels including exposure to physical, chemical and biological risk factors or by triggering changes to individual or group/community behaviour. The effects may be direct (such as injury or death) or indirect (through changes in lifestyle and health behaviours).
- The environment has the potential to affect physical health (for example, respiratory problems due to air pollution) and mental wellbeing (for example, poor mental health associated with drought conditions). Conversely, there are natural and modified features of the environment (such as green space and water fluoridation) which benefit health.

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There is a growing awareness that intervention in the environment can exacerbate or reduce health risks\textsuperscript{13}.

The environmental factors commonly associated (in the Australian context) with health outcomes in the natural environment include air temperature, extreme weather events, ultraviolet radiation, food safety and water quality, vector populations (i.e., insects and other animals that transmit disease, including mosquitoes, ticks, flies, lice, and fleas) and outdoor air quality. In the built environment, factors generally include indoor air quality, walkability, transport, green space, environmental noise, overcrowding in housing, housing conditions, hazards in and around the home, and water fluoridation. In recent years there has been growing recognition of the role that built environments play in shaping parental and child behaviours in providing safe places for children and young people to be physically active, socially engaged, and healthy.

Despite a long history of organised efforts related to addressing environmental hazards to improve public health in Australia, there are few data sources which can be used to accurately measure how environmental factors affect health, particularly at the local level. Surveys and administrative data sets may focus on collecting health data or environmental data, but in general do not collect and link both types of data. Also, surveys are often conducted on a one-off basis rather than at regular intervals, which makes it difficult to monitor health responses to ongoing environmental changes, or progress in addressing issues over time. Although jurisdictional data may be available, comparable data that can be used at national level is often incomplete. In addition, the size and geography of Australia poses its own unique challenges as national data is both difficult to collate and compare.

In relation to the natural environment, sun exposure remains a significant environmental risk. Some exposure to sunlight has health benefits, such as through stimulating the production of vitamin D by the body (essential for healthy bones). There is also evidence that exposure to sunlight improves mental wellbeing and may be linked to a reduction in the risk of developing multiple sclerosis.

However, the detrimental effects of excessive exposure to sunlight are serious. Sun exposure during childhood and adolescence is considered to be the most significant risk factor for developing the most serious type of skin cancer—melanoma—as well as other types of skin cancer in adulthood. In 2011-12, only 23% of adolescents wore hats when outdoors. Unfortunately while an indicator is regularly reported for young people in regard to sun protection, no indicator for children is currently reported on a regular basis.

Indicators measuring the exposure to environmental tobacco smoke in early childhood are showing that there is a reduction in children’s exposure to tobacco smoke in households. AIHW data from the National Drug Strategy Household Survey (2009) showed that in 2007, 8% of Australian households with dependent children aged 0–14 years had someone who smoked at least one cigarette, cigar or pipe of tobacco inside the home per day—a marked decrease from 1995, when almost one-third (31%) of children lived in households where someone smoked indoors.

The work done by AIHW in 2013 to map indicators for child and youth health does not provide child specific national indicators for environmental toxic exposure. However, the issues are discussed and baseline data provided where available for each of the areas identified above in \textit{Australia’s Health}.

In the absence of other indicators, regular reporting in the manner already undertaken in the Australia’s Health report, or recommended by AIHW in that context, would offer a source of data for monitoring progress.

1.7 PROMOTE HEALTHY LIFESTYLES

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Efforts since 1992 to increase the proportion of children who have adequate levels of aerobic exercise to maintain fitness were not successful. The proportion of children undertaking recommended levels of physical activity has decreased in all age groups between 1985 and 2011/12. This trend increases with age. Older children and adolescents are very unlikely to have adequate levels of physical activity.

In 1992, overweight and obesity rates were addressed under the goal to reduce the impact of chronic illness. Efforts were not successful in reducing this rate which, for children aged 5-17 years, rose from 20.9% in 1995 to 25.7% in 2012. The incidence of new diagnoses of Type 1 diabetes also appears to be rising.

Current Status:

The reduction of preventable health issues resulting from lifestyle risk factors is a key priority with potential for significant positive impact. Poor nutrition literacy, sedentary lifestyles, effects of increased screen time, substance abuse, poor sexual and reproductive health and other issues contribute to poor health outcomes. Targeting risk factors in children and youth reduces preventable chronic disease in adulthood and equips children with the best life chances.

For example, with poor nutrition literacy and sedentary lifestyles increasing, obesity has been identified as an important health issue. In 2008, obesity was added to the National Health Priority Areas. Increasing physical activity, reducing screen-based leisure activities and improving food choices are amongst a number of evidence-based interventions that could reduce the incidence of obesity and its associated comorbidities.

Health outcomes for children are improved with early detection and intervention in the earliest stages of chronic disease progression and development of a child. Chronic illness in children and youth include a range of conditions such as asthma, cancer, cerebral palsy, cystic fibrosis, dermatitis, allergies, obesity, diabetes and epilepsy which can interrupt normal child development. Chronic diseases are the leading cause of disability in the community. Reduction of risk factors, early detection and treatment can reduce the prevalence of chronic disease in the population. The incidence of preventable chronic diseases can be reduced through a range of strategic actions by individuals and government. This is addressed at Strategic Objectives 2.5 and 2.6.

Health promotion describes activities designed to improve health and prevent disease, often by helping individuals and communities to increase control over the determinants of health. It is often thought of as health education and social marketing, but health promotion activities can also include...

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structural changes, such as policy, social security incentives, taxation, legislation and regulation. By focusing on prevention, these activities aim to have a unified impact on the social and economic burden of ill health in society.

The WHO Ottawa Charter for Health Promotion\(^{15}\) recognised the role of health promotion in achieving health for all. It identified several action areas, including:

- Developing healthy public policy, with a strong focus on achieving health equity
- Reorienting health services toward health promotion rather than disease treatment
- Creating physical and social environments that support and encourage good health
- Strengthening community actions and developing personal skills to empower groups and individuals to take ownership of their health and act to improve it.

It is likely that all these health promotion tools will be required to address the current priority health issues for Australian children, young people and families.

The AIHW reported that in 2003, the leading causes of disease burden out of the largely preventable or treatable risk factors examined—tobacco smoking, high blood pressure and high body mass—each of which caused between 7.5% and 7.8% of the disease burden. The next leading group of risk factors are physical inactivity and high blood cholesterol, which are estimated to have caused 6.6% and 6.2% of the burden respectively. The joint effect of 14 risk factors that were considered by AIHW was estimated to be about 32%, indicating that the total disease burden could be reduced by about one-third if these risk factors could be eliminated\(^{16}\).

Global burden of disease analysis conducted in 2004 found the same top four risk factors for high-income countries as the Australian 2003 study: tobacco smoking, high blood pressure, overweight and obesity, and physical inactivity.

For children, their primary exposure to tobacco smoke is in their home and living environment, and the effect of exposure to environmental tobacco smoke and currently reported indicators are covered elsewhere. For young people however, there are specific indicators about tobacco use relevant to this Strategic Objective. These can be found in Appendix 1.

Reducing the proportion of children and young people who are overweight or obese, and increasing levels of physical activity, are key health promotion priorities for Australia. The prevalence of overweight and obesity among Australians has been steadily increasing for the past 30 years. In 2011–12, around 60% of Australian adults were classified as overweight or obese, and more than 25% of these fell into the obese category. In 2007, around 23% of children aged 2–16 were overweight or obese, with 6% classified as obese\(^{17}\).

While overweight and obesity are prevalent in all population groups, variation exists in their distribution across the Australian population. Obesity is particularly prevalent among those in the most disadvantaged socioeconomic groups, among Aboriginal and Torres Strait Islander peoples and


many people born overseas. Obesity is also more prevalent in rural and remote areas compared to urban areas\textsuperscript{18}.

Health problems associated with excess weight present a substantial cost burden on the health system. The total direct cost for overweight and obesity in 2005 was estimated at $21 billion ($6.5 billion for overweight and $14.5 billion for obesity). The same study estimated indirect costs of $35.6 billion per year, resulting in an overall total annual cost of $56.6 billion\textsuperscript{19}.

Prevention is far more cost effective than cure for these lifestyle related chronic diseases and their risk factors. Promotion of healthy lifestyles to prevent risk factors for chronic disease can include:

- Promoting good infant nutrition and early feeding practices (both breastfeeding and certain infant nutrition practices are associated with healthier attitudes to food and nutrition in children and lower rates of overweight and obesity in later life)
- Promoting good nutrition and healthy eating in early childhood (0-5 years) with parents/carers
- Promoting healthy eating for school aged children and their families
- Increasing physical activity
- Reducing the amount of time spent in sedentary pursuits, and limiting screen time
- Improving sleep practices for all children and young people, and particularly sleep hygiene for young people.

There is significant existing policy in this area, with much of the national work collectively housed at http://www.healthyactive.gov.au/. Specific data collections also provide ample opportunity for monitoring of progress, including the Australian National Children’s Nutrition and Physical Activity Survey.


Strategic Priority Two: Improve social and emotional wellbeing of all children and young people

Improve the social and emotional wellbeing of all children and youth by providing a safe and nurturing environment, a supportive family and increasing the capacity of families to provide the best future for their children and youth.

2.1 SUPPORT AND STRENGTHEN THE CAPABILITY OF PARENTS FROM PRECONCEPTION, THROUGH PREGNANCY AND EARLY CHILDHOOD.

2.2 PROTECT CHILDREN AND YOUTH THROUGH THE PROVISION OF SAFE, NURTURING FAMILY ENVIRONMENTS, FREE FROM ABUSE AND NEGLECT

2.3 IMPROVE THE SOCIAL AND EMOTIONAL WELLBEING OF CHILDREN AND YOUTH

2.4 REDUCE THE PREVALENCE OF CHILDREN EXPERIENCING EARLY ADVERSE EVENTS

2.5 SUPPORT CHILDREN AND YOUTH LIVING WITH A CHRONIC ILLNESS

2.6 SUPPORT CHILDREN AND YOUTH LIVING WITH A DISABILITY

Rationale

This priority is aimed at improving the social and emotional wellbeing of children and youth by keeping children and youth safe; strengthening and supporting family and community environments; supporting parenting capability; and supporting children and youth living with chronic illnesses or disability.

Ensuring that women are as healthy as possible during their pregnancy is important to guarantee the best possible start in life for their child. Psychosocial aspects of health are important prenatal determinants of health in later life, and there is evidence that addressing social and psychological determinants of health in pregnancy for both mothers and fathers has a significant impact on the health of the baby. Quality, comprehensive, universally available public antenatal care focused on the physical, social and emotional determinants of health is important for all families. Access to universal, public antenatal care which is comprehensive and culturally appropriate is particularly important for Aboriginal and Torres Strait Islander families. The National Perinatal Depression Initiative is an Australian Government funded initiative to improve the social and emotional wellbeing of families expecting and caring for a child.

The National Mental Health Policy guides efforts to improve social and emotional wellbeing of Australians. The programs implemented by the Department of Health, with the aim of improving the mental health of Australians, are directed by the: Fourth National Mental Health Plan (2009-2014); National Aboriginal and Torres Strait Islander Suicide Prevention Strategy; National Mental Health Policy 2008; National Mental Health Strategy; National Suicide Prevention Strategy; and the Roadmap For National Mental Health Reform. The Framework does not replicate those policies and plans, but rather describes how the work undertaken under these policies will fit with other priority work to achieve the desired gains in social and emotional wellbeing for children and young people.
Ensuring that children are raised in a safe environment free of neglect and abuse is a key principle under the *National Framework for Protecting Australia’s Children*. Abuse and neglect have significant physical, social and psychological consequences and can lead to impaired development and future health outcomes. Addressing the known risk factors is key to preventing child abuse and neglect. Many of the factors that research has shown to be associated with abuse and neglect are related to parental relationships or behaviours such as domestic violence, alcohol and drug abuse, and mental health issues. The complexity of the issues emphasise the need for interagency, cross sectoral partnerships and approaches to begin to work towards reducing the number of children who experience abuse and neglect.

**Strategic Objectives**

2.1  **SUPPORT AND STRENGTHEN THE CAPABILITY OF PARENTS FROM PRECONCEPTION, THROUGH PREGNANCY AND EARLY CHILDHOOD.**

**Achievements from analysis of progress against the 1992 Health Goals and Targets:**

The *1992 Health Goals and Targets* aimed to enhance parenting, perceived (by parents) parental efficacy and parenting supports (child 0-18) with particular attention to transition or crisis times (ie birth of first child; toddlerhood; transition to school; transition to adolescence; independence from parents; separation or divorce at any age of the child; mother returning to work; loss of a parent). These aims were difficult to measure due to the lack of national baselines and indicator data. However, significant progress was made in reducing the rates of teenage pregnancy, and it was noted that the proportion of divorces involving children has declined as the average age for both marriage and divorce have increased over the last 20 years.

The analysis of progress did note that family structure has been changing over the last 20 years with a higher proportion of people with children cohabiting before marriage, having children outside of a registered marriage, marrying for the first time at an older age and divorcing at an older age.

There was recognition in the *1992 Health Goals and Targets* that postnatal depression diminished parental wellbeing and was an impediment to optimal parent-infant attachment, and reducing rates of postnatal depression was a target. However, there was no national source of data to provide a baseline in the early 1990s. Current data estimates the incidence of postnatal depression at about 10-15%.

A further goal in relation to parenting in the *1992 Health Goals and Targets* was to increase the knowledge of parents, professionals and adolescent patients in management of chronic disease conditions. The analysis of progress was not able to demonstrate an achievement against this goal because no indicators were available. However, it is clear that parental health literacy continues to be a major emphasis for health service providers, with research showing that parents from Indigenous, culturally and linguistically diverse (CALD) and low socio-economic backgrounds have the poorest health literacy status.
Current Status:
Recent examination of the data from the Longitudinal Study of Australian Children (LSAC) examined the links between family environment and child health and development outcomes. It has revealed the strongest association is between family environment and social and emotional outcomes for children, followed by cognitive development. The results linking family environments to key child outcomes (especially around social and emotional wellbeing) suggest that the efficacy of policy may be enhanced if policies and services:

- Are attuned or sensitive to different family environments
- Target behaviour (parental family dynamics) rather than people on the basis of their socio-demographic characteristics
- Recognise that families can change for the better and that families can potentially draw on their own prior (positive) experiences
- Are based on a public health approach to promote safe and supportive family environments

The aim of a public health approach to protecting children is to shift the focus away from a narrow band of children requiring statutory intervention toward addressing the needs of all families, and to move the population distribution on risk factors toward the positive end for all families. The aim of shifting the profile of all families in this way is to reduce the number that would be at risk of statutory intervention and improve the daily lives of many children. In terms of public health interventions, the three potential types of interventions are:

- Parenting programs and supports
- Public information programs
- Targeted referrals for more intensive family support

Policies and programs seeking to address the issue of parenting capacity should consider how they balance the emphasis given to each type of intervention.

Consistent with the World Health Organization Ottawa Charter for Health Promotion, a range of actions can be taken to improve outcomes, based on advocacy, enabling people to take control of factors that affect their wellbeing, and mediating between differing interests in society for the pursuit of health. Current initiatives such as the Raising Children Network cover the requirements for such approaches, but must be promoted and supported in order to deliver outcomes.

While there are no currently reported national indicators of population parenting capacity, the Longitudinal Study of Australian Children, and the recent analysis of the implications of that data with regard to safe and supportive environments for children, provides potential scope for measuring progress. AIHW has also noted this gap in their 2014 Mapping report, and plans under the Framework should monitor emerging indicators in this regard.

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2.2 PROTECT CHILDREN AND YOUTH THROUGH THE PROVISION OF SAFE, NURTURING FAMILY ENVIRONMENTS, FREE FROM ABUSE AND NEGLECT

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Significant progress was made against the target to achieve appropriate child health surveillance and reporting systems, with systems currently in place in each state and territory. There has also been significant progress in efforts to implement and further develop strategies for adequately responding to these children and youth and their families. In 2014, national, state and territory agencies are tasked to manage child safety and protection in their jurisdictions. Manuals, guidelines and procedures for prevention, assessment, intervention and ongoing monitoring are widely available, and a much wider range of individuals and professions have mandatory reporting requirements under these guidelines than ever before.

In 1992 cases of substantiated abuse were at least 5 per 1,000 children (although it was estimated to be up to four times higher). By 2000, 4 per 1,000 children were on care and protection orders. Since then, the substantiation rate increased from 4.8 per 1,000 children in 1999–00 to a peak of 8.1 in 2004–05 and 2005–06, and has since decreased to 7.5 in 2012–13. Although a real change in the incidence of abuse and neglect may contribute to the observed fluctuation, increased community awareness and changes to policy, practice and legislation in jurisdictions are also contributing factors. Either way, the target of reducing the rate of child abuse has not been addressed.

The rate of children in out-of-home-care has also increased significantly. This is addressed in Strategic Objective 3.1.

Current Situation:
In Australia, statutory child protection is the responsibility of state and territory governments. Although the child protection processes in each jurisdiction are broadly similar, there are differences in legislative requirements, including the threshold for reporting suspected abuse and neglect. Such variations contribute to differences in data across jurisdictions.

In 2012–13 there were 135,000 children, a rate of 26.1 per 1,000 children, receiving child protection services (investigation, care and protection order and/or in out-of-home care). More than half (56%) of these children were subject only to an investigation (that is, they were not subsequently placed on an order or in out-of-home care) and 8% were involved in all three components of the system. Aboriginal and Torres Strait Islander children are over-represented and are 8 times more likely than non-Indigenous children to be receiving child protection services (150.9 per 1,000 children compared with 18.5 for non-Indigenous children).

The National Framework for Protecting Australia’s Children 2009–2020 has six outcome areas:

- Children live in safe and supportive families and communities
- Children and families access adequate support to promote safety and intervene early
- Risk factors for child abuse and neglect are addressed
- Children who have been abused or neglected receive the support and care they need for their safety and wellbeing
- Indigenous children are supported and safe in their families and communities
- Child sexual abuse and exploitation is prevented and survivors receive adequate support.

The *National Framework for Protecting Australia’s Children 2009–2020* includes a range of indicator statements, not all of which have regularly associated data collections. There is also the issue of ensuring that indicators measure the correct outcomes. Care must be taken, for example, not to conflate a reduction in the number of reports and substantiations with a reduction in the rate of actual child abuse and neglect – history has shown that high rates of abuse can exist alongside low reporting and substantiation rates.

2.3 **IMPROVE SOCIAL AND EMOTIONAL WELLBEING OF CHILDREN AND YOUTH**

**Achievements from analysis of progress against the 1992 Health Goals and Targets:**

The 1992 target to reduce the overall suicide rate by at least one third for 15-24 year olds was not met, and there was a significant difference in results by gender. By 2012, the suicide rate for males aged 15-24 had been halved compared to 1990 (from 27 per 100,000 in 1990 to 13.6 per 100,000 in 2012) but the rate for females aged 15-24 over the same period had almost doubled from 4 in 1990 to 7.3 per 100,000 in 2012.

Measurement of efforts to reduce the age of identification of children with all types of learning disorders (global, specific, associated and attention deficit disorders) was hampered by the lack of a baseline or quantifiable targets, and the unavailability of data on identification of learning disorders in later years. The scan of the policy environment over the last 20 years undertaken as part of the progress review did, however, identify significant shifts in policy, with assistance packages and programs now far more available than 20 years ago.

The 1992 target to reduce the proportion of children and youth who use alcohol on a weekly basis by at least half by 2000 was met. The proportion of children and youth using alcohol on a weekly basis decreased significantly for all age groups between 1989 and 2011, and for those aged 13, 14, and 15 it reduced by half. The proportion of children and youth never using alcohol has also increased. For young people aged 16 the rate reduced from 30.9% in 1989 to 28.3% in 2011, indicating that more work is required to reduce weekly use of alcohol in this age group.

There was significant progress achieved against the target to reduce the rates of young people in juvenile detention. Between 1981 and 2007 the overall detention rate reduced by 40%, and the rate of Indigenous juvenile detention decreased by 14% between 1997 and 2011. However, the gap between the rates of young people in detention for Indigenous young people compared to the total rate was not well addressed, with the Indigenous juvenile detention rate still 23 times that of non-Indigenous youth, and Indigenous young people as a proportion of the whole juvenile detention population still increasing.

**Current Status:**

The social and emotional wellbeing of children and youth is a key facet in developing healthy and functional adults and evidence is showing that more work is required regarding the mental health of the youngest age group (0-5 year olds) where there traditionally has not been a focus. Mental health
is a key health issue for young people in the developed world, with the prevalence of diagnosable mental health disorders rising sharply after puberty. There is an urgent need to address the prevalence of mental health as developmental trajectories are set early, and opportunities for intervention are most effective and cost effective while children are young. Specially-targeted early intervention programs can address underlying difficulties for children and young people with emerging mental health issues which can range from a spectrum of cognitive, behavioural and emotional disorders. The spectrum covers cognitive impairment, disabilities, phobias, panic attacks, depressive disorders, drug-related harm, anxiety, eating disorders, schizophrenia, psychoses and personality disorders.

The Fourth National Mental Health Plan includes a reporting framework against a range of indicators, and The Roadmap for National Mental Health Reform 2012–22 also includes performance indicators and reporting requirements. The National Survey of Mental Health and Wellbeing\(^\text{21}\) includes as one component a population survey of children. In 1998 findings included that 14% of children and adolescents in Australia had mental health problems. This high prevalence rate of mental health problems was found in all age and gender groups.

Factors contributing to the high prevalence rates of mental health problems include adverse life experiences (see Strategic Objective 2.4). Over the last two decades, awareness of the impact of bullying on children and young people’s social and emotional wellbeing has grown and bullying prevention and management now has a much higher profile in health and education settings. Online bullying and the impact of online antisocial behaviour has also emerged as an area of concern.

A report on work to develop a social and emotional wellbeing indicator under the Children’s Headline Indicators was published by AIHW in 2012, noting that a child’s social and emotional wellbeing is integral to their overall health, development and wellbeing. Children with high levels of social and emotional wellbeing are more likely to successfully negotiate physical, intellectual and social challenges during childhood and adolescence. The report presents the research evidence on the links between social and emotional wellbeing and children's health, development and wellbeing outcomes; assesses potential indicators and data sources; and recommends an indicator of social and emotional wellbeing for Australian children.

In mapping the available indicators in 2013, AIHW noted that social and emotional wellbeing has been included in four frameworks for monitoring children and young people’s health, reflecting the growing interest in this area as a critical aspect of child wellbeing. Policies and plans developed under the Framework must be cognisant of the emerging evidence and indicator advances under this Strategic Objective.

2.4  REDUCE THE PREVALENCE OF CHILDREN EXPERIENCING EARLY ADVERSE EVENTS

Achievements from analysis of progress against the 1992 Health Goals and Targets:

The efforts to protect children from child abuse and neglect were discussed under Strategic Priority 2.2. The 1992 Health Goals and Targets for Australian Children and Youth set additional broad goals for the enhancement of family and social functioning, which included reducing the number of children living in inadequate housing, living below the poverty line, or facing youth unemployment. While these are all strong social determinants of health, health services are partners in advocating for improvements to these issues rather than being the lead on efforts to address them. This is the same for the 1992 target to increase the proportion of children making adequate progress through school, where the health sector partners with the education sector in working with families to optimise early childhood development so children are well equipped for the formal learning environment of schools, and the education sector leads on issues such as academic performance, school retention rates, improving school attendance and improving literacy and numeracy. These issues are now addressed in other high level policies dealing with social inclusion, social security, employment, education and housing.

Current situation:
As referred to under Strategic Objective 1.4, there is now clear evidence of a strong, graded relationship between adverse events in childhood and poorer lifetime health outcomes – for both physical health and social and emotional wellbeing. In this context, adverse events relate to early childhood experiences such as exposure to recurrent physical abuse, recurrent severe emotional abuse, contact sexual abuse, or growing up in a household where: someone was in prison; where the mother was treated violently; with an alcoholic or a drug user; where someone was chronically depressed, mentally ill, or suicidal; and/or where at least one biological parent was lost to the child during childhood – regardless of cause. Such experiences in childhood have been shown to have a strong and cumulative correlation with a range of adult diseases or health issues decades later, including smoking, chronic obstructive pulmonary disease, intravenous drug use, and emotional disorders (eg self-defined current depression or suicide attempts). The more adverse experiences a person had been exposed to as a child, the higher the likelihood that they will experience heart disease, fractures, diabetes, obesity, unintended pregnancy, sexually transmitted diseases, and alcoholism in adulthood.

Preventing exposure to adverse events is more effective than having to ameliorate the effects post exposure, or treat the chronic health problems associated with early exposure to adverse events. High quality family functioning is an important protective factor, and is included in three frameworks listed in AIHW’s Mapping of Children and Youth Indicator Reporting Frameworks 2013. However, an indicator has yet to be developed for family functioning within the child and youth indicator frameworks. Policies and plans developed under the Framework should be cognisant of further developments in the development of indicators for family functioning.

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Felitti, V 2002. The Relationship of Adverse Childhood Experiences to Adult Health: Turning gold into lead. San Diego: Kaiser Permanente Medical Care Program.
2.5 SUPPORT CHILDREN AND YOUTH LIVING WITH A CHRONIC ILLNESS

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Progress in efforts to reduce the impact of chronic illness include a reduction in the prevalence of asthma from 13.5% in 2001 to 9.9% in 2007/08. As noted under Strategic Priority 1.7, efforts to reduce the rates of Type 1 diabetes, overweight and obesity were not successful.

Current Situation:

The management of chronic disease can be complex, costly and has a cumulative toll on these children and youth and their families that is psychological, social and economic in nature. Early intervention and the provision of joined up support services can minimise the negative effects of children living with a chronic illness and disabilities, and support their families. Resources should be targeted towards parental support services and provide the carers and families with the tools and services they need to raise resilient children and youth and foster positive family relationships and support networks.

Several national policies deal directly with supporting children and their families living with chronic illnesses. These include the National Health Priority Areas of asthma, diabetes, arthritis and mental health.

2.6 SUPPORT CHILDREN AND YOUTH LIVING WITH A DISABILITY

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Each year in Australia approximately 550 children are born with moderate to profound permanent childhood hearing impairment. Although a national benchmark is not routinely collected, there has been significant progress against the 1992 target to reduce the age of diagnosis of sensorineural hearing loss. In 1992, diagnosis was generally from 2 years of age. Delays in early identification and treatment of permanent childhood hearing impairment may profoundly affect development in terms of language acquisition, social and emotional development, and education and employment prospects. All states and territories now offer neonatal hearing screening, targeting infants of over 34 weeks gestation born in Australia. The National Framework for Neonatal Hearing Screening proposed target is that over 97% of eligible infants will complete a hearing screen before 1 month corrected age. For children who test positive, the secondary key performance indicator proposed is that for over 97% diagnostic audiology assessment is commenced by three months of corrected age.

Rates of otitis media remain many times higher in Aboriginal and Torres Strait Islander communities compared to non-Indigenous communities, particularly in rural and remote areas. Research studies of Aboriginal and Torres Strait Islander school children in remote communities found prevalence rates of hearing loss from 35-75%. Analysis of progress deemed that there was insufficient progress against this target.

There has been significant progress in efforts to increase the proportion of cases of congenital dislocation of the hip diagnosed in the neonatal period. In 1992 approximately 50% of cases were
diagnosed in the first months of life. In 2013, compliance with newborn screening guidelines which include screening for developmental dysplasia of the hip (previously known as congenital dislocation of the hip) was over 96%.

It was not possible to assess progress toward decreasing the proportion of children reaching school age with a previously undiagnosed moderate intellectual disability. There was no baseline data from 1992, and while later data was available on the prevalence of disability, it did not distinguish between diagnosis before or after school age. It was also noted that clinically, children under 6 years of age may be considered too young to receive a diagnosis of intellectual disability based on an IQ test, and may instead be described as having a ‘developmental delay’.

Poor data availability meant that it was difficult to assess progress on increasing the proportion of children receiving early intervention services in the first year after diagnosis, however it was noted that one difference between 1992 and the current context is that there are intervention programs available, such as the Better Start for Children with Disability initiative which provides early intervention funding of up to $12,000 for children with disabilities to use before the age of seven.

Significant progress was made against the target to increase the proportion of disabled children who are in mainstream schools who receive adequate support. By 2003, it was reported that 65% of children with a disability attended a mainstream school. Of the children with a disability in mainstream schools, it was reported that 40% had a profound or severe core disability.

**Current status:**

A focus on pre-pregnancy and antenatal health of mothers has seen some improvement in the occurrence of disability as the result of birth defects, low birth weight and prematurity, however there appears to have been a shift in the types of established disability since 1992, with a decline in disability from physical and chronic conditions and an increase in intellectual disability and learning disorders.

In 2009, it was estimated that 7% (288,300) of children aged 0-14 years and 7% (204,000) of young people aged 15-24 years reported some form of disability. The most common types of disability reported by children (0-14) were intellectual and sensory/speech disability. The most common causes of disability reported by young people (15-24) were physical conditions, followed by mental or behavioural disorders. Autism and related disorders were the most commonly reported mental or behavioural disorder among children with a disability. In 2009, 13% of children aged 0-14 years with a disability were reported as having autism or related disorders, a twofold increase since 2003 (6.2%).

The National Disability Insurance Scheme (NDIS) has been established to provide people with disability with the support they need. NDIS is to be introduced gradually, seeking to ensure a smooth transition for people with disability and support providers. From 1 July 2013, the first stage of the NDIS rolled out in South Australia, Tasmania, the Barwon area of Victoria and the Hunter area in New South Wales. The Australian Capital Territory and the Northern Territory joined the launch in July 2014.
The success of the NDIS in achieving its aims will determine how well children and young people living with disability are supported. The *NDIS Quality and Best Practice Framework*, when developed, should provide key indicators on whether the outcomes of NDIS are being achieved. In the meantime, existing national indicators can help to provide a picture of children and young people living with a disability.
Strategic Priority Three: Strengthen and improve health outcomes for vulnerable populations

Work towards fairer health opportunities and outcomes for Australians through recognising the diversity of health needs of vulnerable populations

3.1 IMPROVE THE IDENTIFICATION OF VULNERABLE POPULATIONS
3.2 REDUCE DISADVANTAGE AS A RESULT OF SOCIAL DETERMINANTS OF HEALTH
3.3 FAIRER ACCESS TO PRIMARY HEALTH CARE SERVICES

Rationale
There is growing recognition of the complex interplay of biological, lifestyle, socioeconomic, social and environmental factors impacting on an individual’s health and wellbeing, many of which are modifiable to some extent by access to health care and other interventions. The social determinants of health are as diverse as education, geographical location, transport and road infrastructure, housing and socio-economic status.

The mechanisms by which socioeconomic status influences health status are complex and varied. Overall, people from the most disadvantaged areas are more likely to have low birth weight babies, report high levels or very high levels of psychological distress, and have a higher proportion of potentially preventable hospitalisations than those from the least disadvantaged areas. They are more likely to be overweight or obese, to smoke daily, and to drink alcohol at levels that put them at risk of long-term harm. They are also more likely to defer seeing a general practitioner due to the cost, and are more likely to report longer waiting times.

The literature suggests that a child’s capacity to realise their full potential is significantly reduced when being raised in an environment of poverty. It is critical that health services provided to children and youth are designed so that the health needs of the most vulnerable and at risk are appropriately addressed.

Though gains have been made in health outcomes across Australia, evidence continues to show that some population groups continue to have poorer health and welfare outcomes, particularly from Aboriginal and Torres Strait Islander background, refugees, people from culturally and linguistically diverse backgrounds, older people, and people living in rural and remote areas and children in out-of-home care.

Recognising that the population is diverse and has complex healthcare needs, the best outcomes can be achieved when governments work in partnership with other sectors and non-government bodies to identify the populations experiencing disadvantage, their needs and how to address those inequities to improve their health outcomes. Coordinated, multi-sector action addresses social and economic factors that sit outside of the scope of the Australian healthcare system.
Strategic Objectives

3.1 IMPROVE THE IDENTIFICATION OF VULNERABLE POPULATIONS

Achievements from analysis of progress against the 1992 Health Goals and Targets:

The terms of reference for the development of the *Health Goals and Targets for Australian Children and Youth* included that the Project Committee should:

“In setting goals, pay particular attention to children and youth with special needs, for example, Aboriginal children and youth, the homeless and those with chronic disease or disability.”

The final Goals and Targets developed by the Project Committee did include specific targets for each of the listed groups. However, there was not an overarching goal area that attempted to redress the demonstrated differences in health outcomes across almost all indicators for some population groups.

Current situation:

There are certain population groups that experience poorer health and wellbeing because of disadvantage – social, economic, or other disadvantage. Since 1992, there has been significant progress in developing a better understanding of the role of disadvantage experienced early in life plays in increasing vulnerability and determining health outcomes throughout adolescence and adulthood. The importance of improving the health of the most vulnerable and disadvantaged, and reducing the gap between the disadvantaged and advantaged, to benefit the whole population has also become clearer.

Risk factors that increase vulnerability, and protective factors that increase resilience, have both been shown to be cumulative in effect, and both the number of risks (or protective factors) and the spacing between the experiences of those risks plays a role in influencing the outcomes. Some factors that are related to increased vulnerability or risk of poorer outcomes occur in population clusters, making it somewhat easier to identify vulnerable children and families and target programs or services to their needs to increase protective factors. For example, children in out-of-home care are developmentally vulnerable across almost all domains of development. Young people in juvenile justice are similarly vulnerable. Aboriginal children and young people are over-represented in many of the indicators of poor health and wellbeing in childhood, and in groups at-risk for poor adult health outcomes.

Other at-risk populations are less visible and less accessible. Children of mothers and fathers who experience psychosocial distress, depression and anxiety in the perinatal period are at risk of poor parent infant attachment, compromised infant mental health and delays in development. However, as with many types of vulnerability, postnatal depression is not confined to any particular social or economic grouping. While parents in the poorest 10% of the population may be more likely to experience depression, the greatest numbers of depressed parents are in the middle income deciles.

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This can provide challenges for those service providers seeking to identify children and families who are vulnerable early on to prevent poor parent and child outcomes. The evidence is that for vulnerable groups, the greatest benefits are likely to accrue from coordinated, multi-agency action to address their disadvantage and its impact on their health and wellbeing outcomes.

While there are a number of groups identified as at higher risk of poor health outcomes (including children and youth of parents with a mental illness, youth within the criminal justice system, children and youth who are homeless or experience housing instability, and children and youth from families experiencing significant socio-economic disadvantage) the following groups were identified as particular priorities in the development of this Strategic Priority:

**Aboriginal and Torres Strait Islander**

The Aboriginal and Torres Strait Islander Health Performance Framework is the authoritative evidence base for Aboriginal and Torres Strait Islander health policy and combines evidence from national data collections and research literature. It is published biennially and presents a summary of data and policy analysis across a range of performance measures which are grouped under health status and outcomes, determinants of health including socioeconomic and behavioural factors, and health system performance.

**Rural and Remote Children and Youth**

The National Strategic Framework for Rural and Remote Health recognises that health outcomes of Australians living in rural and remote areas are poorer than that of Australians living in major cities and towns. The Framework recognises the social and geographic diversity of the communities in rural and remote Australia and encourages the development of locally relevant solutions.

**Children in Out-of-Home Care**

Children and young people in out-of-home care (OOHC) are recognised as a highly vulnerable group with increased physical, mental and social health needs and with limited access to resources. They are also more likely to have significant, often unrecognised and unmet health needs, increased rates of developmental difficulties and are less likely to access preventive health services such as immunisation. One Australian study found that 97% of children in OOHC who received a comprehensive health screen had medical, developmental, emotional and/or behavioural problems. Over the period 2000 to 2011, rates of children aged 0-12 on care and protection orders have almost doubled from 4 per 1,000 children in 2000 to 7.7 in 2011. The increase reflects the growing number of families considered unable to adequately care for children, which may reflect changing community standards in relation to child safety. Some of the increase is likely to be a flow on effect from the accumulation of children in the system as children remain on orders for longer periods of time. The increased duration of care and protection orders reflects the increasing complexity of family situations these children face.

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Aboriginal and Torres Strait Islander children are known to have increased health problems compared with non-Indigenous children, as well as difficulties accessing culturally appropriate health services. These two issues may combine to lead to significant effects on wellbeing when an Aboriginal or Torres Strait Islander child is taken into OOHC. Indigenous children are more than 10 times as likely as non-Indigenous children to be on care and protection orders (59.2/1,000 Indigenous children compared with 5.8/1,000 non-Indigenous children in 2012/13)28.

Refugees

In 2012–13, the Australian Humanitarian Programme was increased to 20,000 places from 13,750 places in 2011–12. Approximately two-thirds (64%) of all persons lodging applications in 2012–13 were under 30 years of age. Of the 12,515 refugees granted offshore visas (for people who are outside their home country and outside Australia), 39% were aged 0-17 years and a further 24% were aged 18-29 years. Persons aged 0-17 years have been granted the largest share of humanitarian visas in each year from 2008–09 to 2012–1329.

In addition to suffering the same health problems as the general population, asylum seekers and refugees are at particular risk from a range of conditions including psychological disorders such as post-traumatic stress disorder, anxiety, depression, and the physical effects of persecution and torture. They may also often suffer the effects of poor dental hygiene, poor nutrition and diet, and infectious diseases such as tuberculosis, which may be more common in their countries of origin30. They may have nutritional problems relating to Vitamin A, Vitamin D or iron deficiency; and they may have untreated health conditions and injuries exacerbated through poor living conditions and lack of access to treatment. The most frequent physical conditions treated in asylum seekers at Australian immigration detention centres in 2005-06 were dental caries, digestive complaints, respiratory problems, skin lesions, dermatophytosis, otitis externa and infections of the upper respiratory tract31. Refugees may also be less likely to access health services, due to issues including cost and language barriers.

A recent national review of mental health in refugees found that the results of prevalence studies vary widely according to the disorder being studied, particular ethnic or country of birth groups, and the location of the study32. In particular, refugees and asylum seekers are particularly vulnerable to self-harm and suicidal behaviours. The report noted that in Australia the prevalence of self-harm among detained asylum seekers was reported to be higher than in the general population and among prisoners33.

33 Ibid
3.2 REDUCE DISADVANTAGE AS A RESULT OF SOCIAL DETERMINANTS OF HEALTH

Achievements from analysis of progress against the 1992 Health Goals and Targets:

The 1992 Goals and Targets did not seek to set targets to measure how effective the system was in developing innovative ways of reaching disadvantaged, vulnerable groups.

Current situation:
Social determinants influence the health of individuals and communities and affect the sustainability and accessibility of health services. The healthcare system must alleviate and accommodate the system challenges presented by social determinants creating disadvantage, by working in partnership with other agencies, utilising opportunities presented by new technology and exploiting existing resources in a new fashion. Measuring the outcomes of potential action such as those outlined in the National Primary Healthcare Strategic Framework under Strategic Outcome 3[^34], such as health promotion, prevention screening and early intervention is covered under Strategic Priority One and Two of the Framework.

All health service providers across Australia are working to find innovative ways to meet service demand within existing resources, to better meet the needs of those who require assistance most, and to find new ways of providing effective and accessible services.

3.3 FAIRER ACCESS TO PRIMARY HEALTH CARE SERVICES

Achievements from analysis of progress against the 1992 Health Goals and Targets:

Measurement of progress in improving the accessibility of health providers was problematic as there was no baseline data and little detail in the development of the target. The supply of health providers has risen in all areas but per capita supply of all but general practitioners and nursing professions in regional areas still lags behind urban areas.

A report[^35] has found that the availability and accessibility of the Australian healthcare workforce has been influenced by escalating demand related to a growing and ageing population, labour market competition between jurisdictions in Australia and also internationally, and a constrained training system that has historically limited the capacity to provide increasing numbers of workers in time to meet growing demand.

Current Status:

Between 2007 and 2011 the overall supply of medical practitioners in Australia increased by 11.4% from 323.5 FTE / 100,000 to 360.4 FTE / 100,000. This increase stems from 30.7% increase in the availability of specialists –in-training and an 18.3% increase in availability of hospital-based non-specialist medical practitioners. However, during this same period there was an actual decline in the availability of specialist physicians (-18.1%), pathologists (-15%), surgeons (-13.8%) and general practitioners (-2%).

The proportion of health practitioners per 100,000 of the population ranges from 1,123.6 for registered nurses and midwives to 6.4 for osteopaths. There are still significant differences in the geographical distribution of the health workforce in Australia with over 75% of all employed, registered allied health practitioners in Australia working in a major city in 2011-12. The relative availability of health professionals as gauged by the number of FTE/100,000 population for all health disciplines (except general practice, nursing and midwifery and Aboriginal and Torres Strait Islander health practitioner) can be seen to significantly decrease with the distance from a major city.

An ageing workforce is an issue in the medical and nursing professions with one third or more of medical practitioners and nursing professionals providing everyday services required for maternal, child and youth health aged 55 years or older in 2011.

The National Primary Healthcare Strategic Framework takes a broad view of primary healthcare, encompassing the delivery of services by general practitioners, but also by other skilled healthcare professionals and organisations that provide services. Most relevant to the Framework is the strategic outcome related to reducing inequity and improving access to primary healthcare.

Access to primary healthcare is measured by AIHW which creates a geospatial index of access to general practitioners relative to need for primary health care. Most recently, the measure showed that the Indigenous and non-Indigenous populations display markedly different distributions of predicted need for health care by remoteness. On average, the predicted needs of the Indigenous population increase with remoteness, but the predicted needs of the non-Indigenous population are similar in major cities, inner regional and outer regional areas and then fall in remote and very remote areas. This demonstrates the need to improve and better target primary healthcare to the population groups and where the need is most marked.

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Strategic Priority Four: Provide more coordinated systems focused on the health needs of children, young people and their families

Improve child and youth health by encouraging governments and other sectors work together towards better outcomes through efficient systems, better information exchange and collaborative coordination to maximise the opportunities to deliver healthcare where and when it is needed.

Opportunities can be found through investment in research, evaluation and intergovernmental and cross sector coordination.

4.1 PROMOTE AND IMPROVE HEALTH LITERACY
4.2 IMPROVE DELIVERY AND USE OF HEALTH INFORMATION FOR CONSUMERS AND PROFESSIONALS THROUGH BETTER SYSTEMS AND INFRASTRUCTURE
4.3 ENCOURAGE CROSS SECTOR AND INTERGOVERNMENTAL COLLABORATION AND COORDINATION TO DESIGN AND DELIVER OUTCOMES FOR CHILDREN AND YOUTH
4.4 SUPPORT EVIDENCE BASED POLICIES AND PROGRAMS THROUGH RESEARCH, EVALUATION AND ACCOUNTABILITY

Rationale

How consumers and professionals seek, collect and use information has changed significantly with the rise of new technologies such as mobile devices, the internet and social media. Traditional paper based forms of media compete with the popularity, diversity and speed of new media forms. Consequently, the delivery and use of health information needs to keep pace with the changes in how consumers seek information. Initiatives such as e-Health and home monitoring applications present opportunities to utilise new technology and enable equitable access to information.

Technology also offers governments opportunities such as telehealth, better data collection which will facilitate improved follow up and chronic disease management, screening, health promotion via new media and data analysis. Technological advances offer opportunities to build new infrastructure and have a presence in remote geographic areas where it is not practicable to build physical infrastructure. Governments can utilise improved technology to reach consumers and professionals in isolated or remote areas to deliver services and reach children and youth, and for better access across sectors to patient information and data linkage.

Achievements from analysis of progress against the 1992 Health Goals and Targets:

The 1992 Goals and Targets were supported by an indicator framework focussed on population health outcomes rather than system responses. While health literacy was addressed for parents of children with chronic disease, and the importance of intersectoral collaboration to achieving outcomes was integrated within the document, indicators to measure improvements in system coordination were not a feature of the document.
Strategic Objectives

4.1 PROMOTE AND IMPROVE HEALTH LITERACY

In 2006 the Australian Bureau of Statistics found that almost 60% of adult Australians have low health literacy, which means they are not able to effectively exercise their choice or voice when making health care decisions. People with inadequate health literacy have poorer levels of knowledge and understanding about their condition, are less likely to attend appointments, are less adherent to medication regimens and health behaviour advice, make more medication errors and perform worse at self-care activities.

Poor health literacy is also an increasing concern due to the diversity of sources of health information now available to consumers. Empowering individuals to understand and discern the quality and accuracy of sources of health information available is now a new consideration when delivering health promotion.

Coordinated effort across sectors is required to ensure that families, children and youth can develop greater health literacy through the use of new media vehicles to reach consumers seeking information, whether through social media or other means.

In terms of measurement, no national indicators on health literacy exist. However, the Australian Commission for Safety and Quality in Healthcare has developed a National Statement on Health Literacy which highlights the importance of health literacy in ensuring safe and high quality care, supports the need for a coordinated and collaborative approach to address health literacy and sets out possible actions to improve health literacy. The Statement separates health literacy into two components, individual health literacy and the health literacy environment which reflect the two main factors that influence how a person accesses, understands and uses that information. Further work is ongoing to identify appropriate national measurements of health literacy.

Health literacy is also identified as a priority in the following Frameworks:

- Australian Safety and Quality Framework for Health Care, which identifies health literacy as a key action area
- National Safety and Quality Health Service Standards, which implicitly refers to health literacy in nine of the ten Standards
- Australian Safety and Quality Goals for Health Care, which includes Partnerships with Consumers as a Goal and becoming a health literate organisation as a core outcome.

4.2 IMPROVE DELIVERY AND USE OF HEALTH INFORMATION FOR CONSUMERS AND PROFESSIONALS THROUGH BETTER SYSTEMS AND INFRASTRUCTURE

There are no specific measures around this Strategic Objective. However, initiatives such as HealthDirect, telehealth, e-health, including the Personally Controlled Electronic Health Record, are

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the beginnings of collaborative efforts between governments to enable a secure and effective exchange of information.

4.3 **ENCOURAGE CROSS SECTOR AND INTERGOVERNMENTAL COLLABORATION AND COORDINATION TO DESIGN AND DELIVER OUTCOMES FOR CHILDREN AND YOUTH**

There are no specific measures around this *Strategic Objective*. Cross-sector and intergovernmental partnerships and collaboration are integral in working in healthcare to address the Frameworks such as:

- *National Framework for Universal Child and Family Health Services*
- *National Strategic Framework for Rural and Remote Health*
- *National Primary Healthcare Strategic Framework*
- *National Aboriginal and Torres Strait Islander Health Plan*

4.4 **SUPPORT EVIDENCE BASED POLICIES AND PROGRAMS THROUGH RESEARCH, EVALUATION AND ACCOUNTABILITY**

To achieve better health outcomes, governments must invest in evidence-based policies and programs with a clear evaluation and accountability frameworks. Evidence-based practice is increasingly recognised as fundamental to underpinning policy and program development. The aim for this *Strategic Objective* is to embed a whole of government approach towards healthcare for children and youth that is evidence-based, complementary and comprehensive.

However, there are no specific measures around this *Strategic Objective*. The Frameworks above reference and ensure that healthcare is developed using evidence-based planning and policy development to ensure robust and accountable programs and systems.
## Appendix One: Strategic Priorities, Strategic Objectives and Indicators

This table maps the strategic priorities and Strategic Objectives against the existing indicators.

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Strategic Objective</th>
<th>Existing Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1 Maintain and improve good health of babies and their mothers at birth</strong></td>
<td>1.1.1 Increased proportion of mothers who use antenatal services (Mothers who attended at least one antenatal care session(^{18}))</td>
<td>Increase the proportion of women who gave birth where 5 or more antenatal visits were reported</td>
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<td></td>
<td>1.1.2 Increase the proportion of babies born at term</td>
<td>Increase the proportion of babies born at a healthy birth weight</td>
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<td></td>
<td>1.1.3 Increase the proportion of women who smoked during the first 20 weeks of pregnancy</td>
<td>Decrease the proportion of women who smoked during the first 20 weeks of pregnancy</td>
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<td></td>
<td>1.1.4 Decrease the proportion of women who consumed alcohol in pregnancy</td>
<td>Decrease the proportion of women who consumed alcohol in pregnancy</td>
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<td></td>
<td>1.1.5 Decrease the proportion of mothers who used illicit drugs or substances during pregnancy</td>
<td>Decrease the proportion of mothers who used illicit drugs or substances during pregnancy</td>
</tr>
<tr>
<td><strong>1.2 Maintain and improve low mortality rates</strong></td>
<td>1.2.1 Reduce the infant mortality rate</td>
<td>Reduce the proportion of children who are fully immunised</td>
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<td></td>
<td>1.2.2 Reduce the rate of sudden infant death syndrome</td>
<td>Reduce the proportion of households with children/young people where adults/household member smoke inside</td>
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<td></td>
<td>1.2.3 Increase the proportion of children who are fully immunised</td>
<td>Causes of death by age, including monitoring the leading causes of death for infants up to 12 months, children aged 1-14 and young people aged 15-24(^{19}).</td>
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<tr>
<td><strong>1.3 Reduce hospitalisations for:</strong></td>
<td>1.3.1 Reduce hospitalisations for illness</td>
<td>Reduce hospitalisations for illness</td>
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<tr>
<td></td>
<td>1.3.1.1 Reduce rate of avoidable hospitalisation for respiratory disease 0-24</td>
<td>Reduce rate of avoidable hospitalisation for respiratory disease 0-24</td>
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<tr>
<td></td>
<td>1.3.1.2 Encourage appropriate use of antibiotics (Indicator collected is proportion of upper respiratory tract infections managed for which oral antibiotics were prescribed)</td>
<td>Encourage appropriate use of antibiotics (Indicator collected is proportion of upper respiratory tract infections managed for which oral antibiotics were prescribed)</td>
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<tr>
<td></td>
<td><strong>1.3.2 Reduce hospitalisations for injury</strong></td>
<td>Reduce hospitalisations for injury</td>
</tr>
<tr>
<td></td>
<td>1.3.2.1 Reduce age-specific death rates from all injuries for children 0-14</td>
<td>Reduce age-specific death rates from all injuries for children 0-14</td>
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<tr>
<td></td>
<td>• Reduce the injury and poisoning death rate for young people 12–24</td>
<td>• Reduce the injury and poisoning death rate for young people 12–24</td>
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<td></td>
<td>• Reduce road transport accident death rate 0–14 and 12–24</td>
<td>• Reduce road transport accident death rate 0–14 and 12–24</td>
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<td></td>
<td>• Reduce the accidental drowning rate for children 0–14</td>
<td>• Reduce the accidental drowning rate for children 0–14</td>
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<tr>
<td></td>
<td>• Injury and poisoning hospitalisation rate 0–14, 12–24</td>
<td>• Injury and poisoning hospitalisation rate 0–14, 12–24</td>
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<tr>
<td></td>
<td>• Suicide rate for young people</td>
<td>• Suicide rate for young people</td>
</tr>
</tbody>
</table>

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\(^{18}\) All indicators, unless otherwise noted, are drawn from: Australian Institute of Health and Welfare, 2014, *Mapping of Children and Youth indicator Reporting Frameworks*. CWS 48, Canberra: Australian Institute of Health and Welfare

\(^{19}\) AIHW 2013 analysis of AIHW National Mortality Database
<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Strategic Objective</th>
<th>Existing Indicators</th>
</tr>
</thead>
</table>
| Strategic Priority 1: Improve the social and emotional | 1.3.2.2 Reduce rates of serious injury and poisoning resulting in hospitalisation for children and young people including:  
• Age-specific serious injuries for land transport 0–14  
• Assault hospitalisation rate for children 0–14  
• Intentional self-harm hospitalisation rate for children 10–14 |  
1.3.3 Reduce hospitalisations for vaccine preventable diseases  
1.3.3.1 Potentially preventable (ACSC) hospitalisation rate  
1.3.3.2 Proportion of children on the Australian Childhood Immunisation Register who are fully immunised at 2 years  
1.3.3.3 Proportion of Indigenous children who are fully vaccinated 1,2,5 yrs  
1.3.3.4 Proportion of Indigenous children who are fully vaccinated 12–15 mths, 24–27mths, 60–63 mths  
1.3.3.5 Proportion of Australian children fully vaccinated resident in agreed areas of low immunisation coverage 12–15mths, 60-63 mths  
1.3.3.6 Proportion of children who are fully vaccinated 60-63 mths  
1.3.3.7 Proportion of children attending the Children and Family Centres who have had all age-appropriate health checks and vaccinations  
1.3.3.8 Factors influencing decision to immunise children in non-remote areas |

<table>
<thead>
<tr>
<th>Strategic Priority 1: Improve the social and emotional</th>
<th>1.4 Increase the proportion of children who start school developmentally on track</th>
<th>1.4.1 Increase the proportion of Australian children who are developmentally ‘on track’ in each domain measured in the AEDC.</th>
</tr>
</thead>
</table>

| Strategic Priority 1: Improve the social and emotional | 1.5 Reduce the rates of oral health issues | 1.5.1 Increase the proportion of children who are decay free at 6 and 12 years  
1.5.2 Increase the proportion of young people who are decay free at 15 years  
1.5.3 Decrease the mean number of decayed, missing or filled teeth at 12 and 15 years  
1.5.4 Decrease the age-specific hospitalisation rates for dental problems (separations per 1000 population) 0-24 years |  
1.6 Provide clean and safe physical environments | 1.6.1 Increase the proportion of children using sun protection or avoiding the sun on a regular basis  
1.6.2 Increase the proportion of young people using sun protection or avoiding the sun on a regular basis |

| Strategic Priority 1: Improve the social and emotional | 1.7 Promote healthy lifestyles | 1.7.1 Increase the proportion of infants exclusively breastfed to around 4 months of age  
1.7.2 Increase the proportion of children/young people at a healthy weight in each age category.  
1.7.3 Increase the proportion of children meeting the National Physical Activity Guidelines and not exceeding the screen time guidelines  
1.7.4 Increase the proportion of children meeting the national guidelines for fruit and vegetable consumption  
1.7.5 Increase the proportion of young people (aged 12–24) meeting Australian Dietary Guidelines |  
2.1 Support and strengthen the capability of parents from preconception, through pregnancy and early childhood | 2.1.1 Monitor the rate of children who were the subject of a child protection substantiation in a given year (ages 1-12 and 12- |

<p>| Strategic Priority 2: Improve the social and emotional | 2.2 Protect children and youth | 2.2.1 Monitor the rate of children who were the subject of a child protection substantiation in a given year (ages 1-12 and 12- |</p>
<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Strategic Objective</th>
<th>Existing Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>through the provision of safe, nurturing family environments, free from abuse and neglect</td>
<td>2.2.2 Monitor the proportion of children who were the subject of a child protection substantiation for sexual abuse (0–17)</td>
<td>17) compared to previous years</td>
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<td></td>
<td>2.2.3 Monitor the rate of children who were the subject of care and protection orders (0–12 and 12–17)</td>
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<td>2.2.4 Monitor the number of Indigenous children on care and protection orders</td>
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<td>2.2.5 Reduce the rates of children/young people who have been the victims of physical assault or sexual assault (0–12 and 15–24)</td>
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<td>2.2.6 Reduce alcohol- and drug-related victimisation rate for young people 12–24</td>
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<td>2.2.7 Reduce the assault (homicide) death rate for:</td>
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<td>2.2.7.1 Children 0–14; 0–17</td>
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<td></td>
<td>2.2.7.2 Young people 12–24</td>
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<td>2.2.7.3 Indigenous children/young people</td>
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<td>2.2.8 Reduce the number of incidents where adults experienced current partner violence and their children saw or heard the violence in the previous 12 months</td>
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<tr>
<td>2.3 Improve social and emotional wellbeing of children and youth</td>
<td>National indicators under consideration (AIHW)</td>
<td></td>
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<tr>
<td>2.4 Reduce the prevalence of children experiencing early adverse events</td>
<td>2.4.2 Increase the proportion of children whose parent/guardian was usually able to get help when needed</td>
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<td></td>
<td>2.4.2 Decrease the proportion of parents who used any illicit drug, last 12 months (0–14)</td>
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<td>2.4.3 Decrease the proportion of parents who drank alcohol at risky levels</td>
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<tr>
<td>2.5 Support children and youth living with a chronic illness</td>
<td>2.5.1 Long-term condition prevalence 12–24yrs</td>
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<td>2.5.2 Asthma prevalence 0–14, 12–24 yrs</td>
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<td>2.5.3 Cancer incidence 0–14, 12–24 yrs</td>
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<td>2.5.4 Diabetes incidence 0–14, 15–24 yrs</td>
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<td></td>
<td>2.5.5 Mental health problems prevalence 4–14 yrs</td>
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<td>2.6 Support children and youth living with a disability</td>
<td>2.6.1 The number of children/young people living with disability (severe or profound core activity limitation) prevalence 0–14yrs ; 15–24yrs</td>
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<td>2.6.2 Proportion of children identified as requiring a hearing aid who are then fitted with a hearing aid by 6 and/or 12 months of age</td>
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<td>Strategic Priority</td>
<td>Strategic Objective</td>
<td>Existing Indicators</td>
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</table>
| Strategic Priority Three: Strengthen and improve health outcomes for vulnerable populations | 3.1 Improve the identification of vulnerable populations | 3.1.1 Culturally and linguistically diverse groups  
No specific indicators  
3.1.2 Aboriginal and Torres Strait Islander  
3.1.2.1 Causes of Indigenous mortality rates (0-24)  
3.1.2.3 Number/proportion of Indigenous children with reported teeth or gum problems  
- by type of dental or gum problem (0-14)  
- by time since last dental check (0-14)  
3.1.2.3 Caries experience of remote Indigenous children compared with SA, NT and total Australia child populations (5-6) (12-15)  
3.1.2.4 Breast feeding status when first taken home from hospital, Aboriginal and Torres Strait Islander Infants (0-3)  
3.1.2.5 Aboriginal and Torres Strait Islander infants by main reason stopped breast feeding, non-remote areas (0-3)  
3.1.2.6 Age at which given solid food regularly, Indigenous children (0-3)  
3.1.2.7 Whether infant ever given solid food, Indigenous infants (<6months)  
3.1.2.8 Alcohol risk levels, Indigenous persons (18-24)  
3.1.2.9 Alcohol use (and other substances) during pregnancy for Indigenous women  
3.1.2.10 Number of serves of fruit and vegetables consumed daily, Indigenous children, non-remote areas (4-14)  
3.1.2.11 Dietary risk behaviours, by household characteristics, Indigenous children, non-remote areas (1-14)  
3.1.2.12 Proportion of Indigenous teenagers accessing sexual and reproductive health programs and services  
3.1.2.13 Proportion of mothers who used illicit drugs or substances during pregnancy, Indigenous children 0-3yrs  
3.1.2.14 Proportion of Indigenous children by geographical location who are enrolled in a preschool program (4-5)  
3.1.2.15 Proportion of Indigenous children participating in quality early childhood education and development and child care services  
3.1.2.16 Number of Indigenous children on care and protection orders (0-17)  
3.1.2.17 Assault (homicide) death rate for: Indigenous children/young people (0-17)  
3.1.2.18 Proportion of Indigenous children who are fully vaccinated  
3.1.2.19 Use of antenatal service by Indigenous mothers, by selected health issues  
3.1.2.20 Proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy  
3.1.2.21 Risk factors of women who gave birth to an Indigenous baby who attended an antenatal visit; before 13 weeks of pregnancy, in the third trimester of pregnancy, use of antenatal services by mothers (by age of mother), use of antenatal services by Indigenous mothers (by type of service), Distance to hospital or clinic where child was born (Indigenous children), number/proportion of women who gave birth to an Indigenous baby (by timing of the first antenatal visit and mother’s age group)  
3.1.2.22 Major potentially preventable hospital admissions, by age group and Indigenous status (0-24)  
3.1.2.23 Types of regular health care used by Indigenous Australian (0-24)  
3.1.2.24 Proportion of Indigenous children and families accessing a range of services offered at or through Children and Family centres, including but not limited child care, early learning, child and maternal health, and parent and family support services |
<table>
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<tr>
<th><strong>Strategic Priority</strong></th>
<th><strong>Strategic Objective</strong></th>
<th><strong>Existing Indicators</strong></th>
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<tr>
<td></td>
<td>3.1.2.25 Proportion of Indigenous children in out-of-home care placed with extended family or other Indigenous caregivers</td>
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<td>3.1.2.26 Proportion of Indigenous children placed through Indigenous-specific out-of-home care agencies</td>
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<td>3.1.2.27 Proportion of Indigenous children in care who have a cultural support plan</td>
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<td>3.1.2.28 Medicare Benefits Schedule (MBS) health assessments and health checks for Indigenous Australians (0-14)</td>
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<td>3.1.2.29 Indigenous children with a core-activity need for assistance (0-18)</td>
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<td>3.1.2.30 Diseases of the ear and mastoid reported for Aboriginal and Torres Strait Islander children (0-14)</td>
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<td>3.1.2.31 Proportion of Indigenous children reporting ear/hearing problems (0-14)</td>
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<td></td>
<td>3.1.2.32 Proportion of Indigenous children reporting eye or sight problems (1-14)</td>
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</tbody>
</table>

3.1.3 Rural and Remote populations
No specific indicators.
Relevant framework: National Strategic Framework for Rural and Remote Health
3.1.4 Children in Out of Home care

3.1.4.1 Rate of children in out-of-home care
3.1.4.2 Proportion of children aged 0-14 in grandparent families

3.2 Reduce disadvantage as a result of social determinants of health
Measuring the outcomes of potential action such as those outlined in the National Primary Healthcare Strategic Framework under Strategic Outcome 3, such as health promotion, prevention screening and early intervention is covered under Strategic Priority One and Two of the Framework.

3.3 Fairer access to primary health care services
Access to primary healthcare is measured by the Australian Institute of Health and Welfare which creates a geospatial index of access to general practitioners relative to need for primary health care.

4.1 Promote and improve health literacy
National Statement on Health Literacy
And is identified in the following frameworks
- Australian Safety and Quality Framework for Health Care, which identifies health literacy as a key action area
- National Safety and Quality Health Service Standards, which implicitly refers to health literacy in nine of the ten Standards
- Australian Safety and Quality Goals for Health Care, which includes Partnerships with Consumers as a Goal and becoming a health literate organisation as a core outcome

4.2 Improve delivery and use of health information for consumers and professionals through better systems and
There are no specific measures for this Strategic Objective.

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<table>
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<th>Strategic Priority</th>
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</table>
| infrastructure    | 4.3 Encourage cross sector and intergovernmental collaboration and coordination to design and deliver outcomes for children and youth. | There are no specific measures for this Strategic Objective. Relevant frameworks include:  
  - National Framework for Universal Child and Family Health Services  
  - National Strategic Framework for Rural and Remote Health  
  - National Primary Healthcare Strategic Framework  
  - National Aboriginal and Torres Strait Islander Health Plan |
|                   | 4.4 Support evidence based policies and programs through research, evaluation and accountability | There are no specific measures for this Strategic Objective. |
Appendix Two: Life Course Template
This table sets out the existing national indicators across child development

<table>
<thead>
<tr>
<th>SP1</th>
<th>Antenatal care</th>
<th>Minus 9 months – birth</th>
<th>Australian children are developmentally on track, healthy, safe and well. - Families are supported in raising children in strong families and communities 0 – 5 years</th>
<th>Australian children are healthy, secure and safe -children have access to health services, healthy food and physical activities - Parents are supported 6 – 12 years</th>
<th>Australian youth are connected, confident and secure 12 – 24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SP1</strong></td>
<td>Antenatal care</td>
<td>(AIHW) Proportion of women who have had at least 5 antenatal visits during pregnancy Proportion of pregnant Indigenous women with an antenatal contact in the first trimester of pregnancy</td>
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<tr>
<td><strong>SP1</strong></td>
<td>Alcohol use during pregnancy</td>
<td>(AIHW) Proportion of women who consumed alcohol during pregnancy</td>
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<tr>
<td><strong>SP1</strong></td>
<td>Tobacco use during pregnancy</td>
<td>(AIHW) Proportion of women who smoked in the first 20 weeks of pregnancy</td>
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<tr>
<td><strong>SP1</strong></td>
<td>Substance abuse during pregnancy (Indigenous)</td>
<td>(AIHW) proportion of women who used substances (tobacco, alcohol, illicit drugs) during pregnancy</td>
<td></td>
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<tr>
<td><strong>SP1</strong></td>
<td>Mortality and morbidity</td>
<td>Infant mortality rate (AIHW) Infant mortality (OECD)</td>
<td>Death rate (AIHW) SIDS rate (AIHW) Infant mortality OCED Infant mortality rate (AIHW) Mortality (OECD) Causes of death by age, including monitoring the leading causes of death for infants up to 12 months, children aged 1-14 and young people aged 15-24.</td>
<td>Death rate (AIHW) Mortality (OECD) Causes of death by age, including monitoring the leading causes of death for infants up to 12 months, children aged 1-14 and young people aged 15-24.</td>
<td>Death rate (AIHW) Mortality (OECD) Causes of death by age, including monitoring the leading causes of death for infants up to 12 months, children aged 1-14 and young people aged 15-24.</td>
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<tr>
<td><strong>SP1</strong></td>
<td>Birth weight</td>
<td>Low birth weight (OECD) (AIHW) Live born infants of low birth weight</td>
<td></td>
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<tr>
<td><strong>SP1</strong></td>
<td>Neonatal hearing screening</td>
<td>(AIHW) Proportion of children identified as requiring a hearing aid</td>
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<tr>
<td>Category</td>
<td>Description</td>
<td>Reference</td>
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<tr>
<td>Australians are born healthy, into families supported to have them, feel, secure and safe</td>
<td>- Families are supported in raising children in strong families and communities</td>
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<tr>
<td>Australian children are developmentally on track, healthy, safe and well.</td>
<td>- Children have access to health services, healthy food and physical activities - Parents are supported</td>
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<tr>
<td>Australian children are healthy, secure and safe</td>
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<td>Australian youth are connected, confident and secure</td>
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<tr>
<td>Breast feeding</td>
<td>Breast feeding rates (OECD)</td>
<td>(AIHW) Proportion of infants exclusively breastfed at 4 months</td>
<td></td>
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<tr>
<td>Congenital anomalies</td>
<td>Selected congenital anomalies rate among infants &lt;1 (AIHW)</td>
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<tr>
<td>Immunisation</td>
<td>Measles vaccination (OECD)</td>
<td>Pertussis vaccination (OECD)</td>
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<tr>
<td></td>
<td>(AIHW) Proportion of children on the Australian Childhood immunisation Register who are fully immunised at 2 years</td>
<td>(AIHW) Proportion of Indigenous children attending the children and Family Centres who have had all the age appropriate health checks/vaccinations</td>
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<tr>
<td>Overweight/obesity</td>
<td>(AIHW) Proportion of children who are overweight or obese for their age and sex (5-14)</td>
<td>(AIHW) Proportion of children who are overweight or obese for their age and sex (5-14)</td>
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<td></td>
<td>(AIHW) Proportion of children who are overweight or obese for their age and sex (12-24)</td>
<td>(AIHW) Proportion of children who are overweight or obese for their age and sex (12-24)</td>
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<tr>
<td>Dental health</td>
<td>(AIHW) Decay free</td>
<td>Mean number of decays, missing or filled teeth</td>
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<tr>
<td>Physical activity</td>
<td>ABS Australian Health Survey Proportion of children meeting National Physical Activity Recommendations</td>
<td>(OECD) (11-15) ABS Australian Health Survey Proportion of children meeting National Physical Activity Recommendations</td>
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<td></td>
<td>(OECD) (11-15)</td>
<td>(AIHW) (15-24) ABS Australian Health Survey Proportion of 12-17 year olds meeting National Physical Activity Recommendations</td>
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<td>Nutrition</td>
<td>ABS Profiles of Health</td>
<td>ABS Profiles of Health</td>
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<td>Category</td>
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<td>Australians are born</td>
<td>healthy, into families supported to have them, feel, secure and safe</td>
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<td>Australian children</td>
<td>are developmentally on track, healthy, safe and well.</td>
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<td>Australian children</td>
<td>- Families are supported in raising children in strong families and</td>
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<td>communities</td>
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<td>Australian children</td>
<td>are healthy, secure and safe -children have access to health services,</td>
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<td>healthy food and physical activities - Parents are supported</td>
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<td>Australian youth</td>
<td>are connected, confident and secure</td>
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<td>Sun protection</td>
<td>Proportion of children meeting recommendations for daily intake of fruit</td>
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<td>and vegetables</td>
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<tr>
<td>Injuries</td>
<td>(AIHW) Death rates for all injuries</td>
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<td></td>
<td>Road transport accident death rate</td>
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<td>Accidental drowning death rate</td>
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<td>Injury hospitalisation rate</td>
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<td>Intentional self harm hospitalisation – (AIHW) (currently published in</td>
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<td></td>
<td>Trends in Hospitalised Injury)</td>
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<td>Hospital admissions</td>
<td>(AIHW) Hospitalisation by principle diagnosis</td>
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<tr>
<td>Communicable diseases</td>
<td>(AIHW) Vaccine preventable disease incidence</td>
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<td>Hepatitis A, B and C notification rates</td>
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<td>HIV infection notification rate</td>
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<td>Notifiable STI incidence</td>
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<td>Chronic conditions</td>
<td>(AIHW) Long term condition prevalence</td>
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<td></td>
<td>Asthma prevalence</td>
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<td>Diabetes</td>
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<tr>
<td>Cancer survival</td>
<td>(AIHW) 5 year relative survival rate</td>
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<td>Australians are born healthy, into families supported to have them, feel, secure and safe</td>
<td>Australian children are developmentally on track, healthy, safe and well. - Families are supported in raising children in strong families and communities</td>
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<td>for leukaemia (0-14) (AIHW) 5 year survival rate for melanoma of the skin (12-24)</td>
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<td>SP1</td>
<td>Social and emotional wellbeing (includes resilience of abuse survivors)</td>
<td>(AIHW) Proportion of children leaving care and scoring ‘of concern’ on the SDQ Children scoring ‘of concern’ on the SDQ</td>
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<td>SP1</td>
<td>Disability (incl developmental disability)</td>
<td>(AIHW) Severe or profound core activity limitation prevalence</td>
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<td>SP1</td>
<td>Allergies</td>
<td>ABS Australian Health Survey Proportion of children meeting National Physical Activity Recommendations (maximum screen-based activity time)</td>
<td>ABS Australian Health Survey Proportion of children meeting National Physical Activity Recommendations (maximum screen-based activity time)</td>
<td>ABS Australian Health Survey Proportion of 12-17 year olds meeting National Physical Activity Recommendations (maximum screen-based activity time)</td>
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<td>SP1</td>
<td>Sleep and sleep disorders</td>
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<td>SP1</td>
<td>Environment -education</td>
<td>(AIHW) Proportion of children who are enrolled in and attending a preschool program (AIHW) Proportion of children read to by a parent on a regular basis (AIHW) Proportion of children developmentally vulnerable on one or more domains on the AEDI</td>
<td>(OECD) Liking school (11-15)</td>
<td>(OECD) Literacy inequality (age 15) Average mean literacy score Youth NEET rates (OECD) Liking school (11-15)</td>
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<td>SP1</td>
<td>Sexual and reproductive health</td>
<td></td>
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<td>(AIHW) Proportion who have had sexual intercourse (yr 10 and 12) Proportion who used a form on contraception at their most recent sexual encounter (yr 10 and 12) Proportion of Indigenous teenagers accessing sexual and reproductive health programs and services (yr 10 and 12)</td>
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</table>
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<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
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<tr>
<td><strong>Teenage births</strong></td>
<td>(OECD) Teenage births [15-19] (AIHW) Birth rate [15-19]</td>
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<td><strong>Alcohol misuse</strong></td>
<td>(OECD) drunkenness – risk behaviours [13-15] (AIHW) Proportion of children who have engaged in risky drinking on any one occasion [12-14] (AIHW) Risky or high risk drinking in the short or long term [12-24]</td>
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<td><strong>Substance abuse</strong></td>
<td>(AIHW) Reported rate of substance use disorders for young people [16-24]</td>
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<td>Proportion of young people [12-24] who had used an illicit drug within the past 12 months.</td>
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<td>Proportion of teenage drinkers who personally purchased their most recent alcoholic drink [12-17]</td>
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<td><strong>Tobacco use</strong></td>
<td>(AIHW) Current smokers from 12-14 (AIHW) Daily smokers 12-24</td>
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<td>(OECD) smoking (risk behaviours) age 15 (AIHW) Proportion of teenage smokers who personally purchased their most recent cigarette [12-17]</td>
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<tr>
<td><strong>Mental health - Non-Suicidal Self-Injury, suicide</strong></td>
<td>(OECD) suicide rates (0-19)</td>
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<td><strong>Mental health and child behavioural problems</strong></td>
<td>(AIHW) Mental health problems prevalence [4-14] (AIHW) Child behavioural problems TBC</td>
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<td>(AIHW) Child behavioural problems TBC (AIHW) mental health disorders</td>
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<td></td>
<td>(AIHW) High/very high levels of psychological distress [16-24] (AIHW) mental health disorders</td>
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<tr>
<th>SP2</th>
<th>Environmental – social/educational setting</th>
<th>(AIHW) School relationships and bullying TBC</th>
<th>(OECD) Bullying (11-15) (quality of school life) (AIHW) School relationships and bullying TBC</th>
<th>(OECD) Bullying (11-15) (quality of school life) (AIHW) School relationships and bullying TBC</th>
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<tr>
<td>SP2</td>
<td>Environmental – physical</td>
<td>Tobacco smoke in the home (AIHW) 0-14</td>
<td>Tobacco smoke in the home (AIHW) 0-14</td>
<td>Tobacco smoke in the home (AIHW) 0-14</td>
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<td>SP2</td>
<td>Environment – family/parenting</td>
<td>(AIHW) Proportion of parents with a mental health problem (0-14) Parenting quality/capacity TBC Family functioning TBC Proportion of parents with child who used any illicit drugs in within the last 12 months (0-14) Proportion of parents who drank alcohol at risky levels (0-14)</td>
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<td>(AIHW) Proportion of parents with a mental health problem (0-14 and 12-24) Parenting quality/capacity TBC Family functioning TBC Proportion of parents with child who used any illicit drugs in within the last 12 months (0-14) Proportion of parents who drank alcohol at risky levels (0-14)</td>
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<td>SP2</td>
<td>Environment – housing</td>
<td>Overcrowding (OECD) Poor homes</td>
<td>(OECD) Children in poor homes</td>
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<td>SP2</td>
<td>Material wellbeing</td>
<td>(OECD) Children in poor homes</td>
<td>(OECD) Children in poor homes</td>
<td>Educational deprivation (OECD)</td>
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<td>SP2</td>
<td>Child abuse</td>
<td>(AIHW) Rate of children who were subject of a child protection substantiation in a given year Rate of children who were subject of care and protection orders Proportion of children who were subject of child protection substantiation for sexual abuse Rate of children/young people who have been the victim of physical or sexual assault Alcohol and drug related violence victimisation rate Assault (homicide) death rate Proportion of adults who experienced current partner violence and their children saw/heard the violence in the last 12 months Rate of children who were subject of a child protection re-substantiation in a given year</td>
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<td>Sexual and reproductive health</td>
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<td>SP2</td>
<td>Equitable access to healthcare</td>
<td>Indigenous populations</td>
<td>(AIHW) Proportion of Indigenous children and families accessing services at the Children and Family Centres</td>
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<td>Social determinants of health and wellbeing</td>
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<td>SP3</td>
<td>Equitable access to healthcare</td>
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<td>(AIHW) number of children seeking assistance through treatment and support services (Family support service use) (0-17)</td>
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<td>(AIHW) rate of general practice encounters for young people (12-24)</td>
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<td>SP3</td>
<td>Equitable access to healthcare - Geographical mapping of areas of need</td>
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<td>SP3</td>
<td>Equitable access to healthcare - Cultural and linguistically diverse populations, and refugees</td>
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<td>SP4</td>
<td>Infrastructure/coordination</td>
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<td>Information systems –</td>
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<td>e-health records</td>
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<td>Health education - Health literacy / technology</td>
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<td>Cross sector coordination</td>
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Appendix Three: Relevant National Government Strategic Frameworks

- National Framework for Universal Child and Family Health Services
- National Tobacco Strategy 2012-2018
- National Disability Strategy 2010-2020
- National Road Safety Strategy 2011-2020
- National Safe Schools Framework
- Protecting Australia from communicable diseases: Everybody’s business (2004)
- National Immunisation Strategy
- National Strategic Framework for Rural and Remote Health
- National Primary Healthcare Strategic Framework
- Protecting Children is Everyone’s Business, National Framework for Protecting Australia’s Children 2009 – 2020
- National Framework for Secondary and Tertiary Child Health Services (in development)
- National Aboriginal and Torres Strait Islander Health Plan
- Australian Safety and Quality Framework for Health Care
- National Safety and Quality Health Service Standards
- Australian Safety and Quality Goals for Health Care
- National Statement on Health Literacy
- Roadmap for National Mental Health Reform 2012-2022
- National Suicide Prevention Strategy
- National Mental Health Strategy
- National Aboriginal and Torres Strait Islander suicide prevention strategy
- National Framework for Neonatal Hearing Screening
- Commonwealth Foetal Alcohol Spectrum Disorder Action Plan
- National Perinatal Depression Initiative