



2001

4829.0.55.001
New Issue

THE HEALTH OF CHILDREN AUSTRALIA

EMBARGO: 11.30AM (CANBERRA TIME) WED 27 OCT 2004

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INQUIRIES

- For further information about these and related statistics, contact the National Information and Referral Service on 1300 135 070.

NOTES

ABOUT THIS PUBLICATION This publication outlines the prevalence of common conditions in childhood. In addition, causes of death, reasons for hospital and general practitioner visits, types of mental disorders and level of disability are analysed.

EFFECTS OF ROUNDING Where estimates have been rounded, discrepancies may occur between sums of the component items and total.

ACKNOWLEDGEMENTS Australian Bureau of Statistics (ABS) publications draw extensively on information provided freely by individuals, businesses, governments and other organisations. Their continued cooperation is very much appreciated. Without it, the wide range of statistics published by the ABS would not be available. Information received by the ABS is treated in strict confidence as required by the *Census and Statistics Act 1905*.

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ABBREVIATIONS

- ABS Australian Bureau of Statistics
- ADHD Attention Deficit Hyperactivity Disorder
- AIHW Australian Institute of Health and Welfare
- BEACH Bettering the Evaluation and Care of Health
- CBCL Child Behaviour Checklist
- DoHA Department of Health and Ageing
- GP General Medical Practitioner
- IMR infant mortality rate
- NHS National Health Survey
- OHP Other health professional
- SDAC Survey of Disability, Ageing and Carers
- SIDS Sudden Infant Death Syndrome

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Australian Statistician

SUMMARY OF RESULTS

INTRODUCTION

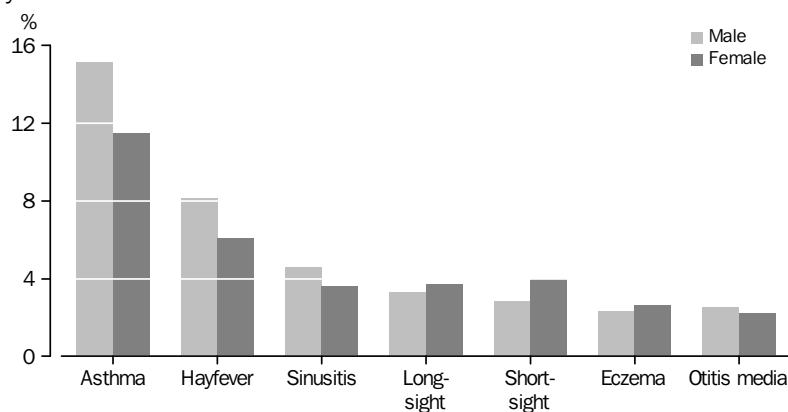
In March 2004, about 4 million Australians were children (aged 0-14), which represented 20% of the total population. In general, Australian children enjoy good health. Their life expectancy at birth is increasing, and perinatal, infant and childhood deaths are declining. This paper aims to provide information on the health and wellbeing of Australian children. Unless otherwise stated, children are defined in this paper as persons aged 0-14 years.

MORBIDITY

Long-term conditions

National Health Survey (NHS) 2001 results showed that the most commonly reported long-term conditions for children (aged 0-14 years) were allergic related diseases, such as asthma (13.4%), hayfever (7.1%), sinusitis (4.2%), and eczema (2.5%). Other common long-term conditions included otitis media (middle ear infection) (2.4%) and eyesight problems. In 2001, 3.5% of children aged 0-14 years were reported to have long-sightedness, and 3.4% were reported to have short-sightedness.

SELF-REPORTED LONG-TERM CONDITIONS, children aged 0-14 years—2001



Source: ABS 2001 National Health Survey

Recent injury event

Respondents to the 2001 NHS were asked about events in the four weeks prior to interview that resulted in an injury for which they had sought medical treatment or taken some other action (see Glossary: Recent injury event). Results showed that 17.6% of children aged 0-14 years (19.5% of boys and 15.6% of girls) reported sustaining a recent injury in the four weeks before the interview. When the type of event leading to injury is considered, falls were the most common (ABS 2003a).

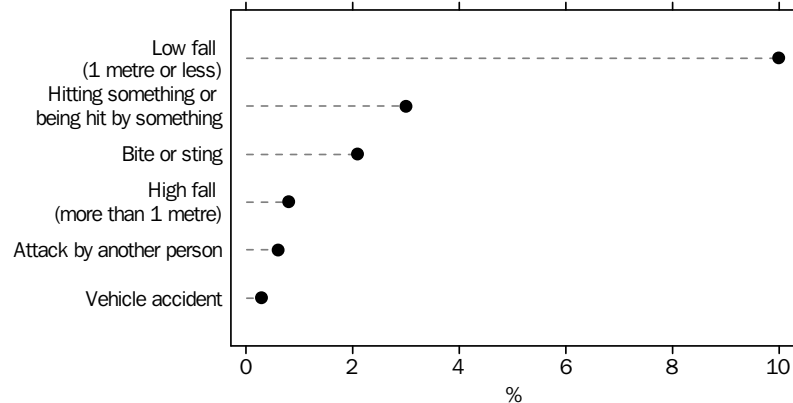
It is estimated that 10% of children were injured in a low fall (1 metre or less) and 0.8% in a high fall (more than 1 metre). Of children aged 0-14 years who were injured in a low fall, 74% were engaged in sporting or leisure activities at the time, and around 16% had visited a doctor or other health professional (see Glossary) as a result of their low fall.

Around 3% of children were injured by hitting something or being hit by something. Other types of events leading to injury included bites or stings (2.1%), attacks by another person (0.6%), and vehicle accidents (0.3%).

SUMMARY OF RESULTS *continued*

Recent injury event *continued*

MOST COMMON RECENT INJURY EVENTS, children aged 0-14 years—2001

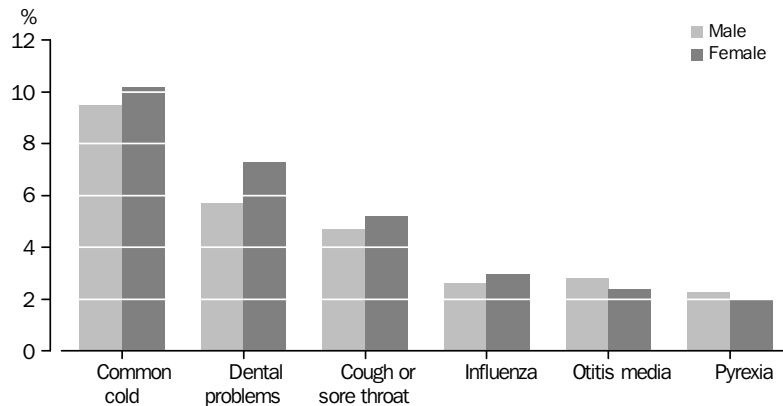


Source: ABS 2001 National Health Survey

Recent illness

While children do experience long-term conditions, such as asthma, they are more likely to have short-term illnesses, such as infectious diseases. The 1995 ABS National Health Survey collected data on recent illness and findings indicated that the most commonly reported recent condition for children was the common cold (9.8%). Other recent conditions included dental problems (6.5%), cough and sore throat (4.9%), influenza (2.8%), otitis media (2.6%), and pyrexia (high temperature) (2.1%).

SELF-REPORTED RECENT ILLNESS, children aged 0-14 years—1995



Source: ABS 1995 National Health Survey

DISABILITY

Disability was defined in the 2003 Survey of Disability, Ageing and Carers (SDAC), as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities (ABS 2004). There are four levels of core activity restriction: profound, severe, moderate and mild (see Glossary). Children with a disability can also have a core activity restriction, if the disability limits their ability to some degree to perform tasks, such as self-care, mobility, communication, and schooling.

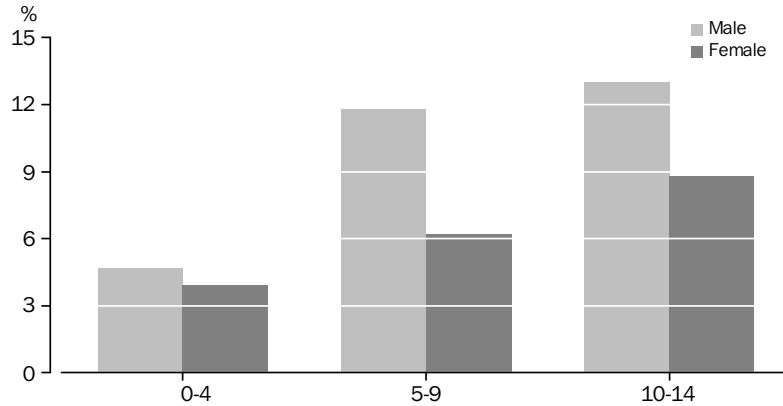
The 2003 Survey of Disability, Ageing and Carers indicated that approximately 319,900 Australian children (aged 0-14 years) had a reported disability. Of children with a disability, 69% (around 221,700 children) had a core activity restriction. The rate of disability was estimated to be about 8.2% for children aged 0-14 years. Overall, more boys

SUMMARY OF RESULTS *continued*

DISABILITY *continued*

in this group were reported to have a disabling condition than girls (9.9% and 6.4% respectively). In all age groups, boys had higher rates of disability than girls.

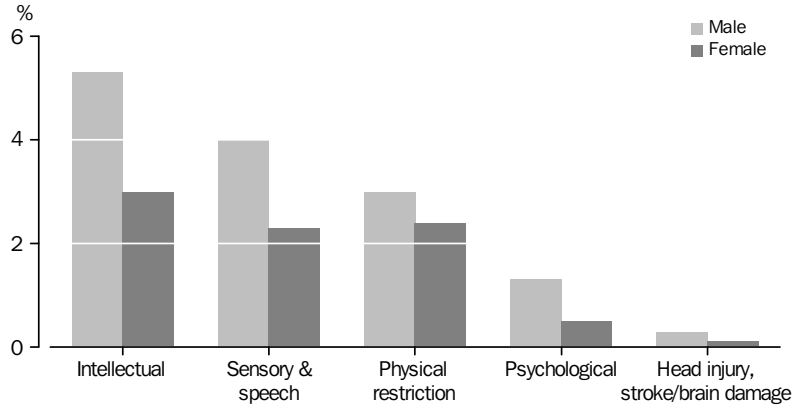
DIASBILITY, in children aged 0-14 years—2003



Source: ABS 2003 Survey of Disability, Ageing and Carers

Intellectual disability was the most commonly reported disabling condition for children aged 0-14 years, with a rate of 4.2% in 2003. This was followed by sensory and speech conditions (3.2%), physical restrictions (2.7%), psychological conditions (0.9%), and head injury, stroke or brain damage (0.2%).

TYPE OF DISABILITY, children aged 0-14 years—2003



Source: ABS 2003 Survey of Disability, Ageing and Carers

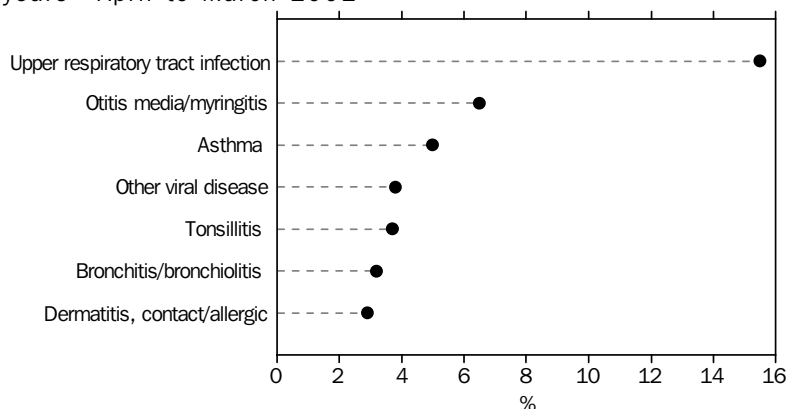
CONSULTATION WITH GENERAL PRACTITIONERS (GPS)

The Bettering and Evaluation And Care of Health (BEACH) study, was a national study of general practice activity in Australia conducted by the GP Statistics and Classification Unit (a collaborating Unit of the University of Sydney and the AIHW). Results from the study showed that the most common problems managed by General Medical Practitioners (GPs) were acute upper respiratory tract infections, making up 15.5% of all problems (for children aged 0-14 years). This was followed by acute otitis media/myringitis (6.5%), and asthma (5.0%). Other viral disease (3.8%), tonsillitis (3.7%), acute bronchitis/bronchiolitis (3.2%), and contact/allergic dermatitis (2.9%) were also frequently seen by GPs (AIHW 2002).

SUMMARY OF RESULTS *continued*

CONSULTATION WITH GENERAL PRACTITIONERS (GPS) *continued*

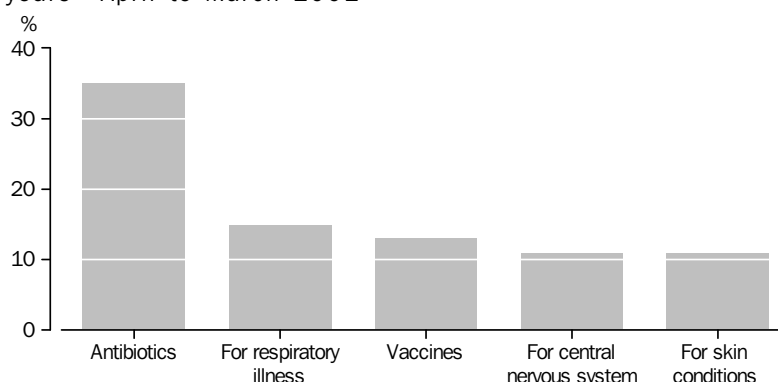
COMMON PROBLEMS MANAGED BY GPS, children aged 0-14 years—April to March 2001



Source: AIHW, BEACH Survey, April - March 2001 in AIHW 2002

The medications most commonly prescribed by GPs for children aged 0-14 years were antibiotics (35% of all prescriptions). This was followed by medications for the treatment of respiratory illness (eg: asthma and bronchitis) which made up 15% of all prescriptions. Vaccines totalled 13% of all medications, followed by medications for problems of the central nervous system (11%) and skin conditions (11%) (AIHW 2002).

PROPORTION OF PRESCRIBED MEDICATIONS (a), children aged 0-14 years—April to March 2001



(a) Medications as prescribed during consultations with GPs.

Source: AIHW, BEACH Survey, April to March 2001 in AIHW 2002

HOSPITALISATION

Hospitalisation rates are lower for children compared to adults. While children aged 0-14 years made up around 20% of the total population, the total number of hospitalisations in 2002-03 for children aged 0-14 years was around 544,400 which represented 8.2% of all hospitalisations (AIHW 2004). The main reasons for hospitalisation included diseases of the respiratory system and injuries and poisoning.

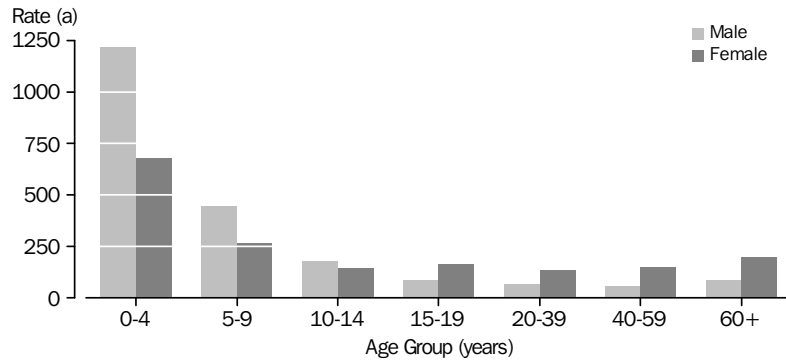
Asthma

Asthma is one of the most common reasons for children to be hospitalised. In 2002-03, just over half (51%) of the 37,200 hospital separations with a principal diagnosis of asthma (19,200) were for children aged 0-14 years. Hospitalisation for asthma is highest among young children (aged 0-4 years). Boys are more likely to be admitted to hospital for asthma than girls, particularly for those aged up to 9 years (AIHW 2004).

SUMMARY OF RESULTS *continued*

Asthma *continued*

HOSPITAL SEPARATIONS FOR ASTHMA—2002-03



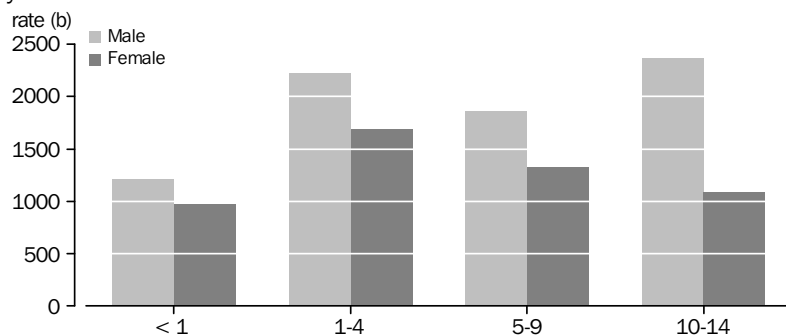
(a) Hospital separation rate per 100,000 population using estimated resident population as at December 2002.

Source: AIHW, National Hospital Morbidity Database.

Injury

Injury (including poisoning) is one of the main causes of ill-health in Australia. In 2002-03, there were approximately 68,000 hospitalisations for injury in children. Boys were more likely to be hospitalised for an injury than girls (42,600 and 25,400 respectively). This difference between boys and girls was consistent for all age groups. Among boys, those aged 10-14 years had the highest rate of hospitalisation for injuries while among girls, those aged 1-4 years had the highest rate (AIHW 2004).

HOSPITAL SEPARATIONS FOR INJURY(a), children aged 0-14 years—2002-03



(a) Includes poisoning and certain other consequences of external causes.

(b) Hospital separation rate per 100,000 population, using estimated resident population as at December 2002.

Source: AIHW, National Hospital Morbidity Database

MENTAL DISORDERS

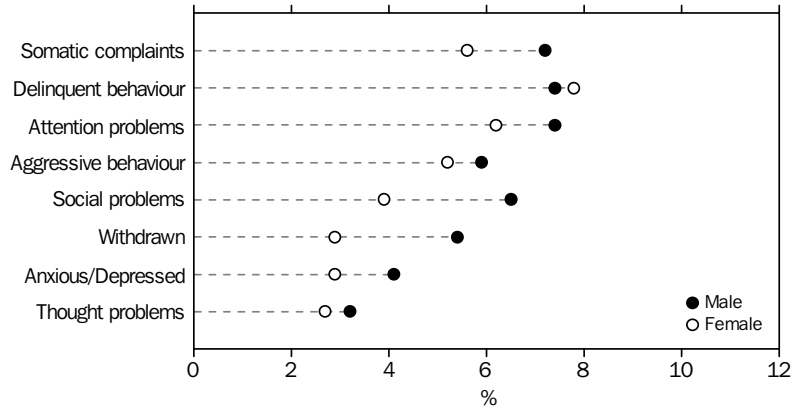
The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing, conducted in 1998 by the then Commonwealth Department of Health and Aged Care, studied 4,500 children and young people from metropolitan and rural areas across Australia. The prevalence of mental health problems was based on scores obtained from the Child Behaviour Checklist (CBCL) completed by parents (see Glossary).

The results showed that 14% of children and young people (aged 4-17 years) had mental or behavioural health problems. Somatic complaints (chronic physical complaints without known cause or a medically verified basis) and delinquent behaviour were the most common specific problems reported by parents. Around 7% of children and adolescents scored in the clinical range on both these scales. Attention problems (6%) and aggressive behaviour (5%) were also identified.

SUMMARY OF RESULTS *continued*

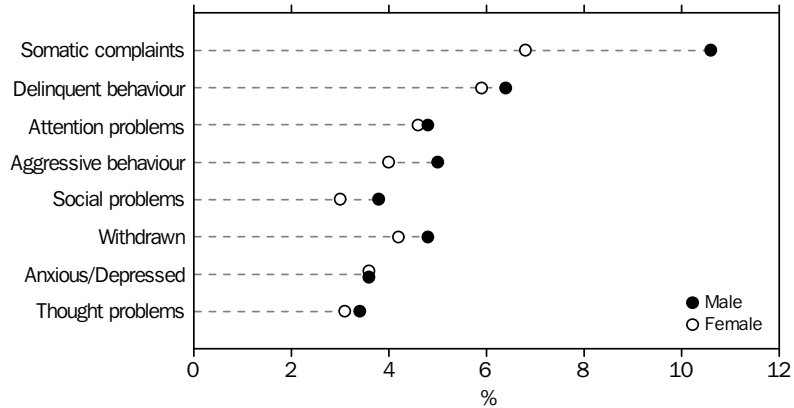
MENTAL DISORDERS
continued

MENTAL HEALTH PROBLEMS IN SPECIFIC AREAS, children aged 4-12 years—1998



Source: Sawyer et al 2000

MENTAL HEALTH PROBLEMS IN SPECIFIC AREAS, children aged 13-17 years—1998



Source: Sawyer et al 2000

Parents of children and adolescents aged 6-17 years were also administered the Diagnostic Interview Schedule for Children (Version IV), a tool used in health services to identify depressive disorder, conduct disorder, and Attention Deficit Hyperactivity Disorder (ADHD) (see Glossary).

The results indicated that among these three disorders, the most common disorder was ADHD, which had a prevalence of 11.2% for all children and adolescents aged 6-17 years. Boys were more likely to have ADHD than girls. For instance, among children aged 6-12, 19.3% of boys and 8.8% of girls were reported as having ADHD. The prevalence of depressive disorder was 3.7% and conduct disorder was 3.0% (DoHA 2000).

SUMMARY OF RESULTS *continued*

MENTAL DISORDERS

continued

SELECTED MENTAL HEALTH DISORDERS (a)(b)—1998

<i>Disorder</i>	6-12		13-17	
	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
	%	%	%	%
Depressive Disorder	3.7	2.1	4.8	4.9
Conduct Disorder	4.8	1.9	3.8	1.0
ADHD	19.3	8.8	10.0	3.8

- (a) As assessed by the Diagnostic Interview Schedule for Children (Version IV) (see Glossary).
- (b) The impairment criteria required by DSM IV could not be incorporated into the criteria for a diagnosis used in this survey. It is also possible that for some children their symptoms may have been better accounted for by another mental disorder that was not assessed in the survey.

Source: Sawyer et al 2000

MORTALITY

Compared to adults, children have a lower death rate. In 2002, children (0-14 years) accounted for around 20% of the total Australian population, and child deaths represented 1.4% of all deaths registered in 2002 (ABS 2002).

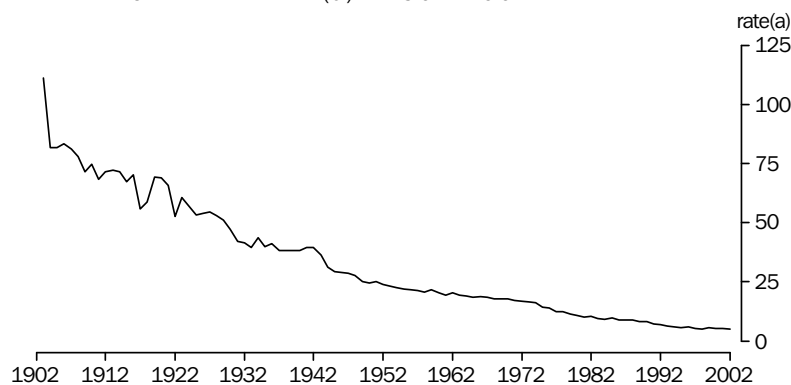
Infant mortality

The Infant Mortality Rate (IMR) is defined as the number of deaths per 1,000 live births between birth and exactly one year of age. The survival of infants in their first year of life is commonly viewed as an indicator of the general health and wellbeing of a population. A low infant mortality rate is a major contributor to increased life expectancy.

Australia's IMR was 5 infant deaths per 1,000 live births in 2002. However, the IMR is higher among Indigenous infants (for further information on the Indigenous IMR, see ABS: *Deaths Australia 2002*, Cat. No. 3302.0).

Australia's IMR has declined by 95% in the last 100 years. In 1902, over 1 in 10 infants born did not survive to their first birthday (IMR of 107.1). In 2002, 1 in 200 infants born did not survive their first year of life (IMR of 5.0). The early decline in infant mortality has been linked to improvements in public sanitation and health education (ABS 2003a).

INFANT MORTALITY RATE (a)—1902-2002



(a) Number of infant deaths per 1,000 live births.

Source: ABS 2003b, *Deaths Australia* Cat. No. 3302.0

SUMMARY OF RESULTS *continued*

Infant mortality continued

Despite a continued decline, infant mortality still counts for two thirds of all deaths of children aged 0-14 years. Of 1,882 registered child deaths in 2002, 1,264 were infants. Leading causes of death among infants included conditions originating in the perinatal period. For example, congenital malformations counted for 22% of infant deaths and Sudden Infant Death Syndrome (SIDS) counted for 9% of infant deaths (ABS 2002).

Death after infancy

For children aged 1-14 years, external causes of death (such as injuries and poisoning) and cancer are the leading causes of death for children.

In 2002, external causes of death, such as injuries or poisoning accounted for the deaths of 229 children aged 1-14 years, representing 37% of all deaths of this age group. Of deaths from external causes, 105 (46%) children died from transport accidents (ABS 2002).

Malignant neoplasms caused the deaths of 118 children aged 1-14 years, representing 19% of all deaths of children aged 1-14 years in 2002. Leading causes of cancer deaths for children were leukaemia and brain cancer (AIHW 2002), while leading causes of cancer deaths for adults were lung cancer (for men) and breast cancer (for women) (AIHW 2003).

REFERENCES

ABS 2002. data available on request, *Causes of Death*

ABS 2003a. *National Health Survey: Injuries* ABS Cat. No. 4384.0

ABS 2003b. *Deaths Australia 2002* ABS Cat. No. 3302.0

ABS 2004. *Disability, Ageing and Carers 2003: Summary of Findings* ABS Cat. No. 4430.0

AIHW 2002. *Australia's Children 2002* AIHW Cat. No. PHE36.

AIHW 2003. *Cancer in Australia 2000* AIHW Cat. No. CAN 18.

AIHW 2004. *Interactive National Hospital Morbidity Data 2001-02* last viewed 25 October 2004 <<http://www.aihw.gov.au/cognos/cgu-bin/ppdscgi.exe>>

Sawyer et al 2000. *The mental health of young people in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

GLOSSARY

Core-activity limitation Four levels of core-activity limitation are determined based on whether a person needs help, has difficulty, or uses aids or equipment with any of the core activities (communication, mobility or self care). A person's overall level of core-activity limitation is determined by their highest level of limitation in these activities.

The four levels of limitation are:

- profound: the person is unable to do, or always needs help with, a core-activity task
- severe: the person
 - sometimes needs help with a core-activity task
 - has difficulty understanding or being understood by family or friends
 - can communicate more easily using sign language or other non-spoken forms of communication.
- moderate: the person needs no help but has difficulty with a core-activity task
- mild: the person needs no help and has no difficulty with any of the core-activity tasks, but
 - uses aids and equipment
 - cannot easily walk 200 metres
 - cannot walk up and down stairs without a handrail
 - cannot easily bend to pick up an object from the floor
 - cannot use public transport
 - can use public transport but needs help or supervision
 - needs no help or supervision but has difficulty using public transport.

Diagnostic Interview Schedule for Children (Version IV)

This interview was conducted as part of the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. (The Mental Health Branch of the then Commonwealth Department of Health and Aged Care commissioned the University of Adelaide to undertake the survey.) Parents of children and adolescents aged 6–17 years were administered the Diagnostic Interview Schedule for Children (Version IV) (Shaffer et al., 2000) to identify the prevalence of:- depressive disorder; conduct disorder; and Attention-Deficit/Hyperactivity Disorder (ADHD). The Diagnostic Interview Schedule uses the criteria described in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, to identify these disorders (American Psychiatric Association, 1994).

It should be noted that the use of the Diagnostic Interview Schedule for parents to identify the three mental disorders may have influenced the prevalence estimates in two ways. First, because parents may not always recognise subjective distress experienced by children and adolescents, it is possible that a higher prevalence of depressive disorder may have been identified if interviews had been conducted with the young people themselves. Second, it is possible that some children or adolescents identified as having ADHD may have been more appropriately diagnosed with another disorder not included in the survey. It should also be noted that few children and adolescents were identified with dysthymic disorder. For that reason, dysthymic disorder and major depressive disorder have been combined in the presentation of results.

For a description of the three disorders covered in the Diagnostic Interview Schedule for Children (Version IV) and for further information regarding the Diagnostic Interview Schedule for Children (Version IV) as collected in the Child and Adolescent Component of the National Survey of Mental Health and Well-being, please refer to the following text:

- Sawyer et al 2000. *The mental health of young people in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Disability Groups

Disabilities can be broadly grouped depending on whether they relate to functioning of the mind or the senses, or to anatomy or physiology. Each disability group may refer to a single disability or be composed of a number of broadly similar disabilities. The SDAC module relating to disability groups was designed to identify four separate groups based on the particular type of disability identified.

These groups are:

GLOSSARY *continued*

Disability Groups *continued*

Sensory

- Loss of sight (not corrected by glasses or contact lenses)
- Loss of hearing where communication is restricted, or an aid used
- Speech difficulties, including loss.

Intellectual

- Difficulty learning or understanding things

Physical

- Shortness of breath or breathing difficulties that restrict everyday activities
- Blackouts, fits or loss of consciousness
- Chronic or recurrent pain or discomfort that restricts everyday activities
- Incomplete use of arms or fingers
- Difficulty gripping or holding things
- Incomplete use of feet or legs
- Restriction in physical activities or in doing physical work
- Disfigurement or deformity.

Psychological

- Nervous or emotional condition that restricts everyday activities
- Mental illness or condition requiring help or supervision
- Head injury, stroke or other brain damage, with long-term effects that restrict everyday activities.

The following categories were not included in any of the four groups above but were included in the total:

- Receiving treatment or medication for any other long-term conditions or ailments and still restricted in everyday activities
- Any other long-term conditions resulting in a restriction in everyday activities.

In the disability groups module people could be counted more than once if they had multiple disabilities which belonged to more than one disability group. For example, a person with a hearing loss and speech difficulties would be counted once in the sensory disability group. However, a person with a hearing loss and a physical deformity would be counted once in the sensory disability group and once in the physical disability group. As a result, the sum of the components of data from the disability groups module does not add to the total persons with disabilities.

Disabilities which resulted from head injury, stroke or other brain damage were classified to the appropriate group. For example, a person reporting speech loss as a result of stroke would be classified to the sensory disability group. However, a person who reported having had a head injury, stroke or other brain damage was also classified to a separate disability category of this name (ABS 2004).

Mental Health problems assessed by the Child Behaviour Checklist (CBCL)

The Child Behaviour Checklist was administered as part of the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. (The Mental Health Branch of the then Commonwealth Department of Health and Aged Care commissioned the University of Adelaide to undertake the survey.) The prevalence of mental health problems was based on scores obtained from the scales of the CBCL which was completed by parents. The CBCL scales identify mental health problems in three general areas and eight specific areas.

The three general areas are:

Internalising Problems Scale: inhibited or over-controlled behaviour (e.g., anxiety or depression).

Externalising Problems Scale: antisocial or under-controlled behaviour (e.g., delinquency or aggression).

Total Problems Scale: all mental health problems reported by parents or adolescents.

GLOSSARY *continued*

Mental Health problems assessed by the Child Behaviour Checklist (CBCL) *continued*

The eight specific areas are:

Somatic Complaints Scale: chronic physical complaints without known cause or medically verified basis.

Delinquent Behaviour Scale: breaking rules and norms set by parents and communities (e.g., lying, swearing, stealing or truancy).

Attention Problems Scale: difficulty concentrating and sitting still, and impaired school performance.

Aggressive Behaviour Scale: bullying, teasing, temper tantrums and fighting.

Social Problems Scale: impaired peer relationships.

Withdrawn Scale: shyness and social isolation.

Anxiety/Depression Scale: feelings of loneliness, sadness, being unloved, worthlessness, anxiety and general fears.

Social Problems Scale: strange behaviour or ideas, obsessions (Sawyer et al 2000).

For further information on the Child Behaviour Checklist as collected in the Child and Adolescent Component of the National Survey of Mental Health and Well-being, please refer to the following text:

- Sawyer et al 2000. *The mental health of young people in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Other health professional

Comprises:

- Aboriginal health worker (n.e.c.)
- Accredited counsellor
- Acupuncturist
- Alcohol and other drug worker (n.e.c.)
- Audiologist/audiometrist
- Chemist (for advice)
- Chiropodist/podiatrist
- Chiropractor
- Dietitian/nutritionist
- Herbalist
- Hypnotherapist
- Naturopath
- Nurse
- Occupational therapist
- Optician/optometrist
- Osteopath
- Physiotherapist/hydrotherapist
- Psychologist
- Social worker/welfare officer
- Speech therapist/pathologist

Recent injury event

A recent injury event is an event meeting the following criteria:

- the event was an accident, harmful incident, exposure to harmful factors or other incident
- occurred in the four weeks prior to interview
- resulted in an injury
- resulted in one or more of the following actions being taken:
 - consulting a health professional
 - seeking medical advice
 - receiving medical treatment
 - reducing usual activities
 - other treatment of injury such as taking medications, or using a bandage or band aid or heat or ice pack.

Excluded were food poisoning and minor insect bites (e.g. mosquito bites) regardless of action taken by the respondent (ABS 2003a).

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