Child health

CouncilFest 2015

For a while now the Alliance has held the view that there is a pressing need for the development of a National Rural Child Health Strategy in response to significant health disparities between those living in major cities and those living in rural and remote areas. There is an extensive list of figures pertaining to these later in this paper.

We envision that the Strategy would, through thorough consultation with relevant stakeholders, identify key priorities, develop specific targets (both short- and long-term) and strategies to achieve these targets, and outline performance indicators by which the effectiveness of these strategies will be measured (and by whom).

The Strategy would be cross-sectoral and include a focus on the key social determinants of health in these settings, such as family income levels and access to education, health care, transport and personal support services. The Strategy would see collaboration between relevant government and non-government agencies, and focus on the provision of child-centered early intervention.

NSW Kids and Families are currently working on a National Child and Youth Strategic Framework for Health. It is expected to be released later this year.

"The Framework identifies 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. It will assist in developing national service strategies that delineate roles and responsibilities and set priorities, so that action can be taken where it is most needed and within the context of current policy initiatives."

The draft (available here) is rather brief and light-on in terms of rural-specific content.

There are also some state-based child health strategies already in existence:

- Healthy, Safe and Well: A strategic health plan for children, young people and families of NSW 2014-2024
- Children’s Health Queensland Strategic Plan 2013-2017
- Child Health and Parenting Service Strategic Plan 2009 - 2014 (Tasmania)

To follow is an extensive list of figures which highlight the need for (a) a response and (b) a rural-specific strategy. These are broken down into three dimensions: remoteness, socio-economic status and indigeneity.

**Remoteness-related indicators:**

- Six year olds in *Remote and very remote* areas had more than twice as many teeth with decay as those in *Major cities* (3.6 compared with 1.6).¹
- The proportion of children living in Very remote areas who were developmentally vulnerable was twice that of those living in Major cities (47% and 23%).
- Students in *Remote* and *Very remote* areas were less likely to meet the reading and numeracy minimum standards than those in *Metropolitan* areas— for reading, 47% and 80% of students

respectively, compared with 93% of students in Metropolitan areas. For numeracy, the corresponding proportions were 60% and 87%, compared with 95%.²

- Exposure to tobacco smoke in the home was highest in households with children in Remote and very remote areas (10%) and lowest in households in Major cities (5%).³
- People living in Major cities were less likely to feel (very) safe walking in their local area at night as those living in Inner regional areas of Australia (57% compared with 65%).⁴
- Rural and remote areas have higher birth rates than the Australian average (up to 20% higher in rural areas, and up to 40% higher in very remote areas) and rural women also experience higher rates of maternal, neonatal and foetal death than their urban counterparts.⁵
- In 2005, infant mortality rates were highest in very remote areas (12.2 deaths per 1,000 live births) and lowest in major cities (4.4). Between major cities and remote areas, the difference in rates was 2.0 and between remote and very remote areas, the difference in rates was 5.8.⁶
- Death rates for infants in rural and remote areas are higher than for those infants in metropolitan areas.⁷

SDoH-related indicators:

- In 2009, the proportion of children with severe disability was highest among low-income households (6.5%) and lowest among high-income households (2.7%).⁸
- Babies from the least socioeconomically disadvantaged areas were 1.4 times as likely to be exclusively breastfed to around 4 months (45%) as babies from the most disadvantaged areas (33%).⁹
- Children living in the most socioeconomically disadvantaged areas had more decay than children in areas of least disadvantage (2 and 1.5 times as many decayed teeth, on average, for 6 and 12 year olds, respectively).¹⁰
- The proportion of children living in the most socioeconomically disadvantaged areas who were developmentally vulnerable was twice that of those living in the least disadvantaged areas (32% and 16%).
- Mothers in the most socioeconomically disadvantaged areas were more than 4 times as likely to have smoked in pregnancy as those in the areas of least disadvantage (23% and 5%, respectively).¹¹
- Babies born to mothers living in the most socioeconomically disadvantaged areas were 1.3 times as likely to be of low birthweight as babies born to mothers living in the areas of least disadvantage.¹²
- Children living in the most socioeconomically disadvantaged areas were 1.7 times as likely to be overweight or obese (31%) as those living in the least disadvantaged areas (18%) in 2007-08.¹³
- Children living in the most socioeconomically disadvantaged areas were 4 times as likely as those in the least disadvantaged areas to be exposed to tobacco smoke in the home (12% compared with 3%).¹⁴

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• Students aged 12–14 from the most socioeconomically disadvantaged areas were more likely to be smokers than those from the least socioeconomically disadvantaged areas (5% compared with 3%).

• Similarly, people living in the most socioeconomically disadvantaged areas were less likely to feel (very) safe walking at night than those in the least disadvantaged areas (41% compared with 71%).

Indicators related to Aboriginal and Torres Strait Islander cultural identity (for the sake of brevity, “Indigenous”):

• Indigenous children aged 0–14 are 30% more likely than non-Indigenous children to require assistance with a core activity of self-care, mobility and communication.

• Indigenous babies were half as likely to be exclusively breastfed to around 4 months as non-Indigenous babies (19% compared with 40%).

• Indigenous children were much less likely to be decay-free at age 6 than non-Indigenous children in 2002 (21% compared with 54%); and also less likely at age 12 (48% compared with 60%).

• The proportion of Indigenous children who were developmentally vulnerable on one or more domains was twice that of non-Indigenous children (48% and 22% respectively).

• Indigenous students generally had lower attendance rates than non-Indigenous students, but there were some exceptions. Attendance rates were similar for Indigenous and non-Indigenous students in the Independent school sector in Victoria and in the Catholic and Independent school sectors in Tasmania. The Northern Territory and Western Australia had the largest differences in attendance rates between Indigenous and non-Indigenous students. Attendance rates were 14 to 30 percentage points lower for Indigenous students in the Northern Territory and 12 to 16 points lower in Western Australia.

• Indigenous students were less likely to achieve minimum standards for reading and numeracy (66% and 75% respectively) than non-Indigenous students (93% and 96%). This gap increased with increasing remoteness.

• In 2009, almost half of Indigenous mothers (48%) smoked during pregnancy—3.6 times the rate of non-Indigenous mothers (13%).

• Babies of Indigenous mothers were twice as likely as those born to non-Indigenous mothers to be of low birthweight (12% and 5.9% respectively).

• In 2008, Indigenous children were 3 times as likely to be exposed to tobacco smoke in the home as non-Indigenous children (22% and 7% respectively) based on the 2008 National Aboriginal and Torres Strait Islander Social Survey and the 2007-08 National Health Survey.

• While the proportion of Indigenous students aged 12–15 who were current smokers in 2008 was higher than non-Indigenous students (12% compared with 5%), this has declined from 17% in 2005.

• In 2008, it was estimated that 23% of Indigenous students aged 12–15 had drunk alcohol in the previous week compared with 17% of students overall. The proportion of Indigenous students who had never had a drink was higher than students overall (27% compared with 22%).
• Indigenous children were 8 times as likely as non-Indigenous children to be the subject of substantiated abuse or neglect, and more than 10 times as likely to be on care and protection orders.\textsuperscript{28}

• The rate of Indigenous children accompanying their parent or guardian to a homeless agency was 7 times that for non-Indigenous children under 14 (99 per 1,000 children compared with 14 per 1,000, respectively) in 2010–11.\textsuperscript{29}