Victorian Child Health and Wellbeing Survey

Summary Findings 2017

**CONTENTS**

Background 4

Victorian Child and Adolescent Monitoring System 4

Interpreting VCHWS data 4

Comparing respondents 5

Key statistics 6

Optimal antenatal and infant development 8

Prenatal alcohol exposure 8

Optimal physical health 8

Proportion of children with ‘good health’ 8

Asthma 8

Healthy teeth and gums 9

Oral health status 9

Oral health behaviours 9

Adequate physical activity 9

Physical activity 9

Travelling to school 10

Outdoor spaces 10

Electronic media use 11

Adequate nutrition 11

Fruit and vegetable intake 11

Child development 12

Behavioural difficulties 12

Healthy adult lifestyle 13

Exposure to tobacco smoke 13

Parent promotion of child health and development 13

Reading to children 13

Ability to pay for family essentials 15

Food insecurity 15

Financial insecurity 15

Positive family functioning 16

Family functioning 16

# Background

Victorian Child Health and Wellbeing Survey (VCHWS) collects information about the health and wellbeing of Victorian children. It covers topics including child health, growth, asthma, nutrition (including breastfeeding), oral health, activities, reading, injury, behaviour, family functioning, parental health, parental mental health and health in pregnancy. The survey was first conducted in 2006, and repeated in 2009, 2013 and 2017. This report presents findings from the 2017 survey.

The aims of VCHWS is to:

* provide baseline and ongoing data to support and inform planning, implementation and evaluation of child health, wellbeing, development and learning policies, services and programs throughout Victoria
* enable comparisons of how children are faring over time, in 17 local areas,[[1]](#footnote-2) and in major demographic groups throughout Victoria.

Interviewing for the VCHWS took place between August and November 2017.

Parents completed interviews on behalf of 5,000 randomly selected Victorian children aged 0-12 years.

## Victorian Child and Adolescent Monitoring System

In 2005, the Victorian Government endorsed the Victorian Child and Adolescent Outcomes Framework, comprising 35 outcomes on the health, safety, learning, development and wellbeing of children aged up to 18 years, within an ecological context. The [Victorian Child and Adolescent Monitoring System (VCAMS)](https://www.education.vic.gov.au/about/research/Pages/vcams.aspx) has been established to enable regular monitoring and reporting against this framework to support government and community action. The system is intended to facilitate more informed decision-making across government through better access to validated outcome measures for children and families. Data from the VCHWS is used for these reporting requirements.

## Interpreting VCHWS data

* VCHWS is a cross sectional survey – it is possible to identify associations between variables in the dataset but we cannot attribute cause and effect.
* There are no controls for confounding factors in the analysis – for example, the increased frequency of smoking among those on health care cards and in rural households could be due to socio-economic status or some other variable.
* The estimates provided are based on sample data, and the confidence intervals indicate that there is a 95 per cent probability that the true value lies between the upper and lower limits of the confidence interval. Therefore, if the confidence intervals of two population groups do not overlap, it can be assumed that the true values of the two estimates are unlikely to fall within the same distribution.

## Comparing respondents

The broad characteristics of respondents included in the 2009, 2013 and 2017 surveys were very similar - therefore it has been deemed appropriate to compare results from the surveys (see Table 1).

Table 1. Profile of VCHWS subjects (children aged 0 to 12 years) in the 2006, 2009, 2013 and 2017 surveys

| Selected characteristic | Survey Estimate\* (per cent)2006 | Survey Estimate\* (per cent)2009 | Survey Estimate\* (per cent)2013 | Survey Estimate\* (per cent)2017 |
| --- | --- | --- | --- | --- |
| Sex |
| Male | 51.8 | 51.3 | 51.3 | **51.3** |
| Female | 48.2 | 48.7 | 48.7 | **48.7** |
| Age group |
| < 1 year | 8.0 | 8.0 | 8.2 | **7.5** |
| 1 to 4 years | 31.4 | 30.3 | 31.8 | **31.7** |
| 5 to 8 years | 26.0 | 30.4 | 30.6 | **31.1** |
| 9 to 12 years | 34.7 | 31.3 | 29.3 | **29.7** |
| Area |
| Metropolitan Victoria | 50.4 | 71.1 | 73.7 | **74.9** |
| Rural Victoria | 49.6 | 28.9 | 26.3 | **25.1** |
| Cohort |
| Aboriginal or Torres Strait Islander | 1.5 | 1.4 | 1.3 | **2.2** |

\* Proportions represent demographic splits following the weighting of survey responses.

# Key statistics

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Area** | **2006** | **2009** | **2013** | **2017** | **Cohorts/areas of note (2017)** |
| **Children exposed to alcohol in utero**  | 64.8% | 59.7% | 46.7% | **56.2%** | No significant cohort differences |
| **Children with ‘good, very good or excellent’ health** | 98.0% | 98.5% | 97.9% | **97.3%** | Children from single parent families and those on a health care card were less likely to report good or better general health |
| **Children with current asthma** | 13.2% | 11.2% | 11.3% | **12.1%** | Children from single parent families and those on a health care card were more likely to have current asthma |
| **Children who have had a filling** | 20.0% | 17.5% | 19.5% | **17.7%** | Children from rural areas, children from one parent families and children on a health care card were more likely to have had a filling  |
| **Children aged 5-12 who are active for 60 minutes a day** | 71.2% | 60.3% | 62.2% | **59.4%** | No significant cohort differences |
| **Children aged 5-12 who exceed recommended screen time** | 18.8% | 18.8% | 17.7% | **18.2%** | Children on a health care card were significantly more likely to exceed the recommended screen time than children not on health care card |
| **Proportion of children living in neighbourhoods with good parks, playgrounds and play spaces** | 83.1% | 85.9% | 87.9% | **89.2%** | Children in metropolitan areas, children in couple parent families and children from the most advantaged areas were more likely to live in neighbourhoods with good parks, playgrounds and play spaces |
| **Children meeting fruit intake guidelines\*** | - | - | 73.2% | **76.7%** | Children from single parent families, those on a health care card and younger children (aged 4- 8 years) are more likely to meet fruit intake guidelines |
| **Children meeting vegetable intake guidelines\*** | - | - | 2.9% | **3.8%** | Younger children (aged 4-8) were significantly more likely to have met the fruit intake guidelines than older children (aged 9-12) |
| **Children living in a smoke free home** | 68.1% | 74.8% | 81.5% | **81.9%** | Children in metro areas, children from couple parent families, children from the most advantaged areas and children not on a health care card were more likely to live in a smoke free home |
| **Children under 5 read to every day by a family member** | 69.5% | 74.3% | 69.6% | **68.9%** | Children in rural areas were significantly more likely to be read to by a family member everyday compared to children from metropolitan areas |
| **Proportion of school-aged children (aged 4-12) at low or no risk of behavioural difficulties**  | 83.9% | 83.5% | 86.4% | **81.3%** | Children from couple parent families and children not on a health care card were more likely to be at ‘low’ or ‘no risk’ of behavioural difficulties |
| **Area** | **2006** | **2009** | **2013** | **2017** | **Cohorts/areas of note (2017)** |
| **Children from households reporting running out of food in the last 12 months** | 5.8% | 4.9% | 4.9% | **7.1%** | Children in rural areas, children from one parent families, children from the most disadvantaged areas and children on a health care card significantly more likely come from a household that has experienced food insecurity |
| **Children from households unable to raise $2000 in an emergency** | 12.7% | 11.5% | 12.3% | **11.5%** | Children in rural areas, children from one parent families and children on a health care card were more likely to come from households experiencing financial insecurity |
| **Children from families with unhealthy family functioning** | 8.0% | 6.9% | 7.6% | **8.1%** | Children in one parent families and children on a health care card were more likely live in families with unhealthy family functioning |
| **Proportion of parents rating their health as fair or poor\*\*** | - | - | 8.0% | **9.2%** | Parents in rural areas, single parents, parent from the most disadvantaged areas and parents with a child on a health care card significantly more likely to rate their health as fair or poor |
| **Proportion of families who do not have someone to turn to for advice\*\*** | - | - | 2.4% | **3.3%** | Families with children on a health care card are less likely to have someone to turn to for advice |

\* Guidelines for fruit and vegetable intake changed in 2013, therefore, results from the 2006 and 2009 survey are not comparable to later surveys.

\*\* New measure in 2013.

# Optimal antenatal and infant development

## Prenatal alcohol exposure

In 2017, over half of Victorian mothers (56.2 per cent) recalled drinking at some point during their pregnancy, up from 2013 (46.7 per cent) but similar to 2009 (59.7 per cent) and 2006 (64.8 per cent) levels. Women from more advantaged areas were more likely to drink while pregnant (61.3 per cent in the least disadvantaged quintile compared to 51.8 per cent in the most disadvantaged).

The VCHWS also collected data on whether mothers had “binged” (drinking more than four alcoholic drinks in one day) on alcohol during pregnancy. In 2017, 26.0 per cent of mothers with infants aged under two years recalled binge drinking during their pregnancy. Women were most likely to have binged on alcohol early in their pregnancy, before they were aware of the pregnancy.

# Optimal physical health

## Proportion of children with ‘good health’

Most children (97.3 per cent) were reported to have ‘good health’ or better (on a scale from poor to excellent), similar to previous years’ results. Respondents from one parent families were less likely to rate their child’s health as good, very good or excellent compared to respondents from couple parent families (94.1 per cent compared to 98.0 per cent). Parents of children listed on a health care card were also less likely to rate their child’s health good, very good or excellent (95.4 per cent compared to 98.1 per cent for other children).

Table 2. Proportion of children with good health or better by cohort, 2006 - 2017

| Cohort# | 2006 | 2009 | 2013 | 2017 |
| --- | --- | --- | --- | --- |
| **Victoria** | **98.0%** | **98.5%** | **97.9%** | **97.3%** |
| **Metropolitan** | 98.1% | 98.7% | 98.0% | 97.4% |
| **Rural** | 98.0% | 98.0% | 97.7% | 97.1% |
| **SEIFA IRSED quintile 1** | 98.0% | 98.0% | 96.5% | 98.1% |
| **SEIFA IRSED quintile 5**  | 98.7% | 99.1% | 98.0% | 97.9% |
| **Couple family** | 98.2% | 98.8% | 98.0% | 98.0% |
| **One parent family** | 97.1% | 96.6% | 96.7% | 94.1% |
| **Child on a health care card** | 96.4% | 96.8% | 95.3% | 95.4% |
| **Child not on a health care card** | 98.7% | 99.1% | 98.7% | 98.1% |

# Shaded cells show a significant difference between cohorts

## Asthma

In 2017, 12.1 per cent of Victorian children (aged 1 – 12) reportedly had asthma, similar to previous years. Of those children with current asthma, 67 per cent had an action plan. Children listed on a health care card were more likely to have asthma (16.6 per cent compared to 10.4 per cent). However, there was no significant difference in asthma rates across socio-economic quintiles. Children from one parent families were also more likely to have asthma compared to those from couple parent families (19.1 per cent compared to 10.6 per cent).

# Healthy teeth **and** gums

## Oral health status

The majority of children aged 6 months to 12 years (71.2 per cent) were reported to have excellent or very good oral health, down from 76.2 per cent in 2013 and 77.7 per cent in 2009. In 2017, 17.7 per cent of Victorian children had received a filling. Children in rural Victoria were more likely to have had a filling compared to children in metropolitan Victoria. A small proportion of children had had a tooth extracted (9.3 per cent).

Table 3 Proportion of children who had received a filling, by cohort, 2006-2017

| Cohort# | 2006 | 2009 | 2013 | 2017 |
| --- | --- | --- | --- | --- |
| **Victoria** | 20.0% | 17.5% | 19.5% | 17.7% |
| **Metropolitan** | 18.0% | 15.3% | 17.9% | 16.1% |
| **Rural** | 25.2% | 23.1% | 24.0% | 22.6% |
| **SEIFA IRSED quintile 1** | 23.5% | 18.3% | 23.3% | 20.8% |
| **SEIFA IRSED quintile 5**  | 18.9% | 16.5% | 18.2% | 15.9% |
| **Couple family** | 19.3% | 16.4% | 19.0% | 16.4% |
| **One parent family** | 24.5% | 25.3% | 25.3% | 23.7% |
| **Child on a health care card** | 24.1% | 20.6% | 21.2% | 22.3% |
| **Child not on a health care card** | 18.5% | 16.4% | 19.0% | 16.2% |

# Shaded cells show a significant difference between cohorts

## Oral health behaviours

Most children aged 8 to 12 years were reported to brush their teeth at least twice a day (64.7 per cent, down from 70.7 per cent in 2013).

Parents with children aged under 8 years are advised to assist with tooth brushing as young children lack the manual dexterity to brush their teeth effectively[[2]](#footnote-3). Most parents reported assisting their child to brush their teeth either once a day (37.7 per cent) or twice a day or more (36.7 per cent). Approximately 15 per cent of children had a parent or carer who reported never assisting their child with tooth cleaning.

# Adequate physical activity

## Physical activity

In 2017, more than one in two children aged 5 to 12 years (59.4 per cent) were reported to be physically active for at least 60 minutes every day.[[3]](#footnote-4) This is down from 71.2 per cent in 2006, but similar to 2009 and 2013 levels (60.3 per cent and 62.2 per cent respectively). A similar proportion of girls and boys met the physical activity guidelines (58.3 per cent and 60.4 per cent).

Unlike previous years, in 2017 there was no significant difference between metropolitan and rural areas in the proportion of children meeting physical activity guidelines.

Figure 1 Proportion of children who are active at least 60 minutes a day, by age, Victoria, 2017

Table 4. Proportion of students who are physically active for at least 60 minutes by number of days they are active and age

|  |  |
| --- | --- |
| **Child’s age** | **Number of days physically active for at least 60 minutes** |
| **No days** | **1 day** | **2 days** | **3 days** | **4 days** | **5 to 6 days** | **Everyday** |
| **All** | 0.3% | 2.4% | 3.9% | 7.7% | 9.0% | 16.7% | 60.0% |
| **5 yrs** | 0.2% | 1.0% | 1.9% | 3.3% | 5.8% | 18.1% | 69.7% |
| **6 yrs** | 0.2% | 2.4% | 0.7% | 4.8% | 9.7% | 8.1% | 74.2% |
| **7 yrs** | 0.4% | 1.7% | 3.3% | 5.3% | 8.1% | 14.9% | 66.4% |
| **8 yrs** | 0.0% | 4.2% | 7.5% | 6.8% | 7.1% | 23.0% | 51.4% |
| **9 yrs** | 0.1% | 3.0% | 1.9% | 5.4% | 8.9% | 17.0% | 63.7% |
| **10 yrs** | 0.1% | 0.8% | 3.6% | 12.3% | 13.1% | 17.2% | 53.0% |
| **11 yrs** | 1.1% | 5.3% | 4.1% | 11.1% | 12.5% | 18.5% | 47.3% |
| **12 yrs** | 0.6% | 0.9% | 10.0% | 14.8% | 6.0% | 18.1% | 49.6% |

## Travelling to school

The most common method of travelling to school was by car. On average, Victorian children made 7.1 trips to school by car (out of a possible 10 trips) in a usual week, compared to just 1.7 trips on foot. For children living within 2km of their school, the car was still the predominant method of transport. On average, these children made 6.0 trips to school by car in a usual week compared to 3.0 trips on foot. Trips to school made by bike or public transport were relatively uncommon.

## Outdoor spaces

Promisingly, the proportion of children with access to good outdoor play spaces has been steadily increasing since 2006. In 2017, 89.2 per cent of respondents agreed that the neighbourhood they lived in had good parks, playgrounds and play spaces. However, there were significant differences between cohorts. Respondents in metropolitan Victoria (92.7 per cent) were significantly more likely to live in areas with good outdoor spaces than those living in rural Victoria (78.6 per cent). Respondents in the least disadvantaged areas (96.2 per cent) were significantly more likely to live in areas with good outdoor spaces than those in the most disadvantaged areas (75.7 per cent). Respondents from couple parent families (90.0 per cent) were significantly more likely to live in areas with good outdoor spaces than those from single parent families (85.0 per cent).

Figure 2 Proportion of children living in neighbourhoods with good parks, playgrounds and play spaces, Victoria, 2006 - 2017

## Electronic media use

Inactivity was monitored by asking parents to report on their child’s use of electronic media (including screen time spent in front of computers, television, DVDs, etc). The National Sedentary Behaviour Guidelines[[4]](#footnote-5) recommend children should not exceed more than two hours with electronic media each day. In 2017, 18.2 per cent of Victorian children reportedly exceeded the recommended screen time, similar to previous years. Children listed on a health care card were significantly more likely to exceed recommended screen time than those not listed on a health care card (24.6 per cent compared to 15.7 per cent).

# Adequate nutrition

## Fruit and vegetable intake[[5]](#footnote-6)

In 2017, the majority of Victorian children (76.7 per cent) aged 4 to 12 years met the national recommendations for the minimum daily intake of fruit (excluding fruit juice). However, only a small proportion of children met the minimum daily intake for vegetables (3.8 per cent).

Table 5 Proportion of children meeting the minimum daily intake for fruit and vegetables, 2013 and 2017

| Cohort # | Fruit | Vegetables |
| --- | --- | --- |
| **2013** | **2017** | **2013** | **2017** |
| **Victoria** | 73.2% | 76.7% | 2.9% | 3.8% |
| **Metropolitan** | 72.0% | 77.0% | 2.8% | 3.6% |
| **Rural** | 76.2% | 75.9% | 3.1% | 4.3% |
| **SEIFA IRSED quintile 1** | 70.1% | 72.6% | 2.4% | 3.5% |
| **SEIFA IRSED quintile 5**  | 73.5% | 78.0% | 2.7% | 2.7% |
| **Couple family** | 73.8% | 78.0% | 2.8% | 3.2% |
| **One parent family** | 68.6% | 72.1% | 3.8% | 5.9% |
| **Child on a health care card** | 69.6% | 74.2% | 2.7% | 4.5% |
| **Child not on a health care card** | 74.5% | 77.9% | 3.0% | 3.4% |
| **Children aged 4 to 8 years** | 77.4% | 81.3% | 2.5% | 3.8% |
| **Children aged 9 to 12 years** | 67.5% | 70.7% | 3.4% | 3.7% |

# Shaded cells show a significant difference between cohorts

# Child development

## Behavioural difficulties

In 2017, the majority of school-aged children (aged 4-12 years) were at low or no risk of behavioural difficulties (81 per cent), down slightly from 2013 (86 per cent). Children from one parent families and children on a health care card were significantly less likely to be at low or no risk.

Table 6 proportion of children (aged 4-12 years) at ‘low’ or ‘no risk’ of behavioural difficulties, by cohort, 2006-2017

| Cohort# | 2006 | 2009 | 2013 | 2017 |
| --- | --- | --- | --- | --- |
| **Victoria** | 83.9% | 83.5% | 86.4% | 81.3% |
| **Metropolitan** | 84.2% | 83.6% | 86.8% | 82.7% |
| **Rural** | 83.4% | 83.2% | 85.3% | 77.6% |
| **SEIFA IRSED quintile 1** | 77.0% | 75.3% | 82.9% | 70.4% |
| **SEIFA IRSED quintile 5** | 89.5% | 85.0% | 90.5% | 84.2% |
| **Couple family** | 85.9% | 84.9% | 87.9% | 83.7% |
| **One parent family** | 74.5% | 75.1% | 74.9% | 72.2% |
| **Child on a health care card** | 73.9% | 72.9% | 74.1% | 66.9% |
| **Child not on a health care card** | 88.1% | 87.6% | 90.7% | 87.0% |

# Shaded cells show a significant difference between cohorts

# Healthy adult lifestyle

## Exposure to tobacco smoke

The majority of Victorian children live in smoke free households. In 2017, 81.9 per cent of children aged under 13 years were reported to live in a smoke free household (a household where no adult was reported to be a smoker). This is in line with 2013 results (81.5 per cent) and up significantly from 2009 and 2006 results (74.8 per cent and 68.1 per cent respectively).

Children living in metropolitan Victoria, children living in one parent families and those listed as dependents on Health Care Cards were more likely to live with a smoker.

Figure 3 Proportion of children living in a smoke free home, Victoria, 2006 – 2017

*Error bars show 95% confidence intervals*

# Parent promotion of child health and development

## Reading to children

The frequency of reading to children at a young age has a direct causal effect on their schooling outcomes regardless of their family background and home environment.[[6]](#footnote-7) In 2017, 69 per cent of children aged 0 to 5 years were read to by a family member on a daily basis. This was similar to the proportion of children who were read to on a daily basis in 2013 (70 per cent). In 2017, children from rural Victoria were more likely to have been read to by a family member every day than children from metropolitan Victoria (75.8 per cent compared to 66.8 per cent).

Over half of parents read to children aged 6 to 11 months in 2017 (59.2 per cent), and this proportion rose to 67.5 per cent for 1 year olds. Reading to children peaked at 75.6 per cent for 2 year olds (see Figure 4), then declined slightly though the preschool years, followed by a steep drop as children move through school.

On average, children aged 5 to 12 years of age read to themselves for pleasure for an estimated 4.9 hours a week.

Most children (75.2 per cent) are from households that had more than 30 books (including library books) in the home at the time of the survey.

Figure 4 Proportion of children read to every day by a family member, by age, Victoria, 2017

|  |  |
| --- | --- |
| **Child’s age** | **Number of days read to by a family member** |
| **1 or 2 days** | **3 to 5 days** | **6 or 7 days** | **Not at all** |
| **6 months** | 28.7% | 10.3% | 53.6% | 7.5% |
| **7 months** | 12.7% | 26.9% | 43.3% | 17.1% |
| **8 months** | 24.0% | 0.2% | 75.6% | 0.2% |
| **9 months** | 7.7% | 3.8% | 81.1% | 7.5% |
| **10 months** | 23.0% | 24.7% | 52.3% | 0.0% |
| **11 months** | 25.5% | 11.9% | 50.9% | 11.7% |
| **1 years** | 10.5% | 18.6% | 68.0% | 2.9% |
| **2 years** | 7.3% | 14.3% | 76.3% | 2.2% |
| **3 years** | 10.1% | 19.9% | 69.8% | 0.3% |
| **4 years** | 7.9% | 23.2% | 68.1% | 0.8% |
| **5 years** | 12.5% | 23.5% | 63.1% | 1.0% |
| **6 years** | 8.7% | 24.9% | 58.9% | 7.6% |
| **7 years** | 20.4% | 26.1% | 41.9% | 11.6% |
| **8 years** | 20.6% | 19.3% | 31.0% | 29.2% |
| **9 years** | 22.2% | 20.5% | 15.5% | 41.8% |
| **10 years** | 21.1% | 15.8% | 8.3% | 54.8% |
| **11 years** | 21.7% | 8.7% | 7.6% | 62.0% |
| **12 years** | 20.6% | 2.8% | 1.2% | 75.5% |

# Ability to pay for family essentials

## Food insecurity

In 2017, 7.1 per cent children aged 0 to 12 years came from a household where the main carer reported that there had been a time in the last 12 months when they had run out of food and had not been able to afford to buy more (i.e. experienced ‘food insecurity’). Similar to previous years, one parent families and families from the most disadvantaged areas were more likely to experience food insecurity. In 2017, for the first time since the survey began, families from rural Victoria were significantly more likely to experience food insecurity compared to families in metropolitan Victoria.

Table 7. Proportion of respondents who report experiencing food insecurity in the past 12 months, by cohort, 2006 - 2017

| Cohort# | 2006 | 2009 | 2013 | 2017 |
| --- | --- | --- | --- | --- |
| **Victoria** | 5.8% | 11.5% | 4.9% | 7.1% |
| **Metropolitan** | 5.6% | 11.0% | 4.8% | 6.2% |
| **Rural** | 6.3% | 12.8% | 5.4% | 9.7% |
| **SEIFA IRSED quintile 1** | 9.2% | 21.2% | 9.6% | 13.5% |
| **SEIFA IRSED quintile 5** | 2.9% | 5.2% | 2.3% | 2.7% |
| **Couple family** | 3.5% | 8.8% | 3.5% | 4.2% |
| **One parent family** | 19.7% | 31.3% | 18.7% | 21.3% |
| **Child on a health care card** | 15.5% | 26.3% | 13.8% | 18.7% |
| **Child not on a health care card** | 2.1% | 6.3% | 2.2% | 3.3% |

# Shaded cells show a significant difference between cohorts

## Financial insecurity

In 2017, 11.5 per cent of children were from households where the main carer reported that they would not be able to raise $2000 in an emergency (experiencing financial insecurity), similar to the 2013 result (12.3 per cent).

Similar to previous years, one parent families and those from disadvantaged areas were more likely to report financial insecurity. Unlike previous years, there was a significant difference in the proportion of families experiencing financial insecurity between metropolitan and rural Victoria (9.9 per cent compared to 16.2 per cent).

Table 8. Proportion of respondents who report experiencing financial insecurity in the past 12 months, by cohort, 2006 - 2017

| Cohort | 2006 | 2009 | 2013 | 2017 |
| --- | --- | --- | --- | --- |
| **Victoria** | 12.7% | 11.5% | 12.3% | 11.5% |
| **Metropolitan** | 12.3% | 11.0% | 12.5% | 9.9% |
| **Rural** | 13.7% | 12.8% | 11.6% | 16.2% |
| **SEIFA IRSED quintile 1** | 21.9% | 21.2% | 19.6% | 25.6% |
| **SEIFA IRSED quintile 5**  | 6.9% | 5.2% | 6.5% | 4.2% |
| **Couple family** | 9.4% | 8.8% | 10.2% | 8.7% |
| **One parent family** | 32.4% | 31.3% | 32.5% | 25.2% |
| **Child on a health care card** | 27.4% | 26.3% | 27.9% | 25.2% |
| **Child not on a health care card** | 7.2% | 6.3% | 7.2% | 7.0% |

# Shaded cells show a significant difference between cohorts

# Positive family functioning

## Family functioning

Family functioning was assessed using the General Functioning Scale of the McMaster Family Assessment Device. In 2017, 8.1 per cent of Victorian children were from families classified as having unhealthy family functioning, similar to previous years. One parent families were also more likely to report unhealthy functioning (15.5 per cent) compared to couple parent families (6.6 per cent). Those listed as dependents on Health Care Cards were also more likely to show unhealthy functioning (18.7 per cent compared to 3.3 per cent of those not on a health care card).

In 2017, a small proportion of families (3.3 per cent) indicated that they did not have someone to turn to for advice when having problems, similar to the 2013 result (2.4 per cent). There were no significant differences between cohorts.

**PARENTAL HEALTH**

Most parents rate their health as good or better, with only a small proportion (9.2 per cent) rating their health as ‘poor’ or ‘fair’. This is similar to the 2013 result (8.0 per cent). Parents in single parent families, with children on a health care card, living in rural areas and living in disadvantaged areas were less likely to report being in good health.

Within the VCHWS, the child’s main carer was invited to complete the Kessler 6, a tool to identify adults at risk of mental health problems. In the 2017 survey, a small minority (4.6 per cent) of children had parents who were classified as being at risk of mental health problems. Single parents were significantly more likely to be classified as at risk (10 per cent compared to 3 per cent of parents in couple families), as were parents of children on health care cards (8 per cent compared to 3 per cent for parents with children not on health care cards).

1. [DHHS Area Maps](https://www.dhhs.vic.gov.au/sites/default/files/documents/201610/DHS_Victoria_Map_Areas-LGAs_0.pdf) [↑](#footnote-ref-2)
2. (Dental Health Services Victoria [General Dental advice for Children](https://www.dhsv.org.au/dental-advice/general-dental-advice/children)). [↑](#footnote-ref-3)
3. Note this measure is different from the Education State Physical Activity Target, which looks at the proportion of students doing physical activity for an hour a day and is measured through the Victorian Student Health and Wellbeing Survey. [↑](#footnote-ref-4)
4. Australian Government Department of Health (2014). National Physical Activity and Sedentary Behaviour Guidelines (2014) [↑](#footnote-ref-5)
5. A copy of the Australian dietary guidelines is available here: <https://www.eatforhealth.gov.au/guidelines>. [↑](#footnote-ref-6)
6. Kalb, G. and van Ours, J.C. (2013) Reading to young children: a head-start in life? *Economics of Education* (40). DOI: [10.2139/ssrn.2267795](http://dx.doi.org/10.2139/ssrn.2267795). [↑](#footnote-ref-7)