Victorian public health and wellbeing outcomes framework data dictionary

VICTORIA State Government | Health and Human Services

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Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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Abbreviations

AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ABS	Australian Bureau of Statistics
ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of sexually transmitted infections and blood borne viruses
ACIR	Australian Childhood Immunisation Register
AEDC	Australian Early Development Census
AHS	Australian Health Survey
AIHW	Australian Institute of Health and Welfare
ARIA	Accessibility/Remoteness Index of Australia
ASSAD	Australian School Students Alcohol and Drug Survey
CALD	Culturally and linguistically diverse
CCV	Cancer Council Victoria
COAG	Council of Australian Governments
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DEDJTR	Department of Economic Development, Jobs, Transport and Resources (Victorian Government)
DELWP	Department of Environment, Land, Water and Planning (Victorian Government)
DET	Department of Education and Training (Victorian Government)
DHHS	Department of Health and Human Services (Victorian Government)
GSS	General Social Survey
HBSC	Healthy Behaviour in School-age Children
HILDA	Household Income and Labour Dynamics in Australia Survey
HPV	Human papilloma virus
ICD	International Classification of Diseases
IRSD	Index of relative socioeconomic disadvantage
LEAP	Law Enforcement Assistance Program
LBOTE	Language background other than English
LGA	Local government area
LSAC	Longitudinal Study of Australian Children
NAPLAN	National Assessment Program – Literacy and Numeracy
NaSSDA	National Secondary Students' Diet and Activity Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey

NDSHS	National Drug Strategy Household Survey
NDSS	Notifiable Disease Surveillance System
NHMD	National Hospital Morbidity Database
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NNDSS	National Notifiable Disease Surveillance System
NPDC	National Perinatal Data Collection
MCHC	Maternal and Child Health Collection
PHESS	Public Health Event Surveillance System
ROGS	Report on Government Services
SEIFA	Socioeconomic indexes for areas
SF36	Short Form health survey
SFO	Student family occupation
STI	Sexually transmissible infection
TBD	To be determined
VAED	Victorian Admitted Episodes Dataset
VCHWS	Victorian Child Health and Wellbeing Survey
VHISS	Victorian Health Information Surveillance System
VISTA	Victorian Integrated Survey of Travel and Activity
VPDC	Victorian Perinatal Data Collection
VPHS	Victorian Population Health Survey
WHO	World Health Organization

Purpose

The *Victorian public health and wellbeing outcomes framework* provides a transparent approach to monitoring and reporting progress in our collective efforts to achieve better health and wellbeing. Over 30 data sources are identified to monitor health and wellbeing outcomes for all Victorians and to assess inequalities for specific populations and locations. This data dictionary provides detailed technical specifications for every measure identified in the outcomes framework, specifically:

- rationale for inclusion
- definition of the measure (including numerator, denominator and mode of reporting)
- data source(s) and availability (including baseline year)
- what data breakdowns are available from each data source
- comparability with other state, national or international data
- links with other measures in the outcomes framework
- further information (where relevant).

The outcomes framework will be regularly reviewed to ensure the inclusion of: new relevant measures, anticipated measures (such as liveability and the family violence index); and to replace measures should survey data availability change over time. Changes in the outcomes framework will require updates to the data dictionary.

Measuring inequalities

Monitoring the health and wellbeing of a population is not complete without measuring and reporting on inequalities within the population. The outcomes framework outlines the population groups and geographic 'breakdowns' that we are interested in monitoring:

- age
- sex
- Aboriginal and Torres Strait Islander Victorians
- cultural and linguistic diversity
- sexual orientation and gender identity (LGBTI)
- socioeconomic status
- disability/special health care needs
- mental health/psychological distress
- chronic/long-term conditions
- geography (metropolitan/rural and/or local government level).

A national standard for the measurement of some of these 'breakdowns' exists and for others, there is no agreed measurement standard or definition. Therefore, different data sources may measure the same characteristic differently. For example, socioeconomic status can be measured in a variety of ways and different surveys use different measures – the Victorian Population Health Survey (VPHS) uses household income while the Victorian Child Health and Wellbeing Survey (VCHWS) uses the area-based index of relative socioeconomic disadvantage (IRSD).

To provide a comprehensive picture of health and wellbeing, reporting against this outcomes framework requires some measures to be assessed using different definitions of population or area characteristics. Multiple data sources may be needed to inform a single measure to provide analysis of multiple inequalities. These multiple data sources are listed in the data dictionary as primary, secondary and tertiary sources. The specific way any characteristic is measured is available from the data owner.

Reporting against the outcomes framework will be affected should any changes occur to or within data sources.

Domain 1: Victorians are healthy and well

Outcome 1.1: Victorians have good physical health

Indicator 1.1.1: Increase healthy start in life

Measure	Death rate of children under 5 years	
Rationale	Improving health and wellbeing for all Victorians begins with starting well in life. Reducing the risk of infant and child mortality, through prevention and early intervention, improves life chances and health and wellbeing outcomes for both the mother and the child.	
Measure detail	**1.1.1.1**	**Death rate of children under 5 years**
Target	Not set	
Definition	*Numerator:*	Number of deaths due to all causes of residents aged 0–4 years, registered in the respective calendar year
	Denominator:	Mid-year population estimate aged 0–4 years (Source–ABS)
	Mode:	Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:*	Causes of Death ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2006–2010 (5-year average)
	Frequency:	Annual (rolling 5-year average)
Breakdown	Data available for the state by sex and socioeconomic indexes for areas (SEIFA - Index of relative socioeconomic disadvantage (IRSD)), and by metropolitan/rural and regions. Data may be available for Aboriginal Victorians in future if data quality improves sufficiently. When data becomes available the measure can be reported based on five years of data.	
Comparability	National, state and territory rates available annually from Causes of Death ABS. International rates available for some years. Measure included in the National Healthcare Agreement, and reported in Report on Government Services (ROGS) from the Causes of Death ABS.	
Linked to	Death rate for injury in children and young people (Measure detail 1.1.5.3)	
Further information	In 2008 Council of Australian Governments (COAG) set the target of halving the gap in death rates of children under 5 years between Aboriginal and Torres Strait Islander Australians and other Australians within a generation (by 2031).	

Measure	**Proportion of babies born of low birth weight**	
Rationale	Low birth weight is a key measure of infant health and a principal determinant of a baby's chance of prospective survival, good health, development and wellbeing. Low birth weight babies have a greater risk of poor health and dying and are more likely to develop chronic diseases later in life.	
Measure detail	**1.1.1.2**	**Proportion of babies born of low birth weight**
Target	Not set	
Definition	*Numerator:*	Number of live births of birth weight less than 2500 grams, excluding multiple births, registered in the respective calendar year
	Denominator:	Number of live births, excluding multiple births (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	Victorian Perinatal Data Collection (VPDC) DHHS
	Alternatives:	National Perinatal Data Collection (NPDC) Australian Institute of Health and Welfare (AIHW)
Data availability	*Baseline year:*	2011
	Frequency:	Annual
Breakdown	Data available annually for the state by Aboriginal Victorians, and by metropolitan/ rural.	
Comparability	National, state and territory rates available annually from NPDC. International rates available for some years. Included in the National Healthcare Agreement, sourced from the NPDC AIHW, and reported in ROGS.	
Linked to	Nil	
Further information	Nil.	

Measure	Proportion of mothers who smoked tobacco in the first 20 weeks of pregnancy	
Rationale	Smoking during pregnancy can cause serious pregnancy-related health problems including: complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. Smoking during pregnancy is the most important modifiable determinant of low birth weight and infant mortality.	
Measure detail	**1.1.1.3**	**Proportion of mothers who smoked tobacco in the first 20 weeks of pregnancy**
Target	Not set	
Definition	*Numerator:*	Number of women who smoked at any time during the first 20 weeks of pregnancy, of births registered in the respective calendar year. This includes women who quit smoking after becoming pregnant and before 20 weeks of pregnancy, or continued smoking up to 20 weeks of pregnancy.
	Denominator:	Number of women who gave birth with known smoking status during pregnancy, in the respective calendar year
	Mode:	Proportion
Data source	*Baseline and future:*	VPDC DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2011
	Frequency:	Annual
Breakdown	Data available annually for the state by Aboriginal Victorians, and by metropolitan/ rural and regions.	
Comparability	National, state and territory rates available from NPDC.	
Linked to	Proportion of babies born of low birth weight (Measure detail 1.1.1.2) Proportion of adults and adolescents who smoke (Measure detail 1.3.3.1.A–B)	
Further information	Nil.	

Measure	Proportion of children exposed to alcohol in utero	
Rationale	Maternal alcohol consumption can disrupt foetal development at any stage during a pregnancy, including at the earliest stages before a woman knows she is pregnant. Binge drinking, which for women is defined as consuming four or more drinks per occasion, and regular heavy drinking, places a foetus at the greatest risk for severe problems. There is no known safe level of alcohol consumption during pregnancy.	
Measure detail	**1.1.1.4**	**Proportion of children exposed to alcohol in utero**
Target	Not set	
Definition	*Numerator:*	Number of biological mothers of children aged less than 2 years who report ever drinking alcohol during the pregnancy of that child
	Denominator:	Total number of children aged less than 2 years where respondent is their biological mother, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	Baseline and future:	VCHWS DET
	Alternatives:	Australian longitudinal study on women's health
Data availability	*Baseline year:*	2013
	Frequency:	Triennial
Breakdown	Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs, and by metropolitan/rural and regions (custom request to DET).	
Comparability	Limited comparability, mostly based on research studies.	
Linked to	Proportion of adults and adolescents who consume excess alcohol (Measure detail 1.3.4.1.A–C)	
Further information	According to the 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol,* the safest option for women who are planning a pregnancy, pregnant, or who are breastfeeding, is to not drink alcohol. From 2017, the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.	

Indicator 1.1.2: Reduce premature death

Measure	Premature death rate	
Rationale	Assessment of premature death is a measure of the health of a population. This measure has been used nationally and internationally for decades. A death before the age of 75 years is an arbitrary limit to life used to monitor premature death across Australia. Premature deaths can be reduced through prevention, early diagnosis and treatment of disease.	
Measure detail	**1.1.2.1**	**Premature death rate**
Target	Not set	
Definition	*Numerator:*	Number of deaths due to all causes of residents before the age of 75 years, registered in the respective calendar year
	Denominator:	Mid-year population estimate aged less than 75 years (Source–ABS)
	Mode:	Direct age standardised rate per 100,000 population, standardised to the 2011 population of Australia
Data source	*Baseline and future:*	Causes of Death ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2010 or 2006–2010 (five year average)
	Frequency:	Annual (single year and rolling 5-year average, depending on breakdown)
Breakdown	Data available for SEIFA (IRSD), and by metropolitan/rural and regions for single years and by LGA using rolling 5-year averages. Data may be available for Aboriginal Victorians in future if completeness of identification improves sufficiently. When available the measure would be reported based on rolling 5-year averages.	
Comparability	National, state and territory rates available annually from Causes of Death ABS. Limited international rates available for some years.	
Linked to	Premature death rate due to chronic diseases (Measure detail 1.1.2.2.A–E) Inequality of premature death rate (Measure detail 1.1.2.3.A–C)	
Further information	Nil.	

Measure	**Premature death rate due to chronic diseases**
Rationale	Chronic diseases are the largest cause of premature death and ill health in Victoria, as well as the largest cause of the difference in health between population groups and geographic areas. Cancer, cardiovascular disease, diabetes and chronic respiratory disease are the main preventable causes of premature death. The four lifestyle behaviours of poor nutrition, physical inactivity, smoking and excess alcohol are important risk factors for these chronic diseases.
Measure detail	This measure includes five measure details, one included in this section: **1.1.2.2.A** **Premature death rate due to cancer, cardiovascular disease, diabetes and chronic respiratory disease**
Target	25 per cent decrease in premature deaths due to chronic disease by 2025 (Measure 1.1.2.2.A)
Definition	*Numerator:* Number of deaths of residents before age of 75 years, where the underlying cause was recorded as International Classification of Diseases (ICD)-10 codes below, registered in the respective calendar year *ICD–10 codes* — *Condition group* C00–C97 — Cancer I00–I99 — Circulatory disease E10–E14 — Diabetes J30–J98 — Chronic respiratory disease *Denominator:* Mid-year population estimate aged less than 75 years (Source–ABS) *Mode:* Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:* Causes of Death ABS *Alternatives:* Nil
Data availability	*Baseline year:* 2010 or 2006–2010 (5-year average) *Frequency:* Annual (single year and rolling 5-year average, depending on breakdown)
Breakdown	Data available for the state by age, sex and SEIFA (IRSD), and by metropolitan/rural and regions for single years and by LGA using rolling 5-year pooled data. Data may be available for Aboriginal Victorians in future if data quality improves sufficiently. When available, measure can be reported by rolling 5-year average.
Comparability	National, state and territory rates available for some years from Causes of Death ABS.
Linked to	Premature death rate (Measure detail 1.1.2.1) Inequality of premature death rates (Measure detail 1.1.2.3.A–C)
Further information	The World Health Organization (WHO) has set a 25 per cent target for decreasing the premature death rate due to chronic disease by 2025 from a 2010 baseline. The target is for the age group 30–70 years for the ICD codes specified above. For international comparison, this Measure detail 1.1.2.2.A will also be reported at state level for this age group. When deaths are reported by the underlying cause of death only, the involvement of certain diseases in overall mortality may be underestimated. This is particularly evident for diabetes and chronic obstructive pulmonary disease (COPD) (included in chronic respiratory disease).

Measure	Premature death rate due to chronic diseases
Rationale	Cardiovascular disease (CVD) is the largest cause of premature death in Victoria. The major, preventable risk factors for CVD are smoking, high blood pressure, high blood cholesterol, insufficient physical activity, overweight and obesity, poor nutrition, and diabetes. More than 80 per cent of the burden of disease of coronary heart disease and stroke are due to modifiable risk factors, hence inclusion of the measure details of these diseases in this outcomes framework.
Measure detail	This measure includes five measure details, three included in this section: **1.1.2.2.B** **Premature death rate due to circulatory diseases** **1.1.2.2.C** **Premature death rate due to coronary heart disease** **1.1.2.2.D** **Premature death rate due to stroke**
Target	Not set
Definition	**Measure 1.1.2.2.B** *Numerator:* Number of deaths of residents before age of 75 years, where the underlying cause was recorded as ICD–10 code I00–I99, registered in the respective calendar year **Measure 1.1.2.2.C** *Numerator:* Number of deaths of residents before age of 75 years, where the underlying cause was recorded as ICD–10 code I20–I25, registered in the respective calendar year **Measure 1.1.2.2.D** *Numerator:* Number of deaths of residents before age of 75 years, where the underlying cause was recorded as ICD–10 code I60–I69, registered in the respective calendar year **For all measures:** *Denominator:* Mid-year population estimate aged less than 75 years (Source–ABS) *Mode:* Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:* Causes of Death ABS *Alternatives:* Nil
Data availability	*Baseline year:* 2010 or 2006–2010 (5-year average) *Frequency:* Annual (single year and rolling 5-year average, depending on breakdown)
Breakdown	Data available for the state by age, sex, metropolitan/rural and SEIFA (IRSD) and by regions for single years; and by LGA using rolling 5-year pooled data for Measure detail 1.1.2.2.B. Data may be available for Aboriginal Victorians in future if data quality improves sufficiently. When available, Measure detail 1.1.2.2.B can be reported by rolling 5-year average.
Comparability	Some state and territory rates may be available from Causes of Death ABS. ROGS annually reports death rate due to circulatory disease for all ages from Causes of Death ABS not premature death as per Measure detail 1.1.2.2.B.

Measure	Premature death rate due to chronic diseases
Linked to	Premature death rate due to chronic diseases (Measure detail 1.1.2.2.A) Prevalence rate of type 2 diabetes in adults (Measure detail 1.1.3.1) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F) Proportion of adults and adolescents who smoke (1.3.3.1.A–B)
Further information	Nil.

Measure	**Premature death rate due to chronic diseases**	
Rationale	Cancer is the largest cause of death in Victoria. More than one-third of the burden of premature death and ill health caused by cancer is due to modifiable risk factors, particularly smoking, poor nutrition and physical inactivity.	
Measure detail	This measure includes five measure details, one included in this section: **1.1.2.2.E**	**Premature death rate due to cancer**
Target	Not set	
Definition	*Numerator:* *Denominator:* *Mode:*	Number of deaths of residents before age of 75 years, where the underlying cause was recorded as ICD–10 code C00–C97, registered in the respective calendar year Mid-year population estimate aged less than 75 years (Source–ABS) Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:* *Alternatives:*	Causes of Death ABS Cancer Council Victoria (CCV)
Data availability	*Baseline year:* *Frequency:*	2010 or 2006–2010 (5-year average) Annual (single year and rolling 5-year average, depending on breakdown)
Breakdown	Data available for the state by age, sex, metropolitan/rural and SEIFA (IRSD), and by regions for single years and LGA using rolling 5-year pooled data. Data may be available for Aboriginal Victorians in future if data quality improves sufficiently. When available, the measure can be reported by rolling 5-year average.	
Comparability	Some state and territory rates may be available from Causes of Death ABS. ROGS annually reports death due to cancer for all ages, not premature death.	
Linked to	Premature death rate due to chronic diseases (Measure detail 1.1.2.2.A)	
Further information	Nil.	

Measure	Inequality of premature death rates
Rationale	This is the only measure in the outcomes framework that is explicitly a heath inequalities measure. It shows health inequalities across Victoria as a whole and within local areas, enabling a focus on small areas of disadvantage that exist everywhere, as well as areas where the whole LGA has comparatively poor average health status. In addition, this measure can report on premature death inequalities of Aboriginal Victorians across the state.
Measure detail	This measure includes three measure details: **1.1.2.3.A** **Rate ratio of premature death between socioeconomic disadvantage quintiles** **1.1.2.3.B** **Rate ratio of premature death between Aboriginal and non-Aboriginal Victorians** **1.1.2.3.C** **Rate ratio of premature death between local government areas**
Target	Not set
Definition	**Measure 1.1.2.3.A:** *Numerator:* Rate of deaths due to all causes before age 75 years for residents of each SEIFA IRSD quintile except the least disadvantaged quintile, registered in the respective calendar year *Denominator:* Rate of deaths due to all causes before age of 75 years for residents of the least disadvantaged SEIFA IRSD quintile, registered in the respective calendar year **Measure 1.1.2.3.B:** *Numerator:* Rate of deaths due to all causes before the age of 75 years for Aboriginal Victorians, registered in the respective calendar year *Denominator:* Rate of deaths due to all causes before age of 75 years for non-Aboriginal Victorians, registered in the respective calendar year **Measure 1.1.2.3.C:** *Numerator:* Rate of deaths due to all causes before age of 75 years for residents of each LGA except the LGA with the statistically lowest rate, registered in the respective calendar year *Denominator:* Rate of deaths due to all causes before age of 75 years for residents of the LGA with the statistically lowest rate, registered in the respective calendar year **For all measures:** *Mode:* Ratio of age-standardised rate per 100,000 population, standardised to the 2011 population of Australia
Data source	*Baseline and future:* Causes of Death ABS *Alternatives:* Nil

Measure	Inequality of premature death rates
Data availability	**Measure 1.1.2.3.A:** *Baseline year:* 2010 *Frequency:* Annual **Measure 1.1.2.3.B:** Data for Aboriginal Victorians is of insufficient quality to robustly report. When available the measure would be reported based on rolling 5-year averages **Measure 1.1.2.3.C:** *Baseline year:* 2006–2010 (5-year average) *Frequency:* Annual (rolling 5-year average)
Breakdown	**Measure 1.1.2.3.A:** Data available by sex, metropolitan/rural and regions. **Measure 1.1.2.3.B:** TBD. **Measure 1.1.2.3.C:** Nil.
Comparability	National, state and territory comparability not available.
Linked to	Premature death rate (Measure detail 1.1.2.1)
Further information	Nil.

Measure	Life expectancy
Rationale	The life expectancy of Victorians improved dramatically during the twentieth century and continues to improve. Life expectancy varies by up to four years between LGAs across the state and across socioeconomic categories. The largest difference in life expectancy is between Aboriginal and Torres Strait Islanders and others.
Measure details	This measure includes two measure details, one included in this section: **1.1.2.4.A** **Life expectancy at birth**
Target	Not set
Definition	The average number of years a person could expect to live from the day they are born if the age specific death rates of the given period continued throughout their lifetime.
Data source	*Baseline and future:* Life Tables, States, Territories and Australia ABS *Alternatives:* Nil
Data availability	*Baseline year:* 2008–2010 (3-year average) or 2006–2010 (5-year average) *Frequency:* Annual (rolling 3-year average) and every five years depending on breakdown
Breakdown	Data available for the state by sex and SEIFA (IRSD), and by metropolitan/rural and regions from 3-year rolling pooled data, and by LGA every five years from 5-year pooled data. AIHW is preparing Aboriginal life expectancy estimates for Victoria. Subsequent availability to be determined.
Comparability	National, state and territory rates available for some years from Causes of Death ABS. Limited international rates available. Measure included in the National Healthcare Agreement, and reported in ROGS from Life Tables, States, Territories and Australia ABS.
Linked to	Life expectancy (Measure detail 1.1.2.4.B)
Further information	In 2008 Council of Australian Governments (COAG) set the target of close the gap in life expectancy between Aboriginal and Torres Strait Islander Australians and other Australians within a generation (by 2031).

Measure	Life expectancy
Rationale	Median age of death is an important measure of health and wellbeing based on factors affecting the health of the individual prior to death. In contrast, life expectancy is a projection into the future.
Measure detail	This measure includes two measure details, one included in this section: **1.1.2.4.B Median age of death**
Target	Not set
Definition	Median age of death is defined as the age at which exactly half the deaths from all causes registered in a given time period were deaths of people above that age, and half were deaths below that age.
Data source	*Baseline and future:* Causes of Death ABS *Alternatives:* Nil
Data availability	*Baseline year:* 2010 or 2006–2010 (5-year average) *Frequency:* Annual (single year and rolling 5-year average, depending on breakdown)
Breakdown	Data available for the state by sex, metropolitan/rural and SEIFA (IRSD) and by regions for single years and by LGA using rolling 5-year pooled data. Data may be available for Aboriginal Victorians in future if data quality improves sufficiently. When available the measure can be reported by rolling 5-year pooled data.
Comparability	National, state and territory rates available annually from Causes of Death ABS. Measure reported in ROGS from Causes of Death ABS.
Linked to	Life expectancy (Measure detail 1.1.2.4.A)
Further information	Comparisons of the median age of death of Aboriginal and Torres Strait Islander Victorians and other Victorians are affected by different age structures in the populations and by differences in the extent of identification of deaths across areas and across age groups.

Indicator 1.1.3: Reduce preventable chronic diseases

Measure	Prevalence rate of type 2 diabetes in adults	
Rationale	Diabetes and diabetes related complications contribute significantly to ill health, disability, poor quality of life and premature death. Diabetes increases the risk of a variety of complications including end-stage kidney disease, coronary heart disease, stroke and other vascular diseases. Type 2 diabetes is often preventable: a healthy diet, regular physical activity, and maintenance of healthy weight, blood pressure and blood cholesterol can substantially reduce the likelihood of developing the disease and reduce some complications. Population prevalence of type 2 diabetes is best monitored though fasting blood glucose and HbA1c tests. However surveys using such tests are very expensive and rarely undertaken in Victoria or Australia. Such infrequent data is insufficient for monitoring changes in type 2 diabetes prevalence and the assessment of health inequalities. Prevalence based on self-report provides an estimate to assess differences between population groups and changes over time.	
Measure detail	**1.1.3.1**	**Prevalence rate of type 2 diabetes in adults (self-report)**
Target	Halt the rise in diabetes prevalence by 2025 (0 per cent increase by 2025) from 2011–12 baseline (Measure 1.1.3.1)	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported that a doctor had told them they had diabetes and diagnosed them with type 2 diabetes (Scale: type 1 diabetes, type 2 diabetes, gestational diabetes, other) (Instrument–National Health Survey (NHS))
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	*Baseline and future:*	VPHS DHHS
	Alternatives:	NHS ABS; and for prevalence of measures type 2 diabetes Australian Health Survey (AHS) ABS, Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) ABS and future biomarker surveys using fasting blood glucose and/or HbA1c tests
Data availability	*Baseline year:*	2011–12
	Frequency:	Annual and triennial, depending on breakdown
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase.	
Comparability	National, state and territory rates available triennially for self-reported prevalence from NHS, and for measured prevalence occasionally. Limited international rates for measured prevalence available for some years. Measured prevalence, sourced from the AHS, is included in the National Healthcare Agreement, and reported in ROGS. Data is available from AHS 2011–12 by age, sex (custom request to ABS). Data is also available from AATSIHS 2012–13 by Aboriginal Victorians and others.	

Measure	Prevalence rate of type 2 diabetes in adults
Linked to	Premature death due to chronic diseases (Measure detail 1.1.2.2.A–D) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F)
Further information	WHO has set a target to halt the rise in age-standardised prevalence of raised blood glucose/diabetes among persons aged 18 years and older (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose) by 2025 from a 2010 baseline. Prevalence of measured type 2 diabetes is available from AHS, AATSIHS and future biomarker surveys using fasting blood glucose and/or HbA1c tests. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Indicator 1.1.4: Increase self-rated health

Measure	Proportion of adults, adolescents and children with very good or excellent self-rated health
Rationale	Self-rated health is a validated measure of health status. Personal perception of physical and mental health has been shown to be a powerful, independent predictor of actual health across many populations irrespective of age, sex, illness, disability, personality and social support.
Measure detail	This measure includes three measure details: **1.1.4.1.A** **Proportion of adults who self-rate their health as very good or excellent** **1.1.4.1.B** **Proportion of adolescents 10–17 years who self-rate their health as very good or excellent** **1.1.4.1.C** **Proportion of children 0–12 years whose health is rated as very good or excellent**
Target	Not set
Definition	**Measure 1.1.4.1.A** *Numerator:* Number of adults aged 18 years and older who reported that in general their health was very good or excellent (Scale: excellent, very good, good, fair, poor) (Instrument–General Health of SF36) *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 population of Victoria **Measure 1.1.4.1.B** *Numerator:* Number of adolescents in Years 5, 8 and 11 who reported that their health was very good or excellent (Scale: excellent, very good, good, fair, poor) (Instrument–Question developed in consultation with DHHS) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion **Measure 1.1.4.1.C** *Numerator:* Number of children aged 0–12 years who were reported by a parent/guardian to have very good or excellent health (Scale: excellent, very good, good, fair, poor) (Instrument–Question developed in consultation with DHHS) *Denominator:* Total number of respondents in survey, weighted to mid-year population estimate, aged 0–12 years (Source–ABS) *Mode:* Proportion

Measure	Proportion of adults, adolescents and children with very good or excellent self-rated health
Data source	**Measure 1.1.4.1.A** **Primary source** *Baseline and future:* VPHS DHHS **Secondary source** *Baseline and future:* GSS ABS **Tertiary source** *Baseline and future:* AATSIHS ABS *Alternatives:* NHS ABS, Household Income and Labour Dynamics in Australia Survey (HILDA), Melbourne Institute of Applied Economic and Social Research **Measure 1.1.4.1.B** *Baseline and future:* About You DET *Alternatives:* Nil **Measure 1.1.4.1.C** *Baseline and future:* VCHWS DET *Alternatives:* Nil
Data availability	**Measure 1.1.4.1.A** **Primary source** *Baseline year:* 2011–12 *Frequency:* Annual and triennial, depending on breakdown **Secondary source** *Baseline year:* 2014 *Frequency:* Ever 4 years **Tertiary source** *Baseline year:* 2012–13 *Frequency:* Every 6 years **Measure 1.1.4.1.B** *Baseline year:* 2014 *Frequency:* Biennial **Measure 1.1.4.1.C** *Baseline year:* 2013 *Frequency:* Triennial

Measure	Proportion of adults, adolescents and children with very good or excellent self-rated health
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background, for adults with psychological distress, for adults with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if response rates increase. Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, recent migrant, speaks English, and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS). Data available from AATSIHS where respondents are aged 15 years and older, for the state by Aboriginal Victorians and others, and by age, sex and metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO, and for adolescents with special health care needs; and by metropolitan/rural and regions (custom request to DET). Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs, and by metropolitan/rural and regions (custom request to DET).
Comparability	**Measure 1.1.4.1.A** National, state and territory rates available at least triennially from NHS and GSS. International rates available for some years.
Linked to	Nil
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Indicator 1.1.5: Decrease unintentional injury

Measure	Deaths due to road traffic crashes
Rationale	Road safety improves the safety of individuals, communities and can reduce the long-term costs to the health and social care systems, as well as to the wider economy. This measure is an established measure used to monitor and assess improvements in road safety.
Measure detail	This measure includes two measure details: **1.1.5.1.A** **Deaths due to road traffic crashes** **1.1.5.1.B** **Death rate due to road traffic crashes**
Target	20 per cent decrease in deaths due to road traffic crashes by 2020 from 2015 baseline (Measure 1.1.5.1.A)
Definition	**Measure 1.1.5.1.A** Number of deaths due to road transport crashes, as reported by Victoria Police. **Measure 1.1.5.1.B** *Numerator:* Number of deaths of residents, where the cause was recorded as ICD–10 codes below, registered in the respective calendar year Underlying cause of death V02–V04 (.1,.9), V09.2, V12–V14 (.3–.9), V19 (.4–.6), V20–V28 (.3–.9), V29 (.4–.9), V30–V39 (.4–.9), V40–V49 (.4–.9), V50–V59 (.4–.9), V60–V69 (.4–.9), V70–V79 (.4–.9), V81.1, V82.1, V83–V86 (.3–.5) V87 (.0–.8), V89.2 or Multiple cause of death V02–V04 (.1,.9), V09.2, V12–V14 (.3–.9), V19 (.4–.6), V20–V28 (.3–.9), V29 (.4–.9), V30–V39 (.4–.9), V40–V49 (.4– .9), V50–V59 (.4–.9), V60–V69 (.4–.9), V70–V79 (.4–.9), V81.1, V82.1, V83–V86 (.3–.5) V87 (.0–.8), V89.2. and at least 1 multiple cause of death classified to diagnosis codes S00–T75 or T79 (injury) *Denominator:* Mid-year population estimate (Source–ABS) *Mode:* Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	**Measure 1.1.5.1.A** *Baseline and future:* Road Crash Information System VicRoads *Alternatives:* Nil **Measure 1.1.5.1.B** *Baseline and future:* Causes of Death ABS *Alternatives:* Nil
Data availability	**Measure 1.1.5.1.A** *Baseline year:* 2015 *Frequency:* Annual **Measure 1.1.5.1.B** *Baseline year:* 2010 or 2006–2010 for 5-year pooled data *Frequency:* Annual

Measure	Deaths due to road traffic crashes
Breakdown	Data available for the state by age and sex and by metropolitan/rural for Measure detail 1.1.5.1.A (custom request to VicRoads). Data available for the state by age, sex, metropolitan/rural, regions and SEIFA (IRSD) for single years for Measure detail 1.1.5.1.B (custom request to ABS).
Comparability	National, state and territory rates available annually from Australian Road Deaths Database and Causes of Death ABS. Included in the Department of Economic Development, Jobs, Transport and Resources, Victorian Government (DEDJTR) outcomes framework sourced from both VicRoads Road Crash Information System VicRoads and Causes of Death ABS.
Linked to	Nil
Further information	VicRoads target is 20 per cent decrease by 2020 in deaths due to road traffic crashes, from a 2015 baseline. The death rate derived from the Causes of Death ABS will be different to that derived from the Road Crash Information System due to the following specifications of the Causes of Death ABS derived rate: • inclusion of deaths of Victorian residents elsewhere in Australia • exclusion of deaths in Victoria of residents from outside Victoria • inclusions of deaths occurring within 12 months as a result of the crash; and • age standardisation of the rate.

Measure	**Hospitalisation rate due to falls in older adults**	
Rationale	Falls are the largest cause of emergency hospital admissions for older people, and have a significant impact on long term health and wellbeing outcomes. Falls can be a major reason older people are required to move from their own home to long term nursing or residential aged care.	
Measure detail	**1.1.5.2**	**Hospitalisation rate due to falls in adults 65 years and older**
Target	Not set	
Definition	*Numerator:*	Number of separations from public and private hospitals of residents aged 65 years and older, where the principal diagnosis was recorded as ICD–10–AM codes S00–T75 or T79 and first reported external cause of unintentional fall W00–W1999 and mode of admission was not from another acute hospital, in the respective 12 month period (July to June). State reporting is inclusive and exclusive of same-day admissions. Sub-state reporting for population groups and areas excludes same-day admissions
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Age standardised rate per 1,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:*	Victorian Admitted Episodes Database (VAED) DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2012-13 or 2012-13 to 2014-15 (three year average)
	Frequency:	Annual (single year and rolling 3-year average, depending on breakdown)
Breakdown	Data available by for the state by age, sex, CALD (country of birth) and SEIFA (IRSD) and by metropolitan/rural and regions for single year and by LGA for rolling 3-year average.	
Comparability	National, state and territory rates available annually from National Hospital Morbidity Database (NHMD) AIHW. Reported in ROGS from NHMD, inclusive of same data hospitalisations.	
Linked to	Nil	
Further information	The baseline year is 2012/13 because the definition used to count numbers of admitted cases in Victoria changed, beginning with cases where the episode of hospital care ended on 1 July 2012. Exclusion of same-day admissions creates more comparable rates because there is variation in admission practices across time and between hospitals.	

Measure	Death rate for injury in children and young people	
Rationale	Injuries are a major cause of premature mortality for children and young people in Victoria. The burden of premature death due to injury is far greater than the non-fatal burden for this age group. However, injuries do cause significant morbidity for children and young people and are a leading cause of hospitalisation and treatment within a general practice or other primary care setting.	
Measure detail	**1.1.5.3**	**Death rate for injury in children and young people 0–25 years**
Target	Not set	
Definition	*Numerator:*	Number of deaths of residents aged 0–25 years, where the underlying cause was recorded as ICD-10 codes V01–X59, Y85–Y86, registered in the respective calendar year
	Denominator:	Mid–year population estimate aged 0–25 years (Source–ABS)
	Mode:	Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:*	Causes of Death ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2008–2010 (3-year average)
	Frequency:	Annual (rolling 3-year average)
Breakdown	Data available for the state by age, sex and SEIFA (IRSD) and by metropolitan/rural and regions.	
Comparability	National, state and territory rates may be available from Causes of Death ABS for some years.	
Linked to	Nil	
Further information	Nil.	

Indicator 1.1.6: Increase oral health

Measure	Rate of potentially preventable dental hospitalisations of children	
Rationale	Tooth decay is the main diagnosis for over 90 per cent of 0–9 year old children admitted for potentially preventable dental hospitalisations in Victoria. Tooth decay is a predominantly preventable disease. The proximal cause is bacteria in the mouth feeding on sugars from foods and drinks and producing acids. Tooth decay can result in pain, sleep loss, time off school and, in some cases, treatment under general anaesthetic.	
Measure detail	**1.1.6.1**	**Rate of potentially preventable dental hospitalisation of children 0–9 years**
Target	Not set	
Definition	*Numerator:*	Number of separations from public and private hospitals of residents, where the underlying cause was as ICD–10 K02–K06, K08, K09.8, K09.9, K12, K13 in the respective 12 month period (July to June). State reporting is inclusive and exclusive of same-day admissions. Sub-state reporting for population groups and areas excludes same-day admissions
	Denominator:	Mid-year population estimate aged 0–9 years (Source–ABS)
	Mode:	Age standardised rate per 1,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:*	VAED DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2012-13 or 2012-13 to 2014-15 (3-year average)
	Frequency:	Annual (single year and rolling 3-year average, depending on breakdown)
Breakdown	Data available as single year for the state by age, sex, SEIFA (IRSD) and CALD (country of birth), and by regions annually and by rolling 3-year average for the state for Aboriginal Victorians and by LGA.	
Comparability	National, state and territory rates available annually from the NHMD AIHW. International rates available for some years. ICD–10 codes are the same as those used by AIHW and Victorian Health Information Surveillance System (VHISS). Included in the National Healthcare Agreement as part of potentially preventable hospitalisations due to chronic conditions, and reported in ROGS from NHMD (inclusive of same-day hospitalisations). For both these reports the additional ICD–10 code of K14.0 (Glossitis) is included, which is a rare condition in children.	
Linked to	Proportion of adults, adolescents and children who consume sugar-sweetened beverages daily (Measure detail 1.3.1.3.B–C)	
Further information	The baseline year is 2012/13 because the definition used to count numbers of admitted cases in Victoria changed, beginning with cases whose episode of hospital care ended on 1 July 2012. Exclusion of same-day admissions creates more comparable rates because there is variation in admission practices across time and between hospitals.	

Indicator 1.1.7: Increase sexual and reproductive health

Measure	Notification rate of newly acquired HIV	
Rationale	HIV is preventable, with advances in prevention, testing and treatment providing great potential to significantly reduce new infections and improve health and wellbeing outcomes for those with HIV. Newly acquired HIV infection provides a measure of recent transmission.	
Measure detail	**1.1.7.1**	**Notification rate of newly acquired HIV**
Target	Virtual elimination of HIV transmission by 2020 (Measure 1.1.7.1)	
Definition	*Numerator:*	Number of notifications of laboratory confirmed new infections with HIV
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Rate per 1,000 population
Data source	*Baseline and future:*	Notifiable Disease Surveillance System (NDSS) DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2014
	Frequency:	Annual
Breakdown	Data available for the state by age, sex and mode of transmission, and by regions.	
Comparability	National, state and territory rates available annually from National Notifiable Disease Surveillance System (NNDSS).	
Linked to	Nil	
Further information	Nil.	

Measure	Proportion of people testing positive for chlamydia	
Rationale	Chlamydia is the most commonly notified curable sexually transmitted infection (STI) in Victoria. Chlamydia infection has become a major public health problem because of the associated long-term consequences of untreated infection, in particular pelvic inflammatory disease in women, and infertility in women and men.	
Measure detail	**1.1.7.2**	**Proportion of people testing positive for chlamydia**
Target	Not set	
Definition	*Numerator:*	Number of people with laboratory confirmed chlamydia, reported to Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Sexually Transmitted Infections and Blood Borne Viruses (ACCESS)
	Denominator:	Number of the population being tested for chlamydia, reported to ACCESS
	Mode:	Rate per 100,000 population
Data source	*Baseline and future:*	ACCESS
	Alternatives:	Nil
Data availability	*Baseline year:*	2013
	Frequency:	Annual
Breakdown	Data available for the sentinel population by age and sex. Data should be available for the total population in the future.	
Comparability	National, state and territory rates available from NNDSS. As these notifications are not derived using sentinel system as in Victoria, the NNDSS rates are not comparable to rates for measure1.1.7.2.	
Linked to	Nil	
Further information	Chlamydia is a notifiable infection across Australia.	

Measure	Notification rate for gonorrhoea	
Rationale	Gonorrhoea is a common curable STI caused by the bacteria *Neisseria gonorrhoeae,* which can be transmitted through vaginal, oral or anal sex. Gonorrhoea affects both men and women, but in Victoria is an infection primarily of men who have sex with men. Notifications have increased over the past five years among both men and women in all age groups. Untreated gonococcal infection can lead to serious health consequences including pelvic inflammatory disease and infertility in women, testicular infection in men and can increase the risk of HIV transmission.	
Measure detail	**1.1.7.3**	**Notification rate for gonorrhoea**
Target	Not set	
Definition	*Numerator:* *Denominator:* *Mode:*	Number of notifications of laboratory confirmed gonorrhoea Mid-year population estimate (Source–ABS) Rate per 1,000 population
Data source	*Baseline and future:* *Alternatives:*	Public Health Event Surveillance System (PHESS) DHHS Nil
Data availability	*Baseline year:* *Frequency:*	2011 Annual
Breakdown	Data available for the state by age and sex, and by regions.	
Comparability	National, state and territory rates available annually from NNDSS.	
Linked to	Nil	
Further information	Gonorrhoea is nationally notifiable in Australia.	

Measure	Proportion of adolescents who practice safe sex by using a condom	
Rationale	Safe sex is sexual contact where both parties are protected against sexually transmissible infections (STIs) and unplanned pregnancy. Unsafe sex may put people at risk of STIs such as chlamydia, gonorrhoea, syphilis, HIV or hepatitis B, or may result in an unplanned pregnancy. Precautions and safe sex behaviours can minimise a person's risk of contracting an STI or of an unplanned pregnancy.	
Measure detail	**1.1.7.4**	**Proportion of adolescents who practice safe sex by using a condom**
Target	Not set	
Definition	*Numerator:*	Proportion of teenagers in Years 8 and 11 who always used a condom during sexual intercourse (Scale: never, sometimes, most times always) (Instrument–Healthy Behaviour in School-aged Children (HBSC) survey)
	Denominator:	Total number of adolescents in survey who have ever had sexual intercourse, weighted to school enrolments in Years 8 and 11
	Mode:	Proportion
Data source	*Baseline and future:*	About You DET
	Alternatives:	National Survey of Secondary Students and Sexual Health (Years 10, 11 and 12; 5-yearly): Gay Periodic Survey (annual: gay male adults): Australian Study of Health and Relationships (16–69 years; 10 yearly)
Data availability	*Baseline year:*	2014
	Frequency:	Biennial
Breakdown	Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, language background other than English (LBOTE), Student family occupation (SFO) and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET).	
Comparability	National, state and territory rates available from infrequent national surveys.	
Linked to	Proportion of people testing positive for Chlamydia (Measure detail 1.1.7.2) Birth rate for young women 15–19 years (Measure detail 1.1.7.6)	
Further information		

Measure	Notification rate of newly acquired hepatitis C	
Rationale	Hepatitis C infection is preventable, treatable and curable. New hepatitis C treatments have the potential to eliminate the disease as a public health concern. Untreated viral hepatitis is the leading cause of liver cancer in Australia, with liver cancer being identified as the fastest increasing cause of cancer death in Australia.	
Measure detail	**1.1.7.5**	**Notification rate of newly acquired hepatitis C**
Target	Not set	
Definition	*Numerator:*	Number of people with notification of laboratory confirmed newly acquired hepatitis C
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Rate per 1,000 population
Data source	*Baseline and future:*	PHESS DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2011
	Frequency:	Annual
Breakdown	Data available for the state by age and sex, and by regions.	
Comparability	National, state and territory rates available from the NNDSS.	
Linked to	Nil	
Further information	Newly acquired hepatitis C is notifiable in Australia. Hepatitis C is classified into two categories: newly acquired and unspecified. Newly acquired hepatitis C is defined as infection acquired within 24 months prior to diagnosis. Unspecified hepatitis C is defined as infection acquired more than 24 months prior to diagnosis or unknown duration. Risk factor information is not collected on unspecified hepatitis C notifications.	

Measure	Birth rate for young women 15–19 years	
Rationale	Teenage pregnancy is a key measure of health inequalities and child poverty. Young mothers may experience an increased risk of postnatal depression and poor mental health in the years immediately following birth. Mothers who are teenagers may also have fewer opportunities to access higher education and employment and can therefore experience significant socioeconomic disadvantages. Their children may experience higher rates of infant mortality and low birth weight, and have a much higher risk of being born into poverty.	
Measure detail	**1.1.7.6**	**Birth rate for young women 15–19 years**
Target	Not set	
Definition	*Numerator:*	Number of live births to mothers aged 15–19 years, registered in the respective calendar year
	Denominator:	Number of live births registered in the respective calendar year
	Mode:	Proportion
Data source	*Baseline and future:*	VPDC DHHS
	Alternatives:	NPDC AIHW
Data availability	*Baseline year:*	2012
	Frequency:	Annual and every five years, depending on breakdown
Breakdown	Data available by for the state by Aboriginal Victorians and SEIFA (IRSD), and by metropolitan/rural and regions annually and for Aboriginal Victorians every five years.	
Comparability and linkage	National, state and territory rates available annually from NPDC AIHW. International rates available.	
Linked to	Proportion of adolescents who practice safe sex by using a condom (Measure detail 1.1.7.4)	
Further information	Nil.	

Outcome 1.2 Victorians have good mental health

Indicator 1.2.1: Increase mental wellbeing

Measure	Proportion of adults and adolescents with psychological distress
Rationale	Good mental health is fundamental to the wellbeing of individuals, their families and the population as a whole. Mental health problems and mental illness are major causes of poor health in Victoria. Mental disorders including anxiety, depression, and substance misuse, are estimated to affect almost half of Australians aged 16–85 during their lifetime. Mental health problems and mental illness include a range of cognitive, emotional and behavioural disorders. The Kessler 10 (K10) Psychological Distress Scale was designed to monitor population prevalence and trends in non-specific psychological distress.
Measure detail	This measure includes two measure details: **1.2.1.1.A** **Proportion of adults who report high or very high psychological distress** **1.2.1.1.B** **Proportion of adolescents 10–17 years who experience psychological distress**
Target	Not set
Definition	**Measure 1.2.1.1.A** *Numerator:* Number of adults aged 18 years and older who reported high or very high levels of psychological distress (Instrument–K10 Psychological Distress Scale) *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 population of Victoria **Measure 1.2.1.1.B** *Numerator:* Number of adolescents in Years 5, 8 and 11 who reported experience of psychological distress (Instrument–modified Communities that Care short version moods and feelings scale) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion
Data source	**Measure 1.2.1.1.A** **Primary source** *Baseline and future:* VPHS DHHS **Secondary source** *Baseline and future:* NHS ABS **Tertiary source** *Baseline and future:* AATSIHS ABS *Alternatives:* Nil **Measure 1.2.1.1.B** *Baseline and future:* About You DET *Alternatives:* Nil

Measure	Proportion of adults and adolescents with psychological distress
Data availability	**Measure 1.2.1.1.A** **Primary source** *Baseline year:* 2011–12 *Frequency:* Annual and triennial depending on breakdown **Secondary source** *Baseline year:* 2011–12 *Frequency:* Triennial **Tertiary source** *Baseline year:* 2012–13 *Frequency:* Every 6 years **Measure 1.2.1.1.B** *Baseline year:* 2014 *Frequency:* Biennial
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS DHHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available triennially from NHS for the state by age, sex and SEIFA (IRSD), and for people with a long term condition and people with a disability, and by metropolitan/rural (Accessibility/remoteness Index of Australia (ARIA)) (custom request to ABS). Data available from AATSIHS, where respondents are aged 15 years and older, by Aboriginal Victorians and others, age, sex and metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs and by metropolitan/rural and regions (custom request to DET).
Comparability	**Measure 1.2.1.1.A:** National, state and territory rates available from NHS **Measure 1.2.1.1.B:** Limited comparisons available principally based on research studies
Linked to	Nil

Measure	Proportion of adults and adolescents with psychological distress
Further information	The K10 consists of 10 questions that have the same response categories based on the amount of time an individual reported experiencing the particular problem: all of the time, most of the time, some of the time, a little of the time and none of the time (that are scored 5 through to 1). The 10 items are summed to yield scores ranging from 10 to 50. Individuals are categorised to four levels of psychological distress based on their score: low (< 16), moderate (16–21), high (22–29) and very high (30–50). The modified 'Communities that Care short version moods and feelings scale' consists of 12 questions that have the same response categories based on whether an individual reports that a statement is: true, sometimes true, or not true in the past 30 days. The items are summed to yield scores ranging from 0 to 24. Adolescents are categorized as having experienced psychological distress if they score 11 or more. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	**Proportion of adolescents with high level of resilience**	
Rationale	Resilience is defined as the ability to function competently in the face of challenges, adversity or stress. It includes the capacity to recover from difficulties or changes in life circumstances and to adapt and grow from disruptive experiences. Young people who are psychologically resilient are more likely to respond constructively to challenges and difficulties they face in their lives. Resilience includes autonomy (sense of personal agency), relatedness (positive connections with others) and competence (feeling capable or masterful). High levels of resilience are an important protective factor for health and wellbeing, especially during the significant transitions of adolescence and early adulthood.	
Measure detail	**1.2.1.2**	**Proportion of adolescents 10–17 years with high level of resilience**
Target	20 per cent increase in resilience of adolescents by 2025 from 2014 baseline (Measure 1.2.1.2)	
Definition	*Numerator:*	Number of adolescents in Years 5, 8 and 11 designated with high level of resilience (Instrument–Ryan and Deci: Basic Psychological Needs Scale)
	Denominator:	Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11
	Mode:	Proportion
Data source	*Baseline and future:*	About You DET
	Alternatives:	Nil
Data availability	*Baseline year:*	2014
	Frequency:	Biennial
Breakdown	Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET).	
Comparability	Limited comparability, mostly based on research studies. Included in DET outcomes framework, sourced from About You.	
Linked to	Nil	
Further information	Education State Target is 20 per cent increase in Victorian students reporting high resilience over the next 10 years, from a 2014 baseline, from About You. The 2001 ‘Ryan and Deci Basic Psychological Needs Scale’ is a measure of positive psychological development, indicated by perceptions of autonomy, relatedness and competence. The scale consists of nine questions that have the same response categories based on whether an individual reports a statement is ‘not at all true’ to ’very true’ using a scale of 1 to 7. Adolescents are categorised as having high resilience if they score a mean of less than five.	

Measure	**Proportion of children living in families with unhealthy family functioning**	
Rationale	Family relationships and interactions influence childhood development. Supportive and loving family and extended family relationships, healthy family functioning and access to social and family supports all contribute strongly to children's optimal health and wellbeing.	
Measure detail	**1.2.1.3**	**Proportion of children living in families with unhealthy family functioning**
Target	Not set	
Definition	*Numerator:*	Number of children aged 0–12 years living in families whose family functioning was rated as unhealthy, as reported by parents/guardians (Instrument–McMaster Family Assessment Device – General Functioning Scale)
	Denominator:	Total number of respondents in survey, weighted to mid-year population estimate, aged 0–12 years (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	VCHWS DET
	Alternatives:	Nil
Data availability	*Baseline year:*	2013
	Frequency:	Triennial
Breakdown	Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs, and by metropolitan/rural and regions (custom request to DET).	
Comparability	Limited comparability, mostly based on research studies.	
Linked to	Nil	
Further information	The 'McMaster Family Assessment Device – General Functioning Scale' consists of 12 questions to assess general family functioning, that have the same response categories based on whether an individual strongly agrees, agrees, disagrees, or strongly disagrees with statements relating to: collective problem solving and planning, mutual support in a crisis, acceptance, confiding and discussion of feelings and emotions. The responses are summed to yield scores ranging from 0 to 12. Families are categorised as functioning 'unhealthily' if the score is 2 or below. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.	

Indicator 1.2.2: Decrease suicide

Measure	Suicide rate	
Rationale	Suicide and self-harm are signs of serious emotional distress. There are about 500 suicides each year in Victoria. This represents only a small proportion of self-harming in the community and the related health and wellbeing burden of suicide and self-harm.	
Measure detail	**1.2.2.1**	**Suicide rate**
Target	Not set	
Definition	*Numerator:*	Number of deaths of residents, where the underlying cause was recorded as ICD–10 codes X60–X84, Y87.0, registered in the respective calendar year
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Direct age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:*	Causes of Death ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2010 or 2008–2010 for pooled data
	Frequency:	Annual
Breakdown	Data available for the state by age, sex, metropolitan/rural and SEIFA (IRSD) for single years and by regions using rolling 3-year pooled data.	
Comparability	National, state and territory rates available from Causes of Death ABS.	
Linked to	Nil	
Further information	Nil.	

Outcome 1.3: Victorians act to protect and promote health

Indicator 1.3.1: Increase healthy eating and active living

Measure	Proportion of adults, adolescents and children who consume sufficient fruit and vegetables
Rationale	Fruit and vegetables are important components of a healthy diet, as described in the *2013 Australian Dietary Guidelines*. There are many nutritional, societal, culinary and environmental reasons to ensure that fruit and vegetables (including legumes/beans) are major components of dietary patterns. The health benefits of consuming diets high in vegetables and fruit have been reported for decades. Their sufficient daily consumption could help prevent major diseases such as CVD and certain cancers. These foods are nutrient dense, relatively low in energy (kilojoules) and are good sources of minerals and vitamins and dietary fibre. Of note, fruit and vegetable access, affordability and availability may be difficult for some groups of people.
Measure detail	This measure includes three measure details: **1.3.1.1.A** **Proportion of adults who consume sufficient fruit and vegetables** **1.3.1.1.B** **Proportion of adolescents 10–17 years who consume sufficient fruit and vegetables** **1.3.1.1.C** **Proportion of children 4–12 years who consume sufficient fruit and vegetables**
Target	Not set
Definition	**Measure 1.3.1.1.A** *Numerator:* Number of adults aged 18 years and older who reported consuming the recommended serves of fruit and vegetables to meet the *2013 Australian Dietary Guidelines* *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 population of Victoria **Measure 1.3.1.1.B** *Numerator:* Number of adolescents in Years 5, 8 and 11 who reported consuming the recommended serves of fruit and vegetables to meet the *2013 Australian Dietary Guidelines*. Number of serves derived from reported number of whole serves *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion. **Measure 1.3.1.1.C** *Numerator:* Number of children aged 4–12 years who were reported by a parent/guardian to consume the recommended serves of fruit and vegetables to meet the *2013 Australian Dietary Guidelines*. Number of serves per day is derived from reporting serves consumed per day or per week, allowing for decimal points of a serve *Denominator:* Total number of children in survey, weighted to mid-year population estimate, aged 4–12 years (Source–ABS) *Mode:* Proportion

Measure	Proportion of adults, adolescents and children who consume sufficient fruit and vegetables
Data source	**Measure 1.3.1.1.A** **Primary source** *Baseline:* NHS ABS *Future:* VPHS DHHS **Secondary source** *Baseline and future:* GSS ABS *Alternatives:* AATSIHS ABS **Measure 1.3.1.1.B** *Baseline and future:* About You DET *Alternatives:* NHS ABS, National Secondary Students' Diet and Activity Survey (NaSSDA) CCV **Measure 1.3.1.1.C** *Baseline and future:* VCHWS DET *Alternatives:* NHS ABS
Data availability	**Measure 1.3.1.1.A** **Primary source** *Baseline year:* 2011–12 *Frequency:* Annual and triennial, depending on breakdown (VPHS); triennial (NHS) **Secondary source** *Baseline year:* 2012–13 *Frequency:* Every 6 years **Measure 1.3.1.1.B** *Baseline year:* 2014 *Frequency:* Biennial **Measures 1.3.1.1.C** *Baseline year:* 2013 *Frequency:* Triennial

Measure	Proportion of adults, adolescents and children who consume sufficient fruit and vegetables
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from AATSIHS where respondents are aged 15 years and older, for the state by Aboriginal Victorians and others, and by age, sex and metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET). Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs), and by metropolitan/rural and regions (custom request to DET).
Comparability	National, state and territory rates available triennially from NHS. International rates available for some years.
Linked to	Mean serves of fruit and vegetables for adults, adolescents and children (Measure detail 1.3.1.2.A–F) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F) Liveability (TBD) (Measure detail 5.1.1.1)
Further information	The *2013 Australian Dietary Guidelines* are: • for children aged 4–11 years – daily 1.5 serves of fruit and 4.5 serves of vegetables for children aged 4–8 years and 2 serves of fruit and 5 serves of vegetables for older children • for people aged 9–18 years – daily 2 serves of fruit and 5 serves of vegetables for all girls and 5 serves for boys 9–11 and 5.5 serves for older boys • for adults 19 years and older – daily 2 serves of fruit and 5 serves of vegetables for women and 6 for men 19–50 years, 5.5 for men 51–70 years and 5 for men 71 years and older. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Measure	Mean serves of fruit and vegetables for adults, adolescents and children
Rationale	Monitoring of the mean number of serves of fruit and vegetables consumed enables assessment of progress towards meeting the *2013 Australian Dietary Guidelines*.
Measure detail	There are six measure details: **1.3.1.2.A** **Mean daily serves of fruit in adults** **1.3.1.2.B** **Mean daily serves of fruit in adolescents 10–17 years** **1.3.1.2.C** **Mean daily serves of fruit in children 4–12 years** **1.3.1.2.D** **Mean daily serves of vegetables in adults** **1.3.1.2.E** **Mean daily serves of vegetables in adolescents 10–17 years** **1.3.1.2.F** **Mean daily serves of vegetables in children 4–12 years**
Target	Not set

Measure	Mean serves of fruit and vegetables for adults, adolescents and children
Definition	**Measure 1.3.1.2.A** Mean number of daily serves of fruit usually consumed each day as reported by adults aged 18 years and older, where a serve of fruit is 1 medium piece or 2 small pieces of fruit or 1 cup of diced pieces (clarification if requested by respondent – excludes fruit juice). Number of serves per day is derived from reporting serves consumed per day (Instrument–NHS) **Measure 1.3.1.2.B** Mean number of daily serves of fruit usually consumed a day as reported by adolescents in Years 5, 8 and 11, where a serve of fruit is equal to 1 piece of fruit, such as an apple or pear, 1 small packet of dried fruit, like sultanas or 1 cup of diced or canned fruit. Number of serves per day is derived from reporting serves consumed per day (Scale: none, 1, 2, 3, 4, 5 or more) (Instrument–Question developed in consultation with DHHS) **Measure 1.3.1.2.C** Mean number of daily serves of fruit consumed each day by children aged 4–12 years as reported by parent/guardian, where 'a serve is one small piece of fruit or half a cup of diced pieces. This also includes dried fruit – equivalent to half a tablespoon' (NSW Centre for Public Health Nutrition). Number of serves per day is derived from reporting serves consumed per day or per week, allowing for decimal points of a serve (Instrument–NSW Centre for Public Health Nutrition) **Measure 1.3.1.2.D** Mean number of daily serves of vegetables usually consumed each day as reported by adults aged 18 years and older, where a serve of vegetables is ½ cup of cooked vegetables or 1 cup of salad vegetables (clarification if requested by respondent – includes potatoes, hot potato chips, but excludes potato crisps and vegetable juice). Number of serves per day is derived from reporting serves consumed per day (Instrument–NHS) **Measure 1.3.1.2.E** Mean number of daily serves of vegetables usually consumed a day as reported by adolescents in Years 5, 8 and 11, where a serve of vegetables is equal to ½ a cup of cooked vegetables or legumes, 1 cup of salad or 1 medium potato. Number of serves is derived from reporting serves consumed per day (Scale: none, 1, 2, 3, 4, 5 or more) (Instrument–Question developed in consultation with DHHS) **Measure 1.3.1.2.F** Mean number of daily serves of vegetables consumed each day by children aged 4–12 years as reported by parent/guardian, where 'a serve is a quarter of a cup of cooked vegetables or half a cup of salad vegetables'. Number of serves per day is derived from reporting serves consumed per day or per week, allowing for decimal points of a serve (Instrument–NSW Centre for Public Health Nutrition)

Measure	Mean serves of fruit and vegetables for adults, adolescents and children
Data source	**Measures 1.3.1.2.A and 1.3.1.2.D** **Primary source** *Baseline:* NHS ABS *Future:* VPHS DHHS **Secondary source** *Baseline and future:* GSS ABS *Alternatives:* AATSIHS ABS **Measures 1.3.1.2.B and 1.3.1.2.E** *Baseline and future:* About You DET *Alternatives:* NHS ABS, NaSSDA CCV **Measures 1.3.1.2.C and 1.3.1.2.F** *Baseline and future:* VCHWS DET *Alternatives:* NHS ABS
Data availability	**Measures 1.3.1.2.A and 1.3.1.2.D** **Primary source** *Baseline year:* 2011–12 *Frequency:* Annual and triennial, depending on breakdown (VPHS); Triennial (NHS) **Secondary source** *Baseline year:* 2012–13 *Frequency:* Every 6 years **Measures 1.3.1.2.B and 1.3.1.2.E** *Baseline year:* 2014 *Frequency:* Biennial **Measures 1.3.1.2.C and 1.3.1.2.F** *Baseline year:* 2013 *Frequency:* Triennial
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from AATSIHS where respondents are aged 15 years and older, for the state by Aboriginal Victorians and others, and by age, sex and metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET). Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs), and by metropolitan/rural and regions (custom request to DET).

Measure	Mean serves of fruit and vegetables for adults, adolescents and children
Comparability	National, state and territory rates available triennially from NHS. International rates available for some years.
Linked to	Proportion of adults, adolescents and children who consume sufficient fruit and vegetables (Measure detail 1.3.1.1.A–C) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F) Liveability (TBD) (measure detail 5.1.1.1)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Measure	**Proportion of adults, adolescents and children who consume sugar-sweetened beverages daily**
Rationale	Diet is a major contributor to chronic disease and premature death in Victoria. Good nutrition is necessary to maintain healthy weight, mental and physical health, resistance to infection and for protection against chronic disease. Poor diet increases the risk of CVD, type 2 diabetes, and some cancers, which are also associated with obesity. For all Victorians in 2011–12, about one-third of energy intake was from discretionary foods and drinks – principally sugary drinks, takeaway foods, biscuits, cakes, snack foods, chocolates and other confectionary, and alcohol. This was about three times the recommended maximum contribution to daily energy intake for active people of healthy weight. Consumption of sugar-sweetened beverages (SSB) is a measure of discretionary drink consumption.
Measure detail	This measure includes three measure details: **1.3.1.3.A** **Proportion of adults who consume SSB daily** **1.3.1.3.B** **Proportion of adolescents 10–17 years who consume SSB daily** **1.3.1.3.C** **Proportion of children 5–12 years who consume SSB daily**
Target	Not set
Definition	**Measure 1.3.1.3.A** *Numerator:* Number of adults aged 18 years and older who reported daily consumption of cordials, soft drinks, flavoured mineral water, energy drinks or sports drinks (Clarification if requested by respondent: Mixers or soft drinks in the form of ready-to-drinks are included, and clear, plain non-flavoured mineral water and soda water are excluded) (Scale daily; several times per week; about once a week; about once a fortnight; about once a month; less often than once per month; never). Includes where these types of drinks are mainly diet variety (Scale: diet; standard; both diet and standard equally) *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older. (Source–ABS) *Mode:* Proportion, direct age standardised to the 2011 population of Victoria **Measure 1.3.1.3.B** *Numerator:* Number of adolescents in Years 5, 8 and 11 who reported daily consumption of sugar-sweetened soft drinks and cordials, fruit drinks, vitamin waters, energy and sports drinks daily (Instrument–HBSC) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion **Measure 1.3.1.3.C** *Numerator:* Number of children aged 5–12 years who consumed at least one cup of soft drink, fruit juice (including freshly squeezed), cordials, or sports drink a day, as reported by parent/guardian (Instrument–Question developed in consultation with DHHS). *Denominator:* Total number of children in survey, weighted to mid-year population estimate, aged 5–12 years (Source–ABS). *Mode:* Proportion.

Measure	Proportion of adults, adolescents and children who consume sugar-sweetened beverages daily
Data source	**Measure 1.3.1.3.A** *Baseline and future:* VPHS DHHS *Alternatives:* AHS ABS; VicHealth Indicators Survey **Measure 1.3.1.3.B** *Baseline and future:* About You DET *Alternatives:* AHS ABS **Measure 1.3.1.3.C** *Baseline and future:* VCHWS, DET *Alternatives:* AHS ABS
Data availability	**Measure 1.3.1.3.A** *Baseline year:* 2011–12 *Frequency:* Triennial **Measure 1.3.1.3.B** *Baseline year:* 2014 *Frequency:* Biennial **Measure 1.3.1.3.C** *Baseline year:* 2013 *Frequency:* Triennial
Breakdown	Data available from VPHS for the state by age, sex, household income, employment, education, CALD background, and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural (custom request to DET). Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs, and by metropolitan/rural (custom request to DET).
Comparability	National, state and territory rates available from infrequent AHS surveys.
Linked to	Rate of potentially preventable dental hospitalisations of children (Measure detail 1.1.6.1) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Measure	Discretionary food consumption of adults, adolescents and children (TBD)
Rationale	Reducing discretionary food consumption in addition to reducing consumption of discretionary drinks, specifically sugar-sweetened beverages (Measure 3.1.1), is central to improving healthy eating across Victoria. Cereal based foods such as biscuits, cakes, muffins, take away foods such as pies, pizzas, hamburgers and commercial pasta dishes made the greatest contribution to discretionary food intake across all age groups in 2011–12. One in two people aged two years and older had consumed a high-energy cereal based product in the previous 24 hours. In addition, in Victoria in 2009–10 average intakes of saturated fat and salt of adults were above recommendations while intakes of fruit and vegetables, fibre and calcium were below recommendations.
Measure detail	This measure includes three measure details: **1.3.1.4.A** **Discretionary food consumption of adults (TBD)** **1.3.1.4.B** **Discretionary food consumption of adolescents (TBD)** **1.3.1.4.C** **Discretionary food consumption of children (TBD)**
Further information	The measure details for this measure are to be developed. How to accurately assess consumption of discretionary food and capture salt intake using short form questions suitable for monitoring is under review.

Measure	**Proportion of infants exclusively breastfed to three months of age**	
Rationale	WHO states that 'breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants'. Breastfeeding provides essential nutrients for healthy growth and aids in resistance to infection and the prevention of allergies. It also facilitates bonding between mother and child. Mothers may not breastfeed or discontinue breastfeeding their infants for a number of reasons including difficulty breastfeeding and unsupportive environments for breastfeeding. The National Health and Medical Research Council (NHMRC) *Infant Feeding Guidelines* recommend exclusive breastfeeding to around six months; continued breastfeeding to around 12 months is encouraged, supported and promoted. A nationally agreed indicator is the proportion of infants exclusively breastfed at four months of age. Regular, local information is available for parents of infants aged three months and thus while not fully aligned with the nationally agreed indicator, exclusive breastfeeding at three months of age is included in this outcomes framework.	
Measure detail	**1.3.1.5**	**Proportion of infants exclusively breastfed to three months of age**
Target	Not set	
Definition	*Numerator:*	Number of infants exclusively breastfed at three months
	Denominator:	Total number of infants aged three months attending Maternal and Child Health Services during the financial year
	Mode:	Proportion
Data source	*Baseline and future:*	Maternal and Child Health Collection (MCHC) DET
	Alternatives:	National infant feeding survey (AIHW) (2010, irregular frequency)
Data availability	*Baseline year:*	2013-14
	Frequency:	Annual
Breakdown	Data available for the state by age of mother and Aboriginal Victorians and by four regions (custom request to DET).	
Comparability	National, state and territory rates available from irregular national survey, using associated indicators. Included on DET outcomes framework as 'Proportion of infants fully or partially breastfed at 3 and 6 months' sourced from MCHC data.	
Linked to	Nil	
Further information	In 2014-15, 94.4 per cent of all infants born attended Maternal and Child Health Services at four months of age.	

Measure	Proportion of adults, adolescents and children who are sufficiently physically active
Rationale	Physical activity provides important benefits throughout life. Establishing an active lifestyle such as participation in active recreation and sport during childhood and early adulthood can lay the foundation for life-long participation in sport and wider physical activity. Children and adolescents who are physically active have better mental, cardio-metabolic and musculoskeletal health and are less likely to gain weight. Physical activity helps adults to live longer, and protects against CVD, type 2 diabetes, some cancers and osteoarthritis. Current levels of physical inactivity have been attributed to increasing sedentariness of domestic and occupational activities, insufficient physical activity during leisure time, increasing use of passive modes of transport and increased urbanisation (which potentially leads to higher density traffic, poorer air quality and lack of sports and recreation facilities, footpaths and parks).
Measure detail	This measure includes three measure details: **1.3.1.6.A** **Proportion of adults who are sufficiently physically active** **1.3.1.6.B** **Proportion of adolescents 10–17 years who are sufficiently physically active** **1.3.1.6 C** **Proportion of children 5–12 years who are sufficiently physically active**
Target	10 per cent increase in sufficient physical activity prevalence of adults by 2025 from 2011–12 baseline (Measure 1.3.1.6.A) 20 per cent increase in sufficient physical activity prevalence of adolescents by 2025 from 2014 baseline **(**Measure 1.3.1.6.B**)**

Measure	Proportion of adults, adolescents and children who are sufficiently physically active
Definition	**Measure 1.3.1.6.A:** *Numerator:* Number of adults aged 18–64 years who reported undertaking sufficient physical activity, at least 150 minutes of moderate intensity physical activity or at least 75 minutes of vigorous intensity physical activity over at least 5 sessions each week, and number of adults aged 65 years and older who reported undertaking at least 30 minutes of physical activity each day, as described in the *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines* (Instrument–Active Australia Survey) *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 population of Victoria **Measure 1.3.1.6.B:** *Numerator:* Number of adolescents in Years 5, 8 and 11 who reported undertaking an accumulated minimum of 60 minutes of moderate to vigorous intensity physical activity every day, as described in the *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines* (Instrument–HBSC) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion **Measure 1.3.1.6.C:** *Numerator:* Number of children aged 5–12 years who were reported by a parent/guardian to undertake an accumulated minimum of 60 minutes of moderate to vigorous intensity physical activity every day, as described in the *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines*. (Instrument–Questions created in consultation with DHHS) *Denominator:* Total number of respondents in survey, weighted to mid-year population estimate, aged 5–12 years (Source–ABS) *Mode:* Proportion
Data source	**Measure 1.3.1.6.A:** *Baseline and future:* VPHS DHHS *Alternatives:* NHS ABS **Measure 1.3.1.6.B:** *Baseline and future:* About You DET *Alternatives:* NHS ABS; NaSSDA CCV **Measure 1.3.1.6.C** *Baseline and future:* VCHWS *Alternatives:* NHS ABS

Measure	Proportion of adults, adolescents and children who are sufficiently physically active
Data availability	**Measure 1.3.1.6.A:** *Baseline year:* 2011–12 *Frequency:* Annual and triennial, depending on breakdown **Measure 1.3.1.6.B:** *Baseline year:* 2014 *Frequency:* Biennial **Measure 1.3.1.6.C:** *Baseline year:* 2013 *Frequency:* Triennial
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET). Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs, and by metropolitan/rural and regions (custom request to DET).
Comparability	National, state and territory rates available triennially from NHS for each measure and from NaSSDA for Measure1.3.1.6.B. International rates are not available due to lack of comparability. Measure 1.3.1.6.B included in DET outcomes framework for school age children, sourced from About You.
Linked to	Proportion of journeys that use active transport (Measure detail 1.3.1.7) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F) Liveability (TBD) (Measure detail 5.1.1.1)

Measure	Proportion of adults, adolescents and children who are sufficiently physically active
Further information	See *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines:* • for children and adolescents aged 5–17 years – accumulate at least 60 minutes of moderate to vigorous intensity physical activity every day. On at least three days per week, children and adolescents should engage in activities that strengthen muscle and bone • for adults aged 18–64 years – accumulate 150 to 300 minutes of moderate intensity physical activity or 75 to 150 minutes of vigorous intensity physical activity or a combination of both each week. Be active on most, preferably all, days every week. Do muscle strengthening activities on at least 2 days each week. • for older adults aged 65 years and older – accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all, days. 20 per cent increase in physical activity in 10 years is an Education State Target (Measure 1.3.1.6.B). WHO has set a 10 per cent target for decreasing the age-standardised prevalence of insufficiently physically active persons aged 18 years and older (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent) by 2025 from a 2010 baseline. WHO has set a 10 per cent target for decreasing the prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily, by 2025 from a 2010 baseline. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Measure	Proportion of journeys that use active transport	
Rationale	Active transport refers to unassisted travel (walking) or non-motorised (bicycle) transportation with an intended purpose or destination. Active transport has many demonstrated benefits – personal (health and fitness), social (community connectivity), environmental (reduced carbon footprint) and economic (infrastructure costs). Adults who walk for transport are more likely to achieve sufficient physical activity than those who do not. A significant proportion of public transport users report that they meet all their recommended levels of physical activity just from their active transport associated with public transport use.	
Measure detail	**1.3.1.7**	**Proportion of journeys that use active transport**
Target	Not set	
Definition	*Numerator:*	Number of trips recorded by household residents on their survey day made in part or fully by walking and/or bicycling
	Denominator:	Total number of trips in survey, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	Victorian Integrated Survey of Travel and Activity (VISTA) DEDJTR
	Alternatives:	VPHS (reported as indicators of adults cycling for transport and adults walking for transport)
Data availability	*Baseline year:*	2012–14
	Frequency:	Annual for Melbourne (based on rolling 2-year average); every 4–5 years for Geelong and regional centres
Breakdown	Data available for the survey area by age, sex, purpose of journey, day (all days, weekday, weekend), transport mode and household income, and by location (Melbourne inner/middle/outer, Geelong and Regional centres).	
Comparability	National, state and territory comparison unavailable.	
Linked to	Proportion of adults, adolescents and children who are sufficiently physically active (Measure detail 1.3.1.6.A–C) Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F) Liveability (TBD) (Measure detail 5.1.1.1)	
Further information	Nil.	

Measure	Proportion of people participating in organised sport (TBD)
Rationale	Participation in organised sport may provide many benefits to health and wellbeing. Organised sport can be a way for people to participate in regular physical activity and meet the *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines*. In addition to the physical fitness benefits, playing sport may help children and adults learn and practice teamwork and develop confidence, respect and self-esteem.
Measure detail	**1.3.1.8 Proportion of people participating in organised sport (TBD)**
Further information	The measure details for this measure are to be developed.

Measure	**Proportion of adults sitting for seven or more hours per day on an average weekday**	
Rationale	Sedentary behaviour – sitting or lying down while awake – includes sitting while watching TV, driving a car, working at a desk, doing schoolwork, and sitting and using a computer or mobile device. Evidence of the adverse effects of sedentary behaviours is growing. Increased sedentary behaviour is associated with overweight and obesity, and poorer cardiovascular, muscular, mental and behavioural health. These risks are separate to the risks of insufficient physical activity. The *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines* recommend that people minimise the amount of time spent in prolonged sitting and break up long periods of sitting as often as possible. For adults, evidence suggests that being sedentary for more than 11 hours a day impairs health, and that the cut-off point for risk may be as low as seven or eight hours of sedentary behaviour a day.	
Measure detail	**1.3.1.9**	**Proportion of adults sitting for seven or more hours per day on an average weekday**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported sitting for seven or more hours a day on an average weekday during the preceding week (Scale: time given in hours) (Instrument–Question developed for VPHS)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VPHS DHHS
	Secondary source	
	Baseline and future:	VicHealth Indicators Survey
	Alternatives:	Nil
Data availability	**Primary source**	
	Baseline year:	2014
	Frequency:	Annual and triennial, depending on breakdown
	Secondary source	
	Baseline year:	2011
	Frequency:	Every 4 years
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from VicHealth Indicators Survey for the state by age, sex, education, employment, Aboriginal Victorians, main language spoken at home, CALD background, household structure, and for people with a disability, and by geographic region (custom request to VicHealth).	
Comparability	Some state and territory rates are available from specific surveys.	
Linked to	Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F)	

Measure	Proportion of adults sitting for seven or more hours per day on an average weekday
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	**Proportion of adolescents and children who use excess electronic media for recreation**
Rationale	To reduce health risks, the *2014 Australia's Physical Activity and Sedentary Behaviour Guidelines* recommend that children aged 5–17 years minimise the time they spend being sedentary every day. Specifically use of electronic media for entertainment (such as television, seated electronic games and computer use) ideally needs to be limited to no more than two hours a day. Lower amounts of screen time are associated with reduced health risks particularly excess body fat (including the prevention of unhealthy weight gain). In addition, the guidelines state that children and adolescents be encouraged to break up long periods of sitting as often as possible.
Measure detail	This measure includes two measure details: **1.3.1.10.A** **Proportion of adolescents 10–17 years who use electronic media for recreation for more than two hours per day** **1.3.1.10.B** **Proportion of children 5–12 years who use electronic media for recreation for more than two hours per day**
Target	Not set
Definition	**Measure 1.3.1.10.A** *Numerator:* Number of adolescents aged 10–17 years who use of electronic media for recreation for more than two hours per day on weekends and weekdays (Instrument–HBSC) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 **Measure 1.3.1.10.B** *Numerator:* Number of children aged 5–12 years who use electronic media for recreation for more than two hours per day on weekends and weekdays, as reported by parents/guardians (Instrument–Question developed in consultation with DHHS) *Denominator:* Total number of respondents in survey, weighted to mid-year population estimate, aged 5–12 years (Source–ABS) **For all Measures:** *Mode:* Proportion
Data source	**Measure 1.3.1.10.A** *Baseline and future:* About You DET **Measure 1.3.1.10.B** *Baseline and future:* VCHWS DET **For all Measures** *Alternatives:* AHS ABS, Longitudinal Study of Australian Children (LSAC), Survey of children's participation in cultural and leisure activities ABS
Data availability	**Measure 1.3.1.10.A** *Baseline year:* 2014 *Frequency:* Biennial **Measure 1.3.1.10.B** *Baseline year:* 2013 *Frequency:* Triennial

Measure	Proportion of adolescents and children who use excess electronic media for recreation
Breakdown	Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET). Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs; and by metropolitan/rural and regions (custom request to DET).
Comparability	National, state and territory rates available for some years.
Linked to	Proportion of adults, adolescents and children who are overweight and obese (Measure detail 1.3.2.1.A–F)
Further information	From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Indicator 1.3.2: Reduce overweight and obesity

Measure	Proportion of adults, adolescents and children who are overweight and obese
Rationale	Excess weight is a major determinant of premature death and avoidable ill health. It affects the risk of CVD, type 2 diabetes, musculoskeletal conditions and some cancers. In addition to affecting the health of the individual, overweight and obesity places an increasing burden on health services, social support and economic productivity. Childhood obesity has both intermediate and long-term effects on health and wellbeing. Excess weight in children often leads to excess weight in adults.
Measure detail	This measure includes six measure details: **1.3.2.1.A** **Proportion of adults who are overweight or obese (measured)** **1.3.2.1.B** **Proportion of adults who are overweight or obese (self-report)** **1.3.2.1.C** **Proportion of adults who are obese (measured)** **1.3.2.1.D** **Proportion of adults who are obese (self-report)** **1.3.2.1.E** **Proportion of children 5–17 years who are overweight or obese (measured)** **1.3.2.1.F** **Proportion of children 5–17 years who are obese (measured)**
Target	5 per cent decrease in prevalence of overweight and obesity in adults by 2025 from 2011–12 baseline (Measure 1.3.2.1.A) 5 per cent decrease in prevalence of overweight and obesity in children by 2025 from 2011–12 baseline (Measure 1.3.2.1.E)

Measure	Proportion of adults, adolescents and children who are overweight and obese	
Definition	**Measure 1.3.2.1.A:**	
	Numerator:	Number of adults aged 18 years and older whose body mass index (BMI), based on measured height and weight, were greater than or equal to 25.00
	Denominator:	Total number of adults in survey aged 18 years and older with measured height and weight, weighted to mid-year population estimate, aged as identified in the measure (Source–ABS)
	Mode:	Proportion, direct age standardised to the 2001 population of Australia
	Measure 1.3.2.1.B:	
	Numerator:	Number of adults aged 18 years and older whose BMI, based on self-reported height and weight, was greater than or equal to 25.00 (Instrument–NHS)
	Denominator:	Total number of adults in survey with self-reported height and weight, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, direct age standardised to the 2011 population of Victoria
	Measure 1.3.2.1.C:	
	Numerator:	Number of adults aged 18 years and older whose BMI, based on measured height and weight, was greater than or equal to 30.00
	Denominator:	Total number of adults in survey with measured height and weight, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, direct age standardised to the 2001 population of Australia
	Measure 1.3.2.1.D:	
	Numerator:	Number of adults aged 18 years and older whose BMI, based on self-reported height and weight, was greater than or equal to 30.00 (Instrument–NHS)
	Denominator:	Total number of adults in survey with self-reported height and weight, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, direct age standardised to the 2011 population of Victoria
	Measure 1.3.2.1.E:	
	Numerator:	Number of children aged 5–17 years whose BMI (appropriate for age and sex), based on measured height and weight, is likely to be greater than or equal to 25.00 at age 18 years, based on centile curves (as defined by International Obesity Task Force)
	Denominator:	Total number of children in survey with measured height and weight, weighted to mid-year population estimate, aged 5–17 years (Source–ABS)
	Mode:	Proportion

Measure	Proportion of adults, adolescents and children who are overweight and obese
Definition (continued)	**Measure 1.3.2.1.F:** *Numerator:* Number of children aged 5–17 years whose BMI (appropriate for age and sex), based on measured height and weight, is likely to be greater than or equal to 30.00 at age 18 years, based on centile curves (as defined by International Obesity Task Force) *Denominator:* Total number of children in survey with measured height and weight, weighted to mid-year population estimate, aged 5–17 years (Source–ABS). *Mode:* Proportion
Data source	**Measures 1.3.2.1.A and 1.3.2.1.C:** **Primary source** *Baseline and future:* NHS ABS **Secondary source** *Baseline and future:* AATSIHS ABS *Alternatives:* Nil **Measures 1.3.2.1.B and 1.3.2.1.D:** *Baseline and future:* VPHS DHHS *Alternatives:* NHS ABS **Measures 1.3.2.1.E and 1.3.2.1.F:** *Baseline and future:* NHS ABS *Alternatives:* AATSIHS ABS; About You DET
Data availability	**Measures 1.3.2.1.A and 1.3.2.1.C:** **Primary source** *Baseline year:* 2011–12 *Frequency:* Triennial **Secondary source** *Baseline year:* 2012–13 *Frequency:* Every 6 years **Measures 1.3.2.1.B and 1.3.2.1.D:** *Baseline year:* 2011–12 *Frequency:* Annual and triennial, dependent on breakdown **Measures 1.3.2.1.E and 1.3.2.1.F:** *Baseline year:* 2011–12 *Frequency:* Triennial

Measure	Proportion of adults, adolescents and children who are overweight and obese
Breakdown	Data available triennially from NHS for the state by age, sex and SEIFA (IRSD), and by metropolitan/rural (ARIA). Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background, and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available every six years from AATSIHS, where respondents are aged 15 years and older, for the state by Aboriginal Victorians and others and by age, sex and by metropolitan/rural (custom request to ABS).
Comparability	National, state and territory rates available triennially from NHS. International rates available for some years. Measures 1.3.2.1.A and 1.3.2.1.E are included in the National Healthcare Agreement, sourced from the NHS, and reported in ROGS.
Linked to	Prevalence rate of type 2 diabetes in adults (Measure detail 1.1.3.1) Proportion of adults, adolescents and children who consume sufficient fruit and vegetables (Measure detail 1.3.1.1.A–C) Mean serves of fruit and vegetables for adults, adolescents and children (Measure detail 1.3.1.2.A–F) Proportion of adults, adolescents and children who consume sugar-sweetened beverages daily (Measure detail 1.3.1.3.A–C) Discretionary food consumption of adults, adolescents and children (TBD) (Measure detail 1.3.1.4.A–C) Proportion of adults, adolescents and children who are sufficiently physically active (Measure detail 1.3.1.6.A–C) Proportion of adults sitting for seven or more hours on an average weekday (Measure detail 1.3.1.9) Proportion of adolescents and children who use excess electronic media for recreation (Measure detail 1.3.1.10.A–B) Liveability (TBD) (Measure detail 5.1.1.1)
Further information	Self-reported overweight and obesity prevalence is known to underestimate the true prevalence, particularly for obesity. In 2011–12 self-reported overweight prevalence was similar to measured prevalence; in contrast self-reported obesity prevalence was eight percentage points lower than measured prevalence. WHO has set a target of halt the rise in age-standardised prevalence of overweight and obesity in persons aged 18 years and older (defined as body mass index ≥ 25 kg/m² for overweight and body mass index ≥ 30 kg/m² for obesity) by 2025 from a 2010 baseline. WHO has set a target of halt the rise in prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex) by 2025 from a 2010 baseline. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Indicator 1.3.3: Reduce smoking

Measure	Proportion of adults and adolescents who smoke
Rationale	Smoking is a major cause of preventable death and ill health, and of health inequalities throughout the state. In 2011–12 about 520,000 adults smoked daily in Victoria, and a further 160,000 smoked less regularly. A large body of evidence shows that smoking behaviour in early adulthood affects health behaviours later in life.
Measure detail	This measure includes two measure details: **1.3.3.1.A** **Proportion of adults who smoke daily** **1.3.3.1.B** **Proportion of adolescents 12–17 years who currently smoke**
Target	30 per cent decrease in smoking by adults by 2025 from 2011–12 baseline (Measure 1.3.3.1.A) 30 per cent decrease in smoking by adolescents by 2025 from 2014 baseline (Measure 1.3.3.1.B)
Definition	**Measure 1.3.3.1.A:** *Numerator:* Number of adults aged 18 years and older who reported their current smoking status as 'smoke daily' *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 population of Victoria **Measure 1.3.3.1.B:** *Numerator:* Number of adolescents in Years 5, 8 and 11 who reported smoking at least once a week (Scale: every day; at least once a week, but not every day; less than once a week; and I do not smoke) (Instrument–HBSC) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion
Data source	**Measures 1.3.3.1.A:** **Primary source** *Baseline and future*: VPHS DHHS **Secondary source** *Baseline and future:* AATSIHS ABS *Alternatives:* National Drug Strategy Household Survey (NDSHS) AIHW (respondents 12 years and older); Smoking and Health survey CCV; NHS ABS **Measure 1.3.3.1.B:** *Baseline and future:* About You DET *Alternatives:* About You DET (Also reported as measure of smoking in the last 30 days); NDSHS (Reported as measure of smoking in the last 7 days); Australian school students alcohol and drug survey (ASSAD) CCV (Reported as measure of smoking in the last 7 days and last month)

Measure	Proportion of adults and adolescents who smoke
Data availability	**Measure 1.3.3.1.A:** **Primary source** *Baseline year:* 2011–12 *Frequency:* Annual and triennial, depending on breakdown **Secondary source** *Baseline year:* 2012–13 *Frequency:* Every 6 years **Measure 1.3.3.1.B:** *Baseline year:* 2014 *Frequency:* Biennial
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from AATSIHS, where respondents are aged 15 years and older, for the state by Aboriginal Victorians and others and by age, sex and by metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET).
Comparability	National, state and territory rates available from NDSHS, NHS and AATSIHS. International rates available for some years. Measure 1.3.3.1.A is included in the National Healthcare Agreement, sourced from the NHS, and reported in ROGS.
Linked to	Age of smoking initiation (Measure detail 1.3.3.2)
Further information	WHO has set a 30 per cent target for decreasing the age–standardised prevalence of current tobacco use among persons aged 18 years and older by 2025 from a 2010 baseline. WHO has set a 30 per cent target for decreasing the prevalence of current tobacco use among adolescents by 2025 from a 2010 baseline. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	Age of smoking initiation
Rationale	The health risks from tobacco increase the earlier a person takes up the habit and the longer they smoke. Monitoring the age of initiation of smoking will provide information on the uptake of smoking among young people.
Measure detail	**1.3.3.2 Age of smoking initiation**
Target	Not set
Definition	Average age of young people aged 14–24 years when they: smoked their first full cigarette of those who reported smoking daily, weekly or less than weekly, and reported smoking at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, or reported no longer smoking.
Data source	*Baseline and future:* NDSHS AIHW *Alternatives:* Nil
Data availability	*Baseline year:* 2013 *Frequency:* Triennial
Breakdown	Data available for the state by sex and SEIFA (IRSD) and by metropolitan/rural (ARIA) (custom request to AIHW).
Comparability	National estimate available from NDSHS, and state and territory rates may be available.
Linked to	Proportion of adults and adolescents who smoke (Measure detail 1.3.3.1.A-B)
Further information	Nil.

Measure	Proportion of children who live with a smoker who smokes inside the home	
Rationale	Passive smoking, or exposure to second hand smoke, is a cause of premature death and disease in children and in adults who do not smoke. Even small amounts of exposure to tobacco smoke can be harmful to people's health. Compared with adults, children are particularly susceptible to the effects of second-hand smoke. Children are most likely to be exposed to second-hand smoke in the home. As exposure to second-hand smoke can be so pervasive, even comparatively small increases in disease risk for individual children may translate into a substantial burden of disease in the child population.	
Measure detail	**1.3.3.3**	**Proportion of children who live with a smoker who smokes inside the home**
Target	Not set	
Definition	*Numerator:*	Number of children aged less than 13 years who live in a household where one or more regular smokers reside and smoke inside the home, as reported by parent/guardian (Instrument–Centre for Behavioural Research in Cancer)
	Denominator:	Total number of children aged less than 13 years in the sample respondents in survey, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	VCHWS DET
	Alternatives:	NDSHS AIHW (for households with children aged 15 years and under)
Data availability	*Baseline year:*	2013
	Frequency:	Triennial
Breakdown	Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs, and by metropolitan/rural (custom request to DET).	
Comparability	Limited comparability, mostly based on one-off surveys or research studies.	
Linked to	Proportion of adults and adolescents who smoke (Measure detail 1.3.3.1.A–B)	
Further information	Nil.	

Indicator 1.3.4: Reduce harmful alcohol and drug use

Measure	Proportion of adults and adolescents who consume excess alcohol
Rationale	Excess alcohol consumption is responsible for a considerable burden of death, disease and injury. Excessive long-term alcohol consumption increases the risk of CVD, diabetes, liver cirrhosis and some types of cancers. Alcohol-related harm can also extend beyond the individual to impact families and the broader community through increased street-based violence, sexual assault, family violence, avoidable injuries, road trauma and reduced public safety. As more alcohol is consumed on a single occasion, skills and inhibitions decrease while risky behaviour increases, leading to a greater risk of injury during or immediately after that occasion.
Measure detail	This measure includes three measure details, two included in this section: **1.3.4.1.A** **Proportion of adults who consume alcohol at lifetime risk of harm** **1.3.4.1.B** **Proportion of adults who consume alcohol at risk of alcohol-related injury on a single occasion at least monthly**
Target	10 per cent decrease in excess alcohol consumption by adults by 2025 from 2014 baseline (Measure 1.3.4.1.A-B)
Definition	**Measure 1.3.4.1.A:** *Numerator:* Number of adults aged 18 years and older adults who consumed alcohol at frequency and quantities that do not meet the 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* to reduce the risk of alcohol related harm over a lifetime **Measure 1.3.4.1.B:** *Numerator:* Number of adults aged 18 years and older adults who consumed alcohol at frequency and quantities that do not meet the 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* to reduce the risk of injury on a single occasion of drinking at least monthly, inclusive of at least weekly consumption **All measures:** *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source** *Baseline and future:* VPHS DHHS **Secondary source** *Baseline and future:* AATSIHS ABS *Alternatives:* NDSHS AIHW; NHS ABS.
Data availability	**Primary source** *Baseline year:* 2014 *Frequency:* Annual and triennial, dependent on breakdown **Secondary source** *Baseline year:* 2012–13 *Frequency*: Every 6 years

Measure	Proportion of adults and adolescents who consume excess alcohol
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from AATSIHS, where respondents are aged 15 years and older, for the state by Aboriginal Victorians and others and by age and sex and by metropolitan/rural (custom request to ABS).
Comparability	National, state and territory rates available from NDSHS and NHS. International rates available for some years. Measure 1.3.4.1.A included in the National Healthcare Agreement and reported in ROGS from NHS.
Linked to	Deaths due to road traffic crashes (Measure detail 1.1.5.1A–B) Rate of alcohol, prescription drug or illicit drug related ambulance attendances (Measure detail 1.3.4.3.A) Rate of incidents of family violence reported by police (Measure detail 2.1.2.1) Family violence index (TBD) (Measure detail 2.1.2.2) Hospitalisation rate due to assault (Measure detail 2.1.3.2) Liveability (TBD) (Measure detail 5.1.1.1)
Further information	The 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* are: • two or less standard drinks on any one day to reduce the risk of alcohol related harm over a lifetime • four or less standard drinks on any one occasion to reduce the risk of injury on a single occasion of drinking • not drinking is the safest option for children and young people under 18 years of age • not drinking is the safest option for women who are pregnant, are planning a pregnancy or who are breastfeeding. WHO has set the target of decreasing age-standardised prevalence of heavy episodic drinking among adults by 10 per cent by 2025, from a 2010 baseline. From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	Proportion of adults and adolescents who consume excess alcohol
Rationale	Risks of injury, violence and self-harm are high among drinkers aged less than 18 years. Drinkers under 15 years of age are much more likely than older drinkers to experience risky or antisocial behaviour connected with their drinking, with the rates also somewhat elevated among drinkers aged 15−17 years. In addition, earlier initiation of drinking is related to more frequent and higher quantity alcohol consumption in adolescence, and these patterns are in turn related to the development of alcohol-related harms in adolescence and adulthood.
Measure detail	This measure includes three measure details, one included in this section: **1.3.4.1.C** **Proportion of adolescents 12–17 years who consume alcohol at least monthly**
Target	10 per cent decrease in excess alcohol consumption by adolescents by 2025 from 2014 baseline (Measure 1.3.4.1.C)
Definition	*Numerator:* Number of adolescents in Years 5, 8 and 11 who reported presently drinking alcohol at least monthly (Instrument–HBSC) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion
Data source	*Baseline and future:* About You DET *Alternatives:* ASSAD CCV
Data availability	*Baseline year:* 2014 *Frequency:* Biennial
Breakdown	Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET).
Comparability	National, state and territory rates available from ASSAD.
Linked to	Deaths due to road traffic crashes (Measure detail 1.1.5.1.A–B) Rate of alcohol, prescription drug or illicit drug related ambulance attendances (Measure detail 1.3.4.3.A) Hospitalisation rate due to assault (Measure detail 2.1.3.2)
Further information	The 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* state that the safest option for children and young people up to 18 years of age is not to drink. WHO has set a 10 per cent target for decreasing the prevalence of heavy episodic drinking among adolescents by 2025 from a 2010 baseline.

Measure	Proportion of adults and adolescents using an illicit drug in the past 12 months	
Rationale	Illicit drug use can cause serious harm to individuals, their families and the broader community. A considerable number of lives are lost every year to overdose, and illicit drug use can be a contributing factor in road trauma, crime, family violence, illness, lost opportunity, and reduced productivity. Monitoring illicit drug related ambulance attendances enables assessment of the prevalence of non-fatal impacts of illicit drugs, which may or may not require hospitalisation.	
Measure detail	**1.3.4.2**	**Proportion of people 14 years and older using an illicit drug in the past 12 months**
Target	Not set	
Definition	*Numerator:*	Number of people aged 14 years and older who reported use of at least 1 of 17 illicit drugs
	Denominator:	Total number of respondents in survey, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	NDSHS AIHW
	Alternatives:	Nil
Data availability	*Baseline year:*	2013
	Frequency:	Triennial
Breakdown	Data available for the state by age, sex, SEIFA (IRSD) and drug type, and by metropolitan/rural (ARIA) (custom request to AIHW).	
Comparability	National, state and territory rates available from NDSHS.	
Linked to	Rate of alcohol, prescription drug or illicit drug related ambulance attendances (Measure detail 1.3.4.3.C)	
Further information	People may not accurately report information relating to illicit drug use and related behaviours. This means that results relating to illicit drugs may be underestimated.	

Measure	Rate of alcohol, prescription drug or illicit drug related ambulance attendances
Rationale	Monitoring alcohol, prescription drug and illicit drug related ambulance attendances enables assessment of the prevalence of non-fatal impacts of consumption of these substances, which may or may not require hospitalisation. As more alcohol is consumed on a single occasion, skills and inhibitions decrease while risky behaviour increases, leading to a greater risk of injury during or immediately after that occasion. In recent years, trends have emerged highlighting increased misuse of over-the-counter and prescription medications such as prescription opioids and benzodiazepines. Mortality and morbidity associated with pharmaceutical drugs, particularly from opioids, has recently increased in Australia.
Measure detail	This measure includes three measure details: **1.3.4.3.A** **Rate of alcohol-related ambulance attendances** **1.3.4.3.B** **Rate of prescription drug-related ambulance attendances** **1.3.4.3.C** **Rate of illicit drug-related ambulance attendances**
Target	Not set

Measure	Rate of alcohol, prescription drug or illicit drug related ambulance attendances
Definition	**Measure 1.3.4.3.A:** *Numerator:* Number of ambulance attendances where alcohol is included in the electronic patient care record and assessed as the only cause, as far as can be ascertained, of the paramedic attendance **Measure 1.3.4.3.B:** *Numerator:* Number of ambulance attendances where a pharmaceutical drug is included in the electronic patient care record and assessed as the immediate or recent use or inappropriate use of a substance or medication is significant to the reason for paramedic attendance. Drugs included are: • anticonvulsants • antidepressants • antipsychotics • opioid analgesics • other analgesics • benzodiazepines, and • inhalants (note that inhalants are not prescription medicines) **Measure 1.3.4.3.C:** *Numerator:* Number of ambulance attendances where an illicit drug is included in the electronic patient care record and assessed as the immediate or recent use or inappropriate use of a substance or medication is significant to the reason for paramedic attendance. Illicit drugs included are: • cannabis • ecstasy • amphetamines • crystal methamphetamine • other amphetamine • cocaine related attendances • gamma-hydroxybutyrate, and • heroin (all heroin-related attendances, including overdose (responding to naloxone) and other heroin) **All measures** *Denominator:* Mid-year population estimate (Source–ABS) *Mode:* Rate per 100,000 population
Data source	*Baseline and future:* Victorian Ambulance Clinical Information System (VACIS®) Ambulance Victoria *Alternatives:* Nil
Data availability	*Baseline year:* 2012-13 *Frequency:* Annual
Breakdown	Data available for the state by sex, age (approximate), and by metropolitan/rural (of attendance) and LGA (of attendance).
Comparability	Limited comparability, mostly based on research studies.

Measure	Rate of alcohol, prescription drug or illicit drug related ambulance attendances
Linked to	Proportion of adults and adolescents who consume excess alcohol (Measure detail 1.3.4.1.A–C) Proportion of adults and adolescents using an illicit drug in the past 12 months (Measure detail 1.3.4.2)
Further information	Nil.

Indicator 1.3.5: Increase immunisation

Measure	Notification rate for vaccine preventable diseases	
Rationale	Vaccine preventable diseases are most commonly monitored using reports of disease notifications (predominantly laboratory diagnoses), hospitalisations and deaths. Notification rates indicate disease incidence in the population.	
Measure detail	**1.3.5.1**	**Notification rate for vaccine preventable diseases**
Target	Not set	
Definition	*Numerator:*	Number of notifications for locally-acquired vaccine preventable diseases for: • all ages – diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps and rubella • infants and children – Haemophilus influenza type b (Hib), hepatitis B, meningococcal C disease, pneumococcal disease and varicella-zoster virus • adolescents and young adult women – hepatitis B and varicella • older people (older than 50 years) – pneumococcal disease • Aboriginal and Torres Strait Islander people – hepatitis A
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Rate per 100,000 population
Data source	*Baseline and future:*	PHESS DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2011
	Frequency:	Annual and triennial, depending on breakdown
Breakdown	Data available for the state by age, sex and Aboriginal Victorians (for some conditions) and by regions and LGA.	
Comparability	National, state and territory rates available from NNDSS.	
Linked to	Immunisation coverage rate at school entry (Measure detail 1.3.5.2) HPV three-dose vaccination coverage for adolescents turning 15 years of age (Measure detail 1.3.5.3)	
Further information	Nil.	

Measure	Immunisation coverage rate at school entry	
Rationale	Immunisation is one of the most effective medical interventions to prevent disease. Vaccination not only protects individuals, but also others in the community, by increasing the level of immunity in the population and minimising the spread of infection. Proper and timely immunisation effectively protects children from a host of debilitating and sometimes deadly diseases and is most effective when a high proportion of the population has been immunised.	
Measure detail	**1.3.5.2**	**Immunisation coverage rate at school entry**
Target	95 per cent coverage of school entry immunisation by 2025 from 2014–2015 (Measure 1.3.5.2)	
Definition	*Numerator:*	Number of children aged 60 to less than 63 months, who have been fully vaccinated according to the National Immunisation Programme Schedule
	Denominator:	Number of children aged 60 to less than 63 months registered in the Australian Childhood Immunisation Register (ACIR)
	Mode:	Proportion
Data source	*Baseline and future:*	ACIR Department of Health Australian Government
	Alternatives:	Nil
Data availability	*Baseline year:*	30 June 2011
	Frequency:	Annual
Breakdown	Data available for the state by Aboriginal Victorians and by LGA.	
Comparability	National, state and territory rates available annually from ACIR. Included in the National Healthcare Agreement and reported in ROGS from ACIR.	
Linked to	Notification rate for vaccine preventable diseases (Measure detail 1.3.5.1)	
Further information	95 per cent immunisation coverage at school entry is a Victorian Government BP3 target.	

Measure	HPV three-dose vaccination coverage for adolescents turning 15 years of age	
Rationale	Human papillomaviruses (HPV) are the major cause of cervical cancer in women. Genital warts and some cancers in males are related to HPV, including most anal cancer, and some cancers of the penis, head and neck. The HPV vaccine triggers the formation of antibodies to produce immunity, thus protecting the body from disease.	
Measure detail	**1.3.5.3**	**HPV three-dose vaccination coverage for adolescents turning 15 years of age**
Target	Not set	
Definition	*Numerator:*	Number of adolescents turning 15 years of age who have received three doses of HPV vaccine which were reported to the National HPV Vaccination Program Register
	Denominator:	Number of adolescents turning 15 years of age, from mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	National Human Papillomavirus Register
	Alternatives:	Nil
Data availability	*Baseline year:*	2013
	Frequency:	Annual
Breakdown	Data available for the state by sex and by LGA.	
Comparability	National, state and territory comparisons available annually from ACIR.	
Linked to	Nil	
Further information	Nil.	

Domain 2: Victorians are safe and secure

Outcome 2.1: Victorians live free from abuse and violence

Indicator 2.1.1: Reduce prevalence and impact of abuse and neglect of children

Measure	Rate of children who were the subject of child abuse and neglect substantiation	
Rationale	The impact of child abuse can have life-long consequences and result in poorer mental and physical health. In Australia, statutory child protection is the responsibility of the state and territory governments. In Victoria, DHHS is responsible for child protection and provides care and protection to vulnerable children who have been, or are at risk of being, abused, neglected, or otherwise harmed, or whose parents are unable to provide adequate care or protection. Concerns of suspected child abuse or neglect can be reported to the statutory child protection service by a family member, member of the public or a professional. Child protection intake services screen incoming reports to determine whether further action is required. Reports that are deemed to require further action and are classified as a 'child protection notification' are investigated. Following an investigation the child protection service determines if the report is 'substantiated', indicating that a child may be at significant risk of harm.	
Measure detail	**2.1.1.1**	**Rate of children who were the subject of child abuse and neglect substantiation**
Target	Not set	
Definition	*Numerator:*	Number of children 0–17 years who were the subject of child abuse and neglect substantiation of a notification received during the receptive financial year
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Rate per 1,000 children
Data source	*Baseline and future:*	Client Relationship Information System (CRIS) DHHS
	Alternatives:	Child Protection National Minimum Data Set AIHW
Data availability	*Baseline year:*	2012–13
	Frequency:	Annual
Breakdown	Data available for the state by age, sex and abuse type and by LGA.	
Comparability	National child protection data are based on those cases reported to departments responsible for child protection and, therefore, are likely to understate the true prevalence of child abuse and neglect across Australia. Notifications made to other organisations, such as the police or non-government welfare agencies, are only included if these notifications were also referred to departments responsible for child protection.	
Linked to	Proportion of children living in families with unhealthy family functioning (Measure detail 1.2.1.3) Rate of incidents of family violence recorded by police (Measure detail 2.1.2.1) Family violence index (TBD) (Measure detail 2.1.2.2)	
Further information	Nil.	

Indicator 2.1.2: Reduce prevalence and impact of family violence

Measure	Rate of incidents of family violence recorded by police
Rationale	Family violence causes substantial physical and psychological harm, particularly to women and children. It can destroy families and undermine communities. People who experience family violence are at greater risk of mental health disorders and their health and wellbeing are likely to be affected in both the short- and long-term. Experiencing of family violence, including witnessing family violence, can have harmful effects on children's and young peoples' physical, cognitive, emotional, behavioural and social development.
Measure detail	This measure includes two measure details: **2.1.2.1** **Rate of incidents of family violence recorded by police** **2.1.2.2** **Family violence index (TBD)**
Target	Not set
Definition	**Measure 2.1.2.1:** *Numerator:* Number of family incidents reports recorded by police *Denominator:* Mid-year population estimate (Source–DEDJTR derived from ABS for the current reference period, ABS for other periods) *Mode:* Rate per 100,000 population **Measure 2.1.2.2:** TBD
Data source	**Measure 2.1.2.1:** *Baseline and future:* Law Enforcement Assistance Program (LEAP) Victoria Police *Alternatives:* Nil **Measure 2.1.2.2:** TBD
Data availability	**Measure 2.1.2.1:** *Baseline year:* 2011-12 *Frequency:* Annual **Measure 2.1.2.2:** TBD
Breakdown	**Measure 2.1.2.1:** Data available for the state by whether children were present; age, sex and relationship of victim and other parties; and Police Service Area and LGA of incident (custom request to Crime Statistics Agency). **Measure 2.1.2.2:** TBD.
Comparability	National, state and territory comparability not available.
Linked to	Proportion of children living in families with unhealthy family functioning (Measure detail 1.2.1.3) Rate of children who were the subject of child abuse and neglect substantiation (Measure detail 2.1.1.1)

Measure	Rate of incidents of family violence recorded by police
Further information	Family violence is defined for the purposes of the Victorian Family Violence Database according to Victorian the *Family Violence Protection Act (2008)*. Family violence is defined, such that: • 'violence' includes behaviours that are physically or sexually abusive, emotionally, psychologically or economically abusive, threatening, coercive or which cause a person to fear for the safety or cause a child to hear or witness the above types of behaviours; • 'family member' includes a relationship between a person with a disability and the person's carer where they are dependent on support. In 2014, the Victorian Government commissioned Australia's National Research Organisation for Women's Safety to develop a family violence index. The index will bring together data from across the fields of crime, justice, health, education and our community to create a single indicator of family violence.

Indicator 2.1.3: Increase community safety

Measure	Proportion of adults experiencing at least one incident of sexual violence since the age of 15 years	
Rationale	Sexual violence can have harmful and lasting consequences for victims/survivors, families and communities. The impacts include immediate and long-term physical and psychological and social consequences. Sexual assault is one of the most under-reported categories of crime to the police. Thus self-report, while underestimating the extent of sexual violence, is the most robust measure available for monitoring.	
Measure detail	**2.1.3.1**	**Proportion of adults experiencing at least one incident of sexual violence since the age of 15 years**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported experiencing at least one incident of sexual violence in their lifetime, since the age of 15 years
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	Personal Safety Survey ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2012
	Frequency:	Every 4 years
Breakdown	Data available for the state by age, sex, SEIFA (IRSD) and metropolitan/rural (ARA) and by type of sexual violence (assault or threat) (custom request to ABS).	
Comparability		
Linked to	Rate of incidents of family violence recorded by police (Measure detail 2.1.2.1) Family Violence Index (TBD) (Measure detail 2.1.2.2.)	
Further information	Nil.	

Measure	Hospitalisation rate due to assault	
Rationale	The measure of the hospitalisation rate due to assault contributes to our understanding of the levels of community safety and wellbeing.	
Measure detail	**2.1.3.2**	**Hospitalisation rate due to assault**
Target	Not set	
Definition	*Numerator:*	Number of separations from public and private hospitals of residents, where the principal diagnosis was recorded as ICD–10–AM code X85–Y09. State reporting is inclusive and exclusive of same-day admissions. Sub-state reporting for population groups and areas excludes same-day admissions
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Age standardised rate per 100,000 population, standardised to the 2001 population of Australia
Data source	*Baseline and future:*	VAED DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2012-13
	Frequency:	Annual (single year and rolling 3-year average, depending on breakdown)
Breakdown	Data available for the state by age, sex, CALD (country of birth) and SEIFA (IRSED) and by metropolitan/rural using single year of data and by regions using rolling 3-year average.	
Comparability	National state and territory comparisons may be available for some years.	
Linked to	Nil	
Further information	The baseline year is 2012-13 because the definition used to count numbers of admitted cases in Victoria changed, beginning with cases whose episode of hospital care ended on 1 July 2012. Exclusion of same-day admissions creates more comparable rates because there is variation in admission practices across time and between hospitals.	

Measure	Proportion of adults feeling safe walking in their street at night	
Rationale	Neighbourhoods perceived as safe foster community participation, encourage physical activity, community connectedness, and add to the health and wellbeing of local residents and visitors. Perception of neighbourhood safety is a measure of the social capital of a community. Research demonstrates that built environment and neighbourhood design and maintenance, have a high impact on perceptions of safety.	
Measure detail	**2.1.3.3**	**Proportion of adults feeling safe walking in their street at night**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported they felt safe walking in their street at night (Scale: no not often, sometimes, yes definitely)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VPHS DHHS
	Secondary source	
	Baseline and future:	GSS ABS (Reported as measure: Feeling very safe or safe walking alone in the local area after dark: Scale: very safe, safe, neither safe nor unsafe and unsafe)
	Alternatives:	VicHealth Indicators Survey; National Survey of Community Satisfaction with Policing
Data availability	**Primary source**	
	Baseline year:	2011–12
	Frequency:	Triennial
	Secondary source	
	Baseline year:	2014
	Frequency:	Every 4 years
Breakdown	Data available from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural, regions and LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS).	
Comparability	National rates available from GSS, and some state and territory estimate may be available. Included in the DEDJTR outcomes framework sourced from GSS. Similar measure reported in ROGS sourced from the National Survey of Community Satisfaction with Policing.	

Measure	Proportion of adults feeling safe walking in their street at night
Linked to	Proportion of adults experiencing at least one incident of crime in the past 12 months (Measure detail 2.1.3.4) Rate of victimisation due to crimes recorded by police (Measure detail 2.1.3.5) Liveability (TBD) (Measure detail 5.1.1.1) Community resilience (TBD) (Measure detail 5.1.2.2)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	**Proportion of adults experiencing at least one incident of crime in the past 12 months**	
Rationale	Crime impacts personal and community safety, wellbeing, security, the attractiveness of an area for recreation, and on general amenity. The incidence of crime is both a cause and symptom of low quality of life, and is associated with poverty and exclusion. Self-reported experience of crime assesses the prevalence of the experience of crime in communities, only some of which is reported to the police.	
Measure detail	**2.1.3.4**	**Proportion of adults experiencing at least one incident of crime in the past 12 months**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported experiencing at least one incident of crime in the last 12 months
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion
Data source	**Primary source**	
	Baseline and future:	: GSS ABS
	Secondary source	
	Baseline and future:	Crime Victimisation Survey ABS
	Alternatives:	Nil
Data availability	**Primary source**	
	Baseline year:	2014
	Frequency:	Every 4 years
	Secondary source	
	Baseline year:	2011–12
	Frequency:	Annual
Breakdown	Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS) Data available from Crime Victimisation Survey ABS for the state by sex, employment and by type of crime (physical assault, threatened assault, sexual assault, robbery)	
Comparability	National, state and territory rates available from GSS.	
Linked to	Proportion of adults feeling safe walking in their street at night (Measure detail 2.1.3.3) Rate of victimisation due to crimes recorded by police (Measure detail 2.1.3.5)	
Further information	Nil.	

Measure	Rate of victimisation due to crimes recorded by police
Rationale	Both prevalence of self-reported experience of crime and official crime statistics monitor crime in Victoria. There is a significant shortfall in the crime counts of police recorded crime, compared with crime reported in 'crime experience' surveys.
Measure detail	**2.1.3.5** **Rate of victimisation due to crimes recorded by police**
Target	Not set
Definition	*Numerator:* Number of victims of crimes recorded by police *Denominator:* Mid-year population estimate (Source–DEDJTR derived from ABS for the current reference period, ABS for other periods). *Mode:* Rate per 100,000 population
Data source	*Baseline and future:* LEAP VP *Alternatives:* Nil
Data availability	*Baseline year:* 2011-12 *Frequency:* Annual
Breakdown	Data available for the state by age and crime type, and by Police Service Area and LGA of incident (custom request to Crime Statistics Agency).
Comparability	National, state and territory rates available annually from Recorded Crime–Victims ABS.
Linked to	Proportion of adults feeling safe walking in their street at night (Measure detail 2.1.3.3) Proportion of adults experiencing at least one incident of crime in the past 12 months (Measure detail 2.1.3.4)
Further information	Nil.

Outcome 2.2: Victorians have suitable and stable housing

Indicator 2.2.1: Decrease homelessness

Measure	Proportion of people who are homeless	
Rationale	Adequate housing meets peoples essential needs for shelter, security and privacy. Shelter is recognised throughout the world as a basic human right. Homelessness is one of the most potent examples of disadvantage in the community, and one of the most important markers of social exclusion.	
Measure detail	**2.2.1.1**	**Proportion of people who met the statistical definition of homelessness**
Target	Not set	
Definition	*Numerator:*	Number of persons in one of the following categories on Census night: • living in improvised dwellings, tents, sleepers out • in supported accommodation for the homeless • staying temporarily with other households • living in boarding houses • in other temporary lodging • living in 'severely' crowded dwellings
	Denominator:	Total number of respondents to survey
	Mode:	Proportion
Data source	*Baseline and future:*	Census of Population and Housing ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2011
	Frequency:	5-yearly
Breakdown	Data available for the state by age, sex and Aboriginal Victorians and by metropolitan/rural (ARIA) and regions (custom request to ABS).	
Comparability	National, state and territory rates available from the Census of Population and Housing ABS. Included in National Affordable Housing Agreement and reported in ROGs sourced from the Census of Population and Housing ABS.	
Linked to	Proportion of people living in households below the 50 per cent poverty line (Measure detail 3.3.1.3)	
Further information	Nil.	

Domain 3: Victorians have the capabilities to participate

Outcome 3.1: Victorians participate in learning and education

Indicator 3.1.1: Decrease developmental vulnerability

Measure	Proportion of children at school entry who are developmentally on track	
Rationale	Supporting children's optimal physical, emotional and social health in the early years has long lasting positive effects on their health, social and emotional wellbeing and achievements throughout life. The benefits include increased school success; increased future productivity; and reduced cost of health and public services. Physical and social developmental deficits or delays may be more difficult to address as children grow older. Children from disadvantaged backgrounds are more at risk of poorer development and evidence demonstrates the differences between children from disadvantaged backgrounds and other children that emerge early in life. The Australian Early Development Census (AEDC) provides a snapshot of children's development within their communities. It reports on five critical domains of children's development: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge.	
Measure detail	**3.1.1.1:**	**Proportion of children at school entry who are developmentally on track on all five domains of the Australian Early Development Census**
Target	Not set	
Definition	*Numerator:*	Number of children at school entry who score as developmentally on track on all five domains of the AEDC
	Denominator:	Number of children who complete the AEDC
	Mode:	Proportion
Data source	*Baseline and future:*	AEDC Commonwealth Department of Education and Training Currently collected in Victoria by The Social Research Centre
	Alternatives:	Nil
Data availability	*Baseline year:*	2012
	Frequency:	Triennial
Breakdown	Data available for the state by sex and for Aboriginal Victorians and by metropolitan/rural, regions, LGA, Statistical Local Areas and Statistical Areas Level 2.	
Comparability	National, state and territory rates available from AEDC. Included in DET outcomes framework, sourced from the AEDC.	
Linked to	Nil	
Further information	Nil.	

Indicator 3.1.2: Increase educational attainment

Measure	Proportion of Year 9 students at the highest level of achievement in maths and reading
Rationale	Meaningful and relevant education plays a fundamental role in both personal and social development. Levels of education influence employment opportunities and income, which in turn influence housing, transport, community participation and many other determinants of health. Education can support the development of interpersonal and life skills, understanding of others and can build relationships among individuals and groups. NAPLAN tests skills in literacy and numeracy that are developed over time through delivery of the school curriculum.
Measure detail	This measure includes two measure details: **3.1.2.1** **Proportion of Year 9 students at the highest level of achievement in maths** **3.1.2.2** **Proportion of Year 9 students at the highest level of achievement in reading**
Target	25 per cent more Year 9 students will reach the highest levels of achievement in maths by 2025 from 2015 baseline (Measure 3.1.2.1) 25 per cent more Year 9 students will reach the highest levels of achievement in reading by 2025 from 2015 baseline (Measure 3.1.2.2)
Definition	**Measure 3.1.2.1:** *Numerator:* Number of Year 9 students in the top two proficiency levels of NAPLAN numeracy **Measure 3.1.2.2:** *Numerator:* Number of Year 9 students in the top two bands of NAPLAN reading **All Measures:** *Denominator:* Number of Year 9 students who participated in testing or were officially exempted. *Mode:* Proportion
Data source	*Baseline and future:* NAPLAN *Alternatives:* Nil
Data availability	*Baseline year:* 2015 *Frequency:* Annual
Breakdown	Data available for the state by sex, Aboriginal Victorians and LBOTE and by LGA.
Comparability	National, state and territory rates available from NAPLAN. Included in DET outcomes framework, sourced from NAPLAN.
Linked to	Nil
Further information	Education State Target is 25 per cent more Year 9 students will reach the highest levels of achievement in reading and maths in 10 years from 2015 baseline.

Outcome 3.2: Victorians participate in and contribute to the economy

Indicator 3.2.1: Increase labour market participation

Measure	Unemployment rate
Rationale	At an individual level, unemployment impacts a person's ability to afford basic necessities such as food and shelter and is linked to levels of personal satisfaction, depression, anxiety, suicide and CVD with a reduction in life expectancy. Insufficient employment opportunities may lead to a decline in health and skill levels of unemployed people, family breakdown and increased crime rates. For the community, unemployed adults lose skills causing a decline in human capital which can impact economic growth. Long-term unemployment substantially reduces future employment prospects and potentially changes entrenched cyclical unemployment into structural unemployment. It can result in deep distress, worse mental and physical health, higher mortality rates, hamper children's educational progress, and lower their future earnings.
Measure detail	This measure includes two measure details: **3.2.1.1.A** **Unemployment rate** **3.2.1.1.B** **Long-term unemployment rate**
Target	Not set
Definition	**Measure 3.2.1.1.A:** *Numerator:* Number of adults aged 18 years and older who are seeking employment and are yet to find it *Denominator:* Number of adults in the labour force (Source–ABS). *Mode:* Proportion **Measure 3.2.1.1.B:** *Numerator:* Number of adults aged 18 years and older who are have been seeking employment for at least one year and are yet to find it *Denominator:* Number of adults in the labour force (Source–ABS) *Mode:* Proportion
Data source	**Measure 3.2.1.1.A:** **Primary source** *Baseline and future:* Census of Population and Housing ABS **Secondary source:** *Baseline and future:* Labour Force Survey ABS *Alternatives:* Nil **Measure 3.2.1.1.B:** **Primary source** *Baseline and future:* Census of Population and Housing ABS **Secondary source** *Baseline and future:* Labour Force Survey ABS *Alternatives:* Nil

Measure	Unemployment rate
Data availability	**Primary source** *Baseline year:* 2011 *Frequency:* Every five years **Secondary source** *Baseline year:* 2011 *Frequency:* Monthly
Breakdown	Data available for the state by age, sex and Aboriginal Victorians, and by LGA from Census of Population and Housing ABS: By state only from Labour Force Survey ABS.
Comparability	National, state and territory rates available from both Census of Population and Housing ABS and Labour Force Survey ABS. Measure 3.2.1.1.A and Measure 3.2.1.1.B are included in the DEDJTR outcomes framework, from the data sources described above.
Linked to	Proportion of young people engaged in full time education and/or work (Measure detail 3.2.1.2) Proportion of adults and children who ran out of food and could not afford to buy more (Measure details 3.3.1.1.A–B) Proportion of households with housing costs that represent 30 per cent or more of household gross income (Measure detail 3.3.1.2) Proportion of people living in households below the 50 per cent poverty line (Measure detail 3.3.1.3) Liveability (TBD) (Measure detail 5.1.1.1)
Further information	Nil.

Measure	**Proportion of young people engaged in full time education and/or work**
Rationale	Young people who are not engaged in education, employment or training are at greater risk of poor health, depression or early parenthood. A school leaver's range of options can include work, university or vocational training and many combinations of work and education. This measure is included to quantify young people's engagement in education, training and work.
Measure detail	**3.2.1.2** **Proportion of young people 17–24 years who are engaged in full time education and/or work**
Target	Not set
Definition	*Numerator:* Number of people aged 17–24 years who are fully engaged in post school education, training or employment *Denominator:* Number of people aged 17–24 years who are not at school (Source–ABS) *Mode:* Proportion
Data source	**Primary source** *Baseline and future:* Census of Population and Housing ABS **Secondary source** *Baseline and future:* Education and Work ABS ***Alternatives:*** **Primary source** National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and AATSIHS **Secondary source** Nil
Data availability	**Primary source** *Baseline year:* 2011 *Frequency:* Every 4 years **Secondary source** *Baseline year:* 2012 *Frequency:* Annual
Breakdown	Data available for the state by age, sex, engagement type, Aboriginal Victorians and SEIFA (IRSD) and by LGA (special request to ABS)
Comparability	National, state and territory rates available from Census of Population and Housing ABS and from Education and Work ABS. Included in the National Education Agreement and reported annually in ROGS, based on Census of Population and Housing ABS and Education and Work ABS.
Linked to	Unemployment rate (Measure detail 3.2.1.1.A–B)
Further information	Nil.

Outcome 3.3: Victorians have financial security

Indicator 3.3.1: Decrease financial stress

Measure	Proportion of adults and children who ran out of food and could not afford to buy more
Rationale	This measure seeks to identify people who may be at risk of a poor diet due to their financial incapacity to purchase food, and/or due to social exclusion. Food and nutrition have long been recognised as important contributors to health. However, food and nutrition affect more than just the physical aspects of our health and wellbeing. The buying, preparing and eating of food is part of everyday life. For many people, food is a focus for social interactions with family, friends and communities.
Measure detail	This measure includes two measure details: **3.3.1.1.A** **Proportion of adults who ran out of food and could not afford to buy more** **3.3.1.1.B** **Proportion of children 0–12 years living in households that ran out of food and could not afford to buy more**
Target	Not set
Definition	**Measure 3.3.1.1.A:** *Numerator:* Number of adults aged 18 years and older who reported they had run out of food in the previous 12 months and could not afford to buy more *Denominator:* Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS) *Mode:* Proportion, age standardised to the 2011 Victorian population **Measure 3.3.1.1.B:** *Numerator:* Number of children aged 0–12 years whose parent/guardian reported that in the past 12 months the households had ran out of food and could not afford to buy more (Instrument–NSW Centre for Public Health Nutrition) *Denominator:* Total number of respondents in survey, weighted to mid-year population estimate, aged 0–12 years (Source–ABS) *Mode:* Proportion
Data source	**Measure 3.3.1.1.A:** *Baseline and future:* VPHS DHHS *Alternatives:* AATSIHS ABS, NHS ABS **Measure 3.3.1.1.B:** *Baseline and future:* VCHWS DET *Alternatives:* Nil
Data availability	**Measure 3.3.1.1.A:** *Baseline year:* 2011–12 *Frequency:* Triennial **Measure 3.3.1.1.B:** *Baseline year:* 2013 *Frequency:* Triennial

Measure	Proportion of adults and children who ran out of food and could not afford to buy more
Breakdown	Data available from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural, regions and LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from VCHWS for the state by age, sex, family type, Aboriginal Victorians, SEIFA (IRSD), health care card and for children with special health care needs) and by metropolitan/rural and regions (custom request to DET).
Comparability	National, state and territory rates available triennially from NHS.
Linked to	Unemployment rate (Measure detail 3.2.1.1.A–B) Proportion of young people engaged in full time education and/or work (Measure detail 3.2.1.2) Proportion of households with housing costs that represent 30 per cent or more of household gross income (Measure detail 3.3.1.2) Proportion of people living in households below the 50 per cent poverty line (Measure detail 3.3.1.3) Liveability (TBD) (Measure detail 5.1.1.1)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure. From 2017 the VCHWS may use a dual sampling frame of landline and mobile phones to recruit respondents. This may affect the appropriateness of using the 2013 VCHWS survey as a baseline for this measure, particularly for some population groups.

Measure	**Proportion of households with housing costs that represent 30 per cent or more of household gross income**	
Rationale	Housing or shelter is one of our most basic needs. While there is a complex relationship between housing and health, poor housing is frequently associated with poorer health. Adequate housing means safe, secure and affordable shelter. The adequacy or otherwise of housing is an important component of individual wellbeing. Housing affordability is a relative term linking the cost, availability, demand, and supply of housing together. Affordability of housing will affect choice of location, access to employment, education, essential services and proximity to social and family networks. The cost of housing is particularly significant to people on lower incomes. When costs are high, people have less income to spend on other essential household items. Multiple measures of housing affordability are used, with no accepted national definition.	
Measure detail	**3.3.1.2**	**Proportion of households with housing costs that represent 30 per cent or more of household gross income**
Target	Not set	
Definition	*Numerator:*	Number of households with housing costs that represent 30 per cent or more of household gross income
	Denominator:	Number of households in census, weighted to mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	Census of Population and Housing ABS
	Alternatives:	Survey of Income and Housing ABS
Data availability	*Baseline year:*	2011
	Frequency:	Every five years
Breakdown	Data available by LGA (custom request to ABS).	
Comparability	National state and territory rates available from ABS Census of Population and Housing.	
Linked to	Unemployment rate (Measure detail 3.2.1.1.A–B) Proportion of young people engaged in full time education and/or work (Measure detail 3.2.1.2) Proportion of adults and children who ran out of food and could not afford to buy more (Measure details 3.3.1.1.A–B) Proportion of people living in households below the 50 per cent poverty line (Measure detail 3.3.1.3) Liveability (TBD) (Measure detail 5.1.1.1)	
Further information	Nil.	

Measure	Proportion of people living in households below the 50 per cent poverty line	
Rationale	Poverty has negative consequences for those who are experiencing it: for their sense of self-worth and physical wellbeing, and perhaps most importantly for their children and for future generations. Poverty also damages our social relationships, and our sense of community. Evidence demonstrates that childhood poverty leads to premature mortality and poor health outcomes for adults. There are multiple measures of poverty. The proportion of people living in households below the 50 per cent poverty line, also used by OECD, equates to a very austere living standard – a disposable income of less than $400 per week for a single adult in 2011–12, with different poverty lines to take account of the number of adults and children in a household.	
Measure detail	**3.3.1.3**	**Proportion of people living in households below the 50 per cent poverty line**
Target	Not set	
Definition	*Numerator:*	Number of people living in households where the equivalised adjusted disposable household income (adjusted to include housing costs and imputed rent), was less than 50 per cent of the median household income
	Denominator:	Number of respondents in survey, weighted to the ABS mid-year population estimate (Source–ABS)
	Mode:	Proportion
Data source	*Baseline and future:*	Survey of Income and Housing ABS
	Alternatives:	HILDA
Data availability	*Baseline year:*	2013–14
	Frequency:	Biennial
Breakdown	Data available for the state by age, sex, country of birth, employment, main income source, family type, and for people with a disability, and by capital city/balance of state (custom request to ABS).	
Comparability	Related national, state and territory rates available from Survey of Income and Housing ABS (Reported as measure of proportion of population in quintiles of equivalised adjusted disposable household income (adjusted to include housing and imputed rent)). Included in the DEDJTR outcomes framework and sourced from the Survey of Income and Housing ABS.	
Linked to	Proportion of young people engaged in full time education and/or work (Measure detail 3.2.1.2) Proportion of adults and children who ran out of food and could not afford to buy more (Measure details 3.3.1.1.A–B) Proportion of households with housing costs that represent 30 per cent or more of household gross income (Measure detail 3.3.1.2) Liveability (TBD) (Measure detail 5.1.1.1)	
Further information	Measure also reported by Australian Council of Social Service derived from Survey of Income and Housing ABS.	

Domain 4: Victorians are connected to culture and community

Outcome 4.1: Victorians are socially engaged and live in inclusive communities

Indicator 4.1.1: Increase connection to culture and communities

Measure	Proportion of adults who belonged to an organised group	
Rationale	Community participation can contribute to wellbeing and can have an intrinsic value for participants, as well as benefits for the community. Community participation is part of the social capital of a community. The experience of participation is generally defined as the capacity in which community members can play a useful and authentic role in the decisions being made by that community, and feel a sense of community and belonging to a larger group. Belonging to an organised group can also include participation in the arts and culture, which can more broadly enrich wellbeing.	
Measure detail	**4.1.1.1**	**Proportion of adults who belonged to an organised group**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported they belonged to a community or action group (sports groups, religious groups, school groups, professional groups or other groups (Instrument–Question developed for VPHS)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VPHS DHHS
	Secondary source	
	Baseline and future:	GSS ABS (Reported as measure: Has actively participated in groups in the last 12 months (social groups, community support groups, civic and political groups))
	Alternatives:	Nil
Data availability	**Primary source**	
	Baseline year:	2011–12
	Frequency:	Triennial
	Secondary source	
	Baseline year:	2014
	Frequency:	Every 4 years

Measure	Proportion of adults who belonged to an organised group
Breakdown	Data available from VPHS for the state by age, sex, household income, employment, education. LBOTE and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural, regions and LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS). Data available from VicHealth Indicators Survey for the state by age, sex, education, employment, Aboriginal Victorians, main language spoken at home, CALD background, household structure, and for people with a disability, and by geographic regions (custom request to VicHealth).
Comparability	National rates available from GSS, and state and territory rates may become available.
Linked to	Proportion of adults who attended or participated in a cultural or arts activity (Measure detail: 4.1.1.2) Proportion of adults connected to culture and country (TBD) (Measure detail 4.1.1.3)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	**Proportion of adults who attended or participated in a cultural or arts activity**	
Rationale	Community participation can contribute to the social capital of a community. Participation can have an intrinsic value for participants, as well as benefits for the community. The experience of participation is generally defined as the capacity in which community members can play a useful and authentic role in the decisions being made by that community, and feel a sense of community and belonging to a larger group. Participation in the arts and culture can more broadly enrich wellbeing. Australians increasingly see the arts as important and relevant to their lives, through impacting on their ability to deal with stress, anxiety or depression and on their personal sense of wellbeing and happiness, on their ability to express themselves and think creatively, and on child development.	
Measure detail	**4.1.1.2**	**Proportion of adults who attended an arts activity in the last three months or cultural activity in the last 12 months**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported attending an arts activity or event in the last 3 months (Scale: daily; 4–6 times a week; 1–3 times a week; 2–3 times a month; once a month; once or twice in the last 3 months; not in the last 3 months)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VicHealth Indicators Survey
	Secondary source	
	Baseline and future:	GSS ABS (Reported as measure: Has attended at least one cultural and leisure venue or event in the past 12 months)
	Tertiary source	
	Baseline and future:	NATSIS ABS
	Alternatives:	Nil
Data availability	**Primary source**	
	Baseline year:	2011
	Frequency:	Every 4 years
	Secondary source	
	Baseline year:	2014
	Frequency:	Every 4 years
	Tertiary source	
	Baseline year:	2014–15
	Frequency:	Every 6 years

Measure	Proportion of adults who attended or participated in a cultural or arts activity
Breakdown	Data available from VicHealth Indicators Survey for the state by age, sex, education, employment, Aboriginal Victorians, main language spoken at home, CALD background, household structure, and for people with a disability, and by geographic region (custom request to VicHealth). Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS). Data available from NATSIS for the state by Aboriginal Victorians and others and by age, sex and by metropolitan/rural (custom request to ABS).
Comparability	National rates available from GSS, and state and territory rates may become available. Measure 4.1.1.2 is included in the DEDJTR outcomes framework sourced from VicHealth Indicators Survey.
Linked to	Proportion of adults who belonged to an organised group (Measure detail 4.1.1.1) Proportion of adults connected to culture and country (TBD) (Measure detail 4.1.1.3)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	Proportion of adults connected to culture and country (TBD)
Rationale	Connection to culture and country is fundamental to the health and wellbeing of Aboriginal Victorians.
Measure detail	**4.1.1.3 Proportion of adults connected to culture and country (TBD)**
Further information	This measure will be specific to Aboriginal and Torres Strait Islander people.

Indicator 4.1.2: Increase access to social support

Measure	Proportion of adults who have someone outside their household they can rely on to care for them or their children, in an emergency	
Rationale	Social support is the perception and actuality that one is cared for, has assistance available from other people and is part of a supportive social network. Perception of social support is an element of the social capital of a community. Social support is linked to many benefits for both mental and physical health. People with low social support are at increased risk of depression, anxiety and psychological distress, as well as poor adjustment to health conditions which can induce high stress. Low social support is also related to increased risk of poor physical health and death from a variety of diseases including cancer and CVD.	
Measure detail	**4.1.2.1**	**Proportion of adults who have someone outside their household they can rely on to care for them or their children, in an emergency**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported having someone outside their household (a relative or a friend not living with them) that they would rely on to care for them (or their children) in an emergency (Instrument–Question developed for VPHS)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VPHS DHHS
	Secondary source	
	Baseline and future:	GSS ABS (Reported as measure: Able to get support in a time of crisis from people living outside the household).
	Tertiary source	
	Baseline and future:	NATSIS ABS
	Alternatives:	Nil
Data availability	**Primary source**	
	Baseline year:	2011–12
	Frequency:	Annual and triennial, depending on breakdown
	Secondary source	
	Baseline year:	2014
	Frequency:	Every 4 years
	Tertiary source	
	Baseline year:	2014–15
	Frequency:	Every 6 years

Measure	Proportion of adults who have someone outside their household they can rely on to care for them or their children, in an emergency
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS). Data available from NATSIS for the state by Aboriginal Victorians and others and by age, sex and by metropolitan/rural (custom request to ABS).
Comparability	National rates available from GSS, and state and territory rates may become available.
Linked to	Life satisfaction of adults and adolescents (Measure detail 4.1.2.2.A–C)
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Measure	Life satisfaction of adults and adolescents
Rationale	Life satisfaction, a lead indicator of wellbeing, measures how people evaluate their life as a whole rather than how they feel at present, or how they feel about particular aspects of their life. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Wellbeing is a complex construct that concerns optimal experience and functioning. It reflects a subjective view of wellness that is more than the absence of disease or illness and incorporates broader concepts such as living conditions, quality of life and community connectedness. It is a valid population outcome measure beyond morbidity, mortality, and economic status that tells us how people perceive their life from their own perspective. Feeling that the things you do in life are worthwhile is part of the happiness and welfare (eudaimonic) approach to wellbeing, which focuses on meaning and self-realisation. Feeling that the things you do in life are worthwhile is conducive to happiness. Being happy is associated with better health, noting that what makes one person happy is often different from the next person.
Measure detail	This measure includes three measure details: **4.1.2.2.A** **Average overall life satisfaction of adults** **4.1.2.2.B** **Average extent that adults report that their life is worthwhile** **4.1.2.2.C** **Proportion of adolescents satisfied with their life**
Target	Not set
Definition	**Measure detail 4.1.2.2.A:** Average score of adults aged 18 years and older to the survey question 'How satisfied are you with your life overall?' (Cantrill Ladder Scale: from 0 'not at all satisfied' to 10 'completely satisfied') (Source–Satisfaction with Life Scale) **Measure detail 4.1.2.2.B:** Average score of adults aged 18 years and older to the survey question: 'Overall, to what extent do you feel the things you do in your life are worthwhile?' (Cantrill Ladder Scale: from 0 'not at all satisfied' to 10 'completely satisfied') **Measure detail 4.1.2.2.C:** *Numerator:* Number of adolescents in Years 5, 8 and 11 who rated six or more to the survey question 'In general where on the ladder do you feel you stand at the moment'? (Scale: 10 is the best possible life for you and 0 is the worst possible life for you) (Source–HBSC) *Denominator:* Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11 *Mode:* Proportion

Measure	Life satisfaction of adults and adolescents
Data source	**Measure 4.1.2.2.A:** **Primary source** *Baseline and future:* VPHS DHHS **Secondary source** *Baseline and future:* GSS ABS *Alternatives:* HILDA **Measure 4.1.2.2.B:** *Baseline and future:* VPHS DHHS *Alternatives:* HILDA **Measure 4.1.2.2.C:** *Baseline and future:* About You Department of Education and Training (DET) *Alternatives:* Nil
Data availability	**Measure 4.1.2.2.A:** **Primary source** *Baseline year:* 2015 *Frequency:* Annual and triennial, depending on breakdown **Secondary source** *Baseline year:* 2014 *Frequency:* Every 4 years **Measure 4.1.2.2.B:** *Baseline year:* 2015 *Frequency:* Annual and triennial, depending on breakdown **Measure 4.1.2.2.C:** *Baseline year:* 2014 *Frequency:* Biennial
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, culturally and linguistically diverse (CALD) backgrounds and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from GSS for the state by age, sex, household income, employment, education, household composition, gay/lesbian, recent migrant, and for people with a mental health condition, a long-term health condition or a disability, and by metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, language backgrounds other than English (LBOTE), student family occupation (SFO) and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET).

Measure	Life satisfaction of adults and adolescents
Comparability	**Measure 4.1.2.2.A:** National rates available from GSS, and state and territory rates may become available in future. International rates available for some years. Reported in ROGS from GSS for adults aged 65 years and older. **Measure 4.1.2.2.B:** Limited national, state, territory and international rates available for some years, based on specific surveys. **Measure 4.1.2.2.C:** Included in DET outcomes framework from About You.
Linked to	Nil
Further information	While Measure 4.1.2.2.A is considered the best overall measure of life satisfaction, how people respond can be affected by personality, mood, cultural norms and relative judgements. Data is available from HILDA for Measure 4.1.2.2.A–B for Aboriginal Australians.

Measure	Proportion of adults who feel most adults can be trusted	
Rationale	Social capital is widely used to explain and describe the social environment of communities, and plays a significant role in individual health and wellbeing. Social and civic trust are important indicators of social capital and may be a cause or consequence of social capital. Concepts of trust and wellbeing are tightly linked.	
Measure detail	**4.1.2.3**	**Proportion of adults who feel most adults can be trusted**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who agreed that definitely most people could be trusted (Scale: no not often, sometimes, yes definitely) (Instrument–Question developed for VPHS)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VPHS DHHS
	Secondary source:	
	Baseline and future:	GSS ABS (Reported as measure: Strongly agree/somewhat agree that most people can be trusted)
	Alternatives:	Nil
Data availability	**Primary source**	
	Baseline year:	2011–12
	Frequency:	*Triennial*
	Secondary source	
	Baseline year:	2014
	Frequency:	Every 4 years
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural, regions and LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS).	
Comparability	National rates available from GSS, and state and territory rates may become available.	
Linked to	Life satisfaction of adults and adolescents (Measure detail 4.1.2.2.A, C)	
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.	

Measure	**Proportion of adolescents 10–17 years who have a trusted adult in their lives**	
Rationale	The presence of a trusted adult in young people's lives is a key component of their capacity to build resilience to face, overcome and be transformed by adversity. Significant adult relationships matter to young people regardless of whether they are working, unemployed or in school. Having a trusted adult is considered a strong protective factor against school disengagement, mental health issues and development of anti-social or risky behaviours. Adults outside the home are important in helping young people navigate their way to adulthood. Parents, carers, relatives and teachers can play a significant role in building resilience in young people and contribute to learning and development, health and wellbeing.	
Measure detail	**4.1.2.4**	**Proportion of adolescents 10–17 years who have a trusted adult in their lives**
Target	Not set	
Definition	*Numerator:*	Number of adolescents in Years 5, 8 and 11 who reported that they agree, strongly agree or very strongly agree that they have a trusted adult in their lives they would turn to for advice on problems (Scale: very strongly disagree, strongly disagree, disagree, neither disagree or agree, agree, strongly agree, very strongly agree) (Instrument–Question developed by DET in consultation)
	Denominator:	Total number of adolescents in survey, weighted to school enrolments in Years 5, 8 and 11
	Mode:	Proportion
Data source	*Baseline and future:*	About You DET
	Alternatives:	Nil
Data availability	*Baseline year:*	2014
	Frequency:	Biennial
Breakdown	Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS). Data available from About You for the state by year level, sex, Aboriginal Victorians, family type, LBOTE, SFO and for adolescents with special health care needs, and by metropolitan/rural and regions (custom request to DET).	
Comparability	National rates available from GSS, and state and territory rates may become available.	
Linked to	Life satisfaction of adults and adolescents (Measure detail 4.1.2.2.B)	
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.	

Measure	Proportion of adults who feel valued by society	
Rationale	Feeling valued by society indicates civic trust, a companion measure to social trust, and is an important component of social capital and wellbeing. The extent to which a person feels valued by others who are important to them is strongly related to psychological wellbeing, and is a source of self-esteem.	
Measure detail	**4.1.2.5**	**Proportion of adults who feel valued by society**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who reported definitely feeling they were valued by society (Scale: no not often, sometimes, yes definitely) (Instrument–Question developed for VPHS)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	*Baseline and future:*	VPHS DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2011–12
	Frequency:	Triennial
Breakdown	Data available from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural, regions and LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase.	
Comparability	Limited national, state and territory comparability, mostly based on research studies.	
Linked to	Proportion of adults and adolescents with psychological distress (Measure detail 1.2.1.1.A)	
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.	

Outcome 4.2: Victorians can safely identify with their culture and identity

Indicator 4.2.1: Increase tolerance of diversity

Measure	Proportion of adults who thought multiculturalism definitely made life in their area better	
Rationale	Victoria is a diverse society. More than a quarter of Victorians were born overseas in more than 200 countries, two-thirds follow 135 faiths, and an estimated 10 per cent identify as lesbian, gay, bisexual, transgender or intersex. Victorian legislation recognises and values the cultural, religious, racial and linguistic diversity of the people of Victoria. Support for multiculturalism joins people from diverse backgrounds together while encouraging and enabling cultural and ethnic diversity. Multiculturalism is an approach that respects and values the diversity of ethnicities, cultures and faiths within a society and encourages and enables their ongoing contribution within an inclusive context that empowers all members of the society. Valuing and respecting diversity means people accept differences amongst individuals and groups, which fosters individual and community wellbeing, and is part of the social capital of a community.	
Measure detail	**4.2.1.1**	**Proportion of adults who thought multiculturalism definitely made life in their area better**
Target	Not set	
Definition	*Numerator:*	Number of adults aged 18 years and older who agreed they thought that multiculturalism definitely made life in their area better (Scale: no or not often, sometimes, yes definitely) (Instrument–Question developed for VPHS)
	Denominator:	Total number of adults in survey, weighted to mid-year population estimate, aged 18 years and older (Source–ABS)
	Mode:	Proportion, age standardised to the 2011 population of Victoria
Data source	**Primary source**	
	Baseline and future:	VPHS DHHS
	Secondary source	
	Baseline and future:	GSS ABS (Reported as measure: Strongly agree/somewhat agree that it is a good thing for society to be comprised of different cultures)
	Alternatives:	VicHealth Indicators Survey.
Data availability	**Primary source**	
	Baseline year:	2015
	Frequency:	Annual and triennial, depending on breakdown
	Secondary source	
	Baseline year:	2014
	Frequency:	Every 4 years

Measure	Proportion of adults who thought multiculturalism definitely made life in their area better
Breakdown	Data available annually from VPHS for the state by age, sex, household income, employment, education, CALD background and for adults with psychological distress and those with a chronic condition, and by metropolitan/rural and regions. Data available triennially from VPHS DHHS by LGA. Data may be available from VPHS triennially from 2017 onwards for Aboriginal Victorians, if respondent numbers increase. Data available from GSS for the state by age, sex, employment, education, income, main source of income, household composition, gay/lesbian, CALD (recent migrant, speaks English), and for people with a mental health condition, a long-term health condition or a disability and by metropolitan/rural (custom request to ABS).
Comparability	National rates available from GSS, and state and territory rates may become available. Included in the DEDJTR outcomes framework sourced from GSS.
Linked to	Social capital measures
Further information	From 2015 onwards the VPHS used a dual sampling frame of landline and mobile phones to recruit respondents. The inclusion of mobile phone users was seen to be critical to improving the representativeness of the VPHS sample and reducing the potential for bias in the survey estimates. This may affect the appropriateness of using the 2011–12 VPHS survey as a baseline for this measure.

Domain 5: Victoria is liveable

Outcome 5.1: Victorians belong to resilient and liveable communities

Indicator 5.1.1: Increase neighbourhood liveability

Measure	Liveability (TBD)
Rationale	Liveable communities are defined as safe, attractive, socially cohesive, environmentally sustainable and providing supportive infrastructure. These characteristics create conditions that can optimise health and wellbeing outcomes of residents by influencing various determinants of health. At its broadest level, liveability includes: crime and safety, housing, education, employment and income, health and social services, transport, public open space, social capital and cohesion, local demography, leisure and culture, food and other local goods, and the natural environment. The supportive infrastructure of liveable communities includes: walkable neighbourhoods, public transport, public open space, local amenities, and social and community facilities. Many of the components of liveability, such as residents feeling safe and socially connected, crime, housing affordability, air and water quality, participation in community and culture, and unemployment are captured elsewhere in this outcomes framework.
Measure detail	**5.1.1.1 Liveability (TBD)**
Target	Not set
Comparability	
Linked to	Measures of liveability included in the DEDJTR outcomes framework are Global Index of Liveability (Melbourne rank) and metropolitan Melbourne transport walkability index
Further information	The measures and measure details for this indicator are to be developed. This may include a composite index, as well as specific spatially derived accessibility indicators such as walkability, access to transport, access to public open space, access to a supermarkets and access to alcohol outlets. The Centre for Research Excellence for Healthy, Liveable Communities, McCaughey VicHealth Community Wellbeing Unit, University of Melbourne is undertaking a Liveability Study. The study aims to develop and validate a national set of spatially derived built environment liveability indicators associated with chronic disease risk behaviours and health outcomes, including a composite measure of urban liveability.

Indicator 5.1.2: Increase adaptation to the impacts of climate change

Measure	Excess death during extreme heat and heatwaves	
Rationale	Climate change will continue to alter global and local climates, and has implications for all Victorians. Climate change has many health and wellbeing effects, including increasing the frequency and severity of heatwaves. Heatwaves have physical and mental health impacts. They can affect anybody and cause illnesses such as heat cramps, heat exhaustion and heat stroke, which may be fatal. Those most at risk are older adults, young children and people with a diagnosed medical condition.	
Measure detail	**5.1.2.1**	**Excess death during extreme heat and heatwaves**
Target	Not set	
Definition	*Numerator:*	Number of deaths of residents from all causes, during the time period designated as extreme heat or a heatwave, registered in the respective calendar year. A day of extreme heat or heatwave (a prolonged event) is based on forecast average temperatures expected to reach or exceed the heat health temperature thresholds in specific weather forecast districts
	Denominator:	Average number of deaths expected for the period of the heat event, derived from the same period in preceding years
	Mode:	Number of excess deaths
Data source	*Baseline and future:*	Causes of Death ABS
	Alternatives:	Nil
Data availability	*Baseline year:*	2010 or 2008–2010 (3-year average)
	Frequency:	Annual (single year and rolling 3-year average)
Breakdown	Data available by age and sex and by metropolitan/rural and regions, pending on the location of the heatwave.	
Comparability	Limited comparability, mostly based on research studies.	
Linked to	Nil	
Further information	Data from Causes of Death ABS is not available for at least two years following a heatwave.	

Measure	Community resilience (TBD)
Rationale	Resilience is the capacity of any entity – an individual, a community, an organisation, or a natural system – to prepare for disruption, to recover from shocks and stresses, and to adapt and grow from a disruptive experience. Resilience helps communities respond to disruptions whether they are caused by natural disasters influenced by climate change, or other events within the community. The ability of a community to bounce back is integral to the health and wellbeing of residents and the future of the community.
Measure detail	**5.1.2.2 Community resilience (TBD)**
Comparability	
Linked to	Nil
Further information	The measures and measure details for this indicator are to be developed.

Outcome 5.2: Victorians have access to sustainable built and natural environments

Indicator 5.2.1: Increase environmental sustainability and quality

Measure	Renewable energy generation as a proportion of total electricity generation	
Rationale	Sustainable energy generation and use requires the adoption of energy conservation measures and emission controls. Energy use is a major limiting factor on the economy, as well as being an important factor for individual's use and community wellbeing. More environmentally sustainable ways of producing energy that result in health and environmental benefits include rooftop solar, as well as large-scale production of power from wind, hydro, solar and bioenergy.	
Measure detail	**5.2.1.1**	**Renewable energy generation as a proportion of total electricity generation**
Target	25 per cent of the state's electricity from Victorian-built renewable generation by 2020, and 40 per cent by 2025 from 2013–14 baseline (Measure 5.2.1.1)	
Definition	*Numerator:*	Amount of electricity generated from renewable fuels of bagasse, wood, biogas, wind, hydro, and solar photovoltaic
	Denominator:	Total amount of electricity generated from all sources.
	Mode:	Proportion
Data source	*Baseline and future:*	Australian Energy Statistics, Department of Industry and Science
	Alternatives:	Nil
Data availability	*Baseline year:*	2013–14
	Frequency:	Annual
Breakdown	Data available for the state by type of fuel.	
Comparability	National, state and territory rates available annually from Australian Energy Statistics. Included in the DEDJTR outcomes framework, sourced from the Australian Energy Statistics.	
Linked to	Per capita greenhouse gas emissions (Measure detail 5.2.1.2)	
Further information	Nil.	

Measure	Per capita greenhouse gas emission	
Rationale	There is international consensus that greenhouse gasses are the key cause of climate change. Greenhouse gases such as carbon dioxide trap heat, helping warm the globe. This measure is included as state and local governments can play a role in mitigating against climate change.	
Measure detail	**5.2.1.2**	**Per capita greenhouse gas emission**
Target	Not set	
Definition	*Numerator:*	Net CO_2 emissions
	Denominator:	Mid-year population estimate (Source–ABS).
	Mode:	Per capita
Data source	*Baseline and future:*	National Greenhouse Gas Inventory, Department of the Environment and Energy
	Alternatives:	Nil
Data availability	*Baseline year:*	2005
	Frequency:	Annual
Breakdown	Data available for the state by industry.	
Comparability	National state and territory rates available annually from National Greenhouse Gas Inventory. Included in the DEDJTR outcomes framework sourced from the National Greenhouse Gas Inventory.	
Linked to	Renewable energy generation as a proportion of total electricity generation (Measure detail 5.2.1.1)	
Further information	Australian Government has set a target to reduce emissions to 26–28 per cent of 2005 levels by 2030.	

Measure	Number of days where the national objective of PM_{10} was not met
Rationale	Airborne particulate matter, or fine particles, are measured in the air as either PM_{10} (smaller than 10 micrometres) or $PM_{2.5}$ (smaller than 2.5 micrometres). Fine particles can exacerbate cardiovascular or respiratory conditions, including asthma. Exposure to fine particles in air is associated with an increase in hospitalisations and premature mortality. The major sources of fine particles in an urban environment are emissions from motor vehicles (particularly diesel-powered), industry and wood combustion for heating. Smoke from bushfires and occasional dust storms also contribute to fine particles in the air environment. PM_{10} air quality monitoring is representative of the general air quality.
Measure detail	**5.2.1.3** **Number of days where the national objective of PM_{10} was not met**
Target	Not set
Definition	The number of days in a year where the average PM_{10} concentration exceeded the national objective of a 24-hour average of 50 µg/m^3 or below
Data source	*Baseline and future:* Air monitoring network Environment Protection Authority (EPA) *Alternatives:* Nil
Data availability	*Baseline year:* 2013 *Frequency:* Annual
Breakdown	Data available for Melbourne, Latrobe valley and one location in Geelong only.
Comparability	National, state and territory rates available annually from National Environment Protection (Ambient Air Quality) Measure Annual Reports. Included in the DEDJTR outcomes framework sourced from the EPA Air monitoring network.
Linked to	Liveability (TBD) (Measure detail 5.1.1.1)
Further information	National Environment Protection Measure for Ambient Air Quality goal is that the average 24-hour PM_{10} concentration does not exceed 50 µg/m^3 on more than five days per year. A Victorian $PM_{2.5}$ air quality monitoring program is under development and from 2018, will report nationally, in line with the national review of ambient air quality standards.

Measure	**Proportion of the population with reticulated drinking water that complies with the *E. coli* water quality standard**	
Rationale	Safe drinking water is an essential component of good public health and a community expectation. Safeguarding drinking water supplies and the safe use of alternative water supplies protects and improves public health and wellbeing. Victoria's approach to safeguarding the water supply system and drinking water quality is outlined in *Victoria's Safe Drinking Water Act 2003* and the Safe Drinking Water Regulations 2015. The quality of supplied drinking water is routinely monitored by local providers.	
Measure detail	**5.2.1.4**	**Proportion of the population with reticulated drinking water that complies with the *E. coli* water quality standard**
Target	Not set	
Definition	*Numerator:* *Denominator:* *Mode:*	Number of people whose reticulated drinking water complies with the water quality standards Mid-year population estimate of population with reticulated drinking water Proportion
Data source	*Baseline and future:* *Alternatives:*	Annual report on drinking water quality in Victoria DHHS Nil
Data availability	*Baseline year:* *Frequency:*	2015–16 Annual
Breakdown	Data available by water sampling locality.	
Comparability		
Linked to	Liveability indicators	
Further information	Drinking water quality standards are: • turbidity • disinfection byproducts (trihalomethanes) • escherichia coli (*E. coli*) and • other parameters that may pose a risk to health (Regulation 12: Safe Drinking Water Regulations 2015).	

Measure	Notification rate of salmonellosis	
Rationale	How food is grown, manufactured, distributed, prepared and sold can affect the safety of the food and its suitability to eat. In Victoria, there are several legislative and regulatory mechanisms in place to ensure food safety. The *Food Act 1984* and food standards, including health and hygiene obligations for food handlers, for example, aim to lower the incidence of food-borne illness and reduce unnecessary regulatory costs for businesses. Salmonellosis comprises the majority of notifications of detected pathogenic microorganisms in food or drinking water. This measure is provided at LGA level as Victoria's LGAs are the main regulators of food retailers.	
Measure detail	**5.2.1.5**	**Notification rate of salmonellosis**
Target	Not set	
Definition	*Numerator:*	Number of notifications of clinically detected salmonellosis
	Denominator:	Mid-year population estimate (Source–ABS)
	Mode:	Rate per 100,000 population
Data source	*Baseline and future:*	PHESS DHHS
	Alternatives:	Nil
Data availability	*Baseline year:*	2012
	Frequency:	Annual
Breakdown	Data available for the state by type of salmonellosis and by LGA.	
Comparability	National, state and territory rates available annually from NNDSS.	
Linked to	Nil	
Further information	Salmonellosis is nationally notifiable in Australia.	

Measure	Biodiversity (TBD)
Rationale	Biodiversity is needed for a healthy natural environment and encompasses all the components of the living world: the numbers and variety of plants, animals and other living things, including micro-organisms, in land, rivers, coast and ocean. Many species are at risk from a range of pressures such as habitat loss, fragmentation and degradation and the added pressures of climate change. Time spent in natural outdoor spaces is linked to positive long-term health outcomes and playing in natural environments contributes to healthy childhood development.
Measure detail	**5.2.1.6 Biodiversity (TBD)**
Further information	Department of Environment, Land, Water and Planning (DELWP) is developing *Protecting Victoria's Environment – Biodiversity 2036*, including measures of the biodiversity of Victoria.

Appendix: Data sources and owners

Data source	Owner
About You (also known as Victorian Student Health and Wellbeing Survey (VSHAWS))	Department of Education and Training
Air monitoring network	Environment Protection Authority Victoria
Annual report on drinking water quality in Victoria	Department of Health and Human Services
Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)	Australian Bureau of Statistics
Australian Childhood Immunisation Register (ACIR)	Department of Health Australian Government
Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Sexually Transmitted Infections and Blood Borne Viruses (ACCESS)	Burnet Institute
Australian Early Development Census (AEDC)	Department of Education and Training Australian Government, Currently collected in Victoria by The Social Research Centre
Australian Energy Statistics,	Department of Industry Innovation and Science, Australian Government
Causes of Death	Australian Bureau of Statistics
Census of Population and Housing	Australian Bureau of Statistics
Client Relationship Information System (CRIS)	Department of Health and Human Services
Crime Victimisation Survey	Australian Bureau of Statistics
Education and Work	Australian Bureau of Statistics
General Social Survey (GSS)	Australian Bureau of Statistics
Labour Force Survey	Australian Bureau of Statistics
Law Enforcement Assistance Program (LEAP)	Victoria Police
Life Tables, States, Territories and Australia	Australian Bureau of Statistics
Maternal and Child Health Collection (MCHC)	Department of Education and Training
National Aboriginal and Torres Strait Islander Social Survey (NATSISS)	Australian Bureau of Statistics
National Assessment Program – Literacy and Numeracy (NAPLAN)	National Assessment Program, Victorian Curriculum and Assessment Authority
National Drug Strategy Household Survey (NDSHS)	Australian Institute of Health and Welfare
National Greenhouse Gas Inventory	Department of the Environment and Energy

Data source	Owner
National Health Survey (NHS)	Australian Bureau of Statistics
National Human Papillomavirus Vaccination Program Register	Victorian Cytology Service, together with the Australian Government Department of Health
Notifiable Disease Surveillance System (NDSS)	Department of Health and Human Services
Personal Safety Survey	Australian Bureau of Statistics
Public Health Event Surveillance System (PHESS)	Department of Health and Human Services
Road Crash Information System	VicRoads
Survey of Income and Housing	Australian Bureau of Statistics
VicHealth Indicators Survey	VicHealth
Victorian Admitted Episodes Dataset (VAED)	Department of Health and Human Services
Victorian Ambulance Clinical Information System (VACIS)	Ambulance Victoria
Victorian Child Health and Wellbeing Survey (VCHWS)	Department of Health and Human Services
Victorian Integrated Survey of Travel and Activity (VISTA)	Department of Economic Development, Jobs, Transport and Resources
Victorian Perinatal Data Collection (VPDC)	Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), Department of Health and Human Services
Victorian Population Health Survey (VPHS)	Department of Health and Human Services
Victorian Student Health and Wellbeing Survey (VSHAWS) (also known as About You)	Department of Education and Training