



parks and  
gardens



sporting  
and leisure  
facilities

information  
services

# POPULATION HEALTH PROFILE

safe  
food

arts and  
culture



street  
trees



libraries



emergency  
management

Murraylands & Riverland Local Government Association  
MRLGA

Comprising Berri and Barmera (DC), Karoonda East  
Murray (DC), Loxton Waikerie (DC), Mid Murray (DC),  
Murray Bridge (RC), Renmark Paringa (DC), Southern  
Mallee (DC) and The Coorong (DC).

climate change  
management

youth  
development

community  
centres  
and halls

safe  
roads

events

urban  
planning

volunteering



safe  
water

street  
lighting

walking  
trails

economic  
development

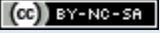


partnerships



immunisation

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The views expressed in this report are solely those of the authors and should not be attributed to the Local Government Association of South Australia.

## Prepared by



July 2019

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# Introduction

In partnership with SA Health, the LGA has commissioned updates to the Population Health Profiles to support a council or group of councils to prepare their Regional Public Health Plans (RPHPs) under Section 51 of the *South Australian Public Health Act 2011* (the Act).

The Act provides a framework for state and local governments to plan for current and emerging public health issues. Mirroring requirements for state government under s.50(3)(a), the Act requires RPHPs to “*comprehensively assess the state of public health in the region*” (s.51(8)(a)). Access to appropriate and relevant data, indicators and evidence-based research is key to effectively making this assessment.

The data contained in population health profiles provide information about a broad range of social, economic and environmental issues that are important to the work of local government as well as local communities.

## Why is data important for local government in public health planning?

Having access to useful and meaningful data can help councils provide more appropriate and higher quality services for their local communities. Data and indicators are important in helping us to understand what is happening in our society and ensure that policies and decisions are based on the best evidence.

These profiles aim to provide a basis for informed and integrated council planning and policy making and to be useful tool for local government policy and planning staff, including senior management, elected members and non-government organisations that operate in the relevant regions as well as the local community.

Good use of data can improve councils’ knowledge, effectiveness, accountability and responsiveness by providing a basis for informed, evidence-based and more comprehensive reporting. They can provide a context for conversations with key partners and stakeholders when developing strategies and actions. This benefits both the council and the community by delivering meaningful result-focused outcomes.

## Purpose of this profile

This population health profile has been prepared to support the Local Government Areas (LGAs) in the Murraylands and Riverland Local Government Association (MRLGA), comprising Berri and Barmera (DC), Karoonda East Murray (DC), Loxton Waikerie (DC), Mid Murray (DC), Murray Bridge (RC), Renmark Paringa (DC), Southern Mallee (DC) and The Coorong (DC) in the preparation of their RPHP under s.51 of the Act. The profiles contain a selection of indicators of public and population health and their determinants, drawn largely from data published for Local Government Areas (LGAs) Population Health Areas (PHAs) by the Public Health Information Development Unit (PHIDU), as part of the Social Health Atlases series available online at [http://atlasesaustralia.au/LGASA/LGA PH Act.html](http://atlasesaustralia.au/LGASA/LGA_PH_Act.html).

The indicators selected are consistent with the approach outlined in the updated State Public Health Plan 2019-2024.

A review of the population profile provided to all councils for the first cycle of RPHP (2013-2018) was undertaken in February 2018, in consultation with councils. Consequently, some modifications have been made for the 2019 profiles.

The revised Population Health Profile can be used as a policy tool to guide evidence-based planning and action to address public health issues as well as a reporting tool to track progress towards agreed goals and outcomes in the longer term. It may even be useful as a tool for wider community use, for example it may assist a local community group in submitting a grant application.

It is acknowledged that the profiles do not present a complete picture, nor will they be representative of the entirety of information available on which to base a comprehensive assessment of public health for a council area or region. Councils have in-depth knowledge of the needs and issues facing their communities and have access to data at catchment levels not routinely captured by much larger survey instruments.

Councils also routinely collect their own data which has relevance to public health planning and can be used to complement the information in this profile. These Profiles have been utilised by councils across SA to inform planning requirements for the first cycle of RPHP, making it a strong foundation on which to build (and compare) a public health-informed picture of key population health issues and trends.

## The SA Public Health Indicator Framework

In 2018, SA Health released the South Australian Public Health Indicator Framework. It is anticipated that these indicators will contribute to monitoring (to inform planning, action and reporting), the public health evaluation framework and any research activity. Data from the Framework inform the biennial Chief Public Health Officer's Report for South Australia.

The Framework and the CPHO Report can assist councils in tracking and/or incorporating state-wide indicators should a council or group of council's wish to expand on the content of their population health profiles or supplement existing RPHP indicators.

## Report content

This report comprises statistics for Local Government Areas (LGAs) in the Murraylands and Riverland Local Government Association (MRLGA), comprising Berri and Barmera (DC), Karoonda East Murray (DC), Loxton Waikerie (DC), Mid Murray (DC), Murray Bridge (RC), Renmark Paringa (DC), Southern Mallee (DC) and The Coorong (DC). The first section presents charts (population pyramids) depicting the age structure in the MRLGA, and its respective LGAs, and providing comparisons with the age structure in Regional SA<sup>1</sup> and between the Population Health Areas (PHAs – see Box) in these LGAs.

A comparison of the age profile in MRLGA is also provided by Indigenous status.

The remainder of the report is comprised of commentary on a table of selected population health indicators (Table A1, in the Appendix) in the MRLGA and its component LGAs and PHAs. The table is structured so as to highlight differences in the percentage, rate or other measure for the indicator value in the MRLGA and its component LGAs and PHAs from that in Regional SA, by means of shading. Cells shaded in green indicate a relatively good outcome, whereas cells in shades of black indicate a relatively poor outcome, or a possible challenge for local government authorities. Note that indicators are only shaded in one colour and that some indicators are not shaded at all.

The commentary consists of a statement as to the value of the indicator for regional health planning, with reference to its value for work by Local Government under the Public Health Act 2011. This is followed by the definition of the indicator and a description of the variation in the percentage, rate or other measure, for each indicator in Table A1, between the geographic areas mapped. In many cases comment is made on changes in the data since the first report was produced.

This PDF copy is supported up by an online atlas, a workbook comprising the data presented in Table A1 including the numbers (numerator and denominator) associated with the percentages shown in the table, and detailed notes on the data (data sources, etc.). You will be able to select the MRLGA group in the interactive online maps located [here](#), to see PHAs in the MRLGA select 'Population Health Areas' from the 'Geography' drop down menu and turn on the 'Local Government Area Clusters'

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<sup>1</sup> Regional SA refers to the area of the state excluding Metropolitan Adelaide (which is the area from Gawler in the north, southwards down the Mt Lofty Ranges to Sellicks Beach, and including Mount Barker).



boundaries in the legend. Further information on how to use the interactive maps can also be found on the linked page.

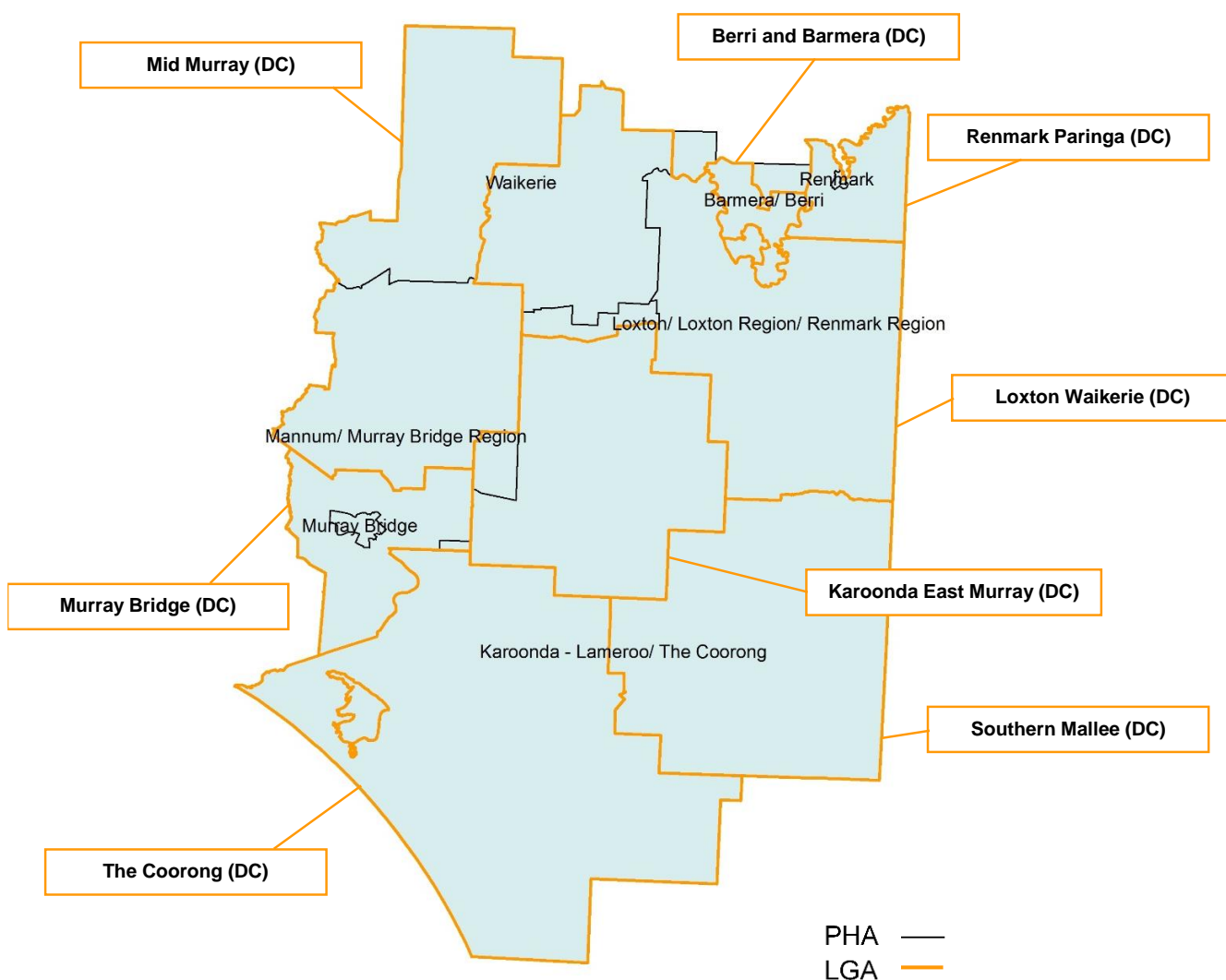
Updates will be included in the online version as they become available. Indicators for which updated data are expected in 2019 are the Australian Early Development Census (2018); estimates of diseases and risk factors (to 2017/18); and hospital admissions (to 2017/18).

### Population Health Areas

Population Health Areas (PHAs) are geographical areas based on suburbs (in cities and larger towns) and localities (in regional and remote areas) as published by the Australian Bureau of Statistics as Statistical Areas Level 2 (SA2s). PHAs are comprised of either whole SA2s or multiple (aggregates of) SA2s.

A list of PHAs in each council area can be found [here](#) and is also shown in Table 1.

### Map 1: The MRLGA; its LGAs and respective PHAs



## Data quality

The data for a majority of the indicators published in this report were provided to PHIDU at the Statistical Areas Level 2 (SA2) or Population Health Area (PHA) level. In many instances the boundaries of these areas do not coincide with the boundaries of LGAs. In order to produce data for LGAs from the SA2 or PHA data, PHIDU has used correspondence files from the Australian Bureau of Statistics (ABS) to allocate whole or part SA2s and PHAs to LGAs. As these correspondences are based on the total population in each SA2 or PHA part which falls within an LGA, their application to other data (e.g., immunisations, income support payments, women smoking during pregnancy) does not necessarily provide an accurate result for the LGA. The indicators likely to be affected are listed in Table A2, in the Appendix.

In addition, some PHAs are relatively large and cover two or three LGAs. As a result, the data for these PHAs are split across multiple LGAs, which further complicates the issue: the affected areas in the MRLGA are listed in Table 1, showing the percentage of the data for the PHAs allocated to each LGA. We leave it to the reader to decide when the PHA data provide useful information for their LGA.

**Table 1: Population Health Areas in the Murraylands and Riverland Local Government Association falling in multiple LGAs**

PHA	LGAs into which PHAs fall (% of PHA in brackets)		
	LGA 1	LGA 2	LGA 3
Karoonda - Lameroo/ The Coorong	Karoonda East Murray (11.8%)	Southern Mallee (24.2%)	The Coorong (63.8%)
Loxton/ Loxton Region/ Renmark Region	Loxton Waikerie (59.3%)	Renmark Paringa (40.7%)	
Waikerie	Loxton Waikerie (66.6%)	Mid Murray (33.4%)	
Mannum/ Murray Bridge Region	Mid Murray (65.5%)	Murray Bridge (33.6%)	

For some indicators, when split between several LGAs, the data provided will give the same result for each LGA. The indicators for which this will occur are marked with an asterisk in Table A2, and a note is included in the commentary to any indicator for which the data for these LGAs are mentioned; in the MRLGA the LGAs of concern are Southern Mallee and The Coorong. In these instances, it may be best to rely on the data by PHA.

For further detail as to these limitations, please contact PHIDU at [phidu@tua.edu.au](mailto:phidu@tua.edu.au).

PHIDU is working to improve the quality of the LGA data, a process which is largely reliant on data custodians coding data to the ABS Statistical Areas Level 1, as these areas more closely align with LGA boundaries.

## Nomenclature

### South Australian LGA Status

In South Australia each incorporated area has an official status. In the 2016 ASGC edition, the various LGA status types currently in use are;

- Cities (C)
- Rural Cities (RC)
- Towns (T)
- Municipalities/Municipal Councils (M)
- District Councils (DC)
- Regional Councils (RegC)
- Aboriginal Councils (AC)

## Terminology

In discussing the extent to which percentages or rates vary from the Regional SA figure, the rate ratio, the following terms are used:

- “Notable”, referring to a rate ratio from 1.10 to <1.20 (a difference of from 10% to <20%), or from 0.90 to <0.80 (a difference of from -10% to <-20%);
- “Marked”, referring to a rate ratio from 1.20 to <1.50 (a difference of from 20% to <50%), or from 0.80 to <0.50 (a difference of from -20% to <-50%);
- “Substantial”, referring to a rate ratio of 1.50 or above (a difference of 50% or more), or of 0.50 and below (a difference of greater than -50%).

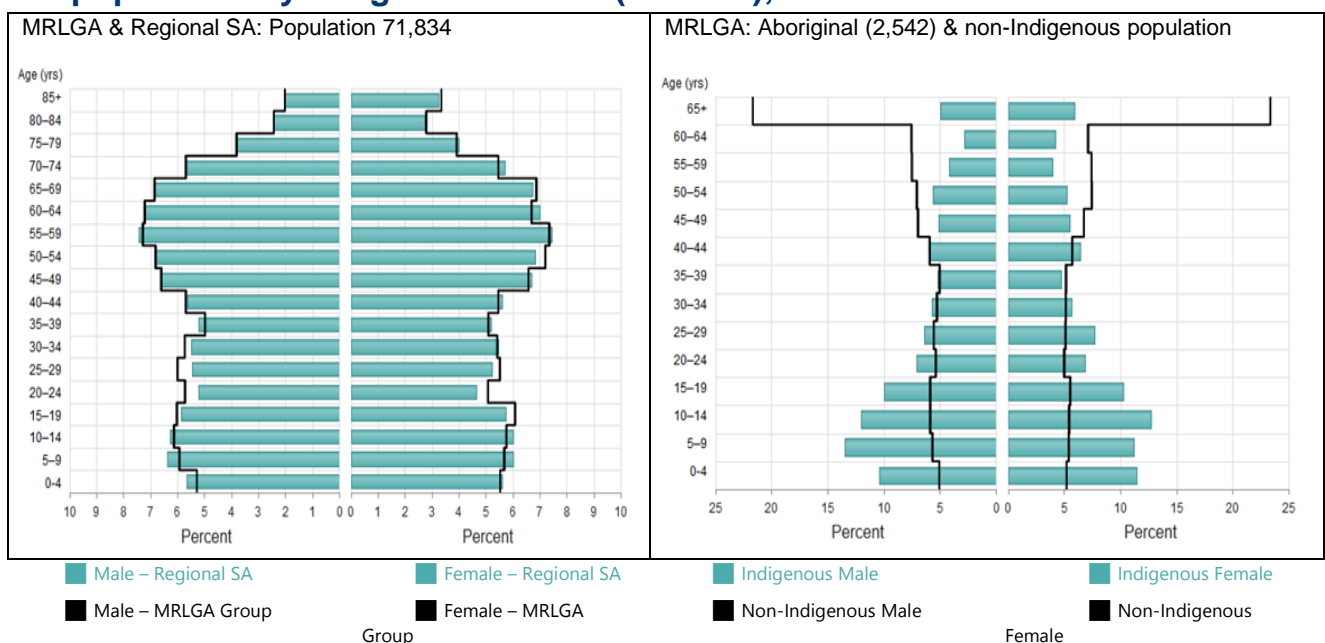
# 1. The age structure of the population

The MRLGA has an age profile which is closely aligned with that in Regional SA overall, with the main differences being fewer children and young people under 15 and more young adults aged 20 to 34 years for males and 15 to 29 years for females (Figure 1).

The Aboriginal population (of 2,542 people, as recorded at the 2016 Census) has a markedly different profile to that of the non-Indigenous population, with more children, young people and young adults and fewer people at all ages from the 40 to 44 age group (Figure 1).

Note: See the indicator 'Aboriginal and Torres Strait Islander people', below, for details of the estimated resident population of Aboriginal people – generally a larger number than the Census figure (in this case 3,231), but for which age group data are not available by LGA.

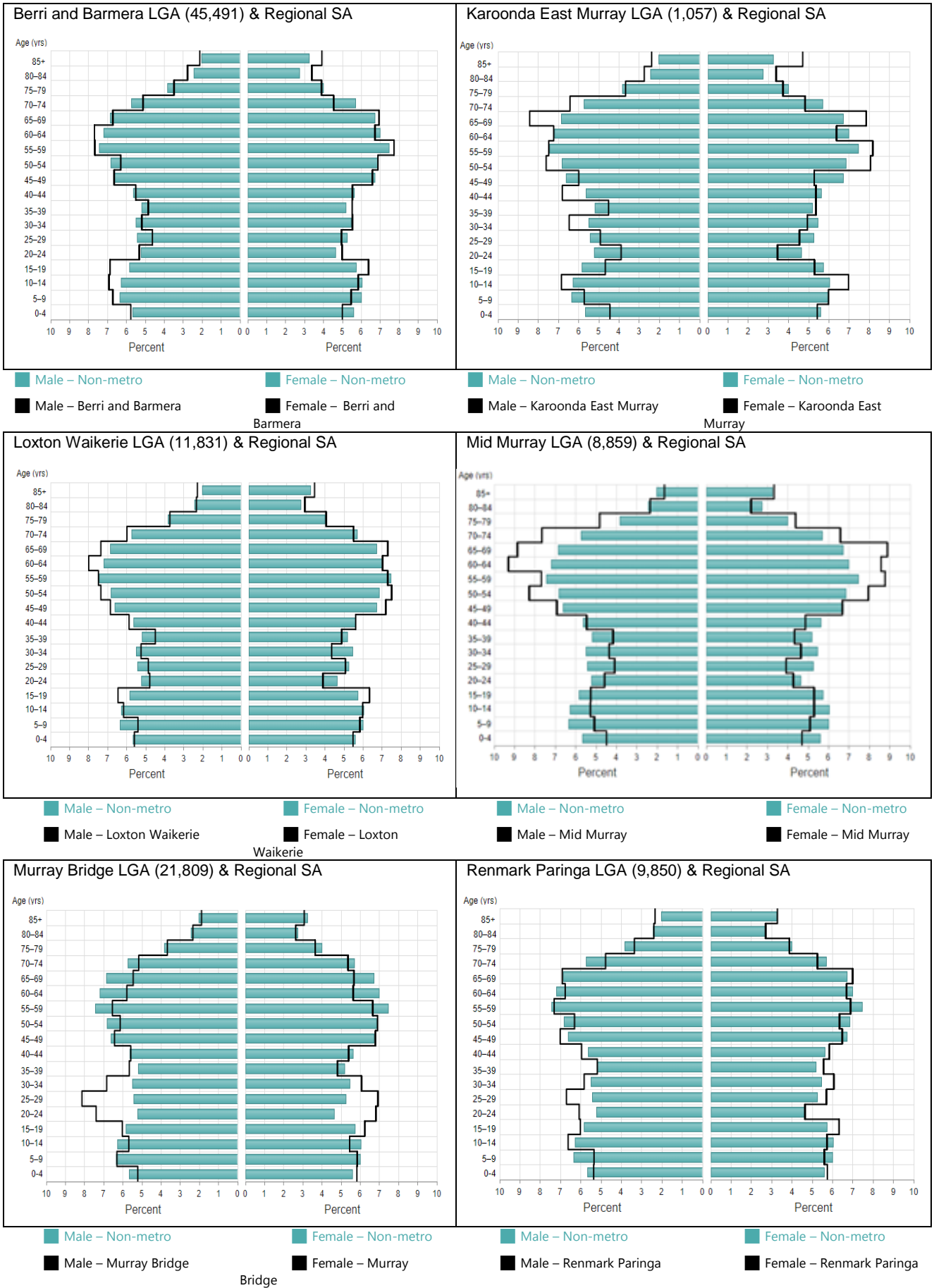
**Figure 1: Age profile comparisons of total population (MRLGA and Regional SA) and population by Indigenous status (MRLGA), 2016**



The LGAs with the largest populations, Berri and Barmera and Murray Bridge, have somewhat different age profiles from Regional SA and each other (Figure 2). In comparison with Regional SA, Murray Bridge has more young adults (males from 20 to 39 years and females from 15 to 34 years) and fewer at older ages, from 45 years for males and 55 years for females. The age profile in Berri and Barmera has a number of relatively small variations from that for Regional SA, with the most notable being higher proportions of the population at ages 5 to 19 years for males, although only 15 to 19 years for females, and from 80 years and over for females.

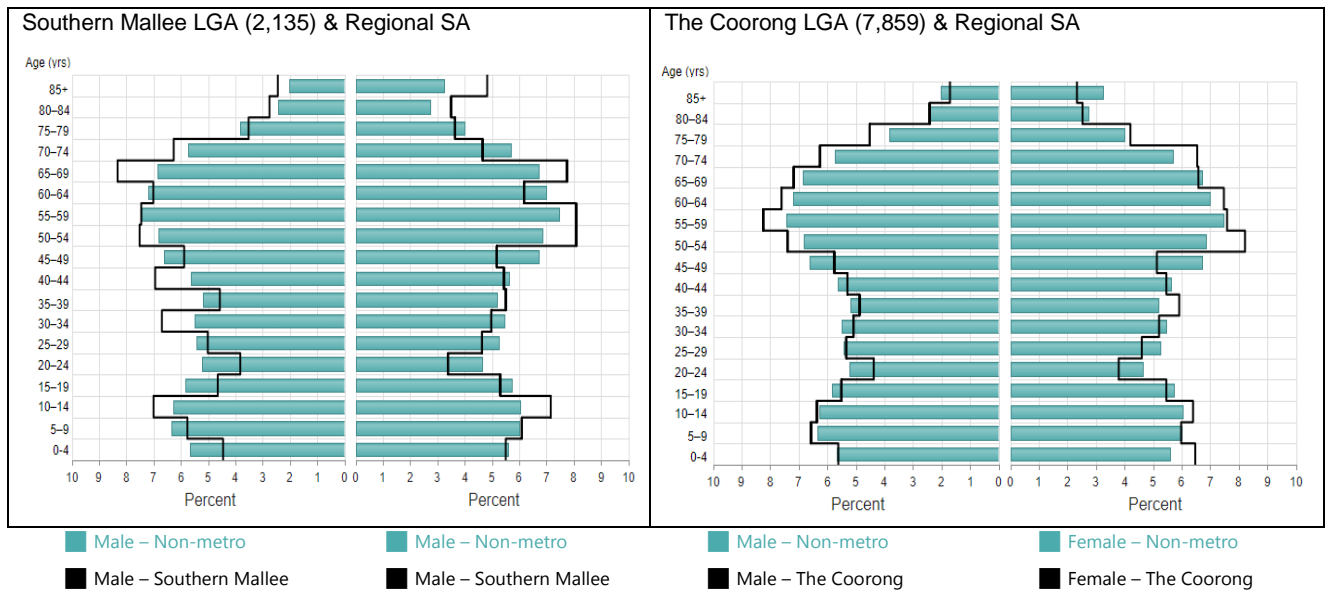
Southern Mallee and Karoonda East Murray, the LGAs with the smallest populations, have profiles that vary in many age groups from the Regional SA profile (in part no doubt a result of their small populations), but which match each other almost perfectly (age pyramids for these and other areas can be generated and viewed on the PHIDU [website](#)). Mid Murray LGA has the oldest age profile, with higher proportions of its population at ages 45 to 79 years and 45 years. The Coorong LGA also has a relatively older age profile, with more people at ages 50 to 79 years. Loxton Waikerie LGA has a higher proportion of its population in the 15 to 19 age group and in most age groups from 40 to 44 years and above. Renmark Paringa has relatively more males aged from 10 to 49, and of females from 15 to 44 years and fewer in most other age groups.

**Figure 2: Age profile comparisons of LGAs in the MRLGA and Regional SA, 2016**



**Figure 2: Age profile comparisons of LGAs in the MRLGA and Regional SA, 2016**

...cont



Murray Bridge PHA has a relatively younger age profile than Regional SA, with more people at ages 20 to 39 years (for males) and 15 to 34 years (for females), and fewer at other ages to 79 years (Figure 3).

Renmark PHA also has a younger population than in Regional SA, with more males aged 20 to 44 years and females aged 0 to 4 years and 15 to 39 years; however, there are proportionately more people at ages 75 years and over.

In Waikerie there are relatively more older adults, other than at ages 75 to 84 years, as well as fewer children and young adults when compared with Regional SA.

In Karoonda - Lameroo/ The Coorong there are more from 50 years of age, other than in the 85 years and over group, and fewer in most age groups from 15 to 50 years. Proportions below 15 years of age vary differentially from the Regional SA profile, and between males and females.

In the Mannum/ Murray Bridge Region there are relatively fewer at most ages under 45 years and more from 45 to 79 years; there are also relatively fewer at the oldest and youngest ages.

The profile in Loxton/ Loxton Region/ Renmark Region shows there to be fewer children and young people (10 to 19 years for males, 5 to 19 for females) and more at ages 45 to 69 for males and 40 to 54 for females.

As noted earlier, for details of the age profile of the Baramba/ Berri PHA, see the comments regarding the Berri and Baramba LGA.

**Figure 3: Age profile comparisons, PHAs in the MRLGA, 2016**



Age pyramids for these and other areas can be viewed on the PHIDU [website](#).

A selection of indicators of population health and its determinants follows.

## 2. Population profile

### 2.1. People born overseas in predominantly non-English speaking countries: country of origin

#### *Rationale*

Australia's population has been and continues to be shaped by international migration. However, for many who arrive without proficiency in English, the combination of economic struggle with adjustment to a new language and a new cultural milieu can be expected to give rise to considerable stresses. Although a relatively small group, they also pose special challenges for deliverers of health, education, welfare and other community services.<sup>9</sup> Despite common experiences including those relating to migration and dislocation, this population is far from a homogeneous group. There is great diversity in language, culture, religion, socioeconomic status, education and age structure.<sup>9</sup> Initially, most of these migrants were born in countries in North-West Europe, and they were then followed by large numbers of migrants born in Southern and Eastern Europe following the end of World War II. In the 1970s, many migrants arrived from South-East Asia and, in recent migration streams, a number of Asian countries made a large contribution, along with African and Middle Eastern countries.<sup>5</sup> Similarly, South Australia's population and demographic profile has historically been influenced by immigration, particularly from the post-war period.

In 2016, over 40% of the South Australian population is an immigrant or has at least one parent who was born overseas; and 17.4% of the population speak a language other than English at home.<sup>6,10</sup> International migration has been a key feature in South Australia's population growth and, since 2004, South Australia has experienced an immense change in this area, chiefly as a result of policy changes.<sup>7,8</sup>

#### **Indicator definition:**

People born (overseas) in predominantly non-English speaking countries as a percentage of the total population (Census 2016). Predominantly non-English speaking countries include all except the following countries: Canada, Ireland, New Zealand, South Africa, United Kingdom and the United States of America

#### ***Our group of councils***

There were almost 5,000 people in the MRLGA at the 2016 Census who had been born overseas in a predominantly non-English speaking country, at 7% of the population substantially (50%) above the 4.7% in Regional SA overall. The highest proportions of this population group were in the LGAs of Renmark Paringa and Murray Bridge (both with 9.9%, although the number in Murray Bridge was the largest, with 2,055 people), and Berri and Barmera (7.0%, 50% above the Regional SA average). Karoonda East Murray had half the Regional SA average proportion.

The three of these birthplaces with the most people in the MRLGA were the Philippines (570 people), India (540) and Greece (366). People born in Greece comprised the largest proportions in the LGAs of Renmark Paringa (1.6% of the population, 148 people), Berri and Barmera (1.5%, 161 people) and Loxton Waikerie (0.4%, 49 people). Those born in India were mainly in Renmark Paringa (2.0%, 193



people) and Berri and Barmera (1.1%, 115 people). The LGAs with the largest proportions of their population from the Philippines were Murray Bridge (1.9%, 398 people), Berri and Barmera (0.7%, 71 people) and The Coorong (0.6%, 34 people).

The highest proportions of people born in Greece in the MRLGA were living in the PHAs of Renmark (83 people, 1.8% of the population), Barmera/ Berri (1.5%, 161 people) and Loxton/ Loxton Region/ Renmark Region (102 people, 0.9%). People born in India made up the largest proportion of this group in Renmark (2.7% of the population, 124 people), Waikerie ((1.0%, 66 people), Loxton/ Loxton Region/ Renmark Region (0.8%, 90 people) and Murray Bridge (0.7%, 122 people). Of those born in the Philippines, 390 were living in Murray Bridge PHA (2.2% of the population) and 61 in Karoonda - Lameroo/ The Coorong (0.7%).

## 2.2. People born overseas and reporting poor proficiency in English

### *Rationale*

For migrants born in predominantly non-English-speaking countries, the rate at which they adapt to live in the host country is directly related to the rate at which they achieve proficiency in English. Their proficiency in English has profound implications for the ease with which they are able to access the labour market, develop social networks, become aware of and utilise services, and participate in many aspects of Australian society. Those people who are not proficient in spoken English are less likely to be in full-time employment and more likely not to be employed.<sup>18</sup>

In 2016, over 40% of the overseas born population spoke only English at home and, of those who arrived in the past 25 years, 11% did not speak English well or at all; this was lower (8.3%) for earlier migrants who arrived prior to 1991.<sup>19</sup>

Just over half (53%) of longer-standing migrants and 76% of recent arrivals reported in the Census that they spoke a language other than English at home.<sup>20</sup> This no doubt reflects the different countries of birth of these two groups, and also the amount of time spent in Australia. However, this does not provide an indication of their ability to speak English. Over half (53%) of longer-standing migrants reported speaking English very well, while 2.5% reported not speaking English at all. For recent arrivals, 39% reported speaking English very well and the proportion who reported not speaking English at all was 4.7%.<sup>20</sup>

From a Local Government viewpoint, the size and location of this population group is relevant for the provision of support services for newly arrived children, youth, and families; and for older people, who may never developed English language skills (especially females who were not employed outside the home), or have returned to using the language of their birthplace as they have aged (both females and males).

### **Indicator definition:**

People born in overseas countries who reported speaking English 'not well' or 'not at all' as a percentage of the population aged 5 years and over (Census 2016).

## Our group of councils

One thousand and nine people in the MRLGA reported not being able to speak English well or at all, some 1.6% of the population aged five years and over. This proportion was 2.75 times that in the MRLGA overall. The highest proportions were in the LGAs of Renmark Paringa (2.8% of the population aged five years and over, 253 people) and Murray Bridge (2.7%, 528 people).

At the PHA level, the highest proportions were in Renmark (3.7% of the population aged five years and over, 162 people) and Murray Bridge (3.2%, 531 people).<sup>2</sup>

## 2.3. Migration Program and Humanitarian Program

### *Rationale*

Alongside the USA, Canada and New Zealand, Australia is regarded as one of the world's leading immigration destinations. At June 2016, 28.5% of the estimated resident population in Australia was born overseas; one of the highest proportions across all OECD countries.<sup>11</sup> The UK and more broadly Europe have traditionally been the leading contributors to the overseas born population in Australia. However, this pattern has changed markedly with Asian countries such as China and more recently India surpassing the UK as the top source country for permanent migrants in Australia.<sup>12</sup>

The Migration Program for skilled and family entrants and the Humanitarian Program for refugees and those in refugee-like situations make up the two formal programs that facilitate the arrival of permanent migrants into Australia. Since 2012-13, the migration planned intake figure has been capped at 190,000 places with the majority allocated to the skill stream, emphasising the focus on skilled migrants who can help address the skill shortages in Australia.<sup>11</sup>

Migrants other than those under the Humanitarian Program generally have better health than the Australian born population in terms of mortality, hospitalisation rates and prevalence of health risk factors associated with lifestyle. While this is largely attributed to the 'healthy migrant effect' - an eligibility requirement for migrants to be in good health in their migration application - this advantage is said to decline over time to levels similar to the Australian born population. Nonetheless, the health status of migrants can vary depending on birthplace country, age, socioeconomic background, English language proficiency, education and income level.<sup>13</sup>

Migrants can present higher or lower patterns of diseases compared with their Australian born counterparts, thus enjoying advantage as well as disadvantage for particular conditions. Those from non-English speaking backgrounds could be prevented from accessing information and services relating to health due to language and cultural barriers resulting in lower health literacy rates. This is not too dissimilar for elderly migrants who also require culturally and linguistically appropriate services.<sup>14</sup>

Of the 135,304 permanent migrants who have arrived in Australia since 2000 and were recorded in the 2016 Australian Census and Migrants Integrated Dataset as resident in South Australia, 15.3% had migrated under the permanent Humanitarian visa stream, with 60.6% under the Skill and 24% under the Family visa stream.<sup>162</sup>

Note: Details of the period of arrival (2000 to 2007, 2007 to 2011 and 2012 to 2016) are available in Table A2 and the workbook available online.

<sup>2</sup> Note that the PHA population reported by the ABS for this indicator is higher than for the Murray bridge LGA (by 3 people); this occurs because, to minimise the risk of identifying individuals in aggregate statistics, the ABS adjusts the true cell value by either increasing or decreasing the value by a small amount.

## 2.3.1. Humanitarian Program

### *Rationale*

The Humanitarian Program is comprised of the offshore (UNHCR referred and the Special Humanitarian Program) and the onshore component (protection provided to onshore refugees). Apart from 2012-13, which saw a 30% increase to 20,000 places under this program, planning levels have hovered between 12,000 and 13,750 places since 1995-96.<sup>15</sup> In 2016-17, 21,968 visas were granted under the Humanitarian Program, the largest intake since 1980-81. This intake included the additional 12,000 places allocated to those displaced by conflicts in Syria and Iran.<sup>16</sup>

Results from the Building a New Life in Australia (BNLA) longitudinal study of humanitarian migrants show that overall 15% of respondents reported (under the General Health item from the SF-36) that their health had been 'very poor' or 'poor'.<sup>167</sup> Proportions were higher among females than males, but lower among those aged 15 to 19 years than older age groups.<sup>167</sup> Further, the proportion of BNLA participants reporting poor or very poor health is higher than the general Australian population in 2007-08 (3%).<sup>168</sup> Poor or very poor self-rated health was associated with a greater number of financial hardships and not feeling welcomed in Australia, after adjusting for age, sex, marital status, education, country of origin, visa subclass, time in Australia and experience of traumatic events.<sup>163</sup>

### ***Indicator definition:***

People (permanent entrants) entering Australia under the Offshore Humanitarian Program, including those who were granted permanent protection post-arrival in Australia, as a percentage of the total population (Census 2016).

### ***Our group of councils***

Although there were only an estimated 154 people in the MRLGA in 2016 who had arrived in Australia under the Humanitarian Program, their proportion of the population, of 0.4%, was nearly twice that in Regional SA (1.77 times). The numbers in each period were 59 people arriving from 2000 to 2006, 75 from 2007 to 2011 and 21 from 2012 to 2016.

The majority of this population group were living in Murray Bridge (an estimated 101 people), with 46 in Renmark Paringa; these same numbers were estimated for both the LGA and the PHA.

## 2.3.2. Family stream

### *Rationale*

The family stream of the Migration Program is designed for the migration of immediate family members of Australian citizens, permanent residents of New Zealand citizens. Family stream migrants need to be sponsored by an Australian citizen, permanent resident or eligible New Zealand citizen; apart from the necessary health and character requirements, they are not required to undergo skills testing or language requirement.<sup>17</sup> In 2016-17, the top 3 source countries receiving a Family stream visa were China, India and the UK. The leading visa in the Family stream was the Partner (85.1%) followed by the Parent visa (13.5%); the main recipients of both these categories were from China.<sup>16</sup>

### ***Indicator definition:***

People (permanent entrants) entering Australia on a Child, Partner, Parent or Other Family stream visa, as a percentage of the total population (Census 2016). These migrants are selected on the basis of their family relationship (spouse, de facto partner, intent to marry, child, parent, other family) with their sponsor who is an Australian citizen, permanent resident, or eligible New Zealand Citizen.

### ***Our group of councils***

At the 2016 Census there were an estimated 662 people in the MRLGA who had arrived in Australia under the Family stream, with numbers increasing each period, from 197 people arriving from 2000 to 2006, 221 from 2007 to 2011 and 243 from 2012 to 2016.

As would be expected, given the distribution of humanitarian migrants in the MRLGA, the largest numbers of people arriving under the family stream were living in Murray Bridge (an estimated 288 people) and Renmark Paringa (137 people). However, there were smaller numbers in several LGAs, the largest of which were 86 in Berri and Barmera, 62 in Loxton Waikerie and 49 in Mid Murray.

At the PHA level the largest numbers were in Murray Bridge (an estimated 266 people) and Renmark (99 people). Other PHAs with populations of note were Loxton/ Loxton Region/ Renmark Region (66 people), Mannum/ Murray Bridge Region (55 people), Waikerie (50 people) and Karoonda - Lamerook/ The Coorong (40 people).

### 2.3.3. Skill stream

#### *Rationale*

The reported outcomes under the Migration Program includes both the primary applicant and secondary applicants (i.e., dependants of the primary applicant). While the majority of places under the Migration Program are allocated to skilled migrants, it is important to note that in recent decades, there has been an increasing emphasis on the skilled stream away from the family stream. In 1996-97, skilled migrants comprised 47% of the Migration Program which increased to 67% in 2008-09; and has remained at that level since.<sup>17</sup> In 2016-17, the top three source countries granted a Skilled migration visa were India, China and the UK.

#### ***Indicator definition:***

People (permanent entrants) entering Australia on a Skill stream visa, as a percentage of the total population (Census 2016). The Skill stream consists of a number of categories for prospective migrants where there is demand in Australia for their particular skills. They could be nominated by an employer or State/Territory Government, apply under points based Skilled Migration, have outstanding talents or demonstrated business skills.

#### ***Our group of councils***

There were estimated to be 1,055 people in the MRLGA in 2016 who had entered Australia on a Skill stream visa, just over a third larger proportion than in Regional SA overall. The numbers have varied over the years, with 321 people arriving from 2000 to 2006, 515 from 2007 to 2011 and 220 from 2012 to 2016.

The largest numbers at the LGA level were estimated for Murray Bridge (590 people), Renmark Paringa (80 people), Loxton Waikerie (78 people), Mid Murray (62 people) and The Coorong (51 people).

At the PHA level, the largest numbers were estimated for Murray Bridge (570 people), Karoonda - Lameroo/ The Coorong (105 people), Loxton/ Loxton Region/ Renmark Region (71 people), Mannum/ Murray Bridge Region (66 people), Renmark (54 people) and Waikerie (48 people).

## 2.4. Aboriginal and Torres Strait Islander people

### *Rationale*

In the 2016 Census of Population and Housing, 34,181 people (or 2% of the total South Australian population) identified as being of Aboriginal and/or Torres Strait Islander origin<sup>21</sup> a slight increase of 0.1% since the 2011 Census; and reflects natural population increase (the excess of births over deaths) and other factors, including improvements in data collection methods especially in rural and remote areas, and people newly identifying as Indigenous in the Census.

The Aboriginal population is considerably younger than the non-Indigenous population, reflecting higher fertility and lower life expectancy. In 2016, the median age for this population was 23.0 years, 17 years less than the state's median age of 40.0 years.<sup>21</sup>

About one in three (33.4%) Aboriginal people were aged less than 15 years, while just 4.6% were aged 65 years and over.<sup>21</sup> The Aboriginal population predominantly lives in South Australia's most populous areas, with 53.8% living in the Greater Adelaide area, and 45.4% living in the rest of the State.<sup>21</sup>

The Aboriginal population is disadvantaged across all domains of wellbeing compared to non-Aboriginal South Australians.<sup>22</sup> Thus, it is important for local government to know the size of its Aboriginal population, and to work with them to improve wellbeing and identify needs, if they are to address existing inequalities in health.

### *Indicator definition:*

People identifying in the Census as Aboriginal and/or Torres Strait Islander as a percentage of the total population (ABS Estimated Resident Population, June 2016).

### ***Our group of councils***

As noted above, there were 2,542 people who reported in the 2016 Census that they were of Aboriginal and/or Torres Strait Islander descent. Following the Census, the Australian Bureau of Statistics (ABS) has estimated that there were 3,231 people of Aboriginal and/or Torres Strait Islander descent resident in the MRLGA at 30 June 2016, comprising 4.6% of the population, 7% below the average across Regional SA.

The Coorong (7.4% of the population, 411 people), Murray Bridge (5.7%, 1,236 people) and Berri and Barmera (5.6%, 611 people) LGAs had the largest proportions of this population group. Other LGAs with at least 50 Aboriginal people were Renmark Paringa (3.2%, 316 people), Mid Murray (2.9%, 260 people), Loxton Waikerie 2.8%, 324 people) and Southern Mallee (2.7%, 56 people).

The following PHAs had the most Aboriginal people in 2016: Murray Bridge (6.2%, 1,125 people), Barmera/ Berri (5.6%, 611 people), Karoonda - Lameroo/ The Coorong (5.6%, 484 people), Renmark (4.8%, 229 people), Waikerie (3.0%, 202 people), Mannum/ Murray Bridge Region (2.9%, 291 people), Loxton/ Loxton Region/ Renmark Region (2.4%, 291 people).

## 2.5. Disability or long-term illness, and care provided

### 2.5.1. People who provide unpaid assistance to others: those with a disability, a long-term illness or problems related to old age

#### *Rationale*

Unpaid activities undertaken by individuals represent a significant contribution to society and the economy. This includes caring for the aged, those with a long-term illness, or those with a disability. In Australia, it is estimated that over 21.4 billion hours of unpaid care work were undertaken in the 2009-10 financial year.<sup>23,24</sup> The unpaid care provided by South Australians not only reduces the strain on the health care system but has substantial flow-on benefits to the individuals and families receiving care.

While there are benefits from the care economy to society at large, unpaid care can affect one's ability to fully participate in paid employment.<sup>25</sup> Women tend to have lower labour force participation than men and also more likely to be undertaking part-time work. However, for many, low labour force participation is likely to be due in part to caring duties.<sup>25</sup>

#### ***Indicator definition:***

People aged 15 years and over who, in the two weeks prior to Census Night, spent time providing unpaid care, help or assistance to family members or others because of a disability, a long-term illness or problems related to old age, as a percentage of the population aged 15 years and over (Census 2016).

#### ***Our group of councils***

One in eight people in the MRLGA reported providing unpaid care, help or assistance to family members or others because of a disability, a long-term illness or problems related to old age, a rate consistent with that in Regional SA overall.

Similar levels of assistance were recorded for each of the LGAs and PHAs.

## 2.5.2. People with a profound or severe disability and living in the community

### *Rationale*

In Australia, almost one in five (18.3%) Australians report living with a disability. The likelihood of living with disability increases with age. The disability rate among 15-24 year olds was 8.2% and the rate was higher for successively older age groups, with 16.4% of 45-54 year olds, and 23.4% and 31.5% of 55-59 and 60-64 year olds living with disability respectively.<sup>26</sup>

In 2015, most people (77.4%) with disability (and living in the community, rather than in institutional care) participated in physical activities, visited public places and engaged with friends and family, although rates of social participation for people with disability declined with age.<sup>164</sup> People with disability are more likely to face challenges than those without a disability, further, they have generally lower participation rates in various aspects of life.<sup>27</sup>

However, rates of social participation for people with a disability were lower than for those without such limitations; and for those with profound or severe limitation were lower than for those with moderate or mild limitation.<sup>164</sup> In 2015, many people with a disability did not leave home as much as they would have like due to their disability or condition.<sup>27</sup>

Personal networks for people with profound or severe disability are particularly important in supporting their integration into the wider community, thereby enhancing their individual wellbeing, as well as the social fabric of the wider community.<sup>15</sup>

Local Government plays an important role in the development of disability-accessible public places and provides community-based services which can increase the social participation of community members living with disability, and their families.

### ***Indicator definition:***

People with a profound or severe disability and living in the community as a proportion of the population (all ages, 0 to 64 years and 65 years and over, Census 2016). People with profound or severe limitation need help or supervision always (profound) or sometimes (severe) to perform activities that most people undertake at least daily, that is, the core activities of self-care, mobility and/or communication, as the result of a disability, long-term health condition (lasting six months or more), and/or older age. Note that this indicator excludes people living in long-term supported accommodation, in residential accommodation in nursing homes, accommodation for the retired or aged (not self-contained), hostels for those with a disability and psychiatric hospitals.

### ***Our group of councils***

There were relatively more people in the MRLGA with a profound or severe disability and living in the community than in Regional SA, both at ages 0 to 64 (4.3% and 3.8% of the population, respectively) and 65 years and over (13.7% and 12.3%, respectively).



At ages 0 to 64 years, the highest proportions were in the LGAs of Berri and Barmera (4.9%, 379 people), Mid Murray (4.8%, 281 people), Murray Bridge (4.5%, 709 people) and Karoonda East Murray (4.5%, 35 people). The PHAs were Barmera/ Berri (4.9%, 379 people), Murray Bridge (4.7%, 621 people), Murray Bridge/ Murray Bridge Region (4.4%, 300 people) and Renmark (4.4%, 146 people).

At ages 65 years and over, proportions were higher, with the highest being in Karoonda East Murray (17.2%, 40 people), Southern Mallee (17.1%, 67 people), Berri and Barmera (16.0%, 340 people) and Renmark Paringa (13.8%, 245 people). The PHAs were Barmera/ Berri (16.0%, 340 people), Renmark (15.1%, 158 people), Murray Bridge (14.1%, 461 people) and Karoonda - Lamerook/ The Coorong (13.8%, 235 people).

## 2.6. Summary measure of disadvantage: IRSD

### *Rationale*

The ABS Index of Relative Socio-economic Disadvantage (IRSD) is a powerful indicator of the socioeconomic disadvantage faced by numerous sub-population groups across Australia. It is based on the social and economic characteristics of the population in each area, and is a useful summary measure, reflecting the patterns of disadvantage seen in many individual indicators of social inequality.<sup>160</sup>

### **Indicator definition:**

The IRSD for the area of analysis, derived by ABS from 2016 Census data. The Index has a base of 1000 for Australia: scores above 1000 indicate relative lack of disadvantage and those below indicate relatively greater disadvantage.

### **Our group of councils**

The Index of Relative Socio-economic Disadvantage (IRSD) score for the MRLGA was 919, slightly below the score of 945 for Regional SA, indicating that the MRLGA as a whole is slightly more socioeconomically disadvantaged than Regional SA overall, and well below the score for Australia, of 1000.

Southern Mallee (with an IRSD score of 990), Karoonda East Murray (953) and Loxton Waikerie (951) had the highest scores, indicating relative socioeconomic advantage, compared with the score of 894 in Murray Bridge, indicating its greater relative disadvantage.

There was little variation in IRSD scores between the PHAs, other than for the higher score in Loxton/ Loxton Region/ Renmark Region of 967 and the much lower score of 875 in Murray Bridge.

## 3. Employment

### 3.1. People receiving unemployment benefits

#### *Rationale*

Although the relationship between unemployment and health is complex and varies for different population groups, there is consistent evidence from research that unemployment is associated with adverse health outcomes; and that unemployment has a direct effect on physical and mental health over and above the effects of socioeconomic status, poverty, risk factors, or prior ill-health.<sup>28-30</sup> These effects may impair a person's ability to find further employment.

Unemployment and its accompanying health effects are not distributed evenly through the population. Youth unemployment rates are generally higher, a trend that is more pronounced since the Global Financial Crisis, with young people faring relatively poorly.<sup>31</sup> In South Australia, unemployment rates are highest among young people aged less than 25 years,<sup>32</sup> and are generally higher in rural and remote areas than in urban areas.<sup>33</sup> This can be the result of limited employment opportunities outside the metropolitan area, changes in regionally-based industries, economic policy, and demographic shift.

Local government plays an important role in attracting new industries to their regions, supporting existing industries and facilitating employment opportunities. Community-based services can assist in preventing health problems among unemployed people, and supporting return to work or re-training and skills development.

#### *Indicator definition:*

Unemployment beneficiaries are people in receipt of an 'unemployment benefit' - the Newstart Allowance or Youth Allowance (other) paid by the Department of Human Services - as a proportion of the eligible population aged 16 to 64 years (June 2017).

#### *Our group of councils*

There were more people in the MRLGA receiving unemployment benefits than in Regional SA (9.4% and 8.6%, respectively). The highest proportions were in Berri and Barmera (10.4% of the population aged 16 to 64 years), Renmark Paringa (10.1%), Murray Bridge (9.9%) and Mid Murray (9.7%).

At the PHA level, Renmark had the highest proportion, with 13.7% of the population aged 16 to 64 years receiving an unemployment benefit, with the next highest, at 10.4% in Murray Bridge.

**Indicator definition:**

Long-term unemployment beneficiaries are people in receipt of an unemployment benefit (as above) for more than 182 days (approximately six months) as a proportion of the eligible population aged 16 to 64 years (June 2017).

**Our group of councils**

Almost as many people in the MRLGA were receiving an unemployment benefit for more than six months as the total of those getting this benefit (3,450, 8.1% of the population aged 16 to 64 years and 3,610, 8.4% respectively). This was 9% above the average for Regional SA.

Of the LGAs, the highest proportions of unemployment beneficiaries were in Mid Murray (9.1%), Berri and Barmera (9.0%), Renmark Paringa (8.7%), Murray Bridge (8.6%) and The Coorong (8.1%).

As for total unemployment beneficiaries, the highest proportion of the population aged 16 to 64 years on this benefit for six months or more were in the PHAs of Renmark (11.7%), Murray Bridge (9.1%) and Barmera/ Berri (9.0%).

**Our group of councils**

A smaller proportion of the population aged 16 to 24 years were receiving an unemployment benefit than shown above for the total population in the MRLGA, at 5.9%, with the highest proportions in the LGAs of Berri and Barmera (7.2% of the population aged 16 to 24 years) and Murray Bridge (6.8%).

Of the PHAs, Renmark (7.4%), Barmera/ Berri (7.2%) and Murray Bridge (7.0%) had the largest proportions.

**Indicator definition:**

Youth unemployment beneficiaries are young people (aged 16 to 24 years) in receipt of an unemployment benefit (as above) as a proportion of the eligible population aged 16 to 24 years (June 2017).

## 4. Education

### 4.1. Young people aged 16 years and not participating in full-time secondary education

#### *Rationale*

In South Australia, students are required to continue their education until the age of 17, either at school or through some combination of vocational training and employment.<sup>34</sup> This policy recognises the need for higher levels of education and skill in the modern globalised economy. It reflects the policy intent expressed in the 2008 Melbourne Declaration that, to maximise their opportunities for healthy, productive and rewarding futures, Australia's young people must be encouraged not only to complete secondary education, but also to proceed into further training or education.<sup>35</sup>

The indicator for 16 year old children not participating in full-time secondary education is not intended as an indicator of educational participation; it is included because young people completing Year 12 (and who would be still at school at age 16) are more likely to make a successful initial transition to further education, training and work than early school leavers.

The key to achieving positive change, especially at the local level, is the way in which sectors, institutions, organisations and agencies work together to assist young people to prepare for and make their transition to the world of work and adulthood.<sup>36</sup> Local communities rely on a well-trained, local labour force, and Local Government may be able to assist young people who live in their region by also supporting vocational training and apprenticeship opportunities.

#### *Indicator definition:*

Young people aged 16 years not in full-time secondary school education, as a proportion of the population aged 16 years (Census 2016).

#### ***Our group of councils***

The MRLGA had slightly more people aged 16 years and not in full-time secondary school education than in Regional SA, with proportions of 18.1% and 17.1%, respectively.

As reported in the 2016 Census, the LGA of Renmark Paringa had almost one third (30.1%) at this age not in full-time secondary school education, and in Karoonda East Murray it was one quarter (25.0%).

The PHA of Renmark had clearly the highest proportion in this population group, of 30.8%.

## 4.2. School leavers enrolling in higher education

### *Rationale*

Higher education refers to education which usually results in the granting of a bachelor's degree or higher qualification. Higher education contributes to South Australia's intellectual, economic, cultural and social development, and the long term prosperity of the State will be influenced by the future activities of higher education graduates.<sup>37</sup> Participation in higher education increases opportunities for choice of occupation and for income and job security, and also equips people with the skills and ability to control many aspects of their lives – key factors that influence wellbeing throughout the life course. A higher education qualification can allow a person to gain an advantage in a competitive labour market and open up new professional opportunities, especially for careers where a qualification is required for employment or practice. On average, graduates earn more than other workers and the unemployment rate for graduates is lower than for the rest of the population.<sup>37</sup> Despite the Global Financial Crisis and the end of the mining boom impacting on the earning of early career graduates, degree holders continue to enjoy a significant income premium over Year 12 holders<sup>38</sup>. For students not enrolling in higher education, there remain other opportunities for training and skills development and pathways to future employment.

### ***Indicator definition:***

School leavers enrolling in higher education are those who attained a Year 12 qualification in 2017 and were enrolled at a South Australian university at 31 March 2018, as a proportion of the population aged 17 years, at 30 June 2017.

### ***Our group of councils***

The MRLGA had slightly more people who finished school in 2017 and were enrolled at a South Australian university at 31 March 2018 than in Regional SA, with proportions of 18.9% and 18.1%, respectively.

The LGAs with the best outcomes under this indicator were Southern Mallee (33.5%, although with only six people), Berri and Barmera (26.0%) and Renmark Paringa (19.5%), all of which had proportions above the Regional SA average; Mid Murray had a proportion on this average (18.1%). The Coorong (14.7%) and Murray Bridge (16.1%) had the poorest outcomes.

Barmera/ Berri (26%), Renmark (20.0%), Loxton/ Loxton Region/ Renmark Region (19.5%) and Karoonda - Lameroo/ The Coorong (19.3%) all had more of this group than in Regional SA overall.

## 4.3. Children whose mother has low educational attainment

### *Rationale*

Strong relationships between education and health outcomes exist in many countries, favouring the survival and health of children born to educated parents, especially mothers; but the pathways are culturally and historically complex and vary between and within countries.<sup>39,40</sup> A lack of successful educational experiences of parents may lead to low aspirations for their children; and may be related to parents' attitudes, their ability to manage the complex relationships which surround a child's health and education, and their capacity to control areas of their own lives.<sup>40-42</sup> Parents may also struggle to offer guidance with school work and career choices, and children can be further impacted by the lack of role models in their extended family network helping to influence job and study choices.<sup>42</sup>

Sustainable communities need individuals to be able to take up new educational opportunities, adapt career trajectories, contribute economically and reach their potential regardless of their social status, background or income in order to achieve wider productivity and participation goals.<sup>42</sup>

### **Indicator definition:**

Children aged less than 15 years living in families where the female parent's highest level of schooling was year 10 or below, or where the female parent did not attend school, as a proportion of all children aged less than 15 years (Census 2016).

### **Our group of councils**

One in five children aged less than 15 years were living in a family where the female parent's highest level of schooling was year 10 or below, or where she did not attend school. This was markedly (21%) higher than in Regional SA overall, 20.3% compared with 16.8% in the MRLGA.

Renmark Paringa (with 24.1% of children aged 15 in this population group) and Murray Bridge (23.1%) had the highest proportions at the LGA level. Of the PHAs, Renmark (28.6%), Murray Bridge (24.3%) and Waikerie (22.2%) had the highest proportions.

## 4.4. Young people learning or earning

### *Rationale*

Levels of participation in education and the labour market are indicators of the wellbeing of young people.<sup>43</sup>

Research suggests that young people who are not fully engaged in education or work (or a combination of both) are at greater risk of school failure, unemployment, cycles of low pay, employment insecurity in the longer term, social exclusion, economic and social disadvantage<sup>46</sup>, and poorer health and wellbeing.<sup>44</sup> The experience of unemployment harms a young person's financial and psychological wellbeing, and these effects are felt more severely by those who experience long-term unemployment.<sup>161</sup> Furthermore, those who experience unemployment while young are more likely to be unemployed, have poor health and have lower educational attainment when they are older, than those who are not affected by unemployment while young.<sup>161</sup>

Participation in education and training and engaging in work locally are also considered important aspects of developing individual capability and building socially inclusive local communities.<sup>42,45</sup>

### ***Indicator definition:***

Young people aged 15 to 24 years engaged in school, work or further education/training as a proportion of the population aged 15 to 24 years (Census 2016).

### ***Our group of councils***

Four in five young people in the MRLGA aged 15 to 24 years were engaged in school, work or further education/ training, a level consistent with the Regional SA average.

The LGAs of Southern Mallee (84.7%), Loxton Waikerie (84.1%), The Coorong (82.2%) and Berri and Barmera (80.7%) had higher proportions than in Regional SA.

Loxton/ Loxton Region/ Renmark Region (85.5%), Karoonda - Lameroo/ The Coorong (82.2%), Waikerie (81.7%) and Barmera/ Berri (80.7%) had the highest proportions among the PHAs, with the lowest in Renmark (76.6%) and Murray Bridge (76.7%).

## 5. Income and wealth

### 5.1. Children in low income, welfare-dependent families

#### *Rationale*

Children living in families either solely or largely dependent on government for their income have the least access to financial and other resources and are more likely to have lower achievements in education and poorer health outcomes than their more advantaged peers. In particular, extreme stressful events, such as homelessness, victimisation or abuse, can have long-term effects on children's outcomes.<sup>47</sup>

Low income families are less likely to have sufficient economic resources to support a minimum standard of living; and low income limits the opportunities parents can offer their children.<sup>41,48</sup> This can affect children and young people in the family through reduced provision of appropriate housing, heating, nutrition, medical care and technology.<sup>49</sup>

Children and young people from low income families can be more prone to psychological or social difficulties, behavioural problems, lower self-regulation and elevated physiological markers of stress.<sup>50</sup> Research indicates that a primary concern of children and young people in economically disadvantaged families is being excluded from activities that other children and young people appear to take for granted, and the embarrassment this can cause.<sup>51</sup>

Having access to this information is important in ensuring that children and families living in low income households are supported in terms of their education, employment, recreation, physical and emotional health, and social inclusion, in addition to having their material needs met.

#### ***Indicator definition:***

Children aged less than 16 years living in families with incomes under \$36,515 p.a. in receipt of the Family Tax Benefit (A) (whether receiving income support payments or not), as a proportion of all children aged less than 16 years (June 2017). The families these children are living in would all receive the Family Tax Benefit (A) at the maximum level.

#### ***Our group of councils***

Almost one third (32.4%) of children aged less than 16 years in the MRLGA were living in low income families, some 18% above the proportion in Regional SA. The LGAs of Berri and Barmera (37.8%) and Murray Bridge (37.1%), and the PHAs of Renmark (43.5%) and Murray Bridge (39.9%), had the highest proportions of this population group.



## 5.2. Recipients of Age and Disability Support Pensions, and Concession Card holders

### 5.2.1. Recipients of the Age Pension

#### *Rationale*

Although older people today are, on average, wealthier than they were in previous generations, these averages mask significant variation in economic circumstances. There are large differences in the distribution of income, wealth and home ownership between older people, with the most disadvantaged being those who live alone and do not own their own home. Those people who enter older age as renters, low paid workers, or who have been out of the labour market for long periods of time (due to unemployment, disability or family responsibilities among other reasons) are the most likely to be exposed to financial vulnerability in older age. Financial limitations may lead to social exclusion, which can result in reduced quality of life, preventable illness and disability, premature institutionalisation and death.<sup>52</sup>

Local Government can support older people who are pension recipients through the provision of in-home services, and transport, social and other opportunities which allow them to continue to be participating members of the community.

#### ***Indicator definition:***

People in receipt of an Age Pension from Centrelink or a Service Pension (Age) from the Department of Veterans' Affairs, as a proportion of the population aged 65 years and over (June 2017). An Age Pension is a restricted income paid by the Australian Government to those who generally do not have (or do not have much) income from other sources and who have reached the qualifying age, with the amount paid subject to income and asset tests.

#### ***Our group of councils***

Almost three quarters (72.9%) of the population aged 65 years and over in June 2017 were receiving an Age Pension in the MRLGA, compared with 69.9% in Regional SA.

Proportions above the Regional SA average were recorded for the LGAs of Berri and Barmera (76.4%), Murray Bridge (76.2%), Karoonda East Murray (75.9%) and Loxton Waikerie (73.0%).

Murray Bridge (79.8%), Barmera/ Berri (76.4%) and Renmark (76.2%) had the highest proportions at the PHA level.

## 5.2.2. Recipients of the Disability Support Pension

### *Rationale*

Disability Support Pensions (DSPs) are designed to give people an adequate means of support if they are unable to work for at least 15 hours per week at or above the relevant minimum wage, independent of a program of support, due to a permanent physical, intellectual or psychiatric impairment.<sup>53</sup> There has been a steady increase in the number of people receiving the Disability Support Pension since its introduction, however a range of has seen a decrease in the number of DSP recipients in recent years. For close to a decade, the proportion of working age people receiving the DSP was relatively stable (5.3% at June 2004 to 5.5% at June 2012)<sup>54</sup>; however, as a result of changes to policy, assessment processes and workforce participation requirements, DSP recipients as a share of the working age population has declined in recent years to 4.7% in 2016-17; similar to levels in 1998-1999.<sup>55</sup> At June 2017, there were 73,365 DSP recipients in South Australia.<sup>56</sup>

In 2013-14, about half of new DSP recipients moved directly from other income support benefits to DSP.<sup>57</sup> Receipt of the DSP is strongly age-related, mainly because the incidence of disability rises with age.<sup>55</sup> In 2016, 2.7% of people aged 16 to 20 received DSP, but this rose with age to 10.3% of people aged 25 to 34, 24.7% of people aged 45-54 and 37.3% of people aged 55-64 years.<sup>58</sup> Disability rises further with increasing age over 65 years, but after 65, most people are entitled to an Age Pension and the DSP is currently no longer relevant.<sup>59</sup>

### ***Indicator definition:***

People aged 16 to 64 years in receipt of a Disability Support Pension from the Department of Human Services or a Service Pension (Permanently Incapacitated) from the Department of Veterans' Affairs, as a proportion of the population aged 16 to 64 years (June 2017).

### ***Our group of councils***

There were 11% more people in the MRLGA in receipt of a Disability Support Pension than in Regional SA, with 9.6% and 8.6%, respectively.

Mid Murray (11.5%) and Berri and Barmera (11.0%) had the highest proportions of the LGAs, and Renmark (12.1%), Barmera/ Berri (11.0%) and Murray Bridge (10.1%) had the highest proportions of the PHAs.

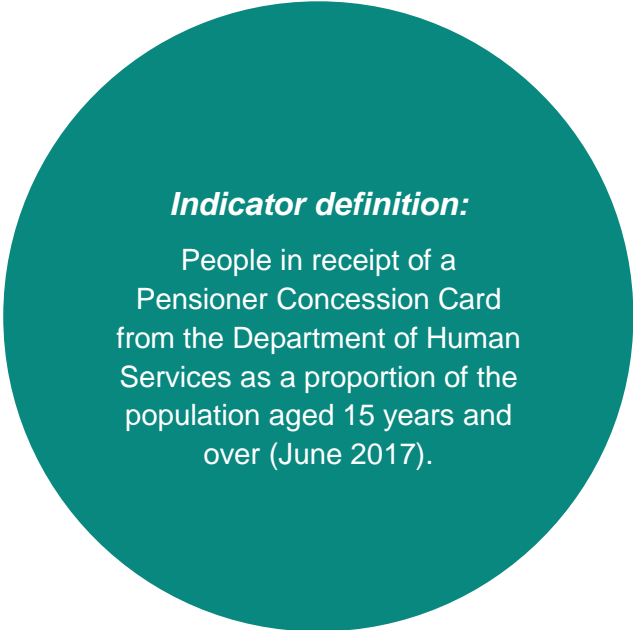
### 5.2.3. People who hold a Pensioner Concession Card

#### *Rationale*

Entitlement to an Australian Government Pensioner Concession Card (PCC) is used here as a proxy for socioeconomic disadvantage, although it is not universally so. People who hold a PCC include those in receipt of a range of pension and benefit types, with the largest group being those receiving the Age Pension. Other groups include people with disabilities, carers, the unemployed and sole parents.

In general, people who have a Pensioner Concession Card or Health Care Card are likely to have poorer health. In 2003, it was reported that these populations were more likely to suffer chronic health problems (most chronic diseases and poorer oral health), including psychosocial problems (such as sleep disturbances, anxiety and depression), have more medications prescribed and receive less preventive care. Female card holders were less likely to have had a sexual health check (including Pap smear).<sup>60-61</sup>

As PCC cardholders have some of the lowest incomes, they are also likely to have poorer health. Compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives, experience higher levels of disease risk factors and use fewer preventive health services.<sup>62</sup>



#### ***Our group of councils***

Almost one third of the population aged 15 years and over in the MRLGA had a Pensioner Concession Card, 7% above the Regional SA average. The LGAs with the highest proportions of this population group were Berri and Barmera (35.8%), Mid Murray (35.6%), Karoonda East Murray (34.0%) and Murray Bridge (32.2%).

Of the PHAs, Renmark (37.9%), Barmera/ Berri (35.8%), Murray Bridge (34.3%) and Waikerie (32.5%) had the highest proportions.

## 5.2.4. People who hold an Australian Government Health Care Card

### *Rationale*

The Australian Government Health Care Card (HCC) is issued to recipients of certain social security benefit or allowance payments to provide access to health concessions, including cheaper pharmaceutical medicines. Also see the note above re holders of a Pensioner Concession Card (PCC), noting that holders of the HCC are generally financially better off than those holding a PCC.

### ***Our group of councils***

In addition to the one third of the population with a Pensioner Concession Card (19,219 people), an additional 5,376 people (9.5% of the population under 65 years) in the MRLGA, held a Health Care Card. Again, the LGAs of Berri and Barmera (10.5%), Karoonda East Murray (10.3%) and Murray Bridge (10.2%) had the highest proportions, with 9.8% in Renmark Paringa.

The PHAs with the highest proportions were Renmark (12.6%), Murray Bridge (10.6%) and Barmera/ Berri (10.5%).

### ***Indicator definition:***

People in receipt of a Health Care Card from the Department of Human Services as a proportion of the population aged 0 to 64 years (June 2017).

## 5.3. Household crowding

### *Rationale*

Adequate and affordable housing is an important determinant of health. An aspect of housing suitability now measured in Australia provides an indication of crowding. Household crowding is defined according to the Canadian National Occupancy Standard, a widely-used guideline for assessing whether a household has a sufficient number of bedrooms for household members. This variable, which is new in the 2016 Census of Population and Housing, can be used to identify if a dwelling is either under or over utilised. The indicator published is of the number of dwellings requiring extra bedrooms, taking into account a series of household demographics, such as the number of usual residents, their relationship to each other, age and sex.<sup>63</sup>

At the 2016 Census of Population and Housing, 3.7% of dwellings were assessed as requiring extra bedrooms. The proportion of dwellings varies widely around this measure, with proportions of over 50% in parts of the Northern Territory. In South Australia, 2.6% of dwellings were assessed as requiring extra bedrooms, with again a wide variation at the small area level.

### ***Indicator definition:***

Private dwellings requiring extra bedrooms as a proportion of all occupied private dwellings.

## Our group of councils

Household crowding was assessed to be an issue for 2.2% of households in the MRLGA, some 15% above the level for Regional SA. Proportions above the Regional SA figure of 1.9% were recorded for Murray Bridge (2.8%), Renmark Paringa (2.2%) and Berri and Barmera and Mid Murray (both 2.1%).

The PHAs of Murray Bridge (2.9%) Renmark (2.6%), Mannum/ Murray Bridge Region (2.3%), Barmera/ Berri (2.1%) and Waikerie (2.0%) had the highest proportions.

## 5.4. Housing stress and rent relief

### 5.4.1. Low income households under mortgage stress

#### *Rationale*

A family or individual is considered to be in mortgage stress if they are in a low income bracket and pay more than 30% of their income on mortgage repayments. In 2017, approximately 18.7% of households paying mortgages in South Australia experienced mortgage stress.<sup>64</sup>

Increasing numbers of families are experiencing mortgage stress, and are at risk of homelessness, and poorer wellbeing.<sup>65</sup> Housing stress is rising due to low investment in public housing, demographic shifts and increases in the number of households including through family breakdown; and a tendency for more affluent people to want to live in the inner city, which increases rents and forces low income earners out of even relatively low standard housing.<sup>66</sup> A

household that is in stress is less likely to contribute to or participate in community life due to financial constraints. This issue can further manifest in other ways such as restricting one to live in lower priced areas thus minimising employment opportunities, delay family formation or cause family breakdown.<sup>67</sup>

#### **Indicator definition:**

Households in the bottom 40% of the income distribution (those with less than 80% of median equivalised income), spending more than 30% of their income on mortgage repayments as a proportion of mortgaged private dwellings. See Notes on the data for more details.

## Our group of councils

Mortgage stress was an issue for 10.8% of low income households in the MRLGA with a mortgage, notably (15%) above the level in Regional SA overall. Karoonda East Murray (16.5%), Mid Murray (13.6%) and The Coorong (12.2%) were the LGAs with the highest proportions of low income households under mortgage stress.

Of the PHAs, Murray Bridge and Karoonda - Lameroo/ The Coorong (both with 11.7%), Mannum/ Murray Bridge Region (11.6%), Waikerie (10.7%) and Renmark (10.4%) had the highest proportions.

## 5.4.2. Low income households under rental stress

### *Rationale*

A family or individual is considered to be under rental stress if they are in a low income bracket and pay more than 30% of their income on rent. In 2016, Census data showed that more than one quarter of Australian households (29.4%) rented their home from a private landlord. In 2017, approximately 60% of South Australian households experiencing house stress were renters and over one in three households (35.8%) paying rent spent more than 30% of their income on rent.<sup>64</sup>

As it is almost impossible for all but the most disadvantaged families to access public housing, renting privately has become the only housing option for low income households. For many low income households who rent, shortages of affordable rental housing, rising rents and stagnant rent relief, and tight vacancy rates are factors that exacerbate their position and move them closer to the poverty line.

<sup>65</sup> This situation can also negatively affect their health and wellbeing. Younger people and older people in private rental, lone-parent and single person households, women, people born in a non-English speaking country, and unemployed people are groups most likely to be living in unaffordable housing.

<sup>68</sup> A household that is in stress is less likely to contribute or participate in community life due to financial constraints. This issue can further manifest in other ways such as restricting one to live in lower priced areas thus minimising employment opportunities, delay family formation or cause family breakdown.<sup>67</sup>

### **Indicator definition:**

Households in the bottom 40% of the income distribution (as above), spending more than 30% of their income on rent as a proportion of rented private dwellings. See Notes on the data for more details.

### ***Our group of councils***

The rate of rental stress of low income households in the MRLGA, was consistent with the proportion across Regional SA.

Murray Bridge (30.5%) and Mid Murray (30.4%) had the highest proportions of low income households in rental stress in 2016, with 31.3% in the PHA of Murray Bridge.

### 5.4.3. Rented social housing

#### *Rationale*

Housing plays an important role in the health and wellbeing of South Australians and, in doing so, promotes positive health, education, employment and security for individuals.<sup>83</sup>

Social housing includes rental housing owned and managed by Housing SA or a housing co-operative, community or church group; social housing rents in general are set below market levels and determined by household income.<sup>69</sup> The social housing services system seeks to provide low income people with access to housing assistance; supporting their wellbeing and contributing to their social and economic participation by providing services that are timely and affordable, safe, appropriate (meeting the needs of individual households), high quality and sustainable.<sup>70</sup> The distribution of social rental housing remains an indicator of socioeconomic disadvantage, with tenants increasingly welfare-dependent (especially single parents; those who are unemployed, aged or with a disability; and Aboriginal and Torres Strait Islander people).

It is of note that the number of houses available for rental through Housing SA, the main provider of social housing, has declined substantially since 1996.

Waiting lists for social housing are long, with 394,300 households in Australia's main social housing programs in 2015-16 which comprise public rental housing, state owned and managed Indigenous housing and mainstream community housing. In 2007-08 to 2015-16, there was a 103 percent increase in the number of households in community housing, from around 35,700 to 72,400.<sup>70</sup> Moreover, housing affordability has declined in Australia as increases in median income has not kept pace with growth in median mortgage and rental payments. In 2001-2011, median mortgage and rental payments increased by 100 percent whereas median household income increased by only 60 percent.<sup>71</sup>

#### ***Indicator definition:***

Occupied private dwellings rented from Housing SA, a housing co-operative, community or church group as a proportion of all occupied private dwellings in 2016.

#### ***Our group of councils***

There were relatively fewer social housing dwellings available for rent in the MRLGA than in Regional SA, with 5.4% and 6.1% respectively.

The LGAs of Murray Bridge (7.9%) and Berri and Barmera (6.6%) and the PHAs of Renmark (10.3%) and Murray Bridge (8.9%) had the most households in this category.

#### 5.4.4. Recipients of rent relief

##### *Rationale*

Affordable, secure and safe housing is fundamental to one's health and wellbeing, employment, education and other life opportunities. Commonwealth Rent Assistance (CRA) assists low income people in housing need. It is a subsidy paid largely to people who receive social security or other income-support benefits from the Commonwealth Government, and who rent in the private rental market, in community housing, and in other renting situations. Most recipients of rent assistance would be paying more than 30% of their gross income on rent if rent assistance was not available – a situation referred to as 'housing stress'.<sup>72</sup>

In 2017, 54% of all CRA recipients were single with no dependent children. Sole parent families represented 21% of the total rent assistance population. If not for CRA received, nearly 7 in 10 CRA recipients (68%) would have been in rental stress.<sup>73</sup> In South Australia, there were 100,518 CRA recipients of whom 42.3% were single with no dependent children. In terms of age distribution, one quarter (25%) of all CRA recipients were in the 60 years and over age group, followed by 22.7% in the 30-39 years age group.

##### ***Indicator definition:***

Renters receiving Commonwealth Rent Assistance from the Department of Human Services (June 2017) as a proportion of all occupied private dwellings (Census 2016).

##### ***Our group of councils***

Rent relief is more commonly provided to households in the MRLGA, at 18.1% some 16% higher than across Regional SA. The LGAs of Murray Bridge (22.4%), Berri and Barmera (19.6%) and Renmark Paringa (18.8%) had the highest proportions of households receiving rent relief. Renmark (24.6%), Murray Bridge (24.4%) and Barmera/ Berri (19.6%) had the highest proportions in the PHAs.



## 5.5. No motor vehicle

### *Rationale*

Ready access to transport provides a link with social and work-related activities. While public transport can adequately provide this link for some households, for others such access can only be achieved through owning a car. Planned land use and the transition to private motor vehicles after World War II led to private motor vehicles as the dominant form of transport, resulting in a high level of dependency on cars in Australia. A number of social groups are more vulnerable to transport disadvantage, particularly the young, aged, poor and disabled.<sup>74</sup>

People living in households without a car face many disadvantages in gaining access to jobs, services and recreation, especially if they are in low-density outer suburbia, or in rural or remote areas, or in a country town. The ability to afford to run and maintain a vehicle in reliable condition to meet their transport needs, and the costs of registering and insuring a vehicle, are other important factors.<sup>75</sup>

Not all South Australians are able to drive, have access to, or own a passenger vehicle. In the 2016 Census, 47,848 householders in South Australia reported having no motor vehicle at the dwelling (7.5% of occupied private dwellings in South Australia).<sup>10</sup> While some of these may be more affluent households living in inner- and near-city areas, the majority are more likely to be disadvantaged households. For the latter, a city which is car-dependent may restrict their access to services, employment, shops, social and other activities.<sup>75</sup> Transport services, which may be provided by local councils, can provide much needed assistance, especially for older residents.

### ***Indicator definition:***

Occupied private dwellings with no motor vehicle garaged or parked there on Census night, as a proportion of all occupied private dwellings (Census 2016).

### ***Our group of councils***

The proportion of dwellings in the MRLGA without a motor vehicle garaged or parked there on Census night was similar to that across Regional SA, with 5.6% and 5.7%, respectively.

Murray Bridge (6.9%) and Berri and Barmera (6.8%) were the only LGAs in which the proportion of dwellings without a motor vehicle was above the level in the MRLGA. At the PHA level, Renmark (8.2%) and Murray Bridge (7.9%) had the highest proportions.

## 6. Early life and childhood

### 6.1. Total fertility rate

#### *Rationale*

Fertility is an important component of population change (particularly population age-structure), and low fertility has implications for a population's ability to sustain itself.<sup>76</sup> Fertility levels vary between population groups, areas with different socioeconomic conditions, and between metropolitan and regional areas. Differences may exist for a variety of reasons, such as culture, social norms, employment, the economy, and socioeconomic status.<sup>76</sup>

The Australian TFR in 2017 stood at 1.74 children per woman, the lowest since 2001<sup>77</sup> and well below the population replacement level of 2.1 children per woman. In South Australia, the TFR declined from 1.9 in 2007 to 1.6 children per woman in 2017 and the lowest rate of all states and territories.<sup>77</sup> Sustained periods of fertility below the replacement level are major drivers of population ageing. Given the potential economic impacts of an ageing population<sup>78</sup>, fertility is of particular interest to local planners and policy-makers.

#### **Indicator definition:**

Total fertility rate per woman, calculated from age-specific fertility rates (total live births as a rate for all women aged 15 to 49 years). The total fertility rate (TFR) represents the average number of children that a woman could expect to bear during her reproductive lifetime: it is calculated from details of the age of the female population, the number of births and the age of the mother at birth.

#### **Our group of councils**

The total fertility rate (TFR) of 2.27 was 4% above the Regional SA rate of 2.19 in the MRLGA.

Of the LGAs, Karoonda East Murray (with a TFR of 3.47) and The Coorong (2.79) had by far the highest rates. Several PHAs had TFRs of around 2.50, namely, Karoonda - Lamerook/ The Coorong, Loxton/ Loxton Region/ Renmark Region, Waikerie and Mannum/ Murray Bridge Region.

## 6.2. Women smoking during pregnancy

### *Rationale*

Maternal smoking during pregnancy carries a higher risk of adverse outcomes for the baby before and after delivery, which include low birthweight, premature birth, miscarriage and perinatal death, poor intra-uterine growth, placental complications and Sudden Infant Death Syndrome.<sup>79</sup> Smoking during pregnancy can also lead to other problems such as a higher risk of disability and developmental delay, childhood cancers, decreased lung function, increased respiratory illness, high blood pressure, and obesity which may affect children through to adulthood.<sup>79</sup>

In 2016, 9.4% of all women in South Australia reported to be smokers at their first antenatal visit, a considerable decline from 21.9% in 2001. The proportion of Aboriginal women who smoked during pregnancy at the time of their first antenatal visit was significantly higher, at 43.9% compared with 8.1% of non-Aboriginal women. Some Aboriginal women (4.9%) reported that they quit smoking prior to their first ante-natal visit; this compared with 2.4% for non-Indigenous women.<sup>80</sup>

### ***Indicator definition:***

Women who reported that they smoked during a pregnancy, as a proportion of the total number of pregnancies over the time period (three years: 2012 to 2014).

### ***Our group of councils***

Almost one quarter of women in the MRLGA reported that they smoked during a pregnancy in the years 2012 to 2014, some 15% above the Regional SA rate.

In the LGAs of Berri and Barmera and The Coorong, 29.0% of pregnant women reported that they smoked at some stage during their pregnancy, with 25.7% in Renmark Paringa and 24.9% in Murray Bridge. Each of these LGAs, other than Renmark Paringa, had higher than average Aboriginal populations, a group among whom smoking prevalence is generally higher than for non-Indigenous people.

Barmera/ Berri (29.0%), Murray Bridge (25.8%), Renmark (25.7%) and Karoonda - Lameroo/ The Coorong (24.1%) had the highest rates among the PHAs.

## 6.3. Childhood immunisation

### *Rationale*

If sufficiently large proportion of children in a community is immunised against a particular infectious disease, then the potential for that disease to spread is greatly reduced. Another important implication of immunisation is the decrease in human suffering, disability and cost of health care and economic loss through preventing an infectious disease and its consequences.

Immunisation data are collected by Medicare Australia, which has maintained the Australian Childhood Immunisation Register (ACIR) since 1996. The ACIR provides information on the immunisation status of children under seven years of age in Australia.

### ***Indicator definition:***

Fully immunised at 1 year means that a child aged 12 months to less than 15 months received three doses of a diphtheria, tetanus and whooping cough-containing vaccine, three doses of polio vaccine, two or three doses of Haemophilus influenzae type b vaccine (dependent of the type of vaccine used), three doses of hepatitis B vaccine, and three doses pneumococcal vaccine, all prior to the age of 1 year. See Data notes for more information.

### 6.3.1. At one year of age

#### ***Our group of councils***

The total for full immunisation at 1 year of age in the MRLGA has not been provided as to do so would reveal confidentialised data in the LGA of Karoonda East Murray.

Immunisation coverage at one year of age was lowest in the LGAs of Mid Murray (92.2%) and Murray Bridge (92.8%); the PHAs with the lowest rates were Mannum/ Murray Bridge Region (92.3%) and Murray Bridge (92.6%).

### 6.3.2. At five years of age

#### ***Our group of councils***

The total for full immunisation at 5 years of age in the MRLGA has not been provided as to do so would reveal confidentialised data in the LGA of Karoonda East Murray.

Although rates in Renmark Paringa and Southern Mallee fell in the latter the decline is quite notable, although the numbers are relatively small, which may have impacted the result.

### ***Indicator definition:***

Fully immunised at 5 years means that a child aged 60 to less than 63 months received four doses of a diphtheria, tetanus and whooping cough-containing vaccine, four doses of polio vaccine, and two doses of a measles, mumps and rubella-containing vaccine, all prior to the age of 5 years. See Data notes for more information.

## 6.4. Obesity: males and females aged 2 to 17 years of age

### *Rationale*

Obesity in childhood can cause a range of physical and emotional health problems, and obesity increases the risk in adulthood of premature illness, a range of chronic diseases, disability and premature death. While there are specific genetic disorders that give rise to overweight and obesity, recent epidemiological trends indicate that the rise in overweight and obesity is a result of environmental and behavioural changes.<sup>81</sup>

In 2017-18, it is estimated that more than one in four (28.4%) children and young people aged 5-17 years in South Australia were overweight or obese, comprised of 17.8% overweight and 9.9% obese.<sup>8a2</sup> This is an increase on the proportions in 2014-15 (23.7%) and 2011-12 (24.1%).<sup>82b</sup>

Overweight and obesity in the South Australian population is not a simple matter of overindulgence or lack of physical activity.<sup>81</sup> There are numerous environmental and societal factors that combine to generate an 'obesogenic' environment; i.e., one that promotes increased energy intake (in food and beverages) and/or reduced energy expenditure (physical activity).

The urban environment is becoming gradually less conducive to supporting active leisure, particularly where young children are concerned, with fears for their personal safety and a lack of child-appropriate play space.<sup>83</sup> Local Government has an important role in developing resources which support greater opportunities for physical activity for children and their families.

### 6.4.1. Males

#### *Our group of councils*

It was estimated that 7.5 male children per 100 population (7.5%) aged from 2 to 17 years in the MRLGA were obese in 2014–15, a rate some 7% above the Regional SA rate.

Rates varied little between the LGAs with the highest in Murray Bridge LGA (8.0%) and PHA (8.2%).

### 6.4.2. Females

#### *Our group of councils*

It was estimated that 7.8 female children per 100 population (7.8%) aged from 2 to 17 years in the MRLGA were obese in 2014–15, a rate some 7% above the Regional SA rate.

Rates varied little between the LGAs with the highest in Murray Bridge LGA (8.2%) and PHA (8.3%).

#### *Indicator definition:*

Estimated number of males or females aged 2 to 17 years who were assessed as being obese, based on their measured height and weight. These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

## 6.5. Daily fruit consumption at ages 4 to 17 years

### *Rationale*

The consumption of adequate daily amounts of fresh fruit and vegetables is associated with good nutrition and better health. Diets high in vegetables and fruit are associated with lower rates of many cancers, coronary heart disease, stroke, hypertension, cataracts and macular degeneration of the eye, and type 2 diabetes. The 2013 Australian Dietary Guidelines recommend a minimum number of serves of fruit and vegetables each day for children and young people, depending on their age and sex, to ensure good nutrition and health.<sup>82</sup> In 2014-15, two thirds (66.6%) of children aged 2 to 18 years in South Australia were estimated to have met the guidelines for recommended daily serves of fruit, with girls more likely than boys to meet the recommended intake.<sup>82</sup>

The current recommended intake of fruit in the 2013 NHMRC Australian Dietary Guidelines is 1.5 serves for children aged 4 to 8 years and two for persons aged 9 years and over.<sup>82</sup>

### ***Indicator definition:***

Estimated number of children aged 4 to 17 years who had an adequate fruit intake meeting the 2013 National Health and Medical Research Council (NHMRC) Australian Dietary Guidelines (see above). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

### ***Our group of councils***

Almost two thirds (65.7%) of children aged from 4 to 17 years in the MRLGA were estimated to have met the guideline for fruit consumption, with lower rates in Southern Mallee and The Coorong (with a rate of 61.4 per 100 children) and Karoonda East Murray (61.7). At the PHA level, the lowest rate was in Waikerie (57.5% meeting the guideline).

Note that the data reported for Southern Mallee and The Coorong LGAs for this variable are the same: see the [Notes on the data](#) for more information.

## 6.6. Infant death rate

### *Rationale*

The survival of infants in their first year of life is viewed as an indicator of the general health and wellbeing of a population.<sup>84</sup> Infant mortality refers to deaths of infants under one year of age and is measured by the infant mortality rate (IMR), the rate of infant deaths per 1,000 births in a calendar year. The IMR for Aboriginal infants is significantly higher than that for non-Indigenous infants, indicating their overall poorer health and wellbeing and the levels of socioeconomic disadvantage of their families, much of which represent the legacy of colonisation, cultural dispossession, discriminatory policies and social exclusion.<sup>85</sup>

### ***Indicator definition:***

Infant death rate per 1,000 live births: deaths that occurred before 12 months of age as a proportion of all births expressed as a rate per 1,000 live births per calendar year (over five years: 2011 to 2015).

## Our group of councils

There were 13 infant deaths in the MRLGA over the five years from 2011 to 2015; although a small number, it was still 36% above the rate across Regional SA.

Many LGAs and PHAs have no infant deaths, although Murray Bridge LGA and PHA had seven and six of these deaths, respectively, a rate in both cases of 5.6 infant deaths per 1,000 live births.

## 6.7. Children and young people who are clients of the Child and Adolescent Mental Health Service

### Rationale

Mental health problems affect significant numbers of children and young people each year.

Approximately 14% of 12-17 year olds and 27% of 18-25 year olds experience such problems each year; and 75% of mental health problems emerge before the age of 25.<sup>54</sup> Mental health problems in childhood and adolescence can have far reaching effects on the physical wellbeing, educational, psychological and social development of individuals. When early signs of difficulty are not addressed, mental health problems may become more serious and develop into mental disorders.

The Child and Adolescent Mental Health Service (CAMHS) provides services for children and young people with emotional, behavioural or mental health problems, and their families. Services are provided by child and family specialists including psychologists, psychiatrists, social workers, nurses, occupational therapists and speech pathologists. CAMHS staff also offer a range of prevention, early intervention and mental health promotion programs.

### Indicator definition:

Children and young people aged 0 to 19 years who are clients of the government-funded CAMHS (data over three years: 2015/16 to 2017/18), expressed as an indirectly age-standardised rate per 100,000 population aged 0 to 19 years.

## Our group of councils

There were markedly more clients of the Child and Adolescent mental Health Service of people aged 0 to 19 years living in the MRLGA, with a rate 20% higher than in Regional SA.

The highest rates were in the LGAs of Murray Bridge (47% above the Regional SA rate), Berri and Barmera (28% above) and The Coorong (19% above).

Murray Bridge PHA had clearly the highest rate, some 62% above the Regional SA average.

## 6.8. Early childhood development

### *Rationale*

The Australian Early Development Census (AEDC) measures the development of children in their first year of full-time school. It provides a picture of early childhood development outcomes and was conducted nationwide in 2009, 2012, 2015 and 2018 (results from the 2018 survey are not yet available). In the 2015 data collection, information was collected on 302,003 Australian children (98.1% of the estimated population) in their first year of full-time school.<sup>85</sup>

The results from the AEDC provide communities, schools, government and non-government agencies and policy makers with information about how local children have developed by the time they start school across five areas of early childhood development: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (schools-based), and communication skills and general knowledge. The AEDC domains have been shown to predict later health, wellbeing and academic success.<sup>85</sup>

### ***Indicator definition:***

The number of children in their first year of school in 2015 who were considered to be 'developmentally vulnerable' (with a score in the lowest 10%) on one or more domains of the AEDC, as a proportion of all children assessed.

### ***Our group of councils***

The total for children assessed as developmentally vulnerable in the MRLGA has not been provided as to do so would reveal confidentialised data in the LGA of Karoonda East Murray.

Mid Murray was the only LGA with a result that was much above the Regional SA proportion, with 41.3% of children developmentally vulnerable. The Southern Mallee proportion of 30.4% was 20% above the Regional SA average.

Several LGAs and PHAs had lower proportions, indicating better outcomes.



# 7. Personal health and wellbeing

## 7.1. Self-assessed health as fair or poor

### *Rationale*

Self-assessed health status is commonly used as a proxy measure of actual health status; and how people rate their health is strongly related to their experience of illness and disability.<sup>87, 88</sup> This measure is therefore an important indicator of key aspects of quality of life.<sup>89</sup>

Australians generally consider themselves to be healthy. In 2017–18, over half (56.4%) of Australians aged 15 years and over rated their health as 'very good' or 'excellent', while only 3.7% rated it as 'poor'.<sup>90</sup> Older Australians generally rated themselves as having poorer health than younger people, with persons aged 75-84 years and 85 years and over recording the highest proportions of fair or poor health, at 30.9% and 35.8% respectively.

<sup>90</sup> There was little difference in the way men and women assessed their overall health, with men slightly more likely to report their health as fair or poor other than at ages 85 years and over, where almost one third more women than men reported poorer health.<sup>90</sup>

### **Indicator definition:**

Estimated number of people aged 15 years and over reporting their health as 'fair' or 'poor' (and not 'good', 'very good' or 'excellent') expressed as a rate per 100 population aged 15 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

### **Our group of councils**

It was estimated that more people in the MRLGA reported their health as fair or poor (and not as good, very good or excellent) than in Regional SA, with 18.8% and 17.0%, respectively.

In Murray Bridge LGA one fifth of people reported their health as fair or poor (a rate of 20.2 people per 100 population aged 15 years and over, or 20.2%), with 19.8% in Mid Murray

Of the PHAs, the highest rates of reporting fair or poor health were in Waikerie (20.7%), Murray Bridge (20.4%) and Mannum/ Murray Bridge Region (19.5%).

## 7.2. High or very high levels of psychological distress

### *Rationale*

Mental health is fundamental to the wellbeing of individuals, their families and the population as a whole. One indication of the mental health and wellbeing of a population is provided by measuring levels of psychological distress using the Kessler Psychological Distress Scale-10 items (K10). The K10 questionnaire was developed to yield a global measure of psychological distress, based on ten questions about people's level of nervousness, agitation, psychological fatigue and depression in the four weeks prior to interview, asked of respondents 18 years and over.<sup>91</sup> Based on previous research, a very high K10 score may indicate a need for professional help.<sup>92</sup>

In 2017-18, 13.5% of South Australians experienced 'high' or 'very high' levels of psychological distress, compared with 13.7% in 2014-15, 11.3% in 2011-12. Proportionally more females than males experienced 'high' or 'very high' psychological distress in 2017-18 (14.9% and 12.0% respectively).<sup>93</sup>

### ***Indicator definition:***

Estimated population aged 18 years and over assessed as having a high or very high level of psychological stress under the K10 expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

### ***Our group of councils***

The estimated level of psychological distress (as high or very high) in the MRLGA was 14.2 people per 100 population aged 18 years and over, 9% above the level across Regional SA overall.

The rate in Murray Bridge, of 17.1%, was almost one third above the Regional SA rate. The other LGAs in the MRLGA had rates at or below the Regional SA rate.

Murray Bridge (17.7%), Renmark (14.6%) and Mannum/ Murray Bridge Region (13.8%) were the only PHAs with proportions above the Regional SA rate.

## 7.3. Type 2 diabetes

### *Rationale*

Diabetes is a serious complex condition which can affect the entire body. Diabetes requires daily self-care and, if complications develop, can have a significant impact on quality of life and can reduce life expectancy. Diabetes mellitus is a chronic disease characterised by high blood glucose levels resulting from defective insulin production, insulin action or both.<sup>94</sup> There are a number of different forms of diabetes, which can cause a number of serious complications, especially cardiovascular, eye and renal diseases.<sup>95,96</sup>

The main types of diabetes include, type 1, type 2 and gestational diabetes. In 2017-18, it was estimated in the National Health Survey that 92,000

### ***Indicator definition:***

Estimated number of people with type 2 diabetes mellitus as a long-term condition, expressed as a rate per 100 total population (indirectly age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

South Australians (5.6%) aged 18 years and over had diabetes mellitus.<sup>93</sup> The prevalence of diabetes tripled between 1989-90 and 2014-15 with males, the elderly, Indigenous Australians and those in remote areas or socioeconomically disadvantaged areas at a higher risk of developing this condition and have much greater hospitalisation and death rates from diabetes than other Australians. Further, diabetes prevalence was almost twice as high in the lowest socioeconomic group compared to those in the highest socioeconomic group. Indigenous Australians are also four times as likely than the non-Indigenous population to have diabetes.<sup>95</sup>

The combination of massive changes to diet and the food supply, combined with massive changes to physical activity with more sedentary work and less activity, means most populations are seeing more type 2 diabetes.<sup>165</sup> Control of modifiable risk factors (such as overweight, obesity and physical inactivity) through lifestyle modification is key to arresting prediabetes and preventing type 2 diabetes and reducing complications such as heart diseases, stroke, kidney disease, blindness, nerve damage, leg and foot amputations, and death.<sup>97-99</sup>

### ***Our group of councils***

The prevalence of diabetes type 2 was estimated to be 4.9 people per 100 population in the MRLGA, slightly above the rate in Regional SA.

The estimates also put prevalence for the LGAs and PHAs within a few per cent of the Regional SA rate.

## 7.4. Mental health problems

### *Rationale*

Good mental health is a state of wellbeing where one is able to cope with the normal stresses of life, work productively and contribute to their community.<sup>100</sup> Mental illness can have negatively impact on individuals, families and carers severely and with far reaching influence on social issues such as poverty, unemployment and homelessness. Further, those with mental illness may also face isolation discrimination and stigma.<sup>101</sup>

In 2011, mental and substance use disorders accounted for 12.1% of the total disease burden in Australia, the third highest group of diseases behind cancer and cardiovascular diseases (AIHW 2016).<sup>102</sup> There were an estimated 4.0 million Australians (17.5%) who reported having a mental and behavioural condition<sup>103</sup> in 2014-15, an increase from 13.6% in 2011-12, 11.2% in 2007-08 and 9.6% in 2001.<sup>104</sup> The most common mental illnesses are anxiety related (11.2%) and mood affective disorders (9.3%). Women (19.2%) are more likely than men (15.8%) to have mental and behavioural conditions.<sup>103</sup>

Of the 20% of Australians (3.8 million people) with a mental illness in any one year, 11.7% with a mental disorder also reported a physical disorder. Further, 5.3% reported 2 or more mental disorders and 1 or more comorbid physical conditions. The onset of mental illness is typically around mid-to-late adolescence, and Australian youth (18-24 years old) have the highest prevalence of mental illness than any other age group<sup>105</sup>. Almost one in two (45%) Australians are estimated to experience a mental illness in their lifetime, equating to 8.6 million people based on the 2016 population.<sup>106</sup>

### ***Indicator definition:***

Estimated number of males/females with current, long-term mental and behavioural problems expressed as a rate per 100 males/females (indirectly age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

### 7.4.1. Males

#### ***Our group of councils***

It was estimated that 17.7 males per 100 male population (17.7%) in the MRLGA reported having mental health problems: this was 8% below the rate in Regional SA.

The highest rates in the LGAs were in Murray Bridge (21.0%) and Mid Murray (20.1%); however, both rates were both below the Regional SA rate.

Only Mannum/ Murray Bridge Region PHA had a rate as high as that in Regional SA, with 19.2% of males estimated to have reported having mental health problems.

### 7.4.2. Females

#### ***Our group of councils***

It was estimated that 19.7 females per 100 female population (19.7%) in the MRLGA reported having mental health problems: this was 7% below the rate in Regional SA of 21.2%.

The highest rates in the LGAs were in Murray Bridge (19.0%) and Mid Murray (18.7%); however, both rates were both below the Regional SA rate.

Of the PHAs, the highest rate was in Murray Bridge, with 21.1% of females estimated to have reported having mental health problems, just below the rate in Regional SA, of 21.2%.

## 7.5. Tobacco smoking

### *Rationale*

Smoking is the leading preventable cause of death and disease in Australia. Around 2 out of three deaths among current smokers is linked to smoking; and in the 50 years from 1960 to 2010 it is estimated to have killed 821,000 Australians.<sup>107,108</sup> The Australian Burden of Disease Study in 2011 found that tobacco use was one of the single leading risk factors to death and disease as it accounted for 9% of the total burden<sup>102</sup>, being linked with a wide range of diseases such as heart disease, diabetes, stroke, cancer, renal disease, eye disease and respiratory conditions.<sup>109</sup>

In 2017-18, the National Health Survey estimated that just under one in seven (13.1%) or 169,100 South Australian adults were daily smokers; while a further 1.4% of people also reported smoking, they did so on a less than daily basis.<sup>90</sup> The negative effects of passive smoking indicate that the risks to health of smoking affect more than just the smoker. Passive smoking increases the risk of heart disease, asthma, and some cancers. It may also increase the risk of Sudden Infant Death Syndrome and may predispose children to allergic sensitisation.<sup>166</sup> Rates of smoking differ between males and females and across age groups; and between 2001 and 2017-18, overall rates of smoking decreased for both males and females. In 2017-18, 16.6% of males and 12.3% of females aged 18 years and over were current smokers (includes daily smokers and other smokers).<sup>90</sup>

For the period 2004-05, tobacco smoking was estimated to cost \$31.5 billion annually in health care, lost productivity and other social costs.<sup>110</sup> Further, the economic impact of long-term lost productivity to smoking was estimated to cost \$388 billion.<sup>111</sup> The prevalence of smoking is also significantly higher among lower socioeconomic groups, particularly those facing multiple personal and social challenges.<sup>112,113</sup> However, the prevalence of smoking in Australia is one of the lowest in the world and has greatly declined from 2001 with 20% of adults who smoke on a daily basis to 13% in 2016.<sup>108,112</sup>

### ***Indicator definition:***

Estimated number of people aged 18 years and over who reported being a current smoker, expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

### ***Our group of councils***

The prevalence of smoking in the MRLGA was estimated to be 19.7 people per 100 population aged 18 years and over (19.7%). This was 9% above the rate in Regional SA.

The highest smoking rates were estimated to be for people living in the LGAs of Berri and Barmera (22.1%) and Mid Murray (21.9%) and the PHAs of Mannum/ Murray Bridge Region (22.6%), Berri and Barmera (22.1%) and Renmark (21.2%).

## 7.6. Obesity

### *Rationale*

Overweight and obesity which refers to an accumulation of excessive fat, is a major health issue in Australia as it presents a number of health risks. The fundamental cause of a sustained energy imbalance results from consuming calories greater than the energy expended through physical activity. A range of factors such as an individual's biological and genetic traits, lifestyle factors and their obesogenic environment (i.e., physical, economic, political and sociocultural factors) play a part in their energy balance.<sup>114,115</sup>

Being overweight or obese increases one's likelihood of developing a range of serious or chronic conditions such as cardiovascular disease, some cancers, musculoskeletal conditions, diabetes, chronic kidney disease, dementia, asthma, gallbladder and bile duct disease<sup>116</sup>; however, there are greater health risks being obese compared with those who are overweight but not obese.<sup>117</sup>

In 2017–18, over a third (35.6%) of South Australians 18 years and over were overweight and a further 30% were obese.<sup>90</sup> Substantially more men than women were overweight (44.1% of men compared with 27.6% of women); for obesity, the gap was much smaller, at 30.0% compared with 28.7%). The proportion of Australians who are obese has increased across all age groups over time, up from 18.7% in 1995 to 30.8% in 2017-18.

Variation in rates of overweight or obesity can also be seen by remoteness area and socioeconomic group with higher prevalence in areas outside of major cities and for those in lower socioeconomic groups. Indigenous adults were also 1.2 times more likely than non-Indigenous adults to be overweight.

There are also significant health and financial impacts relating to obesity. In 2011-12, the direct and indirect cost of obesity to the Australian economy was estimated at \$8.6 billion, however, this is projected to rise to \$87.7 billion in additional costs over a 10-year period (2015-16 to 2024-25) if obesity continues to grow at its current rate.<sup>118</sup>

### **Males**

#### ***Our group of councils***

It was estimated that just over one third of adult males in the MRLGA were obese, slightly above the Regional SA rate. Mid Murray (37.0 males per 100 population aged 18 years and over, 37.0%), Loxton Waikerie (36.9%), Karoonda East Murray, Southern Mallee and The Coorong (each with 36.7%) had the highest rates of obesity at the LGA level.

Of the PHAs, obesity rates above the Regional SA rate were estimated for males in Waikerie (37.6%), Mannum/ Murray Bridge Region (36.8%), Karoonda - Lameroo/ The Coorong (36.7%), Loxton/ Loxton Region/ Renmark Region (36.5%) and Murray Bridge (34.3%).

Note that the data reported for Southern Mallee and The Coorong LGAs for this variable are the same: see the [Notes on the data](#) for more information.

#### ***Indicator definition:***

Estimated number of males/females aged 18 years and over reporting their height and weight at levels assessed as being obese, expressed as a rate per 100 males/females aged 18 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

## Females

### Our group of councils

The proportion of females in the MRLGA estimated to be obese was 39.5%, 11% above the male rate. Proportions above the Regional SA rate were estimated for Mid Murray (41.6%), Loxton Waikerie (41.1%), Karoonda East Murray (40.5%), Southern Mallee and The Coorong (40.4%) and Murray Bridge (39.0%), with a rate equal to that in Regional SA in Berri and Barmera (38.1%).

PHAs with obesity rates at or above the Regional SA rate were Waikerie (42.4%), Mannum/ Murray Bridge Region (41.3%), Karoonda - Lameroo/ The Coorong and Loxton/ Loxton Region/ Renmark Region (both 40.4%), Murray Bridge (38.6%) and Barmera/ Berri (38.1%).

Note that the data reported for Southern Mallee and The Coorong LGAs for this variable are the same: see the [Notes on the data](#) for more information.

## 7.7. Physical inactivity

### Rationale

According to the World Health Organization, physical inactivity is the fourth leading risk factor for global mortality.<sup>119</sup> Physical activity is an important determinant of health and wellbeing and regular exercise can play a role in not only reducing risk in chronic conditions associated with physical inactivity such as cardiovascular disease, diabetes, dementia, cancer, musculoskeletal health and osteoporosis, but also other disease risk factors such as overweight and obesity and high blood pressure.<sup>116</sup> Physical activity can also reduce stress and symptoms of mental health conditions such as anxiety and depression.<sup>120</sup>

Physical inactivity is a major risk factor for poor health in Australia. In 2017-18, self-reported data from the National Health Survey indicate that 50% of South Australians aged 18 years and over were not sufficiently active and failed to meet current Australian Physical Activity and Sedentary Behaviour Guidelines. Levels of physical inactivity also increases with age (due to prevalence of chronic conditions) and can vary by gender. Just over half (52%) of adults aged 18 - 64 years did not undertake sufficient physical activity compared with 75% of adults aged 65 years and over. In general, women across all age groups were more likely to be insufficiently active compared with men. Further variations are evident by remoteness area and by socioeconomic group as those living outside Major cities, and in lower socioeconomic groups more likely to not meet physical activity guidelines.<sup>121</sup>

By increasing walkability and providing safe and accessible areas in the neighbourhood built environment for active recreation and bicycle paths, Local councils can contribute to improving opportunities for their residents to be less physically inactive.

### Indicator definition:

Estimated number of people aged 15 years and over who reported being physically inactive (undertaking no, or a low level of physical activity), expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

## Our group of councils

Just over three quarters of the adult population in the MRLGA were estimated to be physically inactive (excluding workplace physical activity), five per cent above the rate in Regional SA overall. LGAs with poorer outcomes on this measure than in Regional SA overall were Southern Mallee and The Coorong (80.8 people per 100 population aged 15 years and over, 80.8%), Karoonda East Murray (80.3%), Loxton Waikerie (78.3%) and Renmark Paringa (78.3%).

Karoonda - Lameroo/ The Coorong (80.8%), Loxton/ Loxton Region/ Renmark Region (78.9%), Renmark (77.7%) and Waikerie (77.3%) were the PHAs with the highest proportions of the adult population who were estimated to be physically inactive.

Note that the data reported for Southern Mallee and The Coorong LGAs for this variable are the same: see the [Notes on the data](#) for more information.

## 7.8. Daily fruit consumption by adults

### Rationale

Fruits and vegetables are rich in vitamins, minerals and fibre. Regular daily consumption of fruit and vegetables is linked to lower rates of cancer, cardiovascular disease, stroke, hypertension, cataracts and macular degeneration of the eye, and type 2 diabetes but also reduce obesity, assist in weight management and promote gastrointestinal health.<sup>122</sup> The minimum recommended intake of fruit for adults is at least 2 serves a day.<sup>123</sup> In 2017-18, less than half (48.7%) of South Australian adults met the recommended guideline.

### Indicator definition:

Estimated number of people aged 18 years and over with a usual daily intake of two serves of fruit, expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

## Our group of councils

Just under half (45.7%) of the adult population in the MRLGA were estimated to have met the guidelines for fruit consumption, consistent with the level across Regional SA. Berri and Baramba (44.6 people per 100 population aged 18 years and over, 44.6%), Murray Bridge (44.7%), Mid Murray (45.5%), Karoonda East Murray (45.9%), Murray Bridge (44.7%), Renmark Paringa (45.9%) and Southern Mallee and The Coorong (both with 46.0%) all had rates below the Regional SA rate of 46.2%.

PHAs with the poorest outcomes for this indicator were Renmark (43.4%), Baramba/ Berri and Murray Bridge (both 44.6%) and Mannum/ Murray Bridge Region (44.8%).

Note that the data reported for Southern Mallee and The Coorong LGAs for this variable are the same: see the [Notes on the data](#) for more information.



## 7.9. Median age at death

### *Rationale*

The median age at death is the age at which exactly half the deaths registered (or occurring) in a given time period were deaths of people above that age and half were deaths below that age. In 2014, the median age at death for South Australians was 79 years for males and 85 years for females. Median age at death values are influenced to some extent by the age structure of a population. The Aboriginal population has a younger age structure than the non-Indigenous population and this is reflected in the median age at death of the two populations.<sup>125</sup>

### ***Indicator definition:***

Median age at death, 2010 to 2014: the age at which exactly half the deaths registered in the period 2010 to 2014 were deaths of people above that age, and half were deaths below that age.

### 7.9.1. Males

#### ***Our group of councils***

The median age at death for males in the MRLGA was 77 years, very close to the figure for Regional SA, of 78 years. Lower median ages were recorded for the populations of Mid Murray (75 years) and Loxton Waikerie (76 years). The best outcome was a median age at death of 80 years in The Coorong LGA.

The PHAs of Waikerie and Loxton/ Loxton Region/ Renmark Region both had lower median ages at death for males of 75 years, with the lowest median age calculated for Mannum/ Murray Bridge Region, of 74 years.

### 7.9.2. Females

#### ***Our group of councils***

The median age at death for females in the MRLGA was 83 years, some 8% above the male age: this median age was very close to the Regional SA figure for females.

Murray Bridge and Renmark Paringa both had a median age at death for females of 82 years, whereas Karoonda East Murray and Southern Mallee had the highest median age, of 87 years.

## 7.10. Premature mortality

### *Rationale*

Premature mortality refers to deaths that occur early, before the age of 75 years. Between 1907 and 2013, the premature mortality rate in Australia decreased by 71% for males and 78% for females. In Australia in 2013, about one third of all deaths (34%) occurred among people under the age of 75 years; a considerable improvement from 43% in 1997. Males accounted for 62% of premature deaths and the vast majority of premature deaths occurred in the 45-74 years age group. Coronary heart disease and lung cancer were the leading causes of premature mortality across all states and territories in Australia. Premature mortality rates increased with remoteness. The premature mortality rate among people living in Remote areas was 1.6 time as high than those in Major cities and 2.2 time as high in Very remote areas. Those living in lowest socioeconomic areas also had a premature mortality rate that was 2 times as high than those living in the highest socioeconomic areas. Deaths at ages earlier than expected, given life expectancies, imply an economic, personal and social loss for families and for the community.<sup>126</sup>

### ***Indicator definition:***

Deaths of males and of females aged 0 to 74 years, 2011 to 2015 (expressed as an age-standardised rate per 100,000 population).

### 7.10.1. Males

#### ***Our group of councils***

The premature mortality rate for males in the MRLGA was 9% above the Regional SA rate.

Southern Mallee (with a rate 29% above the Regional SA rate), Karoonda East Murray (28% above), Mid Murray (19% above), Renmark Paringa (16% above) and Berri and Barmera (15% above) had the highest rates at the LGA level. The rate in The Coorong was calculated to be 17% below that for Regional SA overall.

Of the PHAs, Waikerie and Renmark had the highest premature mortality rates, of 26% and 21%, respectively, above the Regional SA rates.

### 7.10.2. Females

#### ***Our group of councils***

The total for female premature mortality in the MRLGA has not been provided as to do so would reveal confidentialised data in the LGA of Karoonda East Murray.

There was less variation at the LGA level from the Regional SA rate than seen for males, with only The Coorong (14%) and Murray Bridge (13%) recording rates elevated by more than ten per cent. The lowest rate was in Renmark Paringa, 11% below the Regional SA rate.

The highest rates were in the PHAs of Murray Bridge (23% above the Regional SA rate) and Waikerie (22% above); the lowest was in Mannum/ Murray Bridge Region (21% below the Regional SA rate).

## 7.11. At ages 15 to 24 years

### *Rationale*

In 2012, there were 1,203 deaths among young Australians aged 15-24 years. This age group had the greatest reduction in premature mortality in 1997-2012 from 74 deaths per 100,000 population in 1997 to 39 deaths per 100,000 population in 2012; a 47% decrease. About three-quarters (76%) of deaths of young people in this age group were potentially avoidable, this includes the top 5 leading causes of deaths for this age group. In 2010-2012, suicide was the leading cause of death accounting for 26% of all deaths for this age group, followed by land transport accidents (25.3%), accidental poisoning (5.1%), and assault (3.0%).<sup>127</sup>

In 2015, there were 76 deaths among young people in the 15-24 years age group in South Australia; 34.8 deaths per 100,000. Over one-quarter (27.6%) of these deaths were due to suicide, followed by land transport accident (22.4%).<sup>128</sup>

### ***Indicator definition:***

Deaths from all causes, persons aged 15 to 24 years, 2011 to 2015 (expressed as an age-standardised rate per 100,000 population).

### ***Our group of councils***

There were 18 deaths at ages 15 to 24 years in the MRLGA, with the rate per 100,000 population at those ages being two per cent above the rate in Regional SA.

As a result of the relatively small number of these deaths over the five years from 2011 to 2015, many of the areas had too few numbers to report or on which to reliably calculate rates. Seven of the deaths were of young people from Murray Bridge LGA, of which six were from Mannum/ Murray Bridge Region, a rate of 136.1 deaths per 100,000 population, or 2.42 times the Regional SA rate.

## 7.12. Suicide

### *Rationale*

Suicide is a major social and public health issue.<sup>129,130</sup> While such deaths can occur for many reasons, and many complex factors might influence a person's decision to suicide, these preventable deaths point to individuals who may be less connected to support networks.<sup>129</sup> For instance, they may be less inclined to seek help or may be less intimately connected to people who might otherwise be aware of problems or step in to assist.

In 2010-12, suicide was third leading cause of deaths (4.5%) among people under the age of 75; in particular 92% of suicide deaths were among people less than 75 years old is indicative how unlike chronic diseases, suicide deaths are more prevalent among younger age groups.<sup>127</sup>

Reducing suicides and the impact they have on individuals, families and the state needs a whole-of-community approach, through awareness, prevention, intervention and support for those affected by suicide.<sup>130</sup> Local Government can play a role in developing safe communities and healthy neighbourhoods that are strong and supportive, resilient in adversity and that work together in times of need.

### ***Indicator definition:***

Deaths from suicide and self-inflicted injuries, people aged 0 to 74 years, 2011 to 2015 (expressed as an age-standardised rate per 100,000 population).

### ***Our group of councils***

The 43 suicides before 75 years of age of people living in the MRLGA give a rate of 16.6 deaths per 100,000 population aged 0 to 74 years, which is 19% above the rate in Regional SA.

Despite this high rate, only Mid Murray had a rate above the Regional SA rate of 14.0 deaths per 100,000 population aged 0 to 74 years, with its eleven deaths giving a rate of 29.7 deaths per 100,000 population, 2.11 times the Regional SA rate. Thirteen of the suicide deaths at these ages were in the Mannum/ Murray Bridge Region PHA, a rate of 29.6 deaths per 100,000 population. In Murray Bridge, with ten of these deaths, the rate was 26% below the Regional SA rate.

## 7.13. Hospital admissions

### *Rationale*

Admission to hospital is a formal process, and follows a decision made by an accredited medical practitioner at that hospital that a patient needs to be admitted for appropriate management or treatment of their condition, or for appropriate care or assessment of needs.<sup>131</sup>

Patients are usually admitted to hospital either as an emergency or as a booked admission. Emergency admission patients are usually admitted through the Accident and Emergency Department: these are seriously injured or ill patients who need immediate treatment. Most patients receive hospital-based services as a booked (elective) admission, either as a same-day patient or an inpatient. A same-day patient comes to hospital for a test or treatment and returns home the same day. An overnight admission is recorded where a patient receives hospital treatment for a minimum of 1 night (that is, the patient is admitted to and separated from the hospital on different dates) or longer in the hospital.

The majority of people who have had an episode of care in a hospital express satisfaction with the service when they leave.<sup>132</sup> However, admission to hospital carries with it a risk of harm. In Australia rates of serious adverse medical events are similar to those found in studies in the United States, with 0.3% of hospital admissions associated with an iatrogenic (medically caused) death and 1.7% associated with major iatrogenic disability.<sup>133</sup> Admission to hospital per se also carries a risk of adverse events, in addition to those related to any medical treatment undertaken. These include a risk of cross-infection, injury, or rarely, death.

### ***Indicator definition:***

Admissions to public acute and private hospitals in South Australia in 2016/17, excluding same day admissions for renal dialysis (expressed as an age-standardised rate per 100,000 population).

### ***Our group of councils***

The rate of admission to a hospital of people living in the MRLGA was four per cent above the Regional SA rate. Rates varied widely across the region, from 17% above the Regional SA rate in Renmark, to 16 % below in Loxton Waikerie.

At the PHA level the variation was wider, being from 56% above the Regional SA rate in Renmark, to 25% below in Loxton/ Loxton Region/ Renmark Region.

## 7.13.1. Potentially avoidable hospitalisations

### *Rationale*

Potentially preventable hospitalisations represent a range of conditions for which admission to hospital should be able to be avoided because the disease or condition has been prevented from occurring, or because individuals have had access to timely and effective primary healthcare.<sup>134</sup> There are 22 conditions that fall under 3 broad potentially preventable hospitalisations categories, they are vaccine-preventable conditions, acute conditions and chronic conditions.

Vaccine-preventable conditions are diseases that can be prevented by vaccination, they include influenza and measles. Acute conditions are conditions that would have avoided hospitalisation if adequate and timely care and intervention was received, they include urinary tract infections and cellulitis. Chronic conditions are conditions that can be preventable through modifications and changes to lifestyle and behaviour, and through effective and timely care and disease management, they include chronic obstructive pulmonary disease and cardiac failure.<sup>135</sup>

In 2016-17, there were over 715,000 potentially preventable hospitalisations. The majority of these hospitalisations were for chronic conditions (47%), followed by acute conditions (46%) and vaccine-preventable conditions (8%).<sup>136</sup> There are many factors that can influence rates of potentially preventable hospitalisation such as age, lifestyle risk factors, chronic diseases, ability to afford care and remoteness.<sup>135</sup>

### ***Indicator definition:***

Admissions to hospital for potentially avoidable conditions (from ambulatory care-sensitive conditions, 2016/17) (expressed as an age-standardised rate per 100,000 population).

### ***Our group of councils***

The rate of admission to hospital of people living in the MRLGA for the conditions categorised as being potentially preventable was 14% above the Regional SA rate.

LGAs with rates well above the Regional SA average were Southern Mallee (37% above), The Coorong (32%), Berri and Barmera (30%), Renmark Paringa (28%) and Murray Bridge (16.0%).

The largest differentials at the PHA level from the Regional SA rate were in Renmark (78% above), Karoonda - Lameroo/ The Coorong (30%) and Murray Bridge (22%).

## 7.14. Difficulty accessing healthcare

### *Rationale*

The inability to access services when needed may lead to adverse impacts on an individual, particularly when the services relate to personal health or wellbeing. In Australia in 2014, of those who experienced barriers to health care, 30.8% reported that access to doctor/GP was the leading type of healthcare that was inaccessible, followed by medical specialist (25.6%) and dental professionals (19.6%). The cost of service (34.9%) and lengthy waiting time/lack of appointments (34.1%) were cited as main reasons for not being able to access healthcare.<sup>138</sup>

Access to healthcare varied between population groups. For example, those with a mental health condition (38%) reported greater difficulty than those without a mental health condition (22%) when accessing healthcare and other services.

Similarly, people with disability (11%) were more likely than those without (2.8%) to experience a barrier in accessing healthcare. Over half of people in single parent families (54%) also reported difficulty accessing healthcare, citing cost of service as the main reason. They also experienced barriers accessing other services such as Commonwealth income support (54%), telecommunication services (22%) and dentists (22%).<sup>138</sup>

### ***Indicator definition:***

Estimated number of people aged 18 years and over who had difficulty accessing healthcare, expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014 General Social Survey (see Notes).

### ***Our group of councils***

Although it was estimated that only 1.4% of the adult population in the MRLGA had difficulty in accessing healthcare, this was 16% above the rate in Regional SA overall, of 1.2%

There was little variation at the LGA and PHA levels, other than in Murray Bridge, with a rate in the LGA of 1.9 people per 100 population aged 18 years and over (1.9%) in the LGA and of 2.0 in the PHA, both of which were substantially above the rate for Regional SA.

## 7.15. Home and Community Care Program

### *Rationale*

The Commonwealth Home and Community Care (HACC) Program which merged into to the Commonwealth Home Support Programme (CHSP) in July 2015<sup>139</sup> was a joint Commonwealth, State and Territory initiative, it funded services that supported people who were frail, aged and younger people with a disability (and their carers), who lived at home and whose capacity for independent living was at risk or who were at risk of premature or inappropriate admission to long-term residential care. The broad aim was to offer maintenance and support services to assist frail older people and younger people with disabilities to continue living in their communities.<sup>140</sup>

HACC services were offered in the home or local community by a HACC agency, community health centre or local council. Services include centre-based and other respite; social support and counselling; personal care; home modification and maintenance; transport; meals and other food services; information, advocacy and assessment; support for carers; allied health services; domestic assistance; and community nursing.<sup>140</sup>

### 7.15.1. Clients living alone

#### ***Our group of councils***

Just under one third (30.9%) of HACC clients in the MRLGA were living alone, consistent with the proportion of 31.3% in Regional SA.

Proportions varied from 33% above the Regional SA rate in the LGA of Berri and Barmera (41.7% of HACC clients), to 33% below in Mid Murray (21.1%). In both Loxton Waikerie and Renmark Paringa some 36.6% of HACC clients were living alone.

At the PHA level, Loxton/ Loxton Region/ Renmark Region (37.6%), Renmark (35.7%) and Waikerie (34.6%) had the highest proportions of this population group.

#### ***Indicator definition:***

Number of Home and Community Care Program clients whose status is recorded as living alone at the date of most recent assessment, as a proportion of the total client population (2014/15).

### 7.15.2. Non-English speaking clients

#### ***Our group of councils***

Substantially more HACC clients living in the MRLGA were non-English speaking than in Regional SA overall, with 16.0% compared with 11.4% (41% more).

Very high proportions were found in the HACC data collection for the LGAs of Mid Murray (30.8%, 2.71 times the Regional SA rate), Renmark Paringa (23.9%, 2.10 times), Berri and Barmera (23.5%, 2.07 times) and Loxton Waikerie (16.7%, 1.47 times).

Very high proportions were recorded in the PHAs of Mannum/ Murray Bridge Region (33.9%, 2.99 times the Regional SA rate), Renmark (28.9%, 2.56 times), Barmera/ Berri (23.5%, 2.07 times) and Loxton/ Loxton Region/ Renmark Region (17.9%, 1.57 times).

#### ***Indicator definition:***

Number of Home and Community Care Program clients whose main language spoken at home at the date of most recent assessment is not English, as a proportion of the total client population (2014/15).



## 7.16. Community mental health services

### *Rationale*

Public mental health services in South Australia work in collaboration with private sector health providers and non-government organisations. Services to assist adults aged 18 to 64 years with mental health issues are provided by community mental health services; public hospitals; non-government organisations; general practitioners; allied health professionals providing Medicare-funded and private fee for service allied mental health services (for example psychologists, social workers, occupational therapists); and psychiatrists (working privately on a fee for service basis).<sup>73</sup>

Older persons' community teams provide initial mental health assessment, treatment, care planning, and short term follow-up for people aged 65 and over, Indigenous consumers aged 45 years and over, or younger people who do not fall within the aged care criteria but who have an illness related to mental health and ageing with challenging behaviours. These services are geared specifically towards the care needs of older persons. The nature of the intervention is similar to those offered by general community mental health services.<sup>73</sup>

These data refer to all clients of community-based mental health services, who were aged 15 years and over.

### ***Indicator definition:***

People aged 15 years and over who were clients of government-funded community mental health services (2015/16 to 2017/18), expressed as an indirectly age-standardised rate per 100,000 population aged 15 years and over.

### ***Our group of councils***

Nearly 6,000 people aged 15 years and over living in the MRLGA were clients of a community mental health service, some 18% above the rate in Regional SA.

Bearing in mind that the location and therefore accessibility of these services varies across the region, the highest rates of clients were of people aged 15 years and over living in Murray Bridge (44.0% above the Regional SA rate) and Berri and Barmera (35.0% above). At the PHA level the highest rates were in Murray Bridge (with a rate 59% above Regional SA) and Berri and Barmera (35% above).

## 7.17. Availability of residential aged care

### *Rationale*

Residential Aged Care facilities provide accommodation, personal care and nursing services to people who can no longer manage to live in their own home due to increased care need (permanent residential aged care) or short-term accommodation (respite residential aged care) for people or carers who need a break from their usual living arrangements.<sup>144</sup> In 2017-18, residential aged care is the main contributor (67.3%, \$12.4 billion) on overall spending on aged care services. In this period, 234,798 older people were in permanent care (58.4 per 1000 older people) and 60,278 in respite care (15 per 1000 older people).<sup>145</sup> The expenditure on aged care has quadrupled since 1975 and with the projected increase of older people, spending on aged care is estimated to almost double as a share of the economy by 2055. Expenditure on aged care (based on 'proposed policy' scenario) is projected to increase from 0.9% of the GDP in 2014-15 to 1.7% of GDP in 2054-55; from \$620 to \$2,000 in real spending on aged care per person.<sup>78</sup>

### ***Indicator definition:***

Residential aged care places, including both residential high-level and low-level care places, expressed as a rate per 1,000 population aged 70 years and over (June 2016).

### ***Our group of councils***

There were eight per cent fewer residential aged care places per 1,000 population aged 70 years and over in the MRLGA in 2016 than in Regional SA.

The largest numbers of places were in the LGAs of Murray Bridge (153 places), Loxton Waikerie (150 places) and Berri and Barmera (130 places). The highest rates were in Karoonda East Murray (172.2 places per 1,000 population aged 70 years and over) and Southern Mallee (175.4 places per 1,000 population). The PHAs with the highest rates per 1,000 population aged 70 years and over were Renmark (115.7 places) and Karoonda - Lameroo/ The Coorong (106.4 places).

## 8. Community connectedness

### 8.1. People able to get support in times of crisis

#### *Rationale*

A strong community is one that is sustainable over generations and resilient in times of crisis; and has assets in the resources, skills and commitment of its members, not only material ones [1].<sup>146</sup> Social participation and involvement in local governance are the hallmarks of strong communities. Forms of social participation, such as volunteering or being a member of a community group, can benefit individuals in areas such as improved health and wellbeing, social inclusion and reduced crime, improved local services and facilities, and better educational outcomes [2].<sup>147</sup>

Community strength indicators measure how people feel about aspects of the community in which they live, and their participation in opportunities to shape their community. Healthy communities need a balance between three types of social connection: close personal networks, broader community networks (made through work, school, interest groups, volunteering activities etc.), and governance networks involved in decision-making [3].<sup>148</sup>

Examples of having positive personal networks include the ability to access emotional or financial support in times of crisis, as well as being prepared to offer such support to others beyond immediate household members.<sup>149</sup> Those who do not have such supports experience poorer health and wellbeing, greater stress in their lives and a higher risk of poverty and social exclusion.<sup>147</sup> Community members who report fair or poor health or a disability, and who are also financially stressed may delay in seeking medical care, or in purchasing prescribed medication because of the cost. Other barriers which can adversely affect people's health and wellbeing are lack of transport, other difficulties accessing needed services, and feeling unsafe in their local environment.<sup>150</sup>

#### ***Indicator definition:***

Estimated number of people aged 18 years and over who are able to get support in times of crisis from persons outside the household, expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014 General Social Survey (see Notes).

#### ***Our group of councils***

The majority of people in the MRLGA were able to get support in times of crisis, with little variation at the LGA and PHA levels.

## 8.2. Disagree/strongly disagree with acceptance of other cultures

### *Rationale*

The extent to which adult community members agree or disagree with the statement that 'To what extent do you agree or disagree that it is a good thing for a society to be made up of people from different cultures', gauges acceptance of diverse cultures within the community. Nationally, 83.6% of respondents in the 2014 General Social Survey indicated that they agreed or strongly agreed with this statement in 2014.<sup>151</sup> Immigration has been critical in building Australia's stock of social capital and has played a significant role in increasing the diversity of recreational and cultural activities for all Australians. Further, it has positively contributed to Australia's national infrastructure through investment in housing, new businesses, transforming urban areas, and bringing new skills and technology. Australia has not only benefited from being exposed to more international cultural and business opportunities associated with migration, but also seen an increase in its capacity for innovation, productive diversity and economic prosperity.<sup>152</sup>

### *Indicator definition:*

Estimated number of people aged 18 years and over who disagree/strongly disagree with acceptance of other cultures, expressed as a rate per 100 population aged 18 years and over (age-standardised); modelled estimates from the 2014 ABS General Social Survey

### ***Our group of councils***

A relatively small proportion (6.9%) of the adult population in the MRLGA were estimated to disagree/strongly disagree with acceptance of other cultures, a result some four per cent above the Regional SA rate.

Proportions varied from a rate of 7.6 people per 100 adult population (7.6%) in Murray Bridge to 5.6% in Berri and Barmera. The variation at the PHA level was no greater.

## 8.3. Government support as main source of income in last two years

### *Rationale*

People's standard of living depends on the economic and social resources available to them to support their consumption of goods and services, and their participation in society.<sup>153</sup> These include the income they receive in wages and salaries, their own businesses or investments, and income support from government.

Australia's income support is derived from government revenues which differs from many other OECD countries where employers and employees contribute to the system. Income support, which is redistributed through the income tax stream, functions as a safety net for those who are unable to adequately support themselves. Eligibility for income support is subject to means testing in order to ensure that assistance is directed to those most in need. The rate of support one receives is dependent on the income and assets tests.<sup>154,155</sup>

### ***Our group of councils***

Some 40.7% of the adult population in the MRLGA were estimated to have had government support as their main source of income in the two years prior to being surveyed, a rate 11% above that in Regional SA.

The highest proportions were estimated for the LGAs of Berri and Barmera (46.0% of the adult population), Murray Bridge (44.0%) and Renmark Paringa (40.4%). Barmera/ Berri (46.0%) and Murray Bridge (45.1%) PHAs had the highest rates.

### ***Indicator definition:***

Estimated number of people aged 18 years and over who had government support as their main source of income in the last two years, expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014 General Social Survey (see Notes).

## 8.4. Accessed the Internet at home in the past 12 months

### *Rationale*

A household can be considered to be disadvantaged if it lacks the resources to participate fully in society.<sup>156</sup>

Access to the outside world, through the Internet provides a means of communicating with friends and family, as well as services, employers and schools, thereby increasing educational, employment and other opportunities, including social interaction.<sup>157</sup>

The Multipurpose Household Survey for 2016-17 showed that the proportion of households with internet has steadily increased from 56% in 2004-05 to 86% in 2016-17.<sup>158, 159</sup> Desktop or laptop computers were the most commonly used device (91%) among all connected households alongside mobile phones (91%); other devices used to connect to the internet include, tablets (66%), TVs (27%) and internet connected music or video player devices (19%).<sup>158</sup>

In 2016–17, the highest proportion of internet users (98%) were aged 15 to 17 years, compared with 55% of older 65 years and over age group which had the lowest proportion of internet users. Socioeconomic characteristics of households continue to influence the rate of computer and Internet connectivity across Australia. Higher proportion of households with children under 15 years had access to the internet (97%) compared with 82% of households without children under 15 years. Households which do not have children under 15 years, those that are located in non-metropolitan or regional areas of Australia and/or have lower household incomes are less likely to have access to the Internet.<sup>158</sup> These socioeconomic factors also influence the take-up rate of broadband access (as opposed to dial-up access), in addition to the technical issues regarding service availability in certain locations.

### ***Indicator definition:***

Internet accessed from the dwelling as a percentage of total private dwellings (Census 2016).

### ***Our group of councils***

The proportion of dwellings in the MRLGA from which someone accessed the internet was three per cent below the Regional SA average. There was little variation at the LGA or PHA level.

# 9. Personal and community safety

## 9.1. Feel very safe/safe walking in local area after dark

### *Rationale*

Having trust in others to behave according to accepted social values and norms is a fundamental aspect of a well-functioning community.<sup>23</sup> An indirect measure of trust available from the ABS General Social Survey is people's feelings of safety while walking alone in their local area after dark.

While personal experience relating to being a victim of crime may influence an individual's feelings of safety, it is not the only factor. Other factors impacting on people feeling unsafe include, physical features of the local area such as inadequate street lighting and poorly maintained footpaths; crime levels in their local vicinity; relationships with people living nearby; sense of their own strength and capacity to be in control; perceptions of crime levels generally; and their level of trust in their local

community.<sup>23</sup> In the 2014 General Social Survey, there was slight increase (53% from 48%) in the proportion of people more likely to feel safe or very safe when walking alone in their local area than in 2010.<sup>138</sup>

### *Indicator definition:*

Estimated number of people aged 18 years and over who feel very safe/safe walking alone in local area after dark, expressed as a rate per 100 population aged 18 years and over (age-standardised). These data are modelled estimates from the 2014 General Social Survey (see Notes).

### *Our group of councils*

Some 58.0% of adults in the MRLGA were estimated to have reported that they felt very safe/ safe walking alone in their local area after dark

The LGAs of Southern Mallee and The Coorong (both with 73.8%) and Karoonda East Murray (73.4%) had the highest proportions, results drawing on reporting in the Karoonda - Lameroo/ The Coorong PHA (73.8%).

Note that the data reported for Southern Mallee and The Coorong LGAs for this variable are the same: see the [Notes on the data](#) for more information.

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# Appendix

**Table A1: Selected indicators of population health and its determinants, MRLGA compared with Regional SA**

Indicators	MRLGA	Berri and Barmera (DC)	Karoonda East Murray (DC)	Karoonda - Lameroo - The Coorong*	Loxton Waikerie (DC)	Loxton/ Loxton Region/ Renmark Region*	Waikerie*	Mid Murray (DC)	Mannum/ Murray Bridge Region*	Waikerie*	Murray Bridge (RC)	Mannum/ Murray Bridge Region*	Murray Bridge	Renmark Paringa (DC)	Loxton/ Loxton Region/ Renmark Region*	Renmark	Southern Mallee	Karoonda - Lameroo - The Coorong*	The Coorong (DC)	Karoonda - Lameroo - The Coorong*	Metro Adelaide	Regional SA	South Australia	Australia
<b>Population Profile, 2016 (Per cent, Index)</b>																								
Born overseas in predominantly non-English speaking countries	7.0	7.0	2.3	4.0	4.3	5.3	5.2	4.0	3.3	5.2	9.9	3.3	11.4	9.9	5.3	11.7	5.4	4.0	3.4	4.0	17.1	4.7	14.3	17.9
- country 1 of top three for LGA Cluster - Philippines	0.9	0.7	0.6	0.7	0.3	0.3	0.4	0.3	0.3	0.4	1.9	0.3	2.2	0.3	0.3	0.3	0.6	0.7	0.6	0.7	0.8	0.6	0.7	1.0
- country 2 of top three for LGA Cluster - India	0.8	1.1	0.0	0.1	0.7	0.8	1.0	0.2	0.1	1.0	0.6	0.1	0.7	2.0	0.8	2.7	0.1	0.1	0.1	0.1	2.0	0.3	1.6	1.9
- country 3 of top three for LGA Cluster - Greece	0.6	1.5	0.0	0.0	0.4	0.9	0.2	0.0	0.0	0.2	0.0	0.0	0.1	1.6	0.9	1.8	0.0	0.0	0.0	0.0	0.6	0.2	0.5	0.4
Born overseas & reports having poor proficiency in English	1.6	1.1	0.0	0.4	0.6	1.1	0.8	0.2	0.2	0.8	2.7	0.2	3.2	2.8	1.1	3.7	1.1	0.4	0.1	0.4	2.8	0.6	2.3	2.9
Permanent migrants entering Australia under the Humanitarian Program	0.4	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.6	0.5	0.0	1.0	0.1	0.0	0.0	0.0	1.4	0.2	1.2	0.9
- arrived between 2000 and 2006	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.2	0.2	0.0	0.3	0.0	0.0	0.0	0.0	0.5	0.0	0.4	0.3
- arrived between 2007 and 2011	0.2	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.3	0.2	0.0	0.5	0.1	0.0	0.0	0.0	0.5	0.1	0.4	0.3
- arrived between 2012 and 9th August 2016	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.0	0.2	0.0	0.0	0.0	0.0	0.4	0.1	0.3	0.2
Permanent migrants entering Australia on a Family stream visa	1.0	0.8	0.7	0.5	0.5	0.6	0.8	0.6	0.6	0.8	1.4	0.6	1.5	1.4	0.6	2.1	0.8	0.5	0.3	0.5	2.2	0.8	1.8	2.8
- arrived between 2000 and 2006	0.3	0.4	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.4	0.2	0.5	0.3	0.2	0.2	0.2	0.7	0.3	0.6	1.1
- arrived between 2007 and 2011	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.1	0.3	0.5	0.1	0.5	0.6	0.2	0.9	0.2	0.2	0.1	0.2	0.8	0.2	0.6	1.0
- arrived between 2012 and 9th August 2016	0.4	0.2	0.2	0.1	0.2	0.2	0.3	0.2	0.1	0.3	0.6	0.1	0.7	0.5	0.2	0.8	0.2	0.1	0.0	0.1	0.7	0.2	0.6	0.7
Permanent migrants entering Australia on a Skill stream visa	1.6	1.3	1.7	1.2	0.7	0.6	0.7	0.7	0.7	0.7	2.8	0.7	3.2	0.8	0.6	1.2	1.8	1.2	0.9	1.2	5.7	1.2	4.6	5.1
- arrived between 2000 and 2006	0.5	0.4	0.5	0.4	0.2	0.2	0.4	0.2	0.3	0.4	0.8	0.3	0.9	0.3	0.2	0.4	0.5	0.4	0.4	0.4	1.6	0.4	1.3	1.9
- arrived between 2007 and 2011	0.7	0.6	0.8	0.6	0.3	0.3	0.2	0.3	0.2	0.2	1.4	0.2	1.6	0.5	0.3	0.7	0.9	0.6	0.4	0.6	2.6	0.6	2.1	2.1
- arrived between 2012 and 9th August 2016	0.4	0.3	0.4	0.2	0.1	0.1	0.1	0.2	0.2	0.1	0.7	0.2	0.8	0.0	0.1	0.0	0.4	0.2	0.2	0.2	1.5	0.2	1.2	1.1
Aboriginal and Torres Strait Islander people	4.6	5.6	1.5	5.6	2.8	2.4	3.0	2.9	2.9	3.0	5.7	2.9	6.2	3.2	2.4	4.8	2.7	5.6	7.4	5.6	1.7	5.0	2.5	3.3
People who provide unpaid assistance to others	12.2	12.6	12.6	12.5	12.4	12.4	11.1	13.0	13.4	11.1	12.0	13.4	11.9	11.1	12.4	11.1	11.6	12.5	12.9	12.5	12.2	12.2	12.2	11.3
People with a profound or severe disability and living in the community: all ages	6.3	7.2	6.8	6.1	5.8	5.2	6.1	6.9	6.4	6.1	6.3	6.4	6.6	5.6	5.2	6.9	6.2	6.1	5.9	6.1	5.2	5.6	5.3	4.7
People with a profound or severe disability and living in the community: 0 to 64 yrs	4.3	4.9	4.5	4.0	4.1	3.4	4.5	4.8	4.4	4.5	4.5	4.4	4.7	3.5	3.4	4.4	3.0	4.0	4.1	4.0	3.4	3.8	3.5	2.9
People with a profound or severe disability and living in the community: 65 yrs & over	13.7	16.0	17.2	13.8	11.5	12.1	11.7	13.1	12.6	11.7	13.8	12.6	14.1	13.8	12.1	15.1	17.1	13.8	12.2	13.8	14.1	12.3	13.6	14.3
Index of Relative Socio-economic Disadvantage	919	910	953	949	951	967	930	923	949	930	894	949	875	917	967	851	990	949	933	949	989	945	979	1000
<b>Employment, June 2017 (Per cent)</b>																								
Unemployment beneficiaries: total	9.4	10.4	7.4	8.2	7.3	7.0	8.8	9.7	8.4	8.8	9.9	8.4	10.4	10.1	7.0	13.7	5.4	8.2	9.4	8.2	6.3	8.6	6.8	5.2
Unemployment beneficiaries: six months or longer	8.1	9.0	..	7.2	6.2	6.1	7.4	8.4	7.3	7.4	8.6	7.3	9.1	8.7	6.1	11.7	4.8	7.2	8.1	7.2	5.4	7.5	5.8	4.3
Unemployment beneficiaries: young people	5.9	7.2	..	3.5	5.1	4.5	4.1	4.0	4.8	4.1	6.8	4.8	7.0	5.5	4.5	7.4	3.1	3.5	4.0	3.5	3.8	5.9	4.2	3.4
<b>Education (Per cent)</b>																								
Aged 16 years and not participating in full-time secondary education, 2016	18.1	16.9	25.0	18.5	11.1	13.2	18.1	15.7	14.7	18.1	18.5	14.7	18.2	30.1	13.2	30.8	15.4	18.5	17.8	18.5	12.0	17.1	13.3	15.9
School leavers admitted to university, 2018	n.a.	26.0	..	19.3	17.8	19.5	13.9	18.1	14.9	13.9	16.1	14.9	17.6	19.5	19.5	20.0	33.5	19.3	14.7	19.3	32.2	18.1	28.9	22.2
Children whose mother has low educational attainment, 2016	20.3	19.3	12.6	15.9	18.2	17.6	22.2	17.6	16.2	22.2	23.1	16.2	24.3	24.1	17.6	28.6	8.7	15.9	18.7	15.9	13.6	16.8	14.3	17.0
Young people learning or earning, 2016	80.2	80.7	79.4	82.2	84.1	85.5	81.7	80.5	80.2	81.7	77.0	80.2	76.7	81.2	85.5	76.6	84.7	82.2	82.2	82.2	86.6	80.3	85.3	84.3
<b>Income and wealth (Per cent)</b>																								
Children in low income, welfare-dependent families, June 2017	32.4	37.8	26.2	28.7	25.2	21.0	27.0	29.8	28.3	27.0	37.1	28.3	39.9	30.4	21.0	43.5	18.9	28.7	32.5	28.7	23.0	27.6	24.0	20.9
Age Pension recipients, June 2017	72.9	76.4	75.9	65.5	73.0	68.8	72.4	72.0	67.9	72.4	76.2	67.9	79.8	70.6	68.8	76.2	53.1	65.5	68.1	65.5	67.9	69.9	68.5	63.6
Disability Support Pension recipients, June 2017	9.6	11.0	9.8	9.1	8.5	7.1	9.9	11.5	9.0	9.9	9.4	9.0	10.1	8.3	7.1	12.1	7.7	9.1	9.6	9.1	6.3	8.6	6.7	5.3
Pensioner Concession Card holders, June 2017	32.3	35.8	34.0	30.2	30.3	26.5	32.5	35.6	30.7	32.5	32.2	30.7	34.3	29.9	26.5	37.9	24.0	30.2	31.9	30.2	23.4	30.3	25.0	20.3
Health Care Card holders, June 2017	9.5	10.5	10.3	8.4	8.1	7.6	8.6	9.4	8.9	8.6	10.2	8.9	10.6	9.8	7.6	12.6	6.2	8.4	8.8	8.4	8.4	9.0	8.5	7.3
Household crowding, 2016	2.2	2.1	1.4	1.7	1.5	1.6	2.0	2.1	2.3	2.0	2.8	2.3	2.9	2.2	1.6	2.6	1.4	1.7	1.7	1.7	2.8	1.9	2.6	3.7
Mortgage stress, 2016	10.8	9.8	16.5	11.7	8.2	8.8	10.7	13.6	11.6	10.7	11.3	11.6	11.7	10.7	8.8	10.4	6.1	11.7	12.2	11.7	8.5	9.4	8.7	9.3
Rental stress, 2016	26.4	25.9	18.6	18.6	22.9	21.0	24.1	30.4	26.5	24.1	30.5	26.5	31.3	22.2	21.0	24.1	11.1	18.6	21.7	18.6	29.7	26.7	29.0	27.3
Rented social housing, 2016	5.4	6.6	2.1	2.9	4.4	2.5	4.4	2.3	1.9	4.4	7.9	1.9	8.9	5.4	2.5	10.3	3.0	2.9	3.1	2.9	6.4	6.1	6.3	4.2
Recipients of rent relief from Centrelink, June 2017	18.1	19.6	12.4	12.2	16.1	13.9	15.9	13.7	13.2	15.9	22.4	13.2	24.4	18.8	13.9	24.6	9.8	12.2	13.1	12.2	15.7	15.6	15.7	16.2
No motor vehicle, 2016	5.6	6.8	2.9	3.9	4.7	3.4	4.9	3.7	3.1	4.9	6.9	3.1	7.9	5.6	3.4	8.2	3.3	3.9	4.3	3.9	8.0	5.7	7.5	7.5

**Table A1: Selected indicators of population health and its determinants, MRLGA compared with Regional SA ...cont**

Indicators	MRLGA	Berri and Barmera (DC)	Karoonda East Murray (DC)	Karoonda - Lamerook - The Coorong*	Loxton Waikerie (DC)	Loxton/ Loxton Region/ Renmark Region*	Waikerie*	Mid Murray (DC)	Mannum/ Murray Bridge Region*	Waikerie*	Murray Bridge (RC)	Mannum/ Murray Bridge Region*	Murray Bridge	Renmark Paringa (DC)	Loxton/ Loxton Region/ Renmark Region*	Renmark	Southern Mallee	Karoonda - Lamerook - The Coorong*	The Coorong (DC)	Karoonda - Lamerook - The Coorong*	Metro Adelaide	Regional SA	South Australia	Australia
<b>Early life and childhood (Per cent, Rate)</b>																								
Total fertility rate, 2013-15	2.27	2.16	3.47	2.59	2.67	2.49	2.51	2.25	2.53	2.51	2.07	2.53	1.98	1.98	2.49	2.05	1.97	2.59	2.79	2.59	1.79	2.19	1.85	1.88
Women smoking during their pregnancy, 2012-14	24.1	29.0	0.0	24.1	19.8	20.9	19.6	18.1	16.4	19.6	24.9	16.4	25.8	25.7	20.9	25.7	14.1	24.1	29.0	24.1	12.3	21.1	14.1	10.8
Immunisation at 1 yr of age, 2017	n.a.	96.0	..	97.4	94.0	94.7	94.7	92.2	92.3	94.7	92.8	92.3	92.6	98.4	94.7	98.0	100.0	97.4	96.2	97.4	94.0	94.9	94.3	94.0
Immunisation at 5 yrs of age, 2017	n.a.	96.1	..	96.2	93.2	92.7	97.4	95.3	95.1	97.4	94.5	95.1	94.4	94.9	92.7	93.5	89.0	96.2	100.0	96.2	93.6	94.5	93.8	94.0
Obesity: males aged 2-17, 2014-15	7.5	7.6	6.7	6.7	7.2	7.2	7.2	7.0	7.0	7.2	8.0	7.0	8.2	7.2	7.2	7.2	6.7	6.7	6.7	6.7	6.6	7.0	6.7	6.7
Obesity: females aged 2-17, 2014-15	7.8	8.0	7.0	7.0	7.6	7.6	7.7	7.5	7.4	7.7	8.2	7.4	8.3	7.5	7.6	7.5	7.0	7.0	7.0	7.0	6.7	7.2	6.8	8.4
Fruit consumption: children aged 4 to 17 years, 2014-05	65.7	65.6	61.7	61.4	63.5	66.6	57.5	63.6	65.5	57.5	67.7	65.5	68.1	69.0	66.6	72.6	61.4	61.4	61.4	61.4	65.3	66.4	65.6	66.3
Infant death rate, 2011-15	5.3	..	0.0	..	0.0	0.0	0.0	0.0	..	0.0	5.6	..	5.6	..	0.0	..	0.0	..	..	..	2.6	3.9	2.9	3.5
Children and young people who are clients of CAMHS, 2015/16-2017/18	2,839.0	3,032.7	1,327.8	2,403.8	1,914.4	1,369.8	2,443.8	2,018.3	1,697.6	2,443.8	3,470.2	1,697.6	3,858.3	2,161.5	1,369.8	3,655.4	1,787.8	2,403.8	2,832.9	2,403.8	1,303.9	2,380.9	1,553.1	n.a.
AEDC: Children developmentally vulnerable on one or more domains, 2015	n.a.	22.0	..	24.5	20.9	18.0	22.8	41.3	30.1	22.8	22.4	30.1	23.4	20.9	18.0	29.3	30.4	24.5	25.9	24.5	23.0	25.3	23.5	22.0
<b>Personal health and wellbeing (Per cent, Rate)</b>																								
Self-assessed health as fair, or poor, 2014-15	18.8	18.2	17.0	16.8	18.3	16.8	20.7	19.8	19.5	20.7	20.2	19.5	20.4	17.5	16.8	18.3	16.8	16.8	16.8	16.8	15.6	17.0	15.9	14.8
High/ Very high levels of psychological distress, 2014-15	14.2	12.9	11.8	11.7	11.6	11.4	11.9	13.4	13.8	11.9	17.1	13.8	17.7	13.0	11.4	14.6	11.7	11.7	11.7	11.7	13.9	13.0	13.7	11.7
Type 2 diabetes, 2014-15	4.9	5.0	4.5	4.5	4.8	4.7	5.0	4.9	4.8	5.0	5.1	4.8	5.1	4.6	4.7	4.5	4.5	4.5	4.5	4.5	4.3	4.7	4.4	4.4
Mental health problems: males, 2014-15	17.7	17.5	17.7	17.6	15.9	15.2	17.1	18.7	19.2	17.1	19.0	19.2	18.9	15.7	15.2	16.3	17.6	17.6	17.6	17.6	16.8	19.3	17.3	15.8
Mental health problems: females, 2014-15	19.7	19.3	19.8	19.7	18.1	17.4	19.4	20.1	20.4	19.4	21.0	20.4	21.1	18.3	17.4	19.2	19.7	19.7	19.7	19.7	19.0	21.2	19.4	19.2
Smoking, 2014-15	19.7	22.1	18.7	18.3	18.4	17.7	19.5	21.9	22.6	19.5	18.6	22.6	17.9	19.4	17.7	21.2	18.3	18.3	18.3	18.3	14.2	18.0	15.0	16.1
Obese males, 2014-15	35.4	34.2	36.7	36.7	36.9	36.5	37.6	37.0	36.8	37.6	34.8	36.8	34.3	33.0	36.5	28.9	36.7	36.7	36.7	36.7	26.6	34.2	28.2	28.4
Obese females, 2014-15	39.5	38.1	40.5	40.4	41.1	40.4	42.4	41.6	41.3	42.4	39.0	41.3	38.6	36.9	40.4	33.3	40.4	40.4	40.4	40.4	29.9	38.1	31.6	27.5
Physical inactivity, 2014-15	76.6	75.2	80.3	80.8	78.3	78.9	77.3	76.1	75.7	77.3	73.7	75.7	73.3	78.3	78.9	77.7	80.8	80.8	80.8	80.8	67.0	73.2	68.2	66.3
Fruit consumption: adults, 2014-15	45.7	44.6	45.9	46.0	48.1	48.2	47.9	45.5	44.8	47.9	44.7	44.8	44.6	45.9	48.2	43.4	46.0	46.0	46.0	46.0	49.0	46.2	48.5	49.9
Median age at death: males, 2010-14 <sup>1</sup>	77.3	77.0	78.5	80.0	76.0	74.5	75.0	75.0	74.0	75.0	78.0	74.0	78.0	78.0	74.5	80.0	78.5	80.0	80.0	80.0	80.0	78.0	79.0	78.0
Median age at death: females, 2010-14 <sup>1</sup>	n.a.	84.0	87.0	85.0	83.0	83.0	82.0	86.0	85.0	82.0	82.0	85.0	83.0	82.0	83.0	83.0	87.0	85.0	84.0	85.0	85.0	84.0	85.0	84.0
Premature mortality: males, 2011-15	361.9	377.3	448.3	326.6	346.4	320.1	419.9	382.1	356.6	419.9	347.8	356.6	360.7	383.5	320.1	400.6	417.2	326.6	273.6	326.6	288.0	332.3	301.1	293.9
Premature mortality: females, 2011-15	n.a.	213.3	184.7	213.3	210.2	180.1	241.3	181.4	156.0	241.3	225.9	156.0	242.7	175.9	180.1	189.0	187.5	213.3	225.2	213.3	181.4	197.9	186.3	182.2
Premature mortality: 15 to 24 yrs, 2011-15	58.3	..	0.0	..	..	..	..	..	136.1	..	49.8	136.1	..	..	..	..	..	..	..	..	29.4	56.2	34.6	37.4
Premature mortality from suicides, 2011-15	16.6	12.6	0.0	12.8	13.0	10.9	..	29.2	29.6	..	10.4	29.6	8.9	11.6	10.9	..	..	..	..	..	12.8	14.0	12.9	11.5
Admissions to hospital: total, 2016/17	35,898.4	38,294.1	33,116.2	37,457.9	28,258.2	25,923.5	29,033.3	29,376.8	33,153.7	36,954.7	29,376.8	37,669.7	41,310.1	25,923.5	53,695.1	39,277.8	37,457.9	37,724.4	37,457.9	37,457.9	36,465.0	34,457.8	35,977.6	39,628.3
Admissions to hospital: potentially avoidable conditions, 2016/17	3,635.8	4,140.7	3,466.0	4,151.5	2,332.9	1,916.3	2,406.0	2,241.7	3,213.1	3,704.2	2,241.7	3,896.7	4,069.3	1,916.3	5,689.4	4,365.4	4,151.5	4,211.2	4,151.5	4,151.5	2,891.6	3,190.9	2,965.0	2,988.4
Difficulty accessing healthcare, 2014	1.4	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	1.9	0.9	2.0	1.0	0.9	1.1	0.9	0.9	0.9	0.9	1.2	1.2	1.2	2.0
HACC clients living alone, 2014/15	30.9	41.7	25.5	25.5	36.6	37.6	34.6	21.1	18.6	34.6	29.0	18.6	30.9	36.6	37.6	35.7	25.5	25.5	25.5	37.4	31.3	35.8	37.1	
HACC: Non-English speaking clients, 2014/15	16.0	23.5	9.9	9.9	16.7	17.9	14.7	30.8	33.9	14.7	7.9	33.9	3.3	23.8	17.9	28.9	9.9	9.9	9.9	9.9	19.4	11.4	17.4	14.7
Clients of community mental health services, 2015/16-2017/18	3,658.1	4,181.5	1,824.4	1,980.3	2,532.1	2,124.1	2,417.5	2,536.6	2,341.9	2,417.5	4,475.9	2,341.9	4,934.7	2,970.6	2,124.1	4,556.7	1,753.8	1,980.3	2,108.7	1,980.3	1,892.9	3,104.6	2,178.7	n.a.
Residential aged care places per 1,000 population aged 70 yrs & over, June 2016	74.6	89.6	172.2	106.4	88.2	77.7	56.3	25.5	39.0	56.3	56.4	39.0	63.1	72.2	77.7	115.7	175.4	106.4	107.5	106.4	95.4	81.5	91.7	82.6
<b>Community connectedness (Per cent, Rate)</b>																								
Able to get support in times of crisis, 2014	93.7	93.0	94.4	94.4	94.4	94.9	93.7	94.2	94.3	93.7	93.2	94.3	93.0	93.8	94.9	92.7	94.4	94.4	94.4	94.4	93.9	94.1	93.9	94.3
Disagree/strongly disagree with acceptance of other cultures, 2014	6.9	5.6	7.2	7.2	6.1	5.7	6.5	7.3	7.6	6.5	7.6	7.6	7.6	6.2	5.7	6.7	7.2	7.2	7.2	7.2	4.6	6.6	5.0	4.5
Government support as main source of income in last 2 years, 2014	40.7	46.0	32.7	32.2	35.4	33.1	39.0	38.1	37.8	39.0	44.0	37.8	45.1	40.4	33.1	47.3	32.2	32.2	32.2	32.2	31.0	36.8	32.3	27.1
Accessed the Internet at home in the past 12 months, 2016	73.0	72.6	67.8	73.2	74.1	75.5	72.7	72.1	74.8	72.7	73.3	74.8	72.0	72.3	75.5	68.0	74.5	73.2	73.8	73.2	82.3	75.0	80.6	83.2
<b>Personal and community safety, 2014 (Rate)</b>																								
Feel very safe/safe walking alone in local area after dark	58.0	53.7	73.4	73.8	61.8	60.1	64.5	67.5	68.4	64.5	43.5	68.4	39.0	52.1	60.1	43.4	73.8	73.8	73.8	73.8	49.7	57.6	51.3	52.4

<sup>1</sup>Median age is shown in years  
 \*Note the values represented here are for the entire Karoonda - Lamerook/ The Coorong PHA although only 11.8% of the population of the area falls within the Karoonda East Murray LGA, 24.2% falls within the Southern Mallee LGA, and 63.8% falls within the The Coorong LGA  
 \*Note the values represented here are for the entire Loxton/ Loxton Region/ Renmark Region PHA although only 59.3% of the population of the area falls within the Loxton Waikerie LGA, and 40.7% falls within the Renmark Paringa LGA  
 \*Note the values represented here are for the entire Waikerie PHA although only 66.6% of the population of the area falls within the Loxton Waikerie LGA, and 33.4% falls within the Mid Murray LGA  
 \*Note the values represented here are for the entire Mannum/ Murray Bridge Region PHA although only 65.5% of the population of the area falls within the Mid Murray LGA, and 33.6% falls within the Murray Bridge LGA

Details of abbreviations, calculations etc. are included in the Notes on the data.

Note: Shading for the IRSD has been reversed, with low scores (greater disadvantage) in darker shades.

The indicators for 'Born overseas in predominantly non-English speaking countries', 'Aboriginal and Torres Strait Islander people' and 'Total Fertility Rate' have not been highlighted in this table.

Good outcome	50% or more above metropolitan average	30-49% above metropolitan average	10-29% above metropolitan average	within +/- 10% of metropolitan average	10% or more below metropolitan average
Poor outcome	50% or more above metropolitan average	30-49% above metropolitan average	10-29% above metropolitan average	within +/- 10% of metropolitan average	10% or more below metropolitan average

**Table A2: LGAs for which data were produced using correspondence files (see notes in Data Quality, p. 4)**

<b>Indicator</b>	
<b><i>Population Profile, 2016 (Per cent, Index)</i></b>	
Aboriginal and Torres Strait Islander people	
<b><i>Employment, June 2017 (Per cent)</i></b>	
Unemployment beneficiaries: total	
Unemployment beneficiaries: six months or longer	
Unemployment beneficiaries: young people	
<b><i>Education (Per cent)</i></b>	
School leavers admitted to university, 2018	
<b><i>Income and wealth (Per cent)</i></b>	
Children in low income, welfare-dependent families, June 2017	
Age Pension recipients, June 2017	
Disability Support Pension recipients, June 2017	
Pensioner Concession Card holders, June 2017	
Health Care Card holders, June 2017	
Recipients of rent relief from Centrelink, June 2017	
<b><i>Early life and childhood (Per cent, Rate)</i></b>	
Obesity: males aged 2-17, 2014-15	*
Obesity: females aged 2-17, 2014-15	*
Fruit consumption: children aged 4 to 17 years, 2014-05	*
Infant death rate, 2011-15	
Children and young people who are clients of CAMHS, 2015/16-2017/18	
AEDC: Children developmentally vulnerable on one or more domains, 2015	
<b><i>Personal health and wellbeing (Per cent, Rate)</i></b>	
Self-assessed health as fair, or poor, 2014-15	*
High/ Very high levels of psychological distress, 2014-15	*
Type 2 diabetes, 2014-15	*
Mental health problems: males, 2014-15	*
Mental health problems: females, 2014-15	*
Smoking, 2014-15	*
Obese males, 2014-15	*
Obese females, 2014-15	*
Physical inactivity, 2014-15	*
Fruit consumption: adults, 2014-15	*
Median age at death: males, 2010-14†	
Median age at death: females, 2010-14†	
Premature mortality: males, 2011-15	
Premature mortality: females, 2011-15	
Premature mortality: 15 to 24 yrs, 2011-15	
Premature mortality from suicides, 2011-15	

Note: The asterisk shows that these indicators return the same value for two or more LGAs: see the text on p. 4

**Table A2: LGAs for which data produced using correspondence files ...cont**

<b><i>Personal health and wellbeing (Per cent, Rate) ...cont</i></b>	
Admissions to hospital: total, 2016/17	
Admissions to hospital: potentially avoidable conditions, 2016/17	
Difficulty accessing healthcare, 2014	*
HACC clients living alone, 2014/15	*
HACC: non-English speaking clients, 2014/15	*
Clients of community mental health services, 2015/16-2017/18	
Residential aged care places per 1,000 population aged 70 yrs & over, June 2016	
<b><i>Community connectedness, 2014 (Per cent)</i></b>	
Able to get support in times of crisis	*
Disagree/strongly disagree with acceptance other cultures	*
Government support as main source of income in last 2 years	*
<b><i>Feel very safe/safe walking alone in local area after dark</i></b>	
Feel very safe/safe walking alone in local area after dark	*

Note: The asterisk shows that these indicators return the same value for two or more LGAs: see the text on p. 4

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## Notes on the data

Please click [here](#) to access notes on the data.



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# POPULATION HEALTH PROFILE

sporting  
and leisure  
facilities



information  
services

parks and  
gardens



safe  
food

street  
trees



emergency  
management



arts and  
culture



libraries



climate change  
management

youth  
development

community  
centres  
and halls

safe  
roads



urban  
planning

events

volunteering



safe  
water

street  
lighting

walking  
trails

economic  
development

partnerships



immunisation

