Local Government Association
of South Australia

Population Health Profile

of the Port Adelaide Enfield Local Government Area to assist in the preparation of the Regional Public Health Plan

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Local Government Association of South Australia

Contents

Page

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Local Government Association of South Australia

Introduction

The *South Australian Public Health Act (2011)* is an Act designed to protect and promote public health and provide for the prevention of avoidable illness, disability and injury.

A key element of the Act is a system for public health planning (Part 4 section 50-52). This provides for the development of a State Public Health Plan by the Minister for Health and Ageing and for regional public health plans, developed by Local Councils working either individually or jointly. Plans by Local Councils are to be consistent with and have regard to the State Public Health Plan, whereas the State Public Health Plan is also to incorporate and reflect issues arising from Local Councils' plans.

Public health planning is based on a "*comprehensive assessment of the state of public health*". Access to appropriate and relevant data is required to undertake this assessment. Because public health in the Act is understood to be affected by a wide range of social, economic and environmental factors, it is recognised that the data sets supporting public health planning need to be similarly wide-ranging. However these data sets must also be focussed and manageable in order to have utility.

The development of such data sets is identified as a priority within the State Public Health Plan. It is recognised as a developmental and collaborative task, which will be undertaken between SA Health and the Local Government Association, Local Councils, other state government agencies and other data holders and Public Health Partner Authorities.

As part of that developmental exercise the Local Government Association, together with SA Health, is supporting the development of population health profiles for Local Councils and groups of Local Councils undertaking public health planning.

Purpose of this profile

This population health profile has been prepared to support the City of Port Adelaide Enfield, in the preparation of its Public Health Plan under section 51 of the Act. The document contains a selection of indicators of public and population health and their determinants, drawn largely from data published for Local Government Areas (LGAs) and Statistical Local Areas (SLAs) by the Public Health Information Development Unit (PHIDU) – University of Adelaide, as part of the Social Health Atlases series, online at www.publichealth.gov.au. The indicators selected are consistent with the approach outlined in the State Public Health Plan: *South Australia: A Better Place To Live.* [2]

At this early stage of the development of public health planning in South Australia, this profile does not present a complete picture, nor is it representative of the entirety of information available on which to base a comprehensive assessment of public health. It does, however represent a good start, and a foundation on which we can build. The aim over the life of this first five year cycle of planning is to improve the descriptive and analytical power of these profiles. However, this can only be done by "*real world*" trialling and testing by Local Councils and those involved in public health planning.

In any event, Local Councils are in a good position to understand their own communities. They often have access to their own data collections, which are relevant to public health and are in a prime position to identify the implications of certain measures or indicators for the daily lives of their residents.

What do we mean by population health and its determinants?

In the context of public health, the term population health can be defined as 'the health and wellbeing outcomes of a group of individuals (a population), including the distribution of these outcomes within the population'.[3] 'Populations' can represent communities who live in certain geographic regions, or they can also be groups defined by age, ethnicity, gender, employment status etc., such as people who are unemployed, ethnic groups, people living with disability, or young children. Populations such as these are relevant to Local Councils planning for the wellbeing of their communities.

Population health includes health and wellbeing outcomes, patterns of factors that determine health and wellbeing ('determinants'), and policies and interventions that link these two. Many determinants of health, such as health care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level. Defining population health this way requires some measure(s) of health outcomes of populations, including their distribution throughout the population. Where good health outcomes are not distributed evenly across a group or community, differences, or 'inequalities', in wellbeing become evident.

The overall goal of taking a population health approach is to maintain and improve the health of the entire population and to reduce inequalities in health between population groups.[4] The health of a population can be measured by indicators of population health, which reflect the influences of social, economic, and physical environments, personal health behaviours, individual capacity and coping skills, human biology, early childhood development, gender, social support, disability, and effective health and other services – the determinants of health and wellbeing.[3]

How can Local Government respond in relation to the *Public Health Act 2011*?

The Act recognises that Local Councils are the public health authority for their area. It confers on Councils a range of powers and functions, including the responsibility to undertake public health planning.

Local Councils form part of a system of agencies and providers who undertake public health functions across all spheres of government and the community. For public health protection and promotion to be guaranteed there is a need for effective partnerships and collaborative effort.

It can be expected that public health planning will identify a range of issues which can be directly acted upon by Local Councils through their various functions. This will include the work of Environmental Health Officers, as well as other functions such as waste management, community services and community development, road and footpath maintenance and infrastructure development, parks and gardens maintenance and development, building inspections, planning and development approval, animal management, support for sporting and recreation groups and facilities, emergency management and environmental management.

It is equally expected that public health planning will identify issues which are more relevant to, and more appropriately dealt with, by other agencies or other spheres of government or the community. In these circumstances Local Councils are in the best position to represent their communities' interests to these other agencies.

The planning system in the Act is designed to ensure that good collaboration and partnerships are developed in transparent and mutually accountable ways through a system of Public Health Partner Authorities. These authorities can be any State Government agency, or a non-government organisation or even a commercial enterprise. To become a Public Health Partner Authority, an organisation in the first instance forms an agreement with the Minister, which is confirmed in the regulations and gazetted. Becoming a Public Health Partner Authority entitles an organisation to participate in public health planning both in terms of State Public Health Planning and planning by Local Councils (to the extent relevant). By further agreement these organisations agree to take responsibility for those aspects of a plan that are relevant to their organisation or mandate, and to report back to Councils on their actions. Public Health Partner Authorities also have regard to the State Public Health Plan in their own strategic planning.

SA Health is undertaking responsibility for coordinating this system of planning and the relationships and communication between Local Councils and Public Health Partner Authorities where needed.

Local Government Association of South Australia

Report content

The first section of this report is comprised of charts (population pyramids) depicting the age structure in Port Adelaide Enfield and its component Statistical Local Areas[1] (SLAs), and providing a comparison with the age structure in Metropolitan Adelaide. In this report, Metropolitan Adelaide is consistent with the Adelaide Statistical Division, as determined by the Australian Bureau of Statistics prior to 1 July 2011. The age profile is also provided by Indigenous status.

The remainder of the report is comprised of commentary on a table of selected population health indicators. The table is structured so as to highlight differences in the percentage or rate for the indicator value in Port Adelaide Enfield from that in Metropolitan Adelaide. Indicators in the table are grouped under the preliminary indicator categories from the State Public Health Plan.

The commentary consists of a statement as to the value of the indicator for regional health planning, adding reference to its value for work by Local Government under the Public Health Act. This is followed by the definition of the indicator and a description of the variation in the percentage or rate for each indicator between the geographic areas mapped.

This hard copy is backed up by an online copy, at http://www.atlasesaustralia.com.au/LGA_PH_Act.htm. Updates will be included in the online version as they become available. Indicators for which updated data are expected in 2014 are the Australian Early Development Index; estimates of diseases and risk factors; hospital admissions; and community health, community mental health and Child and Adolescent Mental Health services.

[1] In Metropolitan Adelaide, the SLA is shown to indicate variations within the area described, as very few datasets have as yet been coded to the new statistical geography introduced by the Australian Bureau of Statistics from 1 July 2011.

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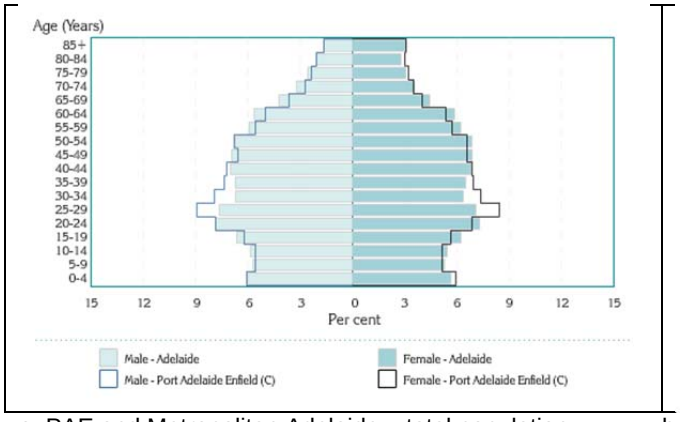
The age structure of the population

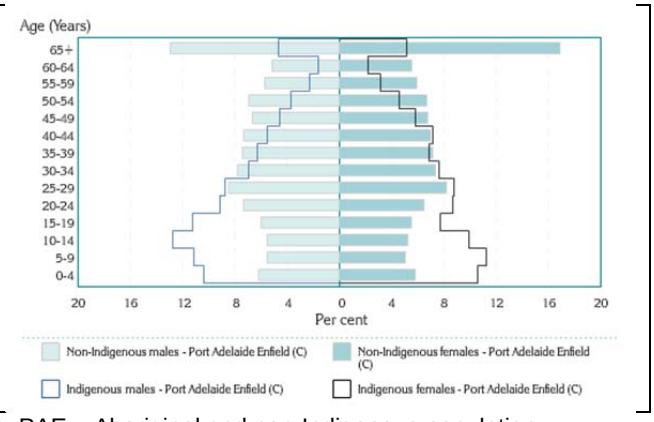
The age structure of the Port Adelaide Enfield population is highly consistent with that in Metropolitan Adelaide overall, other than the smaller proportions of young adults (Figure 1a).

The Aboriginal population (estimated to be 2,712 people, based on the 2011 Census) has a substantially different age structure to that of the non-Indigenous population, with higher proportions of children (substantially higher), young people and young adults, and lower proportions of adults at older ages (Figure 1b). The proportion of the Aboriginal population in the 65 year and over age group (3.9%) is slightly higher than for Metropolitan Adelaide as a whole (3.7%).

Figure 1: Age profile comparisons, Port Adelaide Enfield LGA – total population compared with Metropolitan Adelaide; and population by Indigenous status, 2011



a. PAE and Metropolitan Adelaide – total population

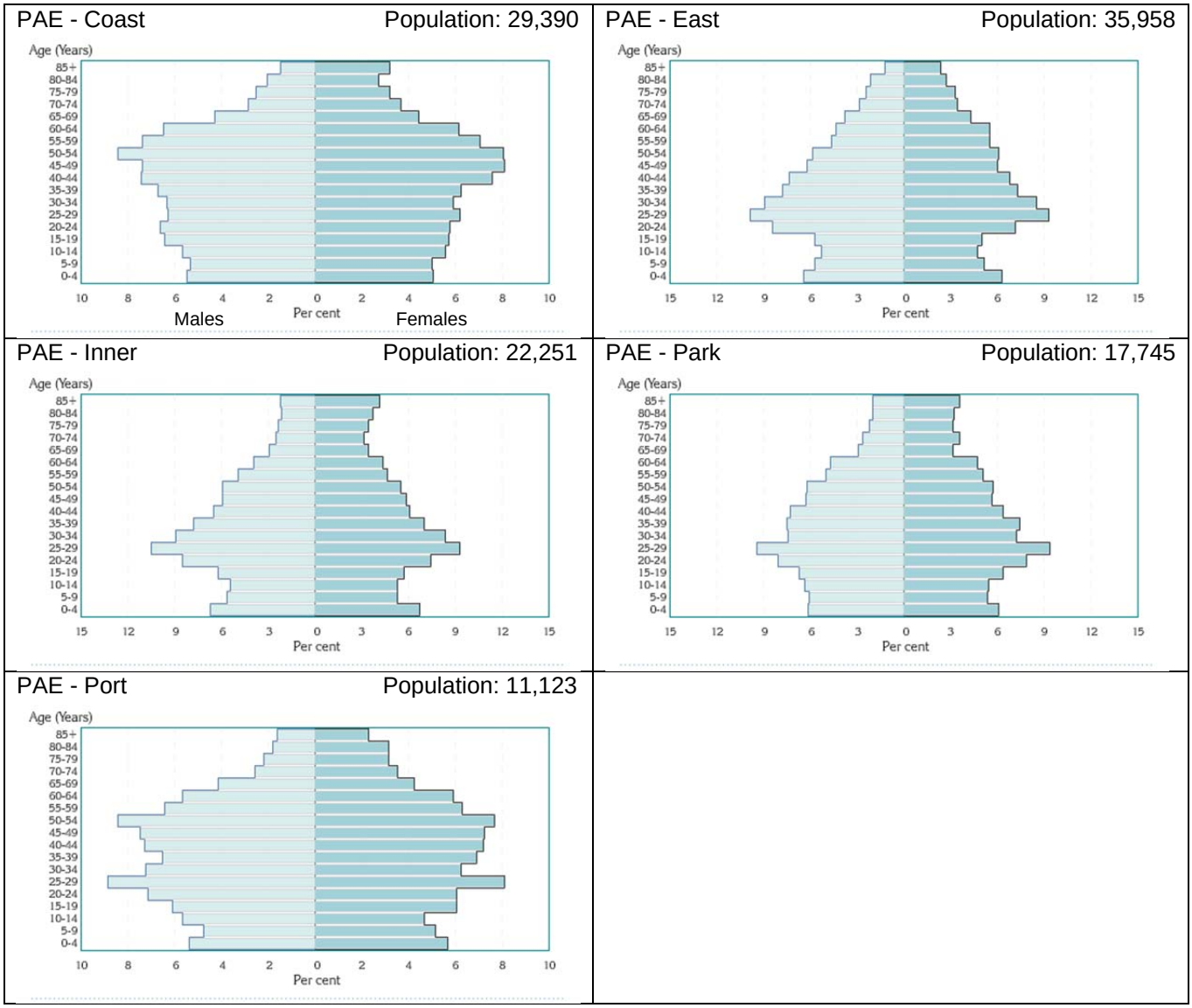


b. PAE – Aboriginal and non-Indigenous population

Port Adelaide Enfield - Coast and - Port have similar age profiles (with relatively more young adults and generally slightly lower proportions at older ages in Port), and the oldest populations of the Port Adelaide SLAs. The SLAs of Port Adelaide Enfield - East and - Inner have similar proportions (with relatively more children and people at the oldest ages in - Inner), and the youngest populations of the Port Adelaide SLAs. Port Adelaide Enfield - Park has a similar profile to - East and - Inner, but with more even proportions of children, and slightly fewer young adults, in particular males.

Note that the charts do not have the same scales.

Figure 2: Age profile comparisons, SLAs in Port Adelaide Enfield, 2011



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

Population profile

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

Immigration has historically played a very important role in South Australia's demographic profile, particularly in the post-war years. 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.[5]

Almost half of the South Australian population is an immigrant or has a parent who was born overseas; and significantly 18.4% of the population speak a language other than English at home.[6] In the last decade, South Australia has experienced an immense change in the area of international migration, chiefly as a result of policy changes.[7]

This information is important because of the range and nature of health and welfare services, housing, employment, and educational opportunities, which are required to support the wellbeing of such diverse and newly arrived communities, especially in terms of social inclusive, non-discriminatory and culturally-responsive approaches. The local community itself can also play a significant role. For example, the wellbeing of older migrants is often enhanced by the size of the ethnic community to which they belong – as the community becomes larger and better established, it provides a wider social milieu and can provide support services for its older members.[8]

Indicator definition: People born (overseas) in predominantly non-English speaking countries as a percentage of the total population (Census 2011). 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.

Port Adelaide Enfield had over twice the metropolitan average proportion of its population born in India at the 2011 Census (3.4 %, or 2.28 times the metropolitan average); the highest proportions were in the SLAs of Port Adelaide Enfield - Inner (6.5%) and - Park (4.8%). The proportion of the population born in China (1.9%, and 42% higher than across the metropolitan area overall) was largely in Port Adelaide Enfield - East (3.0%) and - Park (2.4%). There were fewer people born in Italy (1.4% in Port Adelaide Enfield, compared with 1.7% in Metropolitan Adelaide).

People born overseas and reporting poor proficiency in English

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.[9]

In 2011, almost half (49%) of longer-standing migrants and 67% of recent arrivals spoke a language other than English at home.[10] This probably reflects the main countries of birth for 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 (51%) of longer-standing migrants reported speaking English very well, while 2.6% reported not speaking English at all. For recent arrivals, 43% reported speaking English very well and the proportion who reported not speaking English at all was 3.1%.[10]

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 2011).

The proportion of the population (5.3%) reporting poor proficiency in English (95% above the metropolitan average) were largely located in Port Adelaide Enfield - Park (13.5% of the population aged 5 years and over), - Inner (7.3%) and - Port (5.6%).

Aboriginal and Torres Strait Islander peoples

In the 2011 Census of Population and Housing, 30,431 people (or 5.5% of the total South Australian population) identified as being of Aboriginal and/or Torres Strait Islander origin.[11] This represents an increase since the 2006 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 2011, the median age for this population was 22.0 years, 17 years less than the state's median age of 39.4 years.[11] More than one in three (34.7%) Aboriginal people were aged less than 15 years, while just 4.1% were aged 65 years and over.[11] The Aboriginal population predominantly lives in South Australia's most populous areas, with 51.3% living in the Greater Adelaide area, and 48.2% living in the rest of the State.[11]

The Aboriginal population is disadvantaged across all domains of wellbeing compared to the non-Indigenous South Australians.[12] Thus, it is important for Local Government to know the size of its Aboriginal population, and to work with them to improve wellbeing, identify needs and remedy 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 (Census 2011).

Aboriginal peoples comprised 2.4% of the population at the 2011 Census, 86% higher than the proportion across the metropolitan areas overall. The highest proportion was in Port Adelaide Enfield - Port (3.3%).

Disability:

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

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 (such as cancer) 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.[85,86] 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, there are also substantial costs, often borne by the individuals providing the care.[71] 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.[71]

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 2011).

The proportion of the population providing unpaid assistance to persons with a disability, a long-term illness or problems related to old age (11.2%) was slightly (5%) below the metropolitan average; their distribution at the SLA level is relatively even.

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

The likelihood of living with disability increases with age. In Australia in 2009, the disability rate among 15-24 year olds was 6.6% and the rate was higher for successively older age groups, with 18% of 45-54 year olds, and 31% of 55-64 year olds living with disability in 2009.[13]

People with disability are less likely to be employed than people in the broader population, most likely have lower incomes and may rely on formal or informal care providers to assist in everyday activities.[14] In 2009, people with a disability were less likely to have participated in social and support groups than people without a disability.[15]

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.[15] 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 of all ages with a profound or severe disability and living in the community as a proportion of the total population (Census 2011). 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.

When compared with the metropolitan area overall, Port Adelaide Enfield has a higher proportion of its population living in the community who reported at the 2011 Census that they had a profound or severe disability. This is the result of the 25% higher proportion in both the 65 years and over age group and in the 0 to 64 year age group, compared to the metropolitan average. The highest proportions for the older population group are in Port Adelaide Enfield - Park (22.8%), - Port (19.7%) and - Inner (18.6%). For the under 65 year age group, all of the SLAs have proportions above the metropolitan average.

Summary measure of disadvantage: IRSD

The Index of Relative Socio-economic Disadvantage (IRSD) is one of four Socio-Economic Indexes for Areas (SEIFAs) compiled by the Australian Bureau of Statistics (ABS) after the Census of Population and Housing. The aim is to represent the socioeconomic status (SES) of Australian communities and identify areas of advantage and disadvantage. The IRSD scores each area by summarising attributes of the population, such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. It reflects the overall or average level of disadvantage of the population of an area. Being an average, the score is likely to reduce apparent differences between individuals in an area, and between areas: this is of particular importance for areas with larger populations.

Indicator definition: The IRSD for the area of analysis, derived by ABS from 2011 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.

The IRSD score of 930 indicates that the population of Port Adelaide Enfield is disadvantaged relative to the population in metropolitan area overall (991). Port Adelaide Enfield - Park (847) is the most disadvantaged SLA on this measure, and - Coast (975) the least disadvantaged.

Employment

People receiving unemployment benefits

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.[16-18] 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. For example, unemployment rates in South Australia are highest among young people aged less than 25 years, and are generally higher in rural and remote areas than in urban areas. 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 of unemployed people, and supporting return to work or re-training and skills development.

Indicator definition: Unemployment beneficiaries: People in receipt of an 'unemployment benefit' - the Newstart Allowance or Youth Allowance (other) paid by Centrelink - as a proportion of the eligible population aged 16 to 64 years (June 2011).

In June 2011, 34% more people in Port Adelaide Enfield aged from 16 to 64 years were receiving unemployment benefits (a Newstart Allowance or Youth Allowance (other)) from Centrelink than was the case across the metropolitan area overall – 6.3% compared with 4.7%. Rates ranged from 5.1% in Port Adelaide Enfield - East to the highest level in both - Inner and - Park (7.9%).

Indicator definition: Long-term unemployment beneficiaries: people in receipt of an unemployment benefit (as above) for more than 182 days (approximately 6 months) as a proportion of the eligible population aged 16 to 64 years (June 2011).

Similarly, 35% more people in Port Adelaide Enfield had been unemployed for six months, or longer (4.9% compared with 3.6%). Rates ranged from 3.9% in Port Adelaide Enfield - East, to 6.4% in - Park.

Indicator definition: Youth unemployment beneficiaries: young people (aged 15 to 24 years) in receipt of an unemployment benefit (as above) as a proportion of the eligible population aged 15 to 24 years (June 2011).

People receiving a Newstart Allowance (and aged 15 to 24 years) or Youth Allowance (other) from Centrelink comprised 8.9% of the population aged 15 to 24 years in Port Adelaide Enfield, which was 39% higher than the metropolitan average of 6.4%. Port Adelaide Enfield - Inner had the highest rate (10.9%, and 70% above Metropolitan Adelaide).

Education

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

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. This recognises the need for higher levels of education and skill in the modern globalised economy. It reflects the policy intent expressed in the 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.[19]

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 changes, 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.[20] Local communities rely on a well-trained, local labour force, and Local Government can 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 2011).

The proportion of the 16 year old population in Port Adelaide Enfield not participating in full-time secondary education was 8% higher than the metropolitan average, with almost one quarter (22.5%) of this age group living in Port Adelaide Enfield - Park not participating.

School leavers enrolling in higher education

Higher education refers to education which usually results in the granting of a Bachelor 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.[35] 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.[35] 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 who are identified as enrolled at an Australian university at 31 March 2013, as a proportion of the population aged 17 years, at 30 June 2012. 'School leavers' are students who attained a Year 12 qualification in 2012 in South Australia through the completion of one or more Year 12 courses; may

include (unless noted otherwise below) adult students, part time students and students doing one or more subjects to improve their overall score (repeating students).

A slightly lower proportion of the City's students who attained a Year 12 qualification in 2012 enrolled in a South Australian university in 2013, when compared with the metropolitan area overall (34.9% compared with 35.7%). The highest proportion was in Port Adelaide Enfield - Park (37.6%) and the lowest (29.1%, and 18% below the metropolitan average) was in - Port.

Children whose mother has low educational attainment

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.[21,22] 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.[22-24] 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.[24]

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.[24]

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 2011).

Children in these families in Port Adelaide Enfield comprised 21.2% of children aged under 15 years; this is 24% higher than the metropolitan average of 17.1%. Again, the highest proportion was in Port Adelaide Enfield - Park (30.1%, and 76% above Metropolitan Adelaide), and the lowest was in - East (15.4%).

Young people learning or earning

Levels of participation in education and the labour market are indicators of the wellbeing of young people.[25] Research suggests that young people who are not fully engaged in education or work (or a combination of both) are at greater risk of unemployment, cycles of low pay, employment insecurity in the longer term, and poorer health and wellbeing.[26] 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.[24,27]

Indicator definition: Young people aged 15 to 19 years engaged in school, work or further education/ training as a proportion of the population aged 15 to 19 years (Census 2011).

The proportion of the 15 to 19 year old population in Port Adelaide Enfield engaged in work or full-time study (78.6%) was 3% less than the metropolitan area overall (80.9%), with relatively similar levels across all the SLAs.

Income and wealth

Children in low income, welfare-dependent families

Children and young people living in families with inadequate income are at greater risk of poor health and educational outcomes in the short and long term.[28] 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.[23,28] This can affect children and young people in the family through reduced provision of appropriate housing, heating, nutrition, medical care and technology.[29]

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.[30] 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.[31]

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 $31,786 p.a. in receipt of the Family Tax Benefit (A) (at the maximum level), as a proportion of all children aged less than 16 years (June 2011).

Almost one in three (32.0%) children under 16 years of age in Port Adelaide Enfield were living in low income families receiving welfare payments from Centrelink in June 2011. This was 39% above the level across the metropolitan area overall (23.0%). Proportions varied, from 26.7% in Port Adelaide Enfield - Coast, to a high of 39.5% in - Park, which was 72% above this average.

Recipients of Age and Disability Support Pensions, and concession card holders

Recipients of the Age Pension

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.[32]

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 2011). 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.

Over four fifths (85.1%) of Port Adelaide Enfield's population aged 65 years and over were receiving an Age Pension in June 2011, 11% above the metropolitan average (76.5%). The highest proportion of these pensioners was in Port Adelaide Enfield - Port (91.2%).

Recipients of the Disability Support Pension

Disability support pensions (DSP) 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.[33] ***At June 2011, there were 76,216 DSP recipients in South Australia.***[33]

Between 1997 and 2002, over 40% of new DSP recipients moved directly from receiving unemployment benefits to DSP. Older unemployed people and people with health problems were more likely to transfer to DSP, while those who had some labour market attachment while on unemployment benefits were less likely to do so. Among those people who transferred to DSP from unemployment benefits, a large proportion experienced multiple spells of income support receipt prior to the transition.[34]

Indicator definition: People aged 16 to 64 years in receipt of a Disability Support Pension (DSP) from Centrelink or a Service Pension (Permanently Incapacitated) from the Department of Veterans' Affairs (DVA), as a proportion of the population aged 16 to 64 years (June 2011).

Port Adelaide Enfield also had a higher proportion of its population receiving the Disability Support Pension, being 9.8% compared with 6.9% (or 48% higher) in Metropolitan Adelaide. More than one in ten eligible people in Port Adelaide Enfield - Port (12.0%) were receiving the Disability Support Pension, compared to 8.4% in - East.

People who hold an Australian Government concession card

Total concession card holders comprise people who hold either an Australian Government Health Care Card (HCC) or Pensioner Concession Card (PCC). People who have a HCC or a PCC are generally among the lowest income earners, and, as such, they are likely to also have poorer health.[36,37] Compared with those who are socially and economically advantaged, disadvantaged South Australians are more likely to have shorter lives, higher levels of disease risk factors and lower use of preventive health services.[36,37]

Indicator definition: People in receipt of a Pensioner Concession Card or a Health Care Card from Centrelink as a proportion of the total population (June 2011).

Nearly a third (31.3%) of the Port Adelaide Enfield population held one of these concession cards, 20% above the metropolitan average of 26.2%. Proportions were high across the City, with the highest of 35.9% in Port Adelaide Enfield - Park.

Housing stress and rent relief

Low income households under mortgage stress

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. Acute mortgage stress occurs when 50% of income is spent on mortgage repayments. Increasing numbers of families are experiencing mortgage stress, and are at risk of homelessness, and poorer wellbeing.[38] 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, un-renovated housing.[39]

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.

Relatively more low income households were assessed as being under mortgage stress at the 2011 Census using this definition, with 9.6% in Port Adelaide Enfield compared to 8.4% in the metropolitan area overall (14% more). Again, proportions varied across the SLAs, from 7% in Port Adelaide Enfield - Coast, to 14.8% in - Park.

Low income households under rental stress

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. Acute housing stress occurs when 50% of income is spent on housing. In 2006, Census data showed that around a fifth of Australian households (23%) rented their home from a private landlord. 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 tight vacancy rates are factors that exacerbate their position and move them closer to the poverty line.[38] 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.[40]

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.

The level of rental stress was just below the metropolitan average, with 26.3% of low income families in this category in Port Adelaide Enfield, compared with 26.9%. There was little variation across the SLAs.

Dwelling rented from Housing SA

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.[83] Social housing continues to be rationed to those in the highest category of need, such as people who are homeless, whose life or safety is at risk in their accommodation, whose condition is aggravated by their housing or who have very high rental costs.[84] Housing

assistance is also targeted towards key special needs groups including Aboriginal South Australians, those with disability, the young and the elderly.[84]

Indicator definition: Occupied private dwellings rented from Housing SA, as a proportion of all occupied private dwellings in 2011.

The proportion of the housing stock in Port Adelaide Enfield rented from Housing SA at the 2011 Census was nearly twice the metropolitan average (12.1% compared with 6.4%). At the SLA level, the highest proportions were in Port Adelaide Enfield - Park (20.2%) and - Inner (15.1%).

Recipients of rent relief

Affordable, secure and safe housing is fundamental to one's health and wellbeing, employment, education and other life opportunities. Centrelink rent assistance 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'.[41]

Indicator definition: Renters receiving rent assistance from Centrelink as a proportion of all occupied private dwellings (Census 2011).

Following on from the earlier indicator, the proportion of households receiving rental assistance from the Australian Government in Port Adelaide Enfield (16.9%) was 16% higher than in the metropolitan area overall (14.6%). Relatively fewer households in Port Adelaide Enfield - Coast (13.3%), and 33% more in - Inner (19.4%) were receiving this assistance, when compared with the metropolitan average.

No motor vehicle available to the household

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 this access can only be achieved through owning a car. 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.[42]

Not all South Australians are able to drive, have access to, or own a passenger vehicle. For these people, a city which is car dependent may restrict their access to services, employment, shops, social and other activities.[42] ***Transport services, which are offered by Local Councils, can provide much needed assistance, especially for residents who are older and no longer able to drive.***

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 2011).

A higher proportion of households in Port Adelaide Enfield (when compared with the metropolitan area overall) did not have a motor vehicle garaged or parked there on Census night: 13.4% in Port Adelaide Enfield and 9.6% in the metropolitan area. Proportions varied from 10.8% in Port Adelaide Enfield - Coast to 17.0% in - Park, which was 77% above the average for Metropolitan Adelaide.

Early life and childhood

Total fertility rate

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.[43] ***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.***[43]

Although there are signs that the Australian TFR is stabilising at around 1.8 children per woman, this is still well below the population replacement level of 2.1 children per woman. Sustained periods of fertility below the replacement level are major drivers of population ageing. Given the potential economic impacts of an ageing population, 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, 2011). 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.

The total fertility rate in Port Adelaide Enfield (a rate of 1.89) is 6% higher than the rate in the metropolitan area overall (1.79). The highest rate was in Port Adelaide Enfield - Park (2.01), and the lowest in - Coast (1.72).

Women smoking during pregnancy

Maternal smoking during pregnancy carries a higher risk of adverse outcomes for the baby before and after delivery, which include premature birth, miscarriage and perinatal death, poor intra-uterine growth and Sudden Infant Death Syndrome (SIDS).[44] Other problems include a higher risk of disability and developmental delay, decreased lung function, and increased respiratory illness, which may affect children through to adulthood.[45]

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: 2008 to 2010).

More than one in ten pregnant women living in Port Adelaide Enfield who gave birth over the three years 2008 to 2010 reported smoking during their pregnancy (13.5%) – this was 4% higher than the metropolitan average rate of 13.0%. The rate of smoking varied from 9.6% in Port Adelaide Enfield - East to a high of 18.2% in - Port, which was 40% above the metropolitan average.

Childhood immunisation

Immunisation coverage among South Australian children is a significant public health issue. If a sufficiently large proportion of children in a community are 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.

At one year of age

Indicator definition: Children fully immunised at age 12 months to less than 15 months of age as a proportion of all children aged 12 to less than 15 months, registered on the Australian Childhood Immunisation Register (2011/12). See Data notes for more information.

The rate of full immunisation at one year of age (92.2%) in Port Adelaide Enfield was the same as the metropolitan average (92.2%). Rates varied little across the SLAs, other than in Port Adelaide - Port, with a slightly lower immunisation rate (4% below the metropolitan average).

At five years of age

Indicator definition: Children fully immunised at age 60 months to less than 63 months of age as a proportion of all children aged 60 to less than 63 months, registered on the Australian Childhood Immunisation Register (2011/12). See Data notes for more information.

The proportion of children in Port Adelaide Enfield who were fully immunised at five years of age (84.7%) was slightly lower (3% below) than the metropolitan average (87.0%). Rates varied little across the SLAs, other than in Port Adelaide - Inner, with an immunisation rate, which was 6% below the metropolitan average.

Obese children at four years of age

Obesity in childhood can cause a range of physical and emotional health problems, and obesity increases the risk of premature illness, a range of chronic diseases, disability and death in adulthood. 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.[46] Overweight and obesity in the South Australian population is not a simple matter of overindulgence or lack of physical activity. There are numerous environmental and societal factors that combine to generate an 'obesogenic' environment: one that that promotes positive energy balance, by promoting increased energy intake (in food and beverages) and/or reduced energy expenditure (physical activity).[47]

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.[46] Local Government has an important role in developing communities which support greater opportunities for physical activity for children and their families.

Indicator definition: Four year old boys/ girls assessed as being obese on the basis of their measured height and weight as a proportion of all four year old boys/ girls assessed by staff of the Children, Youth and Women's Health Service (CYWHS) (data for three years: 2010 to 2012).

Boys

The extent of obesity among four year old boys in Port Adelaide Enfield (6.8%) was 29% above the metropolitan average (5.3%). However, proportions varied considerably between the SLAs, from 5.7% in Port Adelaide Enfield - East to 8.3% in - Inner.

Girls

Although relatively fewer girls than boys in Port Adelaide Enfield were assessed as being obese, the proportion of 4.6% was also markedly (21%) above the metropolitan average (3.8%). Again, proportions varied considerably between the SLAs, from 3.3% in Port Adelaide Enfield - Inner, to more than twice that rate in - Park (7.3%).

Daily fruit consumption at ages 5 to 17 years

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 current recommended intake of fruit is between one and two servings each day for children aged 4-7 years, one to two servings each day for children aged 8-11 years, and three to four servings each day for adolescents aged 12-18 years.[48]

Indicator definition: Estimated number of children aged 5 to 17 years with a usual daily intake of two serves of fruit expressed as a rate per 100 population aged 5 to 17 years (modelled estimates from the 2007–08 National Health Survey). A serve is approximately 150 grams of fresh fruit or 50 grams of dried fruit.

Over half (53.4%) of the children aged 5 to 17 years were estimated to have met the recommended daily requirement for fruit consumption. This proportion was 8% below the metropolitan average (57.8%). The highest level of fruit consumption in relation to the guideline was estimated for Port Adelaide Enfield - Park (55.1%), with rates below the metropolitan average in the other SLAs as well.

Infant death rate

The survival of infants in their first year of life is viewed as an indicator of general health and wellbeing of a population.[49] 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 1000 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.[50]

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: 2006 to 2010).

The infant death rate in Port Adelaide Enfield over the five years from 2006 to 2010 was 2.9 infant deaths per 1,000 live births, which is 16% below the metropolitan rate of 3.4 infant deaths per 1,000 live births. The rate was only been calculated for Port Adelaide Enfield - East (with 2.8 infant deaths per 1,000 live births), as there were fewer than five deaths in all other SLAs.

Child mortality rate

Infant and child death rates offer insight into the social and environmental conditions in which Australian children grow and develop.[49] Death rates have halved for Australian infants and children under the age of five years over the last two decades, largely as a result of improved neonatal intensive care, increased community awareness of the risk factors for injury and Sudden Infant Death Syndrome (SIDS), and reductions in vaccine-preventable diseases through national childhood immunisation programs.[51] However, rates among Indigenous children and children from remote areas remain much higher than the national rate.[51]

High rates of infant and child mortality are also strongly associated with social and economic disadvantage.[50,52] Socioeconomic status affects infant and child survival through a number of proximate determinants including maternal factors (such as age, parity, birth interval), environmental contamination, nutritional deficiency, injury, individual preventive measures and access to effective health care.[53]

Indicator definition: Child mortality: deaths that occurred at ages one to four years, expressed as a rate per 100,000 population (five years: 2006 to 2010).

The child mortality rate in Port Adelaide Enfield over the five years from 2006 to 2010 was 19.3 deaths per 100,000 population under five years of age, which is 4% higher than the metropolitan rate of 18.6. There were none of these deaths in Port Adelaide Enfield - East and - Port, and fewer than five in the other SLAs.

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

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.[54] 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: 2005/06 to 2007/08), expressed as an indirectly age-standardised rate per 100,000 population aged 0 to 19 years.

One third more children aged 0 to 19 years in Port Adelaide Enfield were clients of CAMHS when compared with the rate in the metropolitan areas overall. Rates varied considerably between the SLAs, from 5% below the metropolitan average in Port Adelaide Enfield - East, to 95% above it in – Port, indicating the important role these services play in the community.

Early childhood development

In 2009, the Australian Early Development Index (AEDI), which provides a picture of early childhood development outcomes for Australia, was undertaken nationwide.[55] Information was collected on Australian children in their first year of full-time school between 1 May and 31 July, using a teacher-completed checklist.

The results from the AEDI provide communities and schools 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 (school-based), and communication skills and general knowledge.[55]

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

In 2009, more than a quarter (29.7%) of children in Port Adelaide Enfield in their first year of school were assessed under the AEDI measure as being developmentally vulnerable on one or more domains; this was 29% above the metropolitan average of 23.0%. The highest proportions of this population group were in Port Adelaide Enfield - Inner (39.1%) and - Coast (32.2%), and the lowest was in - East (21.9%).

Personal health and wellbeing

Self-assessed health as fair, poor

How people rate their health is strongly related to their experience of illness and disability, and self-assessed health is a commonly used measure of health status.[56] Research has also shown that self-assessed health is a predictor of mortality and morbidity.[57] This measure is therefore an important indicator of key aspects of health, wellbeing and quality of life.

Indicator definition: Estimated population aged 15 years and over reporting their health as 'fair or poor' expressed as a rate per 100 population aged 15 years and over (age-standardised); modelled estimates from the 2007–08 National Health Survey.

It is estimated that, in 2007– 08, 19.0% of the population of Port Adelaide Enfield assessed their health as 'fair', or 'poor', rather than as 'good', 'very good', or 'excellent'; this is 24% above the metropolitan average, of 15.3%. More than one in five (22.1%) adults in Port Adelaide Enfield - Park were estimated to rate their health poorly, compared with a lower 17.2% in Coastal. The rate in - Park was 44% above the metropolitan average.

High or very high levels of psychological distress

In the National Health Survey 2007–08, in addition to the self-reported responses to questions on mental health, information was collected using the Kessler Psychological Distress Scale-10 (K10).[58] People who gave responses which resulted in them being assessed as having high or very high psychological distress are reported here. Based on previous research, a very high K10 score may indicate a need for professional mental health assistance.[58]

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); modelled estimates from the 2007–08 National Health Survey.

Using the K10 measure of psychological distress, it is estimated that 14.6% of the population of Port Adelaide Enfield had high or very high levels of psychological distress, which was 18% above the level across the metropolitan area overall (12.3%). The rate in Port Adelaide Enfield - Park was estimated to be 39% above the metropolitan average.

Type 2 diabetes

Type 2 diabetes is the commonest form of diabetes, and its prevalence is increasing.[59] Control of modifiable risk factors (such as overweight, obesity and physical inactivity) is key to preventing type 2 diabetes and reducing its complications.[59] Aboriginal peoples are three times as likely as non-Indigenous people to have diabetes; and have higher hospitalisation and death rates than other Australians.[59] Diabetes prevalence and death rates for the poorest fifth of the population are also nearly twice as high as for the most affluent fifth of the population.[59]

Indicator definition: Estimated number of people with type 2 diabetes as a long-term condition, expressed as a rate per 100 total population (age-standardised); modelled estimates from the 2007–08 National Health Survey.

The proportion of the population of Port Adelaide Enfield estimated to have type 2 diabetes (3.9%) was 11% above the metropolitan average, of 3.5%. The highest prevalence was estimated to be in Port Adelaide Enfield - Park (4.3%), and the lowest in - Coast (3.7%).

Mental health problems

An individual's mental health, like all aspects of health, is subject to change. Mental health problems can range from short term issues such as anxiety and stress through to more serious clinical problems and psychosis. Most individuals will experience some mental health issues at some time.[60] A diverse range of social, environmental, biological and psychological factors can impact on an individual's mental health. In turn, people can develop symptoms and behaviours that are distressing, and which interfere with their social functioning and capacity to negotiate daily life. These symptoms and behaviours may require treatment or rehabilitation, and sometimes, hospitalisation.[60]

Indicator definition: Estimated number of males/ females with mental and behavioural disorders as a long-term condition expressed as a rate per 100 males/ females (age-standardised); modelled estimates from the 2007–08 National Health Survey.

Males

Mental health problems were estimated to have affected 11.8% of males in Port Adelaide Enfield, 11% above the metropolitan average. Prevalence varied from 12.7% in Port Adelaide Enfield - Port to 11.5% in both - Coast and - East.

Females

The estimated rate of mental health problems among females in Port Adelaide Enfield was higher than for males, at 13.1%, which was 8% higher than the metropolitan average (of 12.1%). All SLAs had prevalence rates above the metropolitan average, with the highest rate of 13.8% in Port Adelaide Enfield - Port.

Tobacco smoking

Tobacco smoking is the greatest single cause of premature death and a leading preventable cause of morbidity in Australia.[61] Smoking rates among Australian adults have declined since the early 1970s. In 2007, 21% of adult males were current smokers, compared to 18% of adult females, with the highest rates for both in the 25-29 year age group (males 30%, females 26%).[61] For the period 2004-05, tobacco smoking was estimated to cost $31.5 billion annually in health care, lost productivity and other social costs.[62] The prevalence of smoking is significantly higher among lower socioeconomic groups, particularly those facing multiple personal and social challenges.[61]

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); modelled estimates from the 2007–08 National Health Survey.

The smoking rate in Port Adelaide Enfield (estimated at 21.7% of adults smoking on a daily basis) was 15% higher than the metropolitan average (18.9%). Smoking rates varied from 21.0% in Port Adelaide Enfield - Coast and - East, to 23.5% in - Port, which was 25% higher than Metropolitan Adelaide.

Obesity

Over consumption, or the consumption of more calories than are required to meet energy needs, is contributing to Australia's increase in obesity which in turn is a significant contributing factor in the development of many chronic diseases.[46] Obesity can in itself lead to high blood pressure and high blood cholesterol. Excess body weight, high blood pressure and high blood cholesterol can all contribute to the risk of heart disease and amplify each risk factor's effects if they occur together. Excess body fat also increases the risk of developing a range of health problems including type 2 diabetes, cardiovascular disease, high blood pressure, certain cancers, sleep apnoea, osteoarthritis, psychological disorders and social problems.[46,47]

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); modelled estimates from the 2007–08 National Health Survey.

Males

The estimated obesity rate for males in Port Adelaide Enfield of 17.9% was 4% above the rate in the metropolitan area overall, of 17.3%. Whereas both Port Adelaide Enfield - Coast and - Inner had elevated rates (19.5% and 19.3%, respectively), the rate in - Park was 15.5%, which was 10% below the metropolitan average.

Females

The estimated obesity rate for females in Port Adelaide Enfield in 2007–08 (18.9%) was 13% above the metropolitan rate (16.7%). There was less variation in the prevalence of obesity across the SLAs than was evident for males.

Physical inactivity

Low levels of physical activity are a major risk factor for ill health and mortality from all causes.[63] People who do not undertake sufficient physical activity have a greater risk of cardiovascular disease, colon and breast

cancers, type 2 diabetes and osteoporosis. Being physically active improves mental and musculoskeletal health and reduces other risk factors such as overweight, high blood pressure and high blood cholesterol.[63]

By providing safe and accessible areas 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, expressed as a rate per 100 population aged 18 years and over (age-standardised); modelled estimates from the 2007–08 National Health Survey.

The extent of physical inactivity among the adult population in Port Adelaide Enfield (40.5%) was estimated to be 15% above the rate in the metropolitan area (35.1%). Port Adelaide Enfield - Park, - Inner and - East had elevated rates of 47.0%, 42.8% and 40.2%, respectively, with a much lower rate in - Coast, of 34.8%.

Daily fruit consumption by adults

The consumption of adequate daily amounts of fresh fruit and vegetables is associated with good nutrition and good 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 current recommended intake of fruit for adults is two serves or more per day.[48]

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); modelled estimates from the 2007–08 National Health Survey.

The extent to which adults in Port Adelaide Enfield met the daily requirement for fruit intake (49.8%) was estimated to be comparable with the metropolitan average (50.9%). There was little variation across the SLAs.

Median age at death

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.[64] 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.[64]

Indicator definitions: Median age at death, 2003 to 2007: the age at which exactly half the deaths registered in the period 2003 to 2007 were deaths of people above that age, and half were deaths below that age.

Males

The median age at death over this five-year period for males in Port Adelaide Enfield was 77.0 years, the same as the metropolitan average. Only Port Adelaide Enfield - Port varied much from this figure, with a lower median age at death of 73.0 years.

Females

The median age at death over this five-year period for females in Port Adelaide Enfield was 82.0 years, consistent with the metropolitan average. There was little variation across the SLAs.

Premature mortality

Premature mortality refers to deaths that occur early, before the age of 75 years. In Australia in 2010, the life expectancy of males was 79.5 years and for females, it was 84.0 years.[65] Deaths at ages earlier than expected, given life expectancies, imply an economic, personal and social loss for families and for the community.

Indicator definition: Deaths of males/ females aged 0 to 74 years, 2006 to 2010 (expressed as an age-standardised rate per 100,000 population).

Males

The premature mortality rate for males in Port Adelaide Enfield (430.8 deaths per 100,000 males) was markedly (41%) higher than the metropolitan average for males (305.3 deaths per 100,000). There were higher rates across all the SLAs, with the highest rate being in Port Adelaide Enfield - Coast (473.0 deaths per 100,000 males, which is 55% above the metropolitan average rate).

Females

The premature mortality rate for females in Port Adelaide Enfield (245.0 deaths per 100,000 females) was 31% above the metropolitan average rate (186.4 deaths per 100,000). There were higher rates across all the SLAs, with the highest being in Port Adelaide Enfield - Inner (272.5 deaths per 100,000 females, which is 46% above the metropolitan average rate) and - Park (266.5, 43% above).

At ages 15 to 24 years

For the period 2003 to 2007 in South Australia, the death rate for young people aged 15-24 years was 52.4 deaths per 100,000 population; and a quarter (25%) of these were due to suicide.

Indicator definition: Deaths from all causes, persons aged 15 to 24 years, 2003 to 2007 (expressed as an age-standardised rate per 100,000 population).

Deaths among young people aged 15 to 24 years in Port Adelaide Enfield (52.1 deaths per 100,000 population at these ages) were 17% higher than in the metropolitan area overall (a rate of 44.4). However, there was a very wide range in rates at the SLA level, from 6% above the metropolitan average in Port Adelaide Enfield - East, to a substantially higher rate in - Port, with 92% more deaths at these ages than in Metropolitan Adelaide overall.

Suicides

Suicide is a major social and public health issue.[65,66] 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.[65] 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.

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.[66] 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, 2006 to 2010 (expressed as an age-standardised rate per 100,000 population).

There were relatively more deaths from suicide before 75 years of age in Port Adelaide Enfield (17.7 deaths per 100,000 population) when compared with the metropolitan average (12.9 deaths per 100,000 population, a difference of 37%). Rates varied from 5% above the metropolitan average in Port Adelaide Enfield - Park, to 79% higher in both - Port and - Inner.

Admissions to hospital

Admission to hospital is a formal process, and follows a decision made by a medical officer that a patient needs to be admitted for appropriate management or treatment of their condition, or for appropriate care or assessment of needs.[67] In 2009/10, there were 80 public acute hospitals in South Australia, offering 3.0 available beds per 1,000 population.[67]

Total

Indicator definition: Admissions to public acute and private hospitals in South Australia in 2009/10, excluding same day admissions for renal dialysis (expressed as an age-standardised rate per 100,000 population).

The rate of admission to a South Australian hospital of residents of Port Adelaide Enfield was consistent with the metropolitan average. The rates varied across the SLAs, from 12% higher than this average in Port Adelaide Enfield - Inner, to 11% below in - Park.

Potentially avoidable hospitalisations

Avoidable 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 health care.[68] A sub-set of avoidable hospitalisations are those arising from ambulatory care-sensitive (ACS) conditions. ACS conditions are certain conditions for which hospitalisation is considered potentially avoidable through preventive health care and early disease

management, usually delivered in a primary care setting, for example by a general medical practitioner, or at a community health centre.[68,69] A number of factors affecting variations in ACSCs have been identified: demographics, socioeconomic status, rurality, health system factors; prevalence; behavioural risk factors; environment; adherence to medication; propensity to seek care; and severity of illness.[69] Of these, socioeconomic factors appear most important in explaining variations in ACSC admissions.[69]

Indicator definition: Admissions to hospital for potentially avoidable conditions (from ambulatory care-sensitive conditions, 2005/06 to 2006/07) (expressed as an age-standardised rate per 100,000 population).

In contrast to the overall admission rate, the rate of admissions for conditions considered to be potentially avoidable through preventive health care and early disease management was 5% higher for residents of Port Adelaide Enfield than it was across the metropolitan area overall. However, in Port Adelaide Enfield - Park, the rate was 7% below the metropolitan average.

Difficulty accessing services

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.[70] In Australia in 2010, 30% of adults reported experiencing difficulty when trying to access a range of service providers. The most often reported types of services that people had difficulty accessing were telecommunications (11%), doctors (10%) and Commonwealth income support, health and related services (9%). A higher proportion of women reported difficulty accessing doctors and Commonwealth income support, health and related services than men (11% compared to 8% for each).[70]

Indicator definition: Estimated number of people aged 18 years and over who had difficulty accessing services, expressed as a rate per 100 population aged 18 years and over (age-standardised); modelled estimates from the 2010 ABS General Social Survey.

The extent to which people in Port Adelaide Enfield had difficulty accessing services is estimated to be at a level similar to that for the metropolitan areas overall, with just over one quarter of the population estimated to face such difficulties (26.1%). There was little variation across the SLAs.

Home and Community Care Program

The Commonwealth Home and Community Care (HACC) Program funds services that support older people to stay living in their homes and be more independent in the community.[72] Services provided under the Program include:

- ***nursing care;***
- ***allied health services, such as podiatry, physiotherapy and speech pathology;***
- ***domestic assistance, including help with cleaning, washing and shopping;***
- ***personal care, such as help with bathing, dressing, grooming and eating;***
- ***social support;***
- ***home maintenance and home modifications;***
- ***assistance with food preparation in the home, and delivery of meals;***
- ***transport;***
- ***assessment, client care coordination and case management;***
- ***counselling, information and advocacy services;***
- ***centre-based day care; and***
- ***support for carers, including respite services.[72]***

Clients living alone

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 (2010/11).

Over one third (37.4%) of HACC clients in Port Adelaide Enfield were living alone, comparable with the proportion (37.2%) across the metropolitan area overall. There was little variation across the SLAs, except for Port Adelaide Enfield - Port, which had 10% fewer of its HACC clients in living alone when compared with the metropolitan average.

Non-English speaking clients

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 (2010/11).

In contrast to the previous indicator, substantially more HACC clients in Port Adelaide Enfield were non-English speaking – 20.4% compared with the metropolitan area overall, at 14.2%; that is, there were 44% more people in this group. Proportions were very high in Port Adelaide Enfield - Park (2.59 times the metropolitan average) and - Port (2.0 times); but - Coast had a proportion, which was 21% below the average.

Community health services

Community health services offer a range of services for their local communities, which may include Community Care home support, Palliative Care support, Aged Care Assessment team, Allied Health Services (i.e., podiatry, physiotherapy, occupational therapy, speech pathology, dietary advice), counselling, health promotion, women's health, support groups, and social work.[73]

Indicator definition: Clients of government-funded community health services (2009-10), expressed as an indirectly age-standardised rate per 100,000 population.

Substantially more people in Port Adelaide Enfield were clients of community health services, with a rate 73% above that across the metropolitan areas overall. There was wide variation across the SLAs, from 13% lower in Port Adelaide Enfield - East, to a substantially higher rate in - Park (which was three times that for the metropolitan areas overall). This not only reflects demand for these important services, but also their availability.

Community mental health services

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).[73]

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.[73]

These data refer to all clients of community-based mental health services, who were aged 18 years and over.

Indicator definition: People aged 18 years and over who were clients of government-funded community mental health services (2009-10), expressed as an indirectly age-standardised rate per 100,000 population aged 18 years and over.

Substantially more people in Port Adelaide Enfield were clients of community mental health services, with a rate 86% above that across the metropolitan areas overall. There were elevated rates evident across all the SLAs, with a rate 81% higher in - Port. This again not only reflects demand for these important services, but also their availability locally.

Availability of residential aged care

Residential Aged Care facilities provide accommodation, personal care and nursing services to people who can no longer manage to live in their own home. They cater for both high and low-level care; and also provide respite services. Australian government spending on aged care between 2009-10 and 2049-50 is projected to rise from 0.8% to 1.8% of GDP.[74] ***Growth in spending on residential aged care is the main contributor to the increase, reflecting the expectation that the number of Australians aged 85 years or older will more than quadruple over the next 40 years. However, spending on community aged care is also projected to rise significantly. Population ageing is the primary driver of increased aged care spending to 2049-50, accounting for around two-thirds of the projected increase in real spending on aged care per person.***[74]

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 2011).

The rate of residential aged care places in Port Adelaide Enfield is 6% higher than the rate across the non-metropolitan areas overall. Rates vary considerably at the SLA level, from 31% above the metropolitan average in - Park and 19% above in - Coast, to 28% lower in - Inner. This measure is highlighted in the table so that Local Councils can plan for the accommodation needs of their older residents – the grey shades have been used to emphasise the extent of the challenge this can present in an ageing population.

Community connectedness

People able to get support in times of crisis

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.[75] 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.[76]

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.[77] 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.[75]

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); modelled estimates from the 2010 ABS General Social Survey.

Nine out of every ten people in Port Adelaide Enfield (90.3%) were estimated to be able to get support in times of crisis, a level consistent with the metropolitan average; there was little variation at the SLA level.

Disagree/ strongly disagree with acceptance of other cultures

The extent to which adult community members agree or disagree with the statement 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.[78] Nationally, 80% of respondents indicated that they agreed or strongly agreed with this statement in 2010.[70] Indeed, migrants have been crucial to building Australia's economy, helping to create its national infrastructure, contributing new ideas and technology and fostering local knowledge of other cultures, languages, foods and lifestyles among the population over the last two centuries.[75]

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 2010 ABS General Social Survey.

Although the proportion is small, the estimate that 5.8% of the adult population of Port Adelaide Enfield disagree/ strongly disagree with the acceptance of other cultures is 30% above the metropolitan average (4.4%). The range at the SLA level was quite marked, from a low of 3.9% in Port Adelaide Enfield - Coast to far higher proportions in - Park (8.6%) and - Inner (7.7%).

Government support as main source of income in last two years

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.[79] These include the income they receive in wages and salaries, their own businesses or investments, and income support from government.

Australia has an income support system that is designed to act as a safety net for individuals who are unable to adequately support themselves.[79] In order to ensure that the assistance is directed to those who are most in need, the eligibility for income support payments are typically means tested, and the rate of income support that a person is entitled to depends upon the income and assets tests.[79]

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); modelled estimates from the 2010 ABS General Social Survey.

In 2010, 40.6% of Port Adelaide Enfield's adult population was estimated to have received government support as their main source of income in the previous two years; this is 37% above the

metropolitan average. The range at the SLA level was quite marked, from 33.7% of the population in Port Adelaide Enfield - Coast to a much higher proportion in - Park (52.5%). This high level of relatively low incomes has important implications for the range of services required, in particular, services provided by government.

Accessed the Internet at home in the past 12 months

A household can be considered to be disadvantaged if it lacks the resources to participate fully in society.[80] Access to the outside world, through a telephone or the Internet provides a means of communicating with family and friends, as well as services, employers and schools, thereby increasing educational, employment and other opportunities, including greater social interaction.[81] For children and young people, access to the Internet and to a computer is increasingly seen as a pre-requisite for learning and education, as access encourages the development of skills, including literacy, numeracy and inquiry.[82]

Indicator definition: Estimated number of people aged 18 years and over who accessed the Internet at home in the past 12 months, expressed as a rate per 100 population aged 18 years and over (age-standardised); modelled estimates from the 2010 ABS General Social Survey.

Less than three quarters of the adult population of Port Adelaide Enfield (69.4%) were estimated to have accessed the Internet at home in the 12 months prior to the survey; this is 6% below the estimate for the metropolitan areas overall (73.8%). The variation at the SLA level is small, with a below-average rate in - Park (64.4%).

Personal and community safety

Feel very safe/ safe walking in local area after dark

Having trust in others to behave according to accepted social values and norms is a fundamental aspect of a well-functioning community.[70] 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. People feeling unsafe may relate to: physical features of the local area such as inadequate street lighting and poorly maintained footpaths; crime levels in their local vicinity; previous experience as a victim of assault or household break-in; 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.[70]

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); modelled estimates from the 2010 ABS General Social Survey.

Less than half the population (41.8%) were estimated to feel very safe or safe walking in their local area after dark; this proportion was 4% below the metropolitan average of 43.5%. There was little variation across the SLAs, with the exception of Port Adelaide Enfield - Park, which was 10% below Metropolitan Adelaide.

Table 1: Selected indicators of population health and its determinants, Port Adelaide Enfield LGA and SLAs compared with metropolitan Adelaide

Indicators	Port Adelaide Enfield						Metro Adelaide	Non-metro SA	South Australia	Australia
	Coast	*East*	*Inner*	*Park*	*Port*	Total				
Population Profile, 2011 Census (Per cent, Index)										
Born overseas in predominantly non-English speaking countries										
- country 1 (in this SLA/ LGA) of top ten for SA - Italy	*0.9*	*1.7*	*1.3*	*1.7*	*1.4*	1.4	**1.7**	0.3	1.3	0.9
- country 2 (in this SLA/ LGA) of top ten for SA - India	*0.2*	*4.2*	*6.5*	*4.8*	*1.0*	3.4	**1.5**	0.3	1.2	1.4
- country 3 (in this SLA/ LGA) of top ten for SA - China	*0.3*	*3.0*	*1.8*	*2.4*	*1.5*	1.9	**1.3**	0.1	1.0	1.5
Born overseas & reports having poor proficiency in English	*0.9*	*3.6*	*7.3*	*13.5*	*5.6*	5.3	**2.7**	0.5	2.1	2.6
Aboriginal and Torres Strait Islander peoples	*2.6*	*2.0*	*2.5*	*2.2*	*3.3*	2.4	**1.3**	3.6	1.9	2.5
People who provide unpaid assistance to others	*11.4*	*11.1*	*11.1*	*10.9*	*12.2*	11.2	**11.8**	11.8	11.8	10.9
People with a profound or severe disability: all ages	*4.7*	*4.8*	*6.1*	*6.6*	*6.2*	5.4	**4.4**	4.6	4.4	4.6
People with a profound or severe disability: 0 to 64 yrs	*3.0*	*3.2*	*3.9*	*3.9*	*3.9*	3.4	**2.8**	3.1	2.8	2.5
People with a profound or severe disability: 65 yrs & over	*13.9*	*14.1*	*18.6*	*22.8*	*19.7*	16.7	**13.4**	11.7	12.7	17.8
Index of Relative Socio-economic Disadvantage	*975*	*974*	*880*	*847*	*898*	930	**991**	962	983	1002
Employment, 2011 (Per cent)										
Unemployment beneficiaries: total	*5.4*	*5.1*	*7.9*	*7.9*	*6.9*	6.3	**4.7**	5.6	5.0	4.2
Unemployment beneficiaries: six months or longer	*4.1*	*3.9*	*6.1*	*6.4*	*5.6*	4.9	**3.6**	4.5	3.9	3.1
Unemployment beneficiaries: young people	*8.3*	*8.0*	*10.9*	*8.3*	*10.0*	8.9	**6.4**	7.7	6.8	5.5
Education (Per cent)										
Aged 16 years and not participating in full-time secondary education, 2011	*15.2*	*16.7*	*18.2*	*22.5*	*16.4*	17.5	**16.2**	18.3	16.9	20.9
School leavers admitted to university, 2013	*33.9*	*35.5*	*35.7*	*37.6*	*29.1*	34.9	**35.7**	19.1	31.1	31.3
Children whose mother has low educational attainment, 2011	*17.6*	*15.4*	*25.9*	*30.1*	*24.5*	21.2	**17.1**	20.1	17.9	22.2
Young people learning or earning, 2011	*78.6*	*79.3*	*77.2*	*81.4*	*74.5*	78.6	**80.9**	76.7	79.8	80.1
Income and wealth (Per cent)										
Children in low income, welfare-dependent families, 2011	*26.7*	*27.6*	*36.8*	*39.5*	*37.4*	32.0	**23.0**	23.9	23.4	21.5
Age Pension recipients, 2011	*86.7*	*87.3*	*76.1*	*85.7*	*91.2*	85.1	**76.5**	78.6	77.2	74.6
Disability Support Pension recipients, 2011	*8.7*	*8.4*	*10.7*	*11.7*	*12.0*	9.8	**6.9**	8.2	7.3	5.6
Pensioner Concession or Health Care card holders, 2011	*29.0*	*29.1*	*32.4*	*35.9*	*35.2*	31.3	**26.2**	29.0	27.0	23.0
Housing stress: mortgage holders, 2011	*7.0*	*8.6*	*10.5*	*14.8*	*11.5*	9.6	**8.4**	10.4	8.9	10.5
Housing stress: renters, 2011	*25.0*	*26.1*	*26.9*	*26.9*	*27.5*	26.3	**26.9**	23.0	25.9	25.2
Housing rented from Housing SA, 2011	*8.4*	*9.9*	*15.1*	*20.2*	*11.5*	12.1	**6.4**	5.5	6.1	4.1
Recipients of rent relief from Centrelink, 2011	*13.3*	*18.2*	*19.4*	*17.7*	*16.1*	16.9	**14.6**	13.8	14.4	15.7
No motor vehicle available to household, 2011	*10.8*	*11.0*	*16.7*	*17.0*	*15.9*	13.4	**9.6**	6.3	8.7	8.6
Early life and childhood (Per cent, Rate)										
Total fertility rate, 2011	*1.72*	*1.89*	*2.00*	*2.01*	*1.74*	1.89	**1.79**	2.21	1.88	1.88
Women smoking during their pregnancy, 2008–10	*17.9*	*9.6*	*13.2*	*13.7*	*18.2*	13.5	**13.0**	20.8	15.0	13.7
Immunisation 1 yr of age, 2011/12	*92.3*	*93.1*	*92.4*	*92.2*	*88.5*	92.2	**92.2**	92.6	92.3	91.8
Immunisation 5 yrs of age, 2011/12	*84.9*	*86.7*	*82.0*	*84.7*	*83.6*	84.7	**87.0**	89.4	87.7	90.0
Obesity: four year old boys, 2010–12	*6.8*	*5.7*	*8.3*	*7.1*	*6.4*	6.8	**5.3**	6.0	5.5	..
Obesity: four year old girls, 2010–12	*4.3*	*4.3*	*3.3*	*7.3*	*5.4*	4.6	**3.8**	4.3	4.0	..
Fruit consumption: children aged 5 to 17 years, 2007–08	*53.3*	*52.3*	*53.4*	*55.1*	*54.2*	53.4	**57.8**	57.8	57.8	61.0
Infant death rate, 2006–10	..	*2.8*	..	..	..	2.9	**3.4**	6.1	4.2	4.3
Child mortality rate (deaths 1 to 4 yrs), 2006–10	..	*0.0*	..	..	*0.0*	19.3	**18.6**	30.0	21.8	20.1
Children and young people who are clients of CAMHS, 2008/09 and 2009/10	*2,026.7*	*1,281.9*	*1,978.3*	*1,686.7*	*2,635.1*	1,797.5	**1,353.0**	3,119.1	1,958.0	..
AEDI: Children developmentally vulnerable on one or more domains, 2009	*32.2*	*21.9*	*39.1*	*29.8*	*27.5*	29.7	**23.0**	22.6	22.9	23.6

Local Government Association of South Australia

Table 1: Selected indicators of population health and its determinants, Port Adelaide Enfield LGA and SLAs compared with metropolitan Adelaide ***...cont***

Indicators	Port Adelaide Enfield						Metro Adelaide	Non-metro SA	South Australia	Australia
	Coast	*East*	*Inner*	*Park*	*Port*	Total				
Personal health and wellbeing (Per cent, Rate)										
Self-assessed health as fair, or poor, 2007–08	*17.2*	*18.3*	*19.7*	*22.1*	*20.6*	19.0	**15.3**	16.2	15.5	14.7
High/ Very high levels of psychological distress , 2007–08	*13.1*	*13.9*	*15.3*	*17.2*	*15.7*	14.6	**12.3**	11.5	12.1	11.7
Type 2 diabetes, 2007–08	*3.7*	*3.8*	*4.0*	*4.3*	*4.1*	3.9	**3.5**	3.5	3.5	3.4
Mental health problems: males, 2007–08	*11.5*	*11.5*	*12.0*	*12.3*	*12.7*	11.8	**10.7**	11.1	10.8	10.1
Mental health problems: females, 2007–08	*12.9*	*12.5*	*13.5*	*13.7*	*13.8*	13.1	**12.1**	12.2	12.1	11.8
Smoking, 2007–08	*21.0*	*21.0*	*22.2*	*22.7*	*23.5*	21.7	**18.9**	22.9	19.9	20.3
Obese males, 2007–08	*19.5*	*19.3*	*16.0*	*15.5*	*16.3*	17.9	**17.3**	19.4	17.9	19.6
Obese females, 2007–08	*19.1*	*18.9*	*19.1*	*18.3*	*19.1*	18.9	**16.7**	18.0	17.0	16.4
Physical inactivity, 2007–08	*34.8*	*40.2*	*42.8*	*47.0*	*42.5*	40.5	**35.1**	37.9	35.8	34.3
Fruit consumption: adults, 2007–08	*49.6*	*50.4*	*49.9*	*49.6*	*48.3*	49.8	**50.9**	48.4	50.2	50.2
Median age at death: males, 2003–07	*77.0*	*77.0*	*78.0*	*76.0*	*73.0*	77.0	**78.0**	76.0	77.0	76.0
Median age at death: females, 2003–07	*83.0*	*82.0*	*83.0*	*81.0*	*83.0*	82.0	**83.0**	83.0	83.0	83.0
Premature mortality: males, 2006–10	*473.0*	*377.2*	*431.6*	*451.9*	*444.9*	430.8	**305.3**	327.2	312.7	303.9
Premature mortality: females, 2006–10	*240.2*	*223.6*	*272.5*	*266.5*	*249.4*	245.0	**186.4**	196.2	189.4	184.4
Premature mortality: 15 to 24 yrs, 2003–07	*51.3*	*23.7*	*61.8*	*73.7*	*85.2*	52.1	**44.4**	79.6	52.4	..
Premature mortality from suicides, 2006–10	*18.9*	*13.6*	*23.0*	*13.5*	*23.0*	17.7	**12.9**	12.2	12.8	12.3
Admissions to hospital: total, 2009/10	*35,570.0*	*32,633.8*	*38,742.0*	*30,908.4*	*34,703.4*	34,527.4	**34,689.3**	32,969.0	34,264.8	..
Admissions to hospital: potentially avoidable conditions, 05/06 to 06/07	*3,137.7*	*3,495.7*	*3,626.0*	*2,945.0*	*3,191.9*	3,316.9	**3,167.3**	3,882.7	3,427.7	..
Difficulty accessing services, 2010	*26.1*	*26.0*	*26.2*	*26.2*	*26.2*	26.1	**26.0**	35.8	28.5	29.7
HACC: clients living alone, 2010/11	*36.6*	*38.3*	*38.3*	*38.5*	*33.5*	37.4	**37.2**	27.9	34.3	37.5
HACC: non-English speaking clients, 2010/11	*11.2*	*17.1*	*19.9*	*36.7*	*28.4*	20.4	**14.2**	3.7	10.9	9.4
Clients of community health services, 2009/10	*3,050.6*	*1,652.1*	*3,677.6*	*5,838.0*	*4,308.0*	3,284.8	**1,893.6**	10,963.0	4,435.9	..
Clients of community mental health services, 2009/10	*1,985.5*	*1,893.7*	*2,042.5*	*1,878.4*	*2,478.6*	2,000.9	**1,372.0**	1,323.1	1,399.4	..
Residential aged care places per 1,000 population aged 70 yrs & over, 2011	*115.7*	*104.0*	*69.7*	*126.9*	*0.0*	94.2	**97.0**	83.1	93.2	87.0
Community connectedness, 2010 (Per cent)										
Able to get support in times of crisis	*91.9*	*90.7*	*89.8*	*87.6*	*89.9*	90.3	**91.9**	91.9	91.9	92.1
Disagree/strongly disagree with acceptance other cultures	*3.9*	*4.3*	*7.7*	*8.6*	*7.5*	5.8	**4.4**	4.1	4.3	5.9
Government support as main source of income in last 2 years	*33.7*	*34.7*	*46.9*	*52.5*	*46.6*	40.6	**29.5**	31.6	30.1	27.6
Accessed the Internet at home in the past 12 months	*71.9*	*71.3*	*67.8*	*64.4*	*67.4*	69.4	**73.8**	72.1	73.4	75.6
Personal and community safety, 2010 (Per cent)										
Feeling very safe/safe walking alone in local area after dark	*42.7*	*42.5*	*41.5*	*39.1*	*41.9*	41.8	**43.5**	51.0	45.4	47.3

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

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Local Government Association of South Australia

Notes on the data

Notes on the Data: General information

Copyright

Terminology:

In discussing the extent to which percentages or rates vary from the State figure, the following terms are used:

- "Notable", referring to a difference in a rate or rate ratio of from 10% to <20%;
- "Marked" referring to a difference in a rate or rate ratio of from 20% to <50%;
- "Substantial" referring to a difference in a rate or rate ratio of 50% or more.

.. not applicable

Statistical information

Presentation of percentages

Percentages are generally presented to one decimal place. However, percentage differences between an LGA/ LGA Group and the comparator (Metropolitan Adelaide or non-metropolitan South Australia) are shown as whole numbers.

Data adjustment

For the Census data, the ABS uses a method of 'introduced random error' to ensure that no data are released which could risk the identification of individuals in the statistics. The technique slightly adjusts all cells, resulting in small introduced random errors. Whilst the totals and subtotals in the Census summary tables are subjected to small adjustments to preserve the additivity within the tables, data at the higher geographic level may not be equal to the sum of the data for the component geographic units.

For further information, please refer to the ABS *Census Dictionary 2011 (ABS Cat. No. 2901.0) on the following topics*:

Introduced random error:
http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2901.0Chapter38202011

Confidentiality:
http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2901.0Chapter26802011

Standardisation of rates

The rates presented are indirectly standardised. Indirectly standardised rates compare the actual number of events in an area (e.g. the LGA of Bankstown) with the expected number of events based on rates of a reference population (e.g. Australia), generally based on the five-year age group data in this reference population. The standardised ratios are the ratio of the observed (actual) to expected number of events. The observed figures comes from the local area, and the expected from applying the rate in the reference population to the local population.

Age-standardisation is used as comparisons between areas for an indicator are likely to be affected by variations in the age profile of the area. This effectively means any differences in age-standardised rates between areas are reflecting the influence of factors other than age. For example, the standardised ratios (SRs) (or standardised death ratios – SDRs) for Australia (or respective standard population) are 100. A SR of 110 in an area means the standardised ratio is 10% higher (for an area of its population size and structure) in the area than expected from the Australian (or respective standard population) rates. An index of 85 means the SR is 15% lower (for an area of its population size and structure) in the area than expected from the Australian rates. The indirect method is used as in most instances we cannot get the age for each record at the small area level: were the age data available, we would use the direct method of standardisation.

Notes on the Data: Indicators and Data sources

POPULATION PROFILE

- Age in 5 year groups: 0 to 85+ years, Estimated Resident Population, 2011

  Notes: The Estimated Resident Population (ERP) is derived by applying the following adjustments to the usual residence Census counts:

  - removing overseas visitors who were in Australia on Census night from the Census counts;
  - adjusting the Census counts for undercounting using results of the Post Enumeration Survey;
  - including Australian residents who were temporarily absent overseas on Census night; and
  - backcasting the resulting estimates which relate to 8 August 2006 to 30 June 2006 using births, deaths and migration data.

  NB: These ERP data are preliminary rebased estimates, and reflect information from the 2011 Census. Final estimates for 2011 will be released in August 2013, based on further refinements to components used to rebase population estimates.

  Source: Compiled by PHIDU based on ABS Estimated Resident Population, 30 June 2011

- Aboriginal population as per cent of total population, Usual Resident Population, 2011

  Notes: This estimate of the Usual Resident Population is from the 2011 Census; the ABS has not produced an Estimated Resident Population at the SLA level from the 2011 Census. .

  The data exclude the 4.9% of people whose Indigenous status was not recorded, based on Australian totals (the proportion excluded was calculated based on the Australian data).

  Source: Compiled by PHIDU based on ABS Census Usual Resident Population, 2011

- Top three birthplaces of people born in non-English speaking countries, 2011

  Notes: The data comprise residents of Australia who were born overseas in one of the predominantly non-English speaking countries which are in the top three in Metropolitan Adelaide (not necessarily representative of the countries in the particular LGA or LGA Group) in terms of the number of people from these countries.

  Source: Compiled by PHIDU based on ABS Census 2011 data

- People aged 5 years and over who were born overseas and reported having poor proficiency in English, 2011

  Notes: The data comprise people born overseas who reported speaking English 'not well' or 'not at all'.

  The data exclude the 0.5% of people born overseas who did not state their proficiency in English, as well as the 5.6% of the population who did not state their country of birth (the proportions excluded were calculated based on the Australian data).

- Unpaid assistance to persons with a disability, 2011

  Notes: The 'Assistance to persons with a disability (unpaid)' variable records people 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 (lasting six months or more) and/or problems related to older age.

  The data exclude the 8.5% of persons aged 15 years and over whose unpaid assistance to persons with a disability was not stated (the proportion excluded was calculated based on the Australian data).

  Source: Compiled by PHIDU based on ABS Census 2011 data

- Persons with a profound or severe disability living in the community, All ages, 2011
- Persons with a profound or severe disability living in the community, 0 to 64 years, 2011
- Persons with a profound or severe disability living in the community, 65 years and over, 2011

  Notes for all *People with a profound or severe disability* and *People with a profound or severe disability living in the community* data: The 'Core Activity Need for Assistance' variable was developed by the Australian Bureau of Statistics (ABS) for use in the five-yearly population Census to measure the number of people with a profound or severe disability, and to show their geographic distribution. A person with profound or severe limitation needs 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. Fewer people are reported under this measure as having a profound or severe disability as are measured in the ABS Survey of Disability, Ageing and Carers (SDAC). The reasons for this are definitional (the SDAC approach, which uses a filtering approach to determine whether the respondent has a disability, and the severity) as compared to the self-report approach in the Census; and the large not-stated category in the Census data, with more people not responding to this set of questions than are reported as having a profound or severe disability. While the SDAC figures should be used as the measure for this concept, the Census data are appropriate for getting an understanding of the geographic distribution of this population group.

  The ABS figures include people – of all ages/ aged 0 to 64 years/ aged 65 years and over, as appropriate – living in long-term residential accommodation in nursing homes, accommodation for the retired or aged (not self-

contained), hostels for the disabled and psychiatric hospitals: the 'total' figure (for each age group shown) in this atlas includes people living in these accommodation types, whereas the figure for 'living in the community' (for each age group shown) excludes them.

Details of the total number of people with a disability – including those with a moderate or mild disability – are not included.

Source for all *People with a profound or severe disability* data: Compiled by PHIDU based on ABS Census 2011 (unpublished) data

- Index of Relative Socio-economic Disadvantage (IRSD), 2011

Notes: The Index has a base of 1000 for Australia: scores above 1000 indicate relative lack of disadvantage and those below indicate relatively greater disadvantage.

For further information see the information provided by the Australian Bureau of Statistics (ABS) at: http://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa

or download the ABS *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2011* (Cat. no. 2033.0.55.001) technical paper at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001

NB: The 2011 IRSD differs from earlier IRSD releases in that the Indigenous variable has been removed – refer to the technical paper (see above) for further information.

Source: Compiled by PHIDU based on ABS Socio -Economic Indexes for Areas (SEIFA), 2011 data. Note: The SLA and LGA data were re-produced from the ABS originals. The PHIDU Statistical Local Area group, Statistical Subdivision, Local Hospital Network, Medicare Local, State/ Territory and Australian totals were constructed using population weighted averages, based on the published ABS SLA data (which was compiled by the ABS from population weighted SA1s).

EMPLOYMENT

Note for *the following* data: The Centrelink data were provided at the Statistical Local Area (SLA) level, with data cells with less than 20 counts removed to confidentialise the data. As a result, there may be undercounting of some of the final numbers presented, where:

a) the geographies (Local Government Area, Medicare Local or Local Hospital Network) were aggregated based on confidentialised (SLA) cells; and/ or

b) the final data presented is based on combining two indicator sub-sets, which may include the aggregation of confidentialised and non-confidentialised cells.

- Unemployment beneficiaries, June 2011

Notes: People receiving an 'unemployment benefit' – which includes the Newstart Allowance or Youth Allowance (other)[2] paid by Centrelink – are shown as proportion of the eligible population (of persons aged 16 to 64 years).

Source: Compiled by PHIDU based on data from Centrelink as agent for the Department of Education, Employment and Workplace Relations, June 2011; and ABS Estimated Resident Population, 30 June 2011

- Long-term unemployment beneficiaries, June 2011

Notes: People receiving an 'unemployment benefit' – which includes the Newstart Allowance or Youth Allowance (other)[Error! Bookmark not defined.] paid by Centrelink – for more than 182 days (approximately 6 months) are shown as proportion of the eligible population (of persons aged 16 to 64 years).

Source: Compiled by PHIDU based on data from Centrelink as agent for the Department of Education, Employment and Workplace Relations, June 2011; and ABS Estimated Resident Population, 30 June 2011

- Youth unemployment beneficiaries, June 2011

Notes: Young people receiving an 'unemployment benefit' – which includes the Newstart Allowance (people aged 15 to 24 years) or Youth Allowance (other)[Error! Bookmark not defined.] paid by Centrelink – are shown as proportion of the population aged 15 to 24 years.

Source: Compiled by PHIDU based on data from Centrelink as agent for the Department of Education, Employment and Workplace Relations, June 2011; and ABS Estimated Resident Population, 30 June 2011

[2] Youth Allowance (other) is largely comprised of unemployed people aged 16 to 21 looking for full-time work or undertaking approved activities, such as part-time study or training. It excludes Youth Allowance customers who are full-time students or undertaking an apprenticeship/ traineeship.

EDUCATION

Note for *the following* data: The Centrelink data were provided at the Statistical Local Area (SLA) level, with data cells with less than 20 counts removed to confidentialise the data. As a result, there may be undercounting of some of the final numbers presented, where:

- Aged 16 years and not participating in full-time secondary school education, 2011

  Notes: As data covering all sectors (government, non-government, Catholic and independent) are not available at the small area level from State and Territory education authorities, the data used in this analysis are from the 2011 Australian Bureau of Statistics (ABS) Population Census. As such they are not official estimates of participation. However, they are useful in showing the extent of variations between areas, by socioeconomic status and by remoteness.

  The data exclude the 4.1% of people whose participation in secondary school education at age 16 was not stated (the proportion excluded was calculated based on the Australian data).

  Note that the extent to which those who have left school at this age to enter the labour force is not accounted for in these data - see *Learning or Earning at ages 15 to 19*.

  Source: Compiled by PHIDU based on ABS Census 2011 (unpublished) data

- School leavers enrolled in higher education, 2013

  Notes: The data comprise school leavers who are identified as enrolled at an Australian university at 31 March 2013, expressed as a proportion of the Estimated Resident Population aged 17 years at 30 June 2012.

  'School leavers' are students who attained a Year 12 qualification in 2012 in any State/ Territory through the completion of one or more Year 12 courses; may include (unless noted otherwise below) adult students, part time students and students doing one or more subjects to improve their overall score (repeating students).

  The Estimated Resident Population is based on the number of 17 year olds in 2012, as this is the age of the majority of Year 12 students at 30 June 2012.

  Data have been provided by individual States and Territories, other than Queensland. The exclusion of Queensland will under-represent participation in other State and Territories to the extent that students from those jurisdictions enrol in Queensland universities.

  Variations in data between States:

  Definitions vary across the States, however, the impact of any differences is considered to be small, other than for WA data which include school leavers who have accepted an offer to enrol although such 'acceptances' may not necessarily translate to 'enrolments' (other States and Territories count enrolments). Other differences of note are:

  - WA data comprise normal school leavers and those who are repeaters, but exclude mature age students; and, for The University of Notre Dame Australia campuses in WA and NSW, comprise students who are under 20 years of age on 1 March in their year of admission and who have not attempted any post-secondary (TAFE or University) study.
  - Tasmanian data include those who apply and are assessed as a Year 12 student (whether in previous year, or earlier).
  - School leaver applicants and enrolees self-identify as being of Aboriginal and Torres Strait Islander descent or not. Those of 'unknown' Indigenous status have been included in the non-Indigenous counts. WA universities also admit some Aboriginal and Torres Strait Islander school leavers directly and data from the Tertiary Institutions Service Centre may therefore under-represent their participation.

  For more information, please consult the relevant admissions centre as listed in the **Source** below.

  Source: Compiled by PHIDU based on data from the:
  1) Universities Admissions Centre (NSW & ACT), Victorian Tertiary Admissions Centre, South Australian Tertiary Admission Centre (SA & NT), Tertiary Institutions Service Centre (WA), The University of Notre Dame Australia (WA & NSW), the University of Tasmania; and
  2) ABS Estimated Resident Population, 30 June 2012

- Children whose mother has low educational achievement, 2011

  Notes: 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 .

  Source: Compiled by PHIDU based on ABS Census 2011 data

- Learning or Earning at ages 15 to 19, 2011

  Notes: The data comprise the number of 15 to 19 year olds who are engaged in school, work or further education/ training, expressed as a proportion of all those aged 15 to 19 years.

  Source: Compiled by PHIDU based on ABS Census 2011 data

INCOME AND WEALTH

Notes for *the following* data: The Centrelink data were provided at the Statistical Local Area (SLA) level, with data cells with less than 20 counts removed to confidentialise the data. As a result, there may be undercounting of some of the final numbers presented, where:

a) the geographies (Local Government Area, Medicare Local or Local Hospital Network) were aggregated based on confidentialised (SLA) cells; and/ or

b) the final data presented is based on combining two indicator sub-sets, which may include the aggregation of confidentialised and non-confidentialised cells.

- Children in low income, welfare-dependent families, June 2011

  For 2011, families included are those with children under 16 years and with incomes under $31,786 p.a. in receipt of the Family Tax Benefit (A) (whether receiving income support payments or not). These families would all receive the Family Tax Benefit (A) at the maximum level.

  The level of income used for this data was based on the *Poverty Lines: Australia, June Quarter 2011, which contains a weekly income for a single parent with two children, including housing costs. Poverty Lines: Australia* is a quarterly newsletter that updates the Henderson Poverty Line as defined in the 1973 Commonwealth Commission of Inquiry into Poverty. Poverty lines are presented for a range of family sizes, in order to avoid the situation of poverty. The updated Poverty Lines take into account changes in the average income level of all Australians, reflecting the idea that poverty is relative.

  [For further information, see: *Poverty Lines: Australia* (ISSN 1448-0530), Melbourne Institute of Applied Economic and Social Research, available from: http://melbourneinstitute.com/miaesr/publications/indicators/poverty-lines-australia.html]

  Source: Compiled by PHIDU based on data from Centrelink as agent for the Department of Families, Housing, Community Services and Indigenous Affairs, June 2011; and ABS Census 2011

- Age pensioners, June 2011

  Notes: The Age Pension is available from Centrelink for persons who have reached Age Pension age. The Age Pension age depends on a person's date of birth, as follows:

  - If born before 1/7/52, Age Pension age is 65

  - If born before 31/12/48, Age Pension age is 64.5

  - If born between 1/1/49 and 30/6/52, Age Pension age is 65

  For men and women:

  - If born between 1/7/52 and 31/12/53, Age Pension age is 65.5

  - If born between 1/1/54 and 30/06/55, Age Pension age is 66

  - If born between 1/7/55 and 31/12/56, Age Pension age is 66.5

  - If born from 1/1/57 or later, Age Pension age is 67.

  The Department of Veterans' Affairs (DVA) provides a Service Pension (Age) to eligible persons who have reached 60 years.

  Centrelink pays the vast majority of Age Pensions. Age pensioners who also receive a Disability Pension from the Department of Veterans' Affairs (DVA) have the choice of having their Age Pension paid by either DVA or Centrelink.

  In some instances, percentages are calculated at greater than 100%; this may be the result of the address data being a postcode which is not allocated to the correct SLA by the concordances available. In time, with more reliable recording of address details, these occurrences should be reduced. Note that it is unlikely to be the result of people claiming both the Age Pension and a DVA Service Pension (Age), as checks are made each year to ensure that such events do not occur.

  Source: Compiled by PHIDU based on data from Centrelink as agent for the Department of Families, Housing, Community Services and Indigenous Affairs, June 2011; Department of Veterans' Affairs, 1 July 2011; and ABS Estimated Resident Population, 30 June 2011

- Disability support pensioners, June 2011

  Notes: People eligible for a Disability Support Pension (DSP) paid by Centrelink, must be aged 16 years or over and have not reached age-pensionable age; be permanently blind or have a physical, intellectual or psychiatric impairment level of 20% or more and a continuing inability to work for at least 15 hours per week. Details of people under 60 years of age receiving the Department of Veterans' Affairs (DVA) Service Pension (permanently incapacitated) – an income support pension – have been combined with the Centrelink DSP data; people above these ages receive an Age Pension or DVA Service Pension (Age).

  Source: Compiled by PHIDU based on data from Centrelink as agent for the Department of Families, Housing, Community Services and Indigenous Affairs, June 2011; Department of Veterans' Affairs, 1 July 2011; and ABS Estimated Resident Population, 30 June 2011

- Pensioner concession or Health Card holders, June 2011

  Notes: People eligible for a Pensioner Concession Card issued by Centrelink comprise people aged 15 years and over who receive one of the following Centrelink payments: Age Pension; Bereavement Allowance; Carer

Payment (adult); Carer Payment (child); Disability Support Pension; Newstart Allowance and Youth Allowance (job seeker) if single and caring for a dependent child; and Parenting Payment (single). People aged over 60 years may receive a Pensioner concession card if they have been receiving income support payments for more than nine months and receive: Newstart Allowance; Parenting Payment (partnered); Partner Allowance; Sickness Allowance; Special Benefit; and Widow Allowance. People may also be eligible for a Pensioner Concession Card if they have a partial capacity to work and are receiving any of the following payments: Newstart Allowance; Parenting Payment (partnered); and Youth Allowance (job seeker). People eligible for a Health care card (HCC) issued by Centrelink are those aged 0 to 64 years who do not hold a Pensioner Concession Card and receive one of the following Centrelink payments: Carer Allowance; Carer Payment (child) (short term or episodic); Exceptional Circumstances Relief Payment; Family Tax Benefit A (maximum rate only); Mobility Allowance (if not receiving a Disability Support Pension); Newstart Allowance; Parenting Payment (partnered); Partner Allowance; Special benefit; Widow Allowance; and Youth Allowance (job seekers only). People may also be eligible for a HCC if they are a foster carer; ex-holder of a Carer Allowance (child) Health Care Card; or are a low income earner.

Source: Compiled by PHIDU based on data from Centrelink, as agent for the Department of Families, Housing, Community Services and Indigenous Affairs, June 2011; and ABS Estimated Resident Population, 30 June 2011

- Low income households with mortgage stress, 2011

  Notes: The data comprise households in the bottom 40% of income distribution (those with less than 80% of median equivalised income), spending more than 30% of income on mortgage repayments.

  Income is equivalised; equivalised household income per week can be viewed as an indicator of the economic resources available to a standardised household. For a lone person household it is equal to household income. For a household comprising more than one person, it is an indicator of the household income that would be needed by a lone person household to enjoy the same level of economic wellbeing.

  Income varies by State/ Territory: NSW, $633; Vic, $640; Qld, $649; SA, $551; WA, $699; Tas, $488; NT, $853; ACT, $987.

  The data exclude the population in the 10.8% of private dwellings for which mortgage stress data was not recorded (the proportion excluded was calculated based on the Australian data).

  NB: For caveats regarding this data, please refer to the attached Housing Costs caveats **(.pdf).**

  Source: Compiled by PHIDU based on ABS Census 2011 (unpublished data)

- Low income households with rental stress, 2011

  Notes: The data comprise households in the bottom 40% of the income distribution (those with less than 80% of median income), spending more than 30% of their income on rent.

  Income is equivalised; equivalised household income per week can be viewed as an indicator of the economic resources available to a standardised household. For a lone person household it is equal to household income. For a household comprising more than one person, it is an indicator of the household income that would be needed by a lone person household to enjoy the same level of economic wellbeing.

  Income varies by State/ Territory: NSW, $633; Vic, $640; Qld, $649; SA, $551; WA, $694; Tas, $488; NT, $853; ACT, $987.

  The data exclude the population in the 9.3% of private dwellings for which rental stress data was not recorded (the proportion excluded was calculated based on the Australian data).

  NB: For caveats regarding this data, please refer to the attached Housing Costs caveats **(.pdf).**

  Source: Compiled by PHIDU based on ABS Census 2011 (unpublished) data

- Dwellings rented from Housing SA, 2011

  Notes: The data exclude the population in the 2.5% of dwellings for which the tenure type was not stated (the proportion excluded was calculated based on the Australian data).

  Source: Compiled by PHIDU based on ABS Census 2011 data

- Households in dwellings receiving rent assistance from Centrelink, June 2011

  Notes: The Centrelink rent assistance data is provided for individual recipients, and there may be multiple individual recipients in a household: to the extent that this occurs, the proportion will be understated. However, dwellings are the most appropriate denominator available for this dataset. In addition, some recipients live in non-private dwellings, which are not included in the denominator: to the extent that this occurs, the proportion will be overstated.

  The Centrelink data were provided at the Statistical Local Area (SLA) level and data cells with less than 20 counts were removed (confidentialised). Due to the confidentialisation of data cells, there may be undercounting of some of the final numbers presented where the geographies (Local Government Area or Medicare Local) were aggregated based on confidentialised (SLA) cells. The 'Unknown' data are calculated from the difference between the sum of the SLA data to the State/Territory totals, and include the sum of these confidentialised data.

  Source: Compiled by PHIDU based on:
  1) Renters: Centrelink as an agent for Families, Housing, Communities and Indigenous Affairs, June 2011; and
  2) Dwellings: ABS Census 2011 data

- Private dwellings with no motor vehicle, 2011

  Notes: The data exclude the population in the 3.0% of dwellings for which the number of motor vehicles was not stated (the proportion excluded was calculated based on the Australian data).

  Source: Compiled by PHIDU based on ABS Census 2011 data

EARLY LIFE AND CHILDHOOD

- Total Fertility Rate, 2011

  Notes: Total fertility rates are not shown for areas recording fewer than 5 births.

  NB: These data are currently only available by Statistical Local Area (SLA) and Local Government Area. Data are also not available for PHIDU SLA groups which include areas in Brisbane, Gold Coast, Townsville, Darwin and Canberra. If you wish to view the 2011 SLA data for these grouped areas, see *Table 3: Births, Summary, Statistical Local Area—2006 to 2011*: Births, Australia, 2011. For Medicare Local, Local Hospital Network and SLA groups, see PHIDU's 2005 to 2007 data.

  Source: Compiled by PHIDU based on ABS data in *Table 3: Births, Summary, Statistical Local Area—2006 to 2011 and Table 4: Births, Summary, Local Government Areas—2006 to 2011:* Births, Australia, 2011

- Smoking during pregnancy, 2008 to 2010 (NSW, Qld, SA & ACT), 2009 to 2011 (Vic, WA & Tas), 2006 to 2008 (NT)

  Notes: The data comprise the women who reported that they smoked during a pregnancy, expressed as a proportion of the number of pregnancies. Note that the data may include women who were pregnant more than once during the time period (3 years).

  Source: Compiled by PHIDU based on data from NSW Department of Health (2008 to 2010), Vic Health (2009 to 2011), SA Health (2008 to 2010), WA Department of Health (2009 to 2011), NT Department of Health and Families (2006 to 2008), the Tasmanian Perinatal Database (2009 to 2011), and ACT Health (2008 to 2010)

- Children fully immunised at 1 year of age and 5 years of age, 2011/12

  Notes:

  The data presented are of registered* children fully immunised at 1 year of age and 5 years of age.

  For the purposes of reporting the data, fully immunised means a child receives the vaccinations due at or immediately prior to the age at which the measurement occurs. It is assumed that all previous vaccinations were received.

  The definitions of fully immunised are:

  - **Children aged 1 year:** Fully immunised at 1 year means that a child aged 12 months to less than 15 months received their third vaccination for diphtheria, tetanus, whooping cough and polio and either their second or third vaccination (dependent on the type of vaccine used) for hepatitis B and Haemophilus influenzae type b, all prior to the age of 1 year. It is assumed that all previous vaccinations were received.
  - **Children aged 5 years:** Fully immunised at 5 years means that a child aged 60 to less than 63 months received their fourth or fifth vaccination (dependent on the type of vaccine used) for diphtheria, tetanus and whooping cough, their fourth vaccination for polio and their second vaccination for measles mumps and rubella, all prior to the age of 5 years. It is assumed that all previous vaccinations were received.

  Data are not shown for areas where there were fewer than 26 registered children or fewer than 6 children immunised.

  *Registered on the Australian Childhood Immunisation Register (ACIR). The ACIR is a national register that records vaccinations given to children under seven years old. It also provides immunisation history statements to parents or guardians.

  Source: Compiled by PHIDU based on data provided by the Australian Childhood Immunisation Register, Medicare Australia, 2011/12

- Obesity: four year old boys, 2010–12

  Notes: Four year old boys assessed as being obese on the basis of their measured height and weight as a proportion of all four year old boys assessed.

  Source: Children, Youth and Women's Health Service (CYWHS) (data for three years: 2010 to 2012

- Obesity: four year old girls, 2010–12
- **Notes: Four year old girls assessed as being obese on the basis of their measured height and weight as a proportion of all four year old girls assessed.**

  Source: Children, Youth and Women's Health Service (CYWHS) (data for three years: 2010 to 2012

- Fruit consumption: children aged 5 to 17 years, 2007–08

  Notes: Estimated number of children aged 5 to 17 years with a usual daily intake of two serves of fruit expressed as a rate per 100 population aged 5 to 17 years (modelled estimates from the 2007–08 National Health Survey:

see notes on modelled estimates below, under PERSONAL HEALTH AND WELLBEING). A serve is approximately 150 grams of fresh fruit or 50 grams of dried fruit.

Source: Compiled by PHIDU based on data estimated from the 2007–08 National Health Survey (NHS), ABS (unpublished); and ABS Estimated Resident Population, average of 30 June 2007 and 30 June 2008

- Infant deaths, 2006 to 2010

  Notes: The data presented are of deaths that occurred before 12 months of age.

  Data are not shown for areas where there were fewer than 20 births.

  Source: Compiled by PHIDU based on deaths data supplied by ABS on behalf of State and Territory Registrars of Deaths for 2006 to 2010; and ABS Births, 2006 to 2010

- Child mortality, 2006 to 2010

  Notes: The data presented are of deaths between 1 and 4 years of age.

  Source: Compiled by PHIDU based on deaths data supplied by ABS on behalf of State and Territory Registrars of Deaths for 2006 to 2010; and ABS Estimated Resident Population, 30 June 2006 to 30 June 2010

- Children and young people who are clients of Child and Adolescent Mental health Services (CAMHS), 20008/09 and 2009/10

  Notes: Children and young people aged 0 to 19 years who are clients of the government-funded CAMHS (data over three years: 2005/06 to 2007/08), expressed as an indirectly age-standardised rate per 100,000 population aged 0 to 19 years.

  Data are not shown for areas where there were fewer than 20 births.

  Source: Compiled by PHIDU using data from SA Health, 2005/06 to 2007/08; and ABS Estimated Resident Population, average of 30 June 2006 and 2007

- AEDI: Developmentally vulnerable on 1 or more domains, 2009

  Notes: In 2009, the Australian Early Development Index (AEDI), which provides a picture of early childhood development outcomes for Australia, was undertaken nationwide. In the 2009 data collection, information was collected on 261,147 Australian children (97.5 per cent of the estimated five-year-old population) in their first year of full-time school between 1 May and 31 July. A follow-up data collection occurred in some small areas in 2010. In addition, small numbers of children were combined so that more communities could have their results released.

  The initial results from the AEDI provide communities and schools 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 AEDI results report on the number of children scoring in the following percentile ranges: 0 to 10th percentile (developmentally vulnerable), 11th to 25th percentile (developmentally at risk), 26th to 50th (on track lower range) and above the 50th percentile (on track higher range).

  The data shown include children who were developmentally vulnerable (0 to 10th percentile) in one or more/ two or more domains; children in each domain who were assessed as being developmentally vulnerable (0 to 10th percentile), developmentally at risk (11th to 25th percentile) or developmentally on track (above the 25th percentile).

  Data are not shown for areas where there were fewer than 15 children tested.

  Source for all *Early child development* data: Compiled by PHIDU based on data from the AEDI 2009 Research CURF Version 1, Released August 2011, DEEWR

PERSONAL HEALTH AND WELLBEING

Notes on the following modelled estimates*:* The estimates have been synthetically predicted at the Statistical Local Area (SLA) level from the 2007-08 National Health Survey (NHS), conducted by the ABS: a note on modelled estimates is at http://www.publichealth.gov.au/data_online/notes_estimates_Aust_2007-08.pdf**.**

Users of these modelled estimates should note that they do not represent data collected in administrative or other data sets. As such, they should be used with caution, and treated as indicative of the likely social dimensions present in an area with these demographic and socioeconomic characteristics.

What the modelled estimates do achieve, however, is to summarise the various demographic, socioeconomic and administrative information available for an area in a way that indicates the expected level of each health indicator for an area with those characteristics. In the absence of accurate, localised information about the health indicator, such predictions can usefully contribute to policy and program development, service planning and other decision-making processes that require an indication of the geographic distribution of the health indicator.

The NHS achieves a response rate in excess of 90%. Although the sample includes the majority of people living in private households, it excludes those living in the most remote areas of Australia; whereas these areas comprise less than 3% of the total population, Aboriginal people comprise up to one third of the population in these areas. This and other limitations of the method mean that predictions have not been published for SLAs:

1) with populations under 1,000;

2) in which 50% or more of the population lives in Very Remote areas, as determined by ABS;

3) in which Aboriginal people comprise 75% or more of the population; and

4) where the relative root mean square errors (RRMSEs) on the predictions was 1 or more.

NB: Estimates with RRMSEs from 0.25 and to 0.50 have been marked (~) to indicate that they should be used with caution; and those greater than 0.50 but less than 1 are marked (~~) to indicate that the prediction is considered too unreliable for general use.

Source*:* Compiled by PHIDU based on data estimated from the 2007–08 National Health Survey (NHS), ABS (unpublished); and ABS Estimated Resident Population, average of 30 June 2007 and 30 June 2008

- Fair or poor self-assessed health, persons aged 15 years and over (modelled estimates), 2007–08

  Notes: Respondents aged 15 years and over in the 2007–08 NHS were asked to rate their health on a scale from 'excellent', through 'very good', 'good' and 'fair', to 'poor' health. The data comprise those respondents who rated their health as fair or poor.

- High or very high levels of psychological distress, persons aged 18 years and over (modelled estimates), 2007–08

  Notes: The data have been derived from the Kessler Psychological Distress Scale-10 items (K-10), which is a scale of non-specific psychological distress based on 10 questions asked of respondents about negative emotional states in the 4 weeks prior to interview. 'High' and 'very high' distress are the two highest levels of distress categories (of a total of four categories).

- Type 2 diabetes (modelled estimates), 2007–08[3]

- High cholesterol (modelled estimates), 2007–08

  Notes for *Type 2 diabetes*: The data are self-reported data, reported to interviewers in the 2007–08 NHS. Respondents to the NHS were asked whether they had been diagnosed with any long term health condition (a condition which has lasted or is expected to last for 6 months or more), and were also asked whether they had been told by a doctor or nurse that they had asthma, cancer, heart and circulatory conditions, and/or diabetes3.

- Males with mental and behavioural problems (modelled estimates), 2007–08

- Females with mental and behavioural problems (modelled estimates), 2007–08

  Notes for *Mental and behavioural problems*: The data are self-reported data, reported to interviewers in the 2007–08 NHS. Mental health and behavioural problems/ mood (affective) problems were identified through the self-reported information on long term conditions obtained by the survey. However, unlike the approach used for conditions such as asthma, cancer, heart and circulatory conditions, and/or diabetes, respondents in the survey were not specifically asked whether they had been diagnosed with any mental disorders. The information provided by respondents could therefore be based on self-diagnosis rather than diagnosis by a health professional.

- Obese males, 18 years and over (modelled estimates), 2007–08

- Obese females, 18 years and over (modelled estimates), 2007–08

  Notes for *Obesity data*: The data are self-reported data, reported to interviewers in the 2007–08 NHS. The BMI was calculated from self-reported height and weight information and grouped as follows to allow reporting against

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[3] Note on diabetes estimates from the NHS and other sources:

The figures for all of Australia for type 2 diabetes published in the 2004-05 and 2007-08 National Health Surveys (NHSs) conducted by the Australian Bureau of Statistics (and used as the basis for the synthetic estimates shown here) is substantially lower than the AusDiab figure of 7.6% in 2000; 3.6% in the 2004-05 survey and 4.0% in the 2007-08 survey. The NHS is based on self-reported data: the AusDiab is based on physical and bio-chemical measures taken by qualified people.

The AusDiab figure is comprised of 3.8% diagnosed and 3.8% undiagnosed – that is, AusDiab state that for every one person with known diabetes, there is one unknown. There is good evidence [Qld and SA] to suggest this relationship is an overstatement. Further, the sample was taken in such a way [highly clustered, households replaced where contact could not be made] and respondents attending the test sites 'self-selected' such that bias in the results is clearly possible: the response rate (as distinct from the contact rate) was also very low. The sample also appears to have relatively few disadvantaged people; this would suggest their diagnosed figure is lower than would be achieved from a well-drawn/ executed sample with reasonable response rates across socioeconomic groups. For a comment on some of these issues from a Queensland perspective, see: http://www.mja.com.au/public/issues/180_02_190104/letters_190104_fm-2.html.

Given the problems with the AusDiab data, PHIDU was not prepared to use those data to predict rates in small areas.

The value of the modelled estimates, albeit on this low overall rate, is in showing likely variations between areas.

both World Health Organization and National Health & Medical Research Council guidelines – normal range: 18.5 to less than 20.0 and 20.0 to less than 25.0; overweight: 25.0 to less than 30.0; obese: 30.0 and greater.

- Current smokers, 18 years and over (modelled estimates), 2007–08

  Notes for *Current smokers*: The data are self-reported data, reported to interviewers in the 2007–08 NHS. A current smoker is an adult who reported at the time of interview that they smoked cigarettes, cigars or pipes at least once a week.

- Physical inactivity, persons aged 15 years and over (modelled estimates), 2007–08

  Notes: The data are self-reported data, reported to interviewers in the 2007–08 NHS. Physical inactivity is defined as those aged 15 years and over who did not exercise in the two weeks prior to interview for the 2007–08 NHS, through sport, recreation or fitness (including walking).

- Usual daily intake of two or more serves of fruit, persons aged 18 years and over (modelled estimates), 2007–08

  Notes for *Usual daily intake of fruit* data: The data are self-reported data, reported to interviewers in the 2007–08 NHS. Data includes respondents reporting usually consuming two or more serves of fruit (excluding drinks and beverages) each day. A serve is approximately 150 grams of fresh fruit or 50 grams of dried fruit.

- Median age at death of males, 2003 to 2007
- Median age at death of females, 2003 to 2007

  Source for *Median age at death* data: Data produced by PHIDU based on deaths data supplied by ABS on behalf of State and Territory Registrars of deaths for 2003 to 2007.

- Deaths of males aged 0 to 74 years, 2006 to 2010
- Deaths of females aged 0 to 74 years, 2006 to 2010
- Deaths of persons aged 15 to 24 years, 2003 to 2007

  Source for all *Premature mortality* data: Data produced by PHIDU based on deaths data supplied by ABS on behalf of State and Territory Registrars of deaths for 2003 to 2007 and 2006 to 2010; and ABS Estimated Resident Population, 30 June 2003 to 30 June 2007 and 30 June 2006 to 30 June 2010

- Deaths from suicide and self-inflicted injuries, persons aged 0 to 74 years, 2006 to 2010

  ICD-10 codes: X60-X84, Y87.0, Y10-Y34

  Source for *Premature mortality* data: Data produced by PHIDU based on deaths data supplied by ABS on behalf of State and Territory Registrars of deaths for 2006 to 2010; and ABS Estimated Resident Population, 30 June 2006 to 30 June 2010

- Admissions to hospital: total, 2009/10

  Notes: Admissions to public acute and private hospitals in South Australia, excluding same day admissions for renal dialysis

  Source: Compiled by PHIDU using data from SA Health, 2007/08; and ABS Estimated Resident Population, average of 30 June 2007 and 2008

- Admissions to hospital: potentially avoidable conditions, 2005/06 to 2006/07

  Notes: Hospital admissions resulting from ambulatory care-sensitive conditions (2 years)

  Source: Compiled by PHIDU using data from SA Health, 2005/06 to 2006/07; and ABS Estimated Resident Population, 30 June 2006

- Persons aged 18 years and over who had difficulty accessing services

  See notes on modelled estimates, under COMMUNITY CONNECTEDNESS, below

  Source: Compiled by PHIDU based on modelled estimates from the 2010 General Social Survey, ABS (unpublished); and ABS Estimated Resident Population, 30 June 2010

- HACC: clients living alone, 2010/11

  Notes: Number of clients

  Source: Data produced by PHIDU based on HACC data supplied by the Department of Health and Ageing, 2010/11; average of ABS Estimated Resident Population, 30 June 2010 and 30 June 2011; and ABS Census 2011, Aboriginal Usual Resident Population

- HACC: non-English speaking clients, 2010/11

  Notes: Number of clients

  Source: Data produced by PHIDU based on HACC data supplied by the Department of Health and Ageing, 2010/11; average of ABS Estimated Resident Population, 30 June 2010 and 30 June 2011; and ABS Census 2011, Aboriginal Usual Resident Population

- Clients of community health services, 2009/10

  Notes: Clients of government-funded community health services

  Source: Compiled by PHIDU using data from SA Health, 2007/08; and ABS Estimated Resident Population, average of 30 June 2007 and 2008

- Clients of community mental health services, 2009/10

  Notes: Clients of government-funded community mental health services

  Source: Data produced by PHIDU based on HACC data supplied by the Department of Health and Ageing, 2010/11; average of ABS Estimated Resident Population, 30 June 2010 and 30 June 2011; and ABS Census 2011, Aboriginal Usual Resident Population

- Total residential aged care places per 1,000 population aged 70 years and over, June 2011

  Notes: These data comprise both residential high-level and low-level care places.

  Source: Compiled by PHIDU based on data from the Department of Health and Ageing, June 2011; and ABS Estimated Resident Population, 30 June 2011

COMMUNITY CONNECTEDNESS, 2010

Notes on the following modelled estimates: The ABS 2010 General Social Survey (GSS) includes a range of questions which aim to assess community strength, both in terms of its positive aspects (such as volunteering, tolerance of other cultures and availability of personal supports) and the negative effects on people when community strength is less apparent (such as feeling unsafe in the community, social isolation and the consequences of financial stress and disadvantage). The GSS collected data on the range of social dimensions from the same individual to enable analysis of the interrelationships in social circumstances and outcomes, including the exploration of multiple advantage and disadvantage experienced by that individual. For further information on the indicators, please refer to the *General Social Survey: User Guide, Australia, 2010 (ABS Cat. No. 4159.0.55.002) - Glossary*, available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4159.0.55.002Glossary12010?OpenDocument.

The ABS survey was conducted by personal interview (using a Computer Assisted Interviewing questionnaire) and included people aged 18 years and over resident in private dwellings, throughout the not very remote areas of Australia, from August to November 2010.

The 2010 GSS achieved a response rate of 87.6%, with a total sample from the survey of 15,028 dwellings. Approximately 2,551 respondents (15%) did not provide one or more required answers but were deemed to have responded adequately to be included in the survey.

The modelled estimates presented have been synthetically predicted at the Statistical Local Area (SLA) level from the 2010 GSS.

Through the use of synthetic estimation techniques it is possible to produce SLA level statistics. Synthetic estimation predicts a value for an area with a small population based on modelled survey data and known characteristics of the area. A modelled estimate can be interpreted as the likely value for a 'typical' area with those characteristics. The model used for predicting small area data is determined by analysing data at a higher geographic level, in this case Australia. The relationship observed at the higher geographic level between the characteristic of interest and known characteristics is assumed to also hold at the small area level. The estimates are made by applying the model to data on the known characteristics that can be reliably estimated at the small area level. This modelling technique can be considered as a sophisticated prorating of Australian estimates to the small area level.

The ABS has used various methods to produce small area predictions from a number of surveys. The methods are described in the *Small Area Estimates Manual version 1.0* **which was released in May 2006 and is available on the National Statistical Service website at:**
http://www.nss.gov.au/nss/home.NSF/pages/Small+Areas+Estimates?OpenDocument

Users of these modelled estimates should note that they do not represent data collected in administrative or other data sets. As such, they should be used with caution, and treated as indicative of the likely social dimensions present in an area with these demographic and socioeconomic characteristics.

What the estimates do achieve, however, is to summarise the various demographic, socioeconomic and administrative information available for an area in a way that indicates the expected social dimensions for a typical area in Australia with the same characteristics. In the absence of accurate, localised information about these indicators, such predictions can usefully contribute to policy and program development, service planning and other decision-making processes that require an indication of the geographic distribution of the social indicator.

The published GSS data and these small area estimates differ in scope. The 2010 GSS covered persons residing in urban and rural areas and excluded persons residing in collection districts (CDs) in Very Remote areas under the ABS remoteness classification. As such estimates were not produced for SLAs with more than 50% of their populations residing in Very Remote CDs. Due to the exclusion of persons living in CDs in Very Remote areas of Australia, survey estimates for the majority of SLAs in the Northern Territory are unreliable.

This and other limitations of the method mean that predictions have not been published for SLAs:

1) with populations under 1,000;

2) in which 50% or more of the population lives in Very Remote areas, as determined by ABS;

3) in which Aboriginal people comprise 75% or more of the population; and

4) where the relative root mean square errors (RRMSEs) on the predictions was 1 or more.

NB: Estimates with RRMSEs from 0.25 and to 0.50 have been marked (~) to indicate that they should be used with caution; and those greater than 0.50 but less than 1 are marked (~~) to indicate that the prediction is considered too unreliable for general use.

Note re additional data (Victoria only): In Victoria, indicators of community strength are collected via computer-assisted telephone interviewing as part of the Victorian Population Health Survey conducted by the Department of Health. Data estimates are available at the Local Government Area. See: http://www.health.vic.gov.au/healthstatus/survey/vphs.htm

Source: Compiled by PHIDU based on modelled estimates from the 2010 General Social Survey, ABS (unpublished); and ABS Estimated Resident Population, 30 June 2010

http://www.health.vic.gov.au/healthstatus/survey/vphs.htm

- Persons aged 18 years and over who are able to get support in times of crisis from persons outside the household (modelled estimates), 2010
- Persons aged 18 years and over who disagree/strongly disagree with acceptance of other cultures (modelled estimates), 2010
- Persons aged 18 years and over who had government support as their main source of income, for 12 months or more, within the past 24 months (modelled estimates), 2010
- Persons aged 18 years and over who accessed the Internet at home in the past 12 months (modelled estimates), 2010

PERSONAL AND COMMUNITY SAFETY, 2010

Notes: See notes on modelled estimates above, under COMMUNITY CONNECTEDNESS.

- Persons aged 18 years and over who feel very safe/safe walking alone in local area after dark (modelled estimates), 2010