Local Government Association of South Australia

Government of South Australia
SA Health

parks and gardens

sporting and leisure facilities

information services

POPULATION HEALTH PROFILE

safe food

arts and culture

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emergency management

Mount Gambier

climate change management

youth development

community centres and halls

safe roads

events

urban planning

volunteering

street lighting

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safe water

economic development

partnerships

immunisation

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September 2019

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Introduction

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

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

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

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

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

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

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

Purpose of this profile

This population health profile has been prepared to support Mount Gambier in the preparation of its RPHP under s.51 of the Act. The profiles contain a selection of indicators of public and population health and their determinants, drawn largely from data published for Local Government Areas (LGAs) and Population Health Areas (PHAs) by the Public Health Information Development Unit (PHIDU), as part of the Social Health Atlases series available on line at http://atlasesaustralia.com.au/LGASA/LGA_PH_Act.html.

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

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

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

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

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

The SA Public Health Indicator Framework

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

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

Report content

This report comprises statistics for Mount Gambier. The first section presents charts (population pyramids) depicting the age structure in the Local Government Area (LGA) of Mount Gambier and providing comparisons with the age structure in Regional SA[1] and the Population Health Area (PHA – see Box) in the LGA, namely Mount Gambier[2].

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

The remainder of the report is comprised of commentary on a table of selected population health indicators (Table 1 – pages 7 and 8). The table is structured so as to highlight differences in the percentage, rate or other measure for the indicator value in Mount Gambier from that in Regional SA by means of shading. Cells shaded in green indicate a relatively good outcome, whereas cells in shades of black indicate a relatively poor outcome, or a possible challenge for local government authorities. Note that indicators are only shaded in one colour and that some indicators are not shaded at all.

The commentary consists of a statement as to the value of the indicator for regional public health planning, with reference to its value for work by Local Government under the Public Health Act 2011. This is followed by the definition of the indicator and a description of the variation in the percentage, rate or other measure, for each indicator in Table 1, between the geographic areas mapped. In many cases comment is made on changes in the data since the first report was produced.

This PDF copy is supported up by an online atlas, a workbook comprising the data presented in Table A1 including the numbers (numerator and denominator) associated with the percentages shown in the table, and detailed notes on the data (data sources, etc.).

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

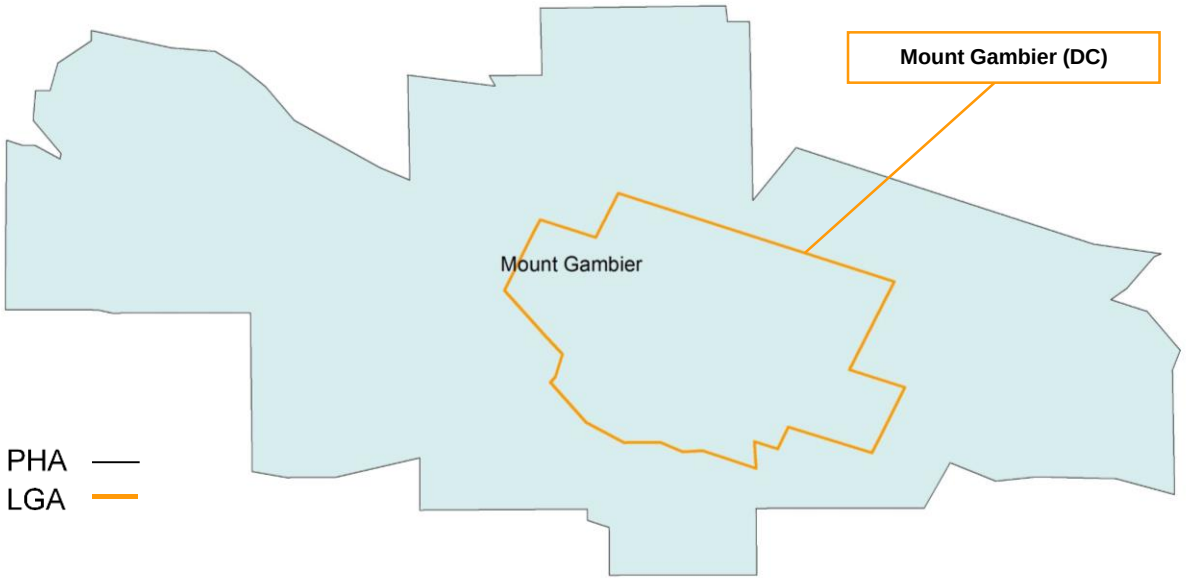
Population Health Areas

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

A list of PHAs in each council area can be found **here** and is also shown in Table 1.

1 Regional SA refers to the area of the state excluding Metropolitan Adelaide (which is the area from Gawler in the north, southwards down the Mt Lofty Ranges to Sellicks Beach, and including Mount Barker).
2 Note the values represented in this report for the PHA of Mount Gambier are for the whole PHA, although only 91.6% of the population of the PHA falls within the Mount Gambier LGA.

Map 1: Mount Gambier and its respective PHA



Data quality

The data for a majority of the indicators published in this report were provided to PHIDU at the Statistical Areas Level 2 (SA2) or Population Health Area (PHA) level. In many instances the boundaries of these areas do not coincide with the boundaries of LGAs. In order to produce data for LGAs from the SA2 or PHA data, PHIDU has used correspondence files from the Australian Bureau of Statistics (ABS) to allocate whole or part SA2s and PHAs to LGAs. As these correspondences are based on the total population in each SA2 or PHA part which falls within an LGA, their application to other data (e.g., immunisations, income support payments, women smoking during pregnancy) does not necessarily provide an accurate result for the LGA. The indicators likely to be affected are listed in Table A1, in the Appendix.

This concern is of relevance to Mount Gambier LGA, as the LGA comprises 91.6% of the population of the PHA of Mount Gambier. Where the data are only available for the PHA (as per the examples in the previous paragraph), the text does not refer to the LGA, only to the PHA.

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

Nomenclature

South Australian LGA Status

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

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

Terminology

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

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

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Table 1: Selected indicators of population health and its determinants, Mount Gambier compared with Regional SA

Indicators	**Mount Gambier (C)**	*Mount Gambier**	Metro Adelaide	**Regional SA**	South Australia	Australia
Population Profile, 2016 (Per cent, Index)						
Born overseas in predominantly non-English speaking countries	**6.2**	6.0	17.1	**4.7**	14.3	17.9
- country 1 of top three for LGA - Myanmar	**0.7**	0.7	0.1	**0.1**	0.1	0.1
- country 2 of top three for LGA - Netherlands	**0.6**	0.6	0.4	**0.5**	0.4	0.3
- country 3 of top three for LGA - Italy	**0.6**	0.6	1.3	**0.3**	1.1	0.7
Born overseas & reports having poor proficiency in English	**0.9**	0.9	2.8	**0.6**	2.3	2.9
Permanent migrants entering Australia under the Humanitarian Program	***1.6***	*1.6*	*1.4*	***0.2***	*1.2*	*0.9*
- arrived between 2000 and 2006	**0.0**	0.0	0.5	**0.0**	0.4	0.3
- arrived between 2007 and 2011	**0.9**	0.9	0.5	**0.1**	0.4	0.3
- arrived between 2012 and 9th August 2016	**0.7**	0.7	0.4	**0.1**	0.3	0.2
Permanent migrants entering Australia on a Family stream visa	***1.6***	*1.6*	*1.4*	***0.2***	*1.2*	*0.9*
- arrived between 2000 and 2006	**0.3**	0.3	0.7	**0.3**	0.6	1.1
- arrived between 2007 and 2011	**0.2**	0.2	0.8	**0.2**	0.6	1.0
- arrived between 2012 and 9th August 2016	**0.1**	0.1	0.7	**0.2**	0.6	0.7
Permanent migrants entering Australia on a Skill stream visa	***1.2***	*1.2*	*5.7*	***1.2***	*4.6*	*5.1*
- arrived between 2000 and 2006	**0.4**	0.4	1.6	**0.4**	1.3	1.9
- arrived between 2007 and 2011	**0.5**	0.5	2.6	**0.6**	2.1	2.1
- arrived between 2012 and 9th August 2016	**0.3**	0.3	1.5	**0.2**	1.2	1.1
Aboriginal and Torres Strait Islander people	**2.7**	2.6	1.7	**5.0**	2.5	3.3
People who provide unpaid assistance to others	**11.8**	11.9	12.2	**12.2**	12.2	11.3
People with a profound or severe disability and living in the community: all ages	**5.7**	5.5	5.2	**5.6**	5.3	4.7
People with a profound or severe disability and living in the community: 0 to 64 yrs	**4.1**	4.0	3.4	**3.8**	3.5	2.9
People with a profound or severe disability and living in the community: 65 yrs & over	**13.0**	12.5	14.1	**12.3**	13.6	14.3
Index of Relative Socio-economic Disadvantage	**925**	936	989	**945**	979	1000
Employment, June 2017 (Per cent)						
Unemployment beneficiaries: total	**n.a.**	7.9	6.3	**8.6**	6.8	5.2
Unemployment beneficiaries: six months or longer	**n.a.**	6.9	5.4	**7.5**	5.8	4.3
Unemployment beneficiaries: young people	**n.a.**	5.2	3.8	**5.9**	4.2	3.4
Education (Per cent)						
Aged 16 years and not participating in full-time secondary education, 2016	**14.1**	14.5	12.0	**17.1**	13.3	15.9
School leavers admitted to university, 2018	**n.a.**	10.8	32.2	**18.1**	28.9	22.2
Children whose mother has low educational attainment, 2016	**18.7**	17.7	13.6	**16.8**	14.3	17.0
Young people learning or earning, 2016	**83.8**	84.7	86.6	**80.3**	85.3	84.3
Income and wealth (Per cent)						
Children in low income, welfare-dependent families, June 2017	**n.a.**	25.8	23.0	**27.6**	24.0	20.9
Age Pension recipients, June 2017	**n.a.**	71.8	67.9	**69.9**	68.5	63.6
Disability Support Pension recipients, June 2017	**n.a.**	8.1	6.3	**8.6**	6.7	5.3
Pensioner Concession Card holders, June 2017	**n.a.**	28.0	23.4	**30.3**	25.0	20.3
Health Care Card holders, June 2017	**n.a.**	8.8	8.4	**9.0**	8.5	7.3
Household crowding, 2016	**1.8**	1.8	2.8	**1.9**	2.6	3.7
Mortgage stress, 2016	**7.0**	6.8	8.5	**9.4**	8.7	9.3
Rental stress, 2016	**27.7**	27.5	29.7	**26.7**	29.0	27.3
Rented social housing, 2016	**9.5**	8.7	6.4	**6.1**	6.3	4.2
Recipients of rent relief from Centrelink, June 2017	**n.a.**	17.6	15.7	**15.6**	15.7	16.2
No motor vehicle, 2016	**7.3**	6.8	8.0	**5.7**	7.5	7.5

Table 1: Selected indicators of population health and its determinants, Mount Gambier compared with Regional SA…*cont*

Indicators	**Mount Gambier (C)**	*Mount Gambier**	Metro Adelaide	**Regional SA**	South Australia	Australia
Early life and childhood (Per cent, Rate)						
Total fertility rate, 2013-15	**2.07**	2.04	1.79	**2.19**	1.85	1.88
Women smoking during their pregnancy, 2012-14	**n.a.**	18.1	12.3	**21.1**	14.1	10.8
Immunisation at 1 yr of age, 2017	**92.0**	92.0	94.0	**94.9**	94.3	94.0
Immunisation at 5 yrs of age, 2017	**94.6**	94.6	93.6	**94.5**	93.8	94.0
Obesity: males aged 2-17, 2014-15	**n.a.**	7.0	6.6	**7.0**	6.7	6.7
Obesity: females aged 2-17, 2014-15	**n.a.**	7.3	6.7	**7.2**	6.8	8.4
Fruit consumption: children aged 4 to 17 years, 2014–05	**n.a.**	67.8	65.3	**66.4**	65.6	66.3
Infant death rate, 2011–15	**3.2**	3.2	2.6	**3.9**	2.9	3.5
Children and young people who are clients of CAMHS, 2015/16-2017/18	**2,751.8**	2,727.2	1,303.9	**2,380.9**	1,553.1	n.a.
AEDC: Children developmentally vulnerable on one or more domains, 2015	**..**	28.6	23.0	**25.3**	23.5	22.0
Personal health and wellbeing (Per cent, Rate)						
Self-assessed health as fair, or poor, 2014-15	**n.a.**	17.6	15.6	**17.0**	15.9	14.8
High/ Very high levels of psychological distress, 2014-15	**n.a.**	13.0	13.9	**13.0**	13.7	11.7
Type 2 diabetes, 2014–15	**n.a.**	4.7	4.3	**4.7**	4.4	4.4
Mental health problems: males, 2014–15	**n.a.**	18.9	16.8	**19.3**	17.3	15.8
Mental health problems: females, 2014–15	**n.a.**	20.8	19.0	**21.2**	19.4	19.2
Smoking, 2014-15	**n.a.**	14.7	14.2	**18.0**	15.0	16.1
Obese males, 2014-15	**n.a.**	35.0	26.6	**34.2**	28.2	28.4
Obese females, 2014-15	**n.a.**	38.6	29.9	**38.1**	31.6	27.5
Physical inactivity, 2014-15	**n.a.**	73.3	67.0	**73.2**	68.2	66.3
Fruit consumption: adults, 2014-15	**n.a.**	45.8	49.0	**46.2**	48.5	49.9
Median age at death: males, 2010–14[†]	**78.0**	78.0	80.0	**78.0**	79.0	78.0
Median age at death: females, 2010–14[†]	**84.0**	84.0	85.0	**84.0**	85.0	84.0
Premature mortality: males, 2011–15	**354.6**	349.4	288.0	**332.3**	301.1	293.9
Premature mortality: females, 2011–15	**223.7**	225.0	181.4	**197.9**	186.3	182.2
Premature mortality: 15 to 24 yrs, 2011–15	**37.6**	38.0	29.4	**56.2**	34.6	37.4
Premature mortality from suicides, 2011–15	**14.8**	14.7	12.5	**14.0**	12.9	11.5
Admissions to hospital: total, 2016/17	**32,098.8**	32,641.1	36,465.0	**34,457.8**	35,977.6	39,628.3
Admissions to hospital: potentially avoidable conditions, 2016/17	**3,042.4**	3,111.6	2,891.6	**3,190.9**	2,965.0	2,988.4
Difficulty accessing healthcare, 2014	**n.a.**	1.6	1.2	**1.2**	1.2	2.0
HACC clients living alone, 2014/15	**n.a.**	35.9	37.4	**31.3**	35.8	37.1
HACC: Non-English speaking clients, 2014/15	**n.a.**	8.0	19.4	**11.4**	17.4	14.7
Clients of community mental health services, 2015/16-2017/18	**4,204.9**	4,205.0	1,892.9	**3,104.6**	2,178.7	n.a.
Residential aged care places per 1,000 population aged 70 yrs & over, June 2016	**n.a.**	100.0	95.4	**81.5**	91.7	82.6
Community connectedness (Per cent, Rate)						
Able to get support in times of crisis, 2014	**n.a.**	94.2	93.9	**94.1**	93.9	94.3
Disagree/strongly disagree with acceptance of other cultures, 2014	**n.a.**	6.2	4.6	**6.6**	5.0	4.5
Government support as main source of income in last 2 years, 2014	**n.a.**	36.0	31.0	**36.8**	32.3	27.1
Accessed the Internet at home in the past 12 months, 2016	**75.1**	75.8	82.3	**75.0**	80.6	83.2
Personal and community safety, 2014 (Rate)						
Feel very safe/safe walking alone in local area after dark	**n.a.**	35.3	49.7	**57.6**	51.3	52.4

[†]Median age is shown in years

**Note the values represented here are for the entire Mount Gambier PHA although only 91.6% of the population of the area falls within the Mount Gambier LGA*

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

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

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

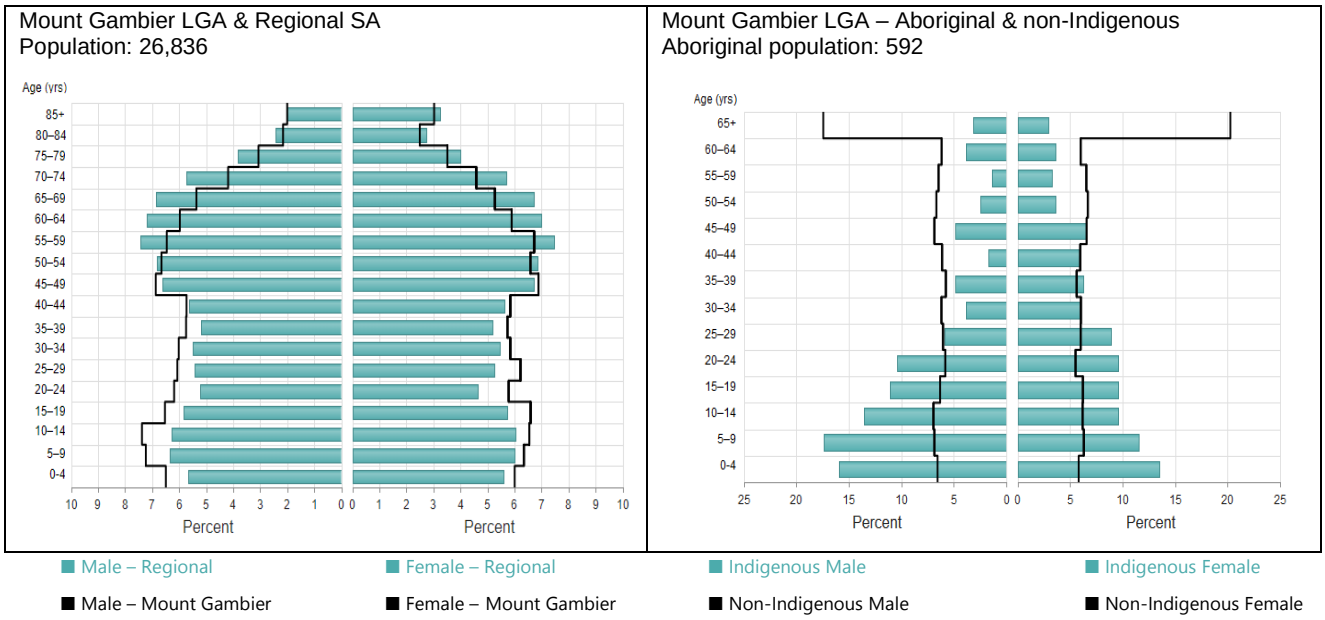
Good outcome		50% or more above metropolitan average		30-49% above metropolitan average		10-29% above metropolitan average		within +/- 10% of metropolitan average		10% or more below metropolitan average
Poor outcome		50% or more above metropolitan average		30-49% above metropolitan average		10-29% above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

1. The age structure of the population

Mount Gambier has an age profile that is similar to that of Regional SA however it was slightly younger; with slightly more children, young people, young adults, and persons aged 20-39. However there were less persons in 55-84 age groups (Figure 1).

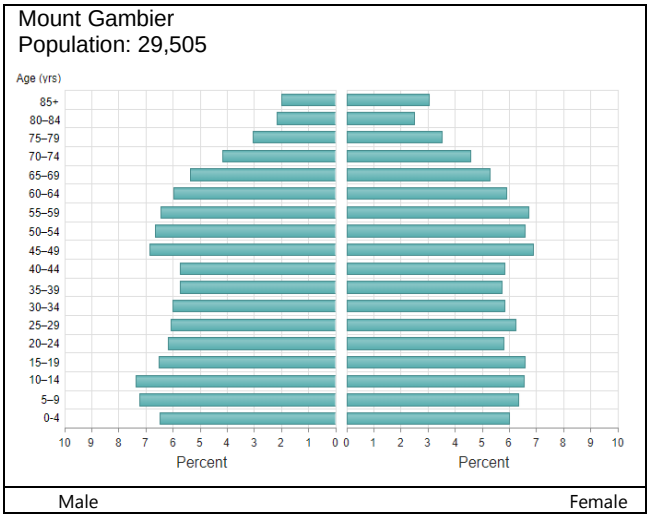
The Aboriginal population (of 592 people, as recorded at the 2016 Census) has a markedly different profile to that of the non-Indigenous population, with more children, young people and young adults, and fewer males aged 30 to 49 years. The most notably difference is among those aged 50 years and over (Figure 1). Note: See the indicator 'Aboriginal and Torres Strait Islander people', below, for details of the estimated resident population of Aboriginal people – generally a larger number than the Census figure (in this case 728), but for which age group data are not available by LGA.

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



There was little or no variation between the age profile of Mount Gambier and the PHA of Mount Gambier

Figure 2: Age profile comparisons, Mount Gambier, 2016



Age pyramids for these and other areas can be viewed on the PHIDU website.

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

2. Population profile

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

Rationale

Indicator definition:

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

Australia's population has been and continues to be shaped by international migration. However, for many who arrive without proficiency in English, the combination of economic struggle with adjustment to a new language and a new cultural milieu can be expected to give rise to considerable stresses. Although a relatively small group, they also pose special challenges for deliverers of health, education, welfare and other community services. [9] Despite common experiences including those relating to migration and dislocation, this population is far from a homogeneous group. There is great diversity in language, culture, religion, socioeconomic status, education and age structure. [9] 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] Similarly, South Australia's population and demographic profile has historically been influenced by immigration, particularly from the post-war period.

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

Our council

The number of people born in non-English speaking countries at the 2016 Census was 1,630, or 6.2% of Mount Gambier's population; this almost a third more than in Regional SA overall (4.7%).

The three largest source (non-English speaking) countries for the South Australian population at the 2016 Census were China, India and Italy: However, Myanmar (192 people, 0.7% of the population, being over twelve times the level in Regional SA overall), Netherlands (157 people, 0.6%), and Italy (156 people, 0.6%) provided the largest populations in Mount Gambier. There were similar proportions of each of these groups in the PHA of Mount Gambier.

2.2. People born overseas and reporting poor proficiency in English

Rationale

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

Indicator definition:

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

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

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

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).

Our council

Consistent with the information above, the proportion of the population in Mount Gambier reporting not speaking English well, or at all at the 2016 Census was over one and a half times the level in Regional SA overall (0.9% and 0.6%, respectively), with the same proportion in the PHA of Mount Gambier.

2.3. Migration Program and Humanitarian Program

Rationale

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

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

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

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

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

Note: Details of the period of arrival (2000 to 2007, 2007 to 2011 and 2012 to 2016) are available in Table 1 and the workbook available online.

2.3.1. Humanitarian Program

Rationale

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

Indicator definition:

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

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

Our council

In Mount Gambier, an estimated 1.6% of the total population entered Australia as part of the Humanitarian Program, over six times the level in Regional SA (0.2%).

The majority of this population group has arrived since 2007, with those arriving between 2007 and 2011 almost seven times, and for those arriving between 2012-9th August 2016 over eight times, the level in Regional SA (0.1%). The PHA of Mount Gambier had the same proportions.

2.3.2. Family stream

Rationale

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

Indicator definition:

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

Our council

There were an estimated 160 people living in Mount Gambier at the 2016 Census (0.6% of the population) who had entered Australia under the Family stream since 2000, below the level recorded in Regional SA (0.8%). The PHA of Mount Gambier had the same proportion The PHA of Mount Gambier had the same proportion.

2.3.3. Skill stream

Rationale

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

Indicator definition:

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

Our council

There were an estimated 316 people in Mount Gambier in 2016 who had entered Australia on a Skill stream visa since 2000 (1.2% of the population), slightly above the level in Regional SA overall (1.2%). The PHA of Mount Gambier had the same proportion.

2.4. Aboriginal and Torres Strait Islander people

Rationale

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

Indicator definition:

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

The Aboriginal population is considerably younger than the non-Indigenous population, reflecting higher fertility and lower life expectancy. In 2016, the median age for this population was 23.0 years, 17 years less than the state's median age of 40.0 years.[21] About one in three (33.4%) Aboriginal people were aged less than 15 years, while just 4.6% were aged 65 years and over.[21] The Aboriginal population predominantly lives in South Australia's most populous areas, with 53.8% living in the Greater Adelaide area, and 45.4% living in the rest of the State.[21]

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

Our council

As noted above, there were 592 people who reported in the 2016 Census that they were of Aboriginal and/or Torres Strait Islander descent. Following the Census, the Australian Bureau of Statistics (ABS) has estimated that there were 728 people of Aboriginal and/or Torres Strait Islander descent living in Mount Gambier at 30 June 2016, comprising 2.7% of the population, just over half the Regional SA average (5.0%). The PHA of Mount Gambier had a similar proportion (2.6%).

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

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

Rationale

Unpaid activities undertaken by individuals represent a significant contribution to society and the economy. This includes caring for the aged, those with a long-term illness, or those with a disability. In Australia, it is estimated that over 21.4 billion hours of unpaid care work were undertaken in the 2009-10 financial year.[23,24] 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.

Indicator definition:

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

While there are benefits from the care economy to society at large, unpaid care can affect one's ability to fully participate in paid employment.[25] 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.[25]

Our council

The proportion of the population in Mount Gambier who provided unpaid care, help or assistance to family members or others because of a disability, a long-term illness or problems related to old age was 11.8% and was generally consistent with the Regional SA average of 12.2%. The PHA of Mount Gambier had a similar proportion (11.9%).

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

Rationale

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

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

Indicator definition:

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

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

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.

Our council

The proportion of the population in Mount Gambier (5.7%) with a profound or severe disability and living in the community was consistent with the proportion recorded in Regional SA (5.6%). The younger age group (0 to 64 years) comprised 4.1% of Mount Gambier's population) and the older group (65 years and over) comprised 13.0%; both proportions were slightly above the respective levels in Regional SA.

There were similar proportions of each of these groups in the PHA of Mount Gambier.

2.6. Summary measure of disadvantage: IRSD

Rationale

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

Indicator definition:

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

Our council

The IRSD score for Mount Gambier of 925 was just below that of 945 in Regional SA. Although the score in the PHA of Mount Gambier was marginally higher (936) it was still below score in Regional SA.

3. Employment

3.1. People receiving unemployment benefits

Rationale

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

Indicator definition:

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

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

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

Our council

There were 1,417 people receiving an unemployment benefit in the PHA of Mount Gambier, comprising 7.9% of the population aged 16 to 64 years; this was just below the level in Regional SA (8.6%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Indicator definition:

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

Our council

Almost as many people in the PHA of Mount Gambier were receiving an unemployment benefit for more than six months (1,230 people, 6.9% of the population aged 16 to 64 years) as the total of those getting this benefit (1,417, 7.9%). The long-term rate was just below the average for Regional SA (7.5%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Our council

Young people in the PHA of Mount Gambier aged 16 to 24 receiving an unemployment benefit comprised 5.2% of their age group, notably (11%) below the level in Regional SA, of 5.9%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Indicator definition:

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

4. Education

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

Rationale

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

Indicator definition:

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

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

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

Our council

As recorded in the 2016 Census, 14.1% of young people aged 16 in Mount Gambier were not participating in full-time secondary school education, notably below the level in Regional SA. of 17.1%.

4.2. School leavers enrolling in higher education

Rationale

Higher education refers to education which usually results in the granting of a bachelor's degree or higher qualification. Higher education contributes to South Australia's intellectual, economic, cultural and social development, and the long term prosperity of the State will be influenced by the future activities of higher education graduates.[37] 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.[37] Despite the Global Financial Crisis and the end of the mining boom impacting on the earning of early career graduates, degree holders continue to enjoy a significant income premium over Year 12 holders[38]. For students not enrolling in higher education, there remain other opportunities for training and skills development and pathways to future employment.

Indicator definition:

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

Our council

In the PHA of Mount Gambier, only 10.8% of school leavers who attained a Year 12 certificate in 2017 were enrolled in higher education in 2018, markedly (41%) fewer than in Regional SA overall (18.1%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

4.3. Children whose mother has low educational attainment

Rationale

Strong relationships between education and health outcomes exist in many countries, favouring the survival and health of children born to educated parents, especially mothers; but the pathways are culturally and historically complex and vary between and within countries.[39,40] 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.[40-42] 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.[42]

Indicator definition:

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

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.[42]

Our council

There were notably more children in Mount Gambier aged less than 15 years whose mother had low educational achievement, comprising 18.7% of children in that age group compared with 16.8% in Regional SA. There was a slightly lower proportion in the PHA of Mount Gambier (17.7%).

4.4. Young people learning or earning

Rationale

Indicator definition:

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

Levels of participation in education and the labour market are indicators of the wellbeing of young people.[43] Research suggests that young people who are not fully engaged in education or work (or a combination of both) are at greater risk of school failure, unemployment, cycles of low pay, employment insecurity in the longer term, social exclusion, economic and social disadvantage [46], and poorer health and wellbeing.[44] The experience of unemployment harms a young person's financial and psychological wellbeing, and these effects are felt more severely by those who experience long-term unemployment.[161] Furthermore, those who experience unemployment while young are more likely to be unemployed, have poor health and have lower educational attainment when they are older, than those who are not affected by unemployment while young.[161] 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.[42,45]

Our council

The proportion of the population in Mount Gambier aged 15 to 24 years who were earning or learning as recorded in the 2016 Census was just above the level in Regional SA, with proportions of 83.8% and 80.3% respectively. There was a slightly higher proportion in the PHA of Mount Gambier (84.7%).

5. Income and wealth

5.1. Children in low income, welfare-dependent families

Rationale

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

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.[41,48] This can affect children and young people in the family through reduced provision of appropriate housing, heating, nutrition, medical care and technology.[49]

Indicator definition:

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

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.[50] 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.[51]

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

Our council

There were slightly fewer children in the PHA of Mount Gambier aged less than 16 years living in a in low income, welfare-dependent family (25.8%), when compared with Regional SA (27.6%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

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

5.2.1. Recipients of the Age Pension

Rationale

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

Indicator definition:

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

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.

Our council

Nearly three quarters (71.8%) of the population in the PHA of Mount Gambier aged 65 years and over was in receipt of an Age Pension in June 2017; this was slightly above the level in Regional SA, of 69.9%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

5.2.2. Recipients of the Disability Support Pension

Rationale

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

Indicator definition:

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

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

Our council

Almost one in twelve people in the PHA of Mount Gambier aged 16 to 64 years were receiving a Disability Support Pension, slightly below the level in Regional SA, of 8.6%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

5.2.3. People who hold a Pensioner Concession Card

Rationale

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

Indicator definition:

People in receipt of a Pensioner Concession Card from the Department of Human Services as a proportion of the population aged 15 years and over (June 2017).

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

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

Our council

Some 28.0% of the population in the PHA of Mount Gambier aged 15 years and over had a Pensioner Concession Card in June 2017, 8% below the level in Regional SA (30.3%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

5.2.4. People who hold an Australian Government Health Care Card

Rationale

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

Indicator definition:

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

Our council

In addition to those on a Pensioner Concession Card, 8.8% of the population in the PHA of Mount Gambier under 65 years had a Health Care Card, consistent with the level in Regional SA overall (9.0%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

5.3. Household crowding

Rationale

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

Indicator definition:

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

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

Our council

Some 1.8% of dwellings in Mount Gambier were assessed as requiring extra bedrooms, consistent with the level in Regional SA overall (1.9%). The PHA of Mount Gambier had the same proportion.

5.4. Housing stress and rent relief

5.4.1. Low income households under mortgage stress

Rationale

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

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.

Increasing numbers of families are experiencing mortgage stress, and are at risk of homelessness, and poorer wellbeing. [65] Housing stress is rising due to low investment in public housing, demographic shifts and increases in the number of households including through family breakdown; and a tendency for more affluent people to want to live in the inner city, which increases rents and forces low income earners out of even relatively low standard housing. [66] A household that is in stress is less likely to contribute to or participate in community life due to financial constraints. This issue can further manifest in other ways such as restricting one to live in lower priced areas thus minimising employment opportunities, delay family formation or cause family breakdown.[67]

Our council

The extent of mortgage stress in Mount Gambier (245 households, or 7.0% of low-income households) was markedly (26%) below the level in Regional SA overall (9.4%). There was a slightly lower proportion in the PHA of Mount Gambier (6.8%).

5.4.2. Low income households under rental stress

Rationale

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

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.

As it is almost impossible for all but the most disadvantaged families to access public housing, renting privately has become the only housing option for low income households. For many low-income households who rent, shortages of affordable rental housing, rising rents and stagnant rent relief, and tight vacancy rates are factors that exacerbate their position and move them closer to the poverty line.[65] 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.[68] A household that is in stress is less likely to contribute or participate in community life due to financial constraints. This issue can further manifest in other ways such as restricting one to live in lower priced areas thus minimising employment opportunities, delay family formation or cause family breakdown.[67]

Our council

There were slightly more low-income households in Mount Gambier who experienced rental stress when compared to Regional SA overall, with proportions of 27.7% and 26.7%, respectively. The PHA of Mount Gambier had a similar proportion (27.5%).

5.4.3. Rented social housing

Rationale

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

Indicator definition:

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

Social housing includes rental housing owned and managed by Housing SA or a housing co-operative, community or church group; social housing rents in general are set below market levels and determined by household income.[69] The social housing services system seeks to provide low income people with access to housing assistance; supporting their wellbeing and contributing to their social and economic participation by providing services that are timely and affordable, safe, appropriate (meeting the needs of individual households), high quality and sustainable.[70] The

distribution of social rental housing remains an indicator of socioeconomic disadvantage, with tenants increasingly welfare-dependent (especially single parents; those who are unemployed, aged or with a disability; and Aboriginal and Torres Strait Islander people).

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

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

Our council

There were over one and a half times more social housing dwellings available for rent in Mount Gambier than in Regional SA overall, with proportions of 9.5% and 6.1% respectively. There were slightly fewer of these dwellings in the PHA of Mount Gambier (8.7%).

These households are likely to have more people reporting their health as fair or poor (rather than good, very good or excellent); relatively high rates of non-communicable diseases and risk factors such as smoking; and strong associations with children assessed in their first year of school as developmentally vulnerable in two or more domains under the Australian Early Development Census.

5.4.4. Recipients of rent relief

Rationale

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

Indicator definition:

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

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

Our council

The proportion of households receiving rental assistance from the Australian Government in the PHA of Mount Gambier (17.6%) was notably above the level in Regional SA (15.6%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

5.5. No motor vehicle

Rationale

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

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.[75]

Indicator definition:

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

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

Our council

The proportion of households in Mount Gambier (7.3%) without access to a motor vehicle at the time of the Census was a markedly above the level in Regional SA Regional SA (5.7%). There was a slightly lower proportion in the PHA of Mount Gambier (6.8%).

6. Early life and childhood

6.1. Total fertility rate

Rationale

Fertility is an important component of population change (particularly population age-structure), and low fertility has implications for a population's ability to sustain itself. [76] 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. [76]

Indicator definition:

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

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

Our council

The total fertility rate in Mount Gambier (2.07) was slightly below the level in Regional SA (2.19); the rate in the PHA (2.04) was marginally lower than in the LGA.

6.2. Women smoking during pregnancy

Rationale

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

Indicator definition:

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

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

Our council

In the PHA of Mount Gambier 18.1% of women reported smoking during their pregnancy, notably (14%) below the level in Regional SA, of 21.1%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

6.3. Childhood immunisation

Rationale

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

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

Indicator definition:

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

6.3.1. At one year of age

Our council

Some 92.0% of infants in Mount Gambier at one year of age were fully immunised in 2017, just below the Regional SA level, of 94.6%.

6.3.2. At five years of age

Our council

The proportion of children in Mount Gambier who were fully immunised at five years of age (94.6%) was consistent with the level in Regional SA (94.5%).

Indicator definition:

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

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

Rationale

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

Indicator definition:

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

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

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

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

6.4.1. Males

Our council

It is estimated that, in 2014–15, 7.0% of males in the PHA of Mount Gambier aged from two to 17 years were obese; this was the same as the Regional SA rate.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

6.4.2. Females

Our council

The estimated rate of obesity in 2014–15 for female children in the PHA of Mount Gambier aged from two to 17 years (7.3%), was consistent with the Regional SA rate, of 7.2%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

6.5. Daily fruit consumption at ages 4 to 17 years

Rationale

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

Indicator definition:

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

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

Our council

More than two thirds (67.8%) of children aged from 4 to 17 years in the PHA of Mount Gambier were estimated to have met the guideline for fruit consumption, marginally above the level in Regional SA, of 66.4%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

6.6. Infant death rate

Rationale

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

Indicator definition:

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

Our council

In the five years from 2011 to 2015, there were five infant deaths in Mount Gambier, a rate of 3.2 deaths per 1,000 live births; this was 18% below the rate in Regional SA overall (3.9 deaths per 1,000 live births). The PHA of Mount Gambier had the same rate.

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

Indicator definition:

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

Rationale

Mental health problems affect significant numbers of children and young people each year. Approximately 14% of 12-17 year olds and 27% of 18-25 year olds experience such problems each year; and 75% of mental health problems emerge before the age of 25.[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.

Our council

There were 597 clients of the Child and Adolescent Mental Health Service living in Mount Gambier (2,751.8 per 100,000 population aged 0 to 19 years), notably (16%) above the Regional SA rate of 2,727.2 per 100,000 population aged 0 to 19 years.

Note that the data reported for this variable are estimated from the PHA of Mount Gambier, as data were not available at the LGA level.

6.8. Early childhood development

Rationale

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

Indicator definition:

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

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

Our council

In the PHA of Mount Gambier, 28.6% of children in their first year of school were assessed as being developmentally vulnerable on one or more domains of the AEDC in 2015, notably above the level in Regional SA, of 25.3%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7. Personal health and wellbeing

7.1. Self-assessed health as fair or poor

Rationale

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

Indicator definition:

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

Australians generally consider themselves to be healthy. In 2017–18, over half (56.4%) of Australians aged 15 years and overrated their health as ‘very good’ or ‘excellent’, while only 3.7% rated it as ‘poor’. [90] Older Australians generally rated themselves as having poorer health than younger people, with persons aged 75-84 years and 85 years and over recording the highest proportions of fair or poor health, at 30.9% and 35.8% respectively. [90] There was little difference in the way men and women assessed their overall health, with men slightly more likely to report their health as fair or poor other than at ages 85 years and over, where almost one third more women than men reported poorer health.[90]

Our council

It is estimated that 17.6% of people in the PHA of Mount Gambier aged 15 years and over reported their health as fair or poor (and not as good, very good or excellent) consistent with level in Regional SA overall (17.0%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.2. High or very high levels of psychological distress

Rationale

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

Indicator definition:

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

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

Our council

The estimated level of psychological distress (as high or very high) in the PHA of Mount Gambier was 13.0 per 100 population aged 18 years and over, or 13.0%, the same rate as in Regional SA overall.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.3. Type 2 diabetes

Rationale

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

Indicator definition:

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

The main types of diabetes include, type 1, type 2 and gestational diabetes. In 2017-18, it was estimated in the National Health Survey that 92,000 South Australians (5.6%) aged 18 years and over had diabetes mellitus. [93] The prevalence of diabetes tripled between 1989-90 and 2014-15 with males, the elderly, Indigenous Australians and those in

remote areas or socioeconomically disadvantaged areas at a higher risk of developing this condition and have much greater hospitalisation and death rates from diabetes than other Australians. Further, diabetes prevalence was almost twice as high in the lowest socioeconomic group compared to those in the highest socioeconomic group. Indigenous Australians are also four times as likely than the non-Indigenous population to have diabetes. [95]

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

Our council

The prevalence of diabetes type 2 in the PHA of Mount Gambier was estimated to be 4.7%, the same as in Regional SA.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.4. Mental health problems

Rationale

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

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

Indicator definition:

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

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

7.4.1. Males

Our council

It was estimated that 18.9% of males in the PHA of Mount Gambier reported having mental health problems: this was generally consistent with the rate in Regional SA overall (19.3%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.4.2. Females

Our council

It was estimated that 20.8% of females in the PHA of Mount Gambier reported having mental health problems: as with males, this was generally consistent with the rate in Regional SA, of 21.2%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.5. Tobacco smoking

Rationale

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

Indicator definition:

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

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

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

Our council

The prevalence of smoking in the PHA of Mount Gambier was estimated at 14.7 smokers per 100 population aged 18 years and over, or 14.7%; this was notably (19%) below the level in Regional SA, of 18.0%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.6. Obesity

Rationale

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 15 years and over (age-standardised). These data are modelled estimates from the 2014–15 National Health Survey (see Notes).

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

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

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

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

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

Males

Our council

It was estimated that over a third (35.0%) of adult males in the PHA of Mount Gambier were obese; this was generally consistent with the Regional SA rate of 34.2%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Females

Our council

The proportion of females in the PHA of Mount Gambier estimated to be obese was 38.6%, consistent with the rate estimated for females in Regional SA (38.1%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.7. Physical inactivity

Rationale

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

Indicator definition:

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

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

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

Our council

Nearly three quarters (73.3%) of adults in the PHA of Mount Gambier were estimated to be physically inactive (excluding workplace physical activity), consistent with the rate in Regional SA overall (73.2%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.8. Daily fruit consumption by adults

Rationale

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

Indicator definition:

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

Our council

Less than half (45.8%) of the adult population in the PHA of Mount Gambier were estimated to have met the guidelines for fruit consumption, consistent with the level across Regional SA (46.2%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.9. Median age at death

Rationale

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

Indicator definition:

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

7.9.1. Males

Our council

The median age at death for males in the LGA and the PHA of Mount Gambier was 78 years, the same as in Regional SA overall.

7.9.2. Females

Our council

The median age at death for females in the LGA and PHA of Mount Gambier of 84 years, was the same as in Regional SA overall. It was six years above the age for males in these areas.

7.10. Premature mortality

Rationale

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

Indicator definition:

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

7.10.1. Males

Our council

The premature mortality rate for males in Mount Gambier was 7% above the rate in Regional SA, with a marginally lower rate in the PHA of Mount Gambier.

Note that the figures reported for this variable for Mount Gambier are estimates, as data were not available at the LGA level.

7.10.2. Females

Our council

The premature mortality rate for females in Mount Gambier was notably (37%) lower than the male rate. The rates in the LGA and PHA were both notably above the level in Regional SA overall, by 13% and 14%, respectively.

Note that the figures reported for this variable for Mount Gambier are estimates, as data were not available at the LGA level.

7.11. At ages 15 to 24 years

Rationale

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

Indicator definition:

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

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

Our council

There were an estimated six deaths in Mount Gambier of young people aged 15 to 24 years, a rate of 37.6 deaths per 100,000 population; this was two thirds of the rate in Regional SA overall (56.2 deaths per 100,000 population). The PHA of Mount Gambier had seven deaths and a similar rate (38.0 deaths per 100,000 population at these ages).

Note that the figures reported for this variable for Mount Gambier are estimates, as data were not available at the LGA level.

7.12. **Suicide**

Rationale

Suicide is a major social and public health issue.[129,130] 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.[129] For instance, they may be less inclined to seek help or may be less intimately connected to people who might otherwise be aware of problems or step in to assist.

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

Indicator definition:

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

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.[130] 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.

Our council

There were an estimated 17 deaths due to suicide in Mount Gambier over the five years 2011 to 2015, a rate of 14.8 deaths per 100,000 population aged 0 to 74 years, consistent with the level in Regional SA overall (14.0 deaths per 100,000 population). There was a similar rate for the 19 deaths in the PHA of Mount Gambier, of 14.7 deaths per 100,000 population).

Note that the figures reported for this variable for Mount Gambier are estimates, as data were not available at the LGA level.

7.13. **Hospital admissions**

Rationale

Indicator definition:

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

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

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

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

Our council

The rate of admission to hospital of Mount Gambier residents was seven per cent below the level in Regional SA; the rate in the PHA of Mount Gambier was five per cent below.

Note that the figures reported for this variable for Mount Gambier are estimates, as data were not available at the LGA level.

7.13.1. Potentially avoidable hospitalisations

Rationale

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

Indicator definition:

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

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

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

Our council

Similarly, the rate of admissions for potentially avoidable conditions was slightly (5%) lower in Mount Gambier when compared to Regional SA overall.

The rate in the PHA of Mount Gambier was just two per cent below the level in Regional SA.

Note that the figures reported for this variable for Mount Gambier are estimates, as data were not available at the LGA level.

7.14. **Difficulty accessing healthcare**

Rationale

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

Indicator definition:

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

Access to healthcare varied between population groups. For example, those with a mental health condition (38%) reported greater difficulty than those without a mental health condition (22%) when accessing healthcare and other services. Similarly, people with disability (11%) were more likely than those without (2.8%) to experience a barrier in accessing healthcare. Over half of people in single parent families (54%) also reported difficulty accessing healthcare, citing cost of service as the main reason. They also experienced barriers accessing other services such as Commonwealth income support (54%), telecommunication services (22%) and dentists (22%).[138]

Our council

It was estimated that 1.6% of the population aged 18 years and over had difficulty accessing healthcare in the PHA of Mount Gambier; although a small proportion, it was above the rate in Regional SA overall (1.2%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

7.15. **Home and Community Care Program**

Rationale

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

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

7.15.1. Clients living alone

Our council

In the PHA of Mount Gambier, 35.9% of HACC clients were living alone in 2014/15, some 15% above the level in Regional SA (31.3%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Indicator definition:

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

7.15.2. Non-English speaking clients

Our council

The proportion of HACC clients in the PHA of Mount Gambier who were non-English speaking (8.0%) was markedly (30%) below the level in Regional SA overall (11.4%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Indicator definition:

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

7.16. **Community mental health services**

Rationale

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

Indicator definition:

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

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 15 years and over.

Our council

There were over a third (35%) more clients aged 15 years and over of community mental health services in both the LGA and PHA of Mount Gambier when compared to the rate in Regional SA overall.

Note that the data reported for this variable are estimated from the PHA of Mount Gambier, as data were not available at the LGA level.

7.17. **Availability of residential aged care**

Rationale

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

Indicator definition:

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

Our council

There were 100.0 residential aged care places per head of its population aged 70 years and over in the PHA of Mount Gambier, 23% more than in Regional SA overall (81.5 places per head of its population).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

8. Community connectedness

8.1. People able to get support in times of crisis

Rationale

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

Indicator definition:

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

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

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. [149] 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. [147] Community members who report fair or poor health or a disability, and who are also financially stressed may delay in seeking medical care, or in purchasing prescribed medication because of the cost. Other barriers which can adversely affect people's health and wellbeing are lack of transport, other difficulties accessing needed services, and feeling unsafe in their local environment.[150]

Our council

The majority of people in the PHA of Mount Gambier (94.2%) were able to get support in times of crisis, consistent with the overall Regional SA rate (94.1%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

8.2. Disagree/strongly disagree with acceptance of other cultures

Rationale

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

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Our council

A relatively small proportion (6.2%) of the adult population in the PHA of Mount Gambier were estimated to disagree/strongly disagree with acceptance of other cultures, a result slightly below the level in Regional SA overall (6.6%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

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

Rationale

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

Indicator definition:

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

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

Our council

Some 36.0% of the adult population in the PHA of Mount Gambier were estimated to have had government support as their main source of income in the two years prior to being surveyed, generally consistent with the rate in Regional SA (36.8%).

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

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

Rationale

A household can be considered to be disadvantaged if it lacks the resources to participate fully in society. [156] Access to the outside world, through the Internet provides a means of communicating with friends and family, as well as services, employers and schools, thereby increasing educational, employment and other opportunities, including social interaction.[157]

Indicator definition:

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

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

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

Our council

As reported in the 2016 Census, just over three quarters (75.8%) of the dwellings in Mount Gambier had someone who accessed the Internet from home in some way, consistent with the Regional SA average of 75.0%.

9. Personal and community safety

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

Rationale

Having trust in others to behave according to accepted social values and norms is a fundamental aspect of a well-functioning community.[23] 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.

Indicator definition:

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

While personal experience relating to being a victim of crime may influence an individual's feelings of safety, it is not the only factor. Other factors impacting on people feeling unsafe include, physical features of the local area such as inadequate street lighting and poorly maintained footpaths; crime levels in their local vicinity; relationships with people living nearby; sense of their own strength and capacity to be in control; perceptions of crime levels generally; and their level of trust in their local community.[23] In the 2014 General Social Survey, there was slight increase (53% from 48%) in the proportion of people more likely to feel safe or very safe when walking alone in their local area than in 2010.[138]

Our council

Some 35.3% of adults in the PHA of Mount Gambier were estimated to have reported that they felt very safe/ safe walking alone in their local area after dark; this was markedly (39%) below the level in Regional SA overall, of 57.6%.

Note that the data reported for this variable are for the PHA of Mount Gambier, as data were not available at the LGA level.

Appendix

Table A1: LGAs for which data were produced using correspondence files (see notes in Data Quality, p. 4)

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

Table A1: LGAs for which data produced using correspondence files …*cont*

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

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Notes on the data

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POPULATION HEALTH PROFILE