Population health profile of the

Monash

Division of General Practice

Population Profile Series: No. 48

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The data in this report are designed to be used for needs assessment and planning purposes: while they are based on the best available data and analytic processes, data available by postcode or Statistical Local Area, as used in this report, cannot be precisely translated to Division. Division totals in the report should, therefore, be seen as estimates. Interpretation of differences between data in this profile and similar data from other sources needs to be undertaken with care as such differences may be due to the use of different methodology to produce the data.

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Population health profile
of the *Monash Division of General Practice*

Introduction

This profile has been designed to provide a description of the population of the Monash Division of General Practice, and aspects of their health. Its purpose is to provide information to support a population health approach, which aims to improve the health of the entire population and to reduce health inequalities among population groups: a more detailed discussion of a population health approach is provided in the supporting information, page 16.

Contents

The profile includes a number of tables, maps and graphs to profile population health in the Division and provides comparisons with other areas (eg. Melbourne and Australia). Specific topics covered include:

- a socio-demographic profile (pages 2-5);
- GP workforce rates (page 6);
- immunisation rates (page 6);
- rates of premature death (page 7); and
- estimates of the prevalence of chronic disease and selected risk factors (pages 8-12).

Key indicators

Location: Victoria

Division number: 312

Population‡:	**No.**	**%**
Total	137,211	
65+	22,050	16.1%
<25	41,505	30.2%
Indigenous	274	0.2%

Disadvantage score[1]: 1001

GP services per head of population:

Division‡	5.8
Australia	4.7

Population per FTE GP:

Division‡	1,309
Australia	1,403

Premature death rate[2]:

Division‡	253.2
Australia	290.4

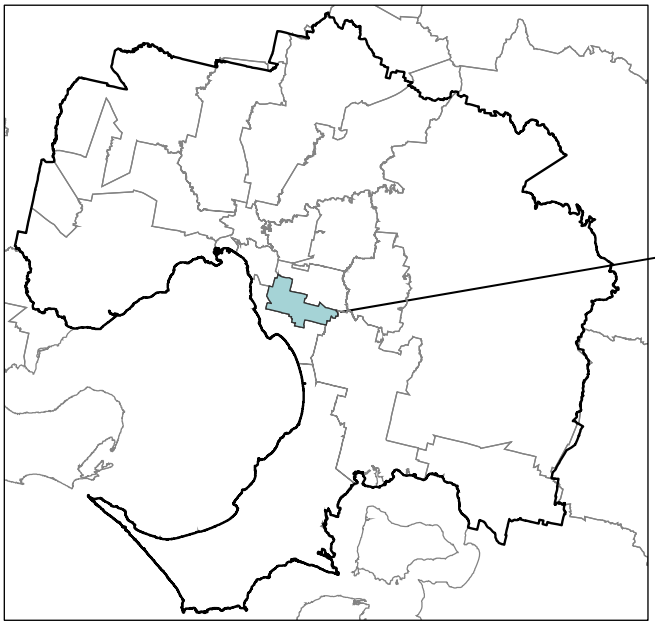
[1] **Numbers above 1000 (the index score for Australia) indicate the Division is relatively advantaged**

[2] **Deaths at ages 0 to 74 years per 100,000 population**

‡ **See note "Data converters and mapping" re calculation of Division Total**

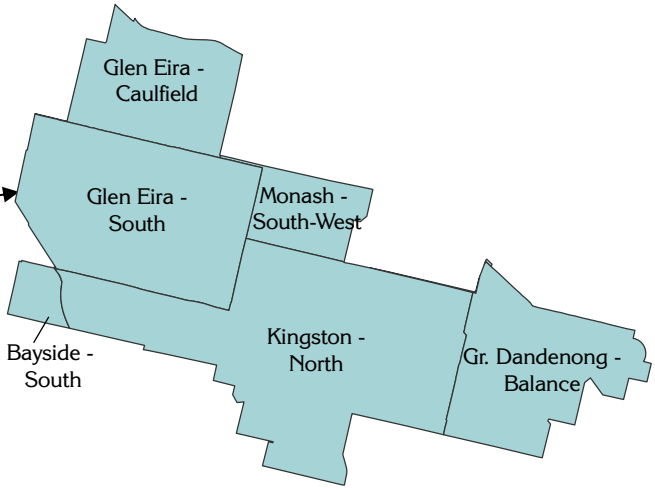
Monash Division of General Practice

Melbourne Divisions of General Practice



Melbourne Divisions of General Practice
Melbourne Statistical Division

Monash DGP by SLA

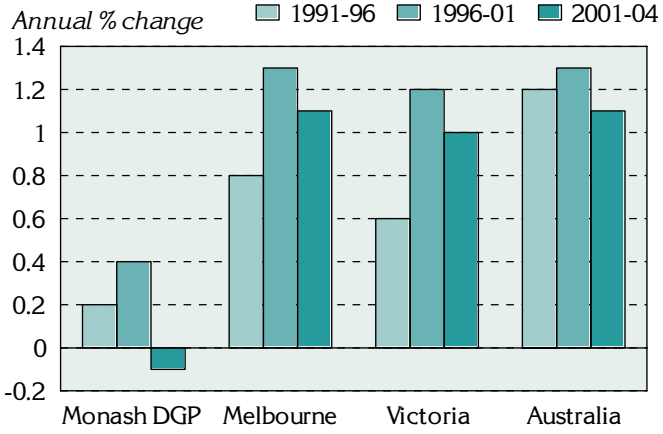


Socio-demographic profile

Population

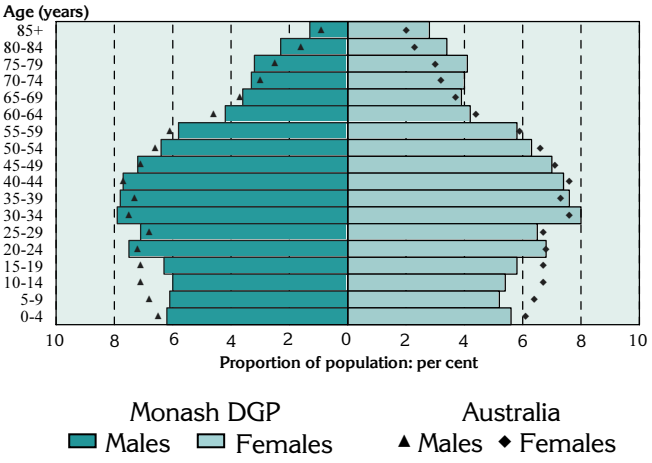
The Monash Division had an Estimated Resident Population of 137,211 at 30 June 2004.

Figure 1: Annual population change, Monash DGP‡, Melbourne, Victoria and Australia, 1991 to 1996, 1996 to 2001 and 2001 to 2004



Over the five years from 1991 to 1996, the Division's population increased by 0.2% on average each year, lower than for Melbourne (0.8%), Victoria (0.6%), and Australia as a whole (1.2%). From 1996 to 2001, the annual percentage increase in the Division was 0.4%, again lower than for the other areas (1.3%, 1.2% and 1.3%, respectively). From 2001 to 2004 the population decreased by an average of 0.1% per year, compared to annual increases of 1.1% for Melbourne, 1.0% for Victoria, and 1.1% for Australia.

Figure 2: Population in Monash DGP‡ and Australia, by age and sex, 2004



The most notable differences in the age distribution of the Division's population (when compared to Australia overall) are:

- at younger ages – lower proportions of children aged 0 to 14 years, and young people aged 15 to 19 years;
- from 30 to 39 years – slightly higher proportions of both males and females; and
- at older ages – higher proportions of males aged 70 years and over, and females aged 65 years and over.

Table 1: Population by age, Monash DGP‡ and Australia, 2004

Age group (years)	Monash DGP		Australia	
	No.	%	No.	%
0-14	23,687	17.3	3,978,751	19.8
15-24	17,818	13.0	2,762,769	13.8
25-44	41,360	30.1	5,881,048	29.3
45-64	32,297	23.5	4,864,037	24.2
65-74	10,249	7.5	1,374,792	6.8
75-84	8,928	6.5	934,505	4.7
85+	2,873	2.1	295,602	1.5
Total	**137,211**	**100.0**	**20,091,504**	**100.0**

As shown in the age-sex pyramid above, the Monash DGP had relatively fewer children aged 0 to 14 years (17.3%) compared to Australia as a whole (19.8%) (Table 1). Conversely, the 65 years and over age groups had higher proportions compared to Australia.

The Monash DGP comprised 25.2% of people born in predominantly non-English speaking countries and resident in Australia for five years or more (Table 2), substantially above the proportion in Melbourne (17.5%). Recent arrivals (resident in Australia for less than five years) from non-English speaking countries also comprised a substantially higher 5.1% of the Division's population (compared to 3.1% in Melbourne).

‡ See note under 'Data converters and mapping' re calculation of Division totals on this page

Data Sources: see 'Data sources and limitations' at end of report

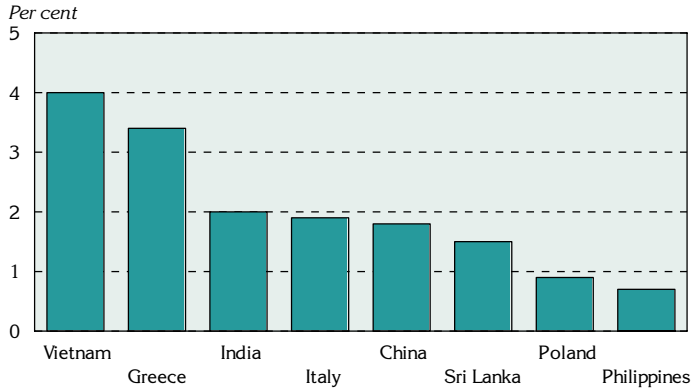
Of these residents, 7.8% had poor proficiency in English (determined when people aged five years and over born overseas in predominantly non-English speaking countries reported in the Census speaking another language and speaking English 'not well' or 'not at all'), well above the proportion in Melbourne (4.4%) and Australia (2.4%).

Table 2: Non-English speaking born, Monash DGP, Melbourne, Victoria and Australia, 2001

People born in predominantly non-English speaking countries	Monash DGP		Melbourne		Victoria		Australia	
	No.	%	No.	%	No.	%	No.	%
Resident in Australia for five years or more	33,555	25.2	587,954	17.5	644,806	13.8	2,019,410	10.8
Resident in Australia for less than five years	6,841	5.1	104,747	3.1	110,557	2.4	408,074	2.2
Poor proficiency in English[1]	9,714	7.8	140,109	4.4	147,394	3.4	425,399	2.4

[1] **Calculated on persons aged 5 years and over who reported speaking another language and speaking English 'not well' or 'not at all'**

Figure 3: Major non-English speaking birthplaces, Monash DGP, 2001



Australian-born people comprised 62.1% of the Division's population, below the Australian figure of 72.6%. Of the 6.2% of people from English speaking countries, 3.7% were from the UK and Eire. The major birthplaces of the non-English speaking population include Vietnam (4.0%); Greece (3.4%); India (2.0%); Italy (1.9%); China (1.8%); Sri Lanka (1.5%); Poland (0.9%); and the Philippines (0.7%).

Socioeconomic status

The indicators presented in this section describe geographic variations in the distribution of the population for a number of key socioeconomic influences, which impact on the health and wellbeing of populations.

The Monash DGP had a similar proportion of single parent families (9.1%) compared to Melbourne as a whole (9.6%), and a much lower proportion of Aboriginal and Torres Strait Islanders (0.2%, compared to 0.4% for Melbourne) (Figure 4, Table 3).

Full-time secondary school education participation of 16 year olds living in the Division (85.0%) was higher than that for Melbourne (81.8%).

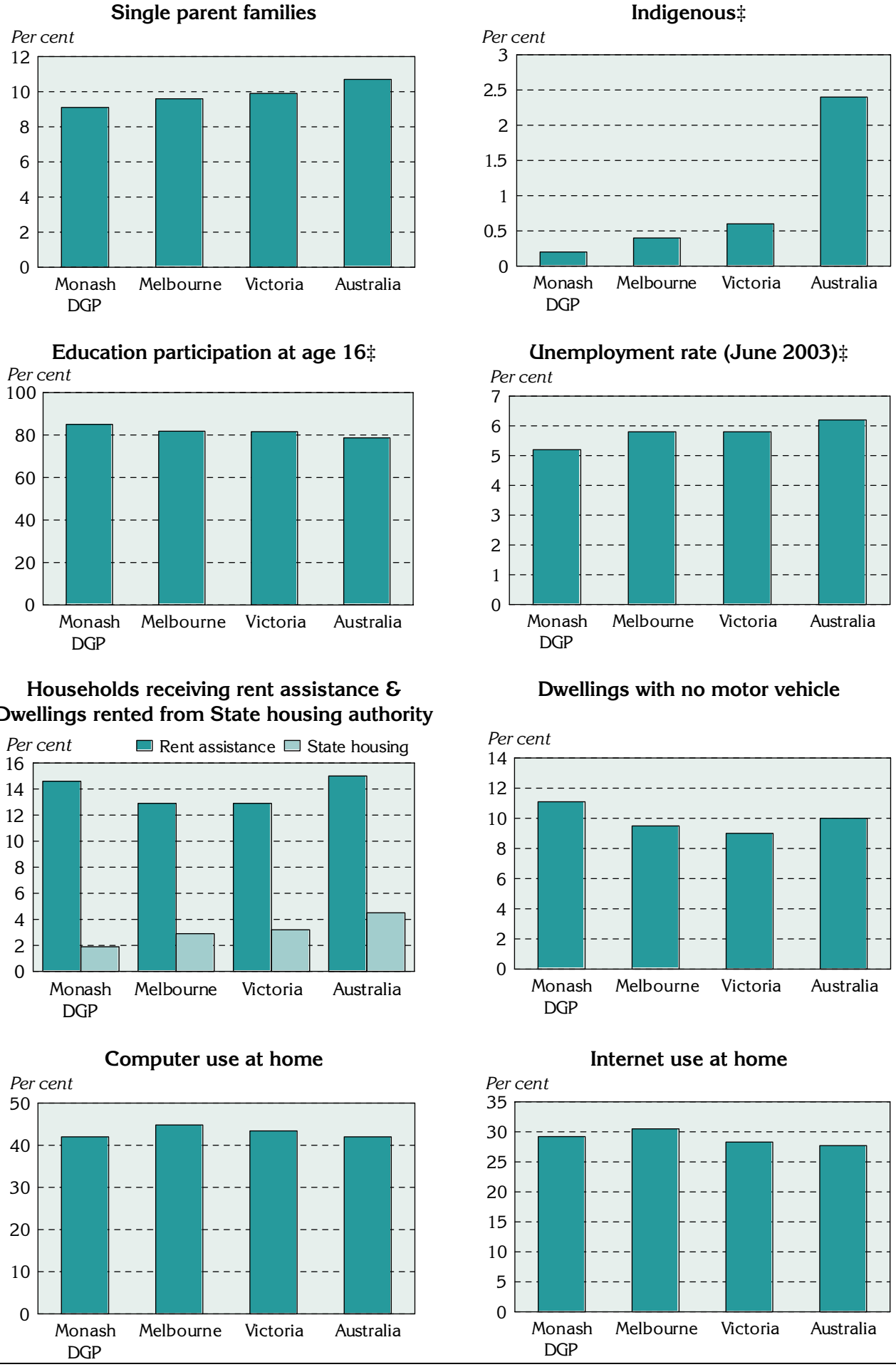
A higher proportion of the Division's households received rent assistance from Centrelink (14.6%) compared to Melbourne and Victoria (both 12.9%), but there were fewer dwellings rented from the State housing authority (1.9%, compared to 2.9% and 3.2%). The proportion of dwellings with no access to a motor vehicle (11.1%) was also higher than the rates for Melbourne (9.5%) and Victoria (9.0%).

The Division had slightly lower proportions of the population who reported using, at home, a computer (42.3%), and the Internet (29.2%) compared to Melbourne (44.8% and 30.5%).

These socioeconomic indicators show the Division to comprise a population of relatively average socioeconomic status: see also the note on page 5 (Summary of socioeconomic ranking).

Figure 4: Socio-demographic indicators, Monash DGP, Melbourne, Victoria and Australia, 2001

Note the different scales



‡ See note under 'Data converters and mapping' re calculation of Division totals

Data Sources: see 'Data sources and limitations' at end of report

Table 3: Socio-demographic indicators, Monash DGP, Melbourne, Victoria and Australia, 2001

Indicator	Monash DGP		Melbourne		Victoria		Australia	
	No.	%	No.	%	No.	%	No.	%
Single parent families	3,180	9.1	84,483	9.6	120,824	9.9	529,969	10.7
Indigenous‡	268	0.2	12,716	0.4	27,846	0.6	458,261	2.4
Full-time secondary school education at age 16‡	1,307	85.0	38,340	81.8	54,494	81.6	130,198	78.7
Households: rent assistance	7,236	14.6	150,482	12.9	212,587	12.9	1,006,599	15.0
Dwellings rented from the State housing authority	971	1.9	35,953	2.9	54,805	3.2	317,171	4.5
Dwellings: no motor vehicle	5,678	11.1	118,190	9.5	155,728	9.0	708,073	10.0
Computer use at home	55,348	42.3	1,495,506	44.8	2,001,169	43.4	7,881,983	42.0
Internet use at home	38,880	29.2	587,954	30.5	644,806	28.3	2,019,410	27.7

‡ **See note under 'Data converters and mapping' re calculation of Division total**

The unemployment rate of 5.2% in Monash DGP was below the rates for Melbourne and Victoria (both 5.8%) (Figure 4, Table 4). The labour force participation rate (77.9%) and female labour force participation rate (72.1%) were both higher than those for Melbourne (75.3% and 71.1%) and Victoria (75.3% and 70.6%).

Table 4: Unemployment and labour force participation, Monash DGP, Melbourne, Victoria and Australia, 2003

Labour force indicators	Monash DGP		Melbourne		Victoria		Australia	
	No.	%	No.	%	No.	%	No.	%
Unemployment rate ‡	3,691	5.2	103,501	5.8	144,584	5.8	623,791	6.2
Labour force participation‡	71,146	77.9	1,787,899	75.3	2,492,980	75.3	10,038,147	75.2
Female labour force participation (2001)	24,841	72.1	633,724	71.1	840,995	70.6	3,306,521	69.7

‡ **See note under 'Data converters and mapping' re calculation of Division total**

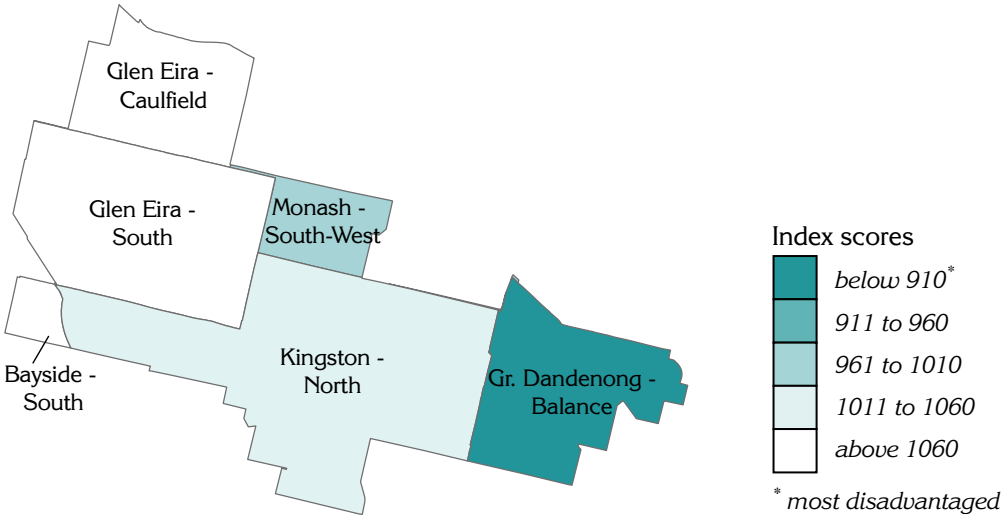
Summary of the socioeconomic ranking of the Monash DGP

Following the 2001 Census, the Australian Bureau of Statistics (ABS) produced four socio-economic indexes for areas (SEIFA) which describe various aspects of the socioeconomic profile of populations in areas. The scores for these indexes for each Statistical Local Area (SLA) or part SLA in Monash DGP are shown in the supporting information, Table 9, page 16: SLAs are described on page 17.

The Monash DGP area's SEIFA index of Relative Socio-Economic Disadvantage (IRSD) score is 1001, just (1.0%) above the score for Australia (1000), and below Melbourne (1021); this highlights the relatively higher socioeconomic status profile of the Monash DGP population. The variations in the IRSD within the Division at the SLA level (Map 1) are over a narrow range (of high scores), other than for the much lower score in Greater Dandenong - Balance (862), of which around one third is in the Division. Note that this is the score for the whole of Greater Dandenong - Balance and may not reflect the socioeconomic make-up of this one third of the SLA.

Map 1: Index of Relative Socio-Economic Disadvantage by SLA, Monash DGP, 2001

See note under 'Methods' re Data converters and mapping concerning SLAs mapped to the Division. This is of particular relevance where part of an SLA is mapped to the Division.



Data Sources: see 'Data sources and limitations' at end of report

General medical practitioner (GP) supply

A total of 104.8 full-time equivalent (FTE) GPs and 129.6 full-workload equivalent (FWE[1]) GPs worked in the Division in 2003/04 (Table 5). Of the FWE GPs, 27.6% were female, and 29.7% were over 55 years of age (compared to 25.6% and 28.3%, respectively, for Victoria).

Apart from the estimated day-time population, the rates of population per FTE GP varied, depending on the population measure used, from a high of 1,309 people per GP (calculated on the average Estimated Resident Population (ERP) as at 30 June 2003 and 30 June 2004) to a low of 1,240 people per GP (calculated on the 1 August 2001 Census Count – all people counted in the Division on Census night, including visitors from Australia and overseas). The rates of population per FWE GP were lower, ranging from 1,003 (calculated on the Census Count) to 1,059 (calculated on the ERP).

When calculated on the estimated day-time population, the rates of population were 6.5% below the Usual Resident Population (usual residents of the Division counted in Australia on Census night).

Based on the ERP, the rates of population per GP in Monash DGP marginally lower than the rates for Victoria and Australia, indicating a higher level of provision of GP services in the Division.

Table 5: Population per GP in Monash DGP, 2003/04

Population measure	Population	GPs		Population per GP	
		FTE	FWE	FTE	FWE
Monash DGP					
Census count (adjusted)*	129,925	104.8	129.6	1,240	1,003
Usual Resident Population (URP) (adjusted)*	131,975	..	..	1,260	1,019
Estimated Resident Population (ERP)	137,167	..	..	1,309	1,059
Day-time population (estimated on the URP)* ‡	123,409	..	..	1,178	953
Victoria (ERP)	4,942,102	3,575	4,157	1,382	1,189
Australia (ERP)	19,989,303	14,246	16,872	1,403	1,185

* **The Census count, Usual Resident Population and Day-time population were adjusted to reflect population change between 2001 and 2003/2004, as measured by the ERP**

‡ **See note under 'Data converters and mapping' re calculation of Division totals**

Immunisation

Data from the Australian Childhood Immunisation Register show that 94.6% of children in the Division in 2002 were fully immunised at age one, marginally above the Australian proportion of 94.2%.

Immunisation by provider type for children between the ages of 0 to 6 is shown in Table 6. The proportion of children in the Division who were immunised by a general practitioner was 78.4%, compared to 70.0% for Australia, with 18.0% immunised at a local government council.

Table 6: Childhood immunisation at ages 0 to 6 by provider type, Monash DGP and Australia, 2003/04

Provider	Monash DGP	Australia
	%	%
General practitioner	78.4	70.0
Local government council	18.0	16.6
Community health centre/ worker	3.6	9.8
Public hospital	0.0	2.1
Aboriginal health service/ worker	0.0	0.9
Other*	0.0	0.6
Total: Per cent	**100.0**	**100.0**
Number	**24,784**	**3,843,610**

* **Includes immunisations in/ by State Health Departments, RFDS and private hospitals**

[1]The FWE value is calculated for each GP location by dividing the GP's total Medicare billing (Schedule fee value of services provided during the reference period) by the mean billing of full-time doctors in that derived major speciality for the reference period. Thus, a GP earning 20% more than the mean billing of full-time doctors is shown as 1.2 FWE: this differs from full-time equivalent (FTE) counts, where the FTE value of any GP cannot exceed 1.0

Premature mortality

Deaths at ages below 75 years are used as an indicator of health status, as they largely reflect premature deaths, given the current levels of life expectancy in Australia.

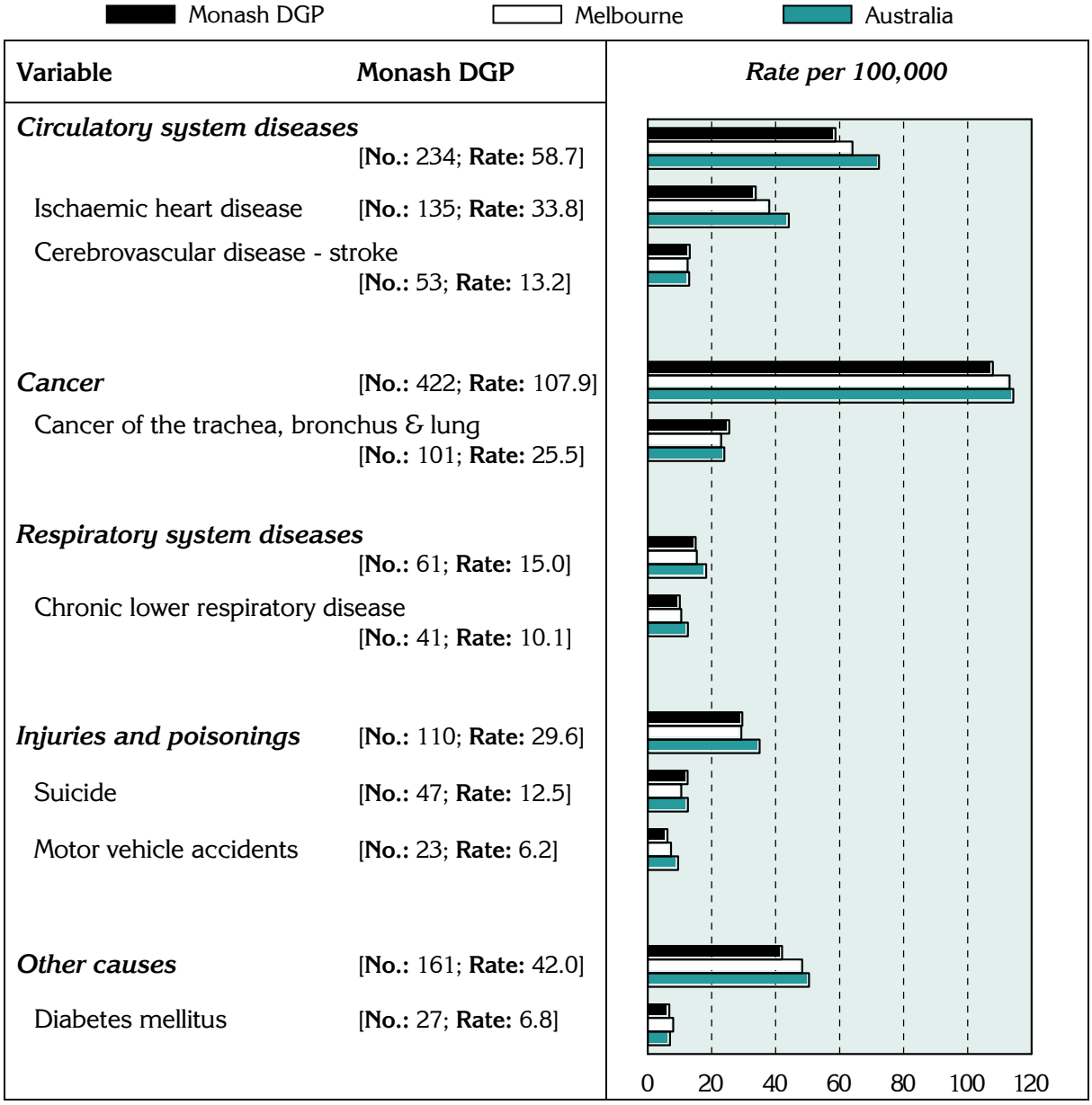
The 'all causes' death rate in the Division at ages 0 to 74 years (253.2 deaths per 100,000 population) is lower than for Melbourne (269.9) and Australia (290.4): the rates have been age standardised to allow for comparisons between areas, regardless of differences in age profiles between the Division and Australia.

The major causes of premature mortality in the Division, as for Melbourne and Australia as a whole, are cancer and diseases of the circulatory system (Figure 5). With the exception of cancer of the trachea, bronchus & lung, death rates in the Division are generally lower than, or similar to, those for Australia as a whole.

The data on which the following chart is based are in Table 11.

Figure 5: Deaths before 75 years of age by major condition group and selected cause, Monash DGP‡, Melbourne and Australia, 2000-02*

Indirectly age standardised rate per 100,000 population



* **'No.' is the total number of deaths for the 2000-02 period; 'Rate' is an annual rate, based on the 3 year average**

‡ **See note under 'Data converters and mapping' re calculation of Division totals**

Chronic diseases and risk factors

The term "chronic disease" describes health problems that persist across time and require some degree of health care management (WHO 2002). Chronic diseases tend to have complex causes, are often long lasting and persistent in their effects, and can produce a range of complications (Thacker et al. 1995). They are responsible for a significant proportion of the burden of disease and illness in Australia and other westernised countries. Given the ageing of the population, this trend is likely to continue.

At different life stages, risk factors for chronic diseases and their determinants include genetic predisposition; poor diet and lack of exercise; alcohol misuse and tobacco smoking; poor intra-uterine conditions; stress, violence and traumatic experiences; and inadequate living environments that fail to promote healthy lifestyles (NPHP 2001). Risk factors are also more prevalent in areas of low socioeconomic status, and in communities characterised by low levels of educational attainment; high levels of unemployment; substantial levels of discrimination, interpersonal violence and exclusion; and poverty. There is a higher prevalence of risk factors among Indigenous communities, and other socioeconomically disadvantaged Australians (NPHP 2001).

Background

In this section, estimates of the prevalence of selected chronic diseases and risk factors, and two summary measures of health, are shown for the Division‡, and for SLAs within the Division: note that the estimates have been predicted from self-reported data, and are not based on clinical records or physical measures. The chronic diseases and risk factors are those for which sufficiently reliable estimates can be made for the Division from national survey data. The process by which the estimates have been made, and details of their limitations, are described in the Notes section, pages 14-15. The data on which the following charts are based are in Table 12.

The estimates provide information of relevance to a number of the National Health Priority Areas (NHPAs – asthma; cardiovascular health; diabetes mellitus; injury prevention and control; mental health; and arthritis and musculoskeletal conditions: estimates have not been made for cancer control, the other NHPA). The risk factors for which estimates have been made are those which are accepted as being associated with these important chronic conditions. They are overweight (not obese), smoking, lack of exercise and high-risk alcohol use.

The numbers are estimates for an area, not measured events as are death statistics: they should be used as indicators of likely levels (and not actual levels) of a condition or risk factor in an area.

Prevalence estimates: chronic disease‡

It is estimated that, with the exceptions of respiratory diseases (including asthma), and diabetes type 2, relatively fewer people in Monash DGP reported having any of the selected chronic conditions than in Australia as a whole (Figure 6): that is, the prevalence rates per 1,000 population were generally lower.

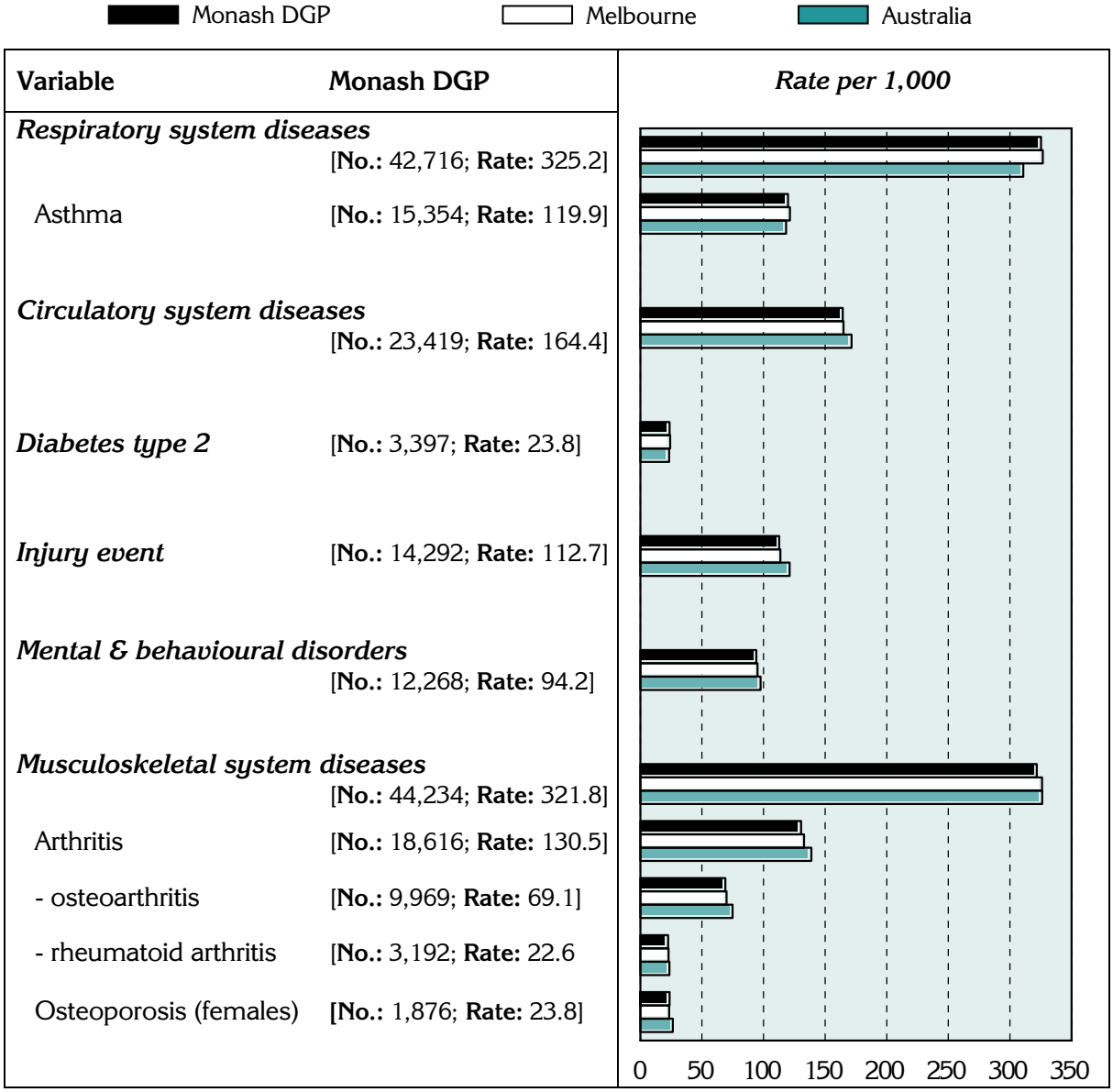
Prevalence estimates: self-reported health‡

The NHS includes two measures of self-reported health. One is the Kessler Psychological Distress Scale–10 items (K–10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the four weeks prior to interview, asked of respondents 18 years and over (ABS 2002). The other asks respondents aged 15 years and over to rate their health on a scale from 'excellent', through 'very good', 'good' and 'fair', to 'poor' health.

The proportion of the population of the Division aged 18 years and over estimated to have very high psychological distress levels as measured by the K–10 (Figure 7) is similar to that for Australia as a whole. The proportion of the population aged 15 years and over estimated to have reported their health as 'fair' or 'poor' is marginally below the national average.

Figure 6: Estimates* of chronic disease and injury, Monash DGP‡, Melbourne and Australia, 2001

Indirectly age standardised rate per 1,000 population

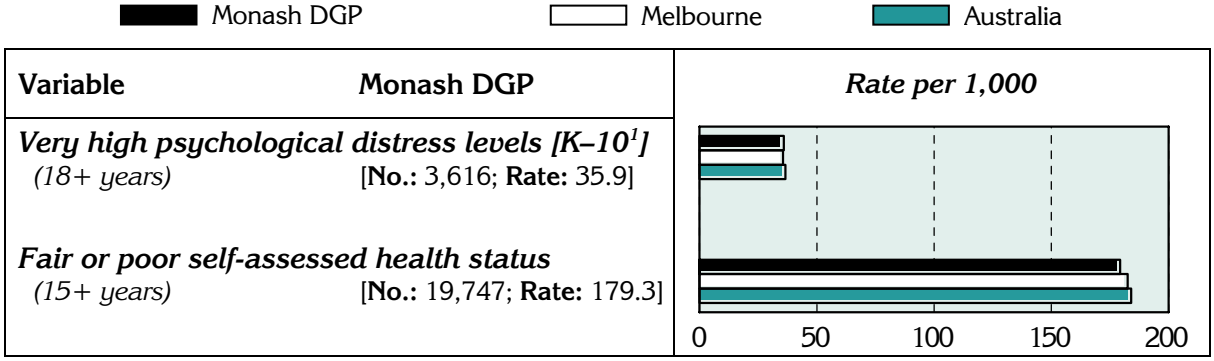


* 'No.' is a weighted estimate of the number of people in Monash DGP reporting each chronic condition and is derived from synthetic predictions from the 2001 NHS

‡ See note under 'Data converters and mapping' re calculation of Division totals

Figure 7: Estimates* of measures of self-reported health, Monash DGP‡, Melbourne and Australia, 2001

Indirectly age standardised rate per 1,000 population



* 'No.' is a weighted estimate of the number of people in Monash DGP reporting under these measures and is derived from synthetic predictions from the 2001 NHS

[1] Kessler 10

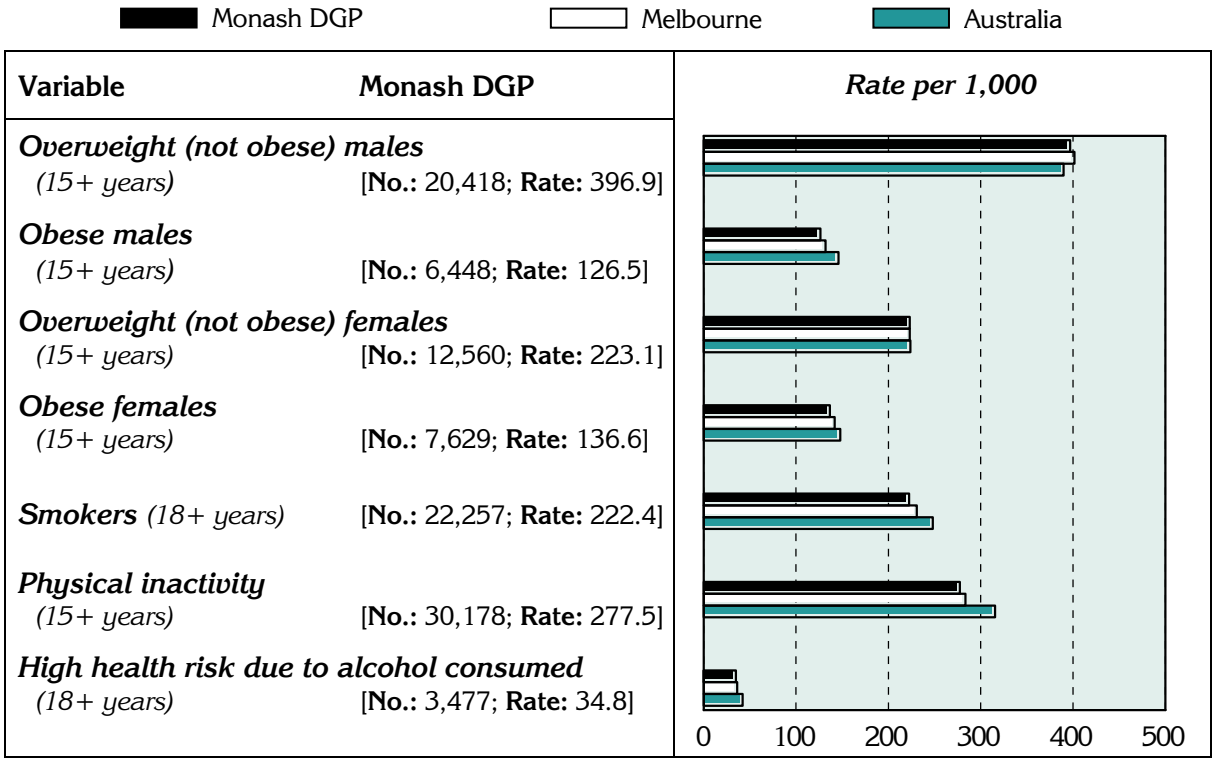
‡ See note under 'Data converters and mapping' re calculation of Division totals

Prevalence estimates: risk factors‡

The relatively lower rates (when compared with the Australian population) for all of the selected risk factors, with the exception of overweight in males (Figure 8), are consistent with the socioeconomic profile status of the Division.

Figure 8: Estimates* of selected risk factors, Monash DGP‡, Melbourne and Australia, 2001

Indirectly age standardised rate per 1,000 population



* 'No.' is a weighted estimate of the number of people in Monash DGP with these risk factors and has been predicted using data from the 2001 NHS and known data for the Division

‡ See note under 'Data converters and mapping' re calculation of Division totals

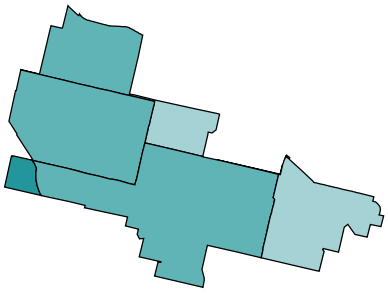
The following maps provide details of the geographic distribution, at the SLA level, of the estimated prevalence of chronic disease (Map 2), self-reported health (Map 3) and risk factors associated with chronic disease (Map 4).

In the following maps, users should note that the estimates shown for part SLAs in the Division (see Table 9, page 17, for per cent of SLA population in the Division) represent the estimates for the whole SLA, and not just the part shown. However, SLAs with only a small proportion of their population in the Division are likely to have little influence on the total estimates for the Division, which have been based on the percentage of the SLA population in the Division.

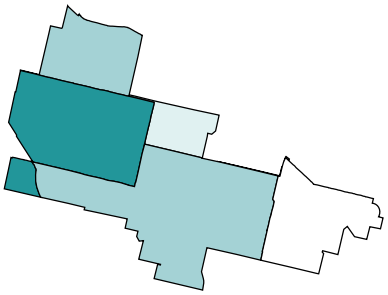
Data Sources: see 'Data sources and limitations' at end of report

Map 2: Estimates* of chronic disease and injury by SLA, Monash DGP, 2001

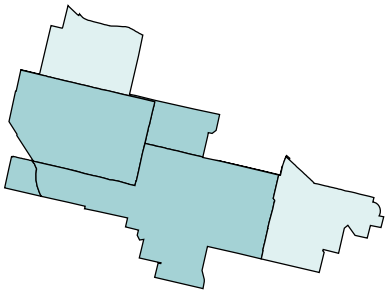
Respiratory system diseases



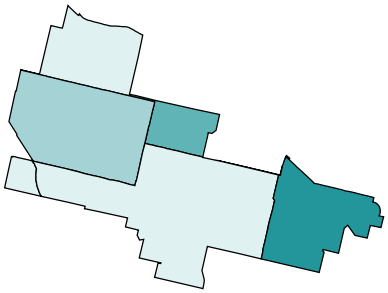
***Respiratory system diseases:* Asthma**



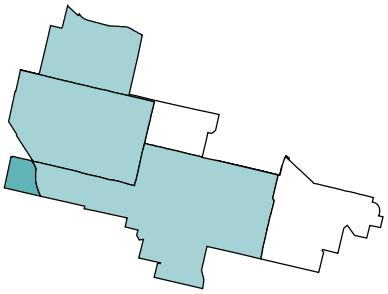
Circulatory system diseases



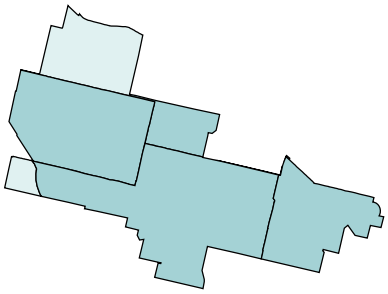
Diabetes type 2



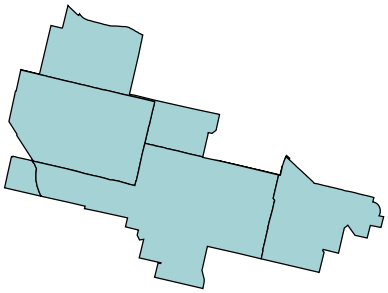
Injury event



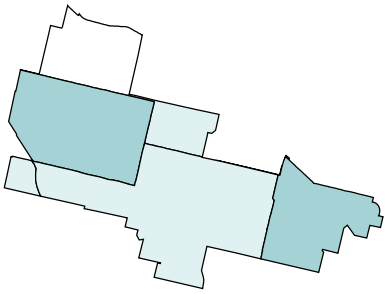
Mental & behavioural disorders



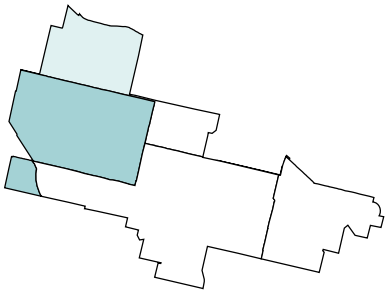
Musculoskeletal system diseases



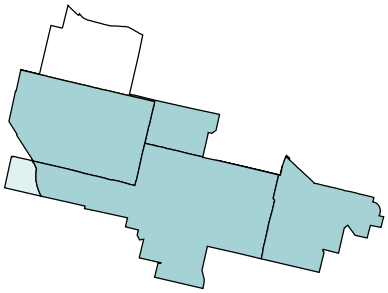
***Musculoskeletal system diseases:* Arthritis**



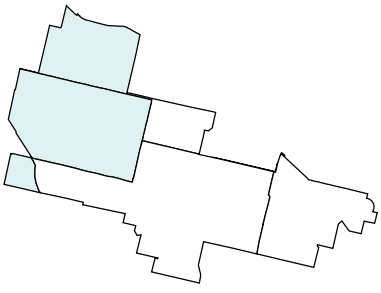
***Arthritis:* Osteoarthritis**



***Arthritis:* Rheumatoid arthritis**



Osteoporosis (females)



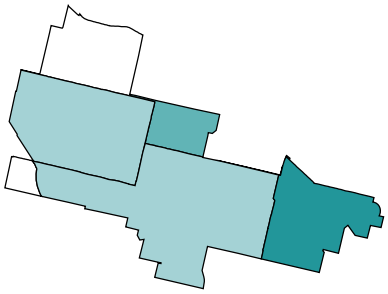
Per cent difference from Australian average

- *10% or more above*
- *5% to less than 10% above*
- *within 5% of the average*
- *5% to less than 10% below*
- *10% or more below*

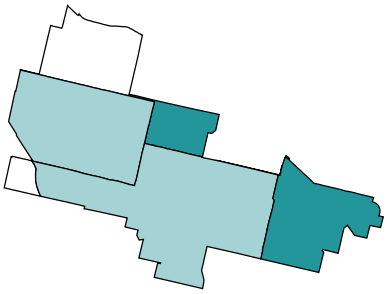
* *The estimates are synthetic predictions of the prevalence of these conditions: see Notes on the data.*

Map 3: Estimates* of measures of self-reported health by SLA, Monash DGP, 2001

Very high psychological distress levels [K–10[1]] (18+ years)



Fair or poor self-assessed health status (15+ years)



Per cent difference from Australian average

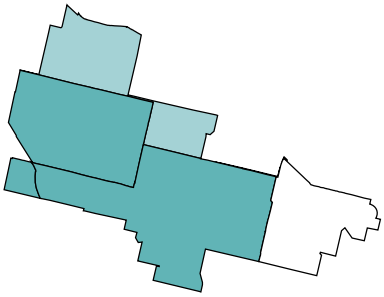
- *10% or more above*
- *5% to less than 10% above*
- *within 5% of the average*
- *5% to less than 10% below*
- *10% or more below*

* *The estimates are synthetic predictions of the prevalence of the population reporting under these measures: see Notes on the data.*

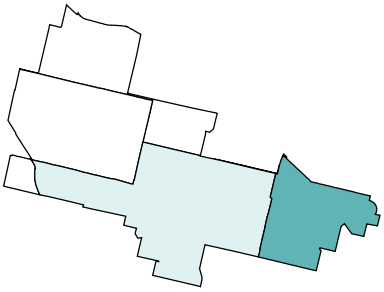
[1] **Kessler 10**

Map 4: Estimates* of selected risk factors by SLA, Monash DGP, 2001

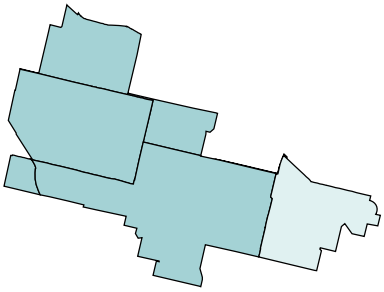
Overweight (not obese) males (15+ years)



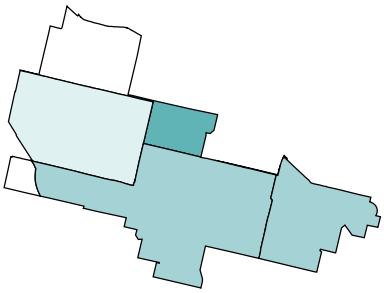
Obese males (15+ years)



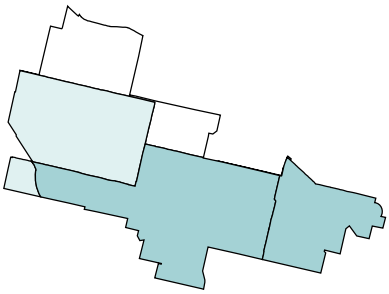
Overweight (not obese) females (15+ years)



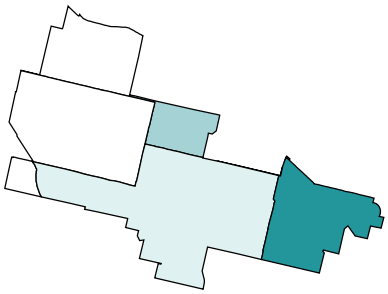
Obese females (15+ years)



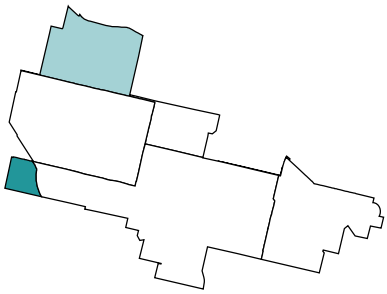
Smokers (18+ years)



Physical inactivity (15+ years)



High health risk due to alcohol consumed (18+ years)



Per cent difference from Australian average

- *10% or more above*
- *5% to less than 10% above*
- *within 5% of the average*
- *5% to less than 10% below*
- *10% or more below*

* *The estimates are synthetic predictions of the prevalence of these risk factors: see Notes on the data.*

Data Sources: see 'Data sources and limitations' at end of report

Notes on the data

Data sources and limitations

General

Unless stated otherwise, references to 'Melbourne' relate to the Melbourne Statistical Division.

Data sources

Table 7 details the data sources for the material presented in this profile.

Table 7: Data sources

Section	Source
Key indicators	
GP services per head of population	GP services data supplied by Department of Health and Ageing, 2003/04 Population data: Estimated Resident Population, ABS, mean of 30 June 2003 and 30 June 2004 populations
Socio-demographic profile	
Figures 1 and 2; Table 1	Estimated Resident Population, ABS, 30 June for the periods shown
Tables 2, 3 and 4; Figures 3 and 4	Data were extracted by postal area from the ABS Population Census 2001[1], except for the following indicators: - *Indigenous* – Experimental estimates of Aboriginal and Torres Strait Islander people, ABS 2001 (unpublished) - *Full-time secondary education participation at age 16* – Census 2001 (unpublished) - *Households receiving rent assistance* – Centrelink, December Quarter 2001 (unpublished) - *Unemployment rate / Labour force participation* – extracted from *Small Area Labour Markets Australia*, June Quarter 2003, Department of Employment and Workplace Relations
Map 1; Table 9	ABS SEIFA package, Census 2001
General medical practitioner (GP) supply	
Table 5	GP data supplied by Department of Health and Ageing, 2003/04 Population estimates used in calculating the population per GP rates are the: - Census count[2], ABS Population Census 2001, scaled to 2003/04 - Usual Resident Population[3], ABS Population Census 2001, scaled to 2003/04 - Day-time population: calculated from journey to work data, ABS Population Census (URP) 2001 (unpublished); and 2001 Census URP, scaled to 2003/04 - Estimated Resident Population, ABS, June 2003/2004
Immunisation	
Text comment: 1 year olds	National Centre for Immunisation Research and Surveillance, 2002
Table 6	Australian Childhood Immunisation Register, Health Insurance Commission, 2003/04 (unpublished)
Premature mortality	
Figure 5; Table 11	ABS Deaths, 2000 to 2002
Chronic diseases and associated risk factors[4]	
Figures 6, 7 and 8; Maps 2, 3 and 4; Table 12	Estimated from 2001 National Health Survey (NHS), ABS (unpublished)

[1] All data extracted from Usual Residents Profile, except for data variables only released in the Basic Community Profile
[2] *Census count* - those counted in the Division on Census night, including tourists, business people and other visitors
[3] *Usual Resident Population* - those who usually live there and who were in Australia at the time and would have provided details in the Census at the address where they were counted
[4] See notes below

Chronic diseases and associated risk factors

The data for chronic conditions and risk factors for SLAs have been estimated from the 2001 National Health Survey (NHS), conducted by the ABS: see note below on synthetic estimates. The NHS sample includes the majority of people living in private households, but excludes the most remote areas of Australia. These areas cover 86.4% of Australia's land mass and comprise just 3% of the total population, however, 28% of Australia's Indigenous population live in these areas. Thus it has not been possible to produce these estimates for Divisions with relatively high proportions of their population in the most remote areas of Australia.

The data for chronic conditions and risk factors are self-reported data, reported to interviewers in the 2001 NHS. Table 8 includes notes relevant to this data.

Table 8: Notes on estimates of chronic diseases and associated risk factors

Indicator	Notes on the data
Estimates of chronic disease and injury (Figure 6 and Map 2)	
Long term conditions	- Respondents were asked whether they had been diagnosed with any long term health condition (a condition which has lasted or is expected to last for 6 months or more), and were also asked whether they had been told by a doctor or nurse that they had asthma, cancer, heart and circulatory conditions, and/or diabetes
Injury event	- Injuries which occurred in the four weeks prior to interview
Estimates of measures of self-reported health (Figure 7 and Map 3)	
Very high psychological distress levels (K10)	- Derived from the Kessler Psychological Distress Scale-10 items (K-10), which is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 4 weeks prior to interview. 'Very high' distress is the highest level of distress category (of a total of four categories)
Fair or poor self-assessed health status	- Respondent's general assessment of their own health, against a five point scale from excellent through to poor – 'fair' or 'poor' being the two lowest in the scale
Estimates of selected risk factors (Figure 8 and Map 4)	
Overweight (not obese)	- Based on self-reported height and weight; BMI calculated and grouped into categories (to allow reporting against both WHO and NHMRC guidelines) - overweight: 25.0 to less than 30.0
Obese	- Based on self-reported height and weight; BMI calculated and grouped into categories (to allow reporting against both WHO and NHMRC guidelines) – obese: 30.0 and greater
Smokers	- Respondent's undertaking regular (or daily) smoking at the time of interview
Physical inactivity	- Did not exercise in the two weeks prior to interview through sport, recreation or fitness (including walking) – excludes incidental exercise undertaken for other reasons, such as for work or while engaged in domestic duties
High health risk due to alcohol consumed	- Respondent's estimated average daily alcohol consumption in the seven days prior to interview (based on number of days and quantity consumed). Alcohol risk levels were grouped according to NHMRC risk levels for harm in the long term, with 'high risk' defined as a daily consumption of more than 75 ml for males and 50 ml for females

Note: For a full description, refer to *ABS 2001 National Health Survey,* Cat. No. 4364.0 and *ABS 2001 Health Risk Factors, Cat. No.* 4812.0

Methods

Synthetic estimates

The estimates of the prevalence of chronic disease and associated risk factors have been predicted for a majority of SLAs across Australia, using modelled survey data collected in the 2001 ABS National Health Survey (NHS) and known characteristics of the area. A synthetic prediction can be interpreted as the likely value for a 'typical' area with those characteristics: the SLA is the area level of interest for this project (where SLAs had small populations they were grouped to larger areas). This work was undertaken by the Australian Bureau of Statistics, as they hold the NHS unit record files: the small area data were compiled by PHIDU.

The approach used is to undertake an analysis of the survey data for Australia to identify associations in the NHS data between the variables that we wish to predict at the area level (eg. prevalence of chronic conditions and risk factors) and the data we have at the area level (eg. socioeconomic status, use of health services). The relationship between these variables for which we have area level data (the predictors) and the reporting of chronic conditions in the NHS is also a part of the model that is developed by the ABS. For example, such associations might be between the number of people reporting specified chronic conditions in the NHS and:

- the number of hospital admissions (in total, to public and to private hospitals, by age, sex and diagnosis),
- socioeconomic status (as indicated by Census data, or for recipients of government pensions and benefits), and
- the number of visits to a general medical practitioner.

The results of the modelling exercise are then applied to the SLA counts of the predictors. The prediction is, effectively, the likely value for a typical area with those characteristics. The raw numbers were then age-standardised, to control for the effects of differences in the age profiles of areas.

The numbers are estimates for an area, not measured events as are death statistics: they should be used as indicators of likely levels of a condition or risk factor in an area.

Premature deaths

Details of deaths by SLA were purchased from the ABS. The raw numbers were then age-standardised, by the indirect method, to control for the effects of differences in the age profiles of areas.

Data converters and mapping

Conversion to Division of data available by postcode

The allocation of postcodes to Divisions was undertaken using information from the Department of Health and Ageing's web site, which shows the proportion of a postcode in a Division (see page 17).

Conversion to Division of data available by SLA
(marked in this profile as ‡ **See note under 'Data converters and mapping' re calculation of Division total**)

Where the data presented in these profiles were only available by SLA they have been converted to Division of General Practice areas using a concordance based on data at the 2001 Census. A copy of the concordance is included in the Population data: A Guide for Divisions of General Practice: it is also available from the Divisions' data area on PHIDU web site.

In brief, the concordance splits the data (eg number of deaths) for each SLA across one or more Divisions. The proportion of an SLA's data that is allocated to each Division was calculated from (a) CD level Census 2001 data that splits SLAs across approximations to postcodes (referred to as postal areas) and (b) data on the DoHA website that splits postcodes across Divisions. This concordance can be adjusted to meet any new configuration of Division boundaries based on the 2001 Collection Districts, or combinations thereof.

The estimated population of each SLA in this Division is shown in Table 10.

Mapping

In some Divisions the maps may include a very small part of an SLA which has not been allocated any population, or either has a population of less than 100 or has less than 1% of the SLA's total population: these areas are mapped with a pattern.

Supporting information

This and other information is also available at www.publichealth.gov.au

A definition of population health

Population health, in the context of general practice, has been defined[1] as:

"The prevention of illness, injury and disability, reduction in the burden of illness and rehabilitation of those with a chronic disease. This recognises the social, cultural and political determinants of health. This is achieved through the organised and systematic responses to improve, protect and restore the health of populations and individuals. This includes both opportunistic and planned interventions in the general practice setting."

The key determinants of health are social support networks, employment and working conditions, social environments, physical environments, geographical isolation, personal health practices, healthy child development, ageing and disability, biology and genetic endowment, health services, gender and culture.

In the Aboriginal and Torres Strait Islander context this means that a population health approach to health services will assist in ensuring "that Aboriginal and Torres Strait Islander people enjoy a healthy life equal to that of the general population, that is enshrined by a strong living culture, dignity and justice".[2] This recognises the importance of achieving improvements to Aboriginal and Torres Strait Islander health and respects the particular health issues facing Indigenous people.

[1] **"The role of general practice in population health – A Joint Consensus Statement of the General Practice Partnership Advisory Council and the National Public Health Partnership Group" (Joint Advisory Group on General Practice and Population Health 2001)**
[2] **As defined in the Strategic Framework for Aboriginal and Torres Strait Islander Health**

SEIFA scores

Following the 2001 Census, the Australian Bureau of Statistics (ABS) produced four socioeconomic indexes for areas (SEIFA). The indexes describe various aspects of the socioeconomic make-up of populations in areas, using data collected in the 2001 Census.

The Index of Relative Socio-Economic Disadvantage (labelled 'Disadvantage' in Table 9) includes all variables that either reflect or measure disadvantage. The Index of Advantage/Disadvantage is used to rank areas in terms of both advantage and disadvantage: any information on advantaged persons in an area will offset information on disadvantaged persons in the area. The Index of Economic Resources and the Index of Education and Occupation were targeted towards specific aspects of advantage/disadvantage.

For further information on the composition and calculation of these indexes see the ABS Information Paper ABS Cat No. 2039.0 available on the ABS web site www.abs.gov.au. The scores for these indexes for each Statistical Local Area (SLA) or part SLA in Monash DGP are shown in Table 9.

In using this table, users should note that the index score shown for SLAs with less than 100 per cent in the Division represents the score for the whole SLA, and not just the part shown. However, SLAs with small proportions may have little influence on the average index score for the Division which has been based on the postcodes in the Division.

Table 9: SEIFA scores by SLA, Monash DGP, 2001

SLA code	SLA name (& per cent of SLA in the Division)		Index score			
			Disadvantage	Advantage	Economic Resources	Education & Occupation
20912	Bayside - South	(8.1)	1093	1117	1110	1116
22311	Glen Eira - Caulfield	(41.3)	1089	1121	1087	1141
22314	Glen Eira - South	(100.0)	1075	1072	1055	1080
22674	Gr. Dandenong Balance	(26.2)	862	903	936	888
23431	Kingston - North	(34.5)	1021	1023	1026	1012
24971	Monash - South-West	(11.2)	1005	1023	999	1043

[*] **Proportions are approximate and are known to be incorrect in some cases, due to errors in the concordance used to allocate CDs to form postal areas**

Statistical geography of the Monash DGP

The postcodes in the Division (all 100%) are 3163, 3165, 3167, 3169, 3171, 3189, 3202, and 3204[2].

Statistical Local Areas (SLAs) are defined by the Australian Bureau of Statistics to produce areas for the presentation and analysis of data. In this Division, Local Government Areas (LGAs) have been split into SLAs. For example, the LGA of Glen Eira has two SLAs – Caulfield and South. All or part of these SLAs and the other SLAs in Table 10 comprise the Division.

Table 10: SLAs in Monash DGP by 2001 boundaries

SLA code	SLA name	Per cent of the SLA's population in the Division*	Estimate of the SLA's 2004 population in the Division
20912	Bayside - South	8.1	4,309
22311	Glen Eira - Caulfield	41.3	31,098
22314	Glen Eira - South	100.0	47,307
22674	Gr. Dandenong Balance	26.2	18,536
23431	Kingston - North	34.5	31,250
24971	Monash - South West	11.2	4,712

* **Proportions are approximate and are known to be incorrect in some cases, due to errors in the concordance used to allocate CDs to form postal areas**

Supporting data

The data used in Figure 5 to illustrate the rates of premature mortality in the Division are shown below in Table 11.

Table 11: Deaths before 75 years of age by major condition group and selected cause, Monash DGP‡, Melbourne and Australia, 2000-02*

Indirectly age standardised rate per 100,000 population

Variable	Monash DGP‡		Melbourne		Australia	
	No.	Rate	No.	Rate	No.	Rate
Circulatory system diseases	234	58.7	5,667	64.0	38,357	72.3
Ischaemic heart disease	135	33.8	3,367	38.0	23,364	44.1
Cerebrovascular disease – stroke	53	13.2	1,109	12.5	6,920	13.0
Cancer	422	107.9	10,035	113.1	60,603	114.3
Cancer of the trachea, bronchus & lung	101	25.5	2,028	23.0	12,715	24.0
Respiratory system diseases	61	15.0	1,364	15.4	9,726	18.3
Chronic lower respiratory disease	41	10.1	931	10.5	6,657	12.6
Injuries and poisonings	110	29.6	2,752	29.3	18,573	35.0
Suicide	47	12.5	994	10.5	6,706	12.6
Motor vehicle accidents	23	6.2	685	7.3	5,014	9.5
Other causes	161	42.0	4,323	48.3	26,735	50.4
Diabetes mellitus	27	6.8	713	8.0	3,734	7.0

* **'No.' is the total number of deaths for the 2000-02 period; 'Rate' is an annual rate, based on the 3 year average**
‡ **See note under 'Data converters and mapping' re calculation of Division totals**

[2] **As per the Department of Health and Ageing web site (accessed online version as at February 2005):** http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-divisions-divspc.htm

The rates used to illustrate the prevalence estimates of chronic disease and injury (Figure 6), measures of self-reported health (Figure 7), and selected risk factors (Figure 8), are shown in Table 12 below.

Table 12: Estimates of chronic disease and associated risk factors, Monash DGP‡, Melbourne and Australia, 2001

Indirectly age standardised rate per 1,000 population

Variable	Monash DGP‡	Melbourne	Australia
Chronic disease and injury (Figure 6)			
Respiratory system diseases	325.2	326.6	310.8
Asthma	119.9	121.4	118.3
Circulatory system diseases	164.4	164.9	171.5
Diabetes type 2	23.8	24.2	23.4
Injury event	112.7	113.7	121.2
Mental & behavioural disorders	94.2	95.1	97.6
Musculoskeletal system diseases	321.8	326.0	326.2
Arthritis	130.5	132.9	138.8
- Osteoarthritis	69.1	70.0	74.9
- Rheumatoid arthritis	22.6	23.0	23.6
Osteoporosis (females)	23.8	23.5	26.4
Measures of self-reported health (Figure 7)			
Very high psychological distress levels (18+ years)	35.9	35.6	36.6
Fair or poor self-assessed health status (15+ years)	179.3	182.5	184.0
Risk factors (Figure 8)			
Overweight (not obese) males (15+ years)	396.9	401.5	389.7
Obese males (15+ years)	126.5	132.0	145.9
Overweight (not obese) females (15+ years)	223.1	223.1	223.9
Obese females (15+ years)	136.6	141.9	148.0
Smokers (18+ years)	222.4	230.8	248.0
Physical inactivity (15+ years)	277.5	283.5	315.5
High health risk due to alcohol consumed (18+ years)	34.8	36.3	42.1

‡ **See note under 'Data converters and mapping' re calculation of Division totals**

References

Australian Bureau of Statistics (ABS) (2002). *2001 National Health Survey: summary of results.* Australia. (ABS Cat. No. 4364.0). Canberra: ABS.

National Public Health Partnership (NPHP) (2001). *Preventing Chronic Disease: A Strategic Framework.* Melbourne, Victoria.

Thacker S, Stroup D & Rothenberg R (1995). Public health surveillance for chronic conditions: a scientific basis for decisions. *Statistics in Medicine* 14: 629-641.

World Health Organization (2002). *The World Health Report 2002: Reducing Risks, Promoting Healthy Life.* Geneva: World Health Organization.

Acknowledgements

Funding for these profiles was provided by the Population Health Division of the Department of Health and Ageing (DoHA). Assistance, by way of comment on the profiles and assistance in obtaining some datasets, has also been received from the Primary Care Division of the DoHA, the ABS and the ACIR.

Further developments and updates

Subject to agreement and funding, a number of developments could be undertaken:

- Details of hospitalisations potentially avoidable through ambulatory care interventions are currently being prepared and will be forwarded to Divisions (and posted on the PHIDU web site) when they are available. Other enhancements will be considered as appropriate datasets become available.

The profiles could be updated as the data are updated. For example:

- Population estimates, avoidable hospitalisations, immunisation, and GP activity and workforce data – annually;
- Chronic disease estimates – three-yearly;
- Census data – five-yearly.

Any developments would be informed by consultation, including with Divisions.

PHIDU contact details

For general comments, data issues or enquiries re information on the web site, please contact PHIDU:

Phone: 08-8303 6236 or e-mail: PHIDU@publichealth.gov.au