

# Population health profile of the Barossa

## Division of General Practice

Population Profile Series: No. 91

PHIDU

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***A Collaborating Unit of the Australian Institute of Health and Welfare***

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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 Barossa Division of General Practice

## Introduction

This profile has been designed to provide a description of the population of the Barossa 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 17.

## 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. country SA and Australia). Specific topics covered include:

- a socio-demographic profile (pages 2-6);
- GP workforce data (page 7);
- immunisation rates (page 7);
- rates of premature death (page 8); and
- estimates of the prevalence of chronic disease and selected risk factors (pages 9-13).

## Key indicators

<b>Location:</b>	South Australia		
<b>Division number:</b>	506		
<b>Population‡:</b>	<b>No.</b>	<b>%</b>	
Total	36,910		
65+	5,088	13.8%	
<25	11,958	32.4%	
Indigenous	247	0.7%	
<b>Disadvantage score<sup>1</sup>:</b>	1011		
<b>GP services per head of population:</b>			
Division‡	4.2		
Australia	4.7		
<b>Population per FTE GP:</b>			
Division‡	1,287		
Australia	1,403		
<b>Premature death rate<sup>2</sup>:</b>			
Division‡	268.6		
Australia	290.4		

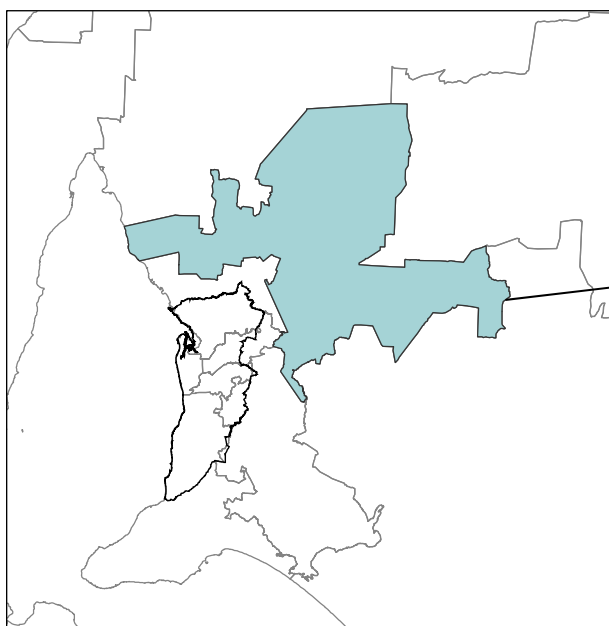
<sup>1</sup> Numbers above 1000 (the index score for Australia) indicate the Division is relatively advantaged

<sup>2</sup> Deaths at ages 0 to 74 years per 100,000 population

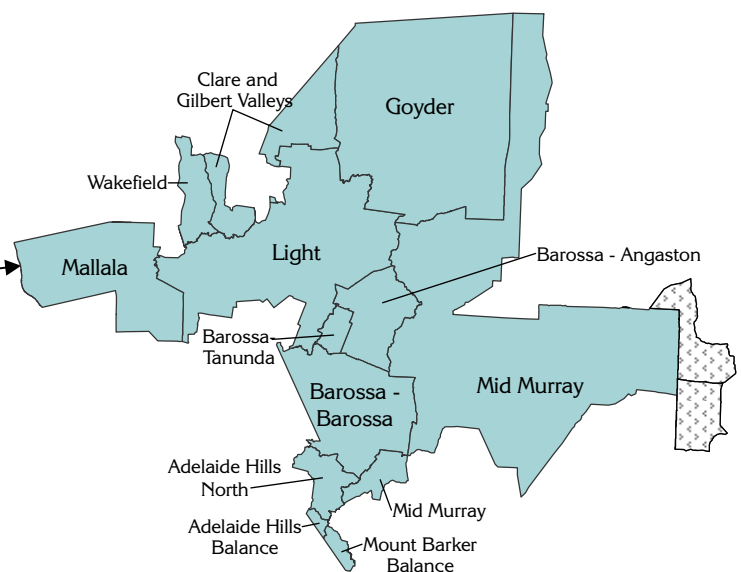
‡ See note "Data converters and mapping" re calculation of Division Total

## Barossa Division of General Practice

SA Divisions of General Practice



Barossa DGP by SLA



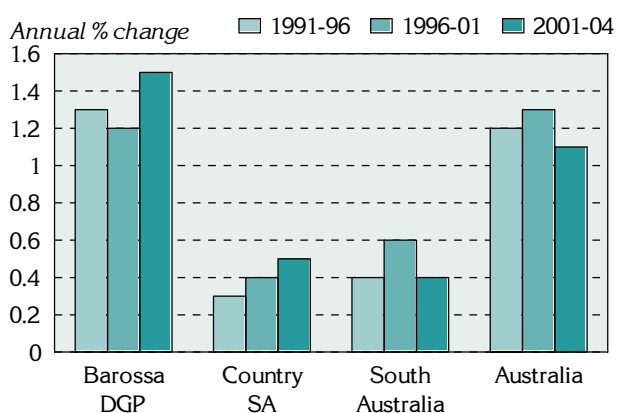
— SA Divisions of General Practice  
 — Adelaide Statistical Division

# Socio-demographic profile

## Population

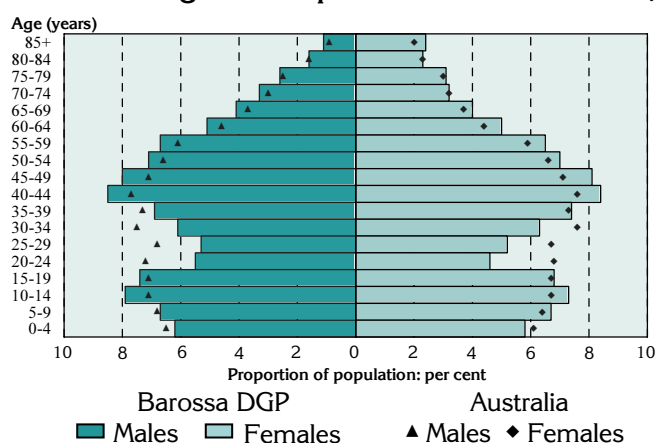
The Barossa Division had an Estimated Resident Population of 36,910 at 30 June 2004.

**Figure 1: Annual population change, Barossa DGP‡, country South Australia<sup>1</sup>, South Australia 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 1.3% on average each year, higher than in country South Australia (0.3%) and South Australia (0.4%). From 1996 to 2001, the annual percentage increase in the Division was 1.2%, greater than for country South Australia (0.4%) and South Australia (0.6%). The Division's growth rate of 1.5% per year on average from 2001 to 2004 was greater than the annual increases for country South Australia (0.5%) and for South Australia (0.4%).

**Figure 2: Population in Barossa 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 – higher proportions of females aged 5 to 14 years, and males aged 10 to 19 years;
- from 20 to 34 years – markedly lower proportions of both males and females;
- from 40 to 69 years – higher proportions of both males and females; and
- at the oldest ages – a higher proportion of females aged 85 years and over.

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

Age group (years)	Barossa DGP		Australia	
	No.	%	No.	%
0-14	7,509	20.3	3,978,751	19.8
15-24	4,449	12.1	2,762,769	13.8
25-44	9,997	27.1	5,881,048	29.3
45-64	9,867	26.7	4,864,037	24.2
65-74	2,697	7.3	1,374,792	6.8
75-84	1,763	4.8	934,505	4.7
85+	627	1.7	295,602	1.5
<b>Total</b>	<b>36,910</b>	<b>100.0</b>	<b>20,091,504</b>	<b>100.0</b>

As shown in the age-sex pyramid above, the Barossa DGP had fewer young people aged 15 to 24 years (12.1%) and people aged 25 to 44 years (27.1%) than Australia as a whole (with 13.8% and 29.3%) (Table 1). Conversely, the proportions of the Division's population aged 45 years and over were higher than for Australia.

The Barossa DGP comprised 2.8% of people born in predominantly non-English speaking countries and resident in Australia for five years or more (Table 2), less than in country South Australia (3.6%) and Australia (10.8%). Recent arrivals (those resident in Australia for less than five years) from non-English speaking countries comprise 0.2% of the Division's population, slightly less than in country South Australia (0.3%).

<sup>1</sup>References to 'country South Australia' relate to South Australia excluding the Adelaide Statistical Division

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

Of these residents, 0.2% 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'), a lower proportion than country SA (0.4%), South Australia (1.8%) and Australia (2.4%).

**Table 2: Non-English speaking born, Barossa DGP, country South Australia, South Australia and Australia, 2001**

People born in predominantly non-English speaking countries	Barossa DGP		Country SA		South Australia		Australia	
	No.	%	No.	%	No.	%	No.	%
Resident in Australia for five years or more	960	2.8	14,103	3.6	129,414	8.8	2,019,410	10.8
Resident in Australia for less than five years	53	0.2	1,124	0.3	17,145	1.2	408,074	2.2
Poor proficiency in English <sup>1</sup>	49	0.2	1,397	0.4	24,927	1.8	425,399	2.4

<sup>1</sup> Calculated on persons aged 5 years and over who reported speaking another language and speaking English 'not well' or 'not at all'

### Major non-English speaking birthplaces, Barossa DGP, 2001

Australian-born people comprised 88.5% of the Division's population, well above the Australian figure of 72.6%. Of the 8.5% of people from English speaking countries, 7.7% were from the UK and Eire. The major birthplaces of the non-English speaking population include Germany (0.8%); The Netherlands (0.5%); and Italy (0.2%); all other birthplaces of non-English speaking populations represented 0.1% or less of the Division's population.

## 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 Barossa DGP had notably fewer single parent families (8.0%) and substantially fewer Aboriginal and Torres Strait Islanders (0.7%) compared to country South Australia as a whole (with 9.7% and 3.5%, respectively) (Figure 3, Table 3).

Full-time secondary school education participation of 16 year olds living in the Division (82.4%) was slightly higher than for country South Australia (78.3%).

A lower proportion of the Division's households received rent assistance from Centrelink (9.0%) compared to country South Australia (10.5%), and substantially fewer dwellings were rented from the State housing authority (1.8%, compared to 6.7%). The proportion of dwellings with no access to a motor vehicle (4.5%) was also markedly lower than in country South Australia (7.4%) and South Australia (9.9%).

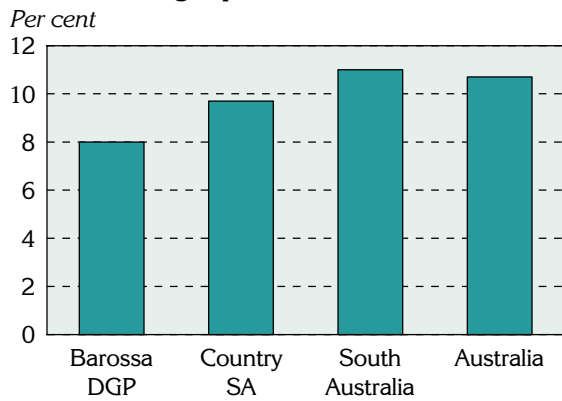
The Division had slightly higher proportions of the population who reported using, at home, a computer (39.6%) and the Internet (21.5%) compared to country South Australia (36.3% and 19.9%).

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

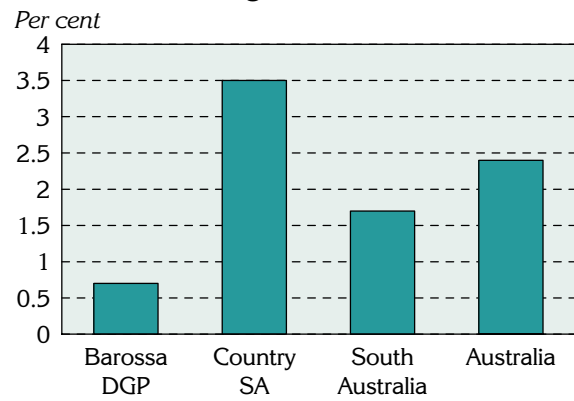
**Figure 3: Socio-demographic indicators, Barossa DGP, country South Australia, South Australia and Australia, 2001**

*Note the different scales*

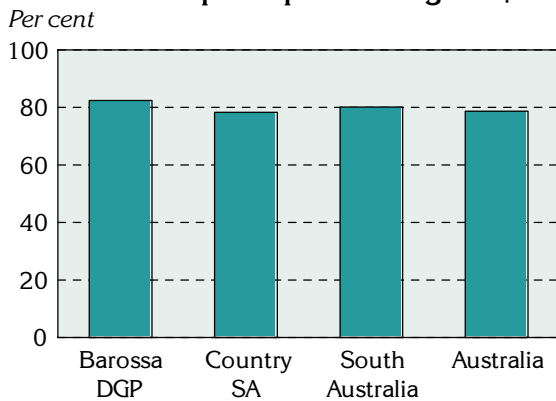
**Single parent families**



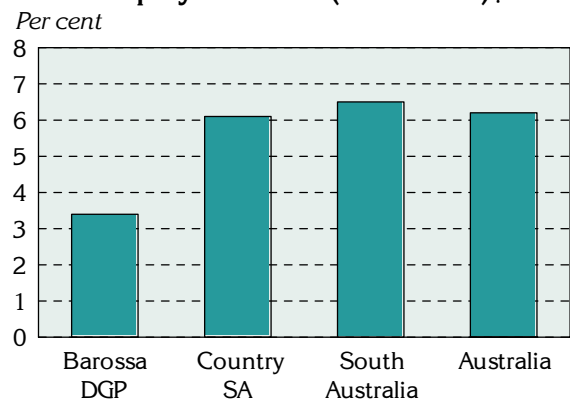
**Indigenous‡**



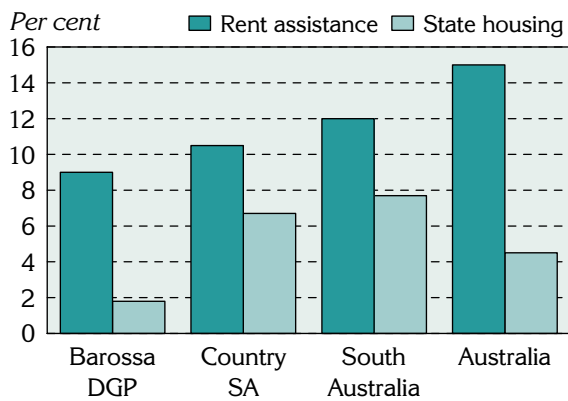
**Education participation at age 16‡**



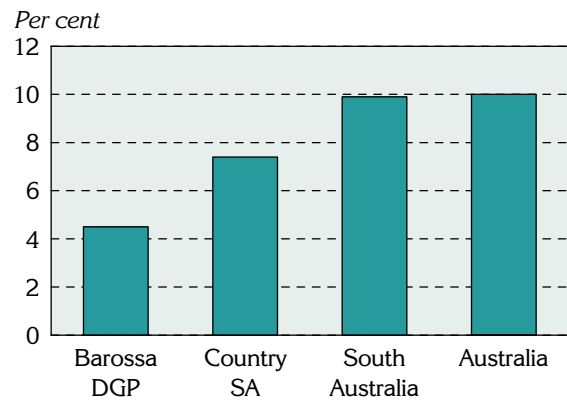
**Unemployment rate (June 2003)‡**



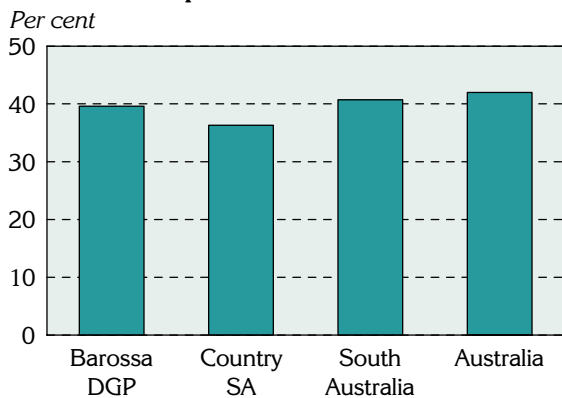
**Households receiving rent assistance & Dwellings rented from State housing authority**



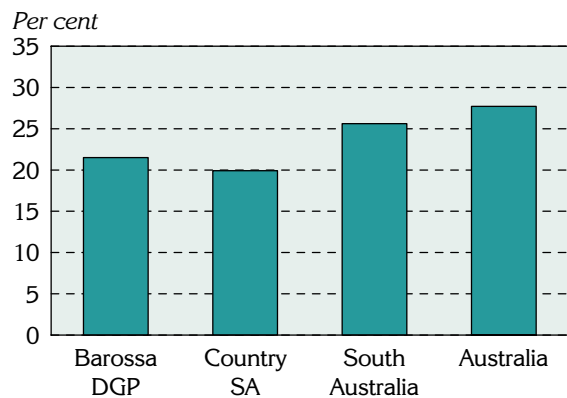
**Dwellings with no motor vehicle**



**Computer use at home**



**Internet use at home**



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

**Table 3: Socio-demographic indicators, Barossa DGP, country South Australia, South Australia, and Australia, 2001**

Indicator	Barossa DGP		Country SA		South Australia		Australia	
	No.	%	No.	%	No.	%	No.	%
Single parent families	763	8.0	10,351	9.7	43,741	11.0	529,969	10.7
Indigenous‡	247	0.7	13,602	3.5	25,542	1.7	458,261	2.4
Full-time secondary school education at age 16‡	437	82.4	4,410	78.3	16,341	80.1	130,198	78.7
Households: rent assistance	1,135	9.0	15,170	10.5	68,260	12.0	1,006,599	15.0
Dwellings: rented from the State housing authority	237	1.8	10,290	6.7	44,684	7.7	317,171	4.5
Dwellings: no motor vehicle	585	4.5	11,317	7.4	58,065	9.9	708,073	10.0
Computer use at home	13,450	39.6	142,671	36.3	594,355	40.7	7,881,983	42.0
Internet use at home	7,352	21.5	78,739	19.9	375,604	25.6	2,019,410	27.7

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

Barossa DGP's unemployment rate of 3.4% was markedly lower than the rates for country South Australia (6.1%) and South Australia (6.5%) (Figure 3, Table 4). The labour force participation rate (75.9%) was similar to that for country South Australia (75.2%) and the same as that for South Australia, while the female labour force participation rate (71.4%) was marginally higher than for country South Australia or South Australia (69.1% and 70.4%).

**Table 4: Unemployment and labour force participation, Barossa DGP, country South Australia, South Australia and Australia, 2003**

Labour force indicators	Barossa DGP		Country SA		South Australia		Australia	
	No.	%	No.	%	No.	%	No.	%
Unemployment rate‡	621	3.4	11,828	6.1	49,292	6.5	623,791	6.2
Labour force participation‡	18,174	75.9	192,901	75.2	761,964	75.3	10,038,147	75.2
Female labour force participation (2001)	5,718	71.4	62,392	69.1	254,312	70.4	3,306,521	69.7

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

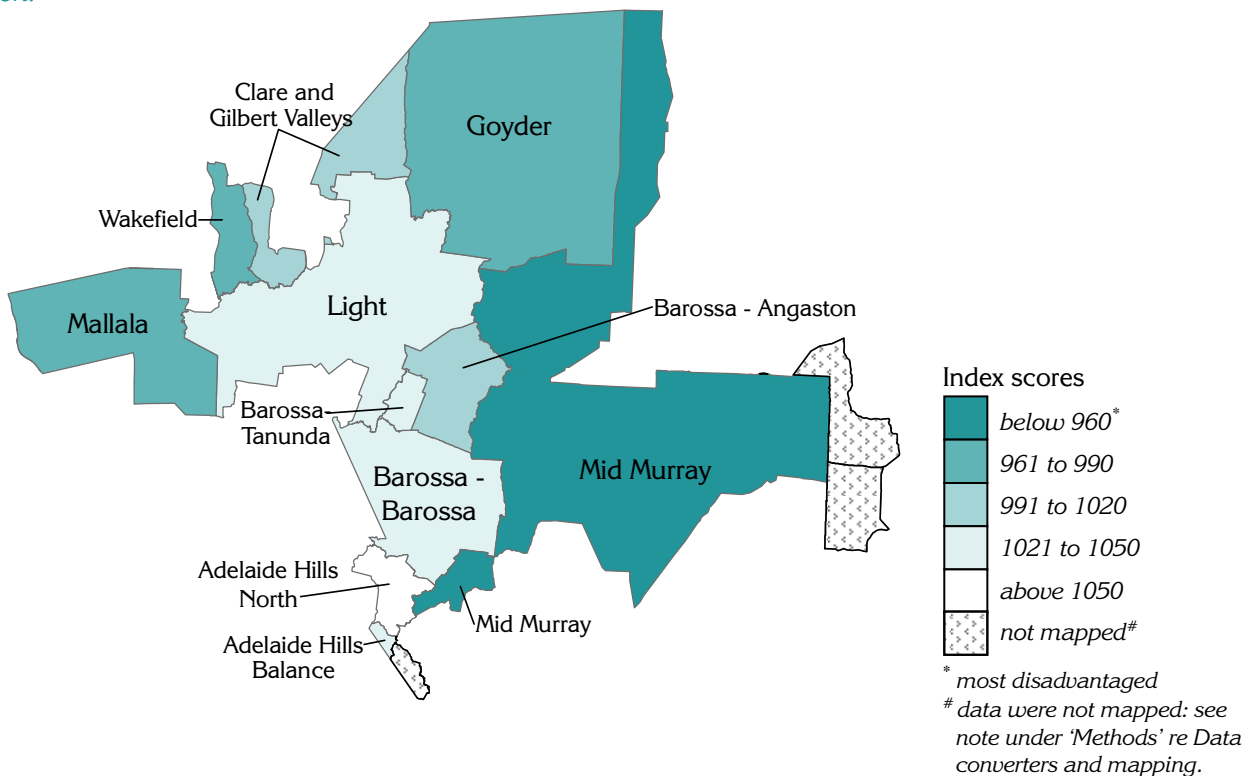
## Summary of the socioeconomic ranking of the Barossa DGP

Following the 2001 Census, the Australian Bureau of Statistics (ABS) produced four socio-economic indexes for areas (SEIFA) which describe aspects of the socioeconomic profile of populations in areas. The scores for these indexes for each Statistical Local Area (SLA) or part SLA in Barossa DGP are shown in the supporting information, Table 11, page 18: SLAs are described on page 19.

The Barossa DGP area's SEIFA Index of Relative Socio-Economic Disadvantage (IRSD) score is 1011, just (1.1%) above the average score for Australia (1000) and above the score for country South Australia (981); this highlights the relatively higher socioeconomic status profile of the Barossa DGP population. Variations in the IRSD within the Division are shown in Map 1 at the SLA level.

**Map 1: Index of Relative Socio-Economic Disadvantage by SLA, Barossa 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.*





## General medical practitioner (GP) supply

A total of 28.5 full-time equivalent (FTE) GPs and 29.3 full-workload equivalent (FWE<sup>2</sup>) GPs worked in the Division in 2003/04 (Table 5). Of the FWE GPs, 15.5% were female, and 15.9% were over 55 years of age (compared to 23.4% and 30.5%, respectively, for South Australia).

There was minimal variation in the rates of population per FTE and FWE GP for the population measures shown, other than for the estimated day-time population, for which rates were 9.1% below those calculated on the Usual Resident Population (usual residents of the Division counted in Australia on Census night). The rates of population per FWE GP were lower than the FTE rates.

Based on the Estimated Resident Population as at 30 June 2003 and 2004, the rate of population per FTE GP in Barossa DGP was similar to the rate for South Australia, indicating a similar level of provision of GP services, but lower than the rate for Australia, indicating a higher level than the national average. The rate per FWE GP was higher than the rates for both South Australia and Australia.

**Table 5: Population per GP in Barossa DGP, South Australia and Australia, 2003/04**

Population measure	Population	GPs		Population per GP	
		FTE	FWE	FTE	FWE
<b>Barossa DGP</b>					
Census count (adjusted)*	35,375	28.5	29.3	1,243	1,209
Usual Resident Population (URP) (adjusted)*	35,634	..	..	1,252	1,217
Estimated Resident Population (ERP)	36,642	..	..	1,287	1,252
Day-time population (estimated on URP)* ‡	32,378	..	..	1,137	1,106
<b>South Australia (ERP)</b>	1,530,276	1,181	1,354	1,296	1,130
<b>Australia (ERP)</b>	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 2003/04, 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 95.2% 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 92.2%, compared to 70.0% for Australia, with 7.8% provided at a community health centre or by a community health worker.

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

Provider	Barossa DGP	Australia
	%	%
General practitioner	92.2	70.0
Local government council	0.0	16.6
Community health centre/ worker	7.8	9.8
Public hospital	0.0	2.1
Aboriginal health service/ worker	0.0	0.9
Other*	0.0	0.6
<b>Total: Per cent</b>	<b>100.0</b>	<b>100.0</b>
<b>Number</b>	<b>5,749</b>	<b>3,843,610</b>

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

<sup>2</sup>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 (268.6 deaths per 100,000 population) is markedly lower than for country South Australia (318.6), and is also well below the rate for 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.

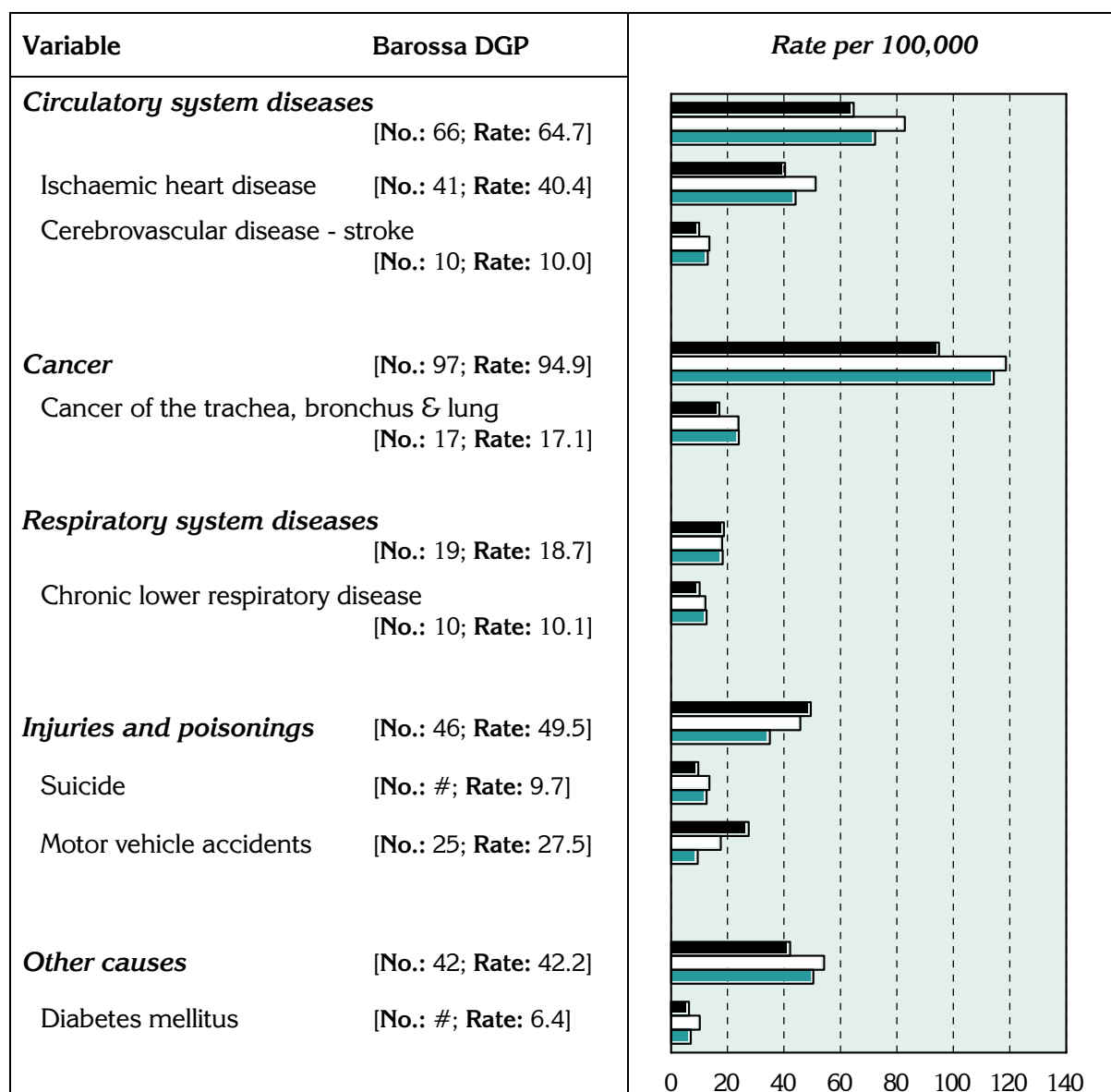
The major causes of premature mortality in the Division, as for country South Australia and Australia as a whole, are cancer and diseases of the circulatory system (Figure 4). With the exception of respiratory system diseases, injuries and poisonings and motor vehicle accidents, death rates in the Division were lower than for country South Australia and Australia.

The data on which the following chart is based are in Table 12.

**Figure 4: Deaths before 75 years of age by major condition group and selected cause, Barossa DGP‡, country South Australia and Australia, 2000-02\***

*Indirectly age standardised rate per 100,000 population*

■ Barossa DGP      □ Country SA      ■ Australia



\* 'No.' is the total number of deaths for the 2000-02 period; 'Rate' is an annual rate, based on the 3 year average  
#not shown, as there are less than 10 cases over the period

‡ 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 non-remote 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 15-16. The data on which the following charts are based are in Table 13.

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), obesity, 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 exception of respiratory system diseases (including asthma) and diabetes type 2 and osteoporosis (females), relatively more people in Barossa DGP reported having any of the selected chronic conditions than in Australia as a whole (Figure 5); that is, the prevalence rates per 1,000 population were higher.

### Prevalence estimates: self-reported health‡

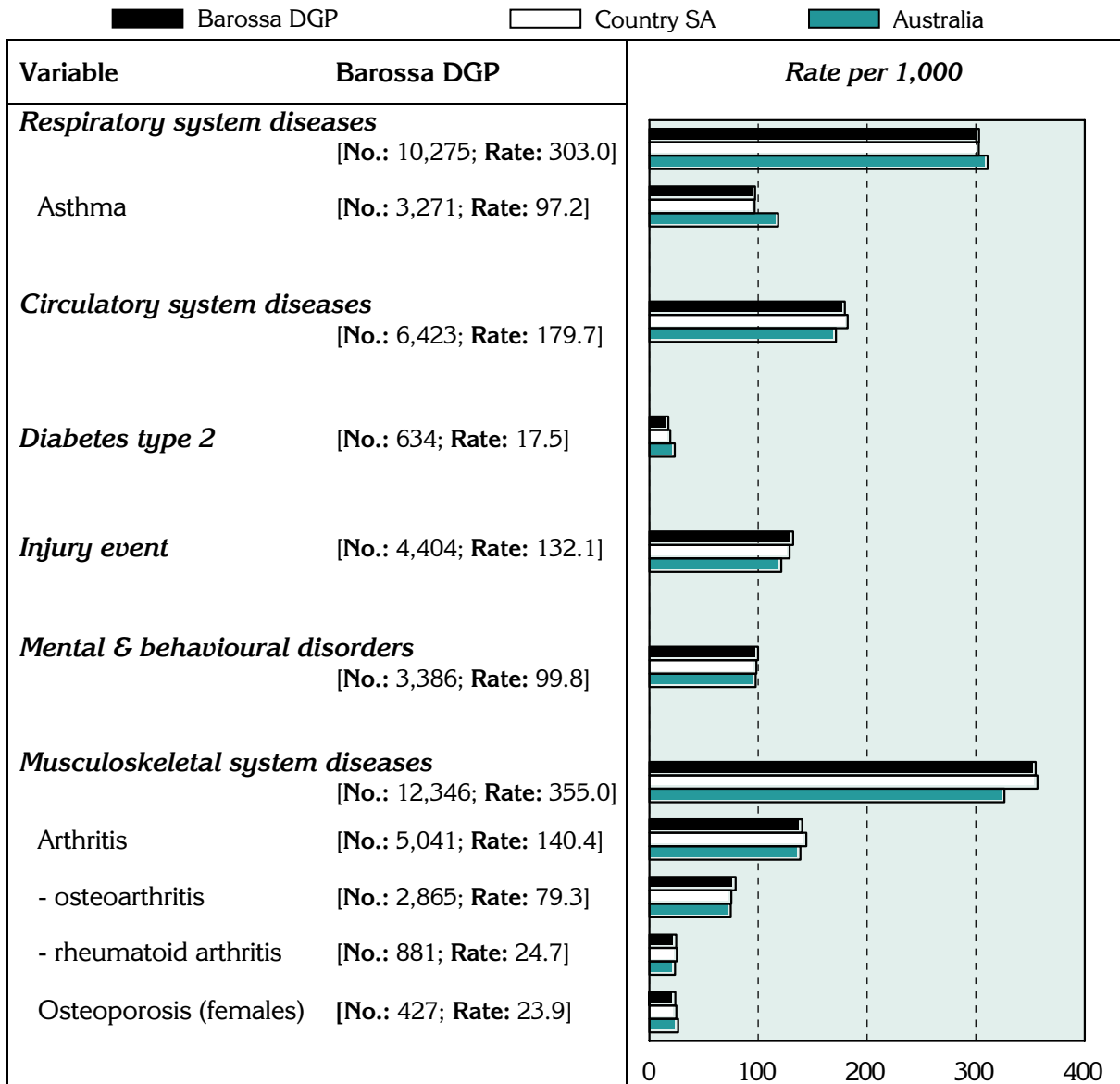
The NHS includes two measures of self-reported health. One is the Kessler Psychological Distress Scale-10 items (K-10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the four weeks prior to interview, asked of respondents 18 years and 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 population of the Division aged 18 years and over is estimated to have fewer people with very high psychological distress levels as measured by the K-10 compared to Australia as a whole (Figure 6). Conversely, the proportion of the population aged 15 years and over estimated to have reported their health as ‘fair’ or ‘poor’ is slightly above the national average.

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

Figure 5: Estimates\* of chronic disease and injury, Barossa DGP‡, country South Australia and Australia, 2001

Indirectly age standardised rate per 1,000 population

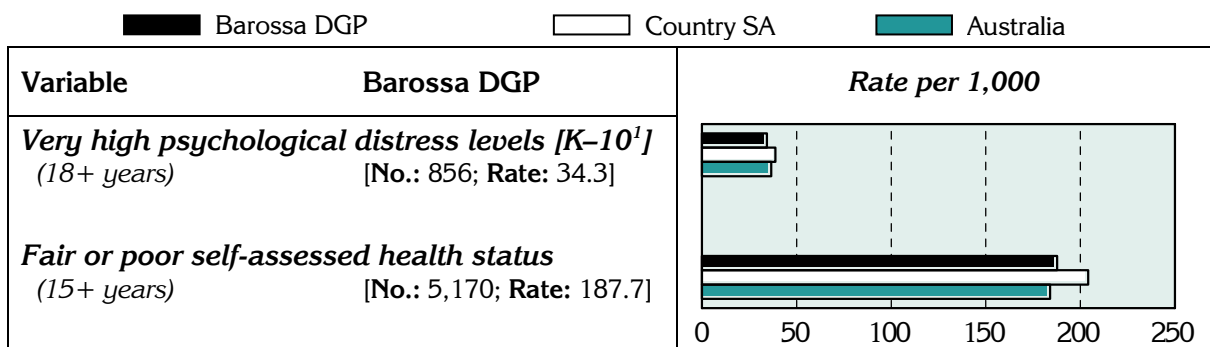


\* 'No.' is a weighted estimate of the number of people in Barossa DGP reporting each chronic condition and is derived from synthetic predictions from the 2001 NHS.

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

Figure 6: Estimates\* of measures of self-reported health by SLA, Barossa DGP‡, country South Australia and Australia, 2001

Indirectly age standardised rate per 1,000 population



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

<sup>1</sup> Kessler 10

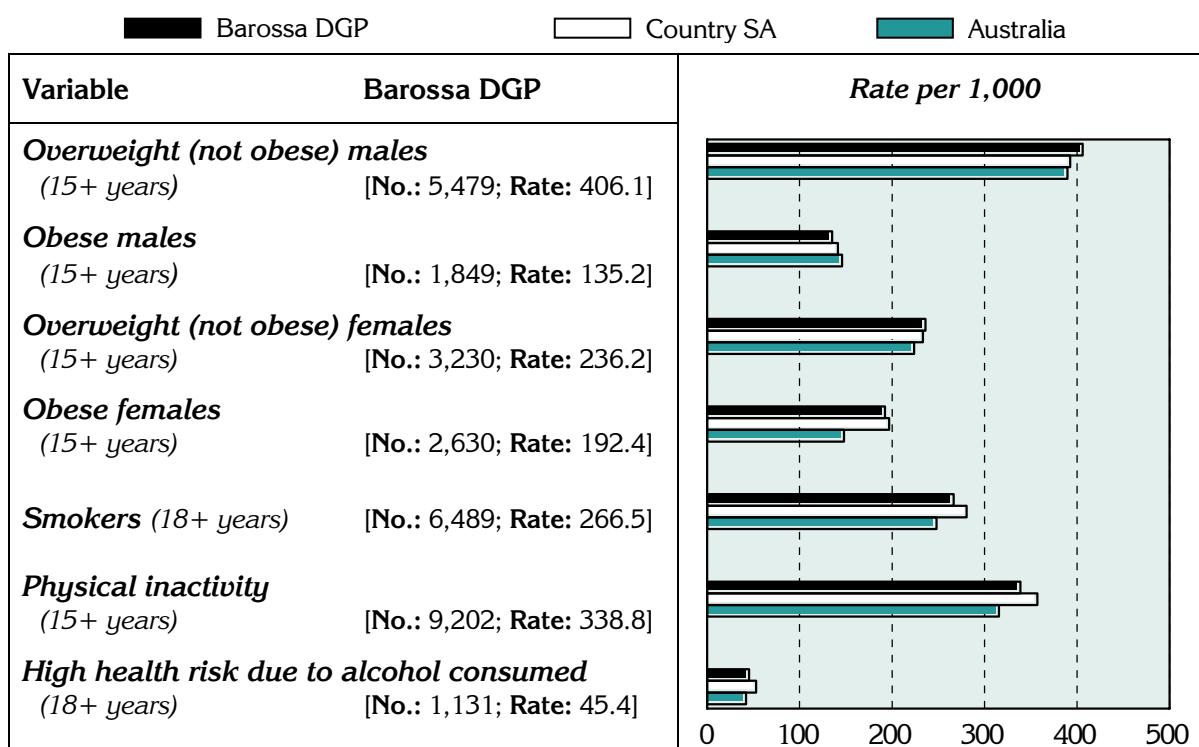
‡ See note under 'Data converters and mapping' re calculation of Division totals

## Prevalence estimates: risk factors‡

The Barossa DGP had higher rates (when compared with the Australian population) for all of the selected risk factors except obesity in males (Figure 7).

**Figure 7: Estimates\* of selected risk factors, Barossa DGP‡, country South Australia and Australia, 2001**

*Indirectly age standardised rate per 1,000 population*



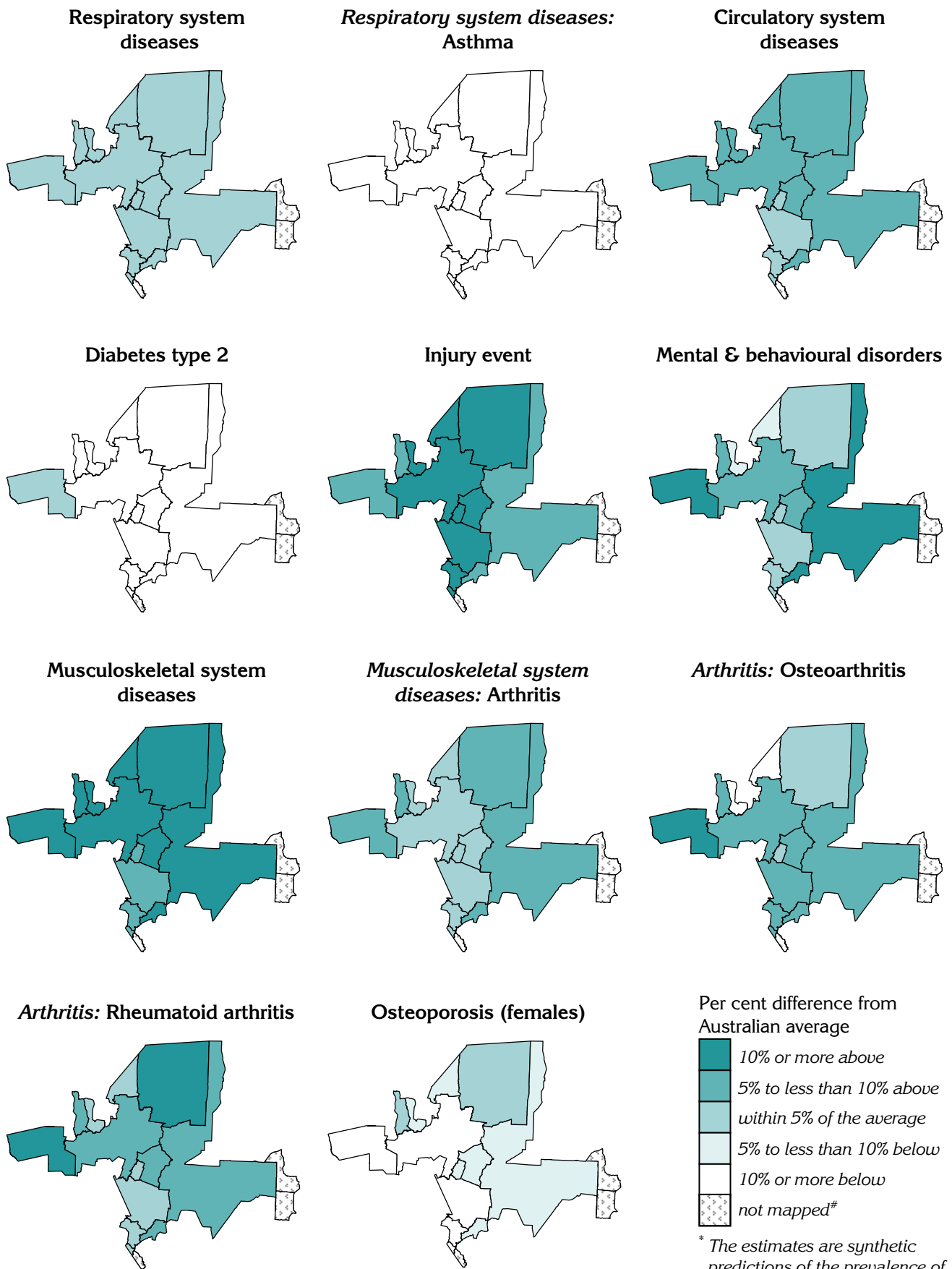
\*'No.' is a weighted estimate of the number of people in Barossa DGP with these risk factors and has been predicted using data from the 2001 NHS and known data for the Division

‡ 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 11, page 19, 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.

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



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
- not mapped<sup>#</sup>

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

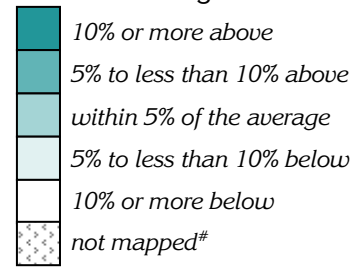
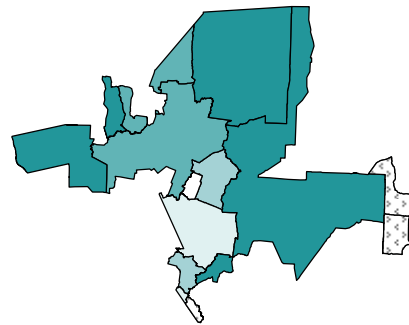
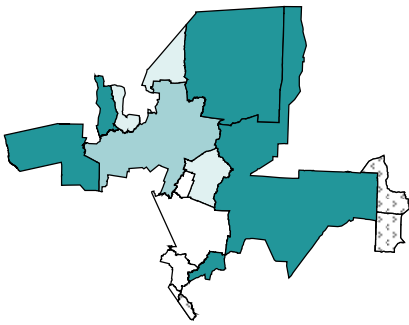
<sup>#</sup> Data not mapped: see Notes on the data.

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

**Very high psychological distress levels [K-10<sup>1</sup>] (18+ years)**

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

Per cent difference from Australian average



<sup>1</sup> Kessler 10

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

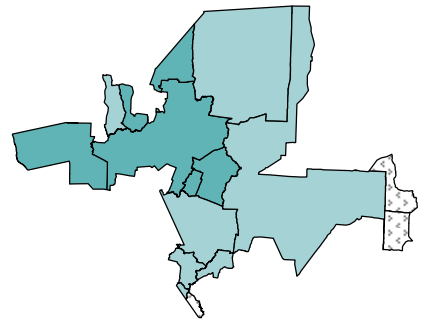
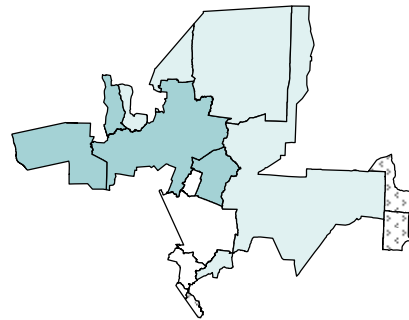
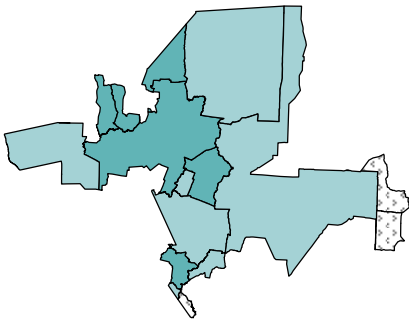
# Data not mapped: see Notes on the data.

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

**Overweight (not obese) males (15+ years)**

**Obese males (15+ years)**

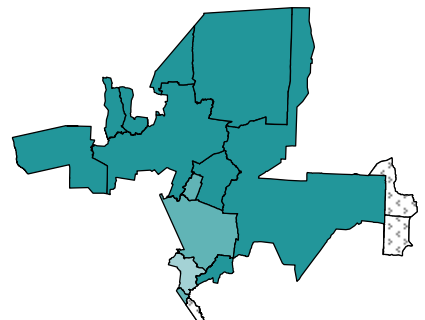
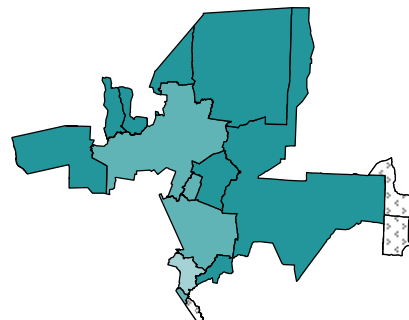
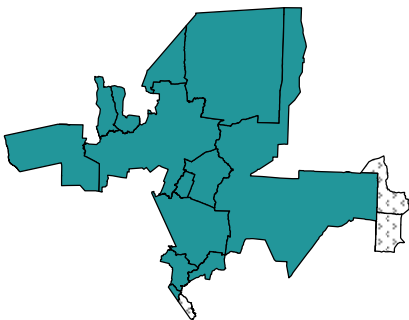
**Overweight (not obese) females (15+ years)**



**Obese females (15+ years)**

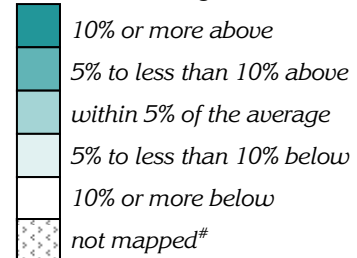
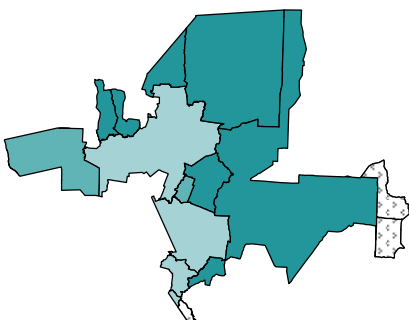
**Smokers (18+ years)**

**Physical inactivity (15+ years)**



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

Per cent difference from Australian average



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

# Data not mapped: see Notes on the data.

# Notes on the data

## Data sources and limitations

### General

References to 'country South Australia' relate to South Australia excluding the Adelaide Statistical Division.

### Data sources

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

**Table 7: Data sources**

Section	Source
<b>Key indicators</b>	
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
<b>Socio-demographic profile</b>	
Figures 1 and 2; Table 1	Estimated Resident Population, ABS, 30 June for the periods shown
Tables 2, 3 and 4; Figure 3	Data were extracted by postal area from the ABS Population Census 2001 <sup>1</sup> , except for the following indicators: - <i>Indigenous</i> – Experimental estimates of Aboriginal and Torres Strait Islander people, ABS 2001 (unpublished) - <i>Full-time secondary education participation at age 16</i> – Census 2001 (unpublished) - <i>Households receiving rent assistance</i> – Centrelink, December Quarter 2001 (unpublished) - <i>Unemployment rate / Labour force participation</i> – extracted from <i>Small Area Labour Markets Australia</i> , June Quarter 2003, Department of Employment and Workplace Relations
Map 1; Table 9	ABS SEIFA package, Census 2001
<b>General medical practitioner (GP) supply</b>	
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 <sup>2</sup> , ABS Population Census 2001, scaled to 2003/04 - Usual Resident Population <sup>3</sup> , 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
<b>Immunisation</b>	
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)
<b>Premature mortality</b>	
Figure 4; Table 12	ABS Deaths, 2000 to 2002
<b>Chronic diseases and associated risk factors<sup>4</sup></b>	
Figures 5, 6 and 7; Maps 2, 3 and 4; Table 13	Estimated from 2001 National Health Survey (NHS), ABS (unpublished)

<sup>1</sup> All data extracted from Usual Residents Profile, except for data variables only released in the Basic Community Profile

<sup>2</sup> *Census count* - those counted in the Division on Census night, including tourists, business people and other visitors

<sup>3</sup> *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

<sup>4</sup> 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
<b>Estimates of chronic disease and injury</b> (Figure 5 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
<b>Estimates of measures of self-reported health</b> (Figure 6 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
<b>Estimates of selected risk factors</b> (Figure 7 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 (Table 10).

#### [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 11.

#### [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](http://www.publichealth.gov.au).

### A definition of population health

Population health, in the context of general practice, has been defined<sup>1</sup> 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”.<sup>2</sup> This recognises the importance of achieving improvements to Aboriginal and Torres Strait Islander health and respects the particular health issues facing Indigenous people.

<sup>1</sup> “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)

<sup>2</sup> 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](http://www.abs.gov.au). The scores for these indexes for each Statistical Local Area (SLA) or part SLA in Barossa 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, Barossa DGP, 2001**

SLA name (% per cent of SLA in the Division)	Index score			
	Disadvantage	Advantage	Economic Resources	Education & Occupation
Adelaide Hills - North (24.9)	1074	1022	997	1019
Adelaide Hills - Balance (7.7)	1047	1000	985	998
Barossa - Angaston (100.0)	1007	956	977	933
Barossa - Barossa (58.7)	1041	983	977	976
Barossa - Tanunda (100.0)	1038	991	996	975
Clare and Gilbert Valleys (12.5)	1019	960	949	961
Goyder (37.8)	984	908	885	922
Light (72.5)	1021	959	958	948
Mallala (38.7)	975	913	940	887
Mid Murray (30.2)	957	887	876	901
Wakefield (10.5)	976	905	898	908

\* 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

Note: Scores are not shown for SLAs in the Division with estimated populations of less than 100 (refer to Table 11)

### Statistical geography of the Barossa DGP

The Barossa DGP covers 7,063 square kilometres, based on 2001 SLA data.

The postcodes in the Division (as per the Department of Health and Ageing website) are shown below (Table 10).

**Table 10: Postcodes in Barossa DGP, 2004**

Postcode	Per cent of postcode population in the Division*	Postcode	Per cent of postcode population in the Division*	Postcode	Per cent of postcode population in the Division*
5233	25	5354	100	5400	100
5234	100	5355	100	5401	100
5235	100	5356	100	5402	100
5236	100	5360	100	5410	100
5244	25	5372	100	5412	33
5351	50	5373	100	5413	33
5352	100	5374	100	5501	25
5353	100	5381	50	5502	100

\* Proportions are approximate

Source: 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>

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, a number of Local Government Areas (LGAs) have been split into SLAs. For example, the District Council of Barossa is comprised of three SLAs - Angaston (all of which is in the Division), Barossa (just over half of which is in the Division), and Tanunda (all in the Division). These SLAs and parts of the other SLAs listed in Table 11 comprise the Division.

**Table 11: SLAs in Barossa 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
40125	Adelaide Hills - North	24.9	1,683
40128	Adelaide Hills - Balance	7.7	683
40311	Barossa - Angaston	100.0	7,973
40314	Barossa - Barossa	58.7	4,567
40315	Barossa - Tanunda	100.0	4,615
41140	Clare and Gilbert Valleys	12.5	1,034
42110	Goyder	37.8	1,572
43650	Light	72.5	8,484
43920	Mallala	38.7	2,994
44210	Mid Murray	30.2	2,544
44554	Mount Barker - Balance	0.9	#
48130	Wakefield	10.5	688

\* 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

# Not shown as the total population is less than 100

## Supporting data

The data used in Figure 4 to illustrate the rates of premature mortality in the Division are shown below in Table 12.

**Table 12: Deaths before 75 years of age by major condition group and selected cause, Barossa DGP‡, country South Australia, and Australia, 2000-02\***

*Indirectly age standardised rate per 100,000 population*

Variable	Barossa DGP‡		Country SA		Australia	
	No.	Rate	No.	Rate	No.	Rate
<b>Circulatory system diseases</b>	66	64.7	1,018	82.8	38,357	72.3
Ischaemic heart disease	41	40.4	631	51.2	23,364	44.1
Cerebrovascular disease – stroke	10	10.0	168	13.6	6,920	13.0
<b>Cancer</b>	97	94.9	1,453	118.6	60,603	114.3
Cancer of the trachea, bronchus & lung	17	17.1	296	23.9	12,715	24.0
<b>Respiratory system diseases</b>	19	18.7	223	18.1	9,726	18.3
Chronic lower respiratory disease	10	10.1	151	12.2	6,657	12.6
<b>Injuries and poisonings</b>	46	49.5	488	45.8	18,573	35.0
Suicide	#	9.7	145	13.6	6,706	12.6
Motor vehicle accidents	25	27.5	183	17.6	5,014	9.5
<b>Other causes</b>	42	42.2	637	54.2	26,735	50.4
Diabetes mellitus	#	6.4	126	10.2	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

# not shown, as there are less than 10 cases over the period

The rates used to illustrate the prevalence estimates of chronic disease and injury (Figure 5), measures of self-reported health (Figure 6), and selected risk factors (Figure 7), are shown in Table 13 below.

**Table 13: Estimates of chronic disease and associated risk factors, Barossa DGP‡, country South Australia and Australia, 2001**

*Indirectly age standardised rate per 1,000 population*

Variable	Barossa DGP‡	Country SA	Australia
<b>Chronic disease and injury (Figure 5)</b>			
Respiratory system diseases	303.0	302.7	310.8
Asthma	97.2	96.8	118.3
Circulatory system diseases	179.7	182.2	171.5
Diabetes type 2	17.5	19.2	23.4
Injury event	132.1	128.9	121.2
Mental & behavioural disorders	99.8	98.3	97.6
Musculoskeletal system diseases	355.0	356.6	326.2
Arthritis	140.4	144.2	138.8
- Osteoarthritis	79.3	75.3	74.9
- Rheumatoid arthritis	24.7	25.3	23.6
Osteoporosis (females)	23.9	24.8	26.4
<b>Measures of self-reported health (Figure 6)</b>			
Very high psychological distress levels (18+ years)	34.3	38.8	36.6
Fair or poor self-assessed health status (15+ years)	187.7	204.1	184.0
<b>Risk factors (Figure 7)</b>			
Overweight (not obese) males (15+ years)	406.1	392.6	389.7
Obese males (15+ years)	135.2	141.4	145.9
Overweight (not obese) females (15+ years)	236.2	233.4	223.9
Obese females (15+ years)	192.4	196.8	148.0
Smokers (18+ years)	266.5	280.6	248.0
Physical inactivity (15+ years)	338.8	357.1	315.5
High health risk due to alcohol consumed (18+ years)	45.4	53.0	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.

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## Further developments and updates [subject to agreement/funding]:

- 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 data in the profiles will be updated as the data are updated: eg
  - Population estimates, avoidable hospitalisations, ACIR and HIC data – annually;
  - Chronic disease estimates – three-yearly;
  - Census data – five-yearly.

## PHIDU contact details

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

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