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Australian Institute for Primary Care & Ageing

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50+ in Banyule: A data story

Report for Banyule agencies

Part 1: Health and Wellbeing

Commissioned by the North East Primary Care Partnership

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Suggested reference:

Wells, Y. (2016). *50+ in Banyule: A data story. Report for Banyule agencies. Part 1: Health and Wellbeing.* Report commissioned by the North Eastern Primary Care Partnership. Melbourne: NEPCP.

Acknowledgements

Thanks to the Department of Health & Human Services for making this report possible, to the City of Whittlesea for sharing their "Living well 50+ … a data story" and allowing us to use their framework, and to our partners. Special thanks to Professor Yvonne Wells, Head, Lincoln Centre for Research on Ageing, Australian Institute for Primary Care & Ageing, La Trobe University, for sharing her expertise in gaining meaning from the data—a true 'curator' of knowledge—and to Tania Nicholls, NEPCP Innovation Coordinator for keeping us on track and bringing the partners together around this project.

Julie Watson, Executive Officer, North East Primary Care Partnership (NEPCP)

GLOSSARY

ABS	Australian Bureau of Statistics
CALD	Culturally and Linguistically Diverse
DHHS	Department of Health and Human Services
DHS	Department of Human Services
LGA	Local Government Area
MDS	Minimum Data Set
NEPCP	North East Primary Care Partnership
PAG	Planned Activity Group
PCP	Primary Care Partnership

Executive Summary

AIM

The aim of this resource is to:

- Capture data specific to the population and local government area of Banyule.
- Provide Banyule services with a useful tool to support planning and change.
- Make available a resource that can be utilised to advocate for the services our communities require, to ensure its members are living life to the full.

METHOD

In this section of the report, the following data sources were used:

- ABS 2011 Census of population and housing
- Id population forecasts based on the 2011 Census
- Victorian Population Health Survey 2011–12
- Diabetes Australia Victoria
- Tables supplied by the Victorian Injury Surveillance Unit (VISU)
- VicHealth Indicators Survey, 2011
- Access Economics reports on dementia prevalence estimates (2009, 2010)
- Australian Department of Social Services, Ageing and Aged Care
- Australian Department of Health Primary Health Network website

RESULTS

Population: Banyule's population will age slowly in the coming decade, with particular increases in the populations aged 70 to 74 (26.9%), 75 to 79 (45.8%), and 80 to 84 (24.3%).

Socio-economic advantage and disadvantage: suburbs with high SEIFA scores are over-represented in Banyule, with only four falling below the mean, and five represented in the top decile of precincts in Victoria. (However, the SEIFA indices for Heidelberg West and parts of Bellfield are amongst the lowest in Australia.)

Prevalence of key health conditions is similar in Banyule to the prevalence in Victoria as a whole. The exception is arthritis, which is more common in Banyule than in Victoria (using age-standardised rates, 24.6% vs. 19.9% for all adults).

Diabetes: Age-specific proportions of people registering with diabetes are relatively low in Banyule.

Dementia: Banyule was ranked 10th in Victoria on the number of people in the municipality living with dementia, and this ranking will not change a great deal (13th in 2030 and 12th in 2050). However, the number of people living with dementia in Banyule is expected to double over this time.

Hospital admissions: Injury rates for people aged 50 years and over for all three kinds of injury requiring hospital admission (falls, unintentional injury, and intentional injury) tend to be slightly lower in Banyule than in Victoria as a whole.

Protective and risk factors: Banyule does not differ significantly from the wider Victorian population on any of the behavioural or bio-medical protective or risk factors. An exception is that Banyule has a significantly higher lifetime prevalence of anxiety and depression than Victoria as a whole. However, Banyule's average score on the Australian Unity Wellbeing Index did not differ significantly from the Victorian average.

Health risks for Banyule adults aged 50 years and over (similar to those for all Victorians in this age group) include low consumption of vegetables (86%) and overweight/obesity (60%).

Community wellbeing: Scores for Banyule on community wellbeing indicators did not differ significantly from Victorian averages for any of the indicators except having a long daily commute to work (less favourable).

Intensive aged care services: Thirty-three providers in Banyule provided intensive care services—16 providing Home Care packages, 15 providing residential care, one in the Innovative Pool and one for Transition Care. Examination of operational care places per 100,000 people aged 65 years and over indicate that Banyule is relatively well placed for all intensive care service types in comparison with average rates across Victoria.

Altogether in 2014, agencies located in Banyule attracted $97,512,657 in Commonwealth Government funding for intensive aged care services.

CONCLUSION

Banyule's population is ageing and service providers can expect increases in demand for health services associated with an ageing population, including services to support people living with dementia and their carers. Particular attention may need to be paid locally to people with arthritis and those with experiences of anxiety or depression. As elsewhere in Victoria, obesity and low vegetable consumption are significant health risk factors.

Introduction

ABOUT US

The North East Primary Care Partnership (NEPCP) is a voluntary alliance of service providers who come together to strengthen relationships across sectors in order to maximise health and wellbeing outcomes. We support activities at a local and network level that have potential to improve population health outcomes.

Our aim is to:

- Learn from leading-edge practice in health and care systems and other industries, and make that knowledge accessible to all
- Build the movement for improvement and safety, making connections across the system, and enthusing and exciting people to engage in change and transformation
- Provide easy access to the latest evidence base, knowledge and training programs
- Help make the most of investment of money and effort across the system, so we all work in alignment.

As part of this remit we seek to develop our work in partnership and co-production with others in the health and care system.

CURATE RATHER THAN CREATE KNOWLEDGE

One of the challenges for service providers and leaders in health and care is keeping up with the amount of information and data as they become available, in the face of multiple and competing demands. Finding the right information and making sense of it is taking an increasing amount of time, attention and focus[1], and the ability to filter and select appropriate information and shape it for a local context is essential. A key role the NEPCP can play is to bring partners together and curate knowledge: reviewing and filtering what is most relevant and connected to our members' experience. In this way we can offer value to others looking for high quality content.

The idea of curation is taken from the NHS White Paper **"The new era of thinking and practice in change and transformation; a call to action for leaders of health and care"** and is defined as "finding things out and determining what's valid from what's just noise . . . quality and coherence, not volume and mass". While this paper looks broadly at large-scale change and transformation in health and care, rather than at local trends, two ideas that really struck us were:

[1] These ideas are expanded at this site: **http://www.nhsiq.nhs.uk/news-events/news/the-new-era-of-thinking-and-practice-in-change-and-transformation.aspx**

- With so much information and data available we do not need more, but we need information that is high quality and right for our context.
- While data are important for population health planning, large-scale change also depends on many partners: clients and families, communities, frontline health and community care providers, and leaders uniting around a common cause for client and population health.

We hope that this report provides our members with the quality and coherence required for future adaption to the reform agenda.

ABOUT THIS PROJECT

When considering how to best support our partner agencies in the context of change and growth in aged care, we were impressed by the work undertaken by the City of Whittlesea called *Living well 50+ … a data story*. This report brings together demographic, social, health and wellbeing data important for understanding life stages, population diversity, and social and environment influences on people as they age.

Given projected changes in the population aged 50+ years, we believed a similar project would strengthen our knowledge of people in this age group living in our catchment and give us information about their potential service requirements. Because the information we have collected is based on the original framework used for the Whittlesea Report, we now have consistent data across four local government areas.

WHAT IS DIFFERENT?

One of the great (and challenging) insights we gained with this project is that long-term projections are often unreliable and need to be used with caution. We have still included them but encourage our partners to use them carefully. We also realise that data can quickly become outdated, so have included links to assist partners to easily access information they may need in the future.

THIS REPORT

This report is Part 1 of a two-volume report, outlining the results of a series of data analyses conducted by the Australian Institute for Primary Care & Ageing at La Trobe University for the North East Primary Care Partnership (NEPCP). The report is intended to act as a resource that captures a population-based approach to planning healthy and active living for the population aged 50 years and over living in Banyule.

Part 1 of the report—this volume—is about the health status of people living in Banyule. Part 2 is about the Home and Community Care service use of people living in Banyule. The report is modelled on a similar project completed for the City of Whittlesea in February 2014.

Partners in the North East PCP indicated they could source statistics for the following sections of the Whittlesea report themselves:

- Section 2 – The 50+ population
- Section 3 – Population growth: the 50+ population

However, they wished to reproduce Section 4 (Health and wellbeing – the 50+ population). Only minimal population data have been included in this report: representation of age groups in Banyule's population (with predicted growth for 2019 and 2024); and socio-economic advantage and disadvantage.

This report is intended to provide key health and wellbeing characteristics of the 50+ population to inform service planning and opportunities for health promotion, positive ageing and preventative strategies.

RISK AND PROTECTIVE FACTORS

The data presented follow a population health approach incorporating the social determinants of health, to provide consideration of the broader issues that influence health and wellbeing. The health and wellbeing of the 50+ population is strongly influenced by social-demographic characteristics and level of disadvantage in the municipality presented in Section 2.

A population health approach to planning seeks to improve the health of the whole population by tackling ill-health as well as underlying causes of ill-health.[2] A population health approach incorporating the social determinants of health provides the framework for understanding the contribution that social and economic conditions have on individual and community health and wellbeing. When identifying strategies to prevent or delay health conditions identified, it is important to recognise that contributing factors are social and environmental as well as behavioural.

Health outcomes data for the population describe health conditions resulting from the net effects of collective risk factors. The Australian Institute of Health and Welfare lists five kinds of risk factors: behavioural, biomedical, environmental, genetic and demographic. [3] The AIHW also lists examples of each kind of factor:

- Behavioural risk factors include tobacco smoking, excessive alcohol consumption, poor diet and nutrition, physical inactivity, excessive sun exposure, insufficient vaccination, and unprotected sexual activity.
- Biomedical risk factors may be influenced by a combination of genetic, lifestyle and other broad factors, and include being overweight and obesity, high blood pressure, high blood cholesterol, and impaired glucose tolerance.
- Environmental risk factors can be split into two broad categories: social, economic, cultural and political; and physical, chemical and biological.
- Genetic risk factors: some diseases result entirely from an individual's genetic make-up whereas others reflect interactions between that make-up and environmental factors.

[2] Victorian Healthcare Association (n.d.). Addressing the social determinants. **http://www.vha.org.au/policy-publications/population-health**

[3] Australian Institute for Health and Welfare, **http://www.aihw.gov.au/risk-factors/**

- Demographic risk factors include age, gender, and belonging to certain population subgroups.

Data for this report have been chosen to correspond with risk factors listed by the AIHW, and, more broadly, because of the impact of chronic disease and injury on the health and quality of life of the community. These data indicate likely areas of demand for community-based services and inform opportunities for preventative action and planning.

Health and wellbeing data are presented in this report by:

- Health outcomes data – key health conditions including chronic disease, dementia, injury and falls. These data are presented because of the significance of chronic disease and injury for the quality of life of the community.
- Health behaviour and risk factors data – patterns of behaviour and other risk factors that may contribute to, or protect from, the development of chronic diseases such as cardiovascular disease, diabetes and dementia.
- Determinants of health and wellbeing – factors that influence health and wellbeing and provide an insight into opportunities for community strengthening, reducing long-term risk, and promoting health and wellbeing.

Similar to the Whittlesea report, data have been primarily sourced from:

- The Department of Health Victoria Population Health Survey. Data for the age groups 50 years and over living in Banyule and Victoria were provided on request.
- Monash University Injury Research Institute injury data based on hospital admission injury data (provided on request)
- VicHealth Indicators Survey. Data for the age groups 50 years and over living in Banyule and Victoria were provided on request.
- Diabetes Australia (**http://www.diabetesmap.com.au/#/**)
- Access Economics, 2009, 2010

In addition, however, in addition we have sourced information on aged care services in the region:

- Department of Social Services, Ageing and Aged Care (**https://www.dss.gov.au/ageing-and-aged-care-overview/about-aged-care/aged-care-service-providers-in-australia**)

Significant differences between estimates for Banyule and those for Victoria are highlighted in tables in the Part 1 report using cell shading: pink shading for areas of concern, green for positive differences.[4]

In addition, data on packaged aged care provision have been included in this part of the report. (Although about access to services, they are included in this report rather than in Part 2, which focuses solely on HACC provision.)

DATA LIMITATIONS

Key challenges in presenting health and wellbeing data for Banyule's 50+ population include the incompatibility of data sets and lack of local age-based data. Where possible, data have been presented at the municipal level. When municipal data are not available, Victoria-wide data have been presented.

The Victorian Population Health Survey (2011–12) on risk factors and health outcomes is the most accurate local data source. The 50+ population cohort, however, is not able to be subdivided into smaller age groupings due to the small sample size. Estimates that are asterisked in this report have large standard errors and should be treated with caution.

The VicHealth Indicators Survey 2011 does not have a large enough number of older respondents at the municipal level to provide statistically valid data by age group.

[4] Significant differences in the Victorian Population Health Survey are indicated in the report and deduced from data provided by the Victorian Department of Health and Human Services. Data are taken as significantly different where the 95% confidence intervals around prevalence estimates are non-overlapping.
Significant differences in the VicHealth Indicators Survey are indicated in LGA reports and the Survey report. Data are taken as significantly different where the 95% confidence intervals around prevalence estimates are non-overlapping.
Significant differences in Diabetes Australia rates are indicated on their website. It is not known what criteria were used to determine significance.

Methodology

The analyses in Part 1 of the report rely on the following sources:

- ABS 2011 Census of population and housing and SEIFA indices based on the Census: **http://www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001**
- Id population forecasts based on the 2011 Census: **http://profile.id.com.au/banyule/population**
- Victorian Population Health Survey 2011–12: **http://www.health.vic.gov.au/healthstatus/survey/vphs2011–12.htm**
- Diabetes Australia Victoria: **https://www.ndss.com.au/diabetes-map**
- Tables supplied by the Victorian Injury Surveillance Unit (VISU)
- VicHealth Indicators Survey, 2011, and fact sheets: **http://www.communityindicators.net.au/vichealth_indicator_survey_2011**
- Estimates from Access Economics reports, 2009 and 2010: **https://fightdementia.org.au/sites/default/files/20090800_Nat__AE_FullKeepDemFrontMind.pdf**; and **https://www.deloitteaccesseconomics.com.au/uploads/File/Alzheimers%20Vol1Final%200710.pdf**
- Department of Social Services, Ageing and Aged Care: **https://www.dss.gov.au/sites/default/files/documents/04_2015/2014_aged_care_service_list_with_funding_-_vic.pdf**
- Department of Health Primary Health Network: **http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Aged-Care-Data**

About Banyule

Figure 1: Banyule suburbs and precincts [5]

[5] Map provided Banyule City Council

The City of Banyule is located in Australia within the Melbourne metropolitan area in the State of Victoria. The name Banyule comes from a Wurundjeri word meaning “hill”. Banyule is between seven and 21 kilometres from the Melbourne central business district (CBD). The Yarra River runs along the City’s south border while the west is defined by Darebin Creek. Banyule is predominantly an established residential area, with significant open spaces and parklands, on a total land area of about 63 square kilometres. There are industrial areas in Heidelberg West, Greensborough/Briar Hill and Bundoora, as well as institutions such as the Austin and Repatriation Medical Centre. The area is served by several major roadways, a railway line and various bus services. Major features of the area include a hospital district, commercial centres, industrial areas and Army barracks.

The municipality includes the suburbs of Bellfield, Bundoora, Briar Hill, Eaglemont, Eltham north, Greensborough, Heidelberg, Heidelberg Heights, Heidelberg West, Ivanhoe and Ivanhoe East, Lower Plenty, Macleod, Montmorency, Rosanna, Viewbank, St Helena, Watsonia and Watsonia North, and Yallambie. Eltham North and Greensborough are shared with the Shire of Nillumbik and Macleod and Bundoora are shared with the City of Darebin.[6][7]

Banyule residents have a median age of 39 years and earn on average $1,394 per week. According to the 2011 Australian Bureau of Statistics (ABS) census, in Banyule:[8]

- 48% of households are couples with children (2% higher than Victorian average)
- 81% live in a separate house (4% higher than Victorian average)
- 24% of residents rent their property (3% lower than Victorian average)
- 19% have a bachelor's degree or higher (4% higher than Victorian average)
- 74% were born in Australia (5% higher than Victorian average)

The most common occupations in Banyule are:

- Professionals (29%)
- Clerical and Administrative Workers (16%)
- Technicians and Trade Workers (13%)

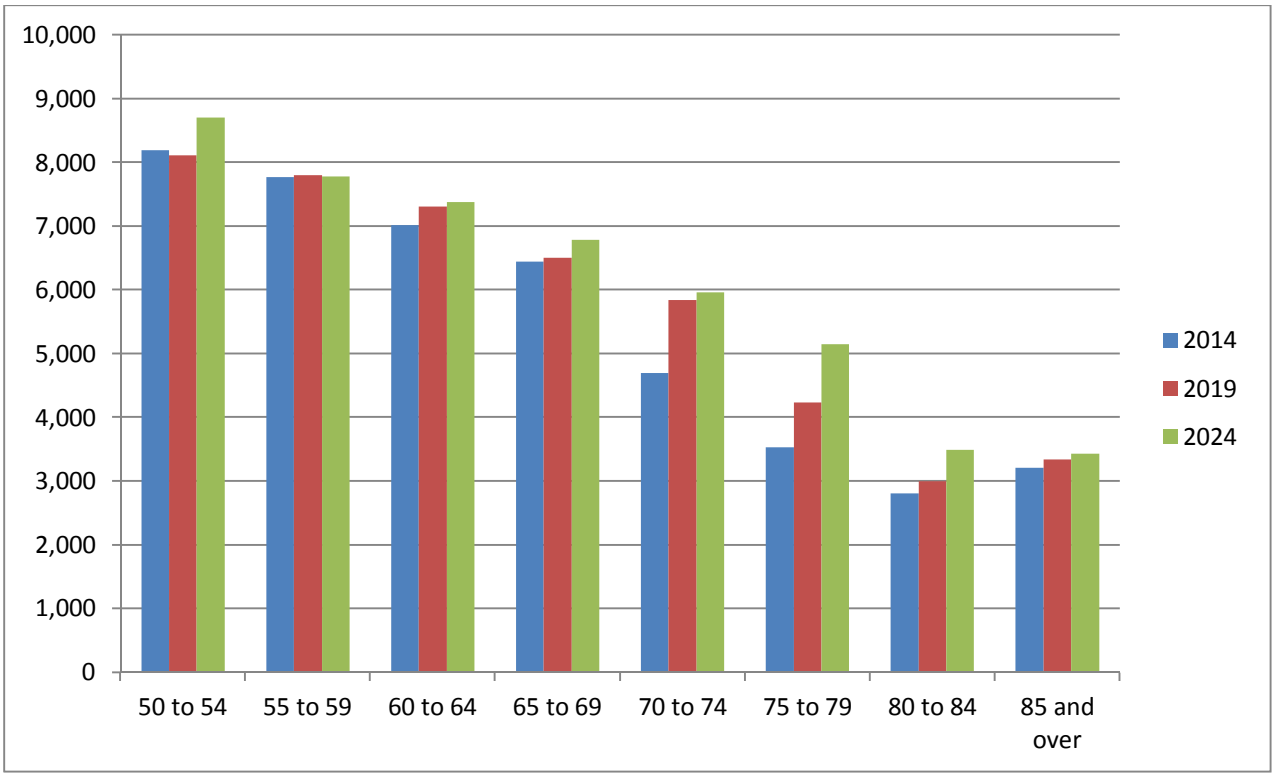
[6] https://en.wikipedia.org/wiki/City_of_Banyule
[7] The municipality also includes a small section of Eltham.
[8] http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/20901

Age groups

The population aged 50 and over provides some insight into the expected level of and change in age-related services, programs and opportunities.

The table and figure below indicate that Banyule's population will age slowly in the coming decade, with particular increases in the populations aged 70 to 74 (26.9%), 75 to 79 (45.8%), and 80 to 84 (24.3%).[9]

Figure 2: Banyule age structure 2014 and population predictions 2019 and 2024 (Ns)



Data source: ID Profile

[9] "Ns" here and elsewhere in this report refers to numbers or counts.

Table 1: Banyule age structure 2014 and population forecasts 2019 and 2024

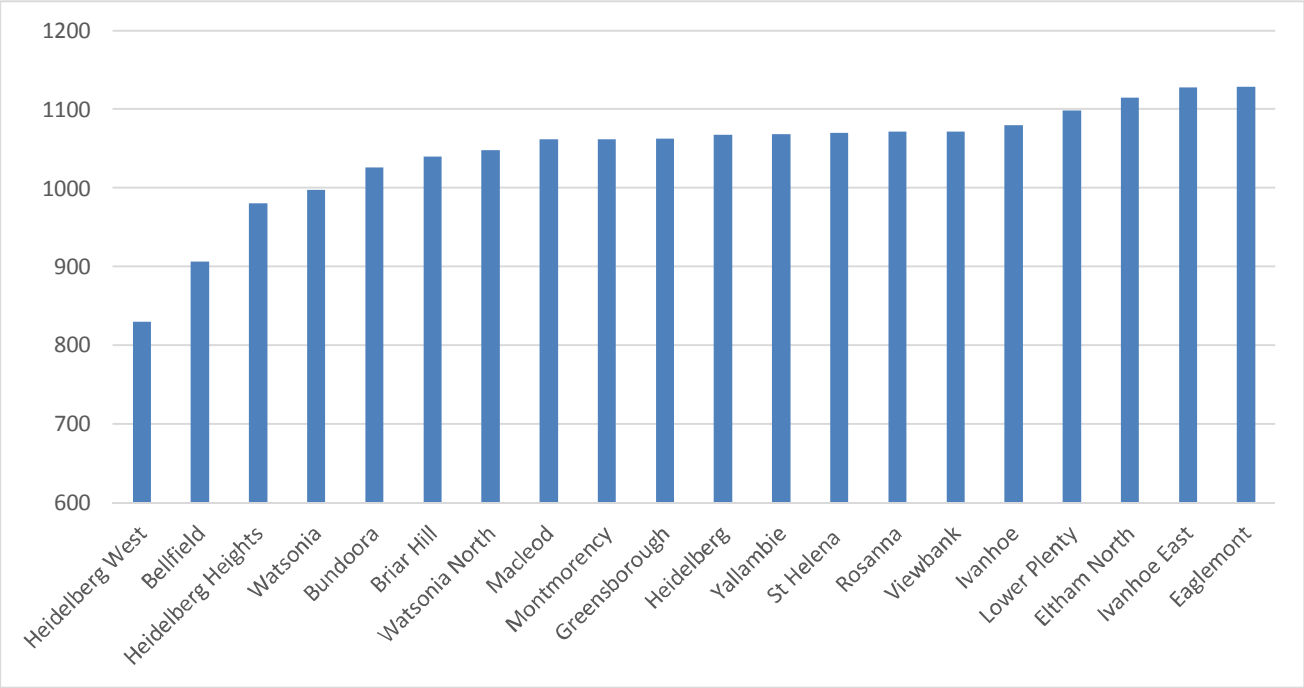
	2014		***2019***		***2024***		
Age group	N	% of total population	N	% of total population	N	% of total population	% increase in N
50 to 54	8,195	6.6	8,109	6.3	8,708	6.5	0.0
55 to 59	7,775	6.2	7,802	6.0	7,778	5.8	5.0
60 to 64	7,023	5.6	7,306	5.6	7,377	5.5	5.3
65 to 69	6,446	5.2	6,510	5.0	6,788	5.1	26.9
70 to 74	4,695	3.8	5,847	4.5	5,960	4.5	45.8
75 to 79	3,534	2.8	4,235	3.3	5,151	3.9	24.3
80 to 84	2,807	2.2	3,001	2.3	3,490	2.6	6.8
85 and over	3,212	2.6	3,343	2.6	3,430	2.6	0.0
Total population (all ages)	**125,107**		**129,400**		**133,679**		
People aged 50+ as proportion of total population		**35.0**		**35.6**		**36.5**	

Socio-economic status

Socio-Economic Indexes for Areas (SEIFA) is a product developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and/or disadvantage. These indices are based on information from the five-yearly Census. SEIFA 2011 is the latest version of this product and was released on 28 March 2013. It is based on 2011 Census data. The Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) summarises information about the economic and social conditions of people and households within an area, including both relative advantage and disadvantage measures. Scores are a weighted combination of selected indicators standardised to a distribution with a mean of 1000 and a standard deviation of 100.

SEIFA indices of advantage and disadvantage are set out below along with their rank among Victorian precincts and decile (with 1 representing the lowest 10% of suburbs and 10 representing the highest 10%). Suburbs with high SEIFA scores are over-represented in Banyule.

Figure 3: Banyule SEIFA indices by suburb, 2011



Data source: Australian Bureau of Statistics, Socio-Economic Indexes for Areas (SEIFA), 2011

Table 2: SIEFA indices for Banyule suburbs, 2011

SUBURB	SEIFA INDEX OF ADVANTAGE AND DISADVANTAGE	RANK (VICTORIA)	DECILE
Bellfield	907	115	1
Briar Hill	1040	1067	8
Bundoora	1026	935	7
Eaglemont	1129	1502	10
Eltham North	1115	1478	10
Greensborough	1063	1253	9
Heidelberg	1068	1287	9
Heidelberg Heights	981	477	4
Heidelberg West	830	20	1
Ivanhoe	1080	1366	10
Ivanhoe East	1128	1500	10
Lower Plenty	1099	1444	10
Macleod	1062	1251	9
Montmorency	1062	1249	9
Rosanna	1072	1317	9
St Helena	1070	1296	9
Viewbank	1072	1318	9
Watsonia	998	628	5
Watsonia North	1048	1144	8
Yallambie	1069	1292	9

Note: Eltham is omitted from this table because only a small section of the suburb belongs to Banyule.

Summary of health and wellbeing

Key health conditions identified in Banyule include arthritis and lifetime prevalence of anxiety and depression, as well as an increase in the number of people living with dementia.

Table 3: Quick statistics – population health and wellbeing

	COMPARISON	*BANYULE*	*VICTORIA*
Health Outcomes (Total population)	Prevalence of most key health conditions is similar in Banyule to the prevalence in Victoria as a whole. Arthritis is more common in Banyule than elsewhere in Victoria. Hypertension is the most common chronic health condition.	24.6% High BP 50+: 51.8%	19.9% High BP 50+: 45.8%
Health Outcomes (Population aged 50+)	Age-specific rates of people registering with diabetes are relatively low in 7 of 10 Banyule postcodes. Rates of injury requiring hospitalisation are slightly lower in Banyule than elsewhere in Victoria.	8.9% (50+) Falls 80+yrs: 7.5%	10.7% (50+) Falls 80+yrs: 7.6%
Behavioural and biomedical risk factors (Total population)	Banyule does not differ significantly from the rest of Victoria on any risk factors.	Smoking 16.9%	Smoking 15.8%
Behavioural and biomedical risk factors (Population aged 50+)	Banyule does not differ significantly from the rest of Victoria on any risk factors. The most common risk factor is low consumption of vegetables. Prevalence of overweight/obesity is similar in Banyule to elsewhere in Victoria.	86.2% 60.1%	88.9% 58.8%
Wellbeing (Total population)	Banyule has a significantly higher lifetime prevalence of anxiety and depression than Victoria as a whole.	26.1%	20.0%
Community wellbeing	Banyule does not differ significantly from the rest of Victoria on any wellbeing indicators except having a long daily commute to work.	20.6%	11.6%

Key health outcomes

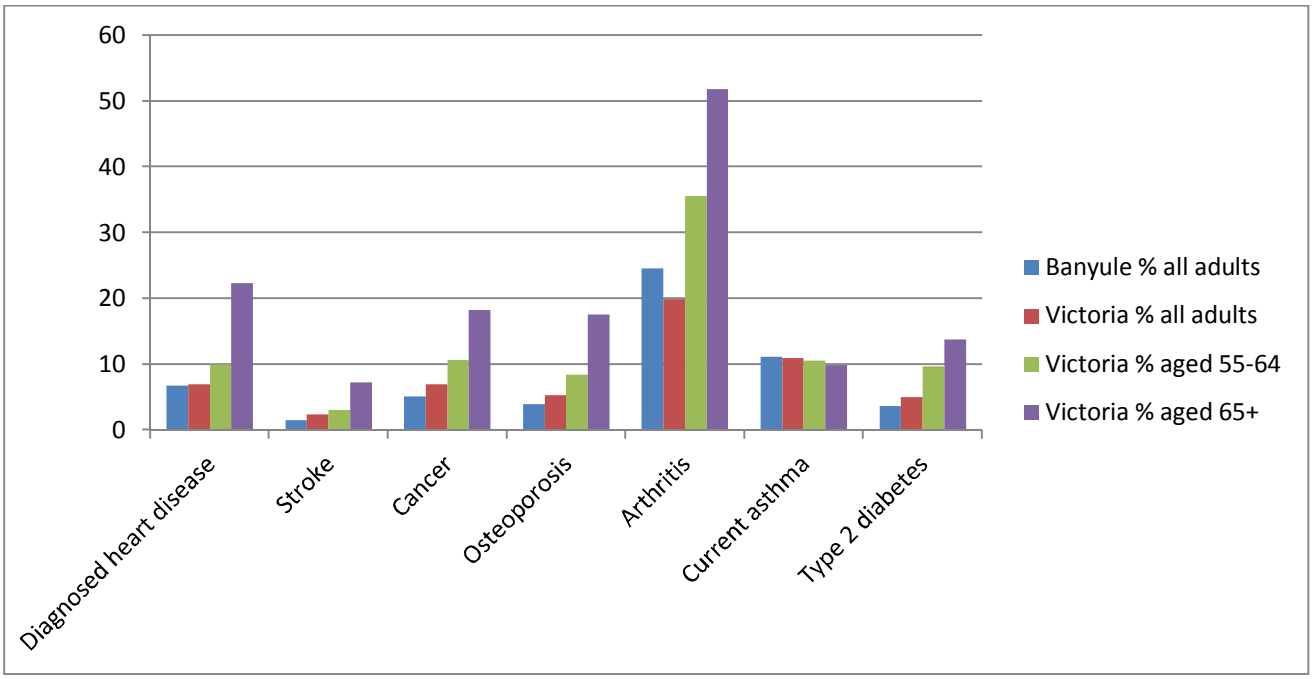
In this section of the report, data are presented on selected chronic diseases, dementia, falls, and other injuries requiring hospitalisation.

CHRONIC DISEASE

The proportions of the Banyule and Victorian populations with specific chronic disease are provided in the figure and table below. Age-related data for the Victorian population identify a clear trend towards increasing prevalence of all chronic diseases (with the exception of asthma) with age. While this comparison is not available at a municipal level, it is reasonable to assume a similar trend for Banyule.

Prevalence of key health conditions is similar in Banyule to the prevalence in Victoria as a whole. The exception is arthritis, which is more common in Banyule than in Victoria (using age-standardised rates, 24.6% vs. 19.9% for all adults).

Figure 4: Banyule and Victoria, self-identified chronic disease type by proportion in age group, 2011–12



Data source: Victorian Population Health Survey, 2011–12

Table 4: Banyule and Victoria, self-identified chronic disease type by proportion in age group, 2011–12

	BANYULE % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Doctor-diagnosed heart disease	6.8	7.0	10.0	22.3
Stroke	1.5	2.4	3.1	7.2
Cancer	5.1	7.0	10.7	18.2
Osteoporosis	3.9	5.3	8.4	17.6
Arthritis	24.6[10]	19.9	35.6	51.8
Current asthma	11.1	10.9	10.6	9.9
Type 2 diabetes	3.6	5.0	9.7	13.8

*Estimates with a large standard error are asterisked in this and subsequent tables, and should be treated with caution.

The following table provides prevalence estimates of key health conditions for the population aged 50 years and over. Again, rates are similar in Banyule to those for Victoria as a whole.[11]

Table 5: Banyule and Victoria, self-identified chronic disease type by proportion for people aged 50+ years, 2011–12

	BANYULE % AGED 50+	VICTORIA % AGED 50+
Doctor-diagnosed heart disease	15.5	14.7
Stroke	5.1*	4.9
Cancer	14.8	13.5
Osteoporosis	12.7	11.9
Arthritis	44.3	40.1
Current asthma	12.2	10.0
Type 2 diabetes	8.9	10.7

[10] As elsewhere in this report, cells shaded green indicate a better result for the municipality than the Victorian (or Australian) average, whereas cells shaded pink indicate a worse result.

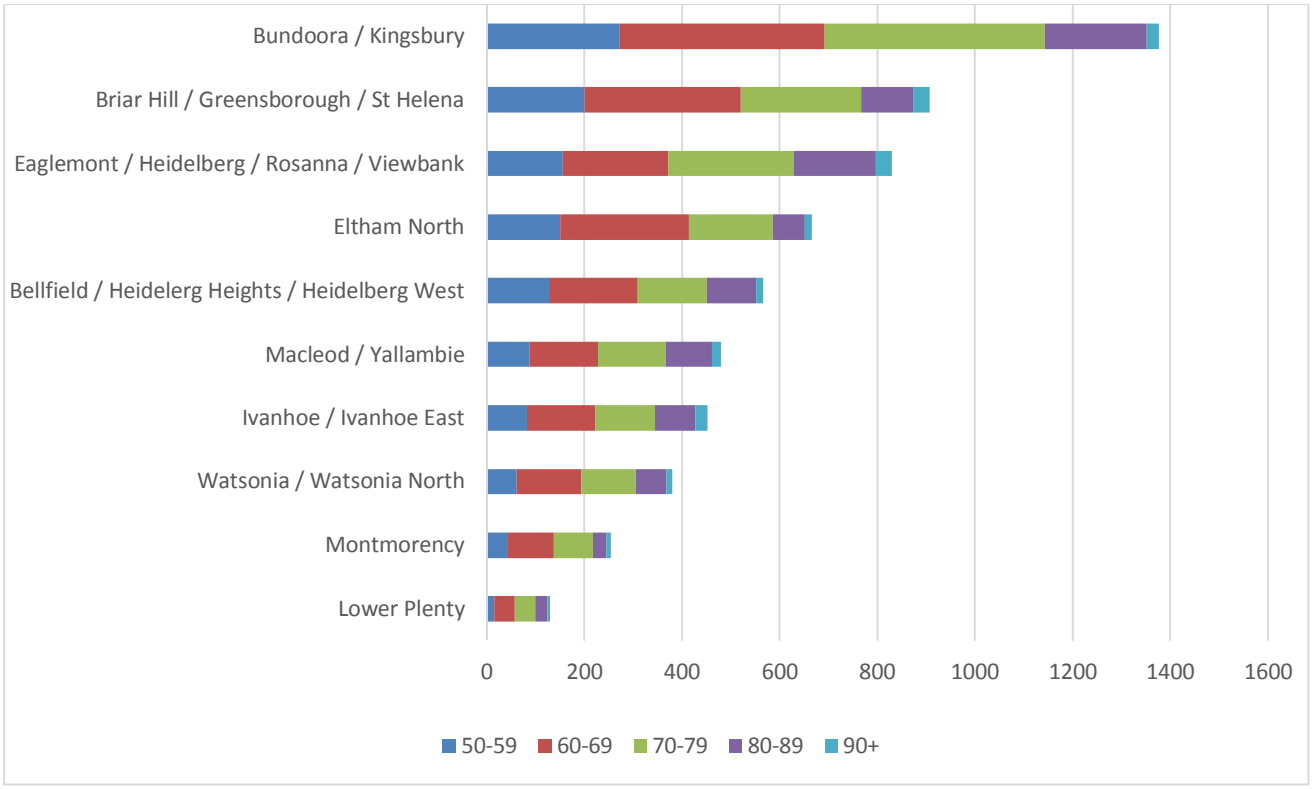
[11] Data for this table were provided by the Department of Health and Human Services on request.
Data are for people aged 50 years or over and are sourced from VPHS 2011–12. Data have been age-standardised to the 2011 Victorian population. Estimates with a large standard error are asterisked and should be treated with caution.

DIABETES

The figure below shows the number of clients registered with diabetes (all types) by age and suburb, defined by postcode.[12] These data are provided on the Diabetes Australia website. Unfortunately, postcode data do not fit neatly into municipal boundaries. Greensborough, for example, belongs partly to Banyule and partly to the Shire of Nillumbik.

While the number of people registered with Diabetes Australia is relatively high in the Bundoora/Kingsbury area, age-specific rates are not significantly different from national averages.

Figure 5: Banyule registered clients with Type 2 Diabetes by age and suburb (postcode), 2015



Data source: Diabetes Australia

[12] http://www.diabetesmap.com.au/#/

Table 6: Banyule, number of people registered with diabetes, by suburb (postcode) and age group

POSTCODE	SUBURB(S)	50-59	60-69	70-79	80-89	90+
3079	Ivanhoe / Ivanhoe East	81	141	122	83	24
3081	Bellfield / Heidelberg Heights / Heidelberg West	129	179	142	101	15
3083	Bundoora / Kingsbury	272	419	451	209	25
3084	Eaglemont / Heidelberg / Rosanna / Viewbank	155	216	258	167	33
3085	Macleod / Yallambie	87	140	139	94	19
3087	Watsonia / Watsonia North	60	133	111	64	11
3088	Briar Hill / Greensborough / St Helena	200	320	246	108	32
3093	Lower Plenty	15	42	41	26	5
3094	Montmorency	41	95	80	28	9
3095	Eltham North	149	264	172	66	14

Table 6b: Banyule, proportion of population registered with diabetes, by suburb (postcode) and age group

POSTCODE	SUBURB(S)	50-59	60-69	70-79	80-89	90+
3079	Ivanhoe / Ivanhoe East	3.8	8.9	12.7	11.7	18.7
3081	Bellfield / Heidelberg Heights / Heidelberg West	7.0	14.5	17.1	11.5	11.6
3083	Bundoora / Kingsbury	7.8	12.6	20.6	18.3	18.2
3084	Eaglemont / Heidelberg / Rosanna / Viewbank	4.8	6.9	12.4	10.3	15.9
3085	Macleod / Yallambie	5.2	10.4	14.8	12.0	9.2
3087	Watsonia / Watsonia North	5.2	11.6	14.2	14.3	35.9
3088	Briar Hill / Greensborough / St Helena	4.6	9.9	15.6	9.8	15.7
3093	Lower Plenty	1.9	8.1	13.4	10.0	9.3
3094	Montmorency	3.9	7.9	14.6	9.0	27.0
3095	Eltham North	2.7	8.3	14.2	11.7	10.9

While the age-specific proportion of people registering with diabetes is relatively low,[13] especially in the suburbs of Ivanhoe/Ivanhoe East, Eaglemont/Heidelberg/Rosanna/Viewbank, and Lower Plenty, a relatively high rate was recorded for Watsonia and Montmorency in the age group 90 years and over (but the numbers are very low in this age group and comparisons are unlikely to be reliable).

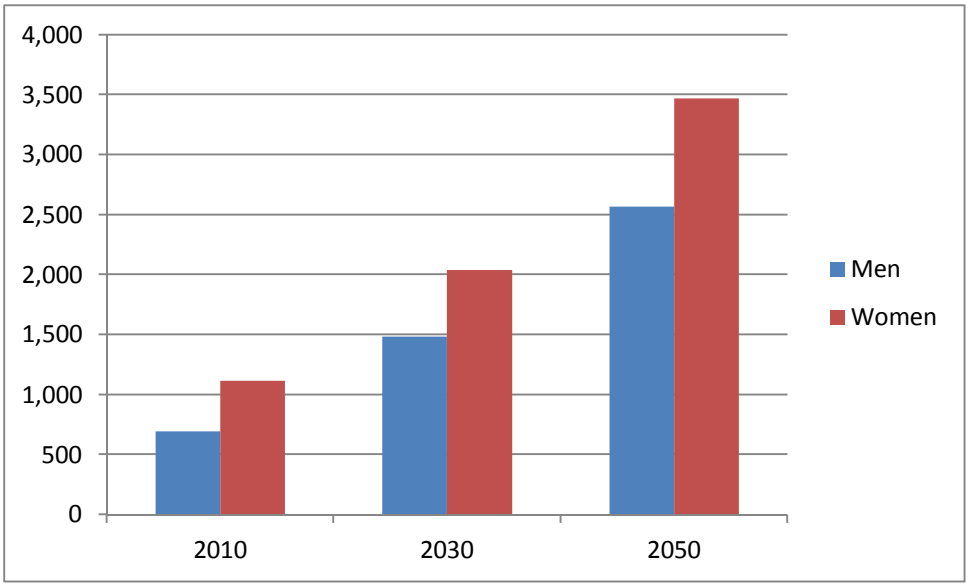
DEMENTIA

Dementia (Alzheimer's disease and related conditions) was the third leading cause of death in Australia in 2010.[14] Modifiable risk factors for dementia include hypertension and physical inactivity (Access Economics, 2009).

A report by Access Economics for Alzheimer's Australia[15] predicts for Banyule that the number of people living with dementia will almost double in 20 years, from 1,808 in 2010 to 3,524 in 2030 (see Figure 6).

In 2010, Banyule was ranked 10th in Victoria on the number of people in the municipality living with dementia, and this ranking will not change a great deal (13th in 2030 and 12th in 2050).

Figure 6: Banyule, predicted growth in dementia by gender 2010-2050[16]



Data source: Access Economics 2010

[13] These comparisons are consistent with those made on the Diabetes Australia website. Age-specific rates for Australia are provided in the Appendix.

[14] https://www.deloitteaccesseconomics.com.au/uploads/File/Alzheimers%20Vol1Final%200710.pdf

[15] https://vic.fightdementia.org.au/vic/research-and-publications/dementia-statistics-for-victoria

[16] http://www.health.vic.gov.au/agedcare/downloads/pdf/dementia_imp2010.pdf

Table 7: Banyule, number of people expected to have dementia, 2010, 2030 and 2050 by gender

	2010	2030	2050
Men	693	1,484	2,566
Women	1,115	2,040	3,469
Total	1,808	3,524	6,035

FALLS AND OTHER INJURIES

Data in this section of the report were obtained from the Monash University Injury Research Unit.

The highest injury rates among people aged 60 years and over are due to falls. This is true for both Victoria and Banyule. The risk of falls and other unintentional injuries increases with age, but the risk of intentional injury decreases with age.

Hospital admission rates among people aged 50 years and over for all three kinds of injury tend to be slightly lower in Banyule than in Victoria as a whole. [17]

Table 8: Banyule and Victoria, Injury hospital admission rate per 100,000 residents by injury type and age, 2013-14

	UNINTENTIONAL (NOT FALLS)		FALLS		INTENTIONAL INJURY	
	Banyule	Victoria	Banyule	Victoria	Banyule	Victoria
50–59 years	736.6	855.4	486.9	475.2	81.2	106.8
60–69 years	604.0	890.2	797.9	843.8	44.7	56.9
70–79 years	962.0	1,132.8	1,961.0	2,051.7	37.0	34.8
80+ years	2,152.0	2,150.3	7,490.2	7,647.9	33.4	37.9

Notes:
1) Intentional injury is defined as injury deliberately inflicted on yourself or another person, including self-harm and assault.
2) LGA applies to the patient's residence and not where the injury took place.
3) Populations used in rate calculations were sourced from the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) of 30th June 2013 and 2014 and a midpoint calculated thereof.
4) Transfers between hospitals and readmissions to the same hospital were excluded.
5) Cases were selected if the injured person was a Victorian resident.

[17] There is a slight difference in case selection from the Whittlesea report as only Victorian residents have been included in the population figures and transfers and readmissions are excluded.

NEPCP agencies asked whether data could be provided on hospital admission rates for intentional injury by gender for the age groups 50 years and over, and in response the Monash University Injury Research Unit was asked to provide these figures. The results are presented in the following table.[18] The results are presented in the following table. Banyule has a particularly low rate of hospital admission due to intentional injury for women.

Table 8a: Banyule and Victoria, hospital admission rate for intentional injury per 100,000 residents aged 50 years and over, by gender, 2013-14

BANYULE		*VICTORIA*	
Male	Female	Male	Female
114	66	121	106

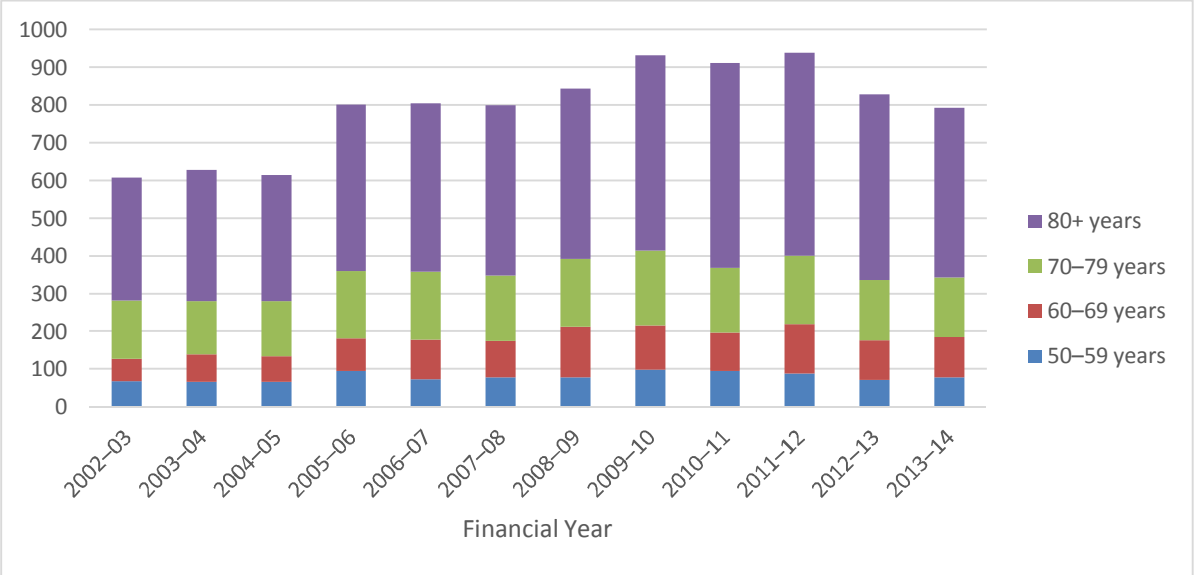
Falls are a significant risk to the safety, health and independence of older Australians. Data on the prevalence of falls for the population aged 50 years and over are not available by LGA. However, the number of hospital admissions for falls provided in the table above is a useful proxy.

The figure and table below show change over time in Banyule's hospital admissions for falls by age group. Hospital admissions for falls for Banyule residents show an age-related gradient as well as an increase in the number of hospital admissions for falls over time. Apparent decreases in 2012–13 and 2013–14 could be an artefact of changes in data collection methods.[19]

[18] Rates could be provided by gender for the whole group aged 50 years and over, but not for gender and 10-year age group at the same time, due to low numbers.

[19] In July 2012, the Victorian Hospital Admission Policy changed significantly. Patients who received their entire care episode within a designated emergency department or urgent care centre could no longer be eligible for admission regardless of the amount of time spent in the hospital. This has had the effect of reducing the number of admissions recorded on the VAED for the 2012–13 financial year. Caution should be exercised when interpreting changes in the number of hospital admissions in 2012–13 compared with previous years.

Figure 7a: Frequency of hospital admissions for falls by age group, 2002–03 to 2013–14



Data source: Monash University Injury Research Unit

Table 9a: Frequency of hospital admissions for falls by age group 2002–03 to 2013–14

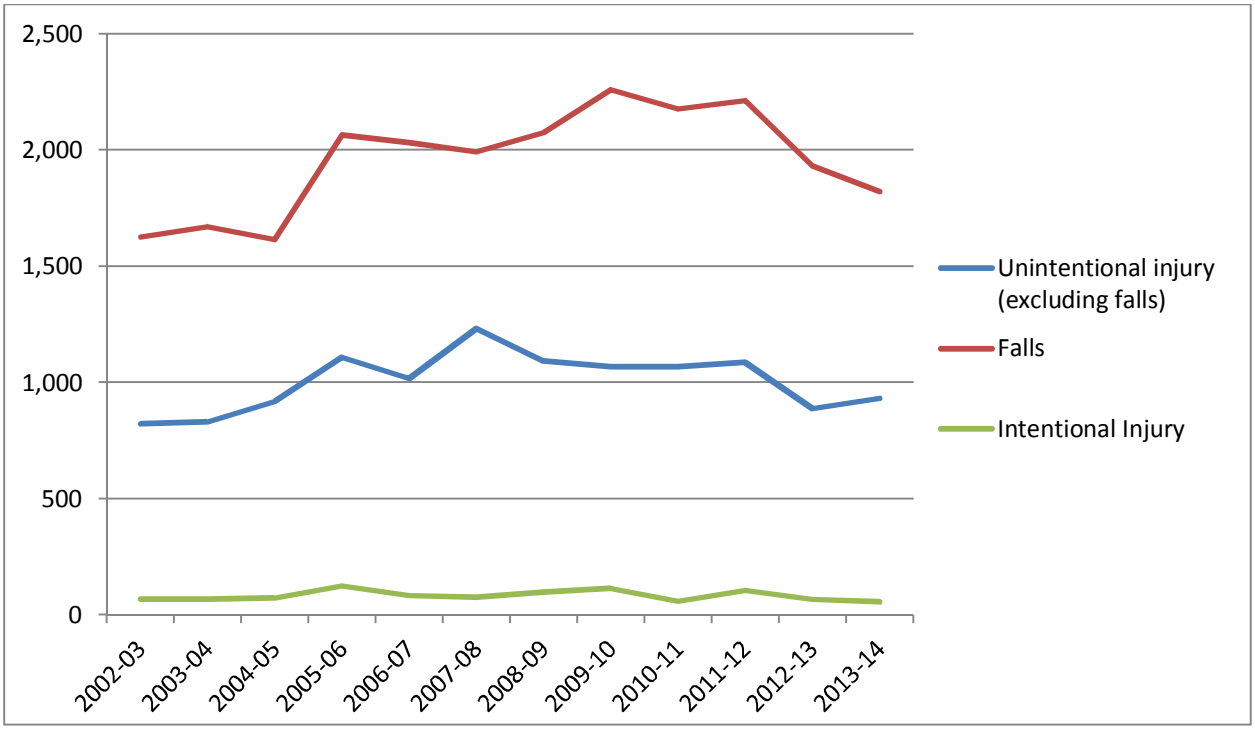
	50–59 YEARS	*60–69 YEARS*	*70–79 YEARS*	*80+ YEARS*	*TOTAL*
2002–03	68	59	155	327	609
2003–04	67	73	140	349	629
2004–05	66	68	147	334	615
2005–06	95	87	179	441	802
2006–07	74	104	180	447	805
2007–08	79	96	174	452	801
2008–09	79	133	180	453	845
2009–10	99	117	199	517	932
2010–11	95	103	171	543	912
2011–12	88	132	181	539	940
2012–13	71	106	159	494	830
2013–14	78	107	159	449	793
Total	959	1,185	2,024	5,345	9,513

Participating agencies also asked for data in change over time of hospital admission rates for intentional injuries. These rates are too small to report by age group, but trends in rates across all people aged 50 and over are reported below. The figures report data for all three injury types and for intentional injury separately.

The following table illustrates how strongly and consistently falls are represented in admissions to hospital in this age group.

The trend over time is for increasing rates of admission to hospital for falls and unintentional injury (excluding falls). Rates for intentional injury are relatively erratic with no clear trend. Apparent decreases in 2012–13 and 2013–14 could be an artefact of changes in data collection methods. [20]

Figure 7b: Hospital admission rates per 100,000 residents aged 50+ by injury type, 2002–03 to 2013–14



[20] In July 2012, the Victorian Hospital Admission Policy changed significantly. Patients who received their entire care episode within a designated emergency department or urgent care centre could no longer be eligible for admission regardless of the amount of time spent in the hospital. This has had the effect of reducing the number of admissions recorded on the VAED for the 2012–13 financial year. Caution should be exercised when interpreting changes in the number of hospital admissions in 2012–13 compared with previous years.

Figure 7c: Hospital admission rates per 100,000 residents aged 50+ for intentional injury, 2002–03 to 2013–14

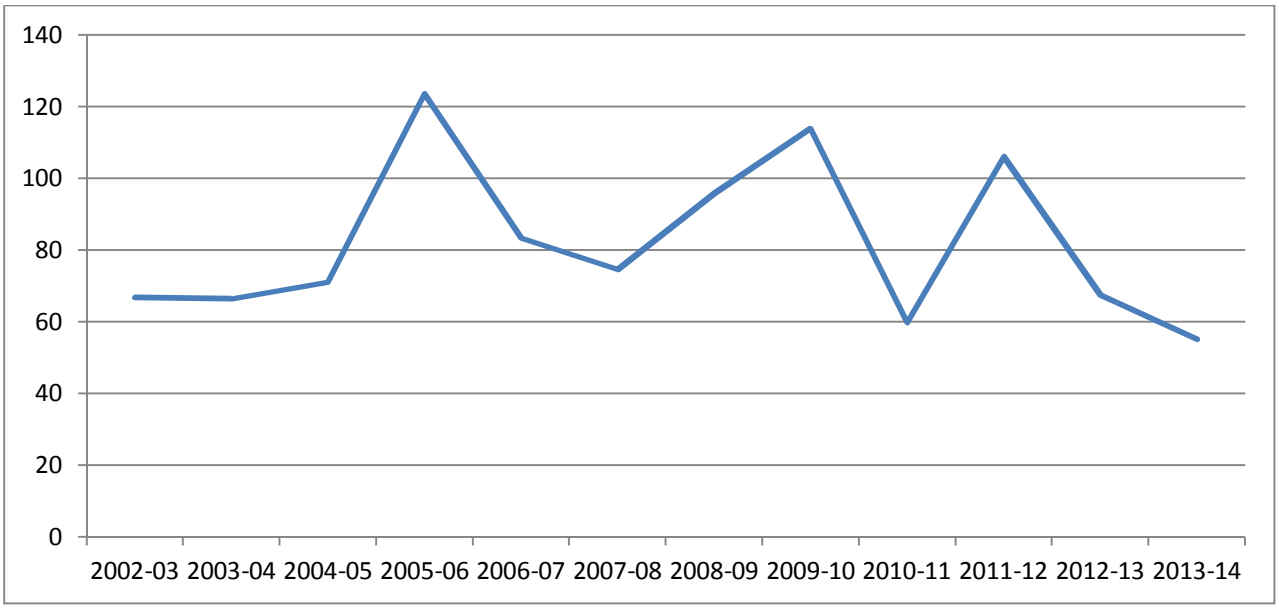


Table 9b: Hospital admission rates per 100,000 residents aged 50+ by injury type, 2002–03 to 2013–14

FINANCIAL YEAR	UNINTENTIONAL INJURY	UNINTENTIONAL INJURY (EXCLUDING FALLS)	FALLS	INTENTIONAL INJURY
2002-03	2,448.8	822.5	1,626.3	66.8
2003-04	2,501.0	831.0	1,670.0	66.4
2004-05	2,532.9	917.0	1,615.9	70.9
2005-06	3,173.6	1,109.4	2,064.3	123.5
2006-07	3,049.6	1,017.4	2,032.2	83.3
2007-08	3,224.9	1,231.7	1,993.2	74.7
2008-09	3,167.8	1,092.8	2,075.0	95.8
2009-10	3,325.4	1,066.5	2,259.0	113.9
2010-11	3,246.7	1,067.9	2,178.8	59.7
2011-12	3,299.7	1,085.8	2,214.0	106.0
2012-13	2,820.6	889.0	1,931.6	67.5
2013-14	2,754.3	932.6	1,821.6	55.1

Modifiable protective and risk factors

This section of the report focuses on behavioural and biomedical protective and risk factors. Data on prevalence and risk factors are potentially useful in predicting growth in particular chronic diseases and offer insight into protective strategies.

The Victorian Population Health Survey 2011–12 is the key source for reporting protective and risk factors in a community. Selected protective and risk factors for Banyule are presented below and compared with the Victorian population. Definitions of the factors are presented in the Appendix. While data on risk factors are presented here individually, in practice they do not operate in isolation but coexist and interact with one another.

PROTECTIVE FACTORS

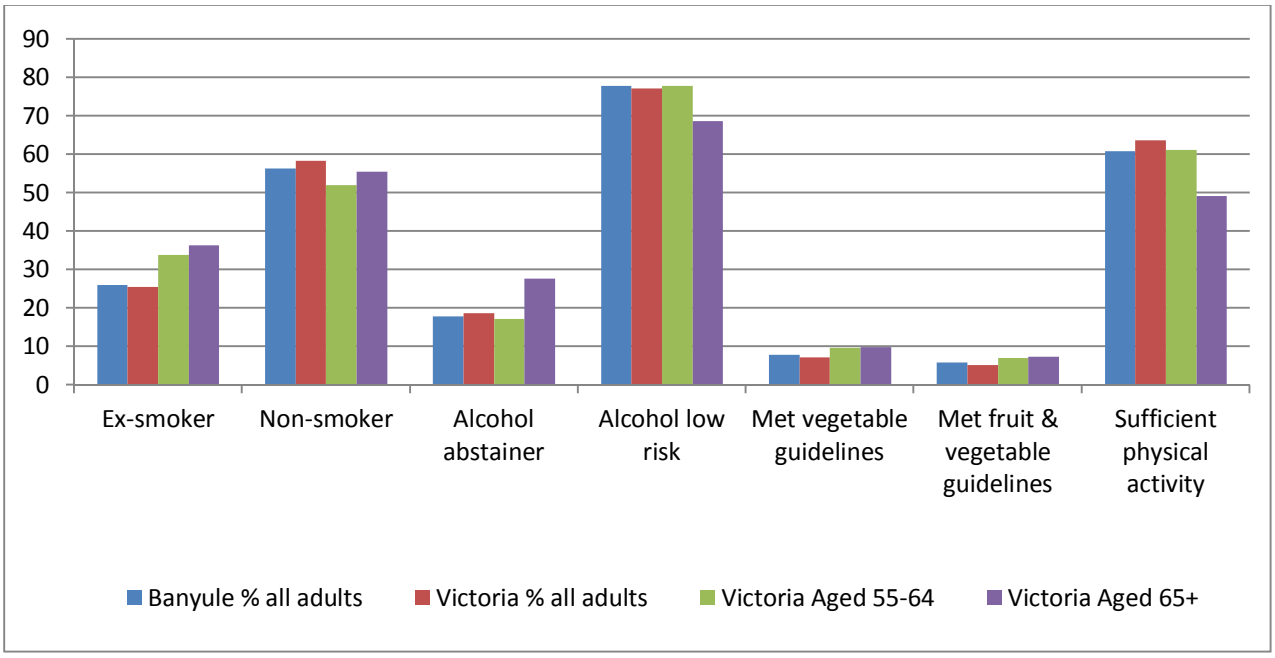
Banyule did not differ significantly from the wider Victorian population on any of the behavioural protective factors included here.

In general, older Victorians are more likely to be ex-smokers and less likely to be non-smokers than all adults.

Adults aged 65 years and older are less likely to be at low risk for long-term harm caused by alcohol consumption than all adults and the group aged 55 to 64 years.

Adults aged 65 years and older are less likely to achieve sufficient physical activity than adults of all age groups and the group aged 55 to 64 years.

Figure 8: Banyule and Victoria, proportion of population by protective behaviours 2011–12



Data source: Victorian Population Health Survey 2011–12

Table 10: Banyule and Victoria, proportion of population protective behaviours, 2011–12

	BANYULE % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Ex-smoker	25.9	25.4	33.8	36.3
Non-smoker	56.4	58.3	52.0	55.5
Alcohol abstainer	17.8	18.6	17.2	27.7
Alcohol low risk (long-term)	77.9	77.2	77.8	68.7
Met vegetable guidelines	7.7	7.1	9.6	9.7
Met fruit and vegetable guidelines	5.7	5.1	7.0	7.2
Sufficient physical activity	60.9	63.7	61.2	49.2

Age-adjusted comparisons between Banyule adults and Victorian adults aged 50 years and over are provided in the following table. No significant differences between Banyule and Victorian estimates are apparent.

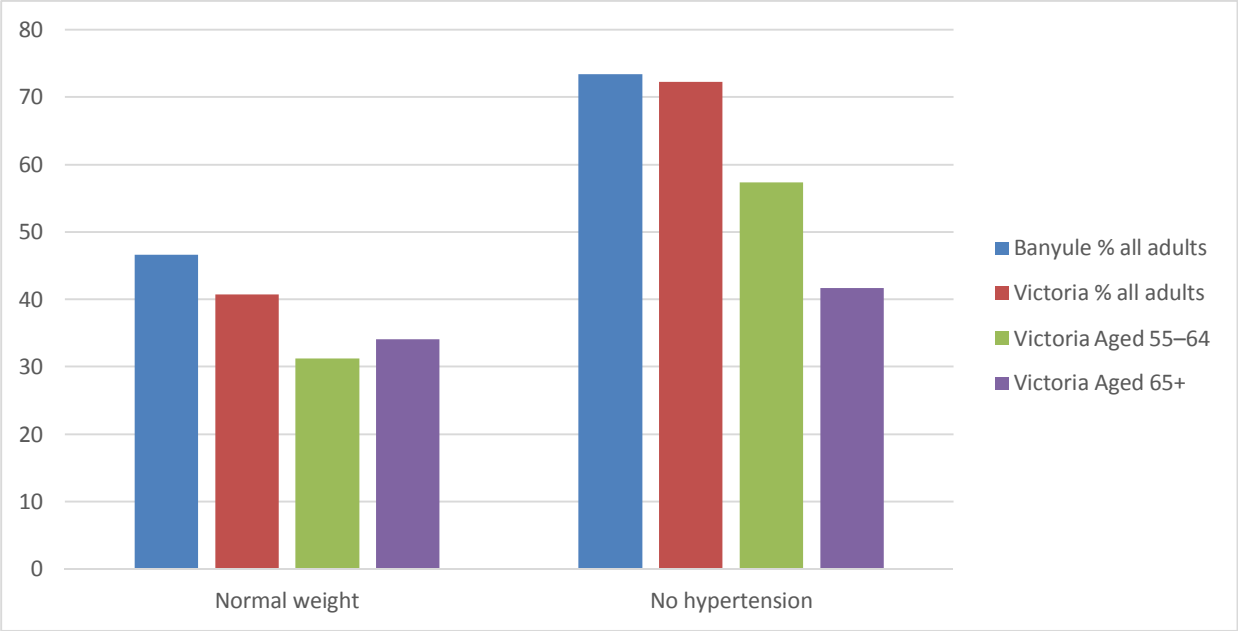
Table 11: Banyule and Victoria, age-adjusted proportion of population aged 50 years and over, protective behaviours, 2011–12

	BANYULE % ADULTS 50+	VICTORIA % ADULTS 50+
Ex-smoker	39.5	34.3
Non-smoker	50.7	53.5
Alcohol abstainer	22.2	21.9
Alcohol low risk (long-term)	73.7	73.7
Met vegetable guidelines	11.5	9.2
Met fruit guidelines	50.5	50.6
Sufficient physical activity	53.4	56.4

Banyule did not differ significantly from the wider Victorian population on any of the biomedical protective factors included here.

In general, adults aged 55 years and over (and especially those aged 65 and over) were less likely to be in the normal weight range and were more likely to have hypertension than all adults.

Figure 9: Banyule and Victoria, proportion of population by protective biomedical factors, 2011–12



Data source: Victorian Population Health Survey 2011–12

Table 12: Banyule and Victoria, proportion of population protective biomedical factors, 2011–12

	BANYULE % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA AGED 55–64	VICTORIA AGED 65+
Normal weight	46.7	40.8	31.3	34.1
No hypertension	73.5	72.3	57.4	41.7

Estimates of the prevalence of protective biomedical factors for Banyule residents aged 50 years and over did not differ significantly from those for all Victorians aged 50 years and over.

Table 13: Banyule and Victoria, age-adjusted proportion of population aged 50 years and over, protective biomedical factors, 2011–12

	BANYULE % ADULTS 50+	VICTORIA % ADULTS 50+
Normal weight	32.9	33.2
No hypertension	47.7	52.5

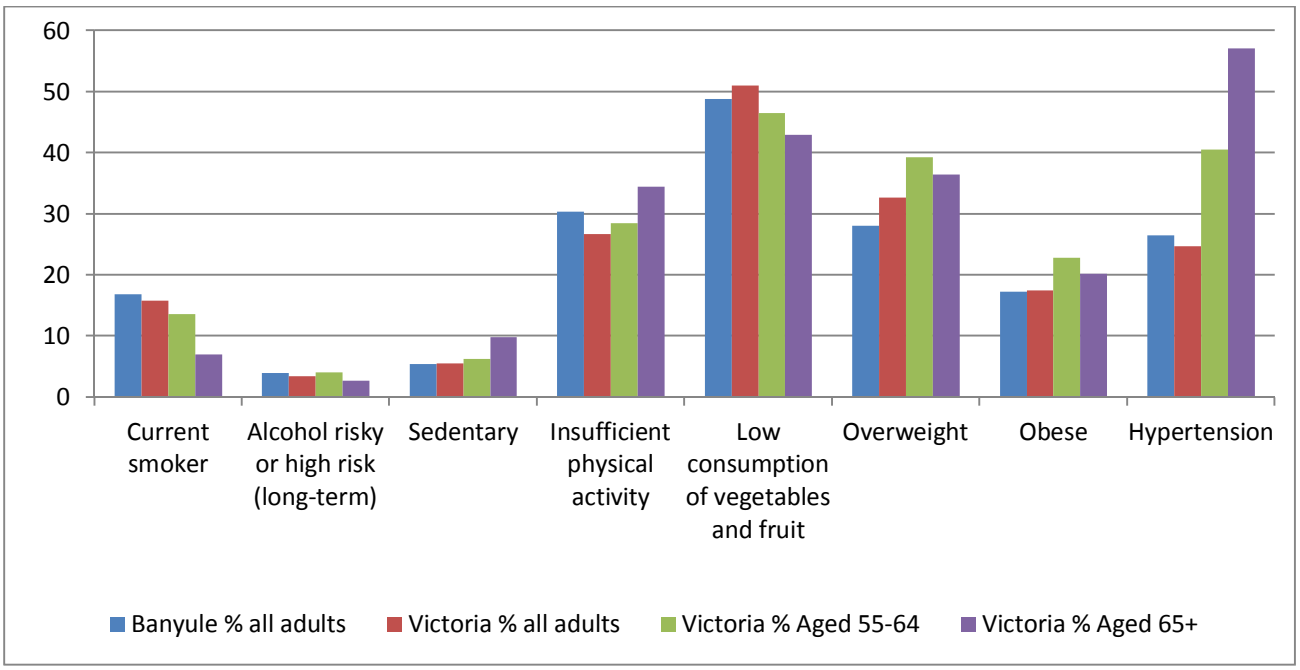
RISK FACTORS

Banyule did not differ significantly from the wider Victorian population on any of the behavioural risk factors included here.

In general, adults aged 65 years and over were less likely than all adults to be current smokers, but were more likely to be sedentary and have insufficient physical activity, were more likely to have low consumption of fruit and vegetables, were more likely to be overweight and were more likely to have hypertension.

In general, adults aged 55 to 64 years were at relatively high risk of overweight and obesity.

Figure 10: Banyule and Victoria, proportion in population by behavioural and biomedical risk factors, 2011–12



Data source: Victorian Population Health Survey 2011–12

Table 14: Banyule and Victoria, proportion in population with behavioural risk factors, 2011–12

	BANYULE % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Current smoker	16.9	15.8	13.6	7.0
Alcohol risky or high risk (long-term)	4.0	3.4	4.1	2.7
Sedentary	5.4	5.5	6.3	9.8
Insufficient physical activity	30.4	26.7	28.5	34.5
Low consumption of both vegetables and fruit	48.8	51.0	46.5	43.0

Banyule adults aged 50 years and over did not differ significantly from the wider Victorian population aged 50 years and over on any of the behavioural risk factors included here.

Table 15: Banyule and Victoria, age-adjusted proportion of population aged 50 years and over, behavioural risk factors, 2011–12

	BANYULE % ADULTS 50+	VICTORIA % ADULTS 50+
Current smoker	8.2	11.3
Alcohol risky or high risk (long-term)	4.0*	3.5
Sedentary	10.4	7.8
Insufficient physical activity	32.0	30.6
Low consumption of vegetables	86.2	88.9
Low consumption of fruit	48.5	48.2

Banyule did not differ significantly from the wider Victorian population on any of the biomedical risk factors included here. However, prevalence of overweight and obesity is slightly lower in Banyule than Victoria (45.4% vs. 50.2%).

Table 16: Banyule and Victoria, proportion in population with biomedical risk factors, 2011–12

	BANYULE % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Overweight	28.1	32.7	39.3	36.5
Obese	17.3	17.5	22.8	20.2
Hypertension	26.5	24.7	40.5	57.1

Banyule adults aged 50 years and over did not differ significantly from the wider Victorian population aged 50 years and over on any of the biomedical risk factors included here.

Table 17: Banyule and Victoria, age-adjusted proportion of population aged 50 years and over, biomedical risk factors, 2011–12

	BANYULE % ADULTS 50+	VICTORIA % ADULTS 50+
Overweight	38.9	37.4
Obese	21.2	21.4
Hypertension	51.8	45.8

The following series of figures compares Banyule adults aged 50+ years with Victorian adults aged 50+ years on selected health behaviours.

Figure 11: Smoking status, Victoria and Banyule, adults aged 50+

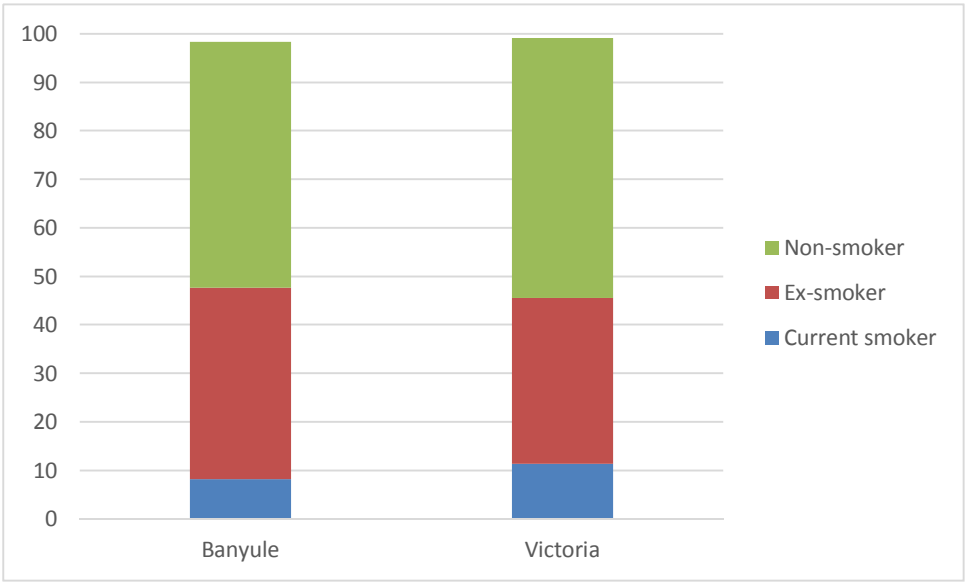


Figure 12: Risk of alcohol harm (long-term), Victoria and Banyule, adults aged 50+

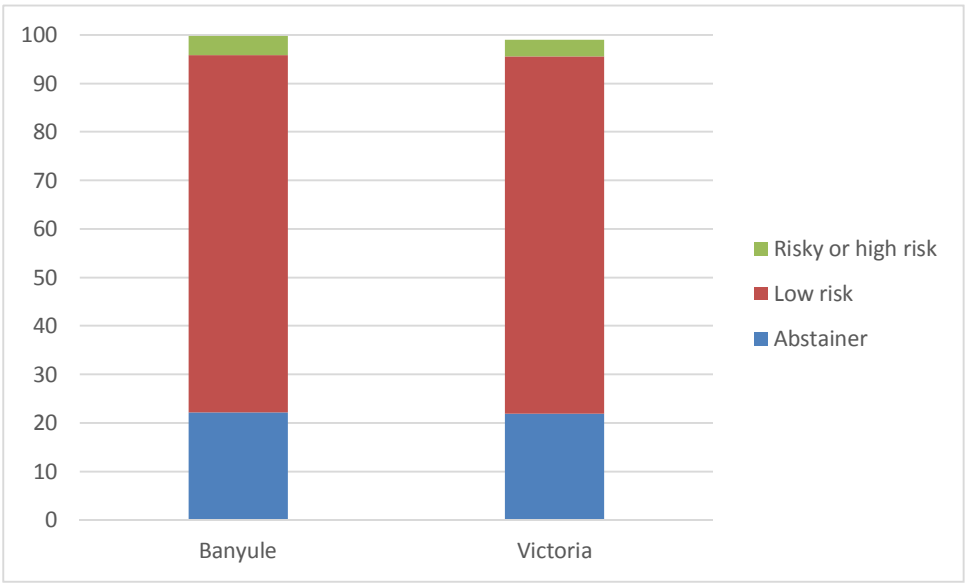


Figure 13: Met guidelines for vegetable consumption, Victoria and Banyule, adults aged 50+

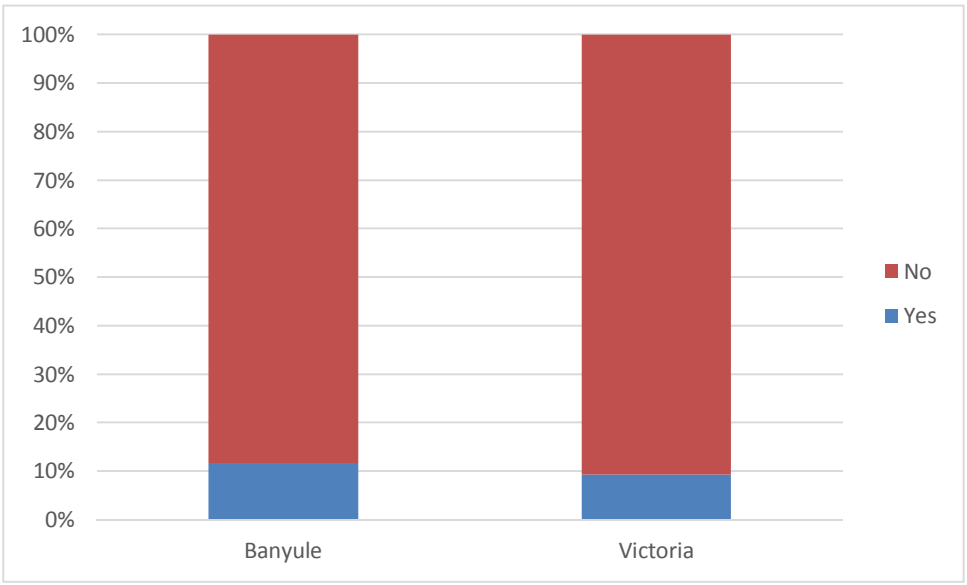


Figure 14: Met guidelines for fruit consumption, Victoria and Banyule, adults aged 50+

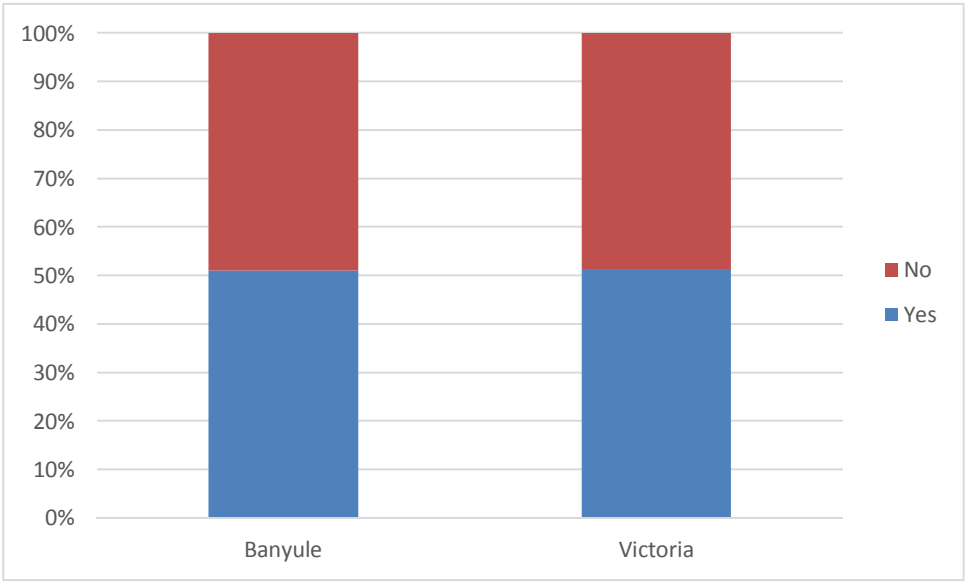


Figure 15: Physical activity, Victoria and Banyule, adults aged 50+

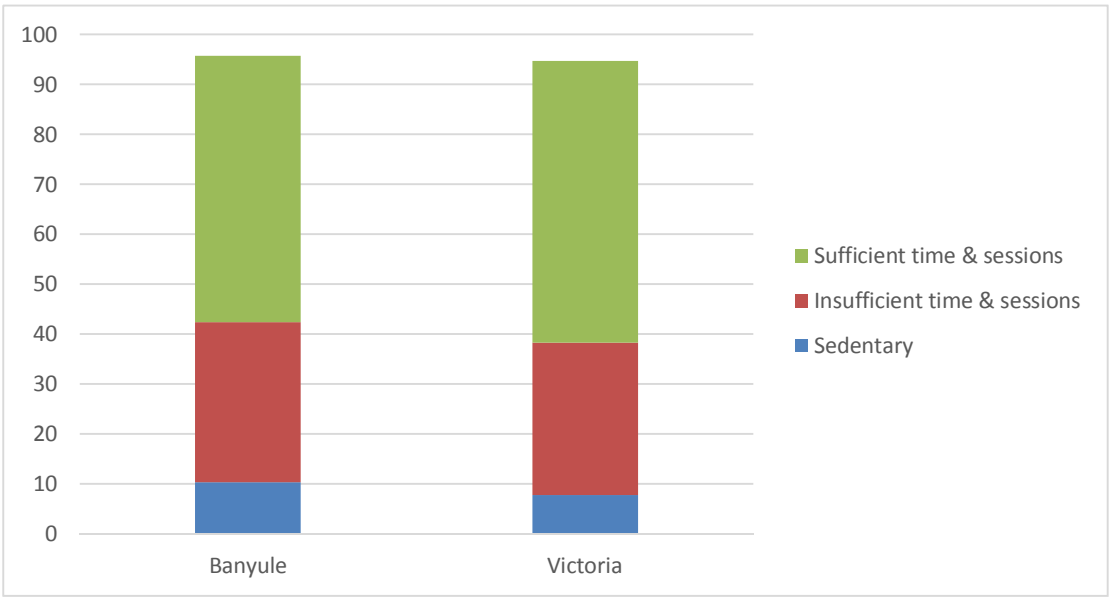
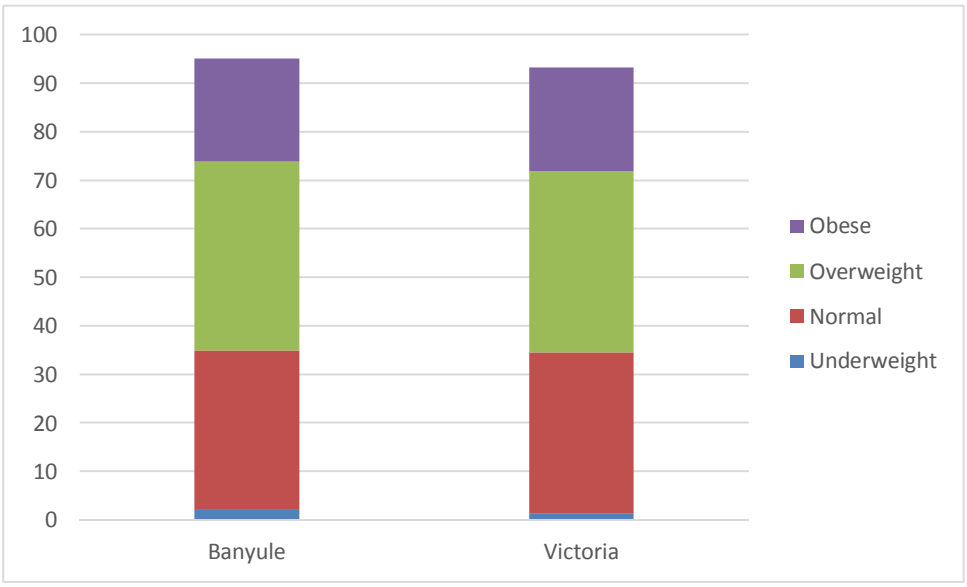


Figure 16: Body weight status, Victoria and Banyule, adults aged 50+

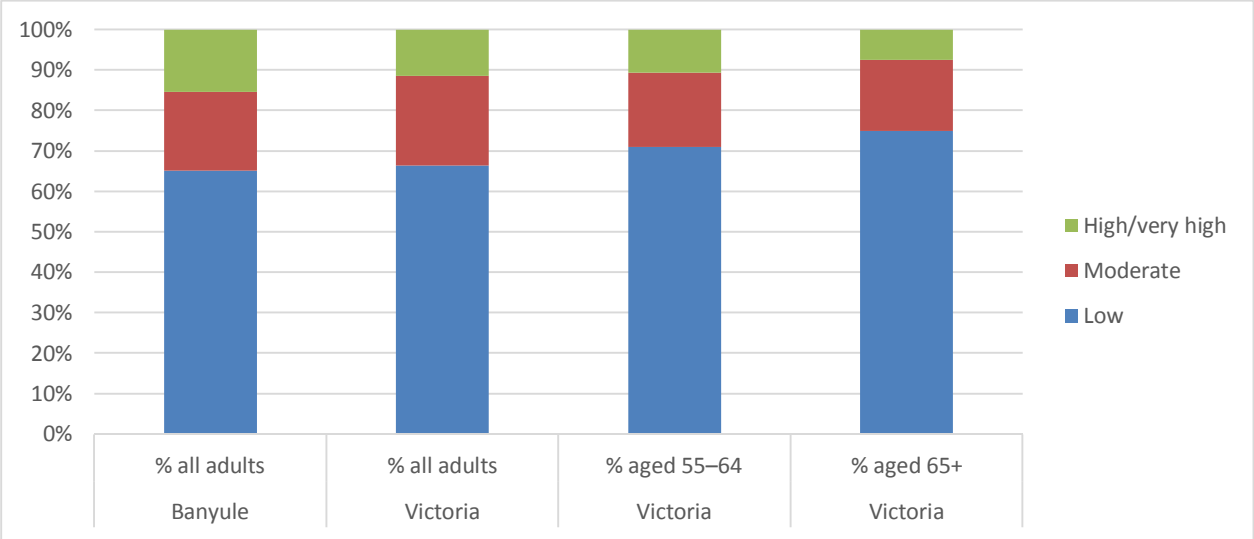


PSYCHOLOGICAL DISTRESS

The Kessler Scale (K-10) measures level of psychological distress. The Victorian Population Health Survey also asks about lifetime prevalence of anxiety and depression and whether or not a health professional has been consulted in the previous 12 months. Figures on these indicators of mental health are provided in the table below.[21] Banyule has a significantly higher lifetime prevalence of anxiety and depression than Victoria as a whole.

In general, a relatively low proportion of adults aged 65 years and over report indicators of psychological distress.

Figure 17: Banyule and Victoria, percentage of the population with psychological distress, 2011–12



Data source: Victorian Population Health Survey

Table 18: Banyule and Victoria, indicators of mental health, 2011–12

	BANYULE % ALL ADULTS	*VICTORIA % ALL ADULTS*	*VICTORIA % AGED 55–64*	*VICTORIA % AGED 65+*
Psychological distress				
Low	62.7	64.6	68.9	71.3
Moderate	18.8	21.5	17.8	16.8
High/very high	14.7	11.0	10.2	7.0
Lifetime prevalence of anxiety and depression	26.1	20.0	22.3	16.8
Sought professional help in previous 12 months	14.5	12.4	10.3	5.2

[21] This table does not appear in the Whittlesea Data Story report.

Community wellbeing indicators

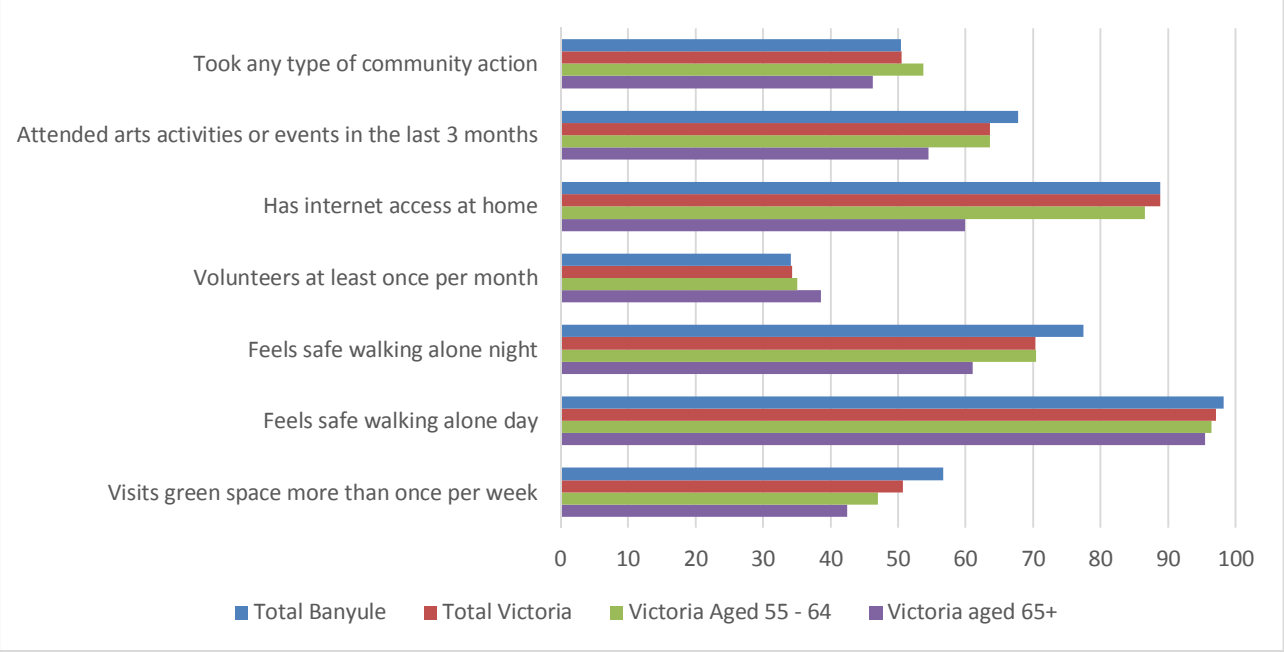
The VicHealth Indicators Survey, undertaken in 2011, includes a range of measures of community wellbeing for Victoria and Victorian municipalities.

The data for all adults presented in the figures and table directly below are age-standardised and were taken from the Banyule VicHealth fact sheet. [22]

Scores for Banyule on **positive** community wellbeing indicators did not differ significantly from Victorian averages for any of the indicators.

In general, adults aged 65 years or over were much less likely to have internet access at home than adults of all ages and adults aged 55 to 64 years.

Figure 18: Banyule and Victoria, VicHealth Indicators (positive), 2011



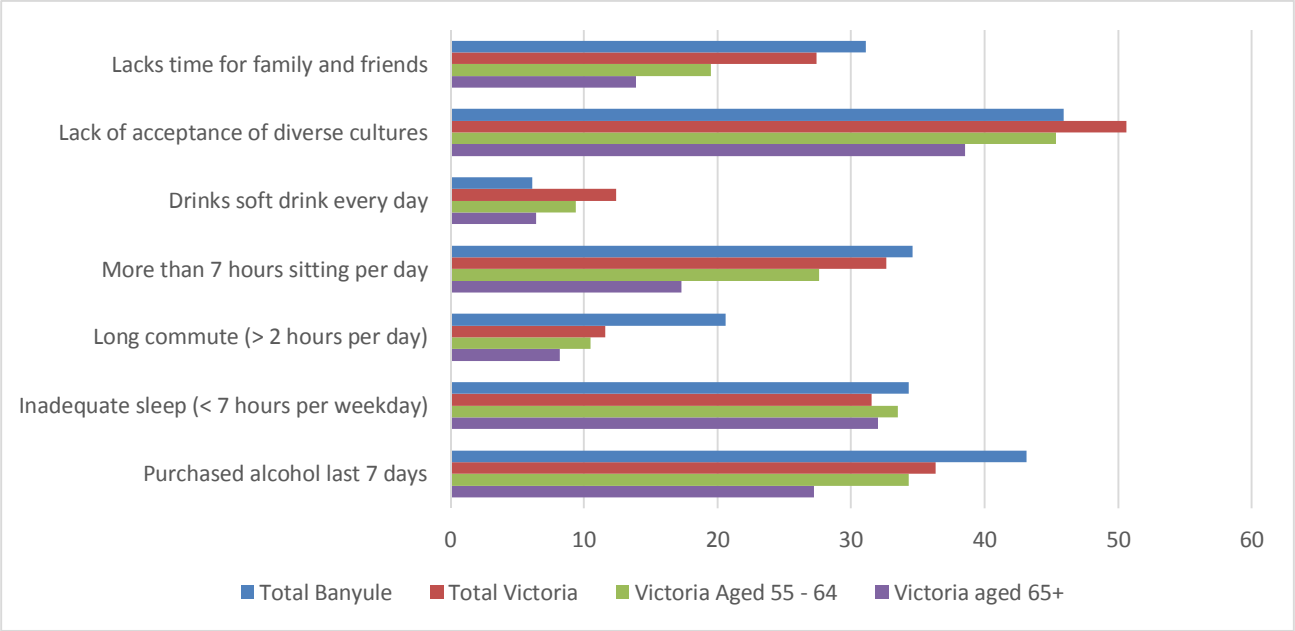
Data source; VicHealth Indicators Survey 2011

[22] https://www.vichealth.vic.gov.au/programs-and-projects/vichealth-indicators-survey-lga-profiles

Scores for Banyule on **negative** community wellbeing indicators did not differ significantly from Victorian averages for any of the indicators except having a long daily commute to work (less favourable).

In general, adults aged 65 years and over were less likely than adults of all ages to spend more than seven hours per day sitting.

Figure 19: Banyule and Victoria, VicHealth Indicators (negative), 2011



Data source: VicHealth Indicators Survey 2011

The data on which the two figures above are based is provided in the following table:

Table 19: Banyule and Victoria, VicHealth Indicators, 2011

	ALL ADULTS, BANYULE	ALL ADULTS, VICTORIA	VICTORIA AGED 55 - 64	VICTORIA AGED 65+
Purchased alcohol last 7 days	43.1	36.3	34.3	27.2
Inadequate sleep (< 7 hours per weekday)	34.3	31.5	33.5	32.0
Long commute (≥ 2 hours per day)	20.6	11.6	10.5	8.2
More than 7 hours sitting per day	34.6	32.6	27.6	17.3
Drinks soft drink every day	6.1	12.4	9.4	6.4
Visits green space more than once per week	56.6	50.7	47.0	42.4
Feels safe walking alone day	98.2	97.0	96.4	95.4
Feels safe walking alone night	77.4	70.3	70.4	61.0
Volunteers at least once per month	34.1	34.3	35.0	38.5
Has internet access at home	88.8	88.8	86.5	59.9
Lack of acceptance of diverse cultures	54.1	50.6	45.3	38.5
Attended arts activities or events in the last 3 months	67.7	63.6	63.6	54.5
Lacks time for family and friends	31.1	27.4	19.5	13.9
Took any type of community action	50.4	50.5	53.7	46.2

Data were also provided on request for age groups 50 years and over. These estimates are not age-standardised and so differ slightly from the figures in the table above.

Table 20: Banyule and Victoria, VicHealth Indicators, aged 50+ years and all adults, 2011

	BANYULE AGED 50+ %	VICTORIA AGED 50+ %	ALL ADULTS BANYULE %	ALL ADULTS VICTORIA %
Purchased alcohol in the last 7 days	29.9	31.2	35.1	33.3
Drinks soft drink every day	3.9	8.3	5.3	10.5
Inadequate sleep (< 7 hours per night)	37.6	32.0	34.6	31.9
More than 7 hours sitting per day	18.9	22.0	27.2	25.4
Long commute (60+ minutes one way per day)	21.7	7.5	20.4	8.5
Visits green spaces less than once a week	47.5	56.5	46.1	52.9
(Low) acceptance of diverse cultures	48.5	54.0	41.1	50.1
Lacks time for family and friends	19.1	17.9	25.8	22.6
Feels safe walking alone (day)	96.5	97.0	97.6	97.2
Feels safe walking alone (night)	56.9	70.2	68.1	70.9
Volunteers at least once per month	36.9	41.8	36.7	41.1
Attended arts activities or events in the las 3 months	60.2	57.4	63.8	59.2
Took part in citizen engagement in last 12 months	42.0	54.9	45.9	55.5
Has internet access at home	72.7	69.1	81.8	77.9

WELLBEING

The Australian Unity Personal Wellbeing Index is a measure of quality of life and a composite measure of life satisfaction in seven domains, including standard of living, health, achievements in life, community connection, personal relationships, safety and future security. The average score on all seven domains is combined into a Personal Wellbeing Index score and converted into a scale ranging from 0 *completely dissatisfied* to 100 *completely satisfied*. Normative data indicate that average Personal Wellbeing on the scale for Australians is about 75.

Banyule's average scores were not significantly different from the Victorian averages. (Data in the following table provided by VicHealth are not age-standardised.)

Table 21: Banyule and Victoria, Wellbeing score, 2011

	BANYULE AGED 50+ %	*VICTORIA AGED 50+ %*	*TOTAL BANYULE %*	*TOTAL VICTORIA %*
Average Wellbeing Score	78.3	78.8	78.2	78.3

Data source: VicHealth Indicators Survey

Provision of intensive services

This section of the data report provides data on provision of services for older people funded directly by the Commonwealth Government, including packaged care in the community (low and high level), residential care (low and high level) and transition care. It does not cover Home and Community Care (HACC), which is funded by all three levels of government and described in detail in Part 2 of this report.

Two sources of data were used in this section: a 2015 list of places and provider counts and a list of providers with funding allocations (2014).

Data provided by the Department of Health Primary Health Network identified 33 providers in Banyule—16 providing Home Care packages, 15 providing residential care, one in the Innovative Pool and one for Transition Care.

The following tables provide data on numbers of operational places for Banyule Statistical Areas (SA2).

Table 22a: Provision of intensive community services and residential care (operational places), 2015

SA2 NAME	*SA2 CODE*	*HCP LEVEL 1*	*HCP LEVEL 2*	*HCP LEVEL 3*	*HCP LEVEL 4*	*RESIDENTIAL CARE*	*INNOVATIVE POOL*	*TRANSITION CARE*
Greensborough	21197	-	-	-	-	228		
Heidelberg - Rosanna	21198	-	30	-	40	246		50
Heidelberg West	21199	-	-	-	-	206		
Ivanhoe	21200	-	-	-	15	-		
Ivanhoe East - Eaglemont	21201	12	244	10	68	44		
Montmorency - Briar Hill	21202	-	-	-	-	90		
Watsonia	21204	-	-	-	-	-	4	
Bundoora - East	21196	-	-	-	91			
Bundoora - North	21216	10	196	18				
Total		22	470	28	217	1,087	4	50

HCP = Home Care Packages

The following table compares Banyule's rates of operational places per 100,000 population aged 65 years and over with those for Victoria as a whole. The population projections used here are also from the Primary Health Network dataset. These figures show that Banyule is relatively well placed for all intensive care service types in comparison with average operational places across Victoria.

Table 22b: Provision of intensive community services and residential care (operational places), Banyule and Victoria, 2015

	NUMBER OF PLACES, BANYULE	NUMBER PER 100,000 POPULATION AGED 65+, BANYULE	NUMBER OF PLACES, VICTORIA	NUMBER PER 100,000 POPULATION AGED 65+, VICTORIA
Home Care Low	492	25.6	13,770	15.4
Home Care High	245	12.8	4,044	4.5
Residential Care	1,220	63.6	50,716	56.6
Innovative Pool	4	0.2	4	0.0
Transition Care	50	2.6	1,000	1.1

Twenty-eight services (representing 23 providers) with Banyule postcodes were funded to provide intensive aged care services in 2014, altogether attracting $97,512,657 in Commonwealth Government funding. Banyule, which has some large providers located within its boundaries, including the Brotherhood of St Laurence (239 places), Embracia Communities (160 places), and Northern Health (148 places), as well as a large range of smaller providers. Agencies located in Banyule and the services they are funded to provide are listed in the following table:

Table 23: Providers of intensive community services and residential care, Banyule postcodes, 2014

SERVICE NAME	HOME CARE LOW PLACES	HOME CARE HIGH PLACES	RESIDENTIAL LOW CARE PLACES	RESIDENTIAL HIGH CARE PLACES	TRANSITION CARE PLACES
Baptcare	✓	✓	✓	✓	
Benetas		✓	✓		
Darley House				✓	
Sir William Hall Hostel			✓		
Grace Garden Aged Care Facility			✓	✓	
Bundoora Extended Care Centre	✓	✓			
Ian Brand Nursing Home				✓	
Merv Irvine Nursing Home				✓	
Vasey House			✓	✓	
Villa Maria Bundoora				✓	
Assisi Centre Aged Care			✓	✓	
Austin Health	✓				✓
BlueCross Clevedon Terrace			✓		
Northern Region Home Care Pack's		✓			
Rosanna Views RACF				✓	
Southern Cross Care	✓	✓			
Regis Heathcliff Manor				✓	
MSV-Changing Needs				✓	
Bupa Greensborough				✓	
Deloraine Private Nursing Home			✓	✓	
Grace Villa Aged Care			✓	✓	
Liscombe House Hostel			✓		
Lower Plenty Garden Views			✓	✓	
Eltham Lodge Nursing Home			✓	✓	
Eltham Retirement Centre	✓				
Ian Rollo Currie Nursing Home				✓	
Outer North Community Options	✓				
Willandra Hostel			✓		

Summary and conclusion

The current report focuses on health and wellbeing indicators in the Banyule area. The problem with having a mass of data and analyses to hand is how best to make sense of the information, some of which is contradictory or partial.

POPULATION

- Age: Banyule's population will age slowly in the coming decade, with particular increases in the populations aged 70 to 74 (26.9%), 75 to 79 (45.8%), and 80 to 84 (24.3%).
- Socio-economic advantage and disadvantage: suburbs with high SEIFA scores are over-represented in Banyule, with only four falling below the mean, and six represented in the top decile of precincts in Victoria.

HEALTH AND WELLBEING

- Prevalence of key health conditions is similar in Banyule to the prevalence in Victoria as a whole. The exception is arthritis, which is more common in Banyule adults than in Victorian adults (using age-standardised rates, 24.6% vs. 19.9% for all adults).
- Age-specific proportions of people registering with diabetes are relatively low in Banyule.
- The number of people living with dementia in Banyule is expected to almost double, from 1,808 in 2010 to 3,524 in 2030.
- Banyule was ranked 10th in Victoria on the number of people in the municipality living with dementia, and this ranking will not change a great deal (13th in 2030 and 12th in 2050).
- Hospital admission rates for all three kinds of injury (falls, unintentional injury, and intentional injury) among people aged 50 years and over tend to be slightly lower in Banyule than in Victoria as a whole.
- Banyule adults do not differ significantly from the wider Victorian population on any of the behavioural or bio-medical protective or risk factors.
- About one-half of Banyule adults aged 50 years and over are non-smokers (51%) and a similar proportion engages in sufficient physical activity (53%) and met guidelines for fruit consumption (51%).
- Risks for Banyule adults aged 50 years and over include low consumption of vegetables (86%) and overweight/obesity (60%).

- Banyule has a significantly higher lifetime prevalence of anxiety and depression than Victoria as a whole. However, Banyule's average score on the Australian Unity Wellbeing Index did not differ significantly from the Victorian average.
- Scores for Banyule on community wellbeing indicators did not differ significantly from Victorian averages for any of the indicators except having a long daily commute to work (less favourable).

INTENSIVE AGED CARE SERVICES

- Thirty-three providers in Banyule provided intensive care services—16 providing Home Care packages, 15 providing residential care, one in the Innovative Pool and one for Transition Care.
- Examination of operation care places per 100,000 people aged 65 years and over indicate that Banyule is relatively well placed for all intensive care service types in comparison with average rates across Victoria.
- Altogether in 2014, local agencies attracted $97,512,657 in Commonwealth Government funding for intensive aged care services.

CONCLUSION

Banyule's population is ageing and service providers can expect increases in demand for health services associated with an ageing population, including dementia. Particular attention may be needed for people with arthritis and those with experiences of anxiety or depression. As elsewhere in Victoria, obesity and low vegetable consumption are key health risk factors.

Appendix: About the data sources

This section provides detail on the data sources used in this report and includes definitions of terms used in the Victorian Population Health Survey.

VICTORIAN POPULATION HEALTH SURVEY 2011–12

The Victorian Population Health Survey 2011–12 used computer-assisted telephone interviews (CATI) with a representative sample of persons aged 18 years or over who resided in private dwellings in Victoria. Random digit dialling (RDD) was used to generate a sample of telephone numbers that formed the household sample for CATI. People who are homeless or itinerant were excluded from the survey, as were people in hospitals or institutions, frail older people, and people with disabilities who were unable to participate in an interview.

The survey sample was stratified by LGA, with a target sample size of 426 respondents per LGA. The response rate was 66.8%. Survey data were weighted to reflect (1) the probability of selecting the respondent within the household, and (2) the age/sex/geographic distribution of the population

All data were self-reported.

Table 24: Banyule and Victoria, Victorian Population Health Survey, 2011–12, sample size

SAMPLE	N
Banyule All	426
Victoria All	33,673

Table 25: Profile of respondents, Victorian Population Health Survey, 2011–12

	BENCHMARK DATA (%)	UNWEIGHTED SURVEY SAMPLE (%)	WEIGHTED SURVEY SAMPLE (%)
Sex			
Males	49	39	49
Females	51	61	51
Age group			
18–24	13.0	3.4	14.2
25–34	18.9	6.2	19.1
35–44	18.4	14.6	17.9
45–54	17.3	19.5	16.7
55–64	14.5	22.6	13.6
65+	18.0	33.7	18.4

Definitions of key terms

Hypertension: A person is conically diagnosed with hypertension is their systolic blood pressure is 140 mmHg or more or their diastolic blood pressure is 90 mmHg or more.

Smoking: A person is defined as an "ex-smoker" if he/she has smoked at least 100 cigarettes or equivalent in their lifetime.

Alcohol consumption:

- High risk – Men are considered at high risk of long-term harm if they consume seven or more drinks on an average day or more than 43 drinks/week. For women, high risk of long-term harm is associated with the consumption of five or more standard drinks on an average day or more than 29 drinks/week.
- Risk – Alcohol consumption is considered risky in the long term if men consume five to six drinks on an average day (29–42/week) and if women consume more than three or four drinks daily (15–28/week).

Fruit and vegetable consumption:

- The recommended daily vegetable intake is five serves for persons aged 19 years or over, where a serve is defined as half a cup of cooked vegetables or a cup of salad vegetables.
- The recommended daily fruit intake is two serves for persons aged 19 years or over, where a serve is defined as one medium piece or two small pieces or fruit or one cup of diced pieces.

Physical activity: Accruing 150 or more minutes of moderate-intensity physical activity (such as walking) on a regular basis over one week (i.e., five-to-seven sessions per week) is believed to be sufficient for health benefits.

Information was collected on time spent doing three types of physical activity: walking (for more than 10 minutes at a time); vigorous household chores (excluding gardening); and vigorous activities such as tennis, jogging cycling or keep-fit exercises. Minutes of vigorous physical activity were weighted by a factor of two.

Overweight and obesity: Self-reported body mass index (BMI) was used. BMI = weight (kg)/height (m) squared

BMI less than 18.5 is considered underweight; 18.5 – 24.9 is normal weight; 25.0 – 29.9 is overweight; and 30.0 or more is obese.

Psychological distress: The Kessler 10 (K10) is a set of questions designed to categorise the level of psychological distress over a four-week period. It covers dimensions of nervousness, hopelessness, restlessness, sadness and worthlessness. Each of the 10 items has five response options (all of the time, most of the time, some of the time, a little of the time, and none of the time). Items are summed to yield scores ranging from 10 to 50. Individuals are categorised on four levels of psychological distress: low (10–15); moderate (16–21); high (22–29) or very high (30–50).

VICHEALTH INDICATORS SURVEY 2011

The VicHealth Indicators Survey is a triennial, local government area survey of approximately 25,000 people. The survey design entailed the conduct of 300 interviews per LGA.

Data were collected through CATI using RDD. All Victorian residential landline telephone numbers were considered in scope. Excluded groups included those without landlines, those living in facilities such as residential aged care, prisons or hospitals, and homeless people. The participation rate was 53.5%.

Table 26: Banyule and Victoria, VicHealth Indicators, 2011, sample size

SAMPLE	N
Banyule 50+	177
Banyule All	299
Victoria 50+	16,440
Victoria All	25,075

NATIONAL DIABETES SERVICES SCHEME (NDSS) REGISTRANTS

National Diabetes Services Scheme data come from the database of registrants on the National Diabetes Services Scheme (NDSS). The NDSS is an initiative of the Australian Government administered by Diabetes Australia. The NDSS delivers diabetes-related products at subsidised prices and provides information and support services to people with diabetes. Registration is free and open to all Australians diagnosed with diabetes. Information that might allow identification of individuals has been removed, and only broad categorisation data has been retained such as postcode, age, gender, and Indigenous status.

The diabetes map uses ABS Population Projections for 2012 to 2101 to automatically calculate and increment population statistics according to the current year and quarter.

Table 27: National estimates of diabetes prevalence by age group

50–59	60–69	70–79	80–89	90+
6.7	12.5	18.1	17.2	17.2

AUSTRALIAN BUREAU OF STATISTICS DATA

The ABS data used are publicly available, and include population statistics such as number of people, gender, age groups, Indigenous status, advantage/disadvantage index and the geographic definition of electorates and postcodes. The map uses ABS Population Projections for 2012 to 2101 to automatically calculate and increment population statistics according to the current year and quarter.

ACCESS ECONOMICS, 2010

Dementia prevalence rates were taken from a previous Access Economics report that used a combination of published epidemiological studies and meta-analyses (Access Economics, 2009). Keeping dementia front of mind; Incidence and prevalence 2009–2050. Report for Alzheimer's Australia, retrieved from https://fightdementia.org.au/national/publications/access-economics-reports). Assumed prevalence rates by age and gender are provided in the table below.

Table 28: Total Australian estimated dementia prevalence projection rates by gender (Access Economics, 2009)

AGE GROUP (YEARS)	MALE (%)	FEMALE (%)
< 60	0.03	0.02
60–64	1.2	0.6
65–69	1.7	1.3
70–74	3.5	3.3
75–79	5.8	6.3
80–84	12.1	12.9
85–89	21.1	24.4
90–94	31.5	35.7
95+	37.2	47.3

Estimated prevalence rates differ by group, and are generally higher, for example, in Indigenous Australians than in the general population.

Table 29: Australian Indigenous estimated dementia prevalence projection rates (Access Economics, 2009)

AGE GROUP (YEARS)	INDIGENOUS AUSTRALIANS (%)
45-59	2.6
60-69	16.9
70-79	16.4
80+	56.7