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50+ in Darebin: A data story

Report for Darebin 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 Darebin: A data story. Report for Darebin agencies. Part 1: Health and wellbeing.* Report commissioned by the North Eastern Primary Care Partnership. Melbourne: NEPCP.

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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 Darebin.
- Provide Darebin 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: unlike many other Melbourne municipalities, Darebin's population will not age in the coming decade. Although the number of people aged 50 years and over living in Darebin will increase, the proportion of the population aged 50 years and over will remain at around 29%.

Socio-economic advantage and disadvantage: Darebin suburbs are socio-economically diverse, with three falling below the median and four above the median on socio-economic advantage and disadvantage.

Prevalence of key health conditions is similar in Darebin to the prevalence in Victoria as a whole. However, in the age group aged 50 years and over, Darebin has a higher proportion of people with osteoporosis than Victoria.

Diabetes: Age-specific proportions of people registering with diabetes are similar to national prevalence figures, but relatively low in Alphington/Fairfield and Northcote among people aged under 70 years.

Dementia: The number of people living with dementia in Darebin will almost double in 20 years, from 1,808 in 2010 to 3,524 in 2030. In 2010, Darebin was ranked 8th in Victoria on the number of people in the municipality living with dementia.

Hospital admission rates among people aged 50 years and over for unintentional injury tend to be slightly lower in Darebin than in Victoria as a whole, and rates for falls are similar to those for Victoria, but rates for intentional injury are relatively high, especially for age groups 50 to 79 years.

Protective and risk factors: Darebin adults do not differ significantly from those in the wider Victorian population on any of the behavioural or bio-medical protective or risk factors except smoking (relatively high rates of smoking for all adults).

No significant differences between Darebin and Victorian estimates for age groups 50 years and over are apparent, except for having sufficient physical activity (Darebin residents aged 50 years and over are less likely than their Victorian counterparts to engage in sufficient levels of physical activity). Risks for Darebin adults aged 50 years and over include low consumption of vegetables (90%) and overweight/obesity (63%).

Community wellbeing: Scores for Darebin on **positive** community wellbeing indicators differed significantly from Victorian averages for two of the indicators: perceptions of safety at night (low) and volunteering (low). Scores for Darebin on **negative** community wellbeing indicators did not differ significantly from Victorian averages.

Intensive aged care services: Data provided by the Department of Health Primary Health Network identified 34 providers in Darebin—14 providing Home Care packages, 19 providing residential care, and one providing Transition Care. Comparison of Darebin's rates of operational places per 100,000 population aged 65 years and over with those for Victoria as a whole indicate that Darebin is relatively well placed for all intensive care service types in comparison with average operational places across Victoria.

Forty-two services located in the Darebin area were funded to provide intensive aged care services (packaged care, residential care, and transition care) in 2014, altogether attracting \$104,963,663 in Commonwealth Government funding.

CONCLUSION

Although Darebin's population is not ageing (in terms of the proportion of citizens aged 65 years and over), service providers can expect increases in demand for health services associated with an increasing **number** of older people, including dementia. Particular attention needs to be paid locally to people aged 50 years and over with osteoporosis. Key local risk factors include smoking, lack of physical activity, and low rates of volunteering. 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 focus¹, 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.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 Darebin'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.

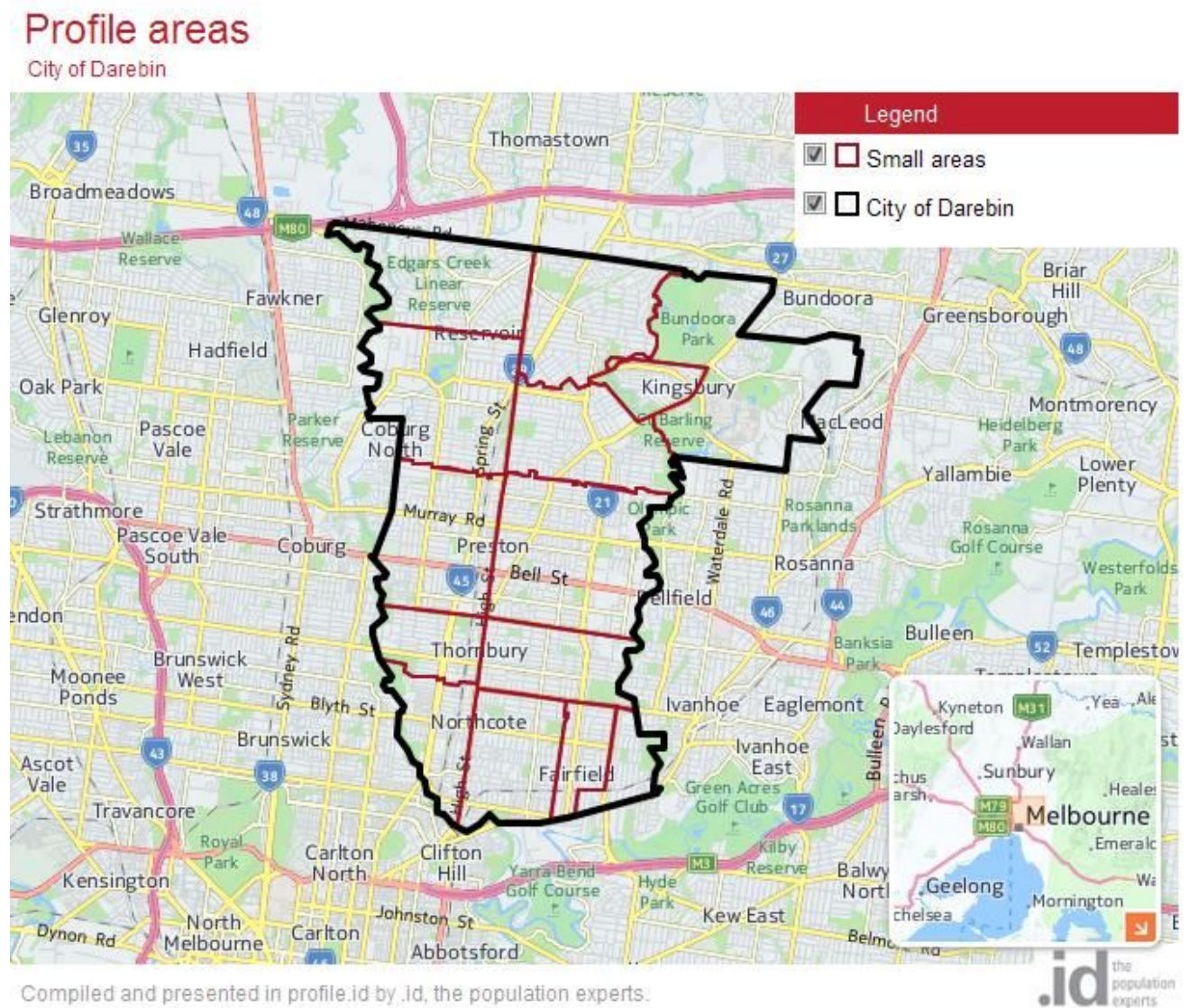
Methodology

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 Darebin

Figure 1: Darebin suburbs⁵



⁵ <http://profile.id.com.au/Darebin/population>

The City of Darebin is located in Australia within the Melbourne metropolitan area in the State of Victoria.

Darebin is located north of Melbourne CBD and its most populous community, Reservoir, is approximately 13 kilometres from Melbourne. Darebin covers an area of roughly 53 square kilometres and has a population of about 138,000. The City of Darebin is an established residential, industrial, commercial, cultural and educational area, with substantial parklands.

The municipality includes the suburbs of Alphington, Bundoora, Fairfield, Kingsbury, Macleod, Northcote, Preston, Reservoir, Thornbury, and small parts of Coburg and Coburg North (shared with the City of Moreland). Alphington and Fairfield are shared with the City of Yarra, Macleod is shared with the City of Banyule, and Bundoora is shared with the cities of Banyule and Whittlesea.⁶

Major features of the City include La Trobe University, Northern Melbourne Institute of TAFE (Preston Campus), Bundoora Extended Care Centre, Reservoir Private Hospital, Northland Shopping Centre, Preston Market, Bundoora Homestead, Cooper's Settlement & Heritage Village, Darebin Arts & Entertainment Centre, Bundoora Park, Darebin Parklands, Edwardes Lake Park, Gresswell Forest Nature Conservation Reserve, Gresswell Hill Nature Conservation Reserve, Coburg Cemetery, Preston General Cemetery, and Darebin and Merri Creeks.⁷

Darebin residents have a median age of 36 and earn, on average, \$1,178 per week. According to the 2011 Australian Bureau of Statistics (ABS) census, in Darebin⁸

- 44% of families are couples with children (2% lower than Victorian average)
- 34% live in medium/high density housing (11% higher than Victorian average)
- 35% of residents rent their property (8% higher than Victorian average)
- 24% have a bachelor's degree or higher (9% higher than Victorian average)
- 22% travel on public transport to work (11% higher than Victorian average)
- 60% were born in Australia (9% lower than Victorian average)

The most common occupations in Darebin are:

- Professionals (28.7%)
- Clerical & Administrative Workers (14.7%)
- Technicians & Trade Workers (12.0%)

⁶ https://en.wikipedia.org/wiki/City_of_Darebin

⁷ <http://profile.id.com.au/darebin/about>

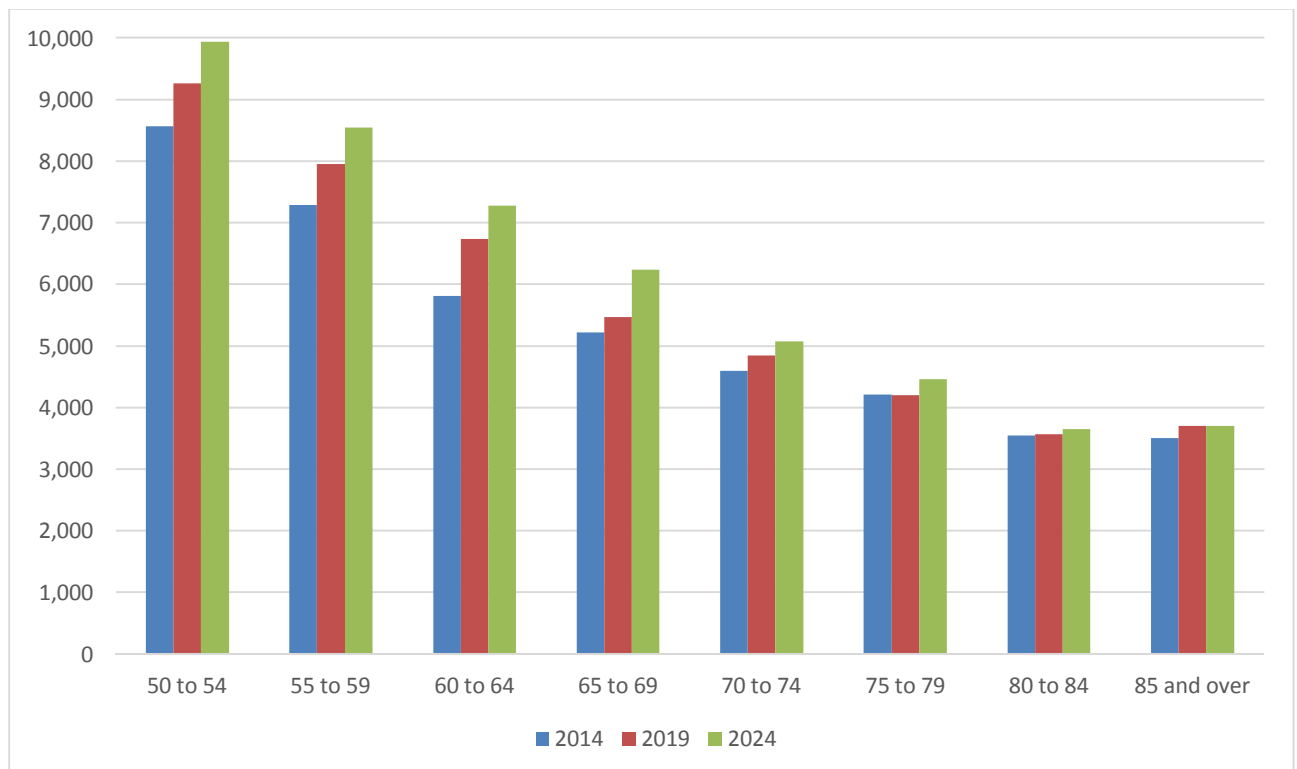
⁸ http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/LGA21890

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 Darebin's population will not age in the coming decade. Although the number of people aged 50 years and over will increase, the proportion of the population aged 50 years and over will not increase (and in fact a slight decrease in proportion is predicted for the group aged 70 years and over, from 10.8% to 9.9%).⁹

Figure 2: Darebin 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: Darebin age structure 2014 and population forecasts 2019 and 2024

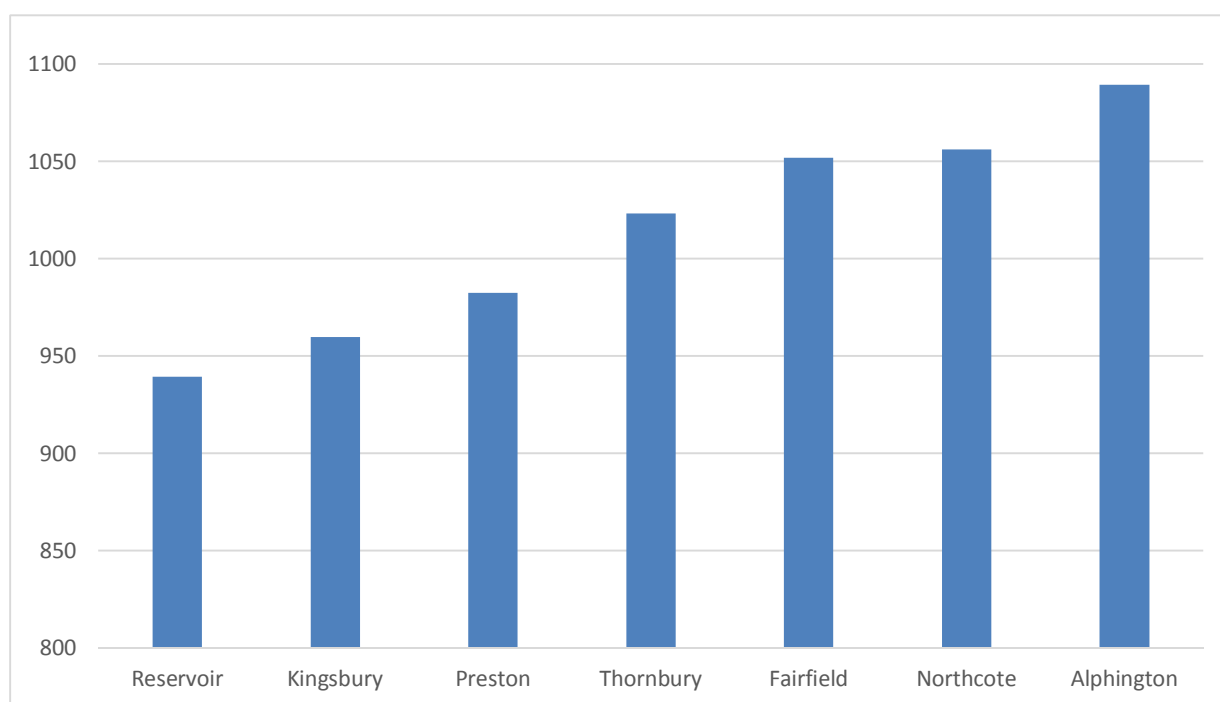
Age group	2014		2019		2024		% increase in N
	N	% of total population	N	% of total population	N	% of total population	
50 to 54	8,567	5.9	9,269	5.8	9,945	5.8	16.1
55 to 59	7,288	5.0	7,955	5.0	8,552	5.0	17.3
60 to 64	5,813	4.0	6,737	4.2	7,287	4.3	25.4
65 to 69	5,223	3.6	5,479	3.4	6,238	3.7	19.4
70 to 74	4,596	3.1	4,850	3.0	5,081	3.0	10.6
75 to 79	4,218	2.9	4,202	2.6	4,466	2.6	5.9
80 to 84	3,553	2.4	3,575	2.2	3,650	2.1	2.7
85 and over	3,514	2.4	3,702	2.3	3,704	2.2	5.4
Total population (all ages)	146,120		159,188		170,244		16.5
People aged 50+ as proportion of total population		29.3		28.5		28.7	

Socio-economic status

Socio-Economic Indexes for Areas (SEIFA)¹⁰ 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%). Darebin suburbs are socio-economically diverse and represented in a wide range of decile groupings.

Figure 3: Darebin SEIFA indices by suburb, 2011



Data source: Australian Bureau of Statistics

¹⁰ <http://www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001>

Table 2: SIEFA indices for Darebin suburbs, 2011

SUBURB	SEIFA INDEX OF ADVANTAGE AND DISADVANTAGE	RANK (VICTORIA)	DECILE
Alphington	1090	1408	10
Fairfield	1052	1169	8
Kingsbury	960	337	3
Northcote	1056	1207	8
Preston	983	490	4
Reservoir	939	227	2
Thornbury	1023	894	6

Summary of health and wellbeing

Key health conditions identified in Darebin include osteoporosis and dementia.

Table 3: Quick statistics – population health and wellbeing

	COMPARISON	DAREBIN	VICTORIA
Health Outcomes (Total population)	Prevalence of key health conditions is similar in Darebin to the prevalence in Victoria as a whole. The most common chronic condition is hypertension.	High BP 50+: 47%	High BP 50+: 46%
Health Outcomes (Population aged 50+)	Darebin has a relatively high proportion of people with osteoporosis. Age-specific rates of people registering with diabetes are relatively low in two Darebin suburbs in the age groups 50–69. Rates of injury requiring hospitalisation are slightly lower in Darebin than elsewhere in Victoria for unintentional injuries but slightly higher for intentional injuries.	16% 12% (50+) Falls 80+ yrs: 7.2% Intentional 50–59 yrs: 1.4%	12% 11 % (50+) Falls 80+yrs: 7.6% Intentional 50–59 yrs: 1.1%
Behavioural and biomedical risk factors (Total population)	Darebin does not differ significantly from the rest of Victoria on any risk factors except smoking (relatively high).	22%	16%
Behavioural and biomedical risk factors (Population aged 50+)	Darebin has a relatively low proportion of people who engage in sufficient physical activity. The most common risk factor is low consumption of vegetables. Prevalence of overweight/obesity is similar in Darebin to the rest of Victoria.	46% 90% 63%	56% 88% 59%
Wellbeing (Total population)	Darebin has similar overall emotional wellbeing to Victoria as a whole (lifetime prevalence of anxiety or depression).	21%	20%
Community wellbeing (Total population)	Darebin had relatively low scores on two positive wellbeing indicators: Safety at night Volunteering	61% 23%	70% 34%

Key health outcomes

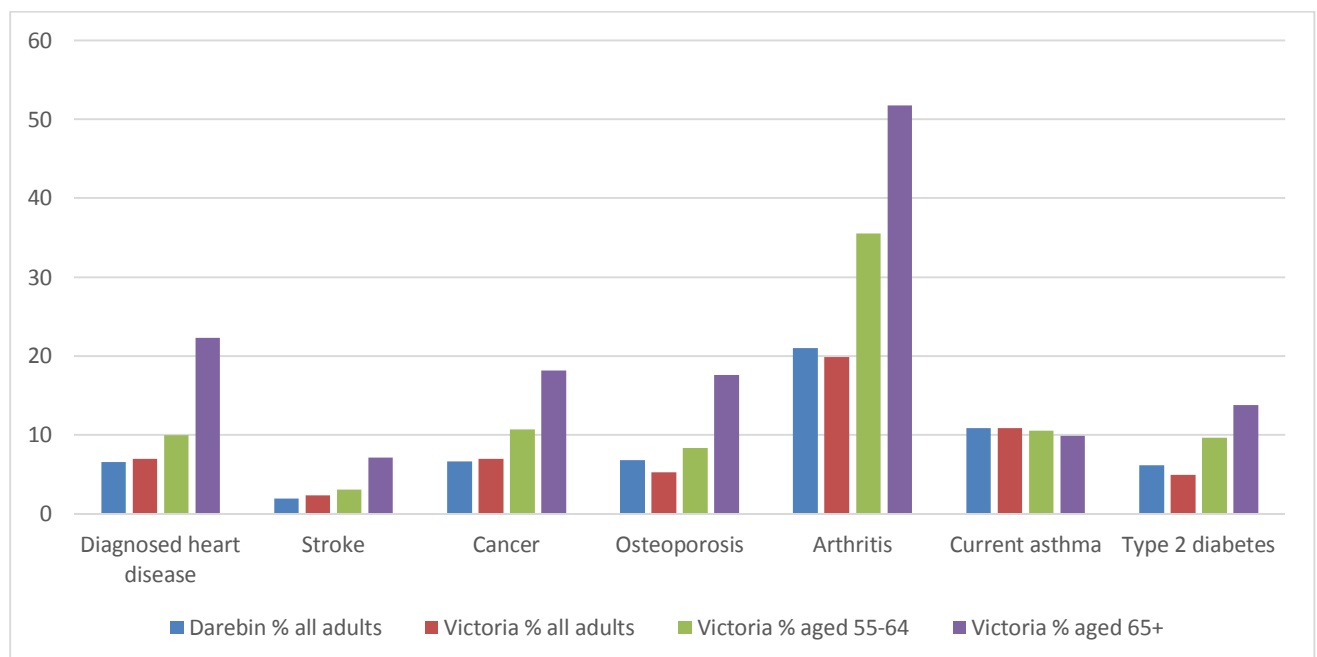
In this section of the report, data are presented on selected chronic diseases, dementia, falls, and other injuries requiring hospitalisation.

CHRONIC DISEASE

The proportion of the Darebin and Victorian population with specific chronic disease are provided in the 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 Darebin.

Prevalence of key health conditions is similar in Darebin to the prevalence in Victoria as a whole.

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



Data source: Victorian Population Health Survey, 2011–12

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

	DAREBIN % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA AGED 55–64	VICTORIA AGED 65+
Doctor-diagnosed heart disease	6.6	7.0	10.0	22.3
Stroke	2.0* ¹¹	2.4	3.1	7.2
Cancer	6.7	7.0	10.7	18.2
Osteoporosis	6.8	5.3	8.4	17.6
Arthritis	21.0	19.9	35.6	51.8
Current asthma	10.9	10.9	10.6	9.9
Type 2 diabetes	6.2	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 Darebin to those for Victoria as a whole, with the exception of osteoporosis.¹²¹³

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

	DAREBIN % AGED 50+	VICTORIA % AGED 50+
Doctor-diagnosed heart disease	16.2	14.7
Stroke	4.6*	4.9
Cancer	14.4	13.5
Osteoporosis	16.2	11.9
Arthritis	41.5	40.1
Current asthma	7.9	10.0
Type 2 diabetes	11.7	10.7

¹¹ Estimates with a large standard error are asterisked and should be treated with caution.

¹² Data for this table were provided by the Department of Health and Human Services on request.

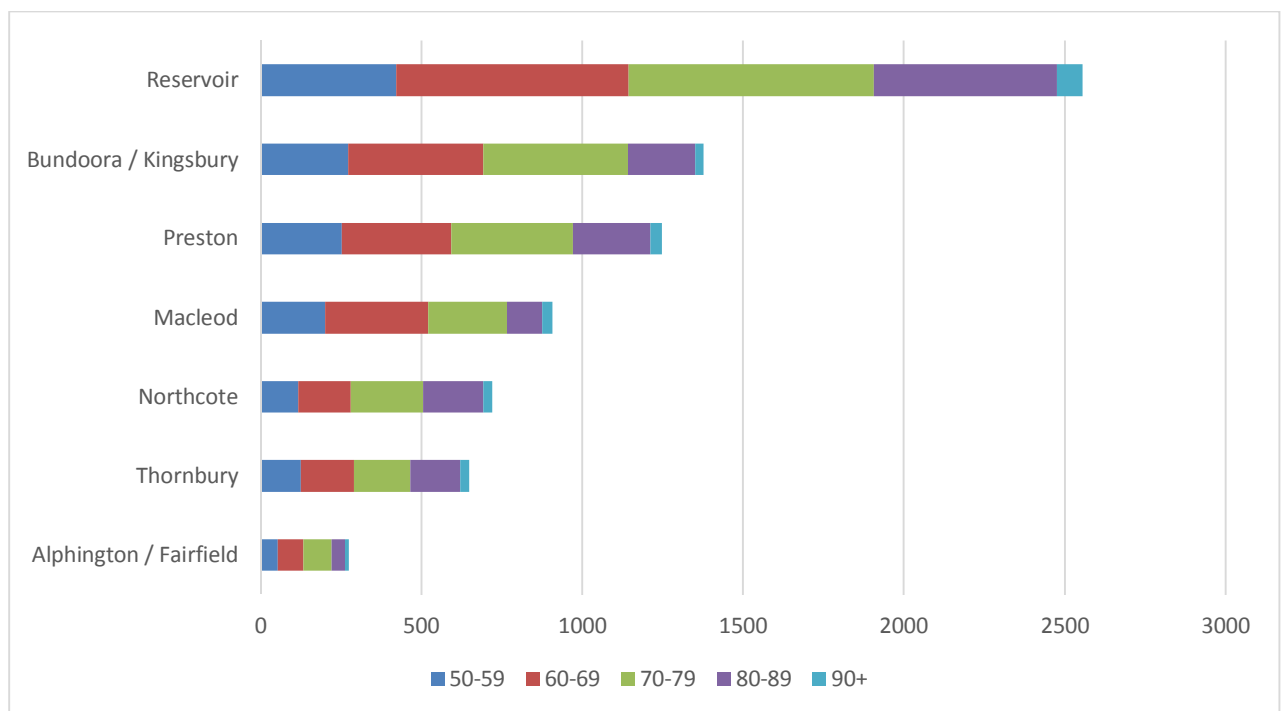
Data are for people aged 50 years or over and are sourced from VPHS 2011-12. Data have been age-standardised to the 2011 Victorian population. Estimates with a large standard error are asterisked and should be treated with caution.

¹³ 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.

DIABETES

Unfortunately, postcode data do not fit neatly into municipal boundaries.¹⁴ These data are provided on the Diabetes Australia website. Unfortunately, postcode data do not fit neatly into municipal boundaries.

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



Data source: Diabetes Australia

¹⁴ <http://www.diabetesmap.com.au/#/>

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

POSTCODE	SUBURB(S)	50-59	60-69	70-79	80-89	90+
3078	Alphington / Fairfield	53	79	88	42	11
3083	Bundoora / Kingsbury	272	419	451	209	25
3085	Macleod	200	320	246	108	32
3070	Northcote	117	162	226	187	27
3071	Thornbury	124	166	175	156	27
3072	Preston	252	340	378	241	36
3073	Reservoir	422	722	761	569	81

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

POSTCODE	SUBURB(S)	50-59	60-69	70-79	80-89	90+
3078	Alphington / Fairfield	3.6	8.5	14.4	10.4	20.0
3083	Bundoora / Kingsbury	7.8	12.6	20.7	18.3	18.2
3085	Macleod	5.2	10.4	14.8	12.0	9.2
3070	Northcote	4.6	9.4	14.7	18.9	17.7
3071	Thornbury	6.3	12.6	14.2	20.3	21.6
3072	Preston	7.0	14.0	18.3	18.7	19.6
3073	Reservoir	7.6	14.6	17.2	16.6	20.2

Age-specific proportions of people registering with diabetes are similar to national prevalence figures (see the Appendix), but relatively low in Alphington/Fairfield among people aged under 50-69 years and in Northcote among people aged 50-59 years.¹⁵

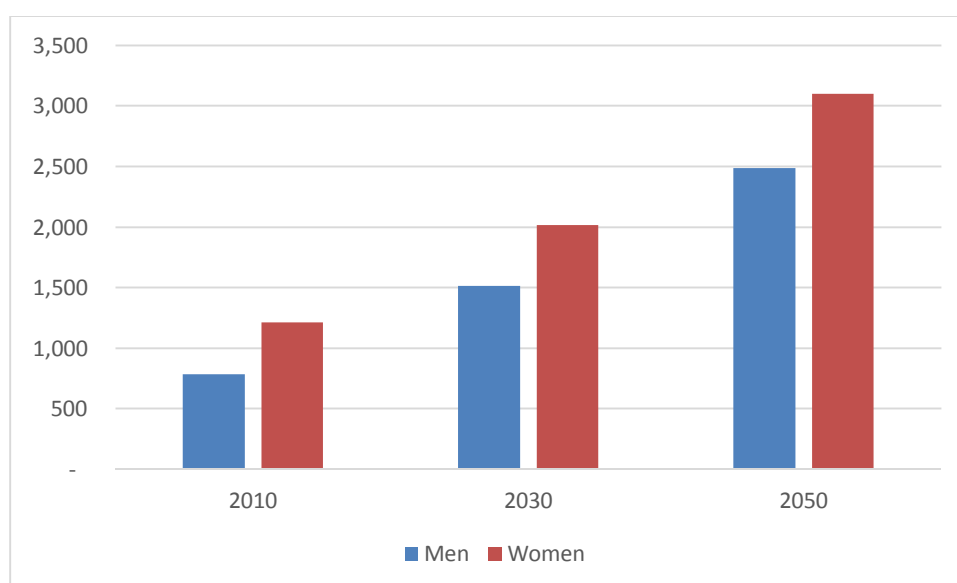
¹⁵ These comparisons are consistent with those made on the Diabetes Australia website. Age-specific rates for Australia are provided in the Appendix.

DEMENTIA

Dementia (Alzheimer's disease and related conditions) was the third leading cause of death in Australia in 2010.¹⁶ A report by Access Economics for Alzheimer's Australia¹⁷ predicts for Darebin 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 21).

In 2010, Darebin was ranked 8th in Victoria on the number of people in the municipality living with dementia, but this ranking will fall (10th in 2030 and 17th in 2050).

Figure 6: Darebin predicted growth in dementia by gender 2010–2050¹⁸



Data source: Access Economics 2010

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

	2010	2030	2050
Men	786	1,519	2,489
Women	1,214	2,021	3,102
	2,000	3,540	5,591

¹⁶ <https://www.deloitteaccesseconomics.com.au/uploads/File/Alzheimers%20Vol1Final%200710.pdf>

¹⁷ <https://vic.fightdementia.org.au/vic/research-and-publications/dementia-statistics-for-victoria>

¹⁸ http://www.health.vic.gov.au/agedcare/downloads/pdf/dementia_imp2010.pdf

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 Darebin. The risk of falls and other unintentional injuries increases with age, but the risk of intentional injury decreases with age.

Hospital admission rates for unintentional injury tend to be slightly lower in Darebin than in Victoria as a whole, and rates for falls are similar to those for Victoria, but rates for intentional injury are relatively high, especially for age groups 50 to 79 years.¹⁹

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

	UNINTENTIONAL (NOT FALLS)		FALLS		INTENTIONAL INJURY	
	Darebin	Victoria	Darebin	Victoria	Darebin	Victoria
50–59 years	804.4	855.4	623.6	475.2	143.4	106.8
60–69 years	816.5	890.2	780.7	843.8	80.8	56.9
70–79 years	1,058.9	1,132.8	1,926.2	2,051.7	45.1	34.8
80+ years	1,819.1	2,150.3	7,190.4	7,647.9	28.6	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.

¹⁹ 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.²⁰ Darebin has a high rate of hospital admission due to intentional injury for both men and women. However, while the rate of hospital admission due to intentional injury is 20% above the state average for women in Darebin, it is 30% above the state average for men.

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

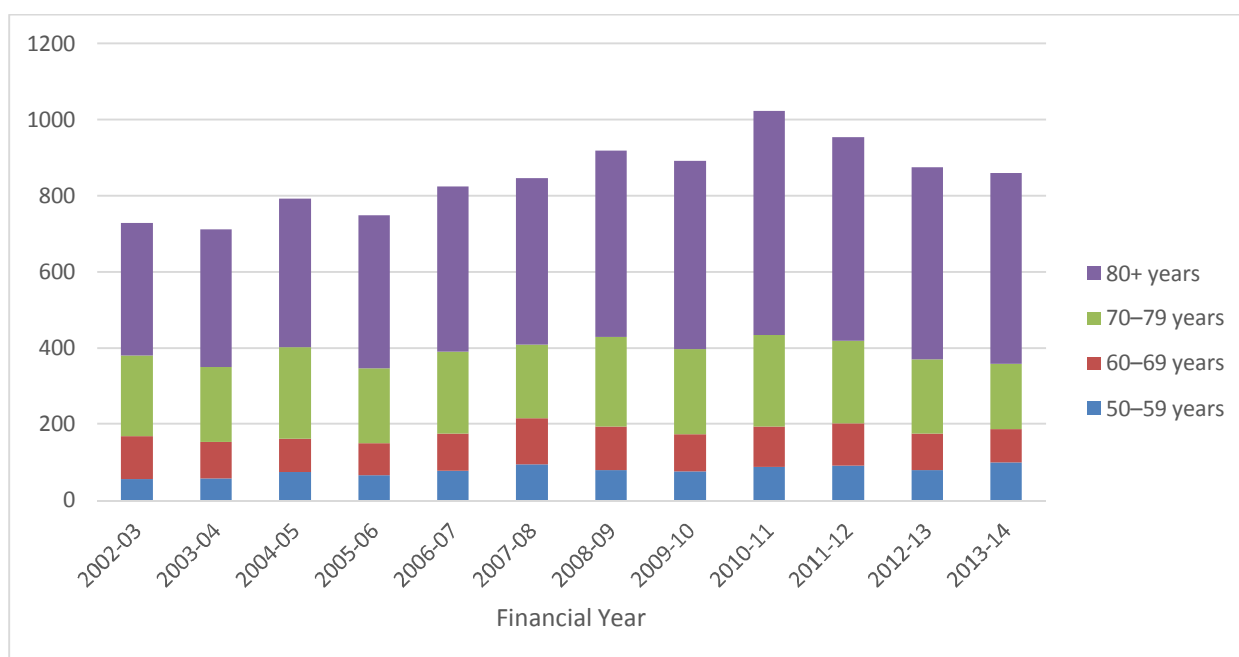
DAREBIN		VICTORIA	
Male	Female	Male	Female
158	127	121	106

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 Darebin's hospital admissions for falls by age group. Hospital admissions for falls for Darebin 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.²¹

²⁰ 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.

²¹ 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 7: 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

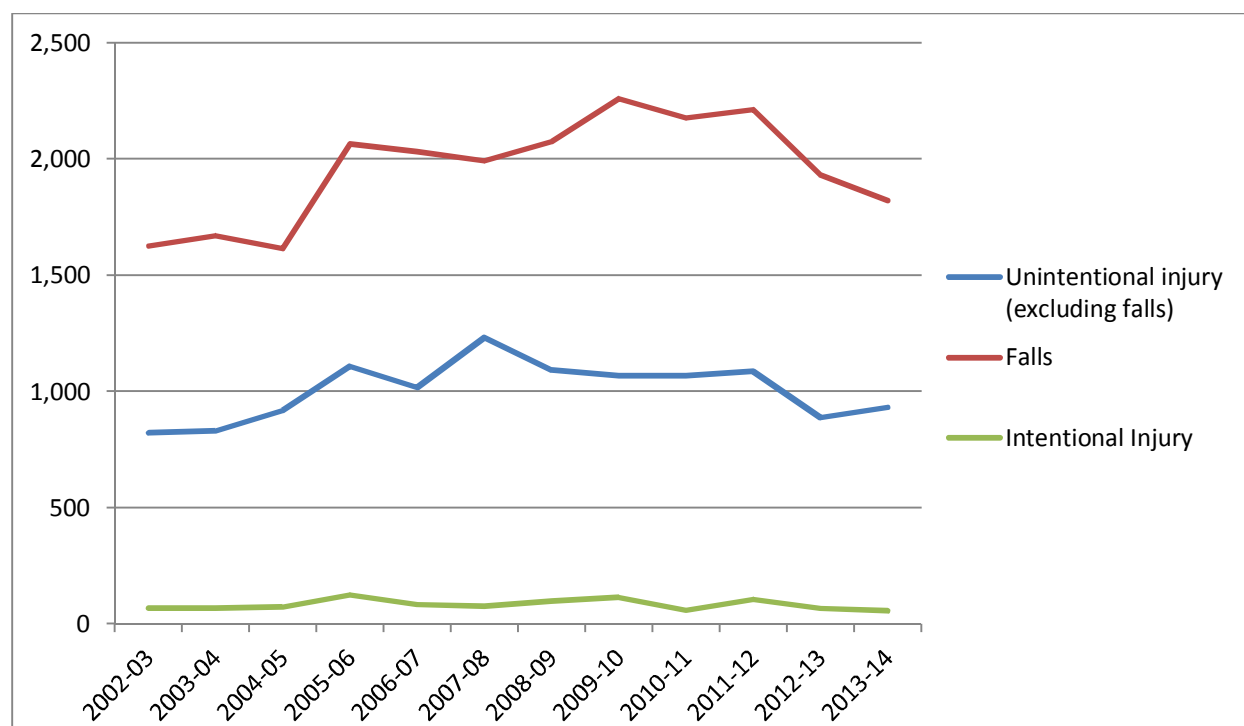
	<i>50–59 years</i>	<i>60–69 years</i>	<i>70–79 years</i>	<i>80+ years</i>	<i>Total</i>
2002-03	55	113	212	350	730
2003-04	57	96	197	362	712
2004-05	74	88	240	392	794
2005-06	65	85	197	402	749
2006-07	78	97	215	436	826
2007-08	94	121	194	438	847
2008-09	80	113	237	490	920
2009-10	75	98	225	494	892
2010-11	87	107	241	589	1,024
2011-12	91	111	217	536	955
2012-13	79	96	195	505	875
2013-14	100	87	171	502	860
Total	935	2,323	2,541	5,496	10,184

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.

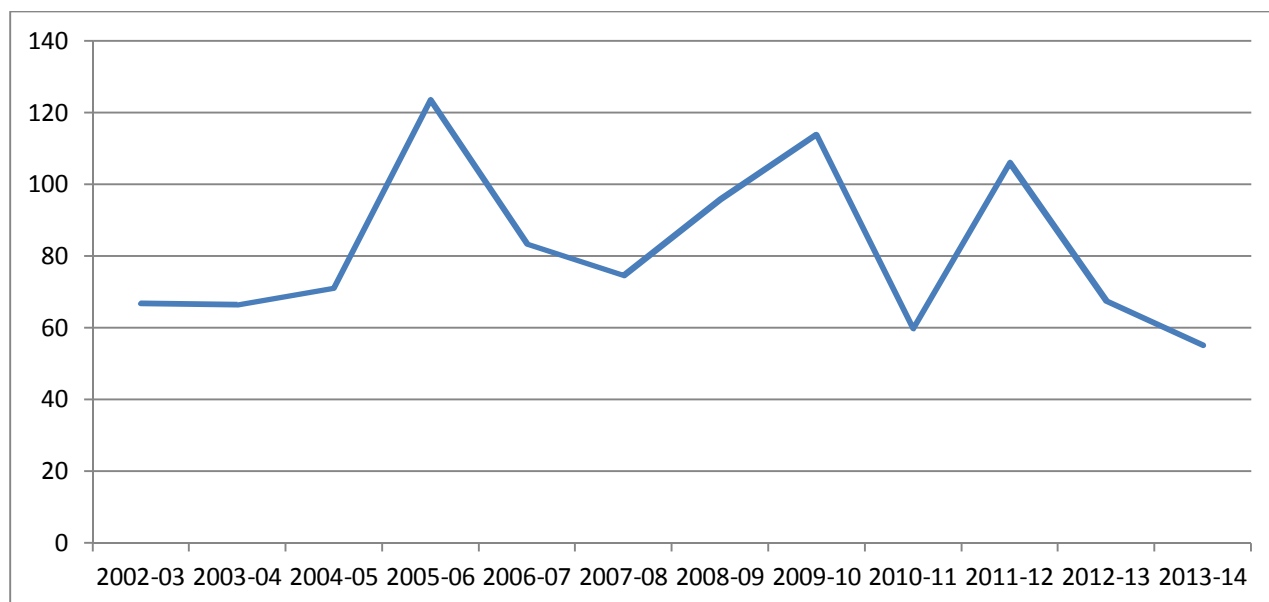
The following table illustrates how strongly and consistently falls are represented in admissions to hospital in this age group.

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.²²

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



²² 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 Darebin 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

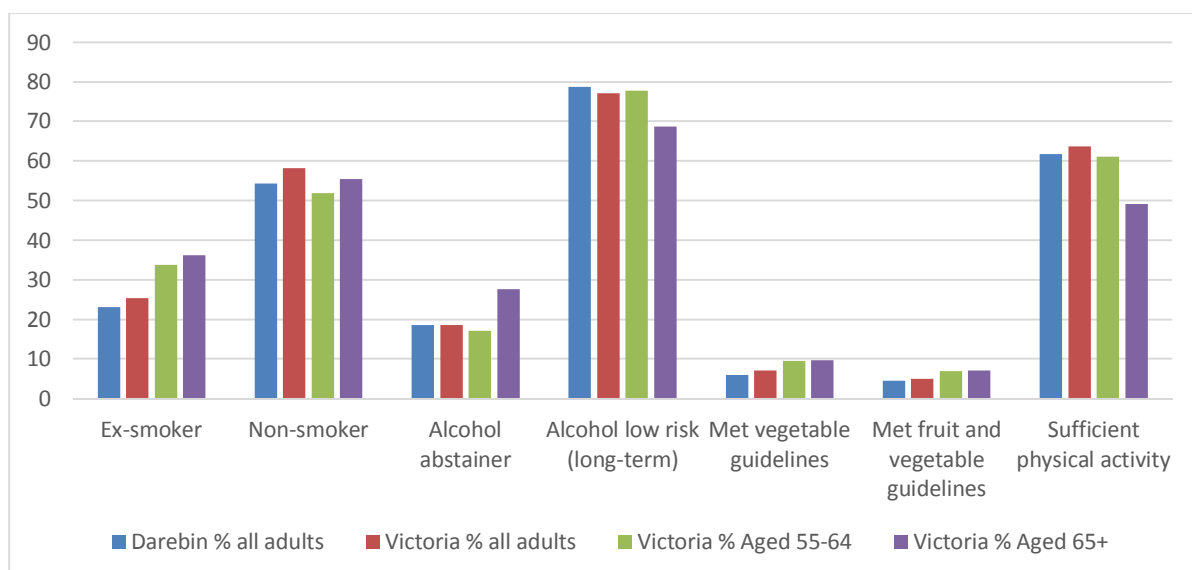
Darebin did not differ significantly from the wider Victorian population on any of the behavioural protective factors included here.

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: Darebin and Victoria, proportion of population by protective behaviours 2011–12



Data source: Victorian Population Health Survey 2011–12

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

	DAREBIN % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Ex-smoker	23.2	25.4	33.8	36.3
Non-smoker	54.4	58.3	52.0	55.5
Alcohol abstainer	18.6	18.6	17.2	27.7
Alcohol low risk (long-term)	78.8	77.2	77.8	68.7
Met vegetable guidelines	6.0	7.1	9.6	9.7
Met fruit and vegetable guidelines	4.5	5.1	7.0	7.2
Sufficient physical activity	61.8	63.7	61.2	49.2

Age-adjusted comparisons between Darebin adults and Victorian adults aged 50 years and over are provided in the following table. No significant differences between Darebin and Victorian estimates are apparent except for having sufficient physical activity (Darebin residents aged 50 years and over are less likely than their Victorian counterparts to engage in sufficient levels of physical activity).

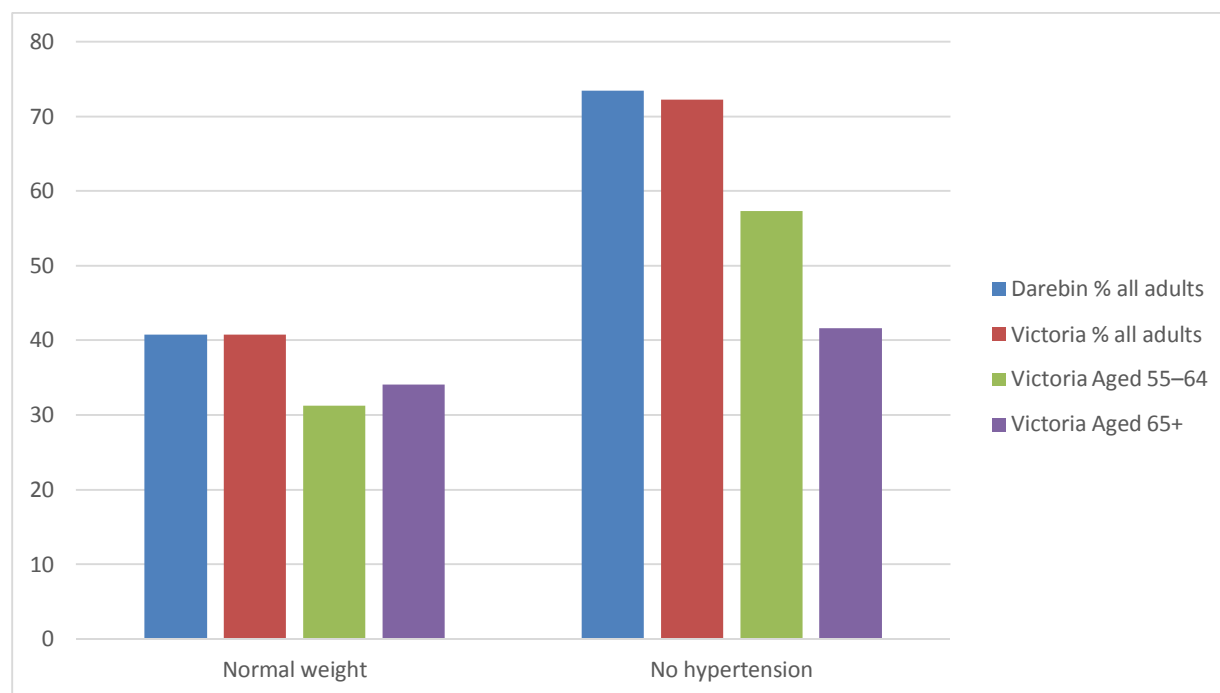
Table 11: Darebin and Victoria, age-adjusted proportion of population aged 50 years and over, protective behaviours, 2011–12

	DAREBIN % ADULTS 50+	VICTORIA % ADULTS 50+
Ex-smoker	32.9	34.3
Non-smoker	56.9	53.5
Alcohol abstainer	25.9	21.9
Alcohol low risk (long-term)	70.2	73.7
Met vegetable guidelines	8.0	9.2
Met fruit guidelines	53.1	50.6
Sufficient physical activity	46.4	56.4

Darebin 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 than all adults to be in the normal weight range and were more likely to have hypertension.

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



Data source: Victorian Population Health Survey 2011–12

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

	DAREBIN % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA AGED 55–64	VICTORIA AGED 65+
Normal weight	40.8	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 Darebin residents aged 50 years and over did not differ significantly from those for all Victorians aged 50 years and over.

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

	DAREBIN % ADULTS 50+	VICTORIA % ADULTS 50+
Normal weight	27.9	33.2
No hypertension	51.1	52.5

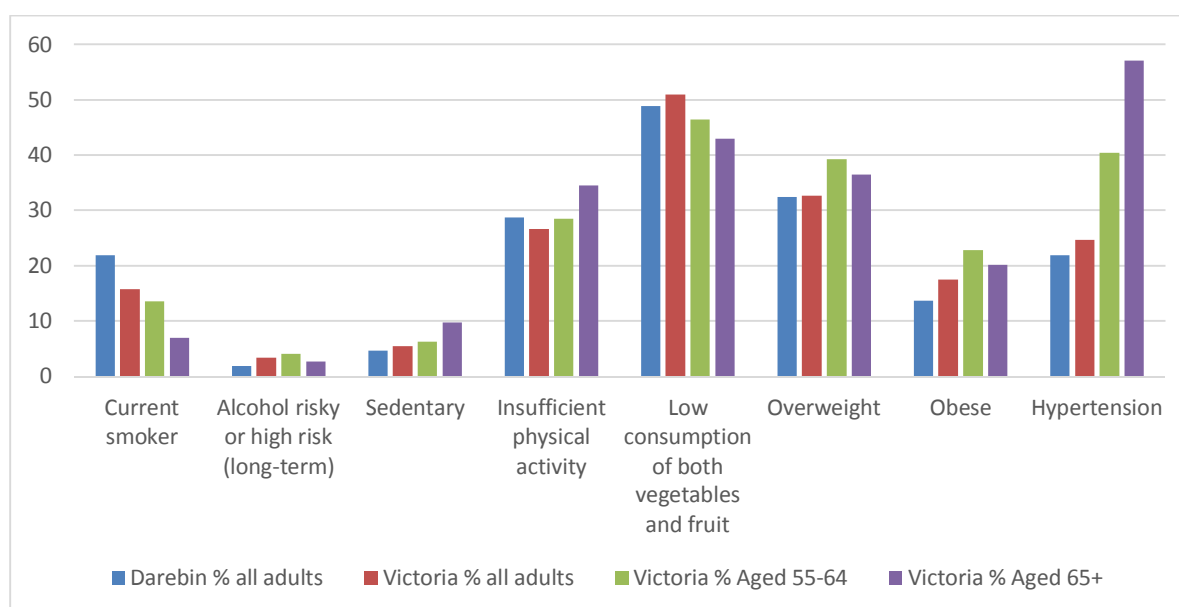
RISK FACTORS

Darebin did not differ significantly from the wider Victorian population on any of the behavioural risk factors included here with the exception of smoking (relatively high rates of smoking for all adults).

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: Darebin and Victoria, proportion in population by behavioural and biomedical risk factors, 2011–12



Data source: Victorian Population Health Survey 2011–12

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

	DAREBIN % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Current smoker	21.9	15.8	13.6	7.0
Alcohol risky or high risk (long-term)	1.9	3.4	4.1	2.7
Sedentary	4.7	5.5	6.3	9.8
Insufficient physical activity	28.8	26.7	28.5	34.5
Low consumption of both vegetables and fruit	48.9	51.0	46.5	43.0

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

	DAREBIN % ADULTS 50+	VICTORIA % ADULTS 50+
Current smoker	9.1	11.3
Alcohol risky or high risk (long-term)	2.1*	3.5
Sedentary	8.7	7.8
Insufficient physical activity	36.1	30.6
Low consumption of vegetables	90.3	88.9
Low consumption of fruit	46.2	48.2

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

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

	DAREBIN % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Overweight	32.5	32.7	39.3	36.5
Obese	13.7	17.5	22.8	20.2
Hypertension	21.9	24.7	40.5	57.1

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

	DAREBIN % ADULTS 50+	VICTORIA % ADULTS 50+
Overweight	41.0	37.4
Obese	21.6	21.4
Hypertension	47.2	45.8

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

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

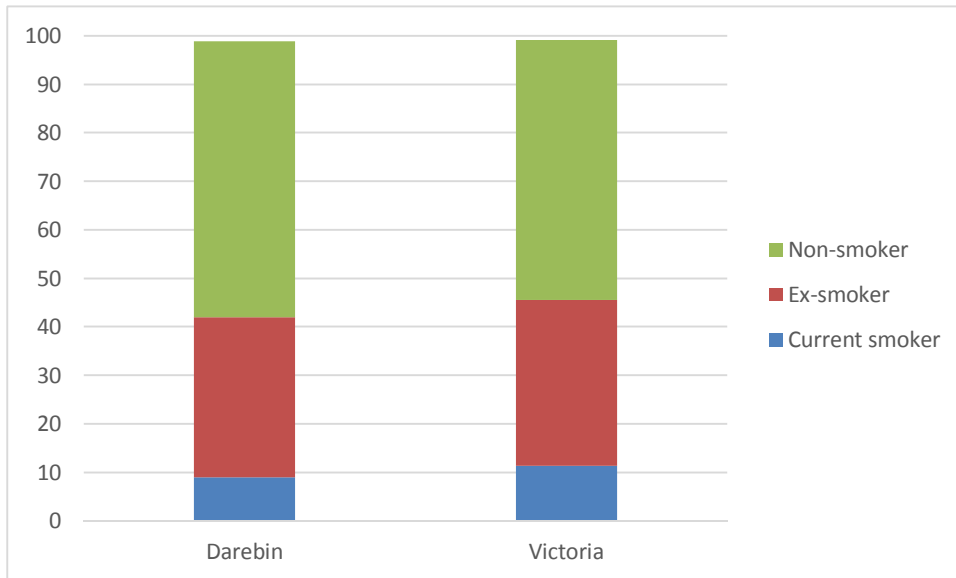


Figure 12: Risk of alcohol harm (long-term), Victoria and Darebin, adults aged 50+

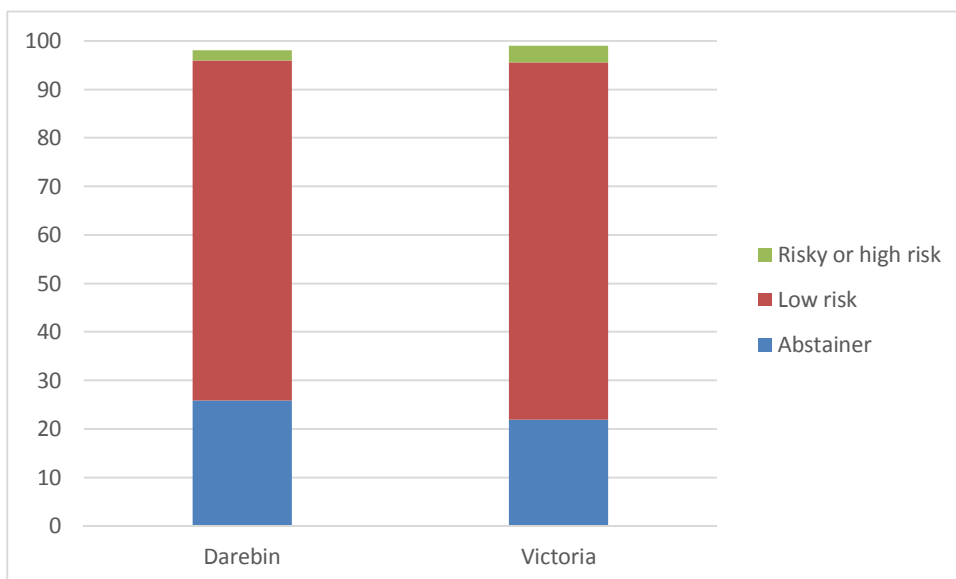


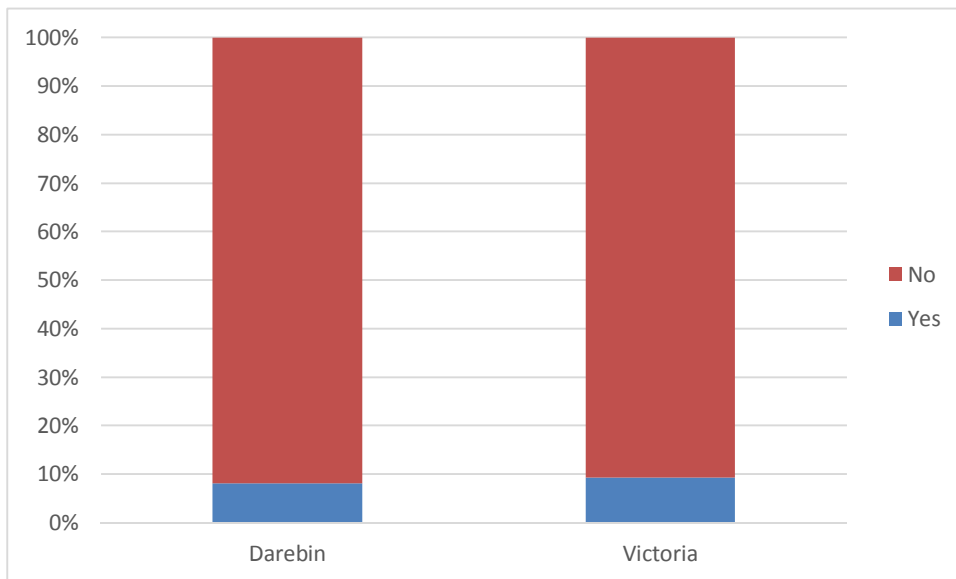
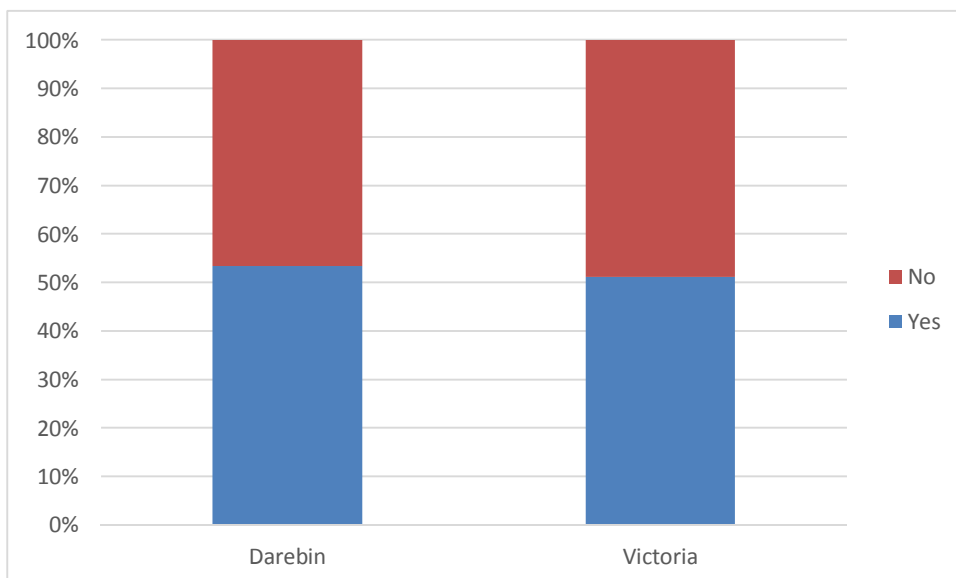
Figure 13: Met guidelines for vegetable consumption, Victoria and Darebin, adults aged 50+**Figure 14: Met guidelines for fruit consumption, Victoria and Darebin, adults aged 50+**

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

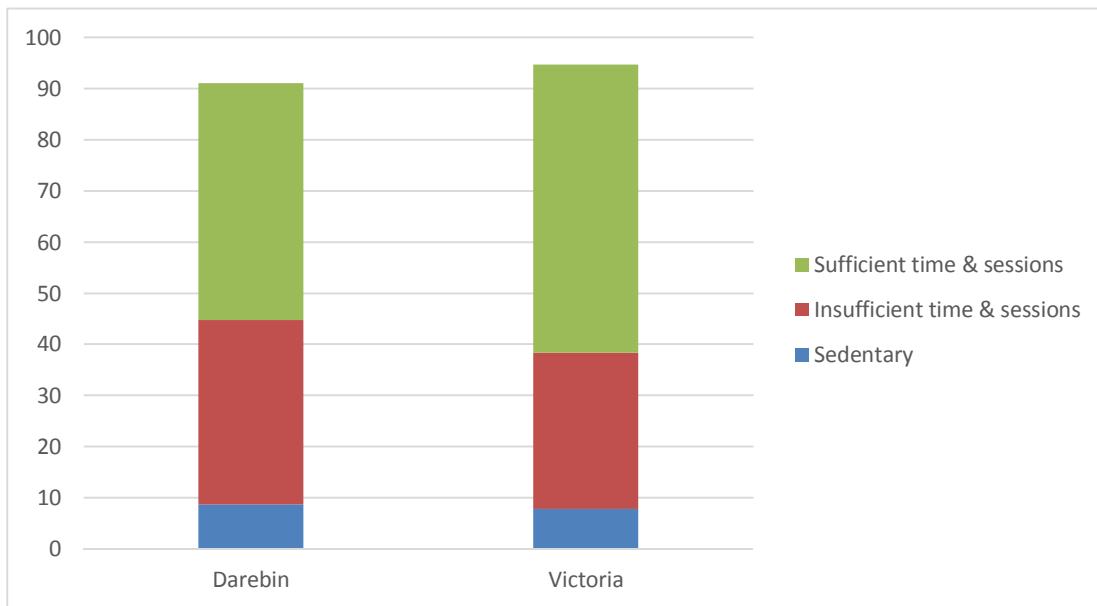
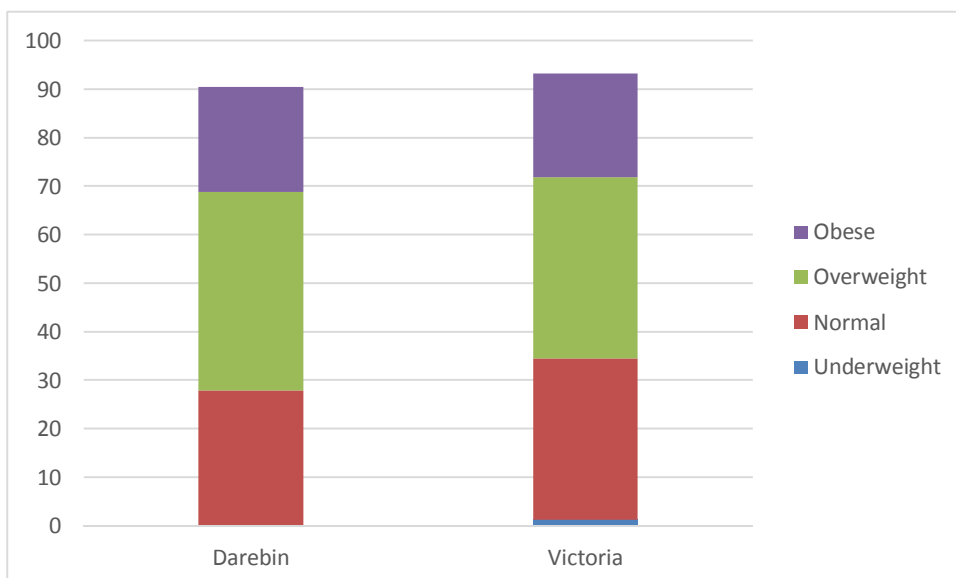


Figure 16: Body weight status, Victoria and Darebin, adults aged 50+

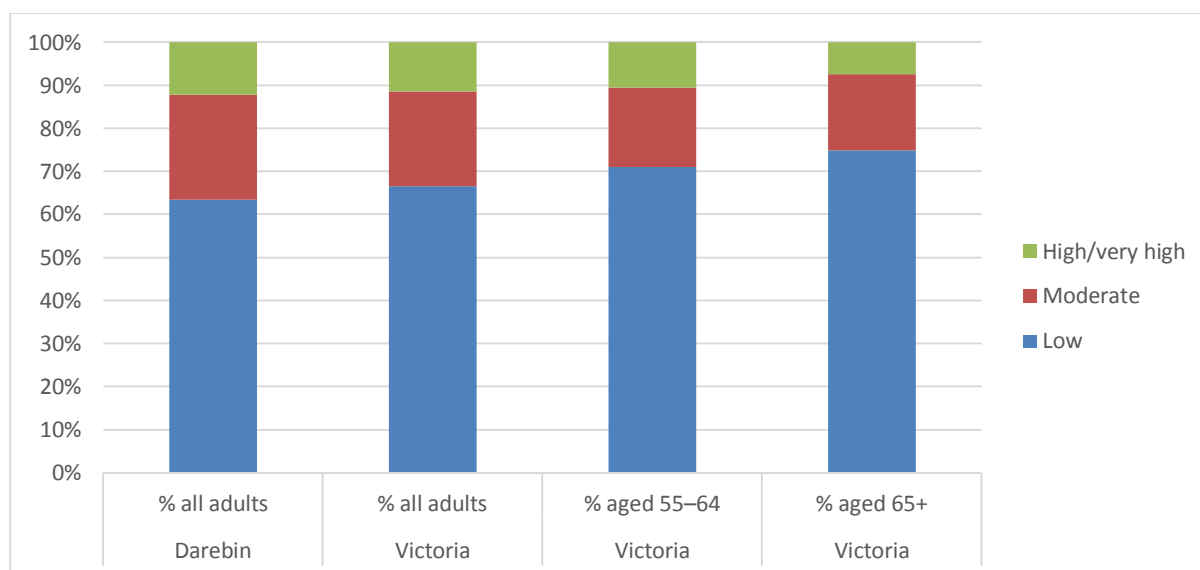


PSYCHOLOGICAL DISTRESS

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.²³ Darebin has similar mental health indicators to Victoria as a whole.

A relatively low proportion of adults aged 65 years and over report indicators of psychological distress.

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



Data source: Victorian Population Health Survey

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

	DAREBIN % ALL ADULTS	VICTORIA % ALL ADULTS	VICTORIA % AGED 55–64	VICTORIA % AGED 65+
Psychological distress				
Low	61.5	64.6	68.9	71.3
Moderate	23.6	21.5	17.8	16.8
High/very high	11.7	11.0	10.2	7.0
Lifetime prevalence of anxiety and depression	20.5	20.0	22.3	16.8
Sought professional help in previous 12 months	13.7	12.4	10.3	5.2

²³ This table does not appear in the Whittlesea Data Story report.

Community wellbeing indicators

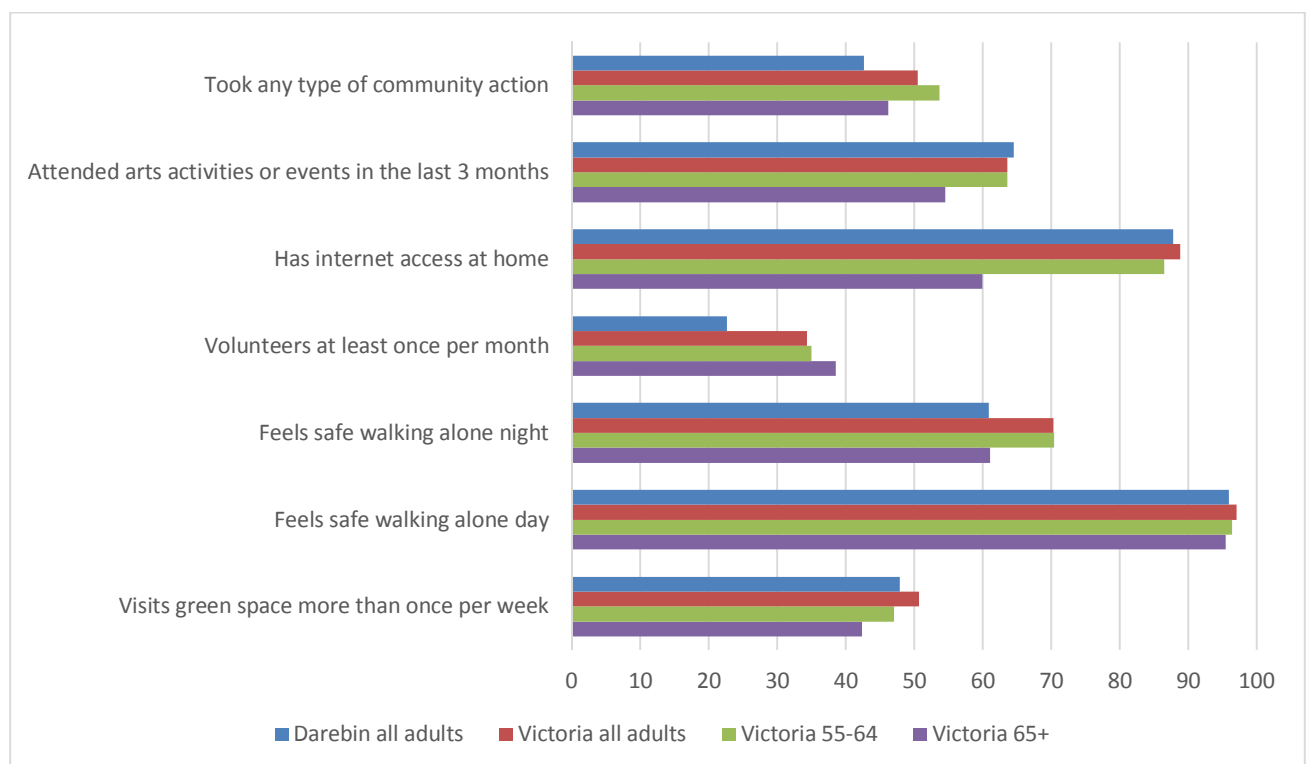
The VicHealth Indicators Survey, undertaken in 2011, includes a range of measures of community wellbeing for Victoria and Victorian municipalities.

The data for all adults presented in the figures and table directly below are age-standardised and were taken from the Darebin VicHealth fact sheet.²⁴

Scores for Darebin on **positive** community wellbeing indicators differed significantly from Victorian averages for two of the indicators: perceptions of safety at night (low) and volunteering (low).

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: Darebin and Victoria, VicHealth Indicators (positive), 2011



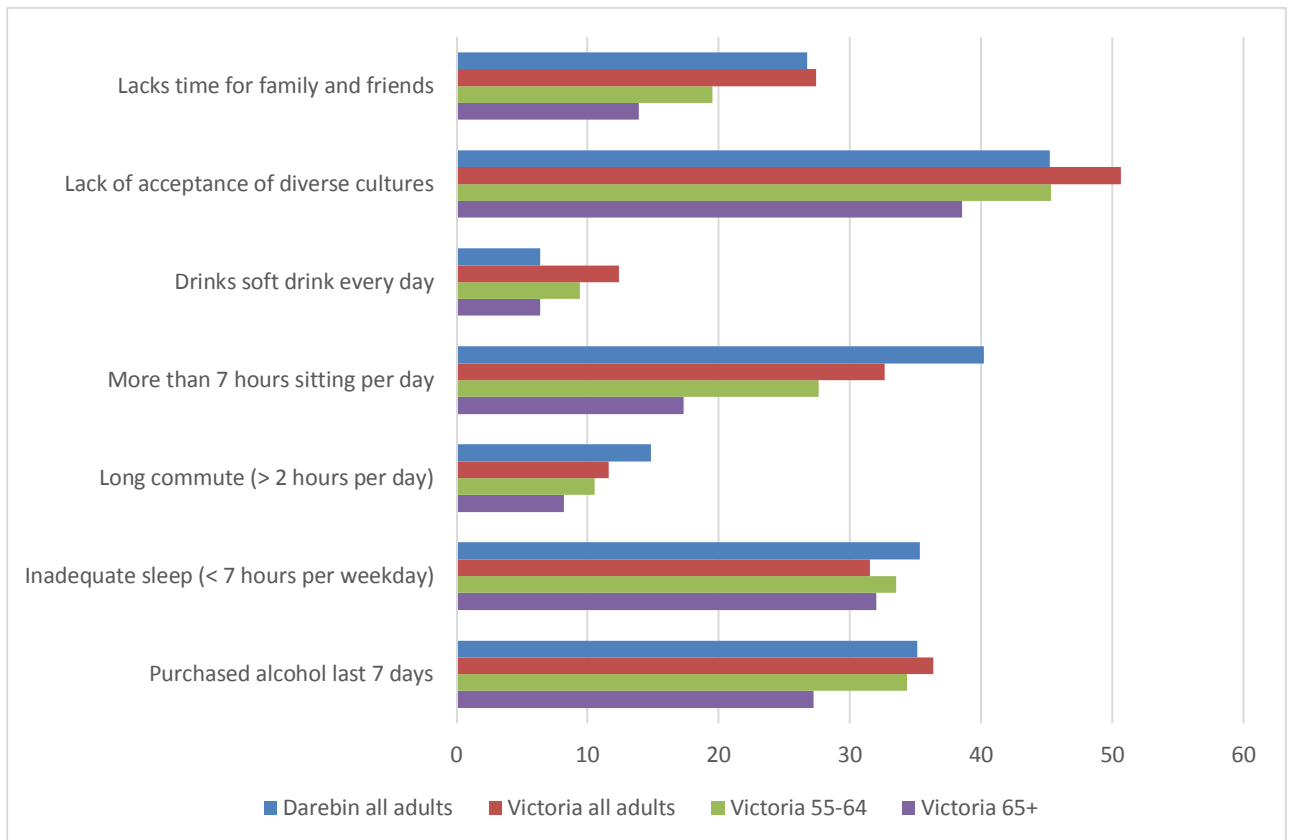
Data source; VicHealth Indicators Survey 2011

²⁴ <https://www.vichealth.vic.gov.au/programs-and-projects/vichealth-indicators-survey-lga-profiles>

Scores for Darebin on **negative** community wellbeing indicators did not differ significantly from those for Victorians as a whole.

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: Darebin 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: Darebin and Victoria, VicHealth Indicators, 2011

	<i>ALL ADULTS DAREBIN</i>	<i>ALL ADULTS VICTORIA</i>	<i>VICTORIA AGED 55–64</i>	<i>VICTORIA AGED 65+</i>
Purchased alcohol last 7 days	35.1	36.3	34.3	27.2
Inadequate sleep (< 7 hours per weekday)	35.3	31.5	33.5	32.0
Long commute (≥ 2 hours per day)	14.8*	11.6	10.5	8.2
More than 7 hours sitting per day	40.2	32.6	27.6	17.3
Drinks soft drink every day	6.4*	12.4	9.4	6.4
Visits green space more than once per week	47.9	50.7	47.0	42.4
Feels safe walking alone day	95.9	97.0	96.4	95.4
Feels safe walking alone night	60.9	70.3	70.4	61.0
Volunteers at least once per month	22.6	34.3	35.0	38.5
Has internet access at home	87.8	88.8	86.5	59.9
Lack of acceptance of diverse cultures	45.2	50.6	45.3	38.5
Attended arts activities or events in the last 3 months	64.5	63.6	63.6	54.5
Lacks time for family and friends	26.7	27.4	19.5	13.9
Took any type of community action	42.6	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: Darebin and Victoria, VicHealth Indicators, aged 50+ years and all adults, 2011

	DAREBIN AGED 50+ %	VICTORIA AGED 50+ %	ALL ADULTS DAREBIN %	ALL ADULTS VICTORIA %
Purchased alcohol in the last 7 days	28.2	31.2	30.5	33.3
Drinks soft drink every day	8.9	8.3	7.0	10.5
Inadequate sleep (< 7 hours per night)	35.9	32.0	36.5	31.9
More than 7 hours sitting per day	24.0	22.0	33.3	25.4
Long commute (60+ minutes one way per day)	20.3	7.5	16.2	8.5
Visits green spaces less than once a week	68.5	56.5	57.9	52.9
(Low) acceptance of diverse cultures	51.2	54.0	42.9	50.1
Lacks time for family and friends	25.1	17.9	25.0	22.6
Feels safe walking alone (day)	89.8	97.0	93.3	97.2
Feels safe walking alone (night)	50.0	70.2	54.2	70.9
Volunteers at least once per month	21.5	41.8	24.2	41.1
Attended arts activities or events in the last 3 months	50.3	57.4	58.9	59.2
Took part in citizen engagement in last 12 months	34.6	54.9	41.7	55.5
Has internet access at home	59.8	69.1	75.2	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 from indicate that average Personal Wellbeing on the scale for Australians is about 75.

Darebin'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: Darebin and Victoria, Wellbeing score, 2011

	DAREBIN AGED 50+ %	VICTORIA AGED 50+ %	TOTAL DAREBIN %	TOTAL VICTORIA %
Average Wellbeing Score	74.0	78.7	74.9	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 34 providers in Darebin—14 providing Home Care packages, 19 providing residential care, and one providing Transition Care.

The following tables provide data on numbers of operational places for Darebin 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
Kingsbury	21205	-	77	-	41	150		
Northcote	21111	-	35	-	17	226		
Preston	21206	-	219	-	41	101		67
Reservoir - East	21207	-	-	-	-	418		
Reservoir - West	21208	-	-	-	-	198		
Thornbury	21112	-	65	5	5	255		
Total		0	396	5	104	1,348	0	67

The following table compares Darebin'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 Darebin 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), Darebin and Victoria, 2015

	NUMBER OF PLACES, DAREBIN	NUMBER PER 100,000 POPULATION AGED 65+, DAREBIN	NUMBER OF PLACES, VICTORIA	NUMBER PER 100,000 POPULATION AGED 65+, VICTORIA
Home Care Low	396	21.3	13,770	15.4
Home Care High	109	5.9	4,044	4.5
Residential Care	1348	72.4	50,716	56.6
Transition Care	67	3.6	1,000	1.1

Forty-two services with Darebin postcodes were funded to provide intensive aged care services in 2014, altogether attracting \$104,963,663 in Commonwealth Government funding. (This includes one service based in Darebin—Australian Unity—contracted to provide services to the Grampians.) Darebin has several large providers located within its boundaries, including Baptistcare (258 places), Northern Health (148 places), the Assisi Centre (150 places), and Southern Cross Care (334 places), as well as a large range of smaller providers. Agencies located in Darebin and the services they are funded to provide are listed in the following table:

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

	HOME CARE LOW PLACES	HOME CARE HIGH PLACES	RESIDENTIAL LOW CARE PLACES	RESIDENTIAL HIGH CARE PLACES	TRANSITION CARE PLACES
Little Sisters of the Poor St Joseph's			✓	✓	
Royal Freemasons		✓			
Royal Freemasons Ltd Outreach Program (EACH) – Northern		✓			
Ruckers Hill Aged Care Facility			✓		
Westgarth Aged Care Facility			✓	✓	
Arlington Aged Care Facility				✓	
Froniditha Anesi Aged Care Services			✓	✓	
Medina Manor			✓		
Northern Metro Care Packages	✓				
St Paul's Hostel for the Elderly			✓		
Brotherhood Community Care	✓	✓			
Brotherhood Of St Laurence	✓	✓			
CCSSCI CACPs Northern	✓				
Darebin Community Aged Care Packages (HLCP)	✓				
Darebin Community Care Packages	✓				
Hilltop Aged Care Home				✓	
Northern Health Transition Care					✓
Aberdeen Aged Care Facility			✓	✓	
Arcare Latrobe			✓		
Embracia in Reservoir			✓	✓	
Embracia on Ashley			✓	✓	
Kia-Ora Private Nursing Home				✓	
Mayflower Reservoir			✓		
Southern Cross Care Keon Park			✓	✓	
Twin Parks Aged Care Centre and Hostel			✓	✓	
Alphington Aged Care			✓		
Australian Unity Community Care	✓	✓			

	<i>HOME CARE LOW PLACES</i>	<i>HOME CARE HIGH PLACES</i>	<i>RESIDENTIAL LOW CARE PLACES</i>	<i>RESIDENTIAL HIGH CARE PLACES</i>	<i>TRANSITION CARE PLACES</i>
Bundoora Extended Care Centre	✓	✓			
Ian Brand Nursing Home				✓	
Merv Irvine Nursing Home				✓	
Vasey House			✓	✓	
Villa Maria Bundoora				✓	
Baptcare - Strathalan Community			✓	✓	
Regis Heathcliff Manor				✓	

Summary and conclusion

The current report focuses on health and wellbeing indicators in the Darebin 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: unlike many other Melbourne municipalities, Darebin's population will not age in the coming decade. Although the number of people aged 50 years and over living in Darebin will increase, the proportion of the population aged 50 years and over will remain at around 29%.
- Socio-economic advantage and disadvantage: Darebin suburbs are socio-economically diverse, with three falling below the median and four above the median on socio-economic advantage and disadvantage.

HEALTH AND WELLBEING

- Prevalence of key health conditions is similar in Darebin to the prevalence in Victoria as a whole. However, in the age group aged 50 years and over, Darebin has a higher proportion of people with osteoporosis than Victoria.
- Age-specific proportions of people registering with diabetes are similar to national prevalence figures, but relatively low in Alphington/Fairfield and Northcote among people aged under 70 years.
- The number of people living with dementia in Darebin will almost double in 20 years, from 1,808 in 2010 to 3,524 in 2030.
- In 2010, Darebin was ranked 8th in Victoria on the number of people in the municipality living with dementia, but this ranking will fall (10th in 2030 and 17th in 2050).
- Hospital admission rates among people aged 50 years and over for unintentional injury tend to be slightly lower in Darebin than in Victoria as a whole, and rates for falls are similar to those for Victoria, but rates for intentional injury are relatively high, especially for age groups 50 to 79 years.
- Darebin adults do not differ significantly from those in the wider Victorian population on any of the behavioural or bio-medical protective or risk factors except smoking (relatively high rates of smoking for all adults).
- No significant differences between Darebin and Victorian estimates for age groups 50 years and over are apparent except for having sufficient physical activity (Darebin residents aged 50 years and over are less likely than their Victorian counterparts to engage in sufficient levels of physical activity).

- About one-half of Darebin adults aged 50 years and over are non-smokers (57%) and a similar proportion meet guidelines for fruit consumption (53%). However, less than half engage in sufficient physical activity (46%).
- Risks for Darebin adults aged 50 years and over include low consumption of vegetables (90%) and overweight/obesity (63%).
- Darebin has similar mental health indicators to Victoria as a whole.
- Scores for Darebin on **positive** community wellbeing indicators differed significantly from Victorian averages for two of the indicators: perceptions of safety at night (low) and volunteering (low).
- Scores for Darebin on **negative** community wellbeing indicators did not differ significantly from Victorian averages.

INTENSIVE AGED CARE SERVICES

- Data provided by the Department of Health Primary Health Network identified 34 providers in Darebin—14 providing Home Care packages, 19 providing residential care, and one providing Transition Care. Comparison of Darebin’s rates of operational places per 100,000 population aged 65 years and over with those for Victoria as a whole indicate that Darebin is relatively well placed for all intensive care service types in comparison with average operational places across Victoria.
- Forty-two services located in Darebin were funded to provide intensive aged care services (packaged care, residential care, and transition care) in 2014.
- Altogether in 2014, local agencies attracted \$104,963,663 in Commonwealth Government funding for intensive aged care services.

CONCLUSION

Although Darebin’s population is not ageing (in terms of the proportion of older people in the population), service providers can expect increases in demand for health services associated with an increasing **number** of older people, including dementia. Particular attention needs to be paid locally to people aged 50 years and over with osteoporosis. Key local risk factors include smoking, lack of physical activity and low rates of volunteering. As elsewhere in Victoria, obesity and low vegetable consumption are significant 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: Darebin and Victoria, Victorian Population Health Survey, 2011–12, sample size

SAMPLE	N
Darebin 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. $BMI = \text{weight (kg)} / \text{height (m)}^2$

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 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: Darebin and Victoria, VicHealth Indicators, 2011, sample size

SAMPLE	N
Darebin 50+	181
Darebin All	302
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