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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Executive Summary

2025-2027 Needs Assessment
2025 Annual Review

EXECUTIVE SUMMARY

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

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Abbreviations used

ABS	Australian Bureau of Statistics
ACPR	Aged Care Planning Region
AHP	Allied Health Professional
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ANSC	Antenatal Shared Care program
AOD	Alcohol and Other Drugs
ASGS	Australian Statistical Geography Standard
ASR	Age Standardised Rate
CALD	Culturally and Linguistically Diverse
CESPHN	Central and Eastern Sydney Primary Health Network
CHB	Chronic Hepatitis B
CPD	Continuing Professional Development
CTG	Closing the Gap
FACS	Family and Community Services
GP	General Practitioner
IARE	Indigenous Area Region
LGA	Local Government Area
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual
LHD	Local Health District
LOTE	Language Other Than English
MBS	Medicare Benefits Schedule
MDS	Minimum Data Set
MH	Mental Health
NBCS	National Bowel Cancer Screening
NDIS	National Disability Insurance Scheme
NGOs	Non-Governmental Organisations
NSW	New South Wales
OSHC	Overseas Student Health Cover
PBS	Pharmaceutical Benefits Scheme
PHA	Population Health Area
PHN	Primary Health Network
PIP	Practice Incentive Program

QI	Quality Improvement
RACF	Residential Aged Care Facility
SA3	Statistical Area Level 3
SA2	Statistical Area Level 2
SESLHD	South Eastern Sydney Local Health District
SLHD	Sydney Local Health District
SCHN	Sydney Children's Hospitals Network
SVHN	St Vincent's Health Network

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Introduction

The purpose of this Needs Assessment is to identify community health and wellbeing needs, gaps in service delivery and how we could work with partners across the region to address these. this needs assessment relates to the population in this region, and the work of CESPHN aimed at improving the health of the population through supporting primary health care and commissioning services that fill health service gaps.

Central and Eastern Sydney Primary Health Network (CESPHN) will use the Needs Assessment to:

- Better meet the health and wellbeing needs of residents
- Inform CESPHN's strategic direction
- Plan for commissioning services and programs
- Prioritise work with partners
- Share insights and data with services and the community
- Build relationships and engage with the community around joint initiatives.

Stakeholder engagement and insights, combined with the rigorous analysis of public datasets, such as Census data and other relevant information, provide us with a comprehensive picture of appropriate and fit-for-purpose responses that support, strengthen, and shape a person-centred primary healthcare system.

CESPHN conducted consultations to gather community and service provider input to identify the health needs of the community as well as the service gaps that exist. This, along with data analysis and a triangulation process has led to the identification of 12 priority needs and two overarching service needs.

These are:

Health issues

- Population health – covering the spectrum of modifiable risk factors, long-term health conditions and sexual health
- Mental Health
- Suicide prevention
- Use of alcohol and other drugs

Health of specific populations

- Aboriginal and Torres Strait Islander peoples' health and wellbeing
- Health and wellbeing of people from multicultural communities
- Older people
- Maternal and child health and wellbeing
- Health and wellbeing of people with disability
- Health and wellbeing of people affected by domestic, family and sexual violence
- Health and wellbeing of LGBTIQA+ people
- Health and wellbeing of people impacted by homelessness

Access and Coordination

- Primary care workforce
- Access and coordinated care.

Each priority need and service gap is outlined in a chapter showing the data and outcomes of consultations. Within each chapter priority needs are outlined and service gaps specific to that need are also identified.

Future directions and priorities

There is a range of national reforms in the planning that will impact the delivery of care and create disruptions to the usual way of doing business for primary and social care providers over the next five years. The Commonwealth has flagged primary health care's key role in prevention and early intervention. Changes to the way health care is funded will impact primary health and consumers.

With an aging population and the resultant increase in health needs, there is increased focus on healthy ageing. Additionally, there is an increased push for strengthened collaboration between primary care and other parts of the system, as well as collaboration with all arms of government.

In primary health care, ongoing digital health developments should improve continuity of care through system interoperability and the incentivisation of system integration. At the state level, the Single Digital Patient Record (SDPR), which is currently in development, will replace the numerous electronic medical records, patient administration and laboratory systems in use across the state public health system with a single source of clinical information. The implementation of cloud-based health systems is also a priority. Efforts are also being made to enhance communication between state and commonwealth systems, ensuring more cohesive healthcare delivery.

The cost of primary health care for consumers has been a key issue raised in the consultations. Community organisation survey responses identified that people are struggling to afford to live in the Sydney region and health and wellbeing costs are expenses they will forgo if possible. Delaying or foregoing treatment has implications for the longer-term health of the population given that early intervention and prevention lead to the best outcomes. Differential access to care also leads to increasing disparities in health between those who can afford to pay for services and those who cannot.

Methodology

The 2025-2027 Needs Assessment development process involved four key phases. It involved a more comprehensive approach to gathering qualitative and quantitative evidence from broader sources and identifying key priorities. We considered feedback from our staff and stakeholders involved in consultations on the current use of the Needs Assessment and opportunities for improvement. We focused on increasing stakeholder engagement throughout the process and providing more opportunities for consultation.

The 2025 annual review, focussed on quantitative data updates across all chapters, and updates to service options for each of the four key health issue, our eight priority populations and our two access and coordination areas.

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Planning and design

- Feedback from CESPHN staff and leadership on the previous Needs Assessment process and report
- Documentation review of key national and regional guides, strategies and policies
- Review of 2022-2024 CESPHN Needs Assessment and Strategy (includes other CESPHN strategies on key areas since 2021)
- Review of Needs Assessments from other PHNs and organisations
- Engagement with Local Health Districts ad Networks (LHDs/LHNs)
- Engagement with local Councils
- Project plan developed to include key timeframes, deliverables, processes, roles and responsibilities
- Market analysis
- Revised Needs Assessment structure to guide writing during the reporting phase

Data collection and engagement

- Quantitative data collection/updates e.g., ABS, AIHW, Population-level statistics, health indicators, etc.,
- Primary care level data through POLAR, LUMOS, NADA (AOD) and primary mental health data
- Qualitative data collection
- Service mapping
- Use of academic articles
- Use of reports from other organisations

Analysis and triangulation

- Initial analysis of quantitative and qualitative data to identify key themes and trends
- Internal sensemaking analysis sessions triangulate data and prioritise needs/gaps identified
- Sense check priorities with CESPHN leadership, staff and key stakeholders
- Confirm priorities

Reporting feedback and submission

- Draft Needs Assessment report and executive summary
- Feedback from relevant CESPHN staff and leadership
- Updated Needs Assessment based on feedback
- Prepare and submit Needs Assessment to the Department
- Develop 2-3 page snapshots on priorities and for different audiences post submission and approval
- Update CESPHN website to make it more interactive

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A mixed methods approach was used to capture, analyse and triangulate data to obtain an understanding of the health needs and services gaps for the region. Quantitative data were derived from internal, administrative, primary care data, and census-based sources, while qualitative data collected from stakeholder consultations and engagement was considered and, where contextually relevant, included in the data synthesis. Additionally, progress made since the last needs assessment has been considered, together with new data, emerging literature, policies, and plans to provide contextual information and insights not obvious from quantitative data sources.

Both quantitative and qualitative methods were used to both gather data and then to cross check. The table below provides an overview of the quantitative and qualitative data gathered during the data collection phase of the Needs Assessment process.

The **quantitative data** gathered and assessed included demographic and epidemiological data predominantly from the following sources:

- Australian Bureau of Statistics (ABS)
- Australian Institute of Health and Welfare (AIHW)
- Public Health Information Development Unit (PHIDU)
- HealthStats NSW
- Commonwealth Department of Health, Disability and Ageing
- National Disability Insurance Scheme (NDIS)
- Lumos dataset on emergency department presentations
- Primary Mental Health Care Minimum Data Set
- headspace Tableau
- Health workforce data tool

We also used data and insights from internal databases used across our steams, including:

- Salesforce, CESPHN's CRM
- The Network of Alcohol and Drugs Agencies (NADA)base
- POLAR primary care data from over 381 GP clinics in the region
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The **qualitative data** gathered and assessed included:

- Survey of 32 community service organisations
- Consultations with CESPHN staff
- Roundtable disability discussions
- Consultations with selected subject matter experts across priority areas
- Consultations with CESPHN advisory committees including the Aboriginal advisory committee and alcohol and other drugs advisory committee
- Insights from 11 in-language focus groups conducted with recently arrived immigrants
- Consultations with the Clinical Leaders Network, Clinical Council, Community Council and Member Chairs
- Strategy workshop with 60 health and community stakeholders
- Insights from local council reports on the overall wellbeing of their population and reports of consultations with community members run by community organisations
- Document review of academic articles on key topics
- Priority areas summary distributed to South Eastern Sydney Local Health District, Sydney Local Health District and St Vincent's Health Network for review and final input

Strategic alignment

Alongside development of the Needs Assessment 2025-2027, CESPHN has developed a strategic plan that aligns with the broader Department of Health and Aged Care direction and priorities.

Key strategies that have an increased emphasis in the strategic plan:

- Be a data-driven organisation

- Improve the way we show our impact
- Actively promote CESPHN in the community and the work we do
- Increase our reach with more stakeholders
- Address health needs more holistically, such as domestic and family violence, gambling harm and social isolation and loneliness
- Increase community involvement in the planning and delivery of services to address needs
- Increase focus on navigation to assist multicultural communities
- Use commissioning to improve equity.

Stakeholder engagement and consultation process

Table 1 Stakeholder engagement process

Stakeholder Engagement	Process
Consultation with CESPHN staff	All staff were involved in initial consultation to identify health needs and service gaps. CESPHN teams working across these priority areas provided further insights from strategy-level discussions, and an initial exploration of quantitative data.
CESPHN board	CESPHNs board was consulted at various stages throughout the process and provided regular updates through governance mechanisms.
Service mapping	Salesforce, CESPHN's CRM, was used to report on data pertaining to the region's general practices, including size, accreditation status and digital health capability. Health Workforce Data (HWD) was used to determine the number and distribution of key primary care services, in particular general practices and general practitioner (GP), GP registrar, practice nurse and allied health professional data. Service mapping undertaken by program teams as part of their program activities has also been utilised.
Market analysis	As part of CEPHN's Strategic Planning process that was also being conducted at the same time, a market analysis, including SWOT and PESTLE analysis were conducted to understand internal and external driving forces for the needs assessment and future strategic directions for our work.
Consultations with experts in specific priorities	Nine paid in-person/online group consultations were held in June and July 2024, consisting of a mix of established stakeholders and stakeholders new to CESPHN. The individual consultations targeted the following: • LGBTIQ+ • Homelessness • Aged care • Domestic and family violence • Sexual health • Maternal and child health • Mental health • AOD • Disability

	The consultations followed a semi-structured approach that included both general questions and questions specific to each area. Deductive thematic analysis was then applied on key points of discussion.
Community Services survey	A 19-question electronic survey was distributed to Community Services in the region in June 2024. The aim of the survey was to gather insights on the health and social needs, as well as services gaps in the community's they work. There were 32 responses, and this information has informed the development of the priority areas addressed.
Aboriginal Consultation	Rather than over consult the community, the writers of this needs assessment attended a consultation held by South Eastern Sydney Local Health District with the Aboriginal community in March with 25 people consulted and gathered the insights from that session to apply to the needs assessment. CESPHN's Aboriginal Advisory Group were consulted throughout this process and members were invited to the Strategy Workshop.
LHD/LHN and Council engagement insights and reports	Invited to subject matter expert consultations, involved in councils and committees, and additional meetings on certain topics, such as LGBTIQ+. An extensive summary of health needs and service gaps was shared with LHDs and LHNs for input.
Consultations with LHDs, Community and Clinical Councils, Clinical Leaders Network, Member Chairs, Multicultural Advisory Group	212 stakeholders were involved in consultations, semi-structured questions designed to gather insights on what community needs and service gaps stakeholders see in their work and engagement with the community they work with, and where the opportunities for improvement are. We used these engagements as an opportunity to gather qualitative and quantitative data that people were using to make statements on community needs and service gaps.
Strategy workshop	A strategy workshop was held in July 2024 with 60 stakeholders from health and community services across the region as a sense checking opportunity. During the workshop, the draft priorities from stakeholder engagements and an initial analysis of quantitative data were put forward to stakeholders, who were then asked to discuss if they agreed with the draft priorities and what priorities, if any, were missing.
In-language focus groups with newly arrived immigrants	Data were collected between 22 June 2024 and 20 July 2024 via 11 in-person, in-language focus groups (125 participants). The focus groups were conducted in: Arabic (2x), Mandarin (2x), Nepali (2x), Bengali (2x), Urdu, Mongolian (women) and one focus group run in English for Indian speaking participants. A report was prepared for each focus group which summarised the conversations and observations for each question outlined in the discussion guide and included translated quotes from the participants. The data were then analysed using a deductive approach, in line with the research questions identified. Quotations from these focus groups are incorporated into the needs assessment.
Consultation with Local Health District Executives	Local Health Districts and Local Health Networks were invited and involved at every consultation. The executives from the Local Health Districts and St Vincent's Hospital received a detailed summary of the Needs Assessment in October and provided feedback.

Analysis, triangulation, and prioritisation of community needs and service gaps

Once data collection ended, CESPHN began the analysis, triangulation, and prioritisation phase of the Needs Assessment process. This involved, using a robust analysis process to identify key community needs and service gaps appearing across both quantitative and qualitative data and insights.

Approach to data analysis

Quantitative data was updated as data became available to use. For most public datasets, data was downloaded, cleaned and then connected to Power BI for transformation, analysis and interpretation. Qualitative data that was gained through consultation was collected with prior informed consent from participants. A CESPHN staff member also took notes. Both recordings and notes were used to summarise key points and conduct an initial thematic analysis of the discussion.

Approach to data triangulation and prioritisation and insights

The writers of this document looked at themes across multiple sources of data and considered.

- Is the key need/gap mentioned across more than one data source?
- If an issue was raised during consultations – is there robust data to back it up and confirm its importance?

Data limitations

Whilst every effort to include all relevant and up-to-date data as part of the analysis of the needs assessment, there are a number of data limitations that need to be acknowledged. These limitations are both around new data sources used and the way previously used data sources have changed.

- Introduction of general practice level data collected through the data extraction tools. CESPHN currently use two data extraction tools, POLAR and CAT4, with POLAR having the highest usage rate of 40.7% of practices. For the Needs Assessment, POLAR and CAT4 were only used to identify Aboriginal and/or Torres Strait Islander patients.
- Utilisation of POLAR for chronic disease, cancer screening and other statistics were investigated, however the following limitations were encountered:
    - Lack of consistent data on ethnicity data, making analysis difficult
    - Limited pickup of free text information, which as a result underreports diagnoses and other figures
    - Reduced functionality when linking with Power BI compared with calculations, free text translation, etc. built into the Qlik portal
- The ability to use data linkage insights though Lumos:
    - There is low frequency of data refreshes (six monthly)
    - There is no breakdown of ethnicity level data
    - Not all general practices in the region participate in Lumos so the numbers may not be 100% representative
    - Not possible to perform state or national comparison analysis because CESPHN only receives data for patients within its catchment.
- Changes in AIHW reporting levels from SA3 to SA4 across some datasets, has reduced the ability to compare across time periods and identify smaller geographic areas. For example the Regional profiles of mental health service activity website reports at SA3 and provides rates per 100,000 population and Medicare mental health services dataset reports at SA4 and provides raw numbers and rates per 100,000 population on the same measures
- Previously available MBS data is no longer consistently available across most priority areas

- PBS data only available for mental health related prescriptions and granularity has changed
- Slow adoption of the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables demographics questions across surveys and datasets This impacts the ability to identify the health needs of trans and gender diverse people.
- Continued limited availability of recent local level data for Aboriginal peoples including:
    - Lifestyle risk factors
    - Infant and child mortality
    - Cancer screening participation
    - Mental health and suicide prevention
- Ongoing limited usage of the National Mental Health Service Planning Framework tool (limited access and cannot publish findings)
- Local level data on dementia and palliative care – local dementia data is still being developed in AIHW
- GEN Aged Care Data is available at ACPR, PHN and LHD level and not at SA3 level.

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Health Needs analysis

Identified need	Key issue	Description of evidence
Population health – chronic conditions	**Key issues** • Increased usage of vaping • Prevalence of hepatitis B virus is the fourth highest in Australia • Prevalence of chronic hepatitis C is above the national average. • High burden of chronic disease in the region • Higher age-standardised rates of melanoma in Sutherland, Woollahra and Waverley LGAs when compared with NSW • High prevalence of behavioural risk factors for chronic disease highlighting the need for risk reduction strategies • Low uptake of cancer screening. • High vaccine preventable PPH rates **Key gaps** • Early detection and prevention of Type II diabetes • Strategies to address increased rates of liver cancer • Variability in prevention and screening behaviours and need to work specifically with multicultural and Aboriginal populations to increase uptake. • Scaled up local lifestyle programs that are effective in reducing risk factors for chronic disease • Engagement with priority population groups that have low health literacy regards chronic disease • Effective monitoring of cerebrovascular risk factors such as hypertension • Need for increased focus on preventive factors and early intervention strategies in primary care	• Quantitative sources include AIHW, NDS and Cancer Institute NSW • Qualitative sources include stakeholder consultation and surveys on cancer management
Population health - Sexual health	• From October 2023 to October 2024, the CESPHN region recorded the highest number of notifications in NSW for chlamydia (11,812), gonorrhoea (565) and non-congenital syphilis (2652). The region accounted for 36.7% of chlamydia NSW notifications, over half	• Quantitative sources include NSW Health, Department of Health and Aged Care, and National Viral Hepatitis Mapping Project

	(51.2%) of gonorrhoea notifications and 46.3% of non-congenital syphilis notifications. Notification rates in males for syphilis and gonorrhoea are the highest in NSW. **Key issues** • Early identification of cases and liaison with general practitioners • Engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing • Knowledge of antimicrobial resistance in the treatment of gonorrhoea • Low health literacy that limits access to sexual and reproductive health services **Key gaps** • Level of general practitioner confidence in diagnosing, testing and treatment prescription • Stronger active identification of cases and engagement with general practitioners • Antenatal screening for syphilis twice for each pregnancy • Promotion of vaccination to increase protection against Mpox • Stigma-free health care provision • Improved accessibility of sexual and reproductive health services.	• Qualitative sources include stakeholder consultation
Mental health	**Key issues** • 71% of GPs report psychological issues in their top 3 reasons for patient presentation • There is an increase in severity of mental health related issues • Self-reported prevalence of a mental health condition varies across the region from 11.7% in Marrickville-Sydenham-Petersham SA3 to 5.0% in Hurstville SA3 • There are a number of vulnerable population groups who experience a higher prevalence of mental health concerns. These include Aboriginal people, children and young people, LGBTIQ+ peoples, older people, veterans, people experiencing social isolation and people engaging in harmful levels of gambling	• Quantitative sources include AIHW, Mental Health MDS, RACGP and headspace • Qualitative sources include Community Services survey, Strategy Workshop, mental health provider and GP consultations

	• In 2021-21 there were 106 mental health related emergency department presentations per 10,000 population and 102.4 overnight admitted mental health-related hospitalisations per 10,000 population **Key gaps** • Access to child mental health services (including a multidisciplinary approach) • Access to psychiatrists across all speciality areas including children, older people, ADHD and autism • Availability of psychological therapies for people experiencing severe and complex mental illness • Affordable access to services for eating disorders • Availability of longer-term therapy for eye movement desensitisation and reprocessing (EMDR) therapy and dialectical behavioural therapy (DBT) • Therapy for children who have experienced Domestic and Family Violence and people who have left a relationship that experienced Domestic and Family Violence • Access to therapy in language	
Suicide prevention	**Key issues** • Modelled rates of suicidal thoughts and behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population) • Individuals in the 25-44 year age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (39.4%), followed by 0-24 year-olds (30.6%) • High rates per 100,000 of suicide in older people aged 80+ **Key gaps** • Primary care professionals identified a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide	• Quantitative sources include AIHW, Mental Health MDS • Qualitative sources include consultations with expert panel

	• Primary care professionals face challenges in identifying individuals at risk of attempting suicide.	
Use of alcohol and other drugs	**Key issues** • Within the CESPHN region, the primary drugs of concern are methamphetamines, alcohol, cannabinoids, and heroin. • The populations most impacted by AOD use include: ○ Aboriginal and Torres Strait Islander people ○ Multicultural communities ○ Young people ○ LGBTQI+ communities ○ People experiencing homelessness ○ Individuals in contact with the criminal justice system **Key gaps** • Limited access to holistic support and care coordination, as well as a lack of pathways for patients navigating AOD services. • A need for additional prescribers to transition patients from public Opioid Treatment Programs (OTP) to private care. • Insufficient services for priority populations, particularly women and multicultural communities. • A shortage of residential rehabilitation beds. • High prevalence of co-occurring mental health and substance use concerns, with a need for further capacity-building initiatives. • Limited access to culturally appropriate rehabilitation for Aboriginal participants. • Workforce shortages and the need for ongoing training and development.	• Quantitative sources include Health Stats NSW, AIHW, NSW Ministry of Health, CESPHN survey and IDRS • Qualitative sources include consultations with internal staff and an expert panel of Local Health District and local service providers
Aboriginal and Torres Strait Islander peoples' health and wellbeing	• There were an estimated 16,265 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2021, accounting for 1.05% of the total population. **Key issues**	• Quantitative sources include AIHW, ED data, HD Australia, MBS data, PHIDU, HWA, NDIS, POLAR, PenCS, Cancer Institute NSW, HealthStats NSW, National

	• The impact of past traumas, injustices and the effects of intergenerational trauma • Aboriginal children in NSW are significantly over-represented in the child protection system • Aboriginal adults in NSW are over-represented in the criminal justice system and the youth justice system • Suicide is 3 times more prevalent in this population than the general population in the region • High rates of ED presentations for mental and behavioural disorders • 30% of all Aboriginal people in the CESPHN region, had at least one long term health condition • High rates of smoking at some time during pregnancy • High rates of domestic violence • Low uptake of preventative health measures such as 715 assessments, cancer screening • The percentage of Aboriginal people living with overweight or obesity increased from 57% in 2014 to 72% in 2023 • Pressures on unpaid carers of people with disabilities and older people due to reluctance to access support services. **Key gaps** • Continuity of healthcare transition from correctional facilities to general practice and other primary care services • Reducing disparities in preventable health measures and trying to improve health outcomes • Promote better use of Urgent Care Centres and primary care to the community to avoid ED and hospital admissions • Appropriate culturally safe care throughout the health system that is tailored to the needs of this community.	Aboriginal and Torres Strait Islander Health Survey, the Aboriginal and Torres Strait Islander Health Performance Framework, and GEN • Qualitative sources included members of the CESPHN Aboriginal Advisory Committee
Health and wellbeing of people from multicultural communities	• 40.7% of residents were born overseas, 46.8% speak a language other than English at home, and 6.3% do not speak English well or at all	• Quantitative sources include ABS, AIHW, Department of Education, Skills and Employment, Cancer

	Key issues • People from CALD backgrounds don't access CESPHN commissioned mental health services at the same rate as non-CALD community. • People from CALD backgrounds attend services later, resulting in more involuntary admissions • Less likely to access preventable screening for breast cancer • International students in the CESPHN region needing support for health and wellbeing issues • Impact of global events on local communities (Gaza conflict) **Key gaps** • There is a need to understand better the experiences shaping health outcomes for multicultural communities • Health navigation assistance can assist people to understand and access the complex health and social support system • Need for culturally responsive care	Institute NSW, and Diabetes Australia • Qualitative data includes CESPHN consultations and in-language focus groups

Older people	• In 2022, 14.9% of the estimated resident population (ERP) in the CESPHN region were aged 65+, and 7.1% were aged 75+
	• The number of people aged 65 years and over is expected to increase by 56% between 2021 and 2041.
	
	Key issues
	• Lower uptake of all recommended vaccines - COVID-19, pneumococcal and shingles (herpes zoster) as well as flu
	• Older individuals (65+ and 85+) experience a range of health issues, including:
	  ○ Higher rates of fall-related hospitalisations
	  ○ Mental health issues
	  ○ Higher use of health care services for those living with dementia and living in the community
	  ○ Chronic conditions and comorbidities
	  ○ Higher levels of disability (2 in 5 people aged 65+)
		• Quantitative sources include AIHW, HealthStats NSW, ABS, DSS, POLAR, DOH and GEN
		• Qualitative sources include stakeholder and subject matter individual consultations

	○ Growing levels of elder abuse by family members/carers **Key gaps** • Better coordination of primary care and other services in the community to ensure timely access to care and continued/seamless support • Reduced access to affordable primary care and aged care services (cost of primary care and aged care services, and long wait times for home care packages and Commonwealth Home Support Program services) • Difficulties in service navigation with poor awareness of available support services • Social isolation, exacerbated by language and cultural barriers. • Underutilisation of general practice preventative health services (health checks, CDM care plans, vaccination) • Residential age care places are reducing against increasing number of people (many of whom will have dementia) with social dislocation occurring as older people have to move out of their locality and social networks to access residential aged care. • Meeting ageing needs of people with a disability in group homes • Older people report barriers to accessing mental health support • Diagnosis and services are limited for people living with dementia, and services vary across the CESPHN region • Increasing difficulties for older people in residential aged care being able to access GPs.	
Maternal and child health	**Key issues** • In some parts of the CESPHN region there are high levels of socio-economic disadvantage • Child immunisation rates are less than the national target • Some SA3s with the highest developmental vulnerability in one or more domains • The proportion of women with their first antenatal visit recorded during the first 14 weeks of gestation is below the NSW average	• Quantitative sources include ABS, Department of Health and Aged Care, HealthStats NSW, CESPHN internal database, and Department of Social Services • Qualitative sources include stakeholder and subject matter individual consultations

	• Aboriginal babies are less likely to be born within a healthy weight range compared with Non-Aboriginal babies (88% versus 95%) **Key gaps** • Immunisation rates in children in several regions within CESPHN have fallen below 90% • Treatment delays for children newly diagnosed with a disability • Access to affordable paediatric care.	
Health and wellbeing of people with disability	• High numbers of people living with a disability in the CESPHN region • Approximately 2 in 5 people aged 65 years and over living within the CESPHN region have some level of disability • NDIS participant numbers across service districts within the CESPHN region increased from 16,950 in December 2020 to 19,715 on 30 June 2023 • The rate of psychosocial disability within the Sydney service district is 1.7 times the national rate • 7-to-14-year age band made up the highest proportion of NDIS participants across the CESPHN region **Key issues** • Access to well-coordinated care between primary, secondary and tertiary for those with a disability • Timely participation in preventive health and screening services for those with a disability • Inadequate Medicare funding models can deter extended consultations for complex medical and psychosocial care. GPs may be financially disincentivised to provide long consults, home visits to group homes, and prepare care plans which are paid at a lower rate or unbillable. • Knowledge of primary care providers and provision of tools and resources to engage in conversations about disability.	• Quantitative sources include AIHW, ABS, NDIA and Department of Social Services • Qualitative sources include stakeholder and subject matter individual consultations, and round table discussions with disability specialists

	• Those from priority population groups with a disability are particularly vulnerable because of low health literacy and economic disadvantage • Intersection between aged care and disability. For example, there is a lack of palliative care support for those in group homes. People receiving NDIS who transfer to residential aged care after age 65 will lose access to the NDIS. • Lack of support for teenagers living with a disability experiencing poor mental health e.g. suicidal thoughts and tendencies. **Key gaps** • Lack of service navigation support tailored to the needs of those with intellectual disability • Lack of support for people with a disability when they receive dental care • Lack of community-based child behavioural management programs for those with ADHD and autism • Provision of support for carers to manage their own health needs • Need for ongoing patient-centred, multidisciplinary and integrated models of care • Support general practices to help address financial barriers to optimal care for people with a disability • Development of tailored strategies to address health inequity • Limited mental health services available for people with intellectual disability with poor mental health • Lack of access to NDIS and psychosocial services for people experiencing severe mental ill health • People with a disability leaving incarceration lose support and access to care and are at high risk of reoffending	
Health and wellbeing of people affected by	• Domestic, Family and Sexual Violence (DFSV) has increased over the 12-month period to March 2024 across NSW.	• Quantitative sources include BOSCAR

domestic, family and sexual violence	• In CESPHN, 5,936 domestic violence related assault incidents were recorded between April 2022 and March 2023, with the Canterbury-Bankstown LGA reporting the highest number of incidents. • Domestic violence-related murders:16 adult women in NSW (12 months to March 2024) • People with disabilities, older people, Aboriginal and Torres Strait Islander peoples, and LGBTIQ+ people experience increased risk, severity and frequency of DFSV and other types of abuse. **Key issues** • Need for continuous DFSV education and support for primary care • Service design and delivery needs to prioritise children and young people **Key gaps** • Fragmented support for the intersecting issues of sexual violence and child sexual abuse. • Support for children impacted by DFSV • Wider range of service options that reduce DFSV.	
Health and wellbeing of LGBTIQA+ people	The Central and Eastern Sydney PHN region has a high number of same sex couples living together (n=11,382), representing 14.5% of same sex couples living together in Australia. By comparison, this region comprises 6% of the total Australian population **Key issues** • LGBTIQ+ people experience higher levels of mental distress and poor mental health • LGBTIQ+ people drink more alcohol and use illegal drugs at higher levels than non-LGBTIQ+ people • Can have higher instances of sexually transmitted diseases, though PReP use remains high amongst gay men • High levels of loneliness and social isolation, especially amongst older adults (see mental health chapter of this Needs Assessment) • The community can experience stigma harassment and discrimination in their daily lives	• Quantitative sources include ABS and Rainbow Realities Report • Qualitative sources include consultation with internal staff and local service providers

	Key gaps • Easy access to gender affirming care for transgender patients • Specific services for intersex people • Delivery of trauma-informed care and sexual diversity training for clinical staff and community services	
Health and wellbeing of people impacted by homelessness	• In the CESPHN region in 2022-23, 8,084 people experienced homelessness (a slight increase from 7,627) **Key issues** • Further investment in access to affordable primary health care services for people experiencing, or at risk of homelessness. • Upskilling of the primary care workforce; refinement of assessment processes, raised awareness of pathways out of homelessness for people at risk of homelessness • Enhanced data management; improved technological solutions and frameworks for capturing and prioritising and referring clients • Strengthening collaboration between housing providers, specialist homelessness service providers and health service providers based around a housing first approach • Embedding of primary health care services with other health, housing, and homelessness support services • Improving coordination between primary mental health and domestic violence support services • Need for more innovative localised responses to priority cohorts including Aboriginal people and those leaving correctional centres and mental health services. **Key gaps** • Integration of the health, housing and homelessness service system • Access to primary care homelessness friendly GPs, pharmacists, allied health, dentistry, mental health, and drug and alcohol detox and support services)	• Quantitative sources include ABS, AIHW and Department of Communities and Justice and SLHD • Qualitative sources include subject matter expert consultations

	• Access to post-crisis support (mental health and drug and alcohol detox and support services) • Capacity of workforce to deliver respectful and person-centred care • Geographic location and reach of specialist homelessness services with most providers choosing to work in the inner-city regions. • Access to coordinated chronic care management • Innovative models that deliver flexible integrated care.	

Service Needs Analysis

Identified Need	Key Issue	Description of Evidence
Primary care workforce	• GP workforce will reduce as many GPs are retiring and yet there will be more demand for services with an ageing population and predicted population growth • The GP FTE in the CESPHN region has decreased despite the increase in population. Analysis of FTE between 2021 and 2023 shows a peak of 1,903.9 FTE in 2021 and a reduction to 1,730.4 FTE in 2023, a decrease of 9.1% • In 2022 an average of 27% of GPs intending to work only another five years in the region • Reduction in the number of registrars, with a 34.8% decrease in AGPT registrars between 2018 and 2023 • Access to psychiatry for a diagnosis for ADHD or other conditions is difficult to get and expensive. • Long waiting lists for public outpatient services. **Key gaps** • Expected ongoing reduction in GP workforce when measured against numbers, FTE and years intending to work against the expected increase in health service needs as the population increases and ages • Reduction in number of GP registrars • Rising out of pocket costs for individuals accessing GP services and subsequent lack of affordability	• Quantitative sources include ABS, NSW Health stats and DoH statistics, MBS data • Quantitative sources include UNSW research and stakeholder consultation
Access and coordinated care	**Key issues** • Rising out-of-pocket costs for individuals accessing GP services • Lack of affordability for GP care, dental care and mental health care was the major concern raised in CESPHN consultations held • Lower rates of practices bulk billing for all services and patient groups	• Quantitative sources include ADHA Collaborate data, CESPHN's CRM and Lumos

	• Limited communication between providers due to lack of integration across primary care system, attributed to limited increase in uptake of My Health Record registration, fragmented allied health professional software landscape and limited health system interoperability • Low interoperability across platforms used by primary and acute care providers • Need to improve transitions for people moving between systems i.e. the justice system to primary care, Defence Force personnel becoming veterans, paediatric to adult services, community to residential care, disability and primary care services • Need for more integrated approach to disaster management. • Low health literacy particularly among vulnerable and priority groups • Provider and consumer challenges with identifying and navigating services **Key gaps** • Improved engagement of primary care in disaster management • Supporting care transitions across the lifecycle • Need for increased focus on multidisciplinary team work • More effective communication and information sharing among healthcare providers including system interoperability that enables continuity of care • Utilisation of My Health Record.	

Priorities and opportunities

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Stepped care	Mental Health	Access	• Consumers have streamlined access to the most appropriate services to support individuals at the stage they are at	• CESPHN to work with partners of the Mental Health and Suicide Prevention Regional Plan to ensure clear and accessible pathways to care at all levels of intensity/acuity, in which consumers, referrers and service providers understand how to navigate, refer to and provide services using a stepped care approach • CESPHN to work with our LHD and LHN partners to fulfill the requirements of the bilateral schedule regarding the promotion of the Initial Assessment and Referral Decision Support Tool. • Promote the use of the Mental Health Services Directory to referrers and service providers to further promote services that are offered in our region across all levels of care.
Workforce Development	Mental Health	Access	• Built a sustainable workforce that is skilled, well distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs	• CESPHN to work with our LHD and LHN partners to fulfill the requirements of the bilateral schedule regarding the actions relating to workforce planning and development, focusing on priorities such as bilingual mental health clinicians, Aboriginal workforce and lived experience workforce.

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Low intensity mental health services	Mental Health	Access	• Increased proportion of population receiving Nationally funded low intensity services and successful promotion of these services	• CESPHN to work with referrers and community members to promote access to low intensity mental health services, including the newly established national low intensity service, other online services, and resources
Child and youth mental health services	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned youth specific services	• CESPHN to continue to commission headspace centres to provide youth mental health services in line with the headspace model integrity framework (hMIF) and within a stepped care approach • CESPHN to continue to commission early intervention services for young people with or at risk of severe mental illness (e.g., psychosis, major depression, severe anxiety, eating disorders and personality disorders) in the primary care setting • CESPHN to support commissioned providers to use telehealth and other technologies to facilitate access to services • CESPHN to work with our LHD and LHN partners to fulfill the bilateral schedule regarding the headspace enhancement initiatives, and child mental health and social and emotional wellbeing commitments. • CESPHN to commit to actions from the joint Mental Health Regional Plan

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				relating to child mental health and emotional wellbeing.
Psychological therapies for priority populations	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned psychological therapies and have improved clinical outcomes	• CESPHN to continue to commission services to ensure access to a range of evidence based psychological therapies for priority groups in the CESPHN region
Severe and complex mental illness	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned care coordination services and have improved functional and clinical outcomes	• CESPHN and LHDs to implement learnings from the evaluation of the Mental Health Shared Care program to improve service access and provision. • Commit to actions from the joint Mental Health Regional Plan relating to the development of the mental health workforce, including increasing the peer workforce • CESPHN to continue to commission care coordination services and other services aimed at supporting the physical and mental health and wellbeing of individuals with severe and/or complex mental illness.
Suicide prevention	Mental Health	Access	• Increase number of people who are supported by PHN-commissioned services following a recent suicide attempt and during a crisis.	• CESPHN to commission universal aftercare services in line with the requirements of the bilateral schedule regarding Universal aftercare. • CESPHN to commission suicide prevention services, and training to increase workforce and community capacity.

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• Support the promotion and awareness of prevention and postvention support services.
Access to alcohol and other drug treatment services	Alcohol and Other Drugs	Access	• Increase access to treatment services	• CESPHN to commission drug and alcohol treatment services that address gaps, are evidence based and accessible to our priority populations • CESPHN to work with service providers to ensure services are accessible and meet the needs of priority populations
Access to alcohol and other drug treatment in the primary care setting	Alcohol and Other Drugs	Care Coordination	• Increase engagement of GPs in responding to AOD problems and shared care arrangements between specialist AOD services and GPs • Increase numbers of GPs prescribing and pharmacy engagement in OTP	• CESPHN to provide support, resources and education to GPs • CESPHN to work with LHD/LHNs to implement the GLAD shared care project with GPs across the region • CESPHN to partner with PHNs to co-fund Primary Care Telehealth Alcohol Withdrawal and Recovery Service Proof of Concept
Capacity to address high need populations and clinical complexity	Alcohol and Other Drugs	Vulnerable Population (Non-Aboriginal Specific)	• Services meet the needs of priority populations and address co-occurring mental health in the context of AOD use	• CESPHN to work with peak bodies and champions to develop effective service models to meet the needs of multicultural communities, gender and sexuality diverse communities, individuals recently released from prison and individuals with co-occurring mental health needs
Sexual health	Population Health	Early Intervention and Prevention	• Increase number of GP prescribers for HVB, HIV S100 medications, HCV and PrEP S85 medications	• CESPHN to support primary care providers to address STIs and other blood borne (HIV and Viral Hepatitis) conditions by building confidence in

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Enhance GP capability to deliver hepatitis B and C, syphilis and Mpox treatment	diagnosing, testing and treatment prescription • CESPHN to support engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing • Promotion of vaccination to increase protection against Mpox
Chronic conditions	Population Health	Chronic Conditions	• Increase cancer screening rates • Reduce prevalence of risk factors • Increase number of patients with chronic diseases managed under GP Management Plan and/or Team Care Arrangements • Reduce potentially preventable hospitalisations for chronic conditions • Increase the number of practices sharing data for quality improvement • Increase the number of practices participating in quality improvement activities •	• Improving the uptake of evidence-based cancer screening programs, specifically, breast, cervical and colorectal cancers where rates are low in the region. Work with LHDs to review availability of mobile screening units across the region. • From July 1, 2025, a National Lung Cancer Screening Program will be launched targeting high risk smokers or ex-smokers accessed through general practice and Aboriginal Health Services. • Promote new smoking and vaping cessation clinic at Concord Hospital. • Continue supporting general practices to connect to the National Cancer Screening Registry and promoting share care and quality improvement activities for cancer screening and prevention. • Work with LHDs to address lifestyle risk factors such as excessive intake of alcohol, lack of physical exercise and poor diet.

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Older people	Aged Care	Chronic Conditions, Care Coordination, Workforce	• Increase MBS services provided by primary care providers in residential aged care facilities • Increase rate of people aged 75 and over with a GP health assessment • Improve communication, coordination and integration of services within the health system and at the interface of the health and aged care systems • More informed consumers and carers • Build primary health care workforce capacity and capability to address the health needs of older people	• CESPHN to commission community-based options for palliative care and to support healthy ageing, social connection and people living at home for longer • CESPHN to work with social interaction models of service • CESPHN to support GPs to complete MBS health checks and medication reviews in the community and in aged care • CESPHN to work with GPs to develop local dementia care and frailty pathways • CESPHN to commission community care finders to assist older Australians accessing and navigating the aged care system. • CESPHN to work with the Department of Health and Aged Care and LHD/ LHNs to identify gaps in system accessibility and opportunities for improved coordination, integration and reform across the aged care and health systems • CESPHN to support GPs and RACF staff with digital technologies including telehealth care for aged care residents, MyHR adoption, and sharing Advance Care Directives and care plans for transitions between health and aged care systems • CESPHN to support Geriatric Flying Squads/E Health programs to enable

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				deteriorating older people to stay at home and out of hospital • CESPHN to provide/ commission training for general practice, allied health and RACF staff on local clinical and service pathways, dementia care, palliative care, mental health, and medication and wound management
Health and wellbeing of people affected by domestic, family and sexual violence	Population Health	Vulnerable Population (Non-Aboriginal specific)	• Primary care providers are better able to identify and respond to DFV presentations • DFV victims receive appropriate services	• CESPHN to provide training to primary care providers to identify and appropriately respond to DFV presentations from patients or colleagues • CESPHN to link primary care providers with appropriate DFV services and secondary consultations to assist health professionals to support their patients
Aboriginal and Torres Strait Islander peoples' health and wellbeing	Aboriginal and Torres Strait Islander Health	Vulnerable Population (Aboriginal specific)	• Increase general practice IHI PIP uptake • Increase rate of patient records with Aboriginal status recorded • Increase rate of Aboriginal population receiving health assessments and follow-ups • Increase rates of service use for: maternal and child services, chronic disease, mental health and AOD services • Increase proportion of PHN-commissioned services delivered to the regional	• CESPHN to support general practice to enrol in the IHI PIP, identify Aboriginal patients and provide health checks • CESPHN to work with the Aboriginal community and LHD/LHNs to address access issues to culturally appropriate maternal and child health, chronic disease, mental health and AOD services • CESPHN to work with commissioned providers to ensure the workforce is culturally competent and continues to upskill in this area • CESPHN to continue providing education to GPs to promote cultural safety and

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			Aboriginal population that are culturally appropriate • Increase cultural awareness training participation rates among the primary care workforce • Increase support for the Aboriginal workforce	understanding of intergenerational trauma and ongoing impacts • CESPHN to support the Aboriginal workforce through the Aboriginal workers circle and training opportunities • CESPHN to promote urgent care as an alternative to attending Emergency departments for non-urgent care • CESPHN to work with partners to deliver community education on accessing relevant health care, domestic violence and sexual abuse resources, mental health and antenatal care
Health and wellbeing of people from multicultural communities	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Culturally appropriate commissioned services • Increase access to services among multicultural communities	• CESPHN to work with community organisations to build health literacy among consumers and their carers so they can be actively involved in decisions about their health • CESPHN to ensure translation and interpreting services are available to allied health professionals and promote TIS National interpreting services to medical practitioners and pharmacies • CESPHN to work with its commissioned service providers to co-design culturally appropriate services, employment of staff from multicultural backgrounds and providing cultural competency training for service providers • CESPHN to commission multicultural health navigators to increase access to health care

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Health and wellbeing of people impacted by homelessness	Population Health	Vulnerable Population (Non-Aboriginal Specific)	Improve health outcomes and access to health care among people experiencing homelessness or at risk of homelessness	• CESPHN to work with partners to implement the Intersectoral Homelessness Health Strategy 2020-2025 • CESPHN to support general practices and allied health professionals working with people experiencing homelessness • CESPHN to work with registered training organisations to enable and support GP registrars to work in homelessness health clinics during their training • CESPHN to provide training to general practices and allied health professionals on the skills and knowledge required to engage and care for people at risk of, or experiencing, homelessness • CESPHN to explore with the primary care sector the feasibility of new models of primary care in key locations to improve service navigation
Health and wellbeing of people with disability	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Primary care providers are better able to provide best practice care for people with a disability • People with an intellectual disability receive appropriate specialist services • Improved access to behavioural interventions for children with ADHD •	• CESPHN to provide training to primary care providers on best practice care for people with a disability, including annual Medicare assessments and access to NDIS care plan • CESPHN to link primary care providers with the most appropriate specialist services for their patients with intellectual disability • CESPHN to work with LHDs to increase the availability and capacity of mental health services for people with

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				intellectual disability with poor mental health • CESPHN to advocate for disability needs during development of the Single Digital Patient Record • CESPHN to lead an annual disability roundtable to bring together key stakeholders in health and primary care and the broader disability sector to showcase progress and highlight areas for further intervention • CESPHN to develop strategies to address needs of people living with a disability who are older, members of multicultural communities, impacted by alcohol and other drugs or exiting the Justice system.
Health and wellbeing of LGBTIQA+ people	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Increase access to LGBTQI inclusive primary care • Distinction between specific LGBTIQ+ sub-groups as priority populations within CESPHN program areas	• CESPHN to arrange provision of training and education for primary care and mental health workforce on LGBTQI+ inclusive care • CESPHN to support upskilling of aged care workforce and adoption of LGBTQI+ person-centred approaches • CESPHN to promote gender affirming care • CESPHN and partners to work on provision of greater support for transgender children and adolescents • Support adoption of trauma informed care approach

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• CESPHN to support ACON in the development of an integrated general practice specializing in LGBTIQ+ health • Promotion of LGBTIQ+ services in CESPHN service directories and HealthPathways • CESPHN to ensure commissioned services are accessible for LGBTQI+ people.
Maternal and child health and wellbeing	Population Health	Early Intervention and Prevention	• Reduce percentage of children with childhood developmental delays • Increase percentage of women attending antenatal visits	• CESPHN to improve collaborations, pathways and partnerships with child and family health services • CESPHN with work with LHD/ LHNs to maintain access to maternal primary care services, including the GP antenatal shared care program • CESPHN to commission activities to address developmental delay, particularly for multicultural communities • CESPHN to work with LHD/LHNs, Department of Communities and Justice, Department of Education, local government and community providers on implementation of First 2000 days framework
Primary care workforce	Health Workforce	Other	• Increase the number of unique health professionals accessing professional development opportunities • Increase in number of accredited general practices •	• CESPHN to commission services to ensure an appropriate use, mix and distribution of afterhours services for the population, including enhanced out of hours support for residential aged care • CESPHN to work with key stakeholders to identify and implement relevant

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				professional development opportunities for GPs, practice nurses, practice staff, mental health and AOD workforce and allied health professionals • CESPHN to commission, deliver and promote training and education to the primary care workforce specific to our priority areas and priority populations • CESPHN to collaborate with universities to train the health workforce • CESPHN to support general practices with accreditation and continuous quality improvement activities (e.g., PIP QI, Lumos) • CESPHN to implement health promotion strategies to improve awareness of after hours services (including HealthDirect helplines), appropriate use of emergency departments/urgent care and options for after hours services, particularly frequent users such as people aged 65 years and over, families with young children and priority populations such as people experiencing homelessness
Access and coordinated care	Population Health	Care Coordination	• Increased number of general practices receiving the after hours PIP • Reduce low urgency care emergency department presentations	• CESPHN to support general practice to participate in the after hours PIP • CESPHN to support increased uptake of digital health systems (smart forms, e-referrals, e-prescribing, telehealth) • CESPHN to work with LHD/LHNs and medical specialists to improve the integration of care through the

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase the number of practices sharing data for quality improvement • Increase the number of practices participating in quality improvement activities • • Increase rate of regular uploads to My health Record • HealthPathways sessions of use, unique page views, different users • Increase rate of discharge summaries uploaded to My Health Record • Increase rate of health care providers using specific digital health systems (smart forms, ereferrals, telehealth) • Improved identification and support of veterans	meaningful use of MyHR (e.g., electronic discharge summaries and e-referrals) in the hospital sector and access to Single Digital Patient Record • CESPHN to work with LHD/LHNs and general practice on virtual care models and management of patients following discharge to prevent readmissions • CESPHN to promote improved identification and support of veterans in primary care • CESPHN to work with partners on implementation of a centralised mental health intake and assessment model to combine intake, assessment and referral services • CESPHN to commission program to support smaller general practices to connect to local allied health providers through a multidisciplinary approach • Promotion of service directories and HealthDirect • Re-engage general practice, allied health and specialists on use of My Health Record • Work with partners to improve engagement of primary care in disaster management

Checklist

Provide a brief description of the PHN's Needs Assessment development process and the key issues discovered.	✓
Outline the process for utilising techniques for service mapping, triangulation and prioritisation	✓
Provide specific details on stakeholder consultation processes.	✓
Provide an outline of the mechanisms used for evaluating the Needs Assessment process.	✓
Provide a summary of the PHN region's health needs.	✓
Provide a summary of the PHN region's service needs.	✓
Summarise the priorities arising from Needs Assessment analysis and opportunities for how they will be addressed.	✓
Appropriately cite all statistics and claims using the Australian Government Style Manual author-date system.	✓
Include a comprehensive reference list using the Australian Government Style Manual.	✓
Use terminology that is clearly defined and consistent with broader use.	✓
Ensure that development of the Needs Assessment aligns with information included in the PHN Needs Assessment Policy Guide.	✓

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

The Central and Eastern Sydney Region

2025-2027 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

Contents

List of tables

List of figures

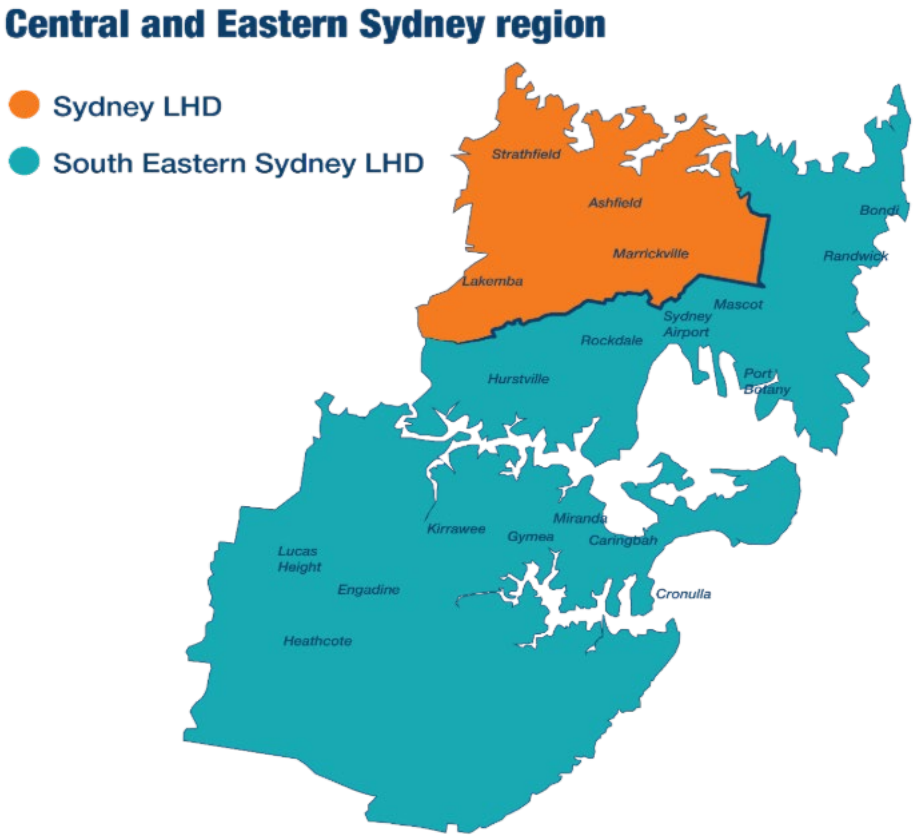
The central and eastern Sydney region is often referred to as the CESPHN region throughout this needs assessment because it is the area where the Central and Eastern Sydney Primary Health Network (CESPHN) focuses their work to address the health needs of the population.

Geography

The region covers an area of over 590 square kilometres. This includes the area from Bondi to the Sutherland Shire in the south, and as far west as Strathfield, encompassing 12 Local Government Areas (and Lord Howe Island).

The region corresponds with the two Local Health Districts of Sydney and South Eastern Sydney, as shown in the image below, and 14 Statistical Area Level 3 (SA3) geographies. SA3 is a geographic classification used in Australia for producing regional data and is used regularly throughout the chapters of this needs assessment.

Figure 1: CESPHN region



Population

The estimated resident population of the CESPHN region at 30 June 2024, was 1,640,521 (1) The CESPHN population equates to 6% of the Australian population and approximately 20% of the NSW population.

As a major employment, education and entertainment hub for the larger Sydney population, this region also has a large non-resident population with 350,761 people entering the region each day.(2) This non-resident population also make use of the range of health services on offer.

The highest concentration of the population live in the Sydney Inner City SA3 (14.9%), followed by Strathfield-Burwood-Ashfield SA3 (10.5%) and Kogarah-Rockdale SA3 (9.5%).(1) The majority of SA3s have densities above 4,000 people per square kilometre (sq km) which rises to over 9,000 per sq km in Sydney Inner City. Conversely the region also includes the remote community of Lord Howe Island.

Table 1: Estimated resident population (ERP) in the CESPHN region by SA3, 2024

SA3	Total persons	% of region	Density (per km^2)
Botany	62,328	3.8	2,194.65
Canada Bay	89,946	5.5	4,565.79
Canterbury	146,381	8.9	4,879.37
Cronulla-Miranda-Caringbah	123,132	7.5	2,214.60
Eastern Suburbs - North	133,328	8.1	5,088.85
Eastern Suburbs - South	144,589	8.8	4,590.13
Hurstville	138,899	8.5	4,097.32
Kogarah-Rockdale	155,571	9.5	4,970.32
Leichhardt	58,273	3.6	5,446.07
Lord Howe Island	448	0.0	27.48
Marrickville-Sydenham-Petersham	57,207	3.5	4,504.49
Strathfield-Burwood-Ashfield	172,236	10.5	5,050.91
Sutherland-Menai-Heathcote	114,213	7.0	475.49
Sydney Inner City	243,970	14.9	9,719.92
CESPHN	**1,640,521**	**100.0**	**2,753.94**

Source: ABS 2025

Aboriginal Community

- 16,225 Aboriginal people living in the region, representing 1.2% of the total CESPHN population

Cultural Diversity

- 40.7% of the community were born outside Australia
- 46.8% speak a language other than English at home and
- 6.3% do not speak English well or at all.(2)

Same-sex couples

- A high concentration of same-sex couples: around 14.5% of all those living in Australia.(2)

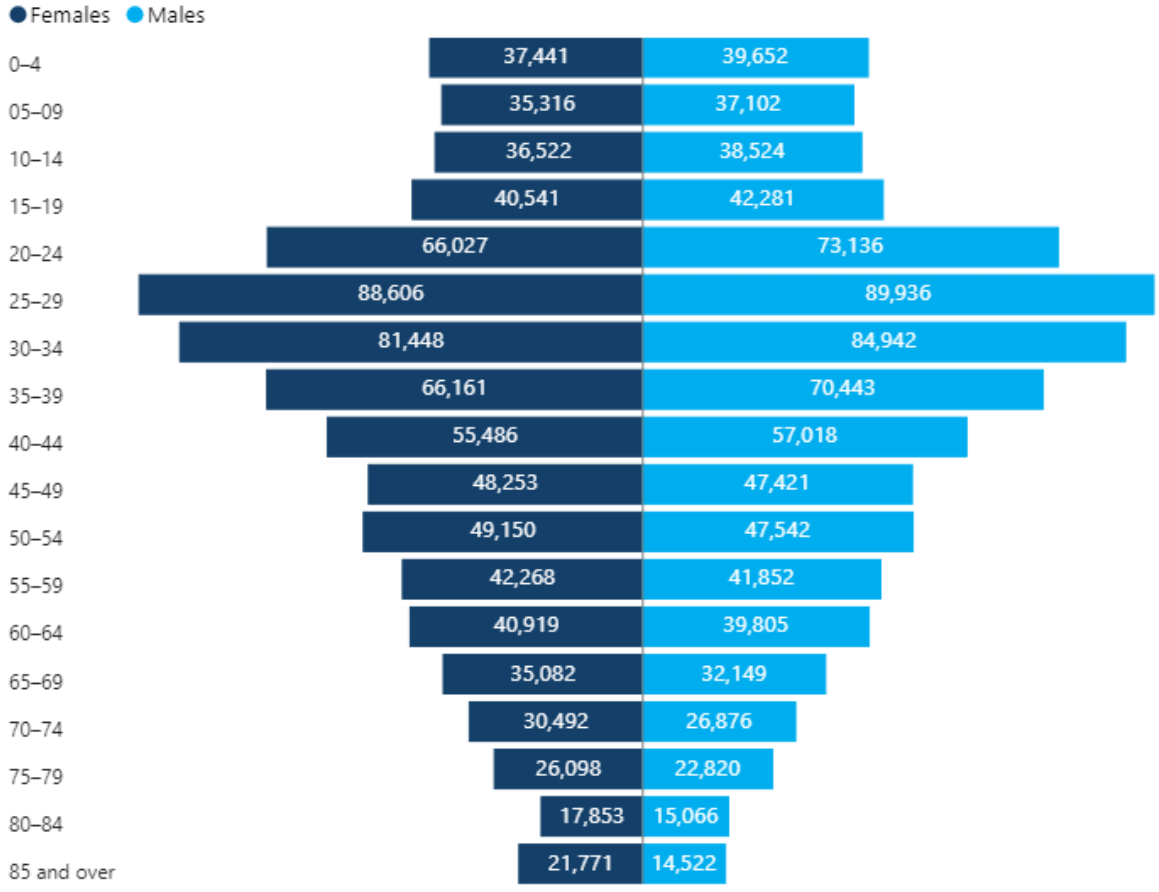
Homelessness

- High numbers of people experiencing homelessness or at risk of homelessness:
  - 35% of the NSW homeless population (3)
  - 66.2% of NSW boarding house residents (3)
  - 18% of NSW social housing residential dwellings and long waitlists for general applicants.(4, 5)

Age and gender

Comparison of 5-year age groups shows the highest proportion of the CESPHN population are aged 25 to 29 years (10.9%) and 30-34 years (10.2%). Adults aged 25-64 years constitute 58.0% of the CESPHN population, while 13.7% of the population is aged 0-14 years and 14.8% of the population is aged 65 years and over. There are 819,434 females and 821,087 males in the region, which is consistent with national rates.(1)

Figure 2: Age breakdown by gender, CESPHN region, 2024



Source: ABS 2025

Dependency Ratios

Dependency ratios provide an indication of the number of children (0-14 years) and older persons (65 years +) compared to the working population (15-64 years); a lower ratio means fewer people are dependent on the working population.

2024 ERP shows that within the CESPHN region, there is an age dependency ratio of 0.40; meaning for every worker, there are 0.40 people dependent on that worker. The child dependency ratio for 2024, is 0.19 and the older dependency ratio is 0.21. The dependency ratios for the CESPHN region are all lower than the ratios at the National level, which are 0.54 for age dependency, 0.27 for child dependency and 0.27 for older dependency.(1)

When examining population projection figures for 2041, we see an age dependency ratio for the CESPHN region of 0.49, with a child dependency ratio steady at 0.19, and the older dependency ratio rising to 0.30.(6) The dependency ratios for the CESPHN region are projected to remain lower than the National ratios, however there is a reduced gap for all dependency groups with the most noticeable difference being in the older dependency ratio highlighting the significance of ageing population.(7)

Table 2: Dependency ratios, CESPHN region and Australia, 2024 and 2041

	Age dependency	Child dependency (0-14 years)	Older dependency (65 years+)
2024			
CESPHN	0.40	0.19	0.21
Australia	0.54	0.27	0.27
2041			
CESPHN	0.49	0.19	0.30
Australia	0.59	0.25	0.34

Source: HealthStats NSW, 2024 and ABS, 2025

Population growth

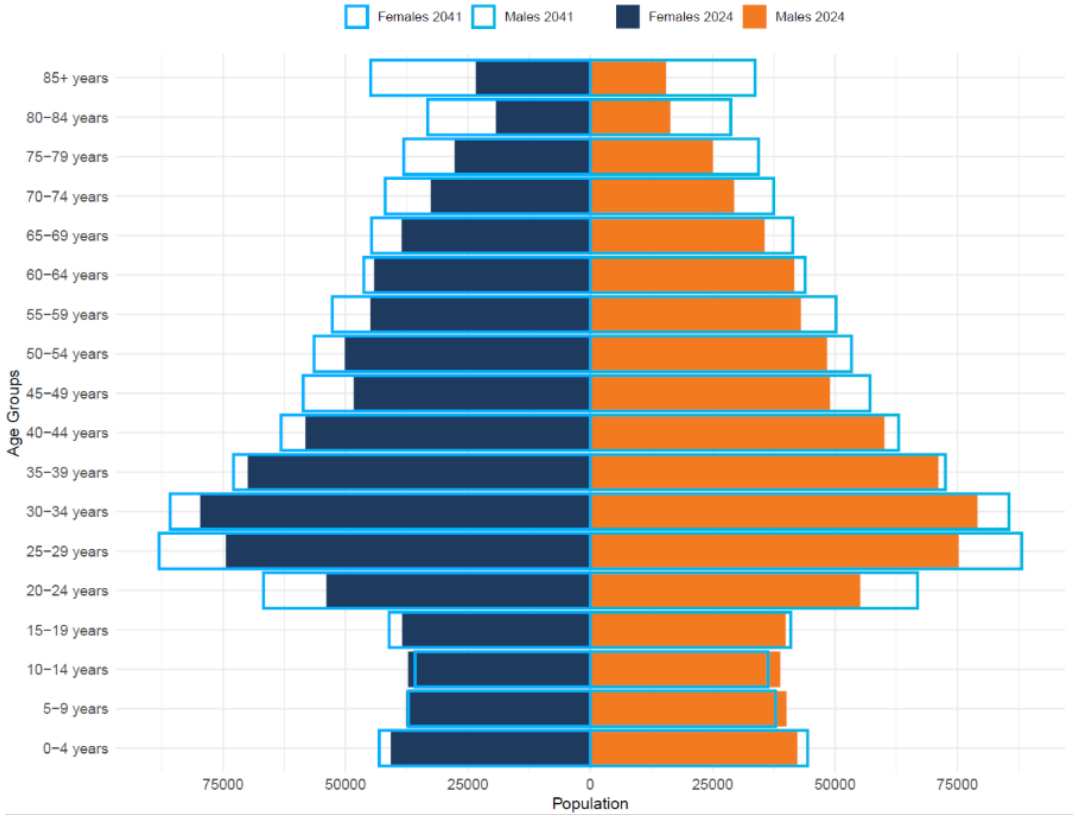
Between 2024 and 2041, the population in the CESPHN region is expected to increase by 12.9% to 1,866,105 residents.(6) The greatest population growth is expected in the 85 years and over age group (n=38,895 in 2024 to n=78,505 in 2041), projecting a 101.8% increase. (6) These projections are based on assumptions about future trends in fertility, mortality and migration.

Table 3: Population projections by age groups, CESPHN region, 2024-2041

Age group	2024	2041	% change	Compound annual growth rate (CAGR)
0-14 years	236,771	234,580	-0.9%	-0.05%
15-64 years	1,124,744	1,253,317	10.3%	0.60%
65+ years	263,366	378,208	30.4%	1.79%
Total	1,624,881	1,866,105	12.9%	0.76%

Source: HealthStats NSW, 2024

Figure 3: Population projections by sex and five-year age groups, CESPHN region, 2024-2041



Source: HealthStats NSW, 2024

NSW Planning projections estimate that between 2024 and 2041, the CESPHN population will increase by 14.2%. Kogarah-Rockdale SA3 is expected to see the largest population growth with a projected 33% increase in total population, followed by Strathfield-Burwood-Ashfield SA3 (25.7% increase) and Marrickville-Sydenham-Petersham SA3 (22.1%).(8)

Table 4: Projected population by SA3, CESPHN region, 2024 and 2041

SA3	2024	2041	% change
Botany	48,720	53,824	10.5%
Canada Bay	88,657	102,099	15.2%
Canterbury	164,410	182,344	10.9%
Cronulla - Miranda - Caringbah	150,214	160,999	7.2%
Eastern Suburbs - North	119,040	124,978	5.0%
Eastern Suburbs - South	147,195	154,737	5.1%
Hurstville	137,373	151,758	10.5%
Kogarah - Rockdale	152,869	203,347	33.0%
Leichhardt	77,131	86,834	12.6%
Lord Howe Island	445	455	2.2%
Marrickville - Sydenham - Petersham	57,933	70,758	22.1%
Strathfield - Burwood - Ashfield	172,640	217,069	25.7%
Sutherland - Menai - Heathcote	107,696	113,610	5.5%
Sydney Inner City	243,581	281,835	15.7%
CESPHN	**1,667,904**	**1,904,647**	**14.2%**

Source: NSW Department of Planning, 2024

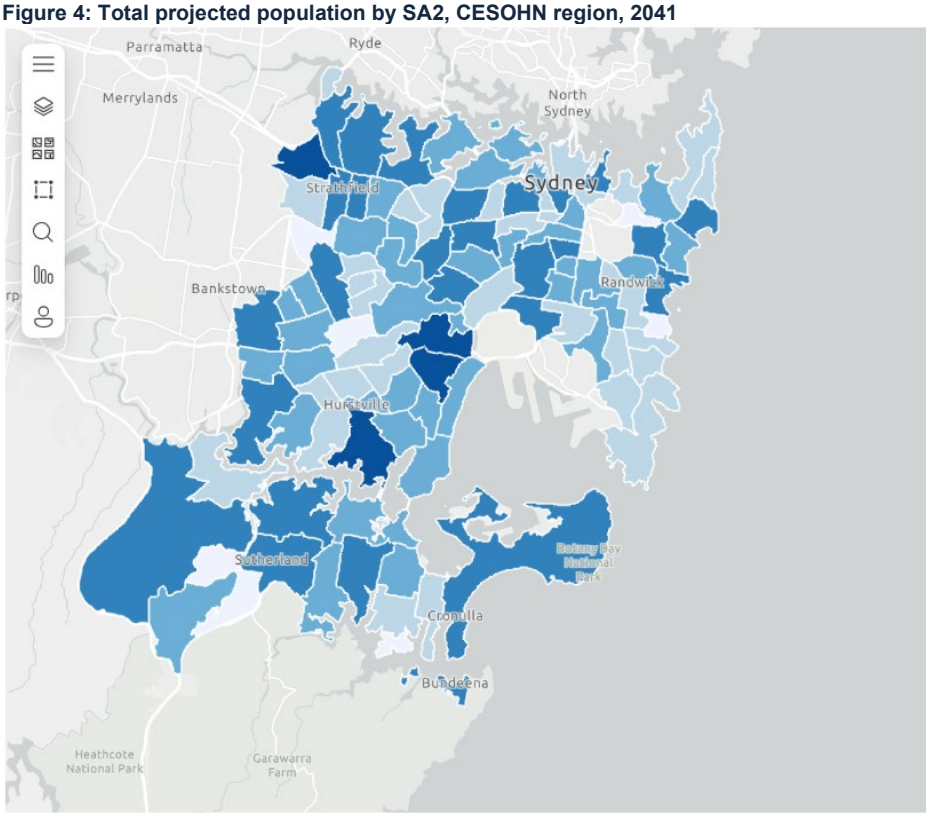
Data at the SA2 level shows the highest projected growth between 2024 and 2041 to be in the following areas:

- Arncliffe-Bardwell Valley SA2
  - 86% increase; 2024 = 17,063; 2041 = 31,741
- Rockdale-Banksia SA2
  - 74.7% increase; 2024 = 21,826; 2041 = 38,131
- Concord West – North Strathfield SA2
  - 61.7% increase; 2024 = 13,114; 2041 = 21,206
- Croydon SA2
  - 59.4% increase; 2024 = 11,031; 2041 = 17,586 (8)

By 2041, the highest population numbers are projected to be in the SA2s of:

- Rockdale – Banksia SA2 (n=38,131)
- Homebush SA2 (n=34,726)
- Caringbah SA2 (n=31,818)
- Arncliffe-Bardwell Valley SA2 (n=31,741) (8)

Figure 4: Total projected population by SA2, CESOHN region, 2041



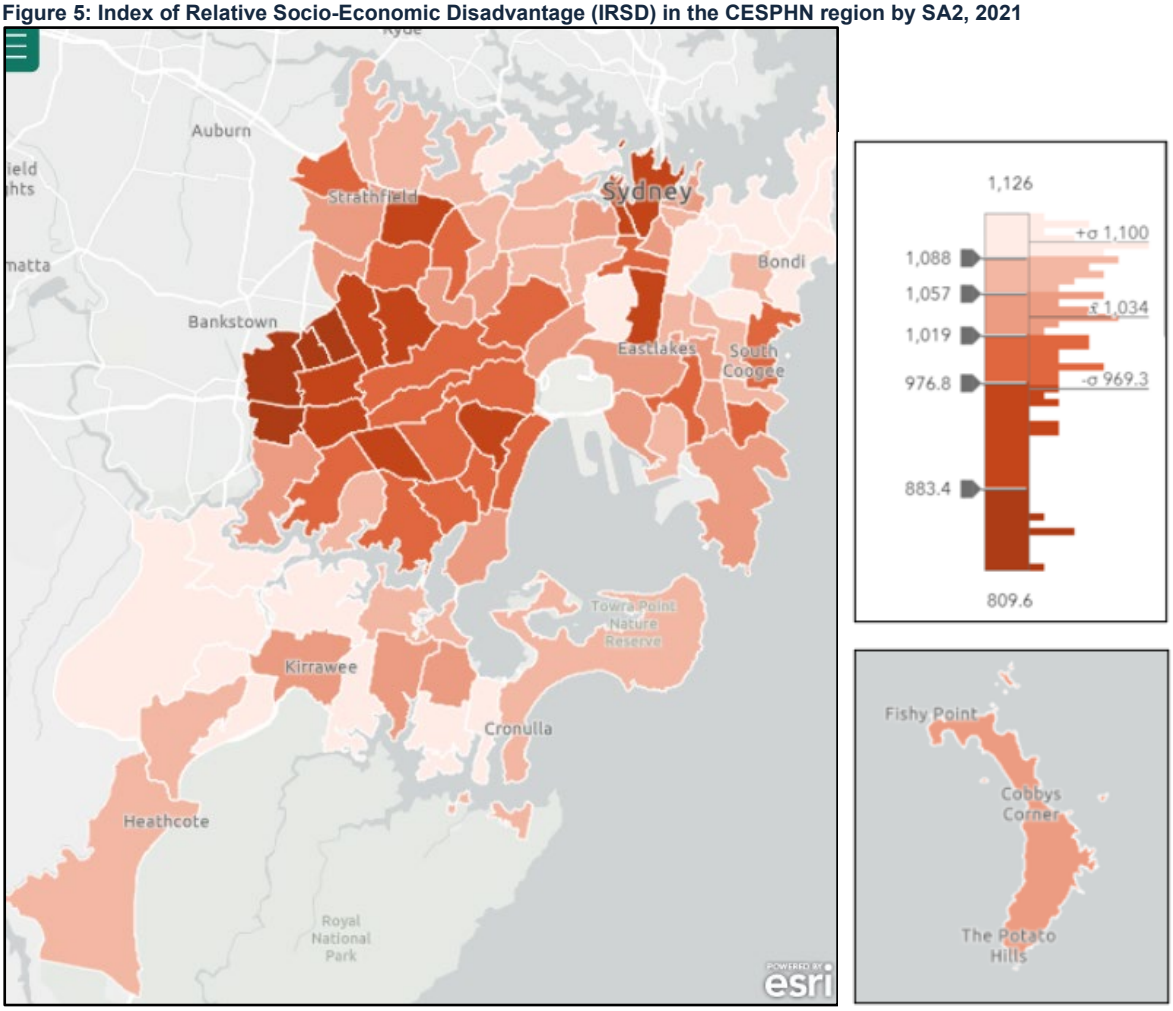
Source: NSW Department of Planning, 2024

Social Determinants of Health

SEIFA

The overall level of advantage in the CESPHN region is above that of the Australian average as measured by the ABS Socioeconomic Indices of Advantage and Disadvantage. Within the CESPHN region there is a gradient from east to west, with the western parts of the region relatively disadvantaged by national standards and the eastern areas relatively advantaged. However, this is not an even distribution: there are locations of considerable disadvantage as measured by factors such as low income, unemployment, and low English proficiency.(9)

Figure 5: Index of Relative Socio-Economic Disadvantage (IRSD) in the CESPHN region by SA2, 2021



Source: ABS SEIFA, 2022

There are 32 SA2s with an Index of Relative Socioeconomic Disadvantage (IRSD) value below 1,000 indicating socioeconomic disadvantage. Almost one third of the most disadvantaged SA2s are in Canterbury SA3. Other pockets of disadvantage are in Hurstville, Sydney Inner City, Kogarah - Rockdale, Strathfield - Burwood - Ashfield, Botany and Eastern Suburbs – South SA3s.(9) A total of 383,561 people, or 24.8% of the CESPHN population live in these SA2s.

Table 5: Most disadvantaged SA2s in the CESPHN region with an IRSD value below 1,000, and SA2 population size 2021

SA2	IRSD	Population size
Botany SA3		
Pagewood - Hillsdale - Daceyville	991	14,843
Eastlakes	936	8,975
Canterbury SA3		
Kingsgrove - North	992	6,268
Canterbury – South	977	12,276
Roselands	970	14,590
Belmore - Belfield	933	20,406
Campsie – North	883	11,943
Punchbowl	847	21,693
Wiley Park	846	10,212
Campsie - South	843	9,114
Lakemba	810	17,232
Eastern Suburbs – South SA3		
South Coogee	993	5,636
Maroubra - South	989	11,130
Hurstville SA3		
Penshurst	987	9,560
Hurstville - North	979	12,135
Narwee - Beverly Hills	964	13,822
Hurstville - Central	931	12,160
Riverwood	856	11,645
Kogarah – Rockdale SA3		
Bexley - North	996	10,162
Arncliffe - Bardwell Valley	984	16,676
Bexley - South	980	15,879
Rockdale - Banksia	974	20,010
Sydney Inner City SA3		
Redfern	981	13,849
Waterloo	969	16,615
Ultimo	960	7,540
Sydney (South) - Haymarket	937	20,306
Strathfield – Burwood – Ashfield SA3		
Homebush	998	21,056
Strathfield - East	979	16,600
Burwood (NSW)	940	16,071
Total population	-	**383,561**

Source: ABS SEIFA, 2023

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Health Profile

2025-27 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

Health Profile

Contents

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Overview

The overall health status of CESPHN residents is higher than the national average. For instance, life expectancy in the region is higher, there are fewer potentially avoidable deaths and deaths among infants and young children. There are also lower rates of premature mortality, potentially preventable hospitalisations, chronic diseases, fair or poor self-reported health and psychological distress.

However, there are considerable disparities in health status in certain locations across the region, particularly areas with a lower socioeconomic status and among certain priority population groups.

Key health issues

- Eastern Suburbs – North SA3 and Eastern Suburbs – South SA3 have the highest infant and young child mortality rates in the region, higher than the national rate.
- Sydney Inner City SA3 has the highest rates of potentially avoidable deaths, higher than the state and national rates.
- The three highest causes of premature mortality are cancer, circulatory system diseases and external causes. Marrickville – Sydenham – Petersham SA3 has higher premature mortality rates for circulatory disease, ischaemic heart disease and cerebrovascular disease than the state and national rates.
- Hurstville SA3 and Canterbury SA3 have the highest rates of poor/fair self-reported health status in the region, higher than the state and national rates.
- There were 8,733 new cases of cancer in 2022. Prostate cancer is the most common type of cancer; lung cancer contributes to the highest proportion of deaths and liver cancer is the fastest growing type of cancer.
- Rates of chronic disease are lower than state and national rates, except for osteoporosis.
- Total vaccine preventable PPH rates in the CESPHN region remain consistently higher than National rates
- Sutherland – Menai – Heathcote SA3 had the highest rates of overweight and obesity among adults in the region.
- Highest rates of chlamydia, gonorrhoea and infectious syphilis notifications in NSW.

Key service gaps

- Low number of CESPHN population living with diabetes registered for NDSS, and low rates receiving annual diabetes cycle of care.
- Bowel, breast and cervical cancer screening rates are lower than the state and national rates.
- Breast cancer screening rates remain lower in CALD and Aboriginal women.
- Low uptake of care and treatment for hepatitis B and hepatitis C.

Health status

Life expectancy

During 2017-19, life expectancy at birth for those living in the CESPHN region (84.7 years) was higher than both the NSW (82.8 years) and national average (82.9 years). Females in the CESPHN region had a higher life expectancy than males (86.8 years compared to 82.8 years).(1)

Table 1: Life expectancy by gender, 2017-19

Region	Female	Male	Total
CESPHN	86.8	82.8	84.7
NSW	85.0	80.7	82.8
National	85.0	80.9	82.9

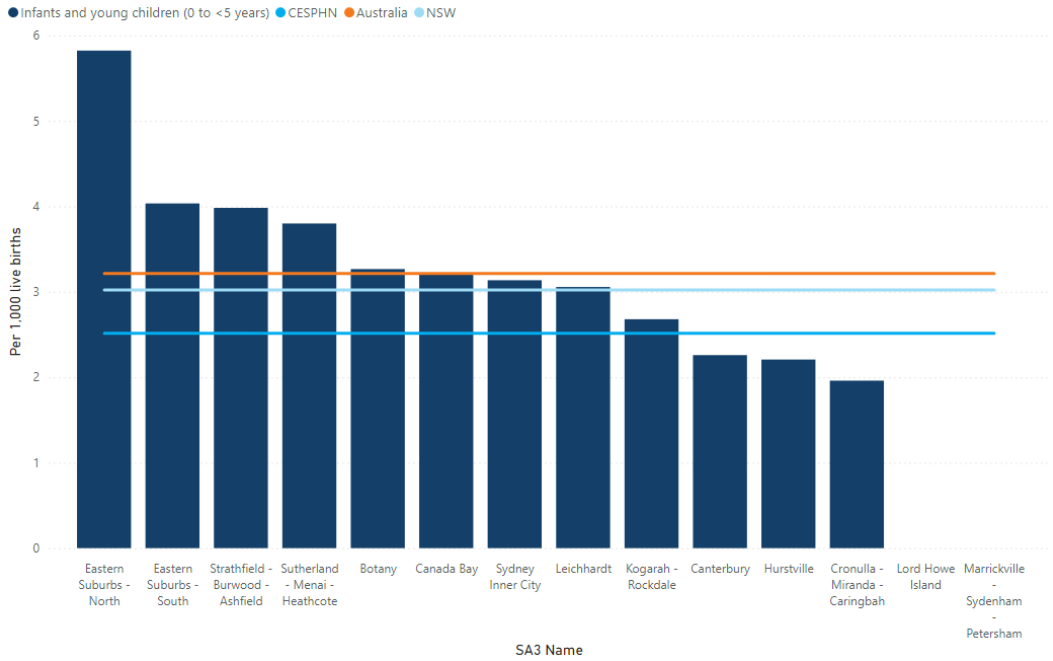
Source: AIHW 2019

Infant and young child mortality

The 2018-22 mortality rate for infants and young children aged less than 5 years was lower in the CESPHN region (2.5 deaths per 1,000 live births) compared to the national rate (3.2 deaths per 1,000 live births).(2)

Eastern Suburbs - North SA3 (5.8 per 1,000 live births) and Eastern Suburbs - South SA3 (4.0 per 1,000 live births) had the highest mortality rates of infant and young children in the region.(2)

Figure 1: Mortality rate among infants and young children in the CESPHN region by SA3, 2018-22



Source: PHIDU 2025

Note: There is no published data available for Lord Howe Island SA3 and Marrickville – Sydenham – Petersham SA3.

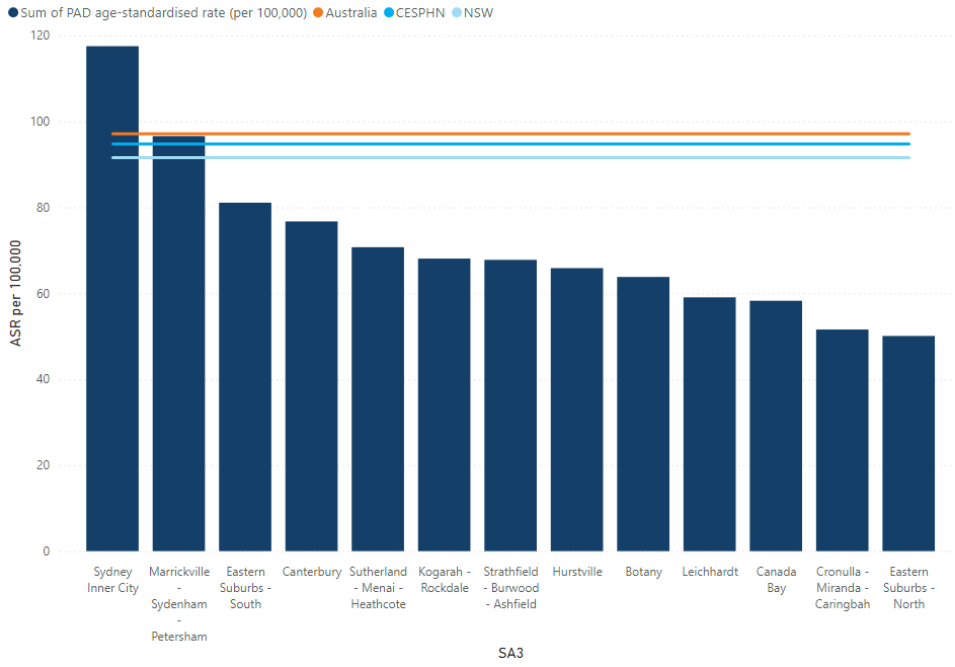
Potentially avoidable deaths

Potentially avoidable deaths are deaths below the age of 75 years from conditions that are potentially preventable through primary or hospital care.

In 2023, the age-standardised rate (ASR) of potentially avoidable deaths in the CESPHN region (94.8 per 100,000 people) was higher than the NSW rate (91.5 per 100,000), but was lower than the national rate (97.1per 100,000 people).The rate for males (94.8 per 100,000 people) was much higher than the rate for females (51.2 per 100,000 people) in the CESPHN region.(3)

In 2023, Sydney Inner City SA3 (117.5 per 100,000 people) had the highest rate of potentially avoidable deaths. Eastern Suburbs – North SA3 (50.1 per 100,000 people) had the lowest rate of potentially avoidable deaths in the CESPHN region.(3)

Figure 2: Potentially avoidable deaths in the CESPHN region (ASR per 100,000) by SA3, 2023



Source: AIHW, 2025

Note: There is no published data available for Lord Howe Island SA3.

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. In 2018-22, premature mortality rates in the CESPHN region (196.1 per 100,000 people) were lower than both NSW (239.9 per 100,000 people) and national rates (240.0 per 100,000 people).(2)

The male rate (244.3 per 100,000 people) was much higher than the female rate (147.8 per 100,000 people) in the CESPHN region. Botany SA3 (167.8 per 100,0000 people) had the highest rate of all SA3s for females and Marrickville – Sydenham – Petersham SA3 had the highest rate for males (298.7). (2)

The three highest causes of premature mortality were from cancer (84.3 per 100,000), circulatory system diseases (32.5 per 100,000) and external causes (22.1 per 100,000).(2) Marrickville –

Sydenham - Petersham SA3 has higher premature mortality rates for circulatory disease (44.1 per 100,000), ischaemic heart disease (21.8 per 100,000) and cerebrovascular disease (8.3 per 100,000) than state and national rates.

Table 2: Premature mortality per 100,000 people by cause and by SA3, 2018-22

SA3	Cancer	Cerebrovascular disease	Circulatory disease	COPD	Diabetes	External causes	Ischaemic heart disease	Respiratory system disease	Road traffic	Suicide
Botany	83.6	10.9	42.9	11.1	11.2	25.9	21.2	16.3	2.2	14.4
Canada Bay	79.6	5.0	22.4	4.1	3.7	19.7	8.7	6.3	2.1	8.4
Canterbury	84.9	7.5	37.6	7.0	6.0	17.5	18.5	11.3	0	5.5
Cronulla - Miranda - Caringbah	80.8	5.0	26.4	5.0	3.8	20.2	12.0	9.7	n.p	9.0
Eastern Suburbs - North	70.2	6.1	22.6	4.5	3.5	20.7	9.2	5.5	3.3	8.8
Eastern Suburbs - South	83.8	9.0	34.1	8.1	6.7	21.2	15.5	8.9	0	8.2
Hurstville	83.3	7.3	31.2	4.8	6.6	21.4	13.2	9.8	3.2	8.8
Kogarah - Rockdale	85.7	7.7	32.1	4.5	8.1	16.1	13.0	9.8	n.p	6.6
Leichhardt	84.6	8.9	34.1	9.7	8.9	22.5	14.6	16.1	n.p	11.3
Marrickville - Sydenham - Petersham	96.5	8.3	44.1	6.6	9.1	28.6	21.8	15.9	n.p	13.2
Strathfield - Burwood - Ashfield	78.8	7.2	34.8	10.1	3.7	19.9	17.4	14.0	n.p	7.1
Sutherland - Menai - Heathcote	87.8	4.6	29.6	4.6	6.0	20.8	15.8	9.2	5.2	8.7
Sydney Inner City	88.5	7.1	36.9	10.1	6.6	31.2	17.3	18.2	0	13.0
CESPHN	**84.3**	**6.8**	**32.5**	**5.9**	**5.1**	**22.1**	**14.9**	**10.9**	**1.6**	**8.8**
NSW	**98.4**	**8.0**	**41.6**	**10.2**	**7.4**	**26.7**	**19.2**	**15.9**	**3.4**	**11.2**
Australia	**96.5**	**7.9**	**42.8**	**9.7**	**7.1**	**30.4**	**21.6**	**15.1**	**4.2**	**12.6**

Source: PHIDU 2025

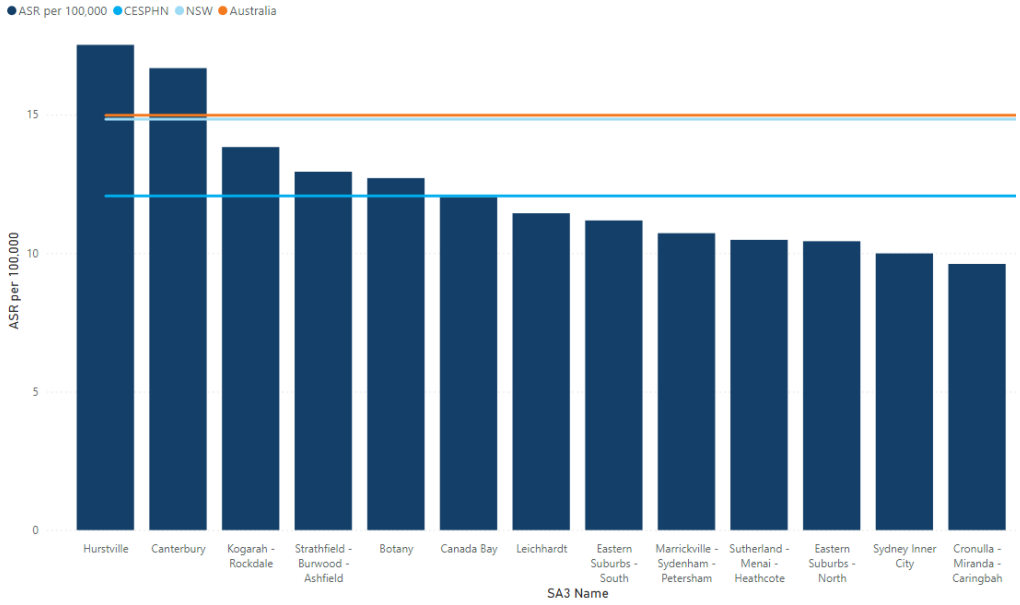
Note: There is no published data available for Lord Howe Island SA3.

Self-assessed health status

In 2022, a lower rate of people living in the CESPHN region (12.1 ASR per 100 people) reported fair or poor health compared to the NSW (14.8 ASR per 100 people) and national average (14.9 ASR per 100 people).(2)

While the CESPHN region is doing well in measures of health status, this is not uniform across all populations. PHIDU modelled estimates of self-reported health status from 2022 show Hurstville SA3 (17.5 ASR per 100 people) had the highest rate of fair or poor self-assessed health in the region.(2)

Figure 3: Number of people aged 15 years and over with fair or poor self-assessed health in the CESPHN region (ASR per 100) by SA3, 2022



Source: PHIDU 2025

Note: No published data available for Lord Howe Island SA3.

Psychological distress

In 2022, 11.4% of persons aged 18 years and over in the CESPHN region reported experiencing high or very high psychological distress compared to 13.0% in NSW.(2)[1]

Chronic disease

Cancer incidence

In 2022, there was a total of 8,733 new cases for all cancers in the CESPHN region. Incidence was higher in males (560.5 ASR per 100,000 males) than females (448.3 ASR per 100,000 females). In terms of number of cases, the 70–79-year age group had the highest number (2,375). However, the 80+ year age group had the highest rate (2,632.3 ASR per 100,000 persons).(4)

Table 3: Incidence of cancer in the CESPHN region by age group, 2022

Age group	Number of cases	ASR per 100,000
0-49	1,244	114.1
50-59	1,318	718.8
60-69	2,067	1,437.7
70-79	2,375	2,340.9
80+	1,729	2,632.3

Source: Cancer Institute NSW 2025

[1] Please refer to the Mental Health and Suicide Prevention reports for further analysis.

Prostate cancer was the most common type of cancer in the CESPHN region (15.6% of all cases), whereas lung cancer contributed to the highest proportion of deaths (16.4% of cancer deaths) from 2019 to 2023.(4)

Table 4: Most common cancer types in the CESPHN region, 2019-23

	% of cases		% of deaths
Prostate	15.6	Lung	16.4
Breast	13.4	Pancreatic	7.6
Melanoma of skin	9.1	Breast	7.4
Lung	7.8	Colon	6.8
Colon	6.4	Prostate	6.3

Source: Cancer Institute NSW 2025

Despite liver cancer having a lower incidence compared to other cancers, it is one of the fastest growing types of cancer in Australia – having seen a 378% increase between 1982 and 2019.(5) Liver cancer is linked to lifestyle risk factors such as excessive intake of alcohol, obesity, diabetes, and non-alcoholic fatty liver disease. It can also be caused by hepatitis B and hepatitis C.[2]

Overall, males in the CESPHN region have seen a faster increase in new liver cancer cases and between 2019-23 had a higher incidence rate (13.4 ASR per 100,000 males) compared to females (5.6 ASR per 100,000 females). Similarly, to all cancer data, number of cases was highest in persons aged 70-79.(4)

Sydney Local Health District (SLHD) has a higher liver cancer incidence rate compared to the NSW rate (10.9 ASR per 100,000 people, 9.0 ASR per 100,000 people respectively).(4)

Table 5: Incidence of liver cancer in the CESPHN region by LHD, 2019-23

Region	ASR per 100,000
SLHD	10.9
SESLHD	8.3
CESPHN	9.3
NSW	9.0

Source: Cancer Institute NSW 2025

Diabetes

In 2021 in the CESPHN region, the rate of people aged 15 years and over who reported they have diabetes (4.8 per 100 person), was lower than both the NSW rate (5.8 per 100) and national rate (5.7 per 100).(2) There were 69,252 registered for the National Diabetes Services Scheme (NDSS) (4.2% of the CESPHN population) in 2025. The majority of CESPHN registrants live with Type 2 diabetes (85.1%), followed by Type 1 (11.3%), gestational (2.4%), and other (1.2%).(6)

In 2020, the incidence of insulin-treated Type 1 diabetes in the CESPHN region was lower (6.1 per 100,000 population) than the NSW rate (10.8 per 100,000 population). Similarly, the incidence for

[2] Please refer to the sexual health section of this report for more information on viral hepatitis.

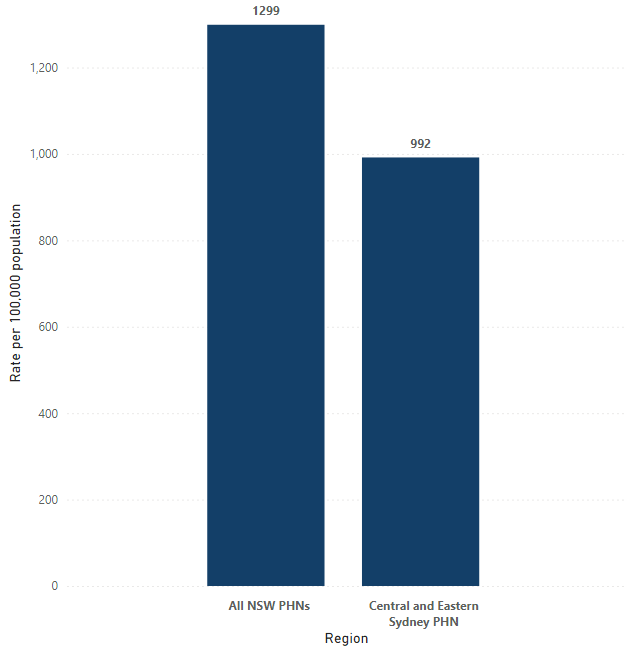
insulin-treated Type 2 diabetes was lower in the CESPHN region (1,683.2 per 100,000 population) than the NSW rate (4,159 per 100,000).(7)

The annual diabetes cycle of care is for patients with established diabetes and includes diabetes management and general health checks. In 2022-23, 1,027 patients in the CESPHN region received an annual diabetes cycle of care (0.07 per 100 people compared to 0.14 per 100 people nationally). Hurstville SA3 had the highest rate of people receiving this MBS item (0.12 per 100 people).(8)

Chronic kidney disease

In 2021-22, the CESPHN region had lower rates of chronic kidney disease hospitalisations (992 ASR per 100,000) compared to all NSW PHNs (1,299 ASR per 100,000).(9) Similarly, a slightly lower rate of chronic kidney disease deaths was reported for the CESPHN region (49 ASR per 100,000), when compared to all NSW PHNs (55 ASR per 100,000).(9)

Figure 4: Chronic kidney disease hospitalisations (ASR per 100,000), CESPHN region, 2020-21



Source: HealthStats NSW 2025

Other chronic diseases

2017-18 modelled prevalence estimates of other chronic conditions showed that rates for the CESPHN region were below both state and national rates for all conditions, except for osteoporosis.(10)

Table 6: Rate of people aged 18 years and over with selected chronic diseases, ASR per 100, by SA3, 2017-18

SA3	Arthritis	Asthma	COPD	Circulatory disease	Osteoporosis
Botany	12.8	7.5	2.1	5.1	3.5
Canada Bay	12.4	7.2	1.6	4.5	4.8
Canterbury	14.5	7.8	2.0	5.0	5.4
Cronulla - Miranda - Caringbah	14.2	11.3	2.0	4.4	4.0
Eastern Suburbs - North	12.2	8.0	1.8	3.6	4.1
Eastern Suburbs - South	12.2	9.8	2.2	4.3	4.3
Hurstville	12.1	7.0	1.8	4.4	5.7
Kogarah - Rockdale	12.1	6.6	1.9	4.7	4.7
Leichhardt	11.3	8.6	2.3	4.4	4.4
Marrickville - Sydenham - Petersham	11.4	9.6	2.2	4.5	4.5
Strathfield - Burwood - Ashfield	11.7	7.3	2.0	4.5	5.1
Sutherland - Menai - Heathcote	14.4	10.8	2.1	4.8	4.0
Sydney Inner City	10.8	7.2	2.4	4.0	4.2
CESPHN	**12.5**	**8.2**	**2.0**	**4.4**	**4.6**
NSW	**15.5**	**10.6**	**2.2**	**4.9**	**4.2**
Australia	**15.0**	**11.2**	**2.5**	**4.8**	**3.8**

Source: PHIDU 2021

Note: There is no published data available for Lord Howe Island SA3.

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) are hospital admissions that could have potentially been prevented by timely and adequate health care in the community.

In 2022-23, there were 13,661 PPHs for chronic conditions across the CESPHN region, equivalent to 722 per 100,000 people; this was lower than the national rate of 1,063 per 100,000 people. The most common PPH was for congestive cardiac failure (148 per 100,000 people), with an average length of stay across the CESPHN region, of 4.8 days.(11)

Table 7: PPHs for chronic conditions in the CESPHN region by condition, 2022-23

PPH condition	PPH per 100,000 (ASR)	No. of PPH	Average length of stay (days)
Angina	88	1,557	1.6
Asthma	106	1,461	2.5
Bronchiectasis	22	402	5.7
COPD	113	2,110	5.8
Congestive cardiac failure	148	2,993	7.5
Diabetes complications	103	1,785	8.2
Hypertension	38	691	2.0
Iron deficiency anaemia	138	2,377	1.7
Nutritional deficiencies	3	55	15
Rheumatic heart disease	13	229	8.2
Total chronic	**772**	**13,661**	**4.8**

Source: AIHW 2025

Vaccine potentially preventable hospitalisations

Total vaccine preventable PPHs in the CESPHN region have decreased from 254 per 100,000 people in 2018-19 to 189 per 100,000 people in 2022-23. Since 2018-19, the total vaccine preventable PPH rates in the CESPHN region have been consistently above the national rates.(11)

Pneumonia and influenza contributed to 61.9% of the total vaccine preventable PPHs in 2022-23.(11)

Table 8: Age-standardised rate of vaccine-preventable PPHs per 100,000 people, 2018-19 to 2022-23

Category	Region	2018-19	2019-20	2020-21	2021-22	2022-23
Pneumonia and influenza	CESPHN	120	144	14	66	72
	National	146	147	15	75	109
Other vaccine preventable conditions	CESPHN	141	123	127	111	117
	National	100	92	86	81	88
Total vaccine preventable	CESPHN	259	266	141	177	189
	National	245	238	101	155	197

Source: AIHW 2025

In 2022-23, the rate for both pneumonia and influenza PPHs and other vaccine-preventable conditions PPH were higher among males (81 per 100,000 population and 141 per 100,000 population respectively), compared to females (65 per 100,000 population and 97 per 100,000 population) in the CESPHN region.(11)

Similarly, the number of other vaccine-preventable PPHs were higher among males (620 and 1,160 respectively) when compared to females (526 and 832 respectively) in the CESPHN region.(11) [3]

[3] For more information regarding child and adolescent immunisation rates, please refer to the Antenatal and Child Health report.

Table 9: Vaccine-preventable PPHs per 100,000 population and number of hospitalisations, by region, 2022-23

Region	Pneumonia and influenza		Other vaccine-preventable conditions	
	ASR	No. of hospitalisations	ASR	No. of hospitalisations
CESPHN	**72**	**1,146**	**117**	**1,992**
Females	65	526	97	832
Males	81	620	141	1,160
National	**109**	**30,132**	**88**	**25,522**
Females	110	15,341	80	11,487
Males	109	14,787	98	14,031

Source: AIHW 2025

Carers

Nationally, an estimated 11.9% of the population are carers; with 4.5% identifying as a primary carer. Just over half of all carers are employed (54.4%), with one-third in full-time employment (33.9%). (12) More than half (58.4%) of all carers are home owners (with or without a mortgage); and more than one-quarter (26.4%) have a bachelor degree or above, with a further almost one-third (30.7%) with a certificate 3 or 4 or advanced diploma/diploma. Over one-quarter of all carers (27.9%) main source of personal income is from government pension or allowance, with almost half (46.4%) main source of personal income coming from employee income.(12)

Almost two-thirds of all primary carers (64.7%) identified family responsibility as a reason for taking on a caring role; a higher proportion of primary carers who are a child to the main recipient of care identified this reason (81.9%). Almost half identified emotional obligation (47.4%) or felt they could provide better care (46.0%).(12)

Carers in Australia are diverse in employment, education, and income meaning identifying carers is difficult. As a population group, we need to be mindful of both the needs of the person seeking care and the needs of the carers providing care.

Lifestyle risk factors

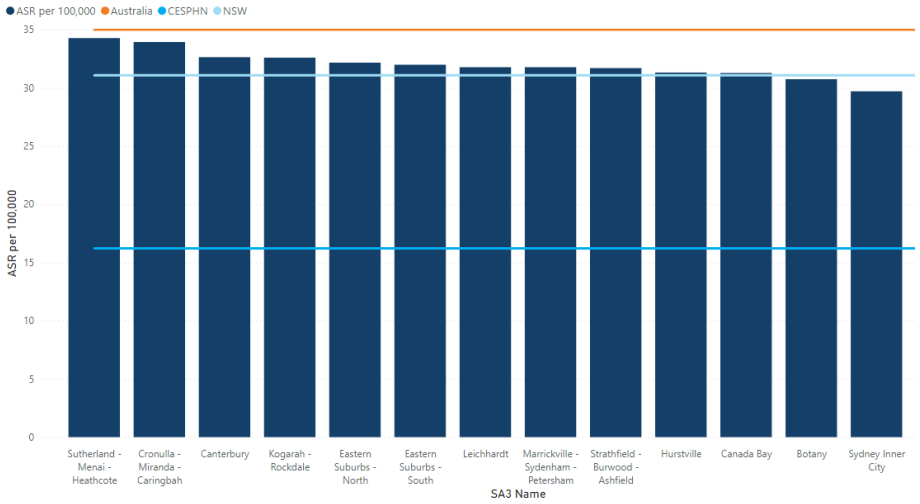
Overweight and obesity

Adults

2022 PHIDU modelled estimates demonstrate that the male population was more likely to be overweight (36.2 ASR per 100) compared to the female population (27.6 ASR per 100), while obesity rates were similar in both genders.(2)

Two SA3s had rates above the state (33.6 ASR per 100) rate – Sutherland-Menai-Heathcote SA3 (34.3 ASR per 100) and Cronulla-Miranda-Caringbah SA3 (33.9 ASR per 100).(2) Sutherland – Menai – Heathcote was the only SA3 in the CESPHN region with a rate higher than the national rate (34 ASR per 100).

Figure 5: Rate of people aged 18 years and over who were overweight (ASR per 100) by SA3, 2022



Source: PHIDU 2025

Note: No published data available for Lord Howe Island SA3.

Obesity rates in CESPHN SA3s were all below the state (31.2 per 100 population) and national (32.7 per 100 population) rates. Sutherland – Menai – Heathcote SA3 had the highest rate (28.8 per 100 population), followed closely by Cronulla – Miranda – Caringbah SA3 (28.3 per 100 population).(2)

Children

In 2022, the estimated rate of children (2-17 years) in the CESPHN region considered overweight was 16.9%, which was similar to the state (17.8%) and national rate (17.9%). Overweight rates were similar across SA3s. However, rates for obese children in CESPHN (5.6%) was much lower than state (7.7%) and national rates (7.9%). Canterbury SA3 (7.1%) had the highest rate of obese children.(2)

Healthy behaviours

Adults

Overall, the CESPHN population practices healthier behaviours compared to the rest of the state and country. SA3s with the highest and lowest percentages (respectively) for the following behaviours were:

- Adequate fruit intake – Canada Bay SA3 (49.6%) and Botany SA3 (44.6%)
- Current smokers – Canterbury SA3 (13.9%) and Eastern Suburbs - North SA3 (7.3%).
- Low, very low or no exercise in past week – Canterbury SA3 (80.3%) and Eastern Suburbs - North SA3 (59.3%).
- More than two standard alcoholic drinks per day **–** Cronulla – Miranda – Caringbah SA3 (25.3%) and Canterbury SA3 (9.9%).(2)

Table 10: Health behaviour rates of people aged 18 years and over by SA3 (ASR per 100), 2022

SA3	Adequate fruit intake	Current smokers	Low, very low or no exercise	More than two alcoholic drinks per day
Botany	44.6	13.0	74.4	16.9
Canada Bay	49.6	8.4	71.3	16.5
Canterbury	44.9	13.9	80.3	9.9
Cronulla - Miranda - Caringbah	48.6	9.9	69.6	25.3
Eastern Suburbs - North	49.1	7.3	59.3	23.6
Eastern Suburbs - South	46.0	9.9	66.8	20.9
Hurstville	46.2	11.2	78.0	10.2
Kogarah - Rockdale	46.3	12.2	78.8	11.4
Leichhardt	48.3	7.5	67.3	24.6
Marrickville - Sydenham - Petersham	46.5	11.1	69.7	22.6
Strathfield - Burwood - Ashfield	45.4	10.5	75.7	12.4
Sutherland - Menai - Heathcote	47.1	8.5	74.3	22.5
Sydney Inner City	44.9	11.9	67.6	22.1
CESPHN	**46.6**	**9.1**	**72.2**	**17.9**
NSW	**44.7**	**11.6**	**76.7**	**17.9**
Australia	**44.29**	**12.2**	**76.9**	**19.7**

Source: PHIDU 2025

Note: There is no published data available for Lord Howe Island SA3.

Children

Only 23% of primary school children and 23% of secondary school adolescents met recommended daily physical activity in NSW. Girls were generally less active than boys. Cultural background appeared to be a factor affecting physical activity level. Primary school children from Middle Eastern or Asian cultural backgrounds and secondary school adolescents from Asian cultural backgrounds were the least active groups.(13)

Preventive health

Screening

In 2020-21, the CESPHN region was below NSW and national rates for bowel cancer screening. The same was seen for breast cancer screening in 2019-2020. Between 2018-2021, cervical screening participation in the CESPHN region was below both the NSW and national rates.(14)

Canterbury SA3 had the lowest bowel cancer screening rate (32.8%), Sydney Inner City SA3 the lowest breast screening rate (40.0%) and Canterbury and Kogarah – Rockdale SA3s the lowest cervical screening rate (both at 57.2%).(14)

Table 11: Percentage of bowel screening participation by SA3, 2020-21

SA3	Bowel (%)
Botany	34.9
Canada Bay	40.1
Canterbury	32.8
Cronulla – Miranda – Caringbah	42.8
Eastern Suburbs – North	33.7
Eastern Suburbs – South	36.9
Hurstville	38.6
Kogarah – Rockdale	35.4
Leichhardt	41.8
Marrickville – Sydenham – Petersham	37.5
Strathfield – Burwood – Ashfield	36.9
Sutherland – Menai – Heathcote	44.3
Sydney Inner City	33.6
CESPHN	**37.2**
NSW	**39.5**
National	**40.9**

Source: AIHW 2023

Note: There is no published data available for Lord Howe Island SA3.

Table 12: Percentage of breast screening participation by SA3, 2019-20

SA3	Breast (%)
Botany	n.p
Canada Bay	45.6
Canterbury	41.4
Cronulla – Miranda – Caringbah	50.0
Eastern Suburbs – North	40.7
Eastern Suburbs – South	50.4
Hurstville	45.8
Kogarah – Rockdale	45.3
Leichhardt	51.0
Marrickville – Sydenham – Petersham	46.1
Strathfield – Burwood – Ashfield	42.5
Sutherland – Menai – Heathcote	52.2
Sydney Inner City	40.0
CESPHN	**45.5**
NSW	**46.8**
National	**49.6**

Source: AIHW 2023

Note: There is no published data available for Lord Howe Island SA3 and Botany SA3.

Table 13: Percentage of cervical screening participation by SA3, 2018-21

SA3	Cervical (%)
Botany	59.7
Canada Bay	66.5
Canterbury	57.2
Cronulla – Miranda – Caringbah	66.1
Eastern Suburbs – North	77.3
Eastern Suburbs – South	70.0
Hurstville	60.6
Kogarah – Rockdale	57.2
Leichhardt	77.2
Marrickville – Sydenham – Petersham	66.9
Strathfield – Burwood – Ashfield	61.3
Sutherland – Menai – Heathcote	67.0
Sydney Inner City	62.0
CESPHN	**64.5**
NSW	**67.2**
National	**68.3**

Source: AIHW 2023

Note: There is no published data available for Lord Howe Island SA3.

There is variation in breast screening rates among Aboriginal people and culturally and linguistically diverse (CALD) women compared to all women rates in the CESPHN region. In 2023-24, CALD women had the lowest participation rate, followed by Aboriginal women and then all women.(15)

Table 14: Percentage of breast screening participation by population group, CESPHN region, 2023-24

Population group	Breast (%)
Aboriginal	43.0
Culturally and linguistically diverse (CALD)	40.3
All women	49.5

Source: Cancer Institute NSW 2025

Although there is no local level data, studies show that Aboriginal women are more likely to have significantly higher incidence and mortality rates of cervical cancer due to disparities in screening participation and later stage presentation.(16)

Sexual health

Sexually transmissible infections (STIs)

In 2025, the CESPHN region continued to have the highest rates of chlamydia, gonorrhoea, and infectious syphilis notifications in NSW. During this period, the region made up 34.7% of chlamydia, 50.3% of gonorrhoea and 44.2% of infectious syphilis NSW notifications.(17)

Table 15: Number of chlamydia, gonorrhoea, and syphilis notifications in the CESPHN region by LHD, 2025

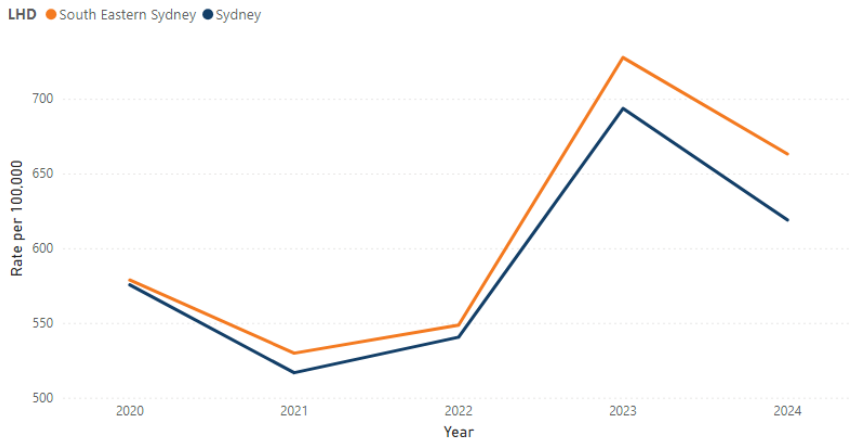
LHD	Chlamydia	Gonorrhoea	Syphilis
Sydney	2,993	2,362	429
South Eastern Sydney	4,437	3,127	439
NSW	21,419	10,904	1,964

Source: NSW Health 2025

Overall, between 2020-24, chlamydia notifications followed a similar pattern across the LHDs, peaking in 2023 in SESLHD (727.6 per 100,000 population) and SLHD (693.5 per 100,000 population), and then declining in 2024 (663.1 per 100,000 population and 618.9 per 100,000 population, respectively). This was equivalent to an 8.9% decrease in SESLHD and 10.8% decrease in SLHD.(18)

In NSW in 2024, chlamydia infections were highest among males (n=15,784, 54.2%), compared to females (n=13,240, 45.5%). Notification rates were highest among the 20-24 years age group (27.8%), followed by the 25-29 years age group (22.1%).(18)

Figure 6: Chlamydia notification rates per 100,000 people by LHD, 2020-24



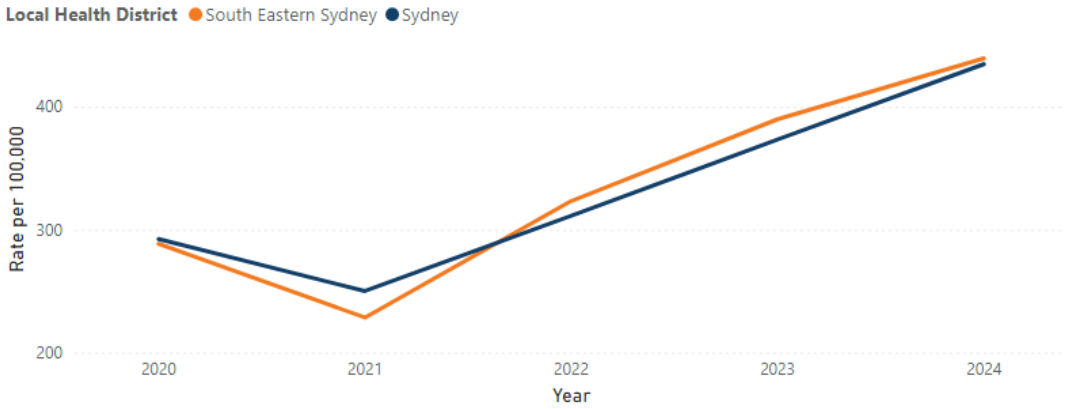
Source: NSW Health 2025

Despite a dip between 2020-21 (likely attributed to limited access to testing during the peak of the covid pandemic), gonorrhoea notification rates have continued to increase between 2021 and 2024 across both SESLHD and SLHD. During this period gonorrhoea infections have increased by 92.3% for SESLHD (from a rate of 228.5 per 100,000 population to 439.5) and 73.8% for SLHD (from a rate of 250.1 per 100,000 population to 434.8).(18)

In 2024, SESLHD and SLHD recorded the highest female notification rates in NSW. In comparison to 2023, the female rate in SESLHD and SLHD increased 20.2% and 30.0%, respectively (97.7 to 117.4 per 100,000 females and 88.2 to 114.7 per 100,000 females).(18)

In males, the highest gonorrhoea notification rates continued to be in SESLHD and SLHD with 762.2 and 759.3 notifications per 100,000 males. When compared to 2023, the male rate in SESLHD and SLHD increased 11.8% and 14.9%, respectively (681.7 to 762.2 per 100,000 males, and 660.6 to 759.3 per 100,000 males).(18)

Figure 7: Gonorrhoea notification rate per 100,000 people by LHD, 2020-24



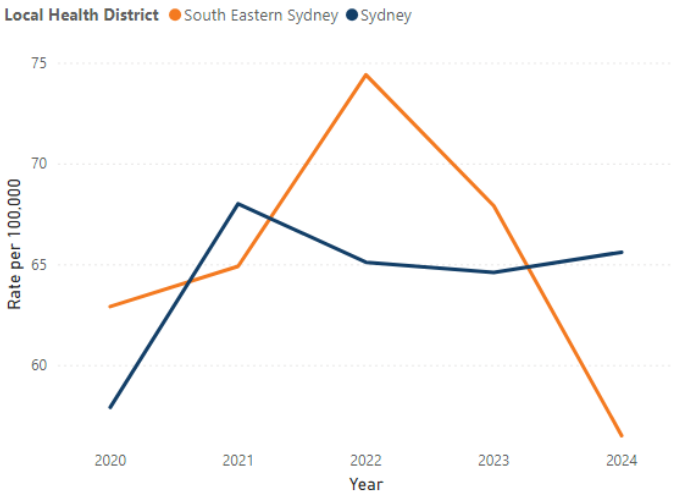
Source: NSW Health 2025

Infectious syphilis notifications fluctuated between 2020 and 2024 in both SESLHD and SLHD. In 2024, the highest infectious syphilis notification rates continued be to in SESLHD and SLHD (64.3 and 65.6 notifications per 100,000 population, respectively). From 2023, the rate increased 1.5% in SLHD (64.6 to 65.6 per 100,000 population) and decreased 16.8% in SESLHD (67.9 to 56.5 per 100,000 population).(18)

For males in NSW, the highest infectious syphilis rates continued to be in the SESLHD and SLHD with 109.4 and 127.8 notifications per 100,000 males. Continuing high notification rates among males in the SESLHD and SLHD reflect large concentrations of MSM in these areas.(18)

For females in 2024, infectious syphilis rates remained low in both SESLHD (4.3 per 100,000 females) and SLHD (4.6 per 100,000 females). Although the absolute number of infectious syphilis numbers among females is low, there has been a continued increase in the number of notifications in women of reproductive age (15–45 years) in NSW.(18)

Figure 8: Infectious syphilis notification rate per 100,000 people by LHD, 2020-24



Source: NSW Health 2025

HIV

In 2024, the number of newly diagnosed human immunodeficiency virus (HIV) cases (235) remained steady in comparison to 2023 new case data (232). Additionally, 20% of cases showed that infection occurred in the 12-months preceding diagnosis – a 3% increase in the past year.(19) Rates for newly diagnosed HIV notification in SESLHD and SLHD remained the highest in NSW, making up 39.6% of all notifications in the state.(19)

Of the 235 NSW cases, 69% occurred among men who have sex with men (MSM). In this group 42% were Australian born and 58% overseas born.(19) Overseas born, particularly MSM from a multicultural background, remain a priority population for prevention efforts as we continue to see higher proportions of late-stage infections at the time of diagnosis when compared to Australian-born MSM at the same time of diagnosis (17% versus 39% respectively). Declines in HIV notifications in inner Sydney, where approximately ≥20% gay-identified men live, were larger compared to those living in outer suburban areas.(19)

In 2024, non-s100 GPs remain the most common diagnosing doctor type for Australian born MSM (48%), while sexual health clinic doctors remain the most common for overseas-born MSM (44%). Overall, the number of HIV tests in publicly funded sexual health clinics decreased by 9.3% compared to the same period in 2023. It should be noted that testing rates continue to remain lower than pre-pandemic levels in 2019.(19)

The life expectancy of people living with HIV (PLHIV) has increased substantially in Australia since 1986, predominantly due to the availability of combination antiretroviral therapy.(20) Despite increased longevity, older PLHIV also experience an increased burden of non-communicable age-associated comorbidities.(20) This has created a need for a shift in focus for how the health sector addresses the health and health service needs of this ageing population.(21)

Hepatitis B

In 2023, the prevalence of hepatitis B (HB) in the CESPHN region was fourth highest (1.3%) in Australia. Nine SA3s had a HB prevalence rate above the national average (0.82%) with the highest rate being in Hurstville SA3 (2.0%).(22)

The highest absolute numbers of people living with HB are in Sydney Inner City SA3 (3,056), Strathfield Burwood-Ashfield SA3 (2,991) and Hurstville SA3 (2,825).(22)

The average proportion of people living with HB receiving recommended treatment in CESPHN is 14.9%, which is lower than other Sydney metro PHNs. Cohorts more likely to have hepatitis B are people from multicultural backgrounds, particularly those born in countries with moderate to high rates.(22)

Table 16: Prevalence of HB and percentage receiving care and treatment by SA3, CESPHN region, 2023

SA3	Prevalence (%)	Care uptake (%)	Treatment uptake (%)
Botany	1.4	18.6	9.5
Canada Bay	1.4	29.5	15.4
Canterbury	1.8	33.3	17.2
Cronulla – Miranda – Caringbah	0.6	21.2	10
Eastern Suburbs – North	0.7	19.3	10.3
Eastern Suburbs – South	0.9	20.8	11.3
Hurstville	2.0	42.2	23.7
Kogarah – Rockdale	1.6	29.2	16.2
Leichardt	0.6	22.9	11.2
Marrickville – Sydenham – Petersham	1.1	32.6	17.7
Strathfield – Burwood – Ashfield	1.8	32.4	15.6
Sutherland – Menai – Heathcote	0.6	21.2	11.8
Sydney Inner City	1.3	20.9	9.4
CESPHN	**1.3**	**28.7**	**14.9**

Source: ASHM 2025

Note: No published data available for Lord Howe Island SA3.

Hepatitis C

Note: The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) no longer publishes prevalence (%), care uptake (%) and treatment uptake (%) data for hepatitis c at the PHN or SA3 level via the Viral Hepatitis Mapping Project national report. Therefore, we are unable to provide an updated prevalence for hepatitis C in our region. However, the report does include treatment uptake ratios relative to the national average, which has been included below.

In 2022-23, Sydney Inner City SA3 had the highest hepatitis C notification rate per 100,000 population (52.4), followed by Eastern Suburbs – South SA3 (27.0), and Marrickville – Sydenham – Petersham SA3 (25.8).(23)

Table 17: Age-standardised Hepatitis C notification rate per 100,000 population by SA3, CESPHN region, 2022-23

SA3	Notification rate per 100,000 population
Botany	21.8
Canada Bay	10.2
Canterbury	17.3
Cronulla – Miranda – Caringbah	11.8
Eastern Suburbs – North	12.3
Eastern Suburbs – South	27.0
Hurstville	14.0
Kogarah – Rockdale	16.8
Leichardt	19.7
Marrickville – Sydenham – Petersham	25.9
Strathfield – Burwood – Ashfield	17.5
Sutherland – Menai – Heathcote	10.8
Sydney Inner City	52.4
CESPHN	**19.8**

Source: UNSW Kirby Institute, 2025

Note: No published data available for Lord Howe Island SA3.

Estimations show that of all the PHNs, CESPHN had the third lowest levels of treatment uptake (-22.4%, relative to the national average of 50%).(23) From 2016-24, the monthly average number of people who have been treated for hepatitis C in the CESPHN region has declined over this period from 255 to 20 people per month.(23) Treatment of hepatitis C is crucial for the prevention of liver cancer.

While people with a history of injecting drug use continue to be a priority population, migrants from countries and regions with a high prevalence of hepatitis C (Egypt, Pakistan, the Mediterranean and Eastern Europe, Africa, and Southern Asia) represent a priority population with low uptake of hepatitis C treatment.(23)

Mpox

Since being introduced to Australia in 2022, there has been a global increase in mpox cases. NSW experienced a large mpox outbreak in 2024. Sexually active people are still at risk of mpox both in NSW and overseas, particularly men who have sex with men, sex workers, and sexual partners of both groups.(24)

In NSW, there have been 65 notifications of mpox in NSW from January 2025 – October 2025. Most cases were likely to have been acquired while in NSW, 13 (20%) in another state or territory, and 10 (15%) while overseas.(24)

During this same period, the most cases of mpox in NSW have been in people aged between 25 – 39 years (n=14, 21.5%) and reported by males (n=59, 91%) and male to male sexual exposure (n=45, 69%).(24)

Most cases were reported in metropolitan Sydney (n=50, 77%). More specific to the CESPHN region, 23 cases were reported in SESLHD (35.4%), and 17 cases were reported in SLHD (26.2%).(24)

Management and treatment

Antimicrobial resistance

Antimicrobial resistance (AMR) is an emerging and urgent issue to address for STIs. For gonorrhoea, there is only one available effective antibiotic for which resistance is rising and there are no other suitable antibiotics.(25) On June 13, 2024, NSW Health notified GPs of rapid increases in drug resistance to azithromycin and ceftriaxone within the jurisdiction.(18)

Of the 17 notifications of AMR gonorrhoea of concern in NSW almost all were from metropolitan Sydney (n=16) while ten cases (58%) were in men who had sex with men. Bisexual males were affected in two cases.(18)

Multi-drug-resistant gonorrhoea is increasing in some countries, particularly Southeast Asian countries. Given that the CESPHN region is a hub for workers, travellers and overseas students, the communicable nature of STIs warrants activities that target non-CESPHN residents.(26)

S100 prescribing for HIV

As at 6 November 2025, ASHM Health advised that there are 63 current HIV s100 prescriber GPs within the CESPHN region. Of all the GP HIV s100 prescribers in NSW, 58.9% are reported to be practicing in the CESPHN region.

International students

Stakeholders and providers have observed an increase in sexual health and reproductive health issues among international students, particularly STI and HIV notifications and unplanned pregnancies. There is anecdotal evidence of a rise in STI and HIV notifications in MSM from south-east Asian and Asian backgrounds. Young female international students are identified as a vulnerable demographic due to a lack of reporting of sexual assault and lack of knowledge on contraception.(27)

Access to sexual and reproductive health services may be limited by lack of knowledge of the Australian health care system, Medicare ineligibility and their private health care cover, and limited understanding and knowledge of sexual health. These may also be exacerbated by a lack of social support, language barriers and cultural stigma.(27)

Opportunities

- Improving uptake of cancer screening programs for breast, bowel and cervical cancer, particularly for breast cancer screening among Aboriginal and CALD women.
- Working with general practice to implement the national lung cancer screening program, through education, promotion and targeted quality improvement activities to identify people who will benefit most from screening.
- Providing education opportunities and further support to build GP confidence in diagnosing, testing and treatment of STIs.
- Increasing uptake of care and treatment for hepatitis B and C in areas where notification rates are highest.
- Increasing GP knowledge of antimicrobial resistance in treatment of gonorrhoea.
- Promoting vaccination to increase protection against Mpox among priority populations.
- Improving accessibility of sexual health services to priority population groups (e.g., MSM, multicultural communities and international students).

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Mental Health

2025-2027 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples or people that identify as from the First Nations community. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

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Overview

The World Health Organisation defines mental health as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is integral to our well-being. At any one time, a diverse set of individual, family, community and structural factors may combine to protect or undermine mental health. Although most people are resilient, people who are exposed to adverse circumstances – including poverty, violence, disability and inequality – are at higher risk of developing a mental health condition (1).

The term mental illness describes conditions diagnosed by a medical professional that significantly affect how a person thinks, feels and interacts with other people. Mental health problems or concerns can also interfere with a person's cognitive, emotional or social abilities; however, the severity of their impact does not meet thresholds for a mental illness or mental health disorder.

In the context of primary health care, an individual's mental health care pathway is founded upon a stepped care approach. Stepped care aims to match a person presenting to the health system with the least intensive level of care that most suits their current treatment need, with the ability to monitor treatment experiences and outcomes to enable a step up or down in treatment intensity as necessary.

To identify the most appropriate level of care, the Initial Assessment and Referral Decision Support Tool (IAR-DST), an evidence-informed tool, has been implemented by PHNs since 2022 to support the initial assessment and referral of individuals presenting with mental health concerns in primary health care settings (2). The IAR-DST is rated across 8 domains including symptom severity and distress, risk of harm, functioning, impact of co-existing conditions, service use and response history, social and environmental stressors, family and other supports, and engagement and motivation. A level of care, between 1 to 5, is recommend based on the ratings entered by the referrer into the IAR-DST after a comprehensive mental health assessment.

The five levels of care in the IAR are defined to sit across the spectrum of mental health concerns:

1. **IAR Level 1: Self-management.** Evidence based digital interventions and other forms of self-help.
2. **IAR Level 2: Low intensity services.** Services that can be accessed quickly & easily and include group work, phone & online interventions and involve few or short sessions.
3. **IAR Level 3: Moderate intensity services**. Moderate intensity, structured and reasonably frequent interventions (e.g., psychological interventions)
4. **IAR Level 4: High intensity services.** Periods of intensive intervention, typically, multidisciplinary support, psychological interventions, psychiatric interventions, and care coordination.
5. **IAR Level 5: Specialist and Acute Community Mental Health Services.** Specialist assessment and intensive interventions (typically, state/territory mental health services) with involvement from a range of mental health professionals (1, 3).

Key needs

- 71% of GPs report psychological issues in their top 3 reasons for presentation
- There is an increase in severity of mental health related issues
- Self-reported prevalence of a mental health condition varies across the region from 11.7% in Marrickville-Sydenham-Petersham SA3 to 5.0% in Hurstville SA3
- There are a number of vulnerable population groups who experience a higher prevalence of mental health concerns, including:
    - Aboriginal people
    - Children and young people
    - LGBTIQ+ peoples
    - Multicultural communities
    - Older people
    - Veterans
    - People experiencing social isolation
    - People engaging in harmful levels of gambling
- In 2022-23 there were 109 mental health related emergency department presentations per 10,000 population and 199.4 admitted mental health-related hospitalisations per 10,000 population.

Key gaps

- Access to child mental health services (including a multidisciplinary approach)
- Access to Psychiatrists across all speciality areas including Children, older people, ADHD and autism
- Availability of psychological therapies for people experiencing severe and complex mental illness
- Affordable access to services for eating disorders
- Availability of longer-term therapy for Eye movement desensitisation and reprocessing (EMDR) therapy and dialectical behavioural therapy (DBT)
- Therapy for children who have experienced Domestic and Family Violence and people have left a relationship that experienced Domestic and Family Violence
- Access to therapy in language.

Prevalence of mental health issues

Mental health in adults

The 2021 Census reported the number of people with selected long-term health conditions across the CESPHN region. A total of 102,526 people responded that they had a mental health condition (including depression or anxiety). This accounted for 6.6% of the CESPHN population and 5.9% of long-term health condition responses; the highest proportion for specific, identified long-term health conditions.

Within the CESPHN region, Marrickville-Sydenham-Petersham SA3 had the highest proportion of the population respond in the Census that they had a mental health condition (11.7%), followed by Leichhardt SA3 (8.9%) and Sydney Inner City SA3 (8.7%) (4).

Table 1: Number and proportion of population with mental health condition by SA3, CESPHN region, 2021

SA3	People with mental health condition	Proportion of people in SA3 with mental health condition
Botany	3,313	5.6%
Canada Bay	4,689	5.4%
Canterbury	6,683	4.7%
Cronulla-Miranda-Caringbah	7,684	6.5%
Eastern Suburbs – North	7,298	5.7%
Eastern Suburbs – South	8,694	6.5%
Hurstville	6,614	5.0%
Kogarah-Rockdale	7,505	5.1%
Leichhardt	5,029	8.9%
Lord Howe Island	10	2.2%
Marrickville-Sydenham-Petersham	6,427	11.7%
Strathfield-Burwood-Ashfield	10,914	6.8%
Sutherland-Menai-Heathcote	8,667	7.8%
Sydney Inner City	18,999	8.7%
CESPHN	102,526	6.6%

Source: ABS, 2022

Psychological distress

Psychological distress is an indication of mental health and wellbeing based on self-reported levels of fatigue, depression, nervousness, and anxiety. Whilst a person with high levels of psychological distress may not necessarily be diagnosed with a mental illness, it may have a negative impact on a person's wellbeing. In 2024, the rate of people experiencing high or very high psychological distress in the CESPHN region was 18.2%, which is below the NSW rate of 19.1% (5).

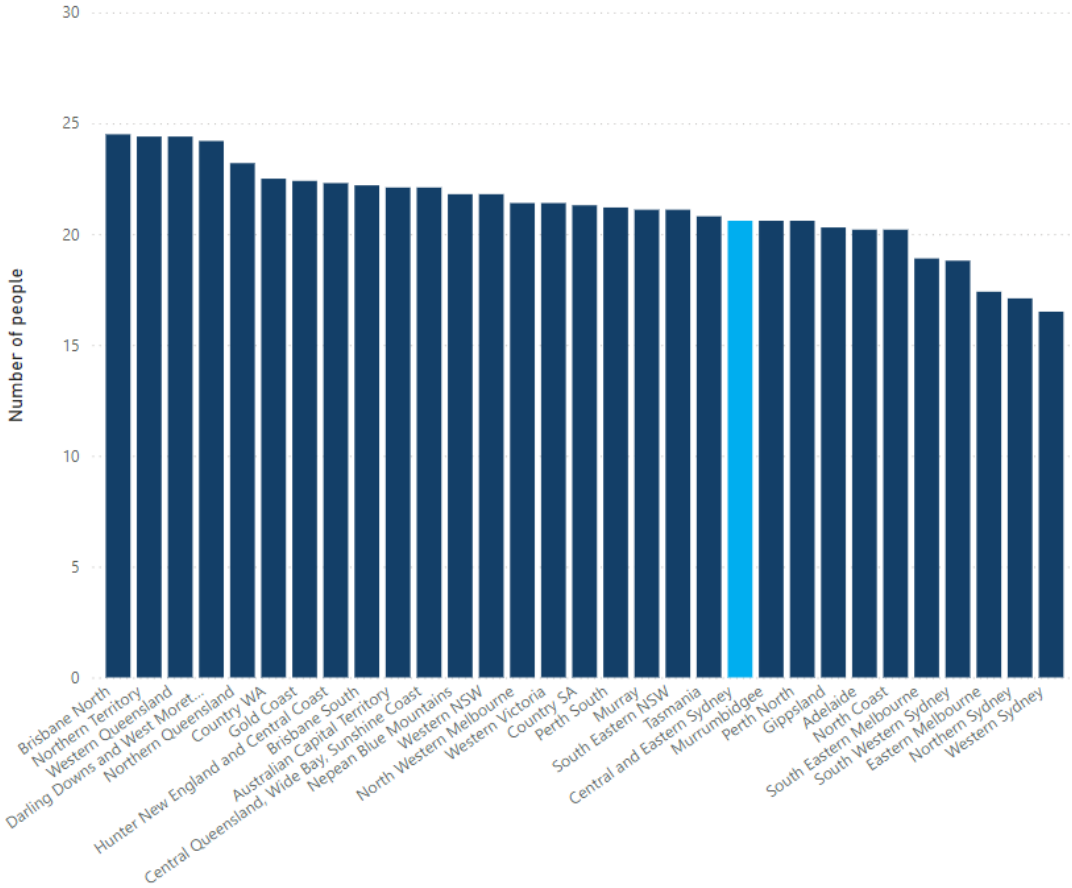
Mental health by condition

In 2024, the ABS released PHN level data from the National Study of Mental Health and Wellbeing report which measures the prevalence of mental health disorders among Australians aged 16-85 years old. The analysis of data at a PHN level used for this needs assessment has been derived using modelled estimates for people who have had symptoms of a disorder in the 12 months prior to completing the survey.

Any mental disorder

The modelled estimates show that 20.6% of the CESPHN population have been diagnosed or had symptoms of a mental disorder in the last 12 months. This is above the New South Wales rate of 19.8% but below the national rate of 21.5% (6).

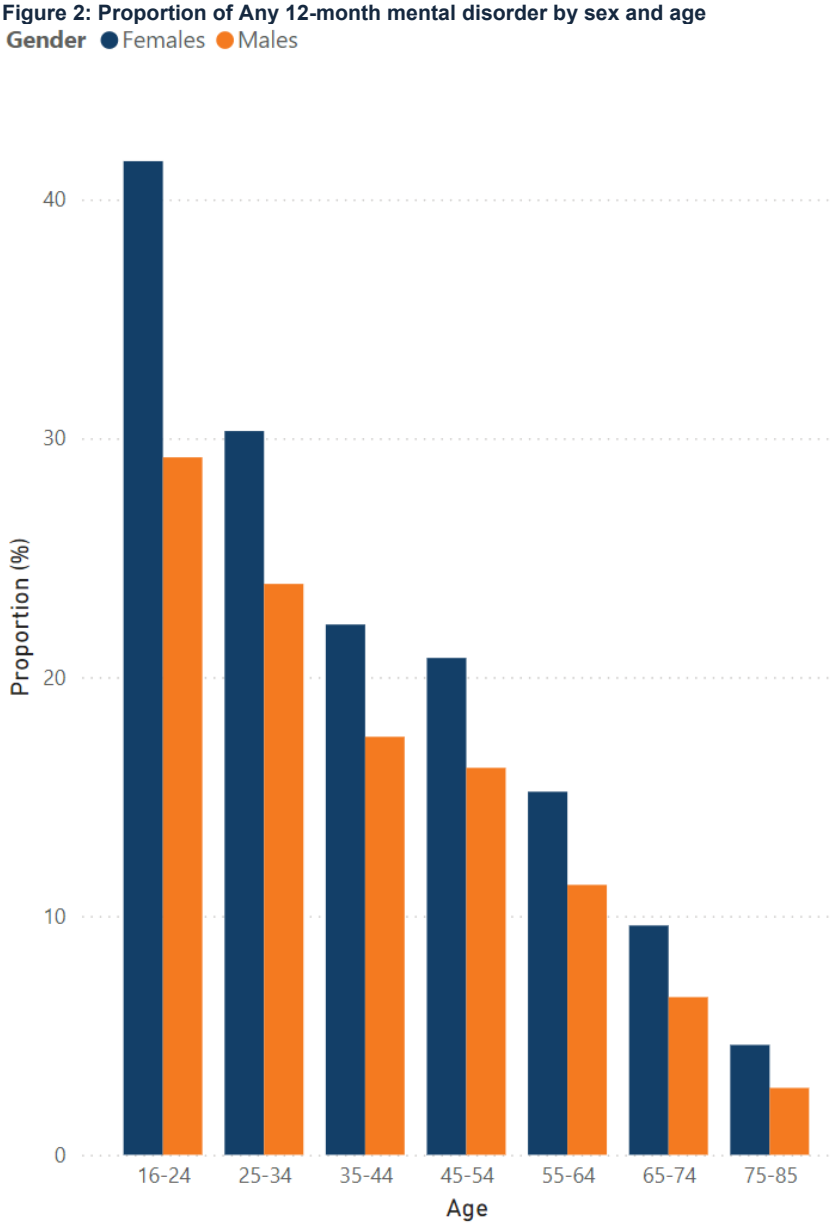
Figure 1: Proportion of any 12-month mental disorder by PHN, 2020-22



Source: ABS, 2024

Looking at the CESPHN population, prevalence is highest in the youngest age group, with 41.6% of females and 29.2% of males aged 16 – 24 years having a mental disorder. Prevalence progressively decreases across age ranges, to the oldest age group of 75-86 years where 4.6% of females and 2.8% of males have a mental health condition. Females have a higher prevalence across all age groups (6).

Figure 2: Proportion of Any 12-month mental disorder by sex and age

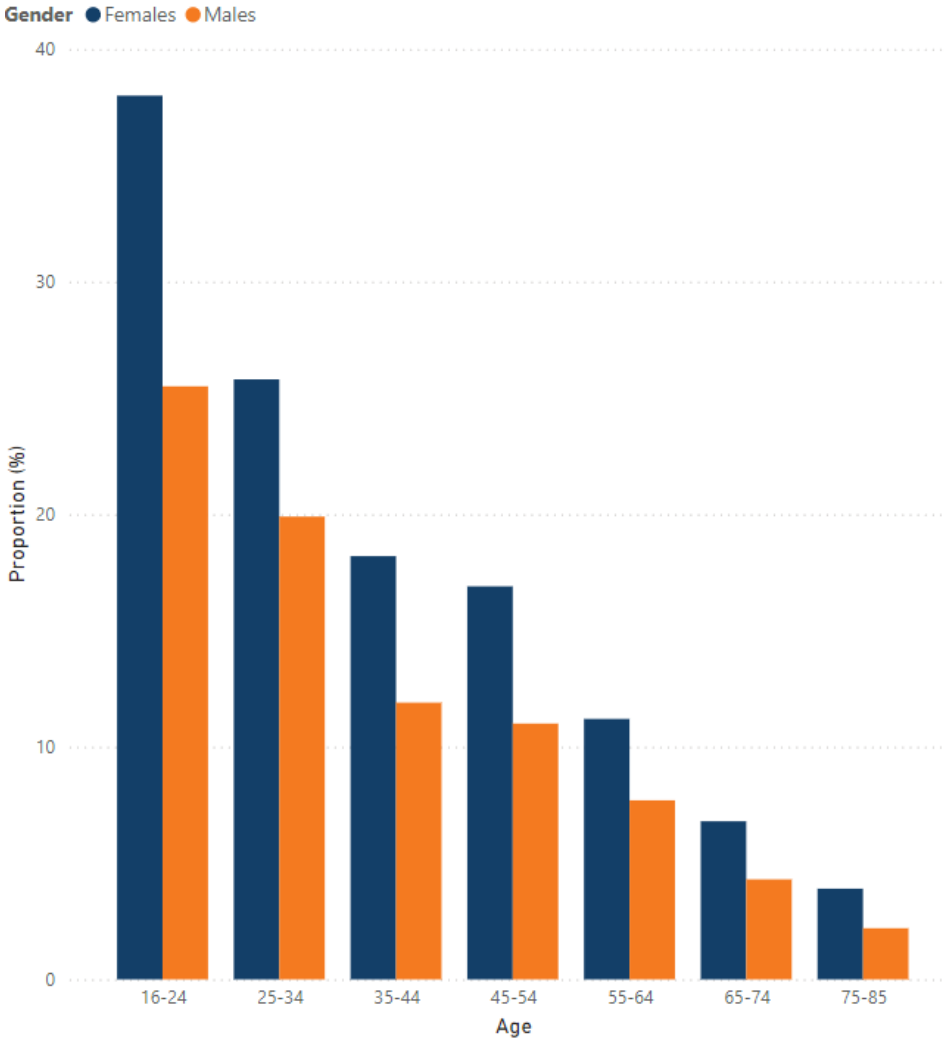


Source: ABS, 2024

Anxiety disorder

Anxiety disorders can include but are not limited to panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, and post-traumatic disorder. Consistent with any mental disorder, anxiety disorder is more prevalent in younger age groups where 38.0% of females 25.5% of males aged 16-24 years report having had an anxiety disorder in the last 12 months, with only 3.9% of females and 2.2% of males aged 75-85 years old having had an anxiety disorder. Across all age groups females have a higher prevalence of an anxiety disorder (7).

Figure 3: Proportion of 12-month anxiety disorders by age and sex

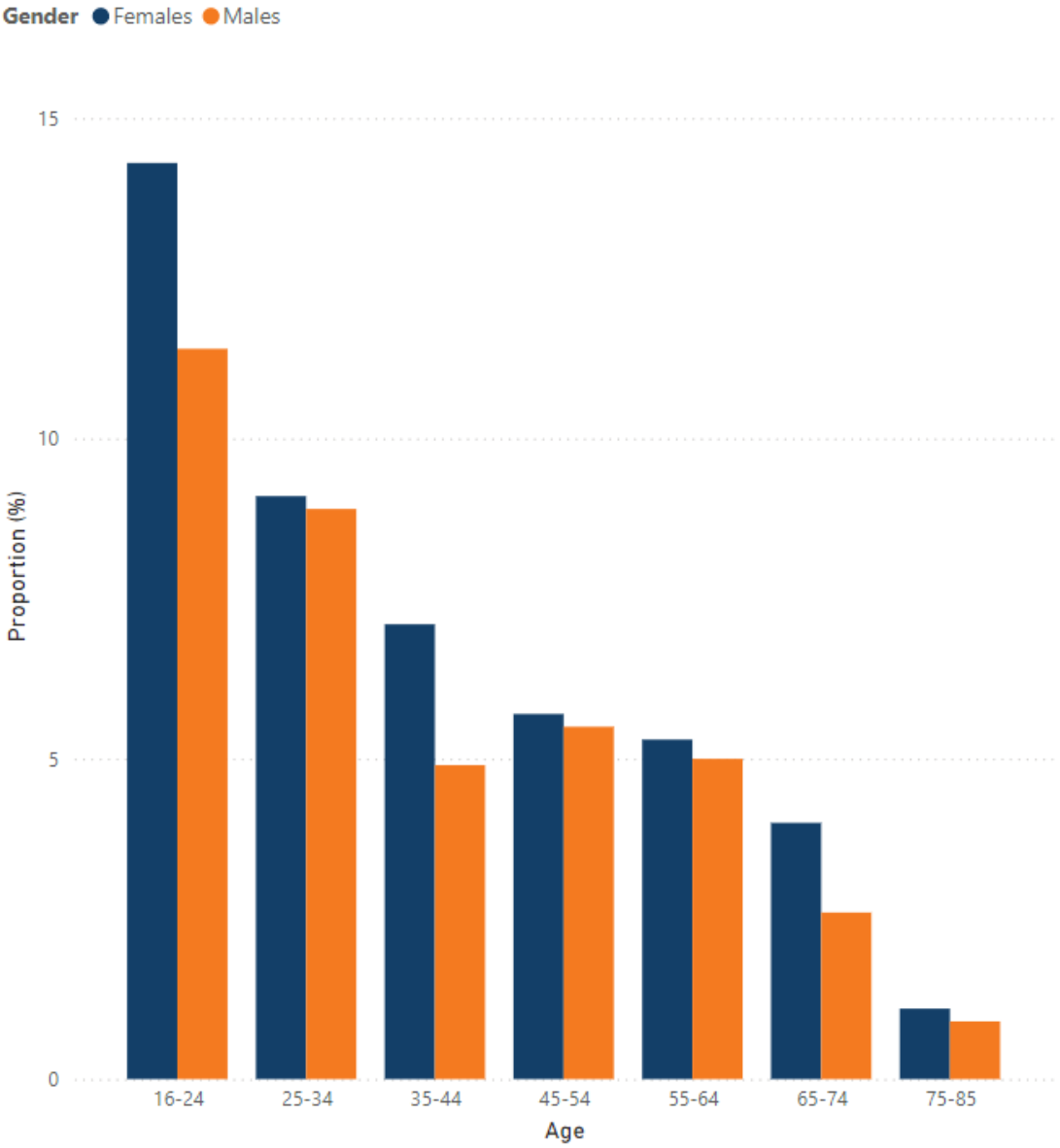


Source: ABS, 2024

Affective mood disorders

Affective mood disorders can include Depressive episodes, dysthymia and bipolar affective disorder. Affective mood disorders are also more prevalent in younger age groups where 14.3% of females and 11.4 % of males aged 16-24 years in the CESPHN region have had an affective mood disorder in the last 12 months, with only 1.1% of females and 0.9% of males aged 75-85 reporting the same(7).

Figure 4: Proportion of 12-month affective mood disorders by age and sex



Source: ABS, 2024

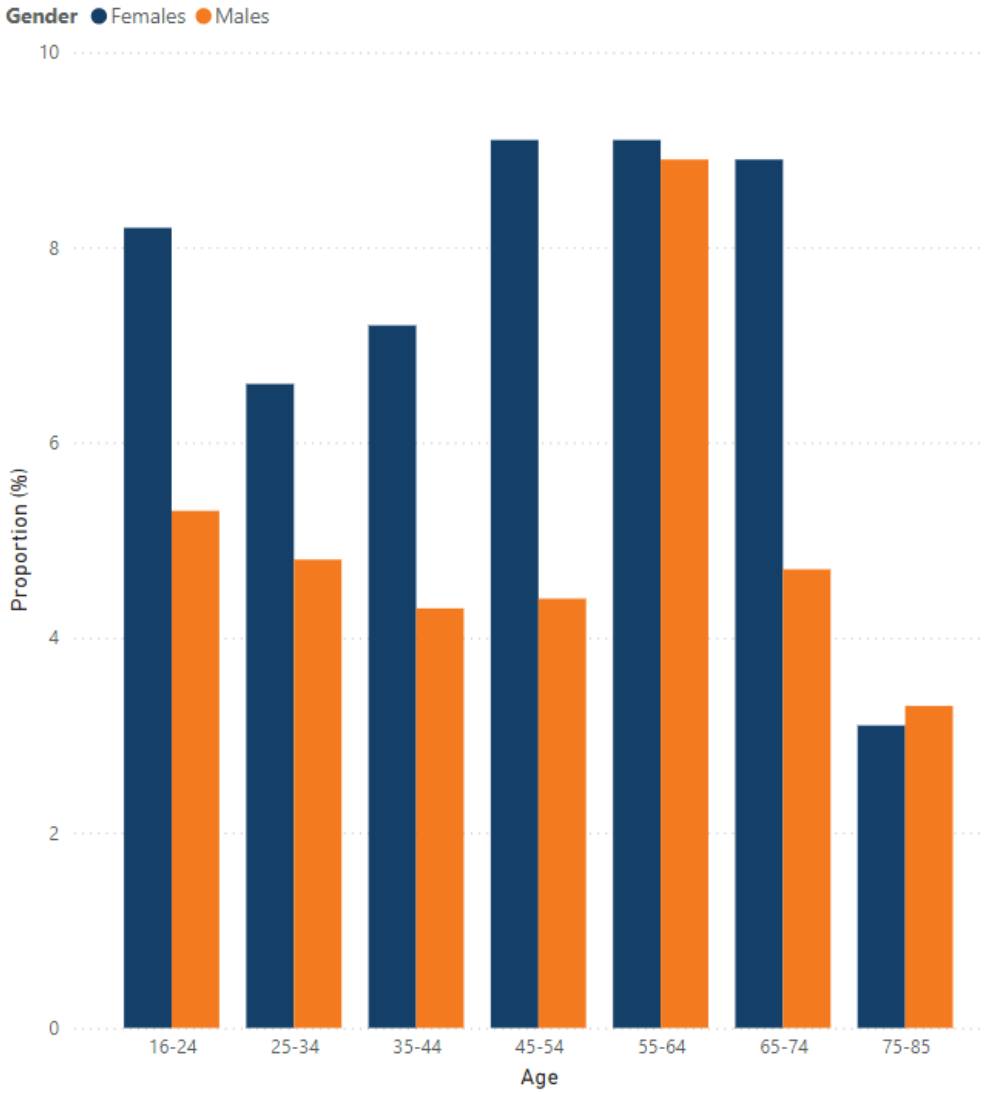
Comorbidity of mental disorders and physical health conditions

Comorbidity is the co-occurrence of more than one disease and/or disorder in an individual. A person with co-occurring diseases or disorders is likely to experience more severe and chronic medical, social and emotional problems than if they had a single disease or disorder.(8)

Within the CESPHN region, 6.4% of the population have a comorbidity of a mental disorder and a physical condition. This is lower than the NSW and Australian rates of 7.5% and 8.4% respectively. Across females, the 45-54 and 55-64 age groups have the highest rate with 9.1% of people in both age groups having a comorbidity of a mental disorder and a physical condition. Among males those aged 55-64 have the highest rate with 8.9% of this age group experiencing comorbidity of a mental disorder and a physical condition.

For the analysis, the measure of having physical conditions has only been included where a person reported having been told by a doctor or nurse that they currently had the long-term physical health condition, which had lasted, or was expected to last, for 6 months or more. The physical conditions for the analysis are arthritis, osteoporosis, asthma, cancer (including remission), dementia, diabetes (excluding during pregnancy), heart disease, effects of a stroke, chronic kidney disease, and bronchitis or emphysema (7).

Figure 5: Proportion of co-morbidity and mental health disorders by age and sex



Source: ABS, 2024

Mental health in children and young people

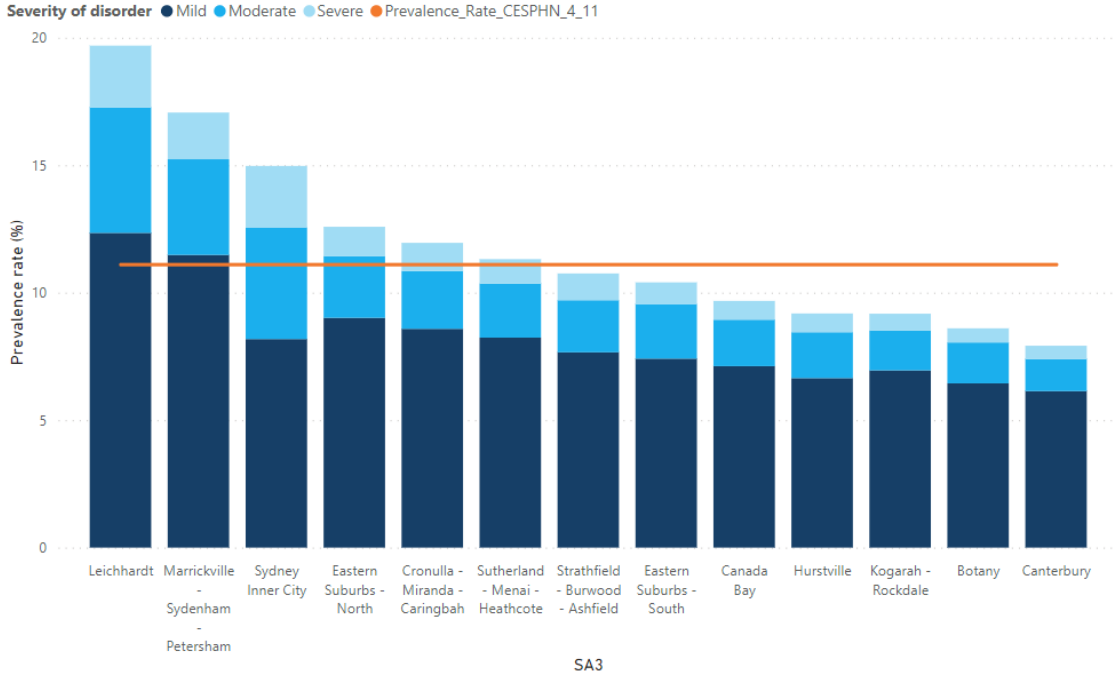
Mental illnesses have a peak age of onset at 15 years, with 63–75% of onsets occurring by 25 years (9). This is also whilst an individual is going through a period of profound biological (hormonal and neural), psychological, and social change. Being able to identify and treat young people within the 12-25 years age range can have a profound effect on the rest of their lives.

The synthetic prevalence estimates of mental health issues among 4-17 year-olds in the CESPHN region is 11.7%, which is lower than the national rate (14.9%) across all severity levels.(8)

However, there are SA3 areas where the prevalence estimates are higher:

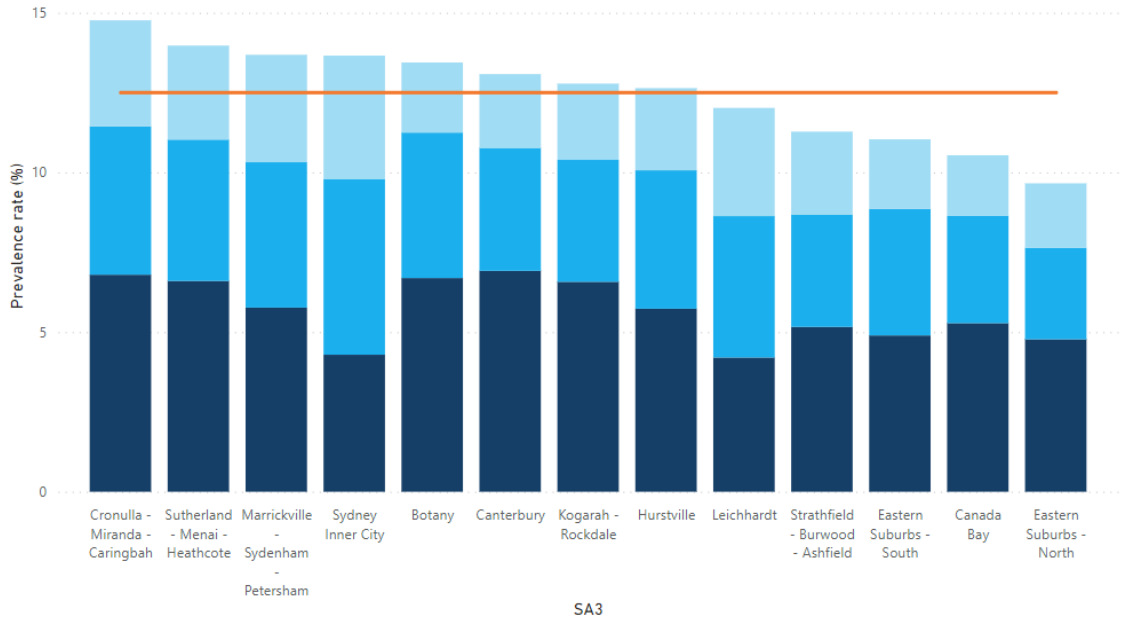
- For children aged 4-11 years old with any disorder:
  - Leichhardt (19.6%), Marrickville–Sydenham–Petersham (17.7%), Sydney Inner City (15.0%), Eastern Suburbs–North (12.6%), Cronulla–Miranda–Caringbah (12.0%), and Sutherland-Menai-Heathcote (11.3%) SA3 had higher prevalence estimates than the CESPHN rate (11.1%)
- For young people 12-17 years old with any disorder:
  - Cronulla-Miranda-Caringbah (14.8%), Sutherland-Menai-Heathcote (13.9%), Marrickville–Sydenham–Petersham (13.7), Sydney Inner City (13.66), Botany (13.4), Canterbury (13.1), Kogarah-Rockdale (12.8%), and Hurstville (12.6%) had higher prevalence estimates than the CESPHN rate (12.5%)
- For children aged 4-11 years old with moderate mental health issues:
  - Leichhardt (4.9%), Sydney Inner City (4.4%), Marrickville-Sydenham-Petersham (3.8%), and Eastern Suburbs North (2.4%) had higher prevalence estimates than the CESPHN moderate mental health rate (2.3%)
- For children aged 12-17 years old with moderate mental health issues:
  - Sydney Inner City (5.5%), Cronulla-Miranda-Caringbah (4.6%), Botany (4.6%), Marrickville-Sydenham-Petersham (4.6%), Leichardt (4.4%), Sutherland-Menai-Heathcote (4.4%), and Hurstville (4.3%) had higher prevalence estimates than the CESPHN moderate mental health rate (4%)
- For children aged 4-11 years old with severe mental health issues:
  - Leichhardt (2.4%), Sydney Inner City (2.4%), Marrickville-Sydenham-Petersham (1.8%), Eastern Suburbs North (1.2%), Cronulla-Miranda-Caringbah (1.1%), and Strathfield-Burwood-Ashfield (1.05%) had higher prevalence estimates than the CESPHN severe mental health rate (1%)
- For children aged 12-17 years old with severe mental health issues:
  - Sydney Inner City (3.9%), Leichhardt (3.4%), Marrickville-Sydenham-Petersham (3.4%), Cronulla-Miranda-Caringbah (3.3%), and Sutherland-Menai-Heathcote (2.9%) had higher prevalence estimates than the CESPHN severe mental health rate (2.6%) (8)

Figure 6: Prevalence of mental health illness in children aged 4-11 years, by severity of disorder and SA3, 2021



Source: Young Minds Matter, 2023

Figure 7: Prevalence of mental health illness in young people aged 12-17 years, by severity of disorder and SA3, 2021



Source: Young Minds Matter, 2023

Children's mental health difficulties can present differently to adult mental health difficulties. Mental health vulnerabilities or difficulties in infants and children might include frequent or intense struggles with their emotions, thoughts, behaviours, learning or relationships. They might have trouble calming down, struggle to control their moods, find it challenging to be separated from a parent, or have problems sleeping, eating or engaging at school.

Aboriginal people

It is well documented that Aboriginal people have poorer mental health outcomes than non-Aboriginal people. A social and wellbeing approach that is sensitive to the unique needs and experiences of Aboriginal people can promote mental health in a way that is both culturally relevant and holistic. By acknowledging the impact of historical trauma, emphasising cultural connection, strengthening community bonds, and providing access to culturally appropriate services, this approach can lead to meaningful improvements in mental health and overall wellbeing and needs to be considered when service planning.

In the 2021 Census, 2,241 people aged 15 years and over who identified as being Aboriginal and/or Torres Strait Islander reported that they had a mental health condition (including anxiety or depression). This equates to 19.5% of the CESPHN Aboriginal population. Within the CESPHN region, Leichhardt IARE had the highest rate of mental health conditions among Aboriginal and/or Torres Strait Islander peoples aged 15 and over (25.2 per 100 people), followed by Sydney – City IARE (24.2 per 100 people) and Marrickville (22.4 per 100 people) (10). In contrast the CESPHN rate is 7.5 per 100 people in the population aged 15 years and over (4).

Mental health in multicultural communities

There are considerable gaps in data and information on the prevalence of mental illness in people from multicultural backgrounds and their experiences with the mental health system. Generally, people from multicultural backgrounds are at greater risk of developing a mental health condition and seek treatment later. They also tend to have a higher number of involuntary admissions.

Multicultural populations accessing mental health support are at times unaware of mental health services that could assist, meaning that significant opportunities for early intervention are absent. For newer migrant and refugee populations, the adjustment to a new country, separation from family and past traumas can lead to mental health conditions that, when finally assessed by a mental health professional, may appear complex and enduring due to the delay in early help-seeking.

With many newer refugees arriving having been exposed to conflict, there is a higher risk of suicidality and a strong need for services that can provide a culturally led and trauma-informed response.

This is discussed in further detail in the Health and Wellbeing of people from Multicultural Backgrounds chapter of the needs assessment.

LGBTQIA+ Community

The Lesbian, Gay, Bi-sexual, transgender and gender diverse, intersex, queer and asexual community (LGBTIQA+) is a diverse cohort a with range of different health and service needs. Whilst local mental health specific data for the region for LGBTIQA+ peoples is not available, national level research is available and is applicable to this region. Research has found that compared to non-LGBTIQA+ individuals, LGBTIQ+ individuals across virtually all societal contexts experience elevated rates of psychological distress, mood-related disorders such as depression, and anxiety, and demonstrate high rates of suicidal ideation and attempts (11). In a survey report which captures the data from six surveys across the population, established that in the LGBTIQ+ adults cohort, 57.2% (n=3,818) of respondents reported high or very high levels of psychological distress in the 10-item Kessler Psychological Distress Scale (K10). This proportion is four-times greater than the 13.0% reported among the general population in Australia (11). It is also important to recognise that within the LGBTIQ+ community there are mental health disparities between Sexually Diverse Populations, Trans and Gender Diverse Populations and Intersex population.

Research has also established that participation in LGBTIQ+ community or social events/activities may promote social protective effects against or reduce feelings of distress among trans and gender diverse individuals and contribute to improvements in their subjective sense of wellbeing (11).

This is discussed in further detail in the LGBTIQA+ chapter of the Needs Assessment.

Older people including those in aged care facilities

Mental distress and mental health conditions are common in later life.(12)The modelled estimates at a PHN level from the National Study of Mental Health and Wellbeing identified that 8.2% of the population aged 65-74 years of age and 3.8% of the population aged 75-85 years have been diagnosed with or experienced symptoms of a mental disorder in the last 12 months (7).

Some of the key issues that older Australians face that may impact their mental health include:

- Depression and anxiety triggered by factors such as loss of independence, bereavement and other chronic health conditions
- Social isolation and loneliness associated with either living alone or moving away from family
- Access to mental health services where barriers such as availability of services, lack of awareness or stigma may exist.
- Access to clinicians and support systems that have experience working with older people and may not be aware of the nuanced concerns and/or support needs of older people.

Veterans

The NSW Office for Veterans Affairs 2021 census data showed that there are 42,900 veterans living in the Sydney Metropolitan area, with 9,350 active Australian Defence Force (ADF) members (13). It is estimated that close to 40% of discharged members in NSW move to the Sydney area, and the CESPHN region hosts a number of military bases and facilities.

Psychosocial factors are considered one of the main risk factors in suicide ideation amongst veterans and serving members of the ADF. A 2022 report showed that rates of suicide are 27% higher amongst ex-serving males compared to currently serving members, and 107% higher amongst female veterans.

Transitional difficulties can centre around lack of civilian support systems, a perceived lack of purpose and a lack of social circles for veterans to move into upon discharge (14). The 2020-21 National Health Survey also showed that nearly 40% of veterans were living with a disability and faced several health risk factors, such as poor diet, smoking and lack of physical exercise(15).

People experiencing social isolation

Loneliness and isolation can be caused by several factors, including living alone, lack of community, economic reasons, retiring or a change in personal circumstances, or being a carer. Social isolation is universally understood to be a chronic health condition which negatively affects both physical and mental health, leading to physical symptoms such as headaches, tiredness and problems with sleeping, as well as negative mental health conditions including anxiety and depression (16).

Social isolation was identified as a key issue affecting residents of the Sydney region through CESPHN's consultation with stakeholders. Social isolation was a cause for concern amongst the priority groups identified in this Needs Assessment, such as the LGBTQI+ population, the multicultural community and the older-adults cohort.

The Voices of Solitude: Loneliness and Social Isolation Among Older Adults in NSW report (17) found that 60% of those surveyed were lonely, and 50% socially isolated. For older LGBTQI+ people this increased to 71%. This report also showed that carers, people living with a disability and First Nations residents often experienced the most severe impacts of loneliness.

Gambling harm

Gambling harm was also identified as a significant issue in the region. Australians have the largest per capita gambling losses per capita in the world, losing approximately $25 billion on legal forms of gambling each year.(18)

Gambling often co-occurs with other mental health disorders such as depression, anxiety, insomnia or drug and alcohol use and smoking. The impact of gambling harm can impact family, friends and community. These harms can include financial insecurity and loss of accommodation, employment disruption or loss, coercive control and domestic and family violence, relationship breakdowns, increased suicidality and criminal behaviour. Gambling harm has been associated with an increased risk of suicidality. Gambling harm disproportionally impacts Aboriginal communities, and the greatest number of electronic gaming devices (poker machines) are in the most disadvantaged communities.(18)

In 2023, people residing in the Central and Eastern Sydney region lost $5.5 million to electronic gaming machines.(19) In Quarter 4 of 2022, the Canterbury-Bankstown local government area recorded the highest losses of any other local government area in NSW with over $178 million.(20) Part of this LGA, the Canterbury SA3 is in the CESPHN region and it has the lowest Socio-Economic Indexes for Areas (SEIFA) values in the region at 914.

CESPHN recently commissioned a multicultural health navigator service. This program aims to provide in-language health navigation support to four multicultural communities, and as part of this support, the navigators will be trained to support people with gambling related issues access services. Navigators will also be attuned to supporting people experiencing social isolation and be able to link them with supports, services and groups in the community.

Other vulnerable groups

Additional groups who are at elevated risk and/or facing unique challenges are:

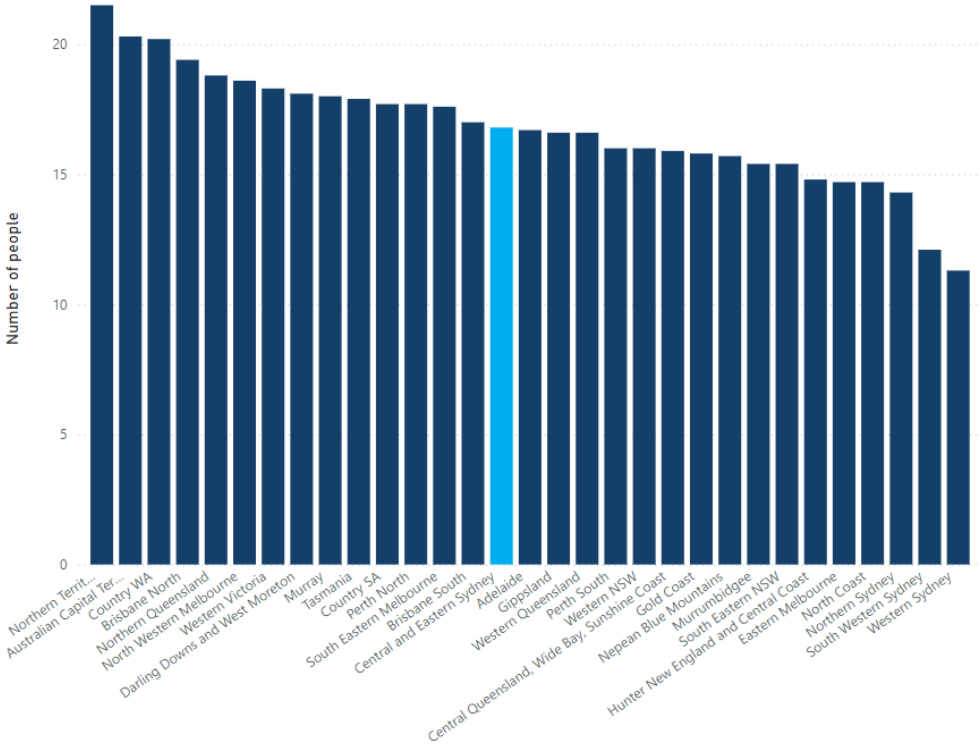
- Asylum seekers and refugees
- Parents experiencing perinatal mental health issues
- People who are homeless or at risk of homelessness
- People with an intellectual disability (discussed in disability chapter)
- People living in highly disadvantaged areas
- People with co-existing alcohol and other drug issues
- Family and carers of people experiencing mental illness
- Neurologically divergent people.

Access and utilisation of mental health service

For people experiencing mental health symptoms, a General Practitioner (GP) is often the first health professional they will disclose to. The 2025 RACGP's General Practice Health of the Nation report stated that 71% of GPs (up from 61% in 2017) have reported that psychological conditions are their patients top reasons for presentation (21).

As part of the national study of Mental Health and Wellbeing, the ABS have provided modelled estimates for individuals who accessed any health professional over a 12-month period. Within the CESPHN population we can expect 16.8% of the population to have accessed any health professional for their mental health. This is lower than the national rate of 17.4% (7).

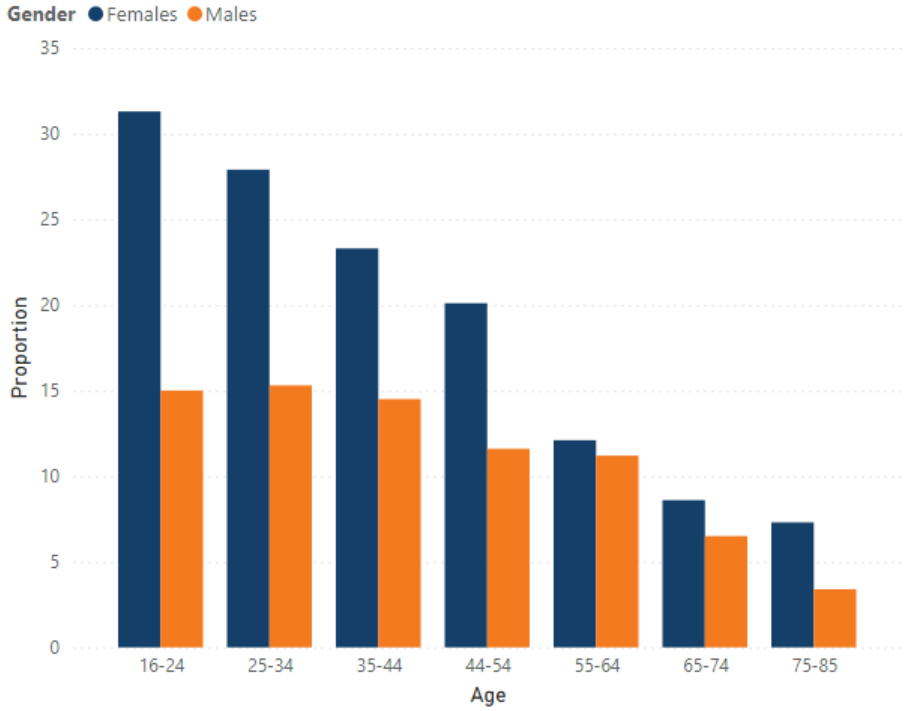
Figure 8: Use of mental health services by PHN 2020-2022



Source: ABS, 2024

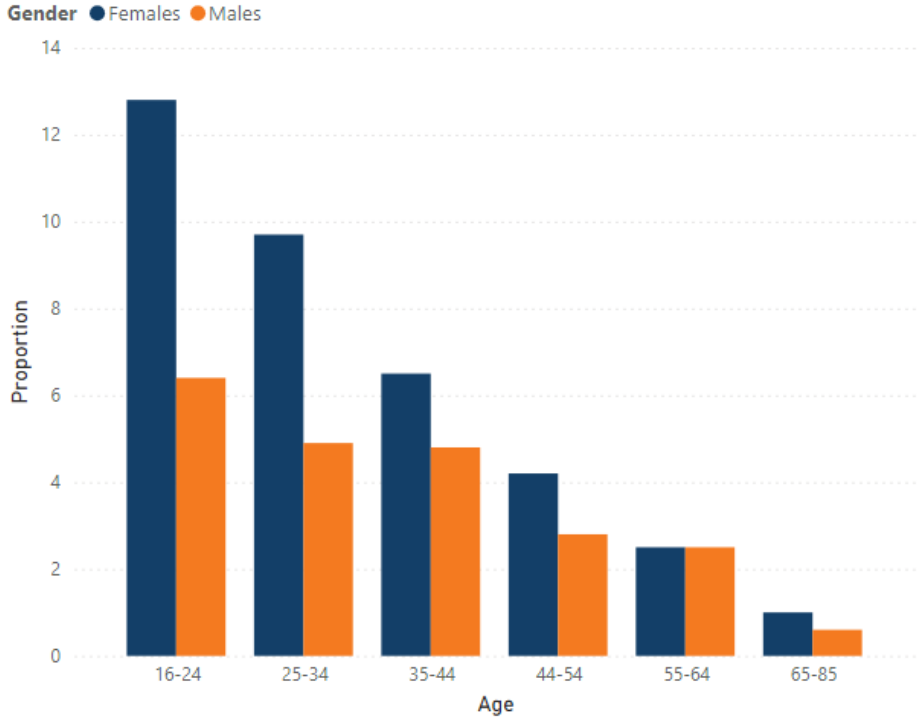
When looking at age and sex breakdowns of mental health related consultations, the rate of females accessing services is higher in every age group, and younger people are more likely to access health professionals for their mental health. The rate of people accessing health professionals is decreasing across every age grouping. The same trend is seen when accessing digital technologies, with young females the most likely to access digital technologies and males aged 65-85 least likely to access digital technologies. The use of digital technologies is defined as using a phone, internet or another digital technology to access services such as crisis support or counselling services, online treatment programs and tools to improve mental health, and mental health support groups and forums. However, internet based CBT programs such as This Way Up have been found to be acceptable to and effective with older adults. In fact, older adults have been shown to have higher completion rates of these programs which is related to a commensurate decrease in distress.(22)

Figure 9: Mental health related consultations, by sex and age 2020-2022



Source: ABS, 2024

Figure 10: Mental health access using digital technologies, by sex and age 2020-2022



Source: ABS, 2024

CESPHN commissioned services

Over the 12 months July 2024 to June 2025, the Primary Mental Health Care Minimum Data Set shows that approximately 7,700 individuals have accessed CESPHN commissioned mental health services (excluding headspace) and received 137,692 service contacts. This is on average 18 service contacts each across all levels of service intensity. Across all levels of care, 48.8% of clients demonstrated a significant improvement.(23)

When looking at access to services in the CESPHN primary care setting, mental health supports can be broken down into the following categories:

1. Young people accessing headspace services
2. Low intensity mental health services
3. Moderate intensity services
4. High intensity services
5. Psychosocial/Support services

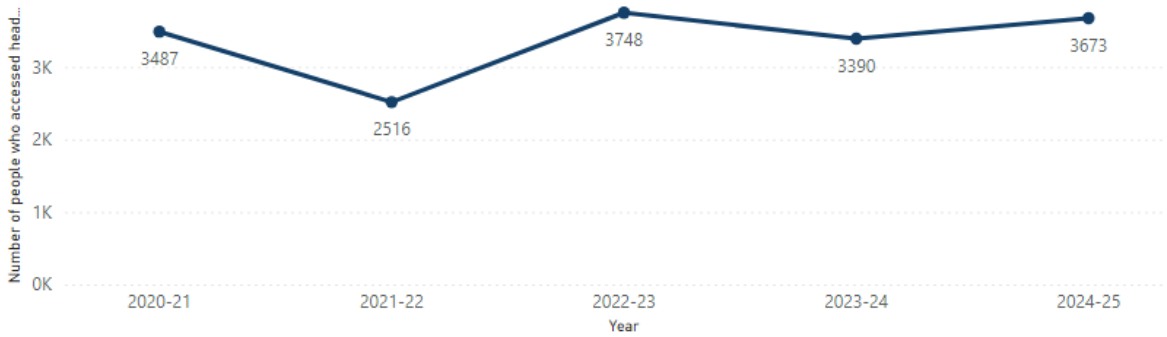
Young people accessing headspace services

Due to prevalence data, which indicates that young people aged 12 -25 are most vulnerable with greatest incidence of mental health issues, and the availability of data from headspace centres that are funded by CESPHN we can explore help seeking behaviour for this cohort.

headspace is Australia's National Youth Mental Health Foundation, providing early intervention mental health services to 12-25 year olds. headspace can help young people with their mental health, physical health (including sexual health), alcohol and other drug services, and work and study support. Within the CESPHN region there are five headspace services that service young people both within and outside the region. These services are located in Ashfield, Bondi Junction, Camperdown, Hurstville and Miranda. It is important to note the size of each headspace centre varies so comparison between centres is not appropriate. However, trends in the sector can be identified.

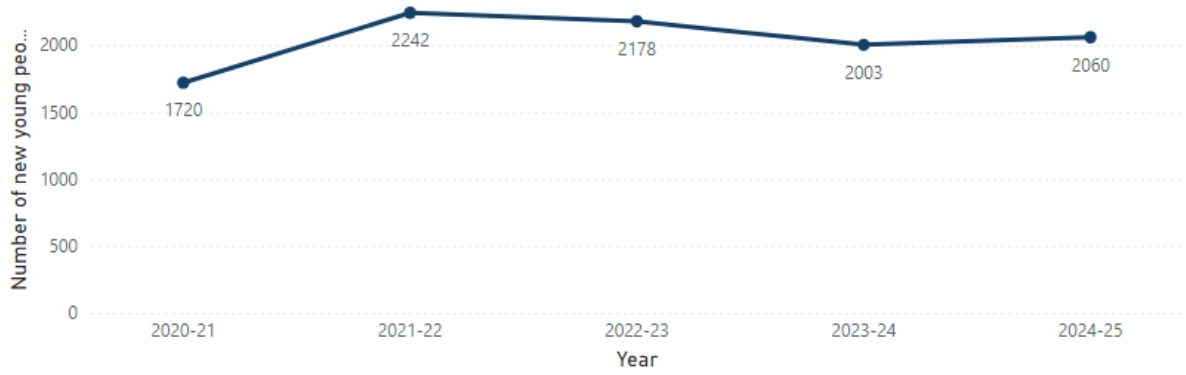
Across 2024-25, 3,673 young people accessed a headspace centre in the CESPHN region. This has been relatively stable for the past three years (24). The same trend can be seen with the number of new young people who access a headspace centre for the first time remaining stable over the last three years.

Figure 11: Number of young people attending a headspace centre 2020-21 to 2024-25



Source: headspace Tableau, 2025

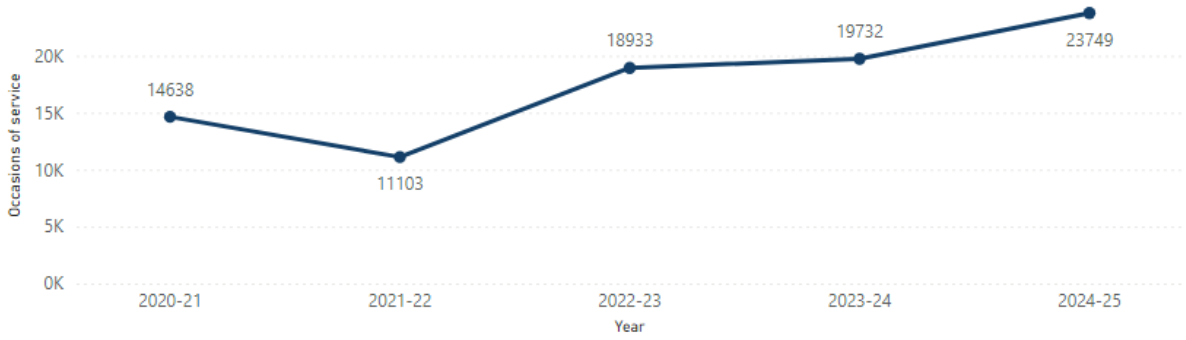
Figure 12: Number of new young people attending a headspace centre 2020-21 to 2024-3425



Source: headspace Tableau, 2024

Occasions of service data also show a similar trend where the total number of occasions of service across all headspace centres over the last three years has remained relatively stable (24).

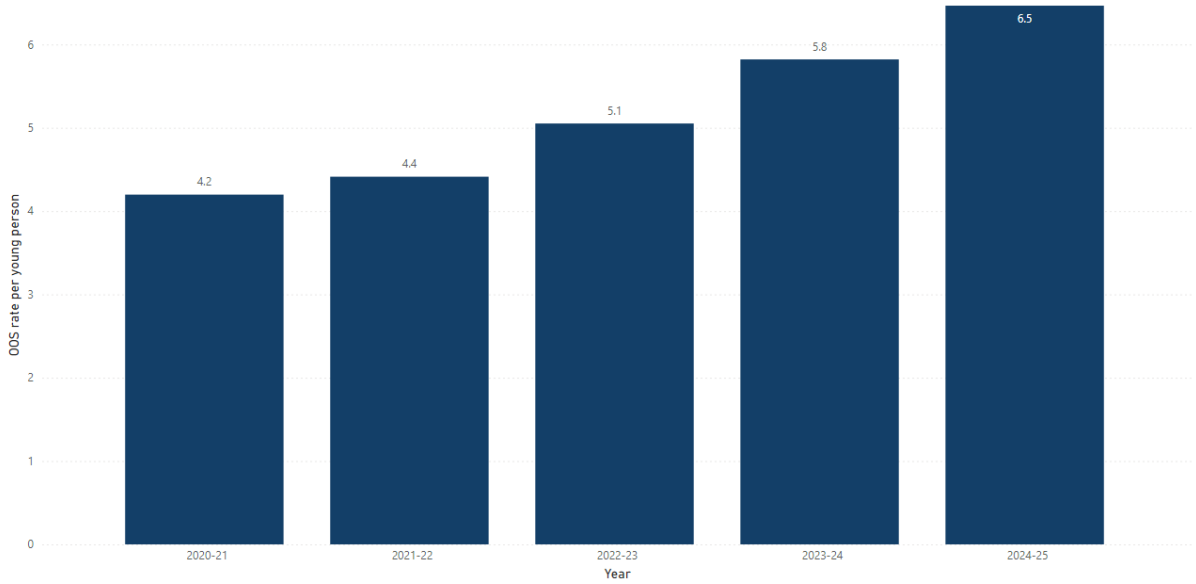
Figure 13: Occasions of service for CESPHN region, 2020-21 to 2024-25



Source: headspace Tableau, 2025

Across all centres young people are receiving increased levels of support. This can be seen by an increase in the average number of services a young person receives a year. This suggests a greater intensity of support possibly due to greater client complexity which has been anecdotally reported by headspace clinicians in our region. In addition, fluctuations in occasions of service may be attributed to workforce instability with clinical and administrative staff shortages reported across all headspace centres in our region (24).

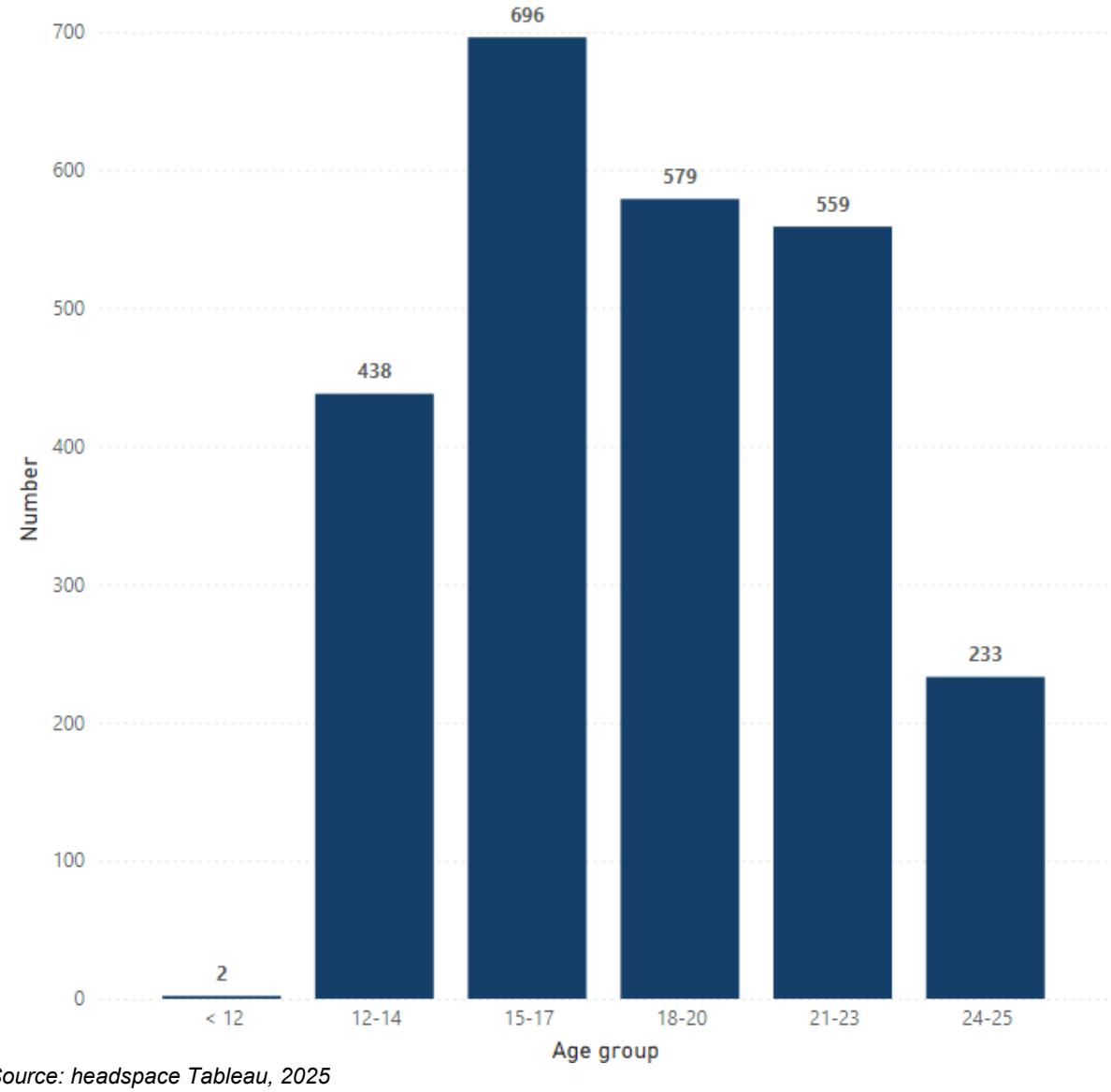
Figure 14: Average number of services received by a young person, by all centres in CESPHN, 2020-21 to 2024-25



Source: headspace Tableau, 2024

The age groups that predominantly access headspace centres are different across the region. Across all five centres 52.0% of young people accessing services are aged 17 years or younger, and 48.0% are aged 18-25 years (24).

Figure 15: Age range of young people accessing headspace services for all centres in CESPHN, 2024-25

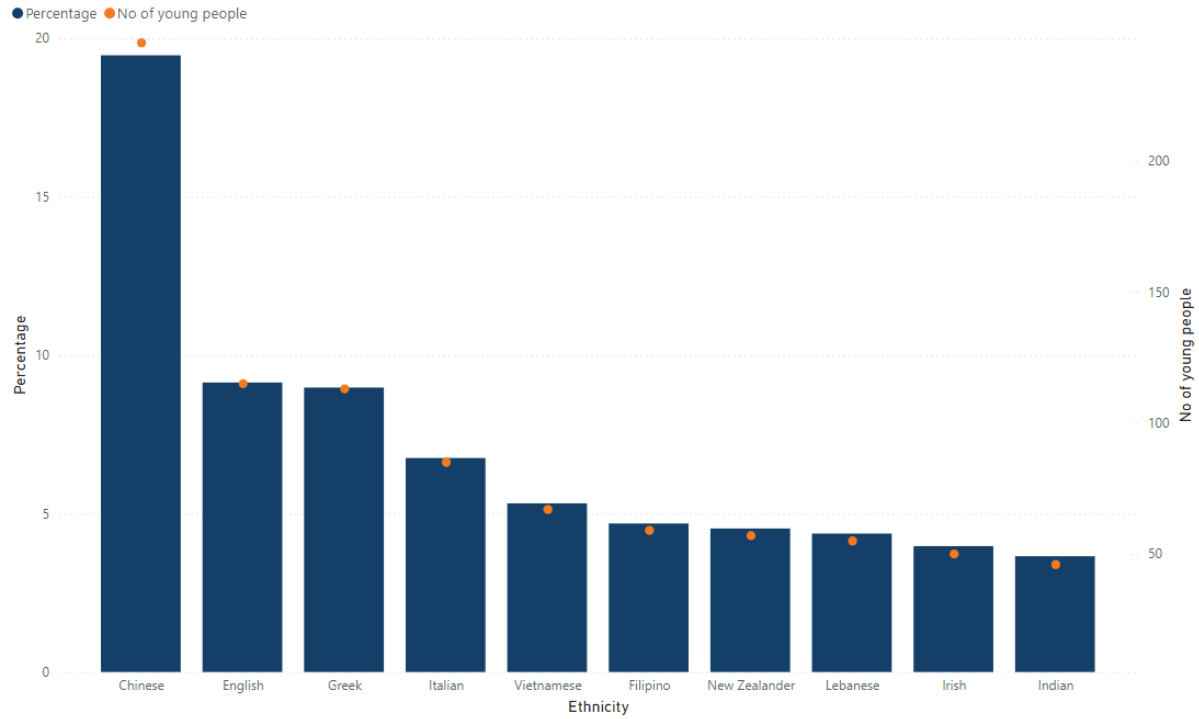


Source: headspace Tableau, 2025

2.9% of young people who attended a service in 2024-25 identified as being Aboriginal and/or Torres Strait Islander (24).

Young people who attend headspace centres identify as belonging to a wide variety of ethnicities outside of Australian. In 2024-25, across all headspace centres in the CESPHN region, 48.3% of young people identified as being from an ethnicity other than Australian or Aboriginal and Torres Strait Islander. For these young people, Chinese was the most commonly identified ethnicity (19.5% of young people), followed by English (9.1%) and Greek (9.0%) (24).

Figure 16: Identified ethnicities attending headspace centres, 20224-25

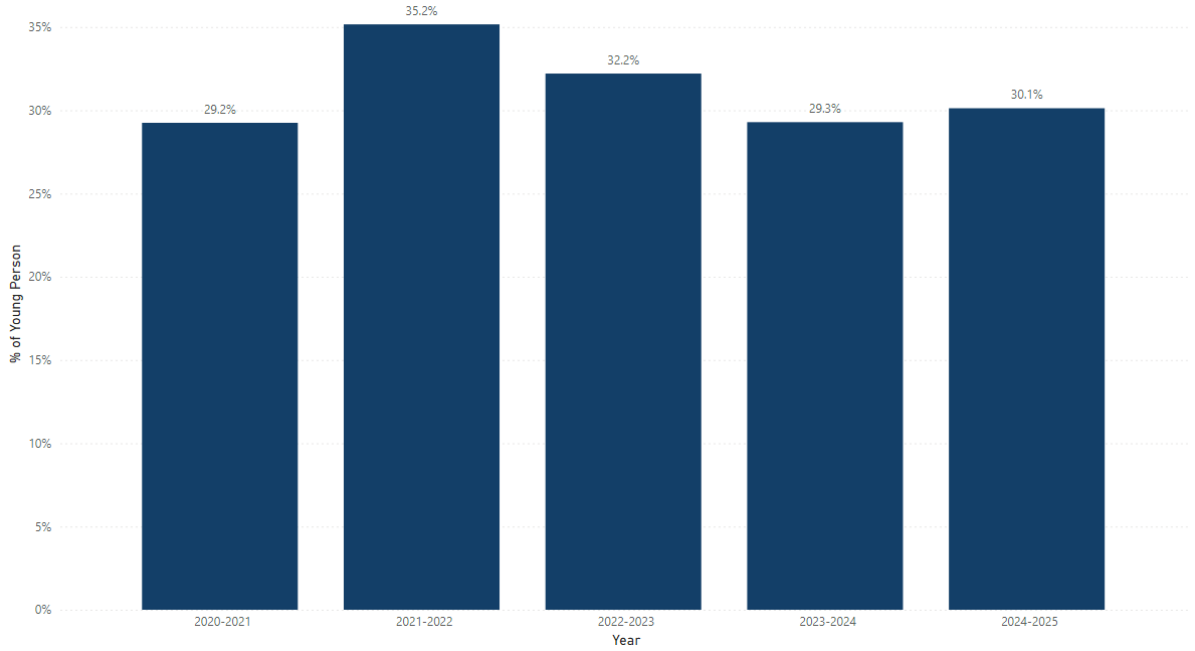


Source: headspace Tableau, 2025

Across all headspace centres in 2024-25, 71.9% of young people identified that they only spoke English at home (24).

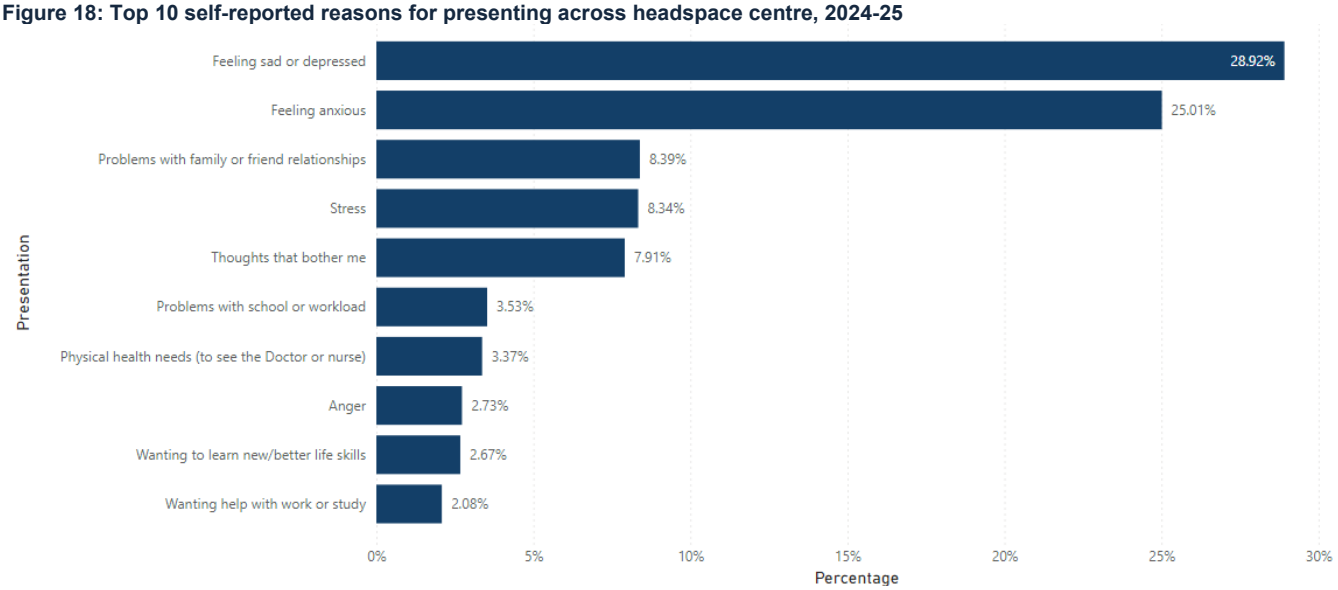
Across the region, over the period between 2021-22- to 2024-25 the proportion of young people identifying as being LGBTIQA+ using a headspace service has remained stable at around 30% (24).

Figure 17: Proportion of young people identifying as LGBTIQA+, 2020-21 to 2024-25



Source: headspace Tableau, 2025

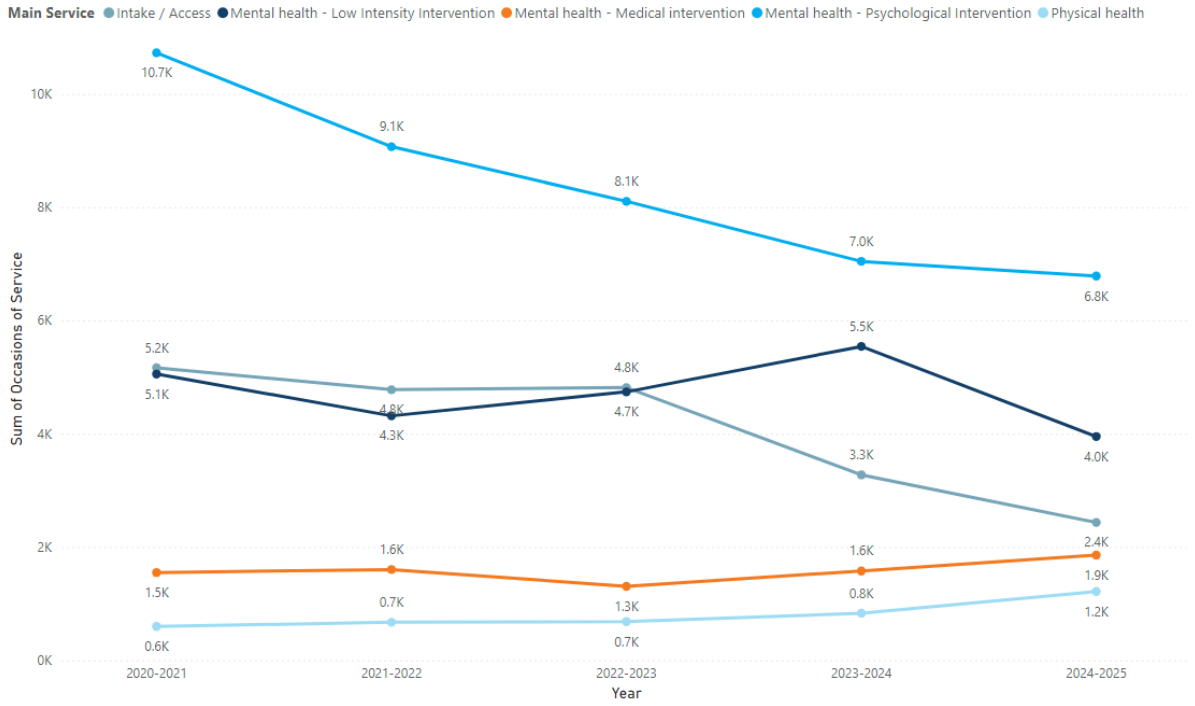
Figure 18: Top 10 self-reported reasons for presenting across headspace centre, 2024-25



Source: headspace Tableau, 2025

Whilst the number of most types of services by service type have been consistent over the five-year period, there has been a 36.4% decrease in psychological interventions from 2020-21 to 2024-25 (24). This is largely due to the reduction of the MBS workforce at headspace centres since the pandemic. The headspace model heavily relied on private practitioners working under MBS to provide the main therapy interventions at the centres, however this workforce has largely ceased working from headspace centres due to other more desirable employment opportunities. Most centres have faced recruitment and retention challenges of mental health trained allied health professionals to be able to consistently provide these services.

Figure 19: Number of the top five types of services across all headspace centres, 2020-21 to 2024-25



Source: headspace Tableau, 2025

Younger children

Needs assessment consultations in 2024 with both internal and external staff highlighted several other areas within the child and youth mental health sector that show areas of need**.** These include the need for child mental health to be approached using a multidisciplinary team care approach, and not to be treated in silos and consideration of the role that social media plays in the incidence, diagnosis and treatment in children and young people**.**

Additionally, consultation with key stakeholders on Child Mental Health and Wellbeing (aged 5-12 years) at CESPHN's 2023 Strategy workshop identified the following gaps:

- Flexibility is required for age-based eligibility criteria to access services, as often 12-14 year olds require child specific services.
- Access to culturally appropriate services for young people and children with severe mental health issues
- Children with Eating Disorders/Body Dysmorphic Disorder are presenting at Emergency Departments due to lack of services to support this cohort
- Ability to provide a timely safe and effective alternative to an emergency department care.
- Workforce development – the need for more training for allied health professionals, nurses and GPs in child mental health assessment and treatment.
- Improved mental health support in the juvenile justice system
- Lack of prioritisation in service of children with disabilities
- There are insufficient services for children requiring more intensive psychological support than what can be supported by current primary care services e.g. via CESPHN commissioned Psychological Support Services program, and services offered by public hospitals e.g. inpatient services, and CAMHS. This service gap is widening as community mental health services scope for service provision is narrowing and workforce shortages contribute to these challenges.

- Mental health services/programs need improved integration with schools/ education department.
- Need for timely and affordable access to paediatricians and allied health professionals, particularly to support diagnosis and treatment for children presenting with neurodivergence.

The CESPHN Joint Mental Health and Suicide Regional Plan, has several activities relating to improving access to care for children experiencing developmental and mental health related difficulties, which will be one of the key areas of focus in 2025/2026 for CESPHN and our joint partners. The gaps identified at our previous Strategy Day workshop in 2023, will be central to discussion and action as part of this regional planning process. As part of the Regional Plan CESPHN will facilitate a Child Mental Health Collaborative bringing together our planning partners along with representative from education and communities and justice. The proposed purpose of this collaborative will be to

- Bring forth the expertise and knowledge across healthcare, education, child protection, and community services regarding the priorities relevant to and strategies most likely to benefit children in the CESPHN region.
- Determine activities that improve care outcomes and experiences for children whose needs are addressed by multiple agencies.
- Explore workforce initiatives that improve capacity and capability.
- Explore, prepare for and respond to future funding and investment opportunities.

Low intensity mental health services

Low intensity mental health services can be accessed quickly and easily and include group work, phone and online interventions and involve few or short sessions. CESPHN commissions the following services:

- **Emotional Wellbeing for Older Persons** - This program provides psychological and psychosocial services for older people with a variety of mental health needs who reside in Residential Aged Care Facilities. In 2024-25 the program supported 561 unique clients at 97 aged care facilities for a total of 10,032 occasions of service. On average, 40% of clients who accessed the service were from multicultural backgrounds.
- **Your Coach Plus** – This program provides coaching using low intensity CBT as well as social prescribing for people experiencing life stressors or low support needs. During 2024-25, Your Coach Plus supported 226 individual clients across 2,562 occasions of service. Overall, 54% of clients self-identified as from multicultural backgrounds, and 312 social prescriptions were provided.
- **Support for communities impacted by the Israel/ Gaza, conflict** – The Wellness and Resilience initiative has commissioned a range of Palestinian, Muslim and Arabic organisations in offering mental health and wellbeing supports that include assessment, referral and navigation, physical activity and community connection, traditional art and dance, healing circles for schools and community and support for Imams and faith leaders. From July 1, 2024, to 30 June 2025 70% of Palestinian individuals reported reduced distress after engaging with the Wellness and Resilience project. Additionally, thousands of Palestinian community members were supported through various physical health activities, mental health literacy workshops, healing circles, and large-scale community events. These activities and events led to a 90% increase in improved wellbeing for Palestinian attendees. In addition to providing mental health and wellbeing support to the Palestinian and Muslim community, support to the Israeli and Jewish community through Jewish Care provided vital care coordination services that are available for the community. These services include support for mental health, accommodation, visa issues and referral to additional support services. Throughout 2024-25 over 400 Jewish individuals were supported with 141 receiving ongoing case management and support as a part of the project. Second-generation Holocaust survivors also attend ongoing support groups held monthly to ensure the mental health and wellbeing of all Jewish community members is supported.

- Medicare Mental Health Centres (MMHC) – (see mild-moderate section below)

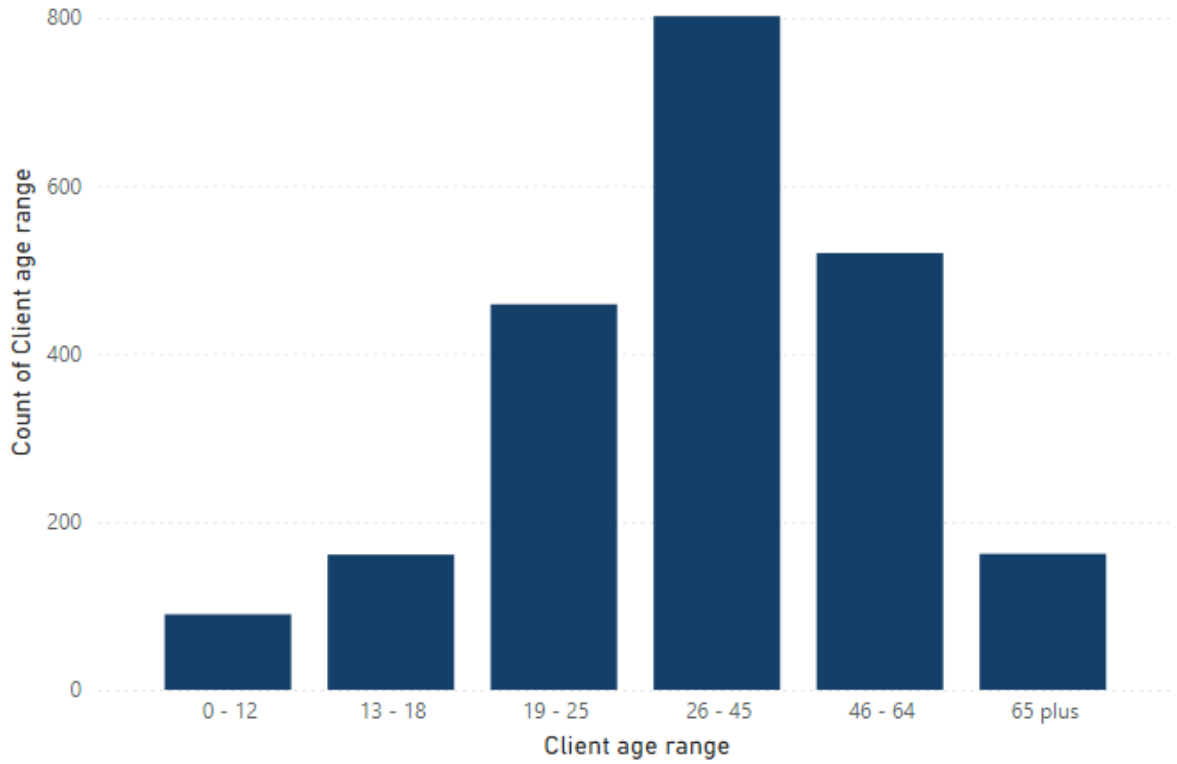
Mild - moderate intensity mental health services

For people experiencing mild to moderate intensity mental health conditions, structured and reasonably frequent interventions (e.g., psychological interventions) are utilised. CESPHN commissions the following services:

- **Cognitive Behavioural Therapy (CBT) Group for people with Autism Spectrum Disorder** – this program provides young people (16 years or older) who are on the Autism Spectrum access to an eight-week group CBT program with the aims of reducing anxiety and improving skills in social situations
- **Emotional Wellbeing for Older Persons (EWOP)** (described in low-intensity section above).
- **headspace** (see headspace section)
- **Medicare Mental Health Centre** - previously called Head to Health Centres, CESPHN commissions a service in Canterbury. MMHCs are a safe and welcoming space to talk to someone for people in distress or needing help finding the right mental health support to meet their needs. Centres have multidisciplinary teams and can provide different levels of support based on client needs. The Canterbury MMHC provided a service to 441 clients and delivered 4,977 occasions of service in 24-25. Despite being predominantly a service for adults, almost 12% of clients presenting to the service were children under 12 years, highlighting the significant need for child mental health services. 37% of the clients seen were born overseas.
- **Psychological Support Services (PSS)** – this program provides people with short term focussed psychological therapies and is aimed at those who would not otherwise be able to access the Better Access scheme. In 2024-25 the PSS program supported 2,774 people in 2024-25 for a total of 12,559 occasions of service. Additionally:
    - 10.5% of clients identified as Aboriginal or Torres Strait Islander, this was a decrease from 14.2% in 2023-24. This is a high representation with 1.05% of the CESPHN population identifying as First Nations.
    - Women make up the largest proportion of clients across with 65%. This is consistent with prevalence and service utilization data presented earlier in the chapter.
    - Individuals identifying as genderqueer or non-binary comprised 1.7% of clients, while transgender clients comprised 1.2% of those accessing the Psychological Support Program. This figure shows that transgender and gender-diverse people make up a significantly small share of program users. Given the consistently high mental health need reported in this population, low uptake is likely to reflect barriers to access than low demand.
    - 8.2% of PSS clients identified as LGBTIQA+. While this exceeds the ABS estimate that approximately 4.5% of Australians aged 16 years and over are LGBTI+ (25), it is unlikely to be proportional to need given the substantially higher burden of mental ill health and elevated help-seeking observed in LGBTIQA+ populations.
    - 30% of clients were born outside Australia. The largest groups were China (7%) and England (3%), followed by New Zealand, Indonesia, India, Lebanon, and the Philippines (1% each), with other countries making up the remaining 15%. This is up from 26% in 2023-24. 5% of clients did not indicate their country of birth.
    - English remained the predominant preferred language (79% up from 77% in 2023-24). Mandarin was next at 4%, followed by Cantonese at 2% and Spanish at 1%. 13% of clients did not state a preferred language at referral. Regarding proficiency, 80% reported speaking English ‘very well’, 10% ‘well’, 3% ‘not well’, and 1% ‘not at all’. The remaining 6% were not recorded or missing from the referral.
    - 37% of clients were aged between 26-45, down from 39% in 2023-24. Clients aged 46-64 increased from 21% to 24% over the same period. The continued increase in clients aged 46-64 suggests rising demand for psychological support in mid-life.

Likely contributors include cost-of-living pressures that push people to prioritise paid work and caregiving over seeking their own mental health support.(23)

Figure 20: Client age range in PSS program, 2024-25



Source: CESPHN, PMHC MDS 2025

From the services that are commissioned by CESPHN that provide care to people who require a mild to moderate level of care, it has been reported that over the 2022 and 2023 there has been an increase in the complexity of clients who have been accessing mild to moderate commissioned services. One of the outcomes of this is a higher resource requirements per client, reducing the number of clients that can access services. To address this CESPHN has implemented demand management strategies and as a result there have been changes in referral patterns into mild-moderate commissioned services. However, due to the numerous referral pathways there are still instances of high complexity clients accessing mild to moderate care.

High intensity services

Periods of intensive intervention typically include multidisciplinary support, psychological interventions, psychiatric interventions, and care coordination. CESPHN commissions the following services:

- GP Mental Health Shared Care Program - aims to enhance the recovery and physical wellbeing of consumers whose care is shared by a GP and a Local Health District/Network. The focus of the program is to provide support for GPs to improve physical health outcomes for those experiencing severe mental health in primary care. CESPHN funds Sydney LHD, South Eastern Sydney LHD and St Vincents Health Network to provide Shared Care, supporting a combined total of 400 consumers and delivering 2,500 hours of support. The programs also deliver several additional activities focused on building capacity of GPs to support people living with mental illness and increasing collaborative care.

- GP Mental Health Shared Care – Clozapine – aims to improve the care of patients prescribed clozapine by establishing a partnership between their GP and the clozapine clinic. Patients are supported to transition smoothly between different healthcare teams while ensuring they continue to receive safe clozapine treatment. CESPHN funds SESLHD to deliver this service to 151 people at any one time, delivering 1,080 hours of support per year.
- Youth Enhanced Services- aims to provide multidisciplinary supports to young people who have more complex needs than headspace centres could normally support, and whose needs cannot be supported by the local public health service.
- Medicare Mental Health Centre (described in low-intensity section above)
- Primary Integrated Care Supports (PICS) Program - provides clinical and recovery-oriented mental health services. All participants are paired with a credentialed mental health nurse for clinical mental health supports, and with a peer worker for psychosocial supports if needed. The program offers care coordination between a person's GP and psychiatrist, liaising with family and carers, monitoring and promoting adherence to medication, and supporting self-management of mental and physical health. The PICS program supports 1,000 people experiencing severe mental illness per year and mental health nurses and peer workers deliver a combined total of 21,500 hours of essential supports per year. With rising costs of living, workforce shortages, workforce pay increases, and increased distress in the community, the program has been unable to maintain initial levels of contracted supports, which across 2019-20 to 2020-21 were to support 3,000 people and deliver 51,750 hours of support cumulatively.
- Telehealth Psychiatry Service (TPS) – provides free telehealth psychiatry services to people experiencing severe mental illness who due to socioeconomic barriers are unable to access private psychiatry support. Clinical Care Coordinators provide pre- and post-appointment psychosocial support to consumers and a large component of the program focuses on capacity building and upskilling GPs to ensure people's mental health can be effectively supported through primary care. Eligibility criteria for TPS has had to tighten since its inception in April 2022 due to increased complexity of client needs and an overwhelming demand for ADHD support. The program has had to implement compulsory Health Care Card or low-income requirements and in February 2025 ceased accepting referrals for the diagnosis and treatment of ADHD.

Psychosocial support services

Through the Commonwealth Psychosocial Support (CPS) program, CESPHN commissions a number of psychosocial support services. These programs assist people experiencing severe mental illness who are not receiving psychosocial supports through the NDIS. Supports are non-clinical and non-therapeutic, aiming to build a person's capacity to meaningfully participate in their community and be an active part of their own recovery journey. To access psychosocial supports, people living, working, or studying in the CESPHN region must experience severe mental illness with reduced psychosocial functional capacity, however, no formal mental health diagnosis is required to be eligible. Supports are generally for people aged 16 or over, but some of CESPHN's commissioned programs have specific age criteria (e.g., a youth group is 14-25). The psychosocial support services CESPHN commissions are:

- **Yarning Circles -** Participating in a traditional Yarning Circle enables a return to historical Aboriginal cultural practices of coming together as a community, sharing, and expanding knowledge. Sitting in a Circle allows conversation and sharing to flow naturally - allowing all members of the group to be seen clearly, facing each other, and placed equally around the Circle. The Yarning circle offers an opportunity for Aboriginal and/or Torres Strait Islander men to gather on a monthly basis to network and receive psychosocial and culturally safe support.
- **Connect and Thrive** - provides individual psychosocial support with a mental health worker or peer worker to support people experiencing severe mental illness. Group support programs such as art therapy are provided, and regular social activities are planned to combat the emerging gap of social isolation. The program also offers targeted strategies supporting

employment and physical health needs, as well as assisting people to test eligibility for NDIS supports.

- **Keeping the Body in Mind** - a life skills and lifestyle program offering free exercise physiology and dietician services for people living with severe mental illness. The program has recently added a nicotine treatment specialist for smoking cessation support, and a mental health peer worker to support engagement across the services offered.
- **Making Space** - supports people living with moderate hoarding disorder/compulsive acquiring who may be living in squalid conditions and/or be at risk of losing tenancy. Supports include case management, living skills training, practical 1:1 support, and support via the Buried in Treasures 16-week group program. The program operates in the SLHD area of the CESPHN region and the eastern suburbs of Sydney, with flexibility for other parts of the CESPHN region based on identified need.
- **Social Rx ® -** comprises a combination of individual care coordination and group-based activities to which aims to support individuals to build capacity in functional and recreational capacities and reduce social isolation and capability, so individuals are able to of people to thrive, reconnect with, meaningfully participate in, and contribute to their community.

Data collected as part of the CPS program has shown that there is a continued increase in clients who are accessing CESPHN's CPS services with 1,595 clients accessing services in 2024-25, a 60.9% increase from 2023-24 (991) and almost triple the number of clients in 2022-23 (593). This data is reflective of CESPHN being in a position to fund a number of short-term psychosocial initiatives across 2024-25. Waitlist times have recently increased as demand for service delivery has increased, with 202 clients on the waitlist on 30 June 2025 compared to 74 in June 2024. The average wait time for services is 95 days.(23) Whilst some of these figures can be attributed to an increased number of services leading to additional waitlists, qualitative and anecdotal data shows that clients are staying in programs for longer due to the complexity of their needs, leading to decreased throughput and capacity to onboard new clients.

As part of the CPS program, clients are supported to test their eligibility to receive psychosocial supports through the National Disability Insurance Scheme (NDIS). The NDIS supports people who are living with psychosocial disability. In 2024-25, 160 clients were supported to test their eligibility for the NDIS, up from 112 in 2023-24. CESPHN's commissioned service providers report an eligibility success rate of 60%+ for clients who have been formally assessed, supporting them with transitioning to the NDIS. This is consistent with commentary provided by stakeholders as part of consultation of the needs assessment, where it was reported that a limited number of people experiencing severe mental illness are able to access NDIS funding to support their functional requirements. Those who are able to access NDIS funding do not receive funding towards any psychological therapies.

The service navigation program commenced in 2021-22 and saw 120 people access the service. In subsequent years, numbers have decreased but remained stable (73 people in 2022-233, 42 people in 2023-24 and 59 people in 2024-25).(23) Rather than demonstrating a decreased need for supports in navigating psychosocial services, this is attributed to the roles of mental health workers and peer workers in sourcing alternate referral pathways, providing warm handovers, and ensuring the people they support are receiving high quality care that meets their needs. As awareness of and access to CESPHN's psychosocial support services increases, the need for navigation support has decreased.

This shows that there is the demand for the services under the CPS program, and that the program is helping to meet the needs of the community. However, due to the complexity of mental health support needs experienced by people living in the central and eastern Sydney region, and the service gaps emerging with regards to lack of supports available, further investment in the provision of psychosocial supports is needed. Nationally, it is estimated that throughout 2022-23, there were 230,500 people with severe mental illness aged 12 to 64 years who required, but were not provided, psychosocial support. The total number of hours that would have been required to support this cohort is estimated to be 14.07 million. For people experiencing moderate mental illness, 263,100 people

aged 12 to 64 did not receive required psychosocial supports, estimated at 2.76 million hours of unmet support.(26)

Through stakeholder consultation as part of the Needs Assessment process, in relation to severe mental health and psychosocial reports, areas that have been identified as gaps, or requiring additional resourcing include being able to involve the family more in the support of clients with high needs, access to case management for coordination of services for people with higher needs that also have lower levels of function, greater resourcing to support the different intersectionalities of people with severe mental health such as housing and homelessness support, hoarding and squalor support and alcohol and other drug support services. From a service provision perspective, it was also identified that the ability to be stepped between different levels of care within the same service to provide continuity of care and not having to move between multiple services, with the likelihood of having to join a long waitlist is a need. An additional challenge that impacts this is the short-term funding of programs, which can lead to uncertainty for clients and staff.

Access through integration

Whilst all the program areas above are designed to meet targeted specific needs of the CESPHN population, being able to access these services in an integrated approach is a gap within the community. Whilst there are models of integrated care within the region such as headspace and Medicare mental health centres, these services are not designed as a one-stop approach to support the mental health needs of the whole population.

In 2022 CESPHN undertook analysis and consultation to co-design a service model for an Integrated mental health hub. Insights as part of the analysis showed that:

- National strategies, policies and frameworks point to a need for an integrated mental health system that provides accessible and equitable mental health services that focus on improving health and recovery outcomes through funding models such as community mental health hubs.
- There are a multiple hub-based models that are being delivered nationally that deliver support to adults with moderate to severe mental health challenges through a mix of person-centred clinical and non-clinical supports that link individuals with social supports, services and clinical care. These hub models have mixed eligibility criteria, are place-based with outreach services and are delivered by a diverse workforce.
- A review of the evidence-base and evaluation of hub models found that there has been success in models that pooled their funding, however there is an opportunity and need to improve integration at a service and system level.
- Establishment could introduce an effective data collection system and strengthening the use of outcome measures to demonstrate recovery outcomes and overall impact.

The hub should deliver person-centred support by connecting people with the right mix of services and supports based on their individuals needs and preferences. This should be supported through an initial assessment of an individual's needs that is undertaken by a trained mental health professional, and using supported decision-making strategies to determine the service that is the best fit for the individual. Integration of the hub should be achieved through the establishment of partnerships with external agencies that are essential for connecting people to services and supports.(27)

Access for vulnerable populations

Access to mental health services across all service levels does not look the same for all members of the community. There are groups in particular who face higher access issues. These groups include:

- LGBTIQ+ communities
- Culturally and linguistically diverse communities
- First nations communities
- Older people

- People with Drug and Alcohol addiction
- Veterans.

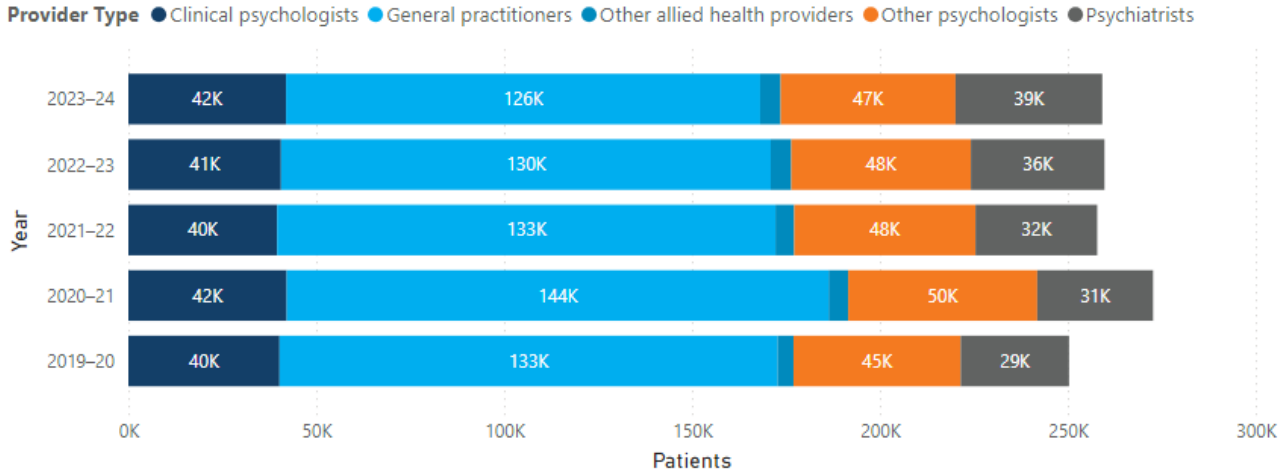
Whilst all these groups face their own unique challenges in accessing mental health services, there are some commonalities. The main barrier faced is being able to access services that are culturally appropriate and safe for their individual needs. Both individuals and communities report that there is both a lack of knowledge around services they can attend, and a lack of providers that are able understand their needs outside of the clinical presentation. Being able to embed different level of cultural safety for vulnerable population groups will improve both access and quality of care.

Medicare-subsidised mental health services

Outside of the services that are commissioned by CESPHN, members of the community have access to Medicare-subsidised mental health services.

In 2023-24, 165,931 people (10.3% of the population) accessed Medicare-subsidised mental health services in the CESPHN region. This is an increase of 3,090 people (1.9%) from 2018-19. Over a five-year period from 2019-20 to 2023-24 the highest number of people accessing Medicare-subsidised mental health services was in 2020-21 (28).

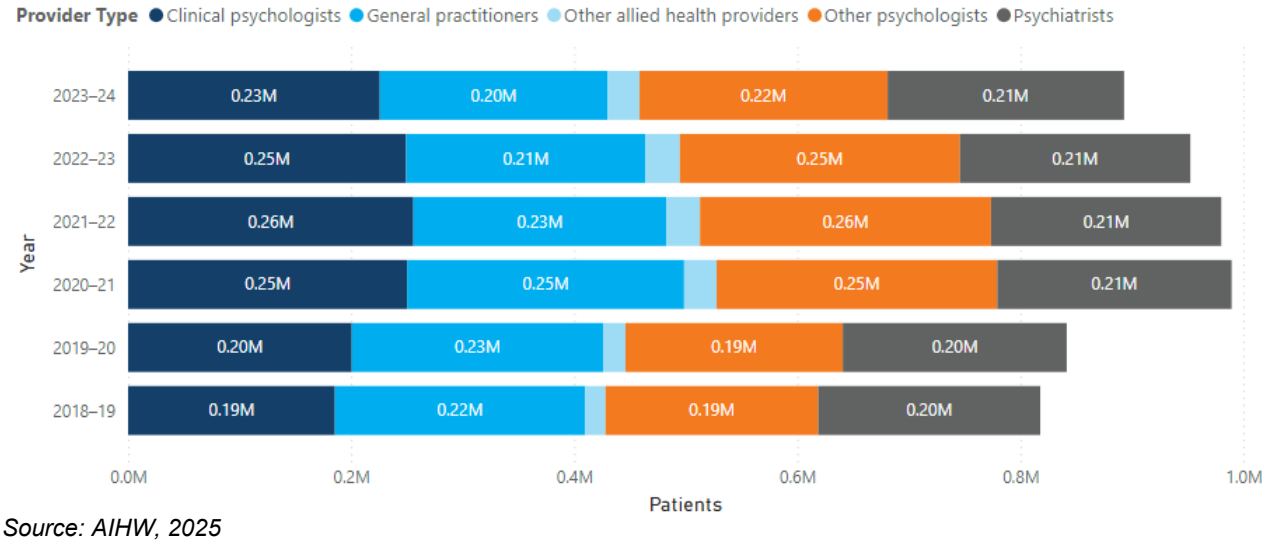
Figure 21: Number of people accessing Medicare-subsidised mental health services by service type, CESPHN, 2019-20 to 2023-24



Source: AIHW, 2025

Over the 5-year period from 2019-20 to 2023-24 the highest number of services accessed was in 2020-21 (989,459), with the number of services decreasing each year since (28).

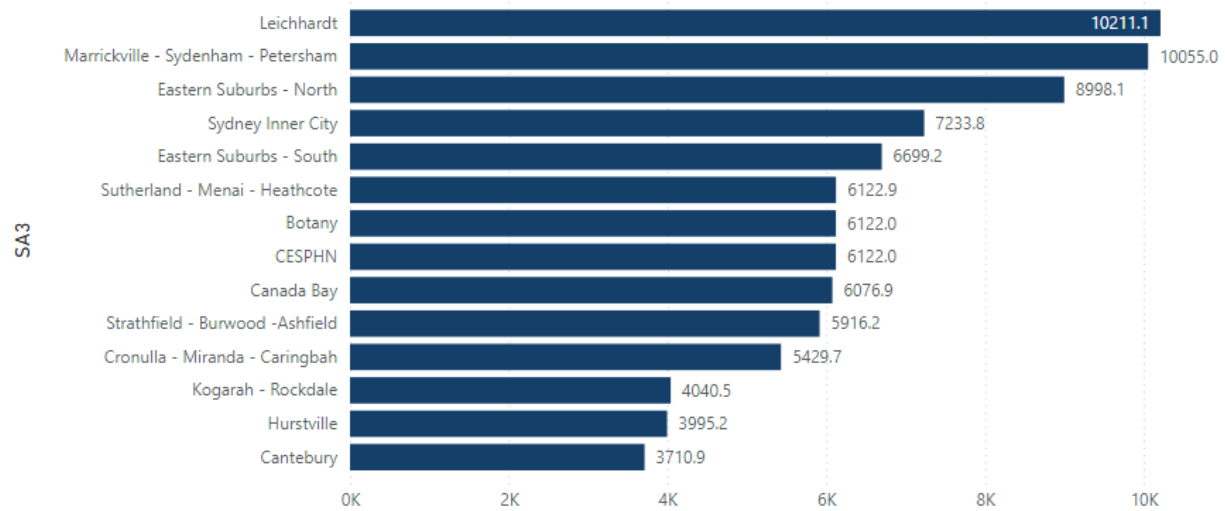
Figure 22: Number of Medicare-subsidised mental health services by service type, CESPHN region, 2019-20 to 2023-24



Source: AIHW, 2025

There are considerable variations in the number of Medicare-subsidised mental health services between SA3s. in 2022-23, Leichhardt SA3 had the highest rate of services per 10,000 population (10,211), followed by Marrickville-Sydenham-Petersham SA3 (10,055 per 10,000 population) and Eastern Suburbs-North SA3 (8,998 per 10,000 population) across all service types. Canterbury SA3 had the lowest number of services (3,711 per 10,000 population).(28)

Figure 23: Number of Medicare-subsidised mental health services (rate per 100,000 population), by SA3, 2022-23.



Source: AIHW, 2025

Mental health related prescriptions

In 2023-24, across the CESPHN region, there were 225,485 people who had a mental health related prescription under the PBS, giving a rate of 140 per 1,000 population. Almost 58.9% of patients were female and 41.1% were male. In this same year, over 1.95 million mental health related prescriptions were filled, at a rate of 1,215 per 1,000 population (28).

Across the five years to 2023-24, rates of patients per 1,000 population have remained stable. In contrast rates of mental health related prescriptions per 1,000 population increased by 8.5% in the same time period, indicating that the patients using mental health related prescriptions have increased their usage (28).

Table 2: Patients and mental health prescriptions, CESPHN region, 2019-20 to 2023-24

Measure	2019–20	2020-21	2021-22	2022-23	2023-24
Number of patients	208577	205713	212610	221544	225,485
Patients per 1,000 population	131	129	137	142	140
Number of prescriptions	1,788,932	1,777,055	1,837,386	1,884,437	1,950,326
Prescriptions per 1,000 population	1,121	1,118	1,185	1,211	1,215

Source: AIHW, 2025

Within the CESPHN region in 2023-24, females account for 58.9% of patients and 59.2% prescriptions across the region. Patients aged 65 years and over have the highest rate of prescriptions at 268 per 1,000 population. This rate has remained consistent since 2020-21. This age group also accounts for 28.1% of the patient profile across the region and 28.9% of mental health related prescriptions. 45-54 year olds account for the next largest patient group (15.9% of patients) and number of prescriptions (16.3% of prescriptions). Whilst the patient and prescription numbers are lower, the rate of people per 1,000 population aged 55-64 years is higher than the 45-54 year olds (197 compared to 187). The prescription rate per 1,000 population in the 55-64 year olds is also higher than in 45-54 year olds (1,734 compared to 1,651) (28).

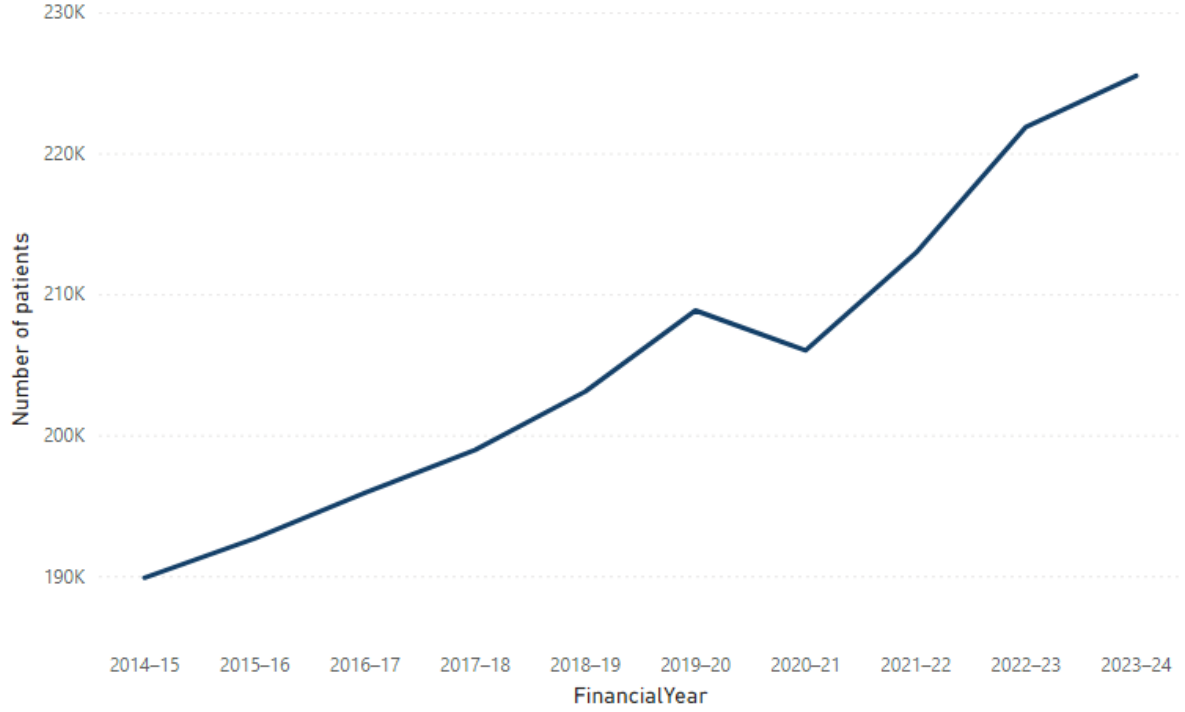
Table 3: Patients and prescriptions by age group, CESPHN region, 2023-24

Age Group	Patients (n)	Patients (%)	Prescriptions (n)	Prescriptions (%)
0–17 years	16,004	7.1%	128,613	6.6%
18–24 years	14,354	6.4%	120,506	6.2%
25–34 years	29,965	13.3%	241,984	12.4%
35–44 years	33,783	15.0%	281,797	14.4%
45–54 years	35,885	15.9%	317,610	16.3%
55–64 years	32,135	14.3%	283,050	14.5%
65+ years	63,359	28.1%	564,596	28.9%
Total	225,485	100.0%	1,950,326	100.0%

Source: AIHW, 2025

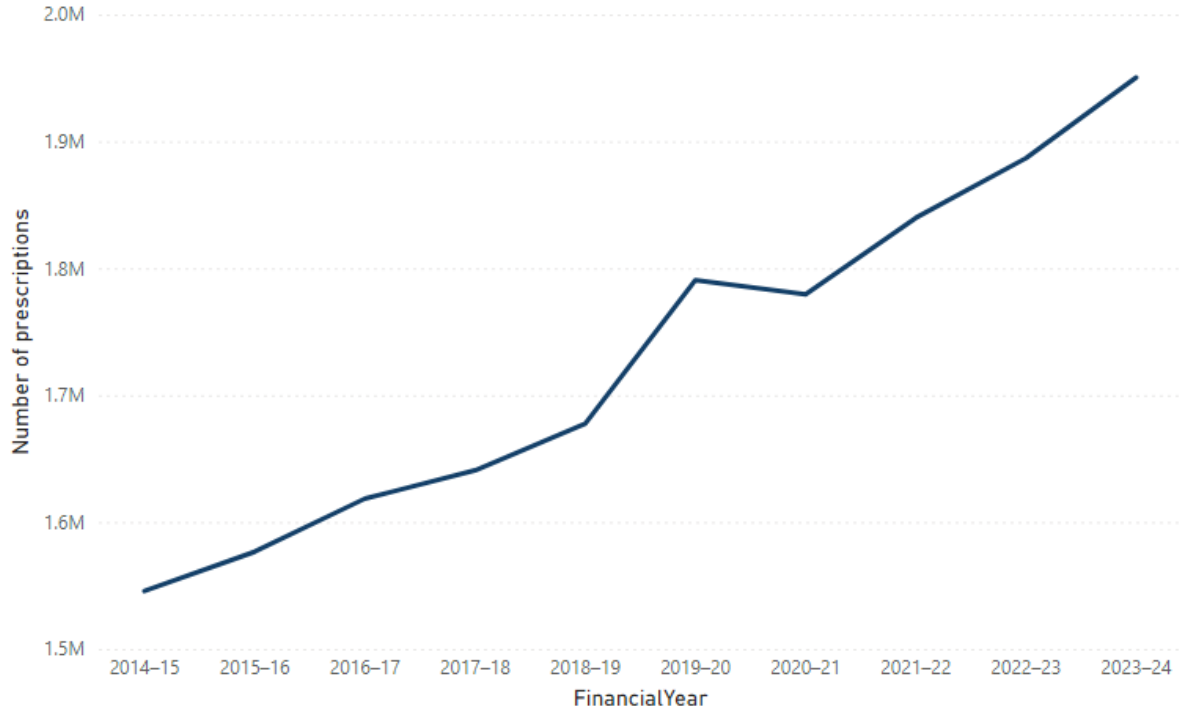
Looking at the total number of patients and prescriptions across the CESPHN region over a ten -year period from 2014-15 to 2023-24, there has been an overall increase 18.8% in the number of patients and 26.2% in the number of prescriptions. The largest annual increase in the number of patients was in 2022-23 with a 4.2% increase. The largest annual increase in the number of prescriptions was in 2021-2022 with an increase of 3.4%. in 2020-21 both total number patients and prescriptions decreased (1.4% and 0.7% decreases respectively) (28).

Figure 24: Number of Patients, 2014-15 to 2023-24



Source: AIHW, 2025

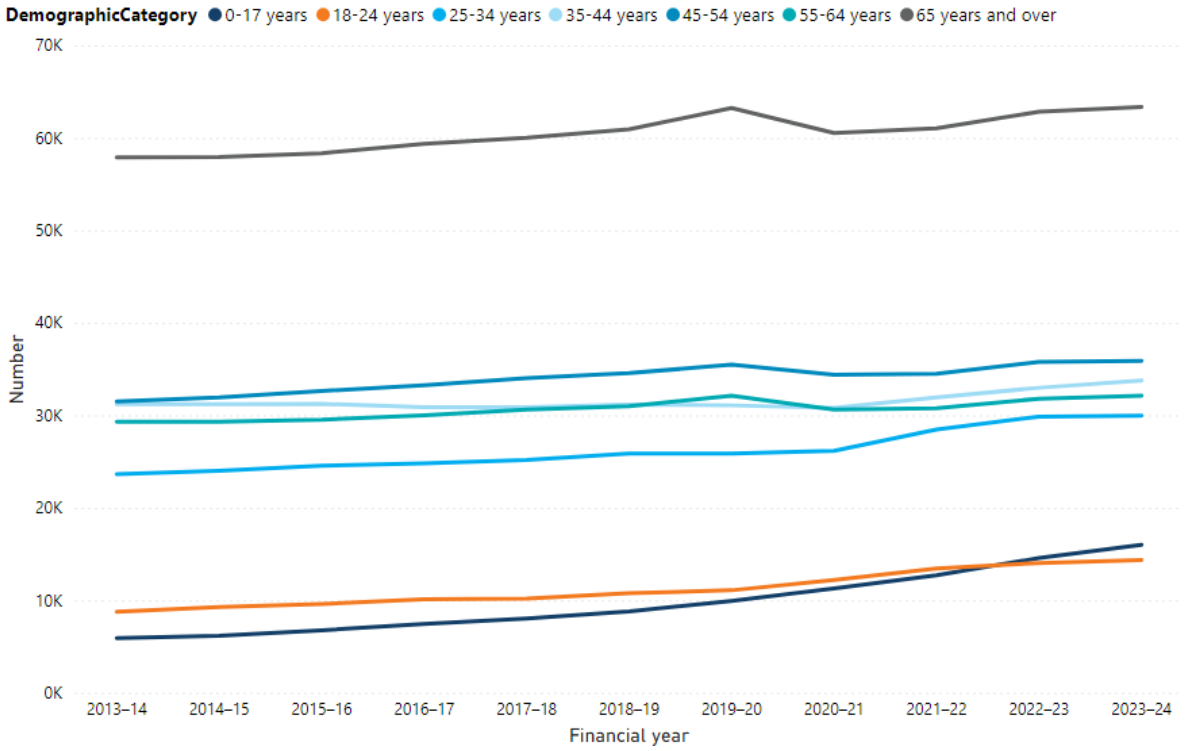
Figure 25: Number of prescriptions, CESPHN, 2014-15 to 2023-24



Source: AIHW, 2025

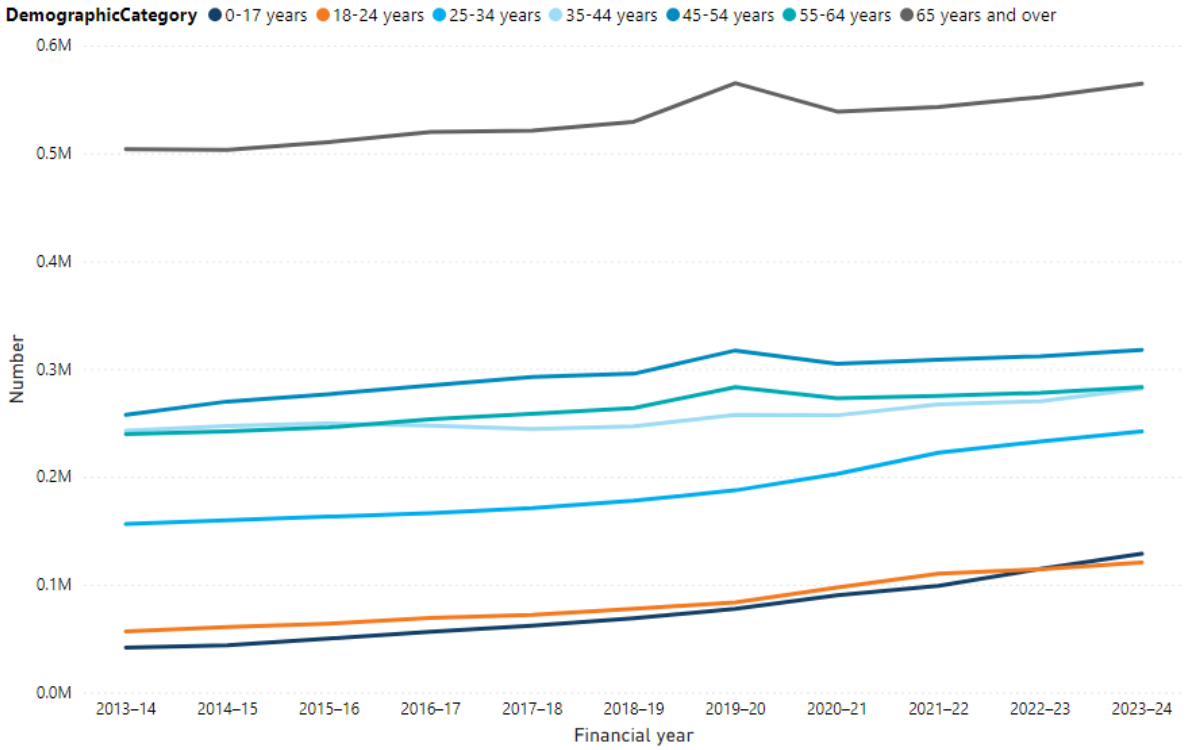
Figures 26 and 27 below show that the number of people and number of prescriptions across each age group is increasing. Across both the number of people and number of prescriptions we can see a spike in the three eldest age groups; 65 years and over, 55-64 years and 45-54 years in 2019-20. (28)

Figure 26: Patients by age group, CESPHN region, 2013-14 to 2023-24



Source: AIHW, 2025

Figure 27: Prescriptions by age group by SA4, CESPHN region, 2013-14 to 2023-24



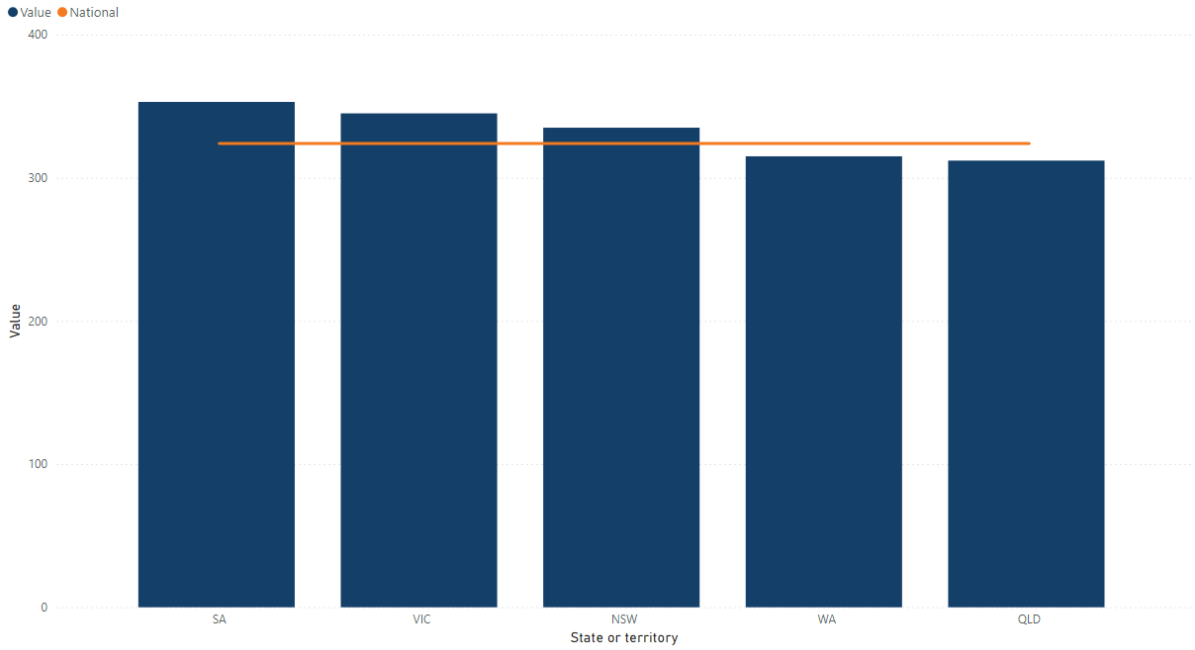
Source: AIHW, 2025

Community mental health care

Community mental health care refers to NSW government-funded and operated specialised mental health care provided by community mental health care services and public hospital-based outpatient and day clinics.

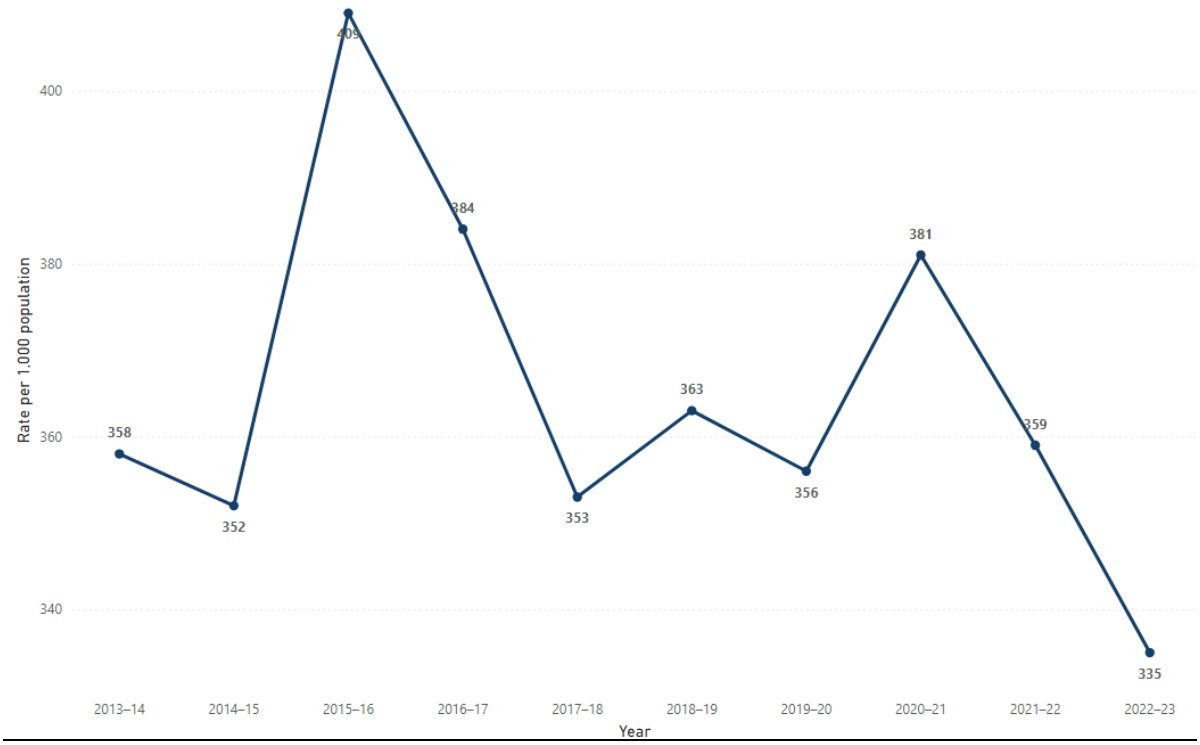
In 2022-23 there were 2,062,562 service contacts provided in major cities in NSW by community mental health care. This equates to a rate of 335 service contacts per 1,000 population, slightly higher than national major cities totals of 324 per 1,000 population (28). This is the lowest rate in the last ten years. Over a ten-year period from 2012-13 to 2022-23 the rate per 1,000 population saw a spike in service contacts in 2015-16 to a rate of 409 per 1,000 population. 2016-17 and 2020-21 saw higher rates at 384 and 381 per 1,000 population respectively. All other years remained consistent at around 350 per 1,000 population (28). With the incidence of mental illness increasing over time, and the rate of service contacts per 1,000 population remaining stable, along with and ED related presentations and hospitalisations increasing, it could be suggestive that these individuals requiring support are either relying on the primary care system to support them, or presenting at emergency departments. This is consistent with feedback provided by primary care providers that there is greater acuity, complexity and demand for mental health services in primary care.

Figure 28: Community mental health service contacts per 1,000 population, by Major cities, by state, 2022-23



Source: AIHW, 2023
Note: Data not available for Tasmania, Northern Territory or Australian Capital Territory

Figure 29: Rate per 1,000 - NSW Major cities Community mental health care service contacts, 202013-14 to 2022-23



Source: AIHW, 2024

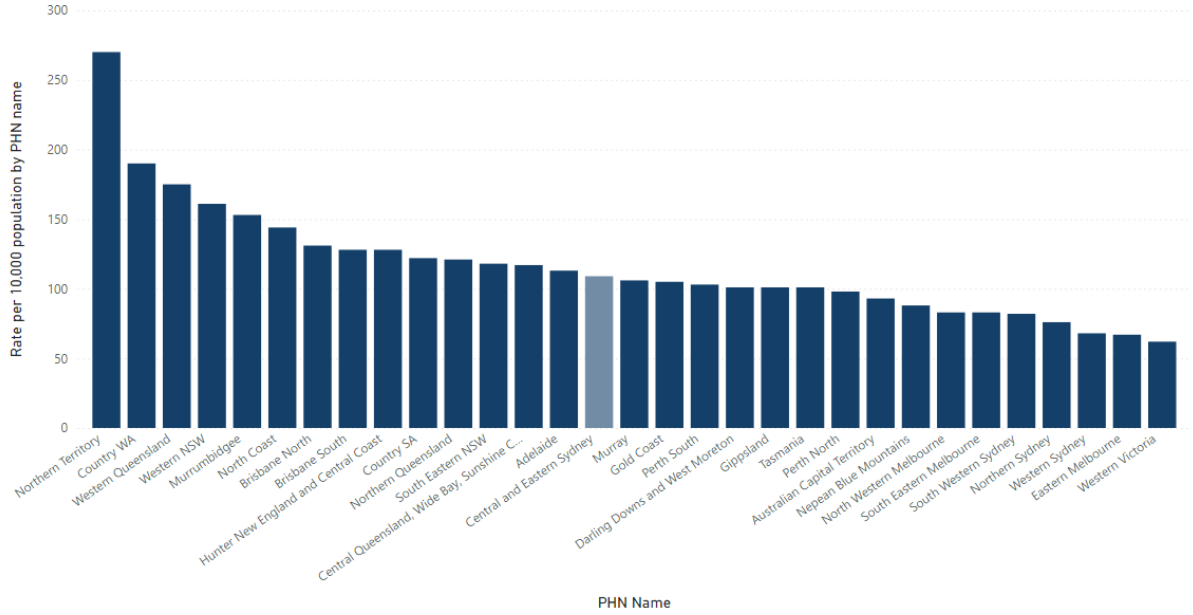
Hospitalisations for mental health conditions

Hospital emergency services

Between 2017-18 to 2021-22, there was a 9.2% increase in the number of mental health related emergency department presentations, with an average annual change of 2%. During this same period, we saw a 4.2% increase in the number of total emergency department presentations in the CESPHN region, with an average annual change of 1% (24).

In 2022-23, there were approximately 17,000 mental health related emergency department presentations across the CESPHN region, equating to 109 mental health related emergency department presentations per 10,000 population. This is higher than rates from 2018- 2019 and 2019-20 (103 and 104 per 10,000 population) but slightly lower than the 2020-21 rate (111 per 10,000 population).(28)

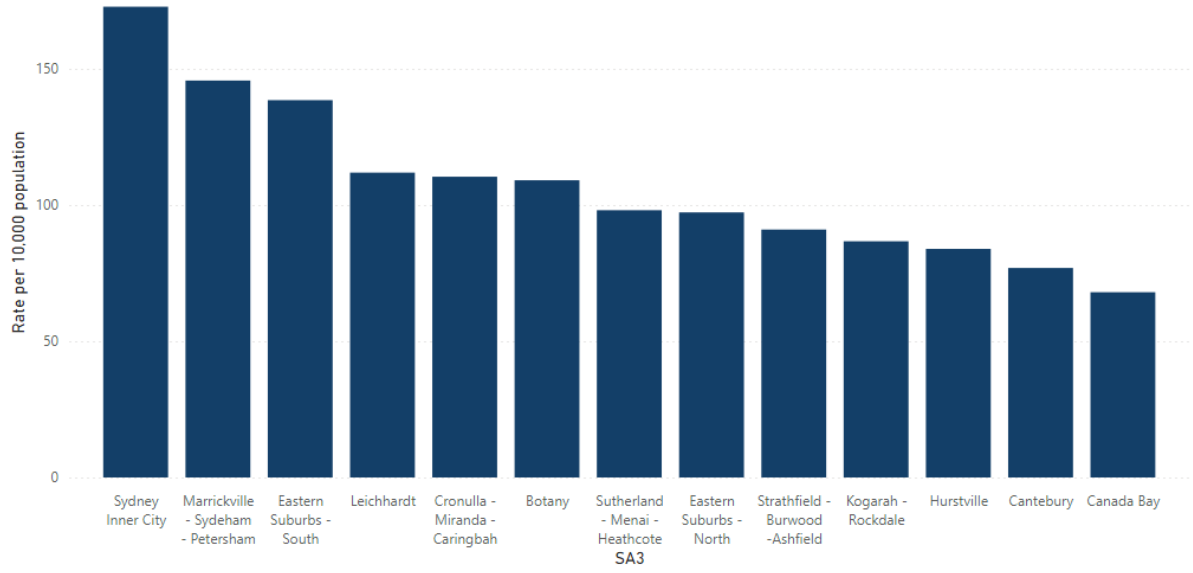
Figure 30: Mental health related emergency department presentations, PHN, 2022-23



Source: AIHW, 2025

In 2022-23 across the CESPHN region, Sydney Inner City SA3 had the highest proportion of mental health related emergency department presentations per 10,000 population (172.8), followed by Marrickville - Sydenham-Petersham SA3 (145.7) and Eastern Suburbs – South (138.5) (28)

Figure 31: Emergency department presentations by SA3, 2022-23



Source: AIHW, 2025

Admitted mental health-related care

In 2022-23, there were 199.4 admitted mental health-related hospitalisations per 10,000 population in the CESPHN region,. The highest rate of admitted mental health-related hospitalisations were

recorded in Leichhardt SA3 (327.0 per 10,000 population), Marrickville-Sydenham-Petersham SA3 (274.1 per 10,000 population), and Canada Bay SA3 (271.5 per 10,000 population).(28)

Table 4: Admitted mental health related rates in the CESPHN region, 2020-21

PHN	Patient days per 10,000 population	Procedures per 10,000 population	Psychiatric care days per 10,000 population	Hospitalisations per 10,000 population
Central and Eastern Sydney	1,655.4	288.6	1,267.8	102.4

Source: AIHW, 2023

The highest rate of admitted mental health-related hospitalisations were recorded in Leichhardt SA3 (144.10 per 10,000 population), Marrickville-Sydenham-Petersham SA3 (131.8 per 10,000 population), and Eastern Suburbs South SA3 (126.4 per 10,000 population)(28)

Residential mental health care

Residential mental health care services provide specialised mental health care on an overnight basis in a domestic-like environment and may include rehabilitation, treatment or extended care. (25)

Whilst there is no local level data available on residential mental health care, national level data is available that can provide insights into the CESPHN community. In 2023-24 it was reported that that:

- people aged 18-24 years of age have the highest rate of access (7 per 10,000 population)
- Women account for 55.3% people who access residential mental health care
- Aboriginal people access residential mental health at a rate of 10 per 10,000 population compared to the other Australians rate of 3 per 10,000
- People from SEIFA quintile 1 (most disadvantaged) access residential mental health care at the highest rate (5 per 10,000) (25).

The 5 most commonly reported mental health-related principal diagnoses for residential mental health care episodes were:

- Schizophrenia (22% of all episodes),
- Specific personality disorders (12%),
- Schizoaffective disorders (9%),
- Depressive episode (9%) and
- Bipolar affective disorder (8%) (28).

Psychosocial disability (NDIS) services

The CESPHN region is covered by two NDIS service districts, South Eastern Sydney and Sydney. As of 31 December 2021, 12% of participants from South Eastern Sydney and 18% of participants from Sydney had a primary disability of psychosocial disability. Both service districts have rates higher than the benchmark rate of 11% of participants (29).

Data shows that both service districts had lower average number of participants per provider where the primary disability was psychosocial disability compared to the benchmark – South Eastern Sydney (2.85), Sydney (2.82) and benchmark (3.27) (29).

Nationally, where psychosocial disability was the primary disability, there was a 72% plan utilisation. Within the CESPHN region, this varied between service districts (73% in South Eastern Sydney and 66% in Sydney) (29).

There were slightly lower proportions of participants who reported that they chose who supported them within the service districts in CESPHN region; South Eastern Sydney had 52% of participants with primary disability of psychosocial disability who chose who supported them compared to 50% in Sydney and 54% nationally. NDIS participants within the service districts in the CESPHN region reported higher proportions of participants who felt NDIS helped them have more choice and control over their life (South Eastern Sydney 75%, Sydney 79%) compared to national benchmark (75%).

Specialist homelessness services

In 2023-24, there were 88,300 clients with a mental health issue receiving specialist homelessness services nationally. This accounts for 32% of all clients receiving specialist homelessness services in NSW. In 2023-24 the main reasons that clients with a current mental health issue sought assistance from a specialist homelessness services agency were not commonly related to mental health issues (4.0% or 3,500 clients). Instead, the main reasons for seeking assistance were for housing crisis (20% or 18,000 clients), family and domestic violence (19% or 16,800 clients), or inadequate or inappropriate dwelling conditions (13% or almost 11,300 clients).(30)

Additional access and service gaps

Further to the above, a number of additional access and service gaps have been identified through consultation processes with **internal and external stakeholders.**

- People are not accessing or delaying the renewing their Mental Health Care Treatments Plans as the cost of seeing a GP increases with the reduction of bulk billing, and the increased cost of living
- The reduction in better access sessions from 20 to ten sessions in December 2022 is impacting clients who were already in the program, but it has allowed for an increase in new clients to be seen.
- Psychologists are being attracted to more privately run services due to better working conditions. This reduces the amount of practitioners available for publicly funded/subsidised service. Also increase staff turnover, which increases the burden of training more staff and impacts continuity of care.
- The short term funding of services has flow on effects from attracting and retaining suitable staff, to continuity of care for clients
- There is a limited availability in programs when a client needs to step up a level of care, this results in either long wait times or limited treatment options at a lower intensity.

Workforce

The mental health workforce consists of both clinically trained professionals, such as psychiatrists, psychologists and mental health nurses and non-clinical roles, such as peer support workers. Other professions that work within the mental health field include: General Practitioners, Social workers, Occupational therapists, Counsellors, Community Mental Health Workers, Aboriginal health workers, dieticians, youth workers, art therapists, pharmacists, alcohol and other drug health workers, primary care physicians, recovery and rehabilitation workers, housing specialists, Justice Health, family therapists, mental health coaches, Acute Care Teams. These professions can all play a valuable role as part of a multidisciplinary team to support individuals for improved outcomes.

There are four main mental health sectors where support can be accessed:

1. The public health system – Local Health Districts or Local Health Networks
2. The primary care system – General Practitioners and Allied Health Providers
3. The private sector – Clinicians working either in private practice or within private hospitals

4. Non-government organisations – this includes Community Managed organisations and helplines and counselling services such as Lifeline and beyond blue.

Data presented in this section does not include Lord Howe Island.

Psychiatry workforce

In 2023, there were 393 psychiatrists working in a clinician role in the CESPHN region (363.5 FTE) giving a rate of 24.0 per 100,000 population (22.2 FTE per 100,000 population), higher than the state and national rates for number of practitioners (13.4 and 14.6) and FTE (12.2 and 13.6) per 100,000 population respectively (31).

Within the region, there is an uneven distribution of psychiatrists. Sydney Inner City SA3 has the highest rate of psychiatrists (52.9 per 100,000 population), followed by Canada Bay (43.4 per 100,000) and Eastern Suburbs – North (39.8 per 100,000). The SA3s of Botany, and Sutherland-Menai-Heathcote have three or less psychiatrists. For this reason, they are excluded from parts of the below analysis.

Table 5: Psychiatrists by location, 2023

Measure	CESPHN	NSW	Australia
Number of Practitioners	393	1,139	3,940
Number of Practitioners (rate per 100,000 population)	24.0	13.4	14.5
FTE Total	363.5	1,038.2	3,688.4
FTE Total (rate per 100,000 population)	22.2	12.2	13.6
FTE Clinical	320.5	921.8	3,230.9
FTE Clinical (rate per 100,000 population)	19.5	10.9	11.9

Source: HWA, 2025

Years intended to work

In 2023, 37.3% of psychiatrists in the CESPHN region intended to only work up to another 10 years. Just over 67.7% of psychiatrists in Hurstville SA3 and 61.6% in Leichhardt SA3 indicate that they do not intend to work more than ten years (31).

Table 6: Psychiatrist years intended to work by SA3, 2023

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Canada Bay	11.1	19.4	0.0	16.7	41.7	11.1	0.0
Canterbury	0.0	0.0	0.0	62.5	37.5	0.0	0.0
Cronulla-Miranda-Caringbah	25.0	25.0	25.0	25.0	0.0	0.0	0.0
Eastern Suburbs – North	18.2	25.5	12.7	10.9	20.0	7.3	5.5
Eastern Suburbs – South	17.5	12.3	14.0	17.5	31.6	7.0	0.0
Hurstville	33.3	33.3	33.3	0.0	0.0	0.0	0.0
Kogarah-Rockdale	13.0	13.0	21.7	21.7	30.4	0.0	0.0
Leichhardt	44.4	16.7	16.7	22.2	0.0	0.0	0.0
Marrickville-Sydenham-Petersham	-	-	-	-	-	-	-
Strathfield-Burwood-Ashfield	31.0	20.7	10.3	37.9	0.0	0.0	0.0
Sutherland-Menai-Heathcote	-	-	-	-	-	-	-
Sydney Inner City	20.5	18.9	15.7	11.8	26.8	3.9	2.4
CESPHN	19.8	17.5	13.4	17.5	24.4	5.7	1.8
New South Wales	20.3	17.5	14.5	19.4	22.1	4.5	1.6
Australia	20.6	18.7	14.7	19.1	21.5	3.7	1.6

Source: HWA, 2025
Note: Data for Marrickville-Sydenham-Petersham and Sutherland-Menai-Heathcote SA3 are too low to report on. Results for Botany and Hurstville are based on small numbers and are to be interpreted with caution.

Psychologist workforce

In 2023 there were 2,941 psychologists working in a clinical role in the CESPHN region (2,433.0 FTE) giving a rate of 179.3 per 100,000 population (148.3 FTE per 100,000 population), higher than the state and national rates for number of practitioners (119.4 and 115.1) and FTE (98.8 and 95.7) per 100,000 population respectively (32).

Sydney Inner City SA3 has the highest rate of psychologists at 417.3 per 100,000 population, followed by Eastern Suburbs – North (294.0 per 100,000) and Leichhardt (259.1 per 100,000). The SA3s of Canterbury, (54.7 per 100,000) and Botany (59.4 per 100,000) have a rate 3 times lower than the CESPHN rate which shows the differential physical access to psychologists across the region (32).

Table 7: Psychologists by region, 2023

Measure	CESPHN	NSW	Australia
Number of Practitioners	2,941	10,125	31,292
Number of Practitioners (rate per 100,000 population)	179.3	119.4	115.1
FTE Total	2,433.0	8,384.9	26,011.6
FTE Total (rate per 100,000 population)	148.3	98.9	95.7
FTE Clinical	1,916.2	6,720.1	20,742.7
FTE Clinical (rate per 100,000 population)	116.8	79.3	76.3

Source: HWA, 2024

Years intended to work

Data on psychologist years intended to work suggests Leichhardt, Marrickville-Sydenham-Petersham and Sutherland-Menai Heathcote may experience shortages in psychologists given the high proportions of psychologists intending to leave within 5 years.

Table 8: Psychologist years intended to work by SA3, 2023

Geography	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	10.3	17.9	10.3	28.2	10.3	15.4	7.7
Canada Bay	11.9	17.5	12.6	23.8	23.1	7.7	3.5
Canterbury	10.7	14.7	16.0	26.7	25.3	6.7	0.0
Cronulla - Miranda - Caringbah	16.6	13.6	17.2	20.7	24.9	5.3	1.8
Eastern Suburbs - North	16.0	18.6	9.8	24.5	21.0	6.9	3.2
Eastern Suburbs - South	15.0	16.9	10.1	15.3	26.7	12.4	3.6
Hurstville	10.6	13.5	11.5	24.0	27.9	8.7	3.8
Kogarah - Rockdale	12.5	11.7	13.3	25.0	28.3	5.0	4.2
Leichhardt	20.3	20.3	11.5	18.2	20.3	7.4	2.0
Marrickville - Sydenham - Petersham	17.2	20.3	7.8	23.4	17.2	14.1	0.0
Strathfield - Burwood - Ashfield	14.1	20.3	14.1	13.5	22.9	13.0	2.1
Sutherland - Menai - Heathcote	16.9	19.4	18.5	14.5	22.6	4.8	3.2
Sydney Inner City	13.4	15.7	10.6	20.6	29.0	8.5	2.3
Central and Eastern Sydney	14.4	16.7	11.8	20.5	25.3	8.6	2.7
New South Wales	16.2	17.9	12.2	20.3	23.3	7.7	2.2
Australia	15.9	18.1	12.4	20.2	23.5	7.8	2.1

Source: HWA, 2023

Mental health nurse workforce

In 2023 there were 1,550 mental health nurses working in a clinician role in the CESPHN region (1,545.2 FTE) giving a rate of 94.5 per 100,000 population (94.2 FTE per 100,000 population), higher

than the national and state rates for number of practitioners (92.1 and 81.0) and FTE (78.8 and 91.4) per 100,000 population respectively (32).

There is an uneven distribution of mental health nurses across the region. Eastern Suburbs – South SA3 has the highest rate of mental health nurses 327.8 per 100,000 population, followed by Canada Bay (276.8 per 100,000) and Sydney Inner City (149.2 per 100,000). Leichhardt SA3 has the lowest rate of mental health nurses (8.6 per 100,000) with Botany and Sutherland - Menai – Heathcote also having low rates (9.6 and 10.5 per 100,00, respectively) (32).

Table 9: Mental health nurses by region, 2023

Measure	CESPHN	NSW	Australia
Number of Practitioners	1,550	6,865	25,036
Number of Practitioners (rate per 100,000 population)	94.5	81.0	92.1
FTE Total	1,545.2	6,747.1	24,338.0
FTE Total (rate per 100,000 population)	94.2	79.6	89.5
FTE Clinical	1,499.2	6,520.8	23,524.4
FTE Clinical (rate per 100,000 population)	91.4	76.9	86.5

Source: HWA, 2023

Years intended to work

In 2023, 46.0% of mental health nurses in the CESPHN region intended to only work up to another 10 years. Of note, 35.1% of the mental health nurses in Strathfield-Burwood-Ashfield SA3 do not intend to work more than 5 years and 75.3% the mental health nurses in Strathfield-Burwood-Ashfield SA3 do not intend to work more than 15 years (32).

Table 10: Mental health nurse years intended to work by SA3, 2023

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	33.3	33.3	0.0	33.3	0.0	0.0	0.0
Canada Bay	16.8	22.7	8.4	24.4	16.8	8.0	2.9
Canterbury	16.2	21.6	21.6	24.3	16.2	0.0	0.0
Cronulla – Miranda – Caringbah	26.8	15.9	14.6	13.4	15.9	13.4	0.0
Eastern Suburbs – North	30.0	40.0	0.0	16.7	0.0	13.3	0.0
Eastern Suburbs – South	27.5	21.0	9.7	13.9	15.6	8.7	3.7
Hurstville	20.0	20.0	0.0	20.0	20.0	20.0	0.0
Kogarah – Rockdale	18.0	28.7	8.2	18.0	22.1	4.9	0.0
Leichhardt	-	-	-	-	-	-	-
Marrickville – Sydenham –Petersham	33.3	33.3	0.0	0.0	0.0	33.3	0.0
Strathfield – Burwood – Ashfield	35.1	24.7	15.5	12.4	7.2	5.2	0.0
Sutherland – Menai – Heathcote	0.0	0.0	0.0	0.0	50.0	50.0	0.0
Sydney Inner City	24.0	20.5	8.5	17.9	19.9	7.0	2.1
CESPHN	24.0	22.0	9.7	17.2	16.6	8.1	2.5
NSW	23.4	21.4	10.7	17.7	17.2	6.9	2.7
Australia	21.4%	20.4%	11.4%	17.8%	19.0%	7.3%	2.8%

Source: HWA, 2024

Note: Data for Leichhardt SA3 is too low to report on.

Lived Experience workforce

The Lived Experience workforce is made up of people who are employed in paid positions that require Lived Experience as an essential employment criterion, regardless of position type or setting. This is a professional approach in which diverse personal experience-based knowledge is applied within a consistent framework of values and principles (33). The lived experience workforce is essential to delivering quality, recover-focused mental health services in Australia. Workers act as "change agents," supporting both individual recovery and broader cultural and practice changes within services.

The Lived Experience workforce offers significant benefits to service users, families, service providers, and the broader community. Their role improves service engagement, treatment outcomes, and staff retention, while reducing critical incidents and healthcare costs. In community settings, it can relieve pressure on other services, such as GPs and youth mental health services.

The central and eastern Sydney Mental Health and Suicide Prevention Regional Plan (2024-2026) identifies the need to support and grow the mental health peer (lived experience) workforce. Currently peer workers are engaged with several of CESPHN's commissioned services including, but not limited to, the Canterbury Medicare Mental Health Centre, headspace Camperdown, the Youth Enhanced Service, CASPAR, Connect and Thrive, Active8 andAvtive9 & WorkWell, Growing Resilience, PICS, and KBIM-p and Keeping the Body In Mind.

Community managed workforce

The Community managed mental health workforce is the workforce that provides mental health services outside of the public sector (Local Health District/Network managed services). Whilst there is no local level data available for the CESPHN region we can use NSW data to provide insights into what may be happening within the CESPHN region.

The Mental Health Coordinating Council (MHCC) undertakes an annual survey of the community managed mental health workforce in NSW. In 2023 it found that:

- 25% of the total mental health workforce in NSW works at a community managed organisation
- 70% of the workforce is less than 45 years of age
- There is 2-3% growth in the workforce each year
- 72% of all workers in the sector are female
- 40% of direct support mental health worker are causal or contract employee
- 19% of the workforce has lived experience of mental health, both in peer and non-peer roles.(34)

The report also highlights a reduction in psychiatrists and other medical practitioners working in the CMO sector. This category has dropped by more than 70% with only 13 Psychiatrists working in the CMO sector in NSW in 2023. Respondents of the survey reported that recruiting psychiatrist to the sector is extremely challenging.(34)This was echoed by participants in CESPHN Mental Health Stakeholder consultation held in July 2024.

A breakdown of workers by the type of direct support from the survey can be seen below.

Table 11: Number of workers by type of direct support roles in NSW, 2023

Type of worker/occupation	Headcount	Proportion of total workforce (%)	FTE	Proportion of FTE workforce (%)
Identified Consumer Peer Worker	406	12.3	309.2	12.9
Identified Carer Peer Worker	51	1.5	37.4	1.6
Recovery Coach	23	0.7	16.4	0.7
Mental Health Support Worker	1236	37.5	945.3	39.3
Support Coordinator	273	8.3	240.1	10
Nurse	57	1.7	38.2	1.6
Psychiatrist	13	0.4	5.5	0.2
Psychologist/counsellor	315	9.6	137.8	5.7
Other medical practitioner	23	0.7	5	0.2
Allied Health	233	7.1	157.9	6.6
Other	663	20.1	512.1	21.3
Total	3293	99.9	2404.9	100.1

Source: MHCC, 2023

A highlight in the sector is the increase in Identified Consumer Peer Workers, who are now the second largest workforce in the community managed sector representing 12.3% of all workers. Participants at the CESPHN Mental Health Stakeholder consultation also highlighted the important

role that Peer workers play in the workforce, however concerns were raised at how this sector of the workforce is supported including the need for different levels of support across different levels of experience, much like how clinicians are supported based on their skills and experience.

The MHCC annual survey also identified that CMO were finding it difficult to fill vacancies, particularly with psychiatrists, followed by psychologists and councillors. Reasons suggested for this include insufficient workers with relevant qualifications, can only offer short-term contracts and unable to offer competitive salaries.(34)As PHN commission services within the CMO space, it is important to note that these challenges need to be taken into consideration for ongoing commissioning.

Service gaps within the workforce

Consultation with both external stakeholders, CESPHN staff and a community services survey have identified a number of service gaps within the workforce:

- Concerns that clinical current workforce shortages may be amplified as the number of psychiatrists and psychologists plan to retire in the next five years
- The lived experience workforce is a valuable resource but is currently underutilised or under resourced
- Psychologists are being attracted to more privately run services due to better working conditions. This reduces the amount of practitioners available for publicly funded/subsidised service. Also increase staff turnover, which increases the burden of training more staff and impacts continuity of care.
- There is a lack of Occupational Therapists to assist in Multidisciplinary Teams as most work withing the NDIS system.
- The workforce is either not supported or does not have steps in place to support vicarious trauma
- There is a high turnover of staff, and difficulty recruiting new staff with the right skills

CESPHN's current work

CESPHN is currently undertaking a large range of initiatives and commissioning to meet the needs of the community. These initiatives and services are described in the relevant sections throughout this chapter are listed below:

Low intensity services

- Medicare Mental Health Centres (MMHC)
- Emotional Wellbeing for Older Persons
- Your Coach Plus
- Support for communities impacted by the Israel/ Gaza, conflict
- Strengthening Our Mob -Youth
- Aboriginal Youth Health and Wellbeing (Inner City) Program

Mild to moderate services

- Cognitive Behavioural Therapy (CBT) Group for young adults with Autism Spectrum Disorder
- Emotional Wellbeing for Older Persons (EWOP)
- headspace
- Medicare Mental Health Centre
- Psychological Support Services (PSS)

High intensity services

- GP Mental Health Shared Care

- GP Mental Health Shared Care – Clozapine
- Youth Enhanced Services
- Medicare Mental Health Centre
- Primary Integrated Care Supports (PICS) Program
- Telehealth Psychiatry Service (TPS)

Psychosocial supports:

- Yarning Circles
- Connect and Thrive.
- Keeping the Body in Mind
- Making Space
- Social Rx ®

Opportunities to address health and service needs

- **Increased access to providers:** this can be achieved by expanding the mental health workforce, peer support workforce, and OTs.
- **Integrate mental health into primary health care:** this can help identify mental health issues early and allows for easier and more universal access to care
- **Establish integrated mental health hubs:** Allow for clients to access services to meet all of their recovery needs in one place
- **Additional training and support for friends and families** e.g., via approaches such as Open Dialogue.

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Suicide prevention

2025-2027 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples or people that identify as from the First Nations community. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

Suicide prevention

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Suicide prevention

Content warning: The following chapter contains information about suicide that may be distressing. Please consider your wellbeing and reach out to services and supports as required.

Suicide prevention

Overview

Over 3000 suicides occur in Australia each year (1) and in 2023, there were 146 deaths by suicide within the central and eastern Sydney region. According to the Australian Institute of Health and Welfare, suicide is the leading cause of death for young people (1).

Key issues

- Individuals in the 0-24 year age group had the highest proportion of self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%)
- High rates per 100,000 of suicide in older people aged 80+

Key gaps

- Primary care professionals identify a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide
- Primary care professionals face challenges in identifying individuals at risk of attempting suicide

Social determinants and risk factors

A multitude of social determinants and individual risk factors contribute to how suicidal thoughts and behaviours and ultimately, suicide might arise as outlined below:

Social determinants include:

- Macroeconomic policies (e.g., taxation policies and austerity measures)
- Public policies (e.g., policies that limit the consumption of alcohol)
- Social policies (e.g., active labour market policies and housing policies)
- Legislative or regulatory frameworks (e.g., firearm ownership laws and online regulatory frameworks)
- Healthcare coverage and health system capacity and responsiveness (e.g., workforce constraints and waiting lists)
- Local environment (e.g., rural or remote location, neighbourhood deprivation and availability of means of suicide)
- Cultural and societal values (e.g., colonisation, racism, discrimination and views of, attitudes towards, and communication and suicide and self-harm)
- Social cohesion and social capital

Commercial determinants include:

- Firearm, pesticide, alcohol and gambling industries

Individual risk factors include:

- Demographic factors (e.g., age, sex, gender identity, sexual orientation, ethnicity and cultural heritage)
- Socioeconomic factors (e.g., education, employment, occupation and income)

Other risk factors include:

- Contextual factors (e.g., stressful life events; job insecurity; homelessness; housing; bereavement by suicide; lack of family support; adverse early life experiences; trauma including intergenerational trauma; exposure to conflict, violence, and war; involvement with the criminal justice system; and access to means used for suicide)

- Clinical factors (e.g., mental illness drug and alcohol use, previous episodes of self-harm and chronic physical illness)
- Personality-based factors (e.g., impulsivity, impressionability, and coping style)
- Genetic or familial factors (e.g., family history of suicide)
- Neurobiological factors (e.g., DNA methylation)

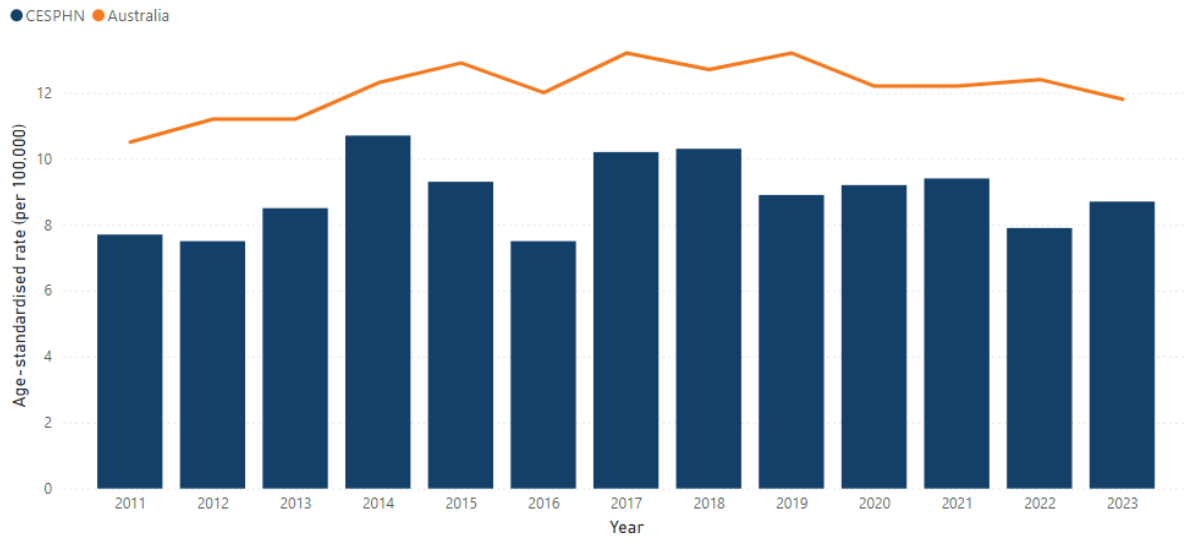
For those bereaved by suicide, the health impacts can be significant and can include further suicidality, complicated grief, PTSD, depression, and substance use disorders (2).

Prevalence of suicide and intentional self-harm

Suicide

Suicide rates in the CESPHN region fluctuate across time with no overt upwards or downwards trend.

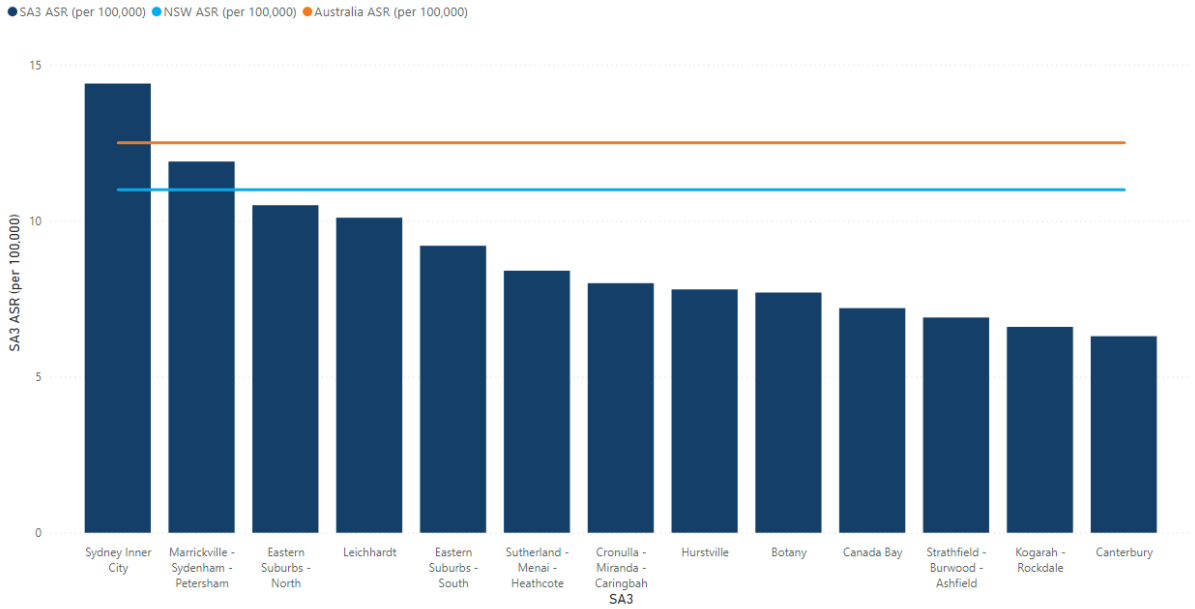
Figure 1: Suicide rate per 100,000 population, CESPHN region, 2011 – 2023



Source: AIHW, 2025

Suicide data for 2019-2023 shows that Sydney Inner City SA3 had the highest rate of suicide within the CESPHN region (14.4 per 100,000 population) with rates higher than both NSW (11.0 per 100,000 population) and Australia (12.5per 100,000 population), followed by Marrickville -Sydenham-Petersham SA3 (11.9 per 100,000 population) and Eastern Suburbs – North (10.5 per 100,000 population) (1).

Figure 2: Suicide rate by SA3, 2018-2023



Source: AIHW, 2024

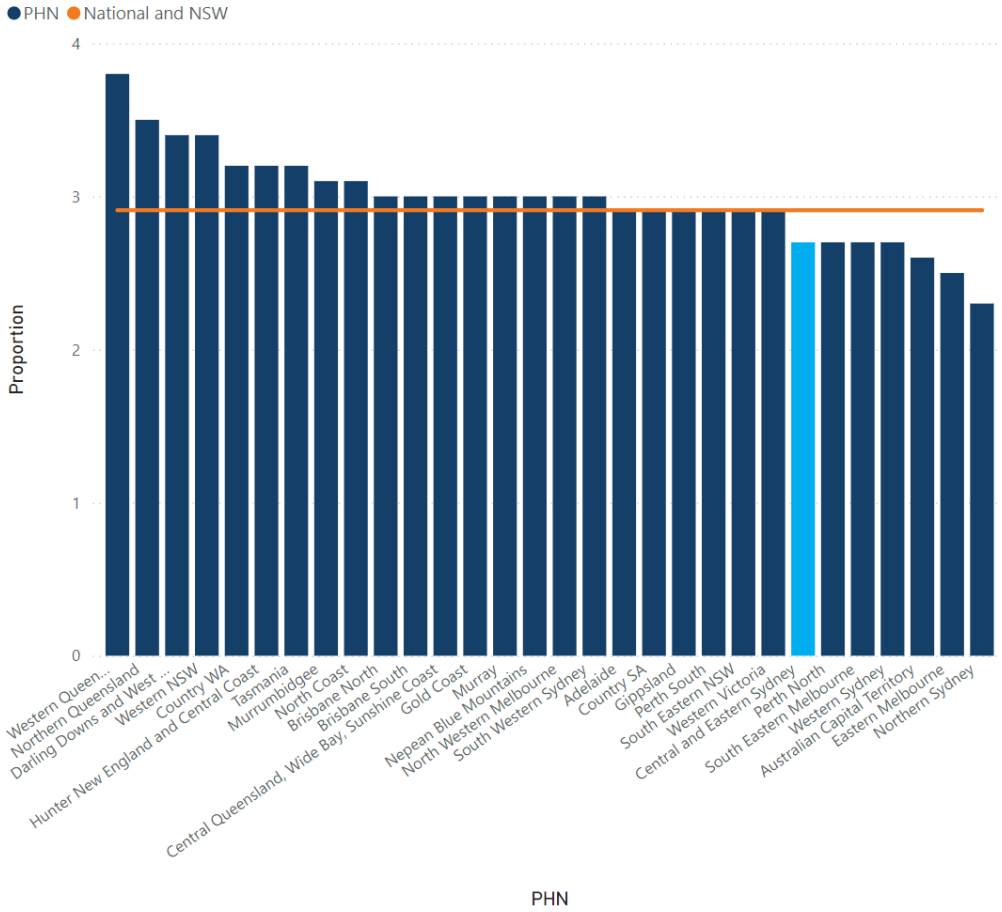
The NSW Suicide Monitoring System reported 951 suspected or confirmed deaths by suicide in NSW in 2024 (3). Monthly frequency data ranges from 108 suspected or confirmed deaths in November to 69 suspected or confirmed deaths in March.

Suicidal thoughts and self-harm behaviours

The 2020-2022 National Study of Mental Health and Wellbeing (NSMHW) report provides modelled estimates for both suicidal thoughts and self-harm behaviours. Suicidal thoughts and behaviours in the NSMHW report refer to whether a person had ever seriously thought about taking their own life, made a plan to take their own life, or attempted to take their own life, and whether they had done so in the last 12 months. A person must have said they had seriously thought about taking their own life to be asked if they had made a plan and/or attempt (4).

In 2020-2022, 2.2% of people aged between 16-85 years in the CESPHN region had experienced suicidal thoughts and behaviours in the previous 12 months. This is below the state and national rates of 2.9% and 3.3% respectively. At a national level, 74.9% of people who had reported any suicidal thoughts or behaviours in the last 12 months also had reported having a mental health disorder in the last 12 months (4).

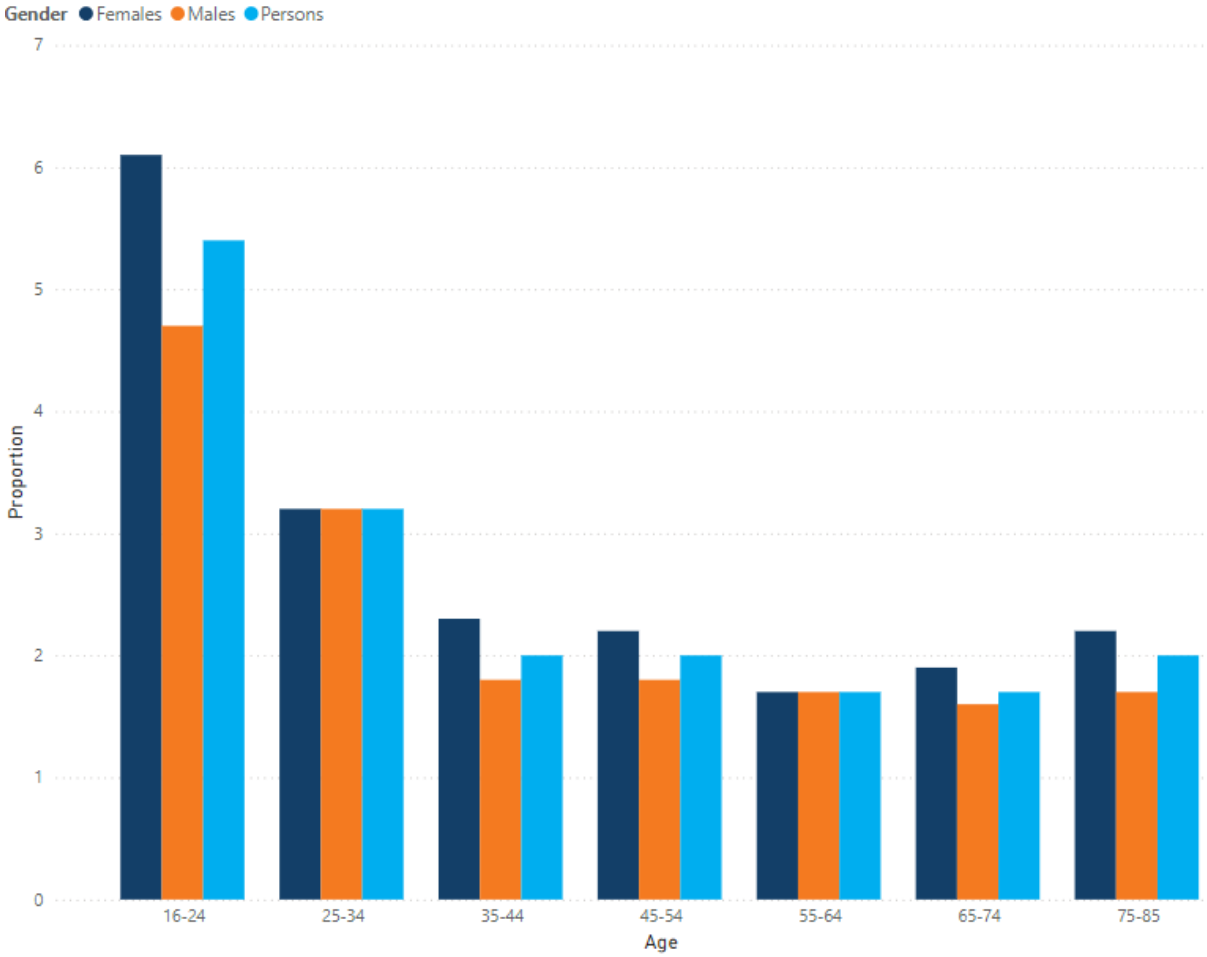
Figure 3. Suicidal thoughts and behaviours in the last 12 month by PHN, 2020-2022



Source ABS, 2024

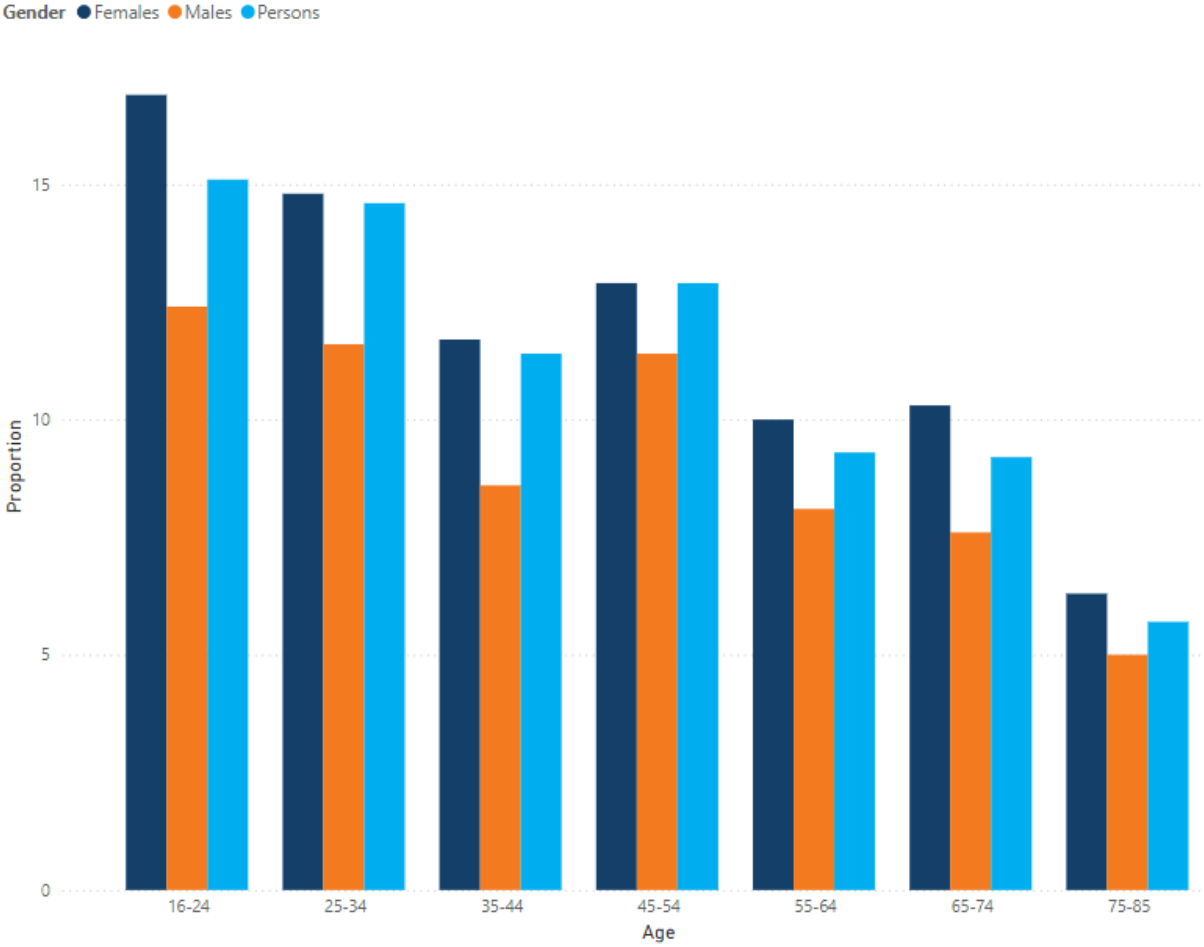
Within the CESPHN region, the modelled rate of suicidal thoughts and behaviours in the last 12 months is higher in females than males. Modelled rate of suicidal thoughts and behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population) with a decline in every age range until 74-85 years where there is an increase (2.0 per 100 population) from 1.7 per 100 population in the 65-74 years (4).

Figure 4: Suicidal thoughts and behaviours in the last 12 month by age and sex, 2020-2022



Source: ABS, 2024

Figure 5: Suicidal thoughts and behaviours by lifetime, by age and sex, 2020-2022

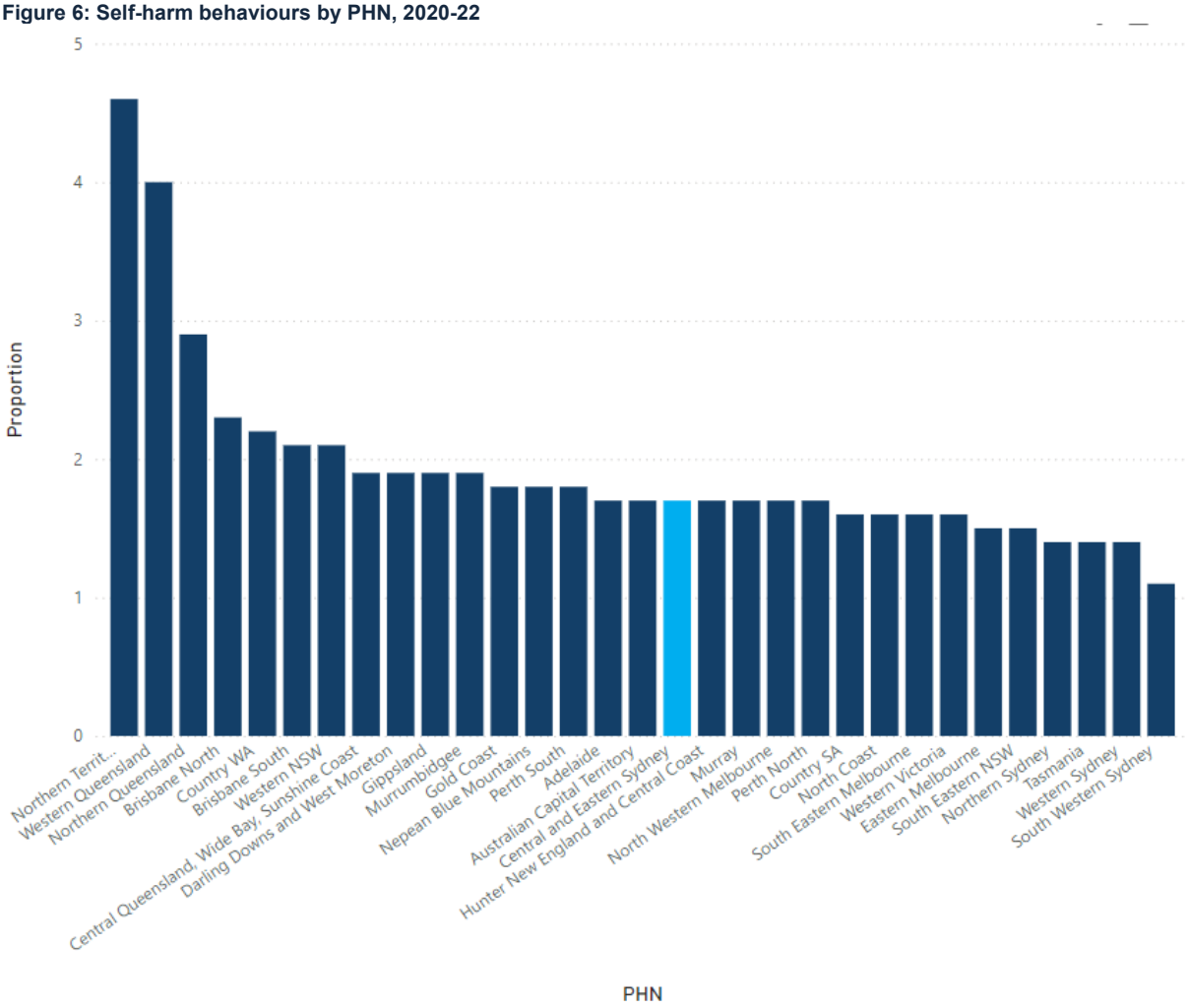


Source: ABS, 2024

Intentional self-harm behaviours

In 2020-22, modelling indicated that 1.7% of the CESPHN population aged 16-85 years displayed self- harm behaviours, which is defined as intentionally causing pain or damage to their own body (4) This behaviour may be motivated as a way of expressing or controlling distressing feelings or thoughts. Self-harm and suicide are distinct and separate acts although people who self-harm are at an increased risk of suicide. (5) Due to the way the data is categorised and collected, there is no distinction in the data between intentional self-harm and suicide attempts. It is therefore impossible to accurately quantify suicide attempts. An awareness of this challenge should apply when interpreting the data. In the previous 12 months CESPHN had the 17th highest rate of self-harm behaviours across PHNs nationally(4).

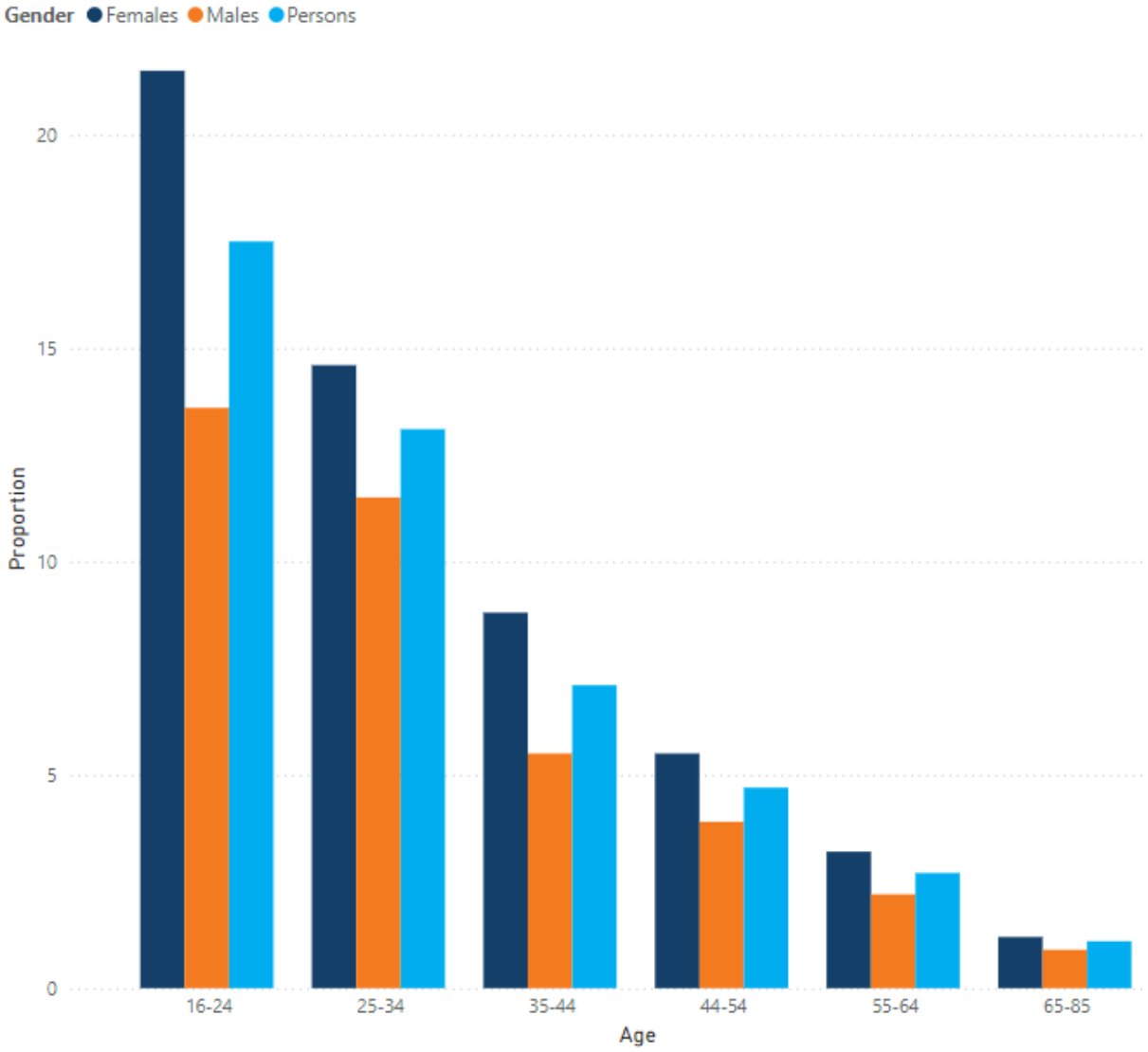
Figure 6: Self-harm behaviours by PHN, 2020-22



Source: ABS, 2024

Within the CESPHN region, the modelled rate of self-harm behaviours (including both intentional self-harm and suicide attempts) in the last 12 months is higher in females than males. This is also consistent across the self-harm behaviours over a lifetime. Modelled rates of self-harm behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population, compared to the total population (1.7 per 100 population). Over a lifetime, 17.5% young people aged 16-24 years have displayed self-harm behaviours, compared to 8.1% of the CESPHN population aged 25-85 years (4).

Figure 7: Rate of Self Harm behaviours in the CESPHN region by lifetime by age and gender



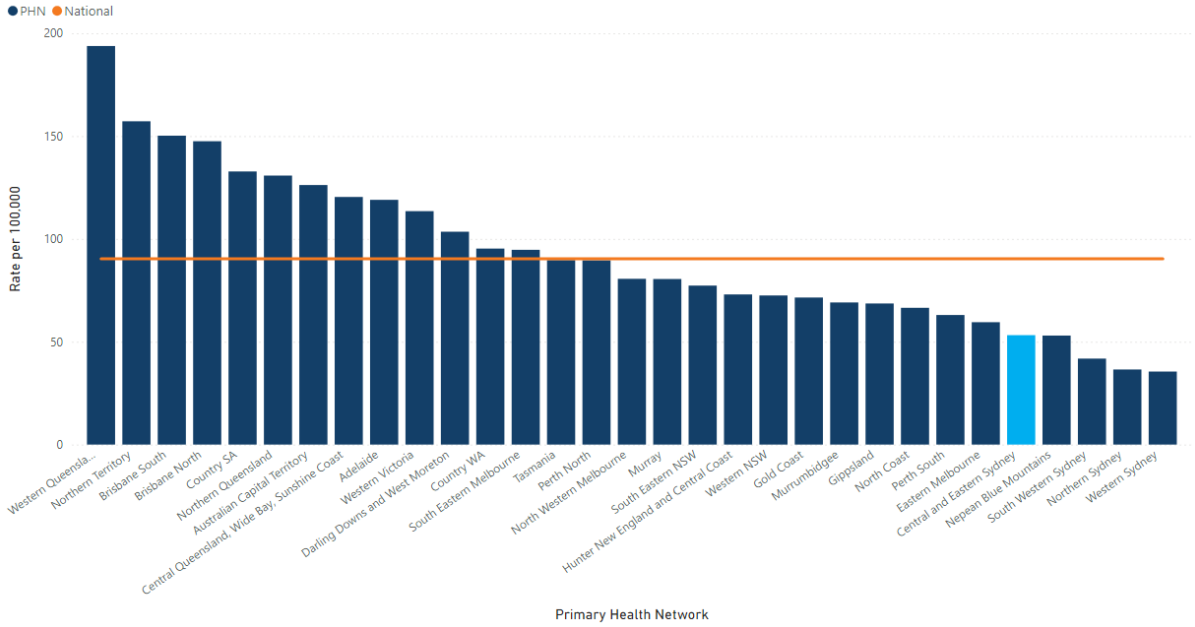
Source: ABS, 2024

Intentional self-harm hospitalisation

In 2023-24, there were 854 intentional self-harm hospitalisations (which include both intentional self-harm and suicide attempts) in the CESPHN region giving a rate of 53.2 per 100,000 population, down from 71.1 per 100,000 in 2019-20. This is lower than both the NSW and national rates (55.8 per 100,000 population and 90.3 per 100,000 population respectively) (1).

Across CESPHN, 60.0% of self-harm hospitalisations in 2022-23 were for females (1).

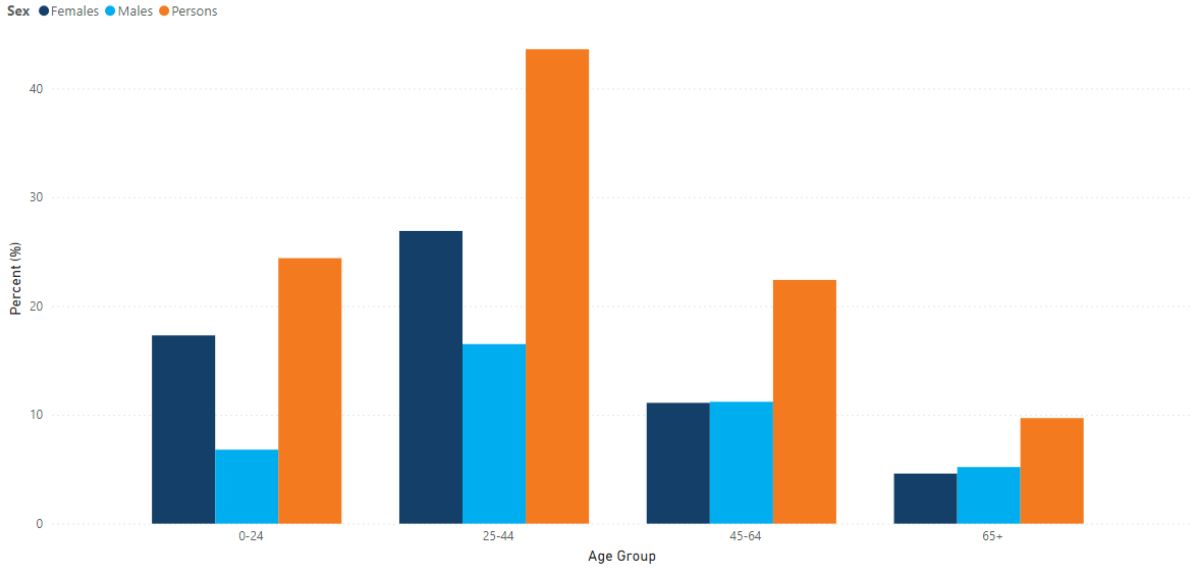
Figure 8: Self harm hospitalisation rate by PHN, 2023-24



Source: AIHW, 2024

Individuals in the 25-44 age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (43.6%), followed by 0–24-year-olds (24.4%). This is a shift from 2021-22 where 0-24 year age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%) (1).

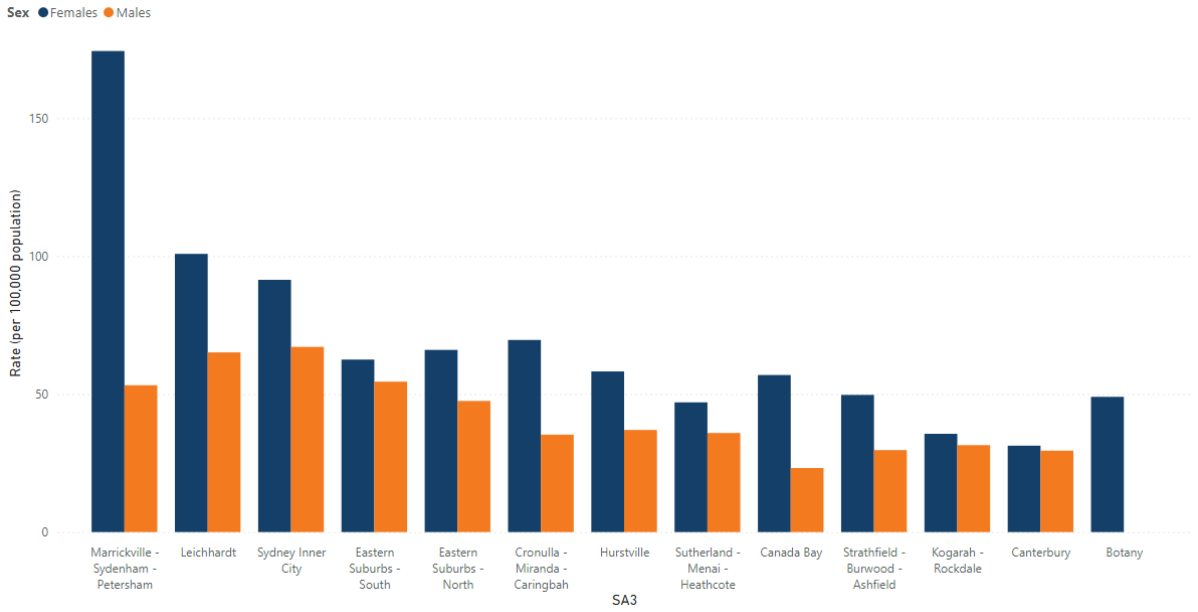
Figure 9: Intentional self-harm hospitalisations by age group and gender, CESPHN, 2023-24



Source: AIHW, 2024

Females in the Marrickville - Sydenham - PetershamSA3 had the highest intentional self-harm hospitalisation rates (174.3 per 100,000 population) within the CESPHN region, followed by LeichhardtSA3 (100.8 per 100,000 population). Across all SA3s with the exception of Canterbury, females had higher rates of intentional self-harm hospitalisations than males (1).

Figure 10: Intentional self-harm hospitalisations rate by sex, by SA3, 2023-24



Source: AIHW, 2024

Means restriction

Restriction of means of suicide plays an important role in reducing suicides. Whilst this is not the focus of suicide prevention activities for CESPHN, important data on suicide means is available at the Australian Institute of Health and Welfare website. Discussion of suicide means and methods has not been included in this Needs Assessment due to the documented risk of contagion.

Groups disproportionately affected

Aboriginal and Torres Strait Islander people

- Nationally in 2023, the rate of suicide in Aboriginal and Torres Strait Islander peoples has increased to 30.8 per 100,000 people from 23.6 per 100,000 people in 2018. This is the highest rate in the last five years and represents an increase of about 30% (6).
- By comparison, in 2023, the suicide rate across all Australians was 12.1 per 100,000 population (6).

Children and young people

Nationally, suicide is the leading cause of death in young people aged 15-24 years. In 2023:

- 298 Australian young people (aged 18–24 years) took died by suicide
- 94 deaths by suicide occurred among children and adolescents (aged 17 and below) with the majority occurring in those aged 15–17 (71.3%)
- Deaths by suicide represented 31.8% of all deaths in young people aged 15–17 years and 33.1% of all deaths in those aged 18–24 years—up from 16.5% and 23.9% respectively of all deaths in these age groups in 2001 (1).

Suicide among humanitarian entrants and other permanent migrants

Whilst multicultural communities who include refugee, humanitarian entrants and other permanent migrants have varied experiences, they may also have some shared experiences that contribute to suicide risk factors. These include difficulties adjusting to a new culture, experiences of stigma, and changes in social and family networks a result of migration (1). Australians from multicultural backgrounds who are refugees or humanitarian entrants may experience additional or more pronounced challenges due to past experiences of persecution or human rights abuses within their country of origin, or trauma associated with war or their refugee journey (1).

Amongst humanitarian entrants who arrived on or after 2000:

- Between 2007 and 2020, the Age-standardised rate (ASR) of death by suicide was 6.7 per 100,000.
- This was higher in males (11.0 per 100,000) than in females (3.0 per 100,000)
- The ASR increased with increased time since arrival in Australia (4.2 deaths per 100,000 person-years for less than 5 years since arrival, 7.3 per 100,000 person-years for 5–10 years since arrival, 11 per 100,000 person-years for more than 10 years since arrival. (1)

Amongst other permanent migrants who arrived on or after 2000:

- Between 2007 and 2020, the ASR of death by suicide is 4.0 per 100,000
- This was higher in males (5.8 per 100,000) than in females (2.3 per 100,000)
- The ASR increase with increased time since arrival in Australia (2.6 deaths per 100,000 person-years) for less than 5 years since arrival, 2.6 per 100,000 person-years for 5–10 years since arrival, 11 per 100,000 person years for more than 10 years since arrival. (1)

This data highlights the difference between the two migrant groups, with humanitarian entrants having higher rates. No specific data is available on refugee status within the National Mortality Database or the National Hospital Morbidity Database

LGBTIQA+ peoples

There is no local national dataset that captures suicide or intentional self-harm rates amongst the whole LGBTIQA+ community. However, research has been undertaken through two surveys which provide aggregated data by state/territory, age-group, gender and sexual orientation. These surveys, Private Lives 3 (PL3) and Writing Themselves In 4 (WTI4) were both undertaken in 2019 and target LGBTQ+ adults and LGBTQA+ young people. Both surveys form part of the 2024 Rainbow Realities report, commissioned by the Department of Health and Aged Care to inform the National LGBTIQ+ strategy. This report is discussed in more detail in the LGBTIQA+ chapter.

The PL3 survey found that for suicidal thoughts

- 75% of people from the LGBTQ+ community in NSW reported having experienced suicidal thoughts in their lifetime
- 91% of trans men nationally reported having experienced suicidal thoughts in their lifetime
- 90% of non-binary people nationally reported having experienced suicidal thoughts in their lifetime
- 86% of trans women nationally reported having experienced suicidal thoughts in their lifetime (7)

The PL3 survey also found that for suicide attempts:

- 28% of people from the LGBTQ+ community in NSW reported having attempted suicide
- 53% of trans men nationally reported having attempted suicide
- 46% of trans women nationally reported having attempted suicide
- 40% of non-binary people nationally reported having attempted suicide (7)

The WTI4 survey of lesbian, gay, bisexual, trans and gender diverse, queer and Asexual (LGBTQA) young people, aged 14 to 21 years found that:

- 79.6% of participants in NSW had experience of suicidal thoughts
- 49.2% of participants in NSW had experience of a suicide plan
- 26.2% of participants in NSW had experience of suicide attempt
- 62.4% of participants in NSW had experience of self-harm
- 92.1% of trans men, 90.7% of trans women and 87.5% of non-binary people had experience of suicidal thoughts
- 73.2% of trans men, 61.3% of trans women and 58.4% of non-binary people had experience of suicide plan
- 46.9% of trans men, 40.0% of trans women and 34.8% of non-binary people had experience of suicide attempt
- 85.8 % of trans men, 68.0% of trans women and 76.1% of non-binary people had experience of self-harm
- Over 80% of pansexual (84.8%), Queer (83.1%), and lesbian (81.5%) peoples had experience of suicidal thoughts
- Over 50% of pansexual (57.2%), Queer (53.8%), and lesbian (50.1%) peoples had experience of suicide plan
- Over 30% of pansexual (35.1%), Queer (30.0%), and lesbian (30.0%) peoples had experience of suicide attempt
- Over 60% of pansexual (74.3%), Queer (70.8%), lesbian (68.4%), and bisexual (62.8%) peoples had experience of self-harm
- Cisgender men and cisgender women had lower rates across every measure (1).

Further groups disproportionately impacted by suicide

Additional priority population groups identified in the Department of Health, Disability and Ageing's Program Guidance for Targeted Regional Initiatives for Suicide Prevention are:

- People experiencing homelessness or housing instability
- Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples)
- People living in regional, rural and remote areas of Australia
- People experiencing or at risk of abuse and violence, including sexual abuse, neglect and
- family and domestic violence
- People with a disability
- Australian Defence Force members and veterans
- People experiencing socioeconomic disadvantage
- People who are (or were previously) in contact with the criminal justice system
- People with complex mental health needs, including people with co-occurring mental health
- and cognitive disability and/or autism.
- People with harmful use of alcohol or other drugs, or people with substance use disorders
- People who have made a previous suicide attempt or who have been bereaved by suicide. (8)

Suicide and self-harm prevention services

Within the CESPHN region, extensive work has been undertaken to map out suicide prevention services across the region. These include services that are commissioned by CESPHN as well as services funded by other organisations include state government and local health districts. Services in the region have been categorised into six different categories all of which have a distinct purpose.

1. Crisis support and aftercare services
2. Treatment and support services for people experiencing suicidality or distress
3. Community awareness, mental health literacy and resilience
4. Joint governance and system change
5. Health and other frontline services
6. Community capacity building.

Table 1: Suicide prevention services, CESPHN region

Crisis support and aftercare	Treatment and support services for people experiencing suicidality or distress
• Zero Suicides in Care initiative • The Way Back NSW • Crisis lines (Lifeline, Suicide Call Back, 13 YARN) • Acute Care Teams in hospitals • ACON SP Aftercare Support Service • Support lines - Kidshelpline, Qlife, Mensline, eheadspace • CAMHS [Child and Adolescent Mental Health Service] • Canterbury Medicare Mental Health Centre • NSW Mental Health Line • SafeGuards team (0-17 years) • Safe Havens • StandBy Support After Suicide • Suicide Prevention Outreach Teams • PACER – Police, Ambulance, Clinical, Early, Response • Thirrili Indigenous Suicide Postvention Service	• The Way Back NSW • Psychological Support Services (PSS) Suicide Prevention • Services [CESPHN] • Head to Health Centre (Canterbury) • headspace centres • Tribal Warrior Connector Service • Support groups (e.g., Alternatives to Suicide; Gender Centre) • Support Groups; local council social groups) • Social Prescribing Models • Your Coach Plus delivered by PCCS • Babana Aboriginal Mens Group • Digital tools and apps (e.g.,WellMob, Beyond Now) • Lifeline Suicide Bereavement Groups • Safe Havens (Darlinghurst, Kogarah, Newtown and Randwick),
Community awareness, mental health literacy and resilience	**Joint governance and system change**
• Suicide Prevention Australia Doing It Tough website • Babana community awareness days and yarning circles • Heal Our Way campaign • headspace centres and beyondblue Be You outreach programs into schools • Community engagement programs run by local councils (e.g. youth groups, gardens, clubs, activities for older people)	• Inner West Suicide Prevention Collaborative • St George Suicide Prevention Collaborative • Establishment of Eastern Suburbs Suicide Prevention Collaborative

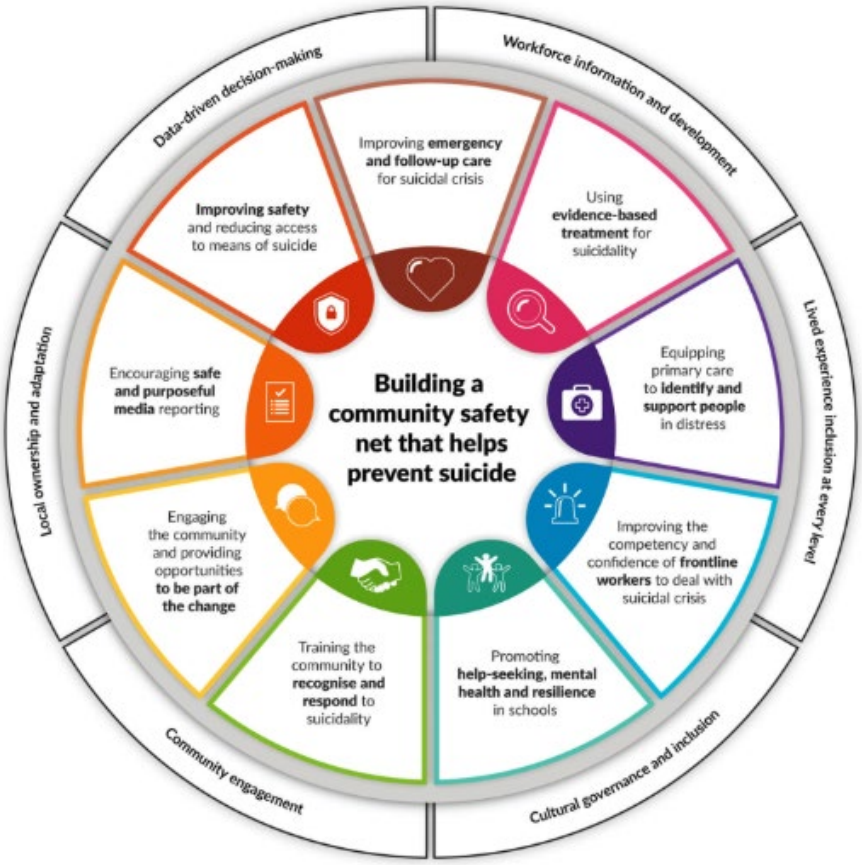
• World Suicide Prevention Day, R U OK Day (Sep) and Mental health month activities (October) • HERE, ACON's LGBTQ+ Suicide Prevention Digital Hub • UrHere, social media campaign by Wellways • STOP campaign for SESLHD • Promotion of Mindframe guidelines	
Health and other frontline services	**Community capacity building**
• Black Dog Institute Suicide Prevention Training for GPs • HETI Mental Health Training for GPs • Vicarious trauma training for youth mental health providers • Mandatory training for PHN-contracted Suicide Prevention • Services (SPS) providers	• Suicide Prevention Training for the Community (ASIST and SafeTALK) • NSW Workplace Mental Health Coaching

Source: Adapted from Beacon Strategies Report: Targeted Regional initiatives in Suicide Prevention (TRISP) Consultation and Co-Design for CESPHN, October 2023

The system's approach to preventing suicide

To support the community at a local level, a systems approach should be used. Lifespan is an integrated framework for suicide prevention that combines nine strategies that have evidence for suicide prevention into one community-led approach.

Figure 11: Lifespan framework



Source: Black Dog Institute 2020

Implementing a systems-based approach is highly complex and requires strong local partnerships and community buy-in. Strategically planned, well-resourced stakeholder engagement, community consultation and genuine co-design with adequate timeframes to build and maintain relationships and community trust are essential to the successful implementation of systems-based suicide prevention (9).

Between 2016-17 and 2020-21 the Department of Health and Aged Care undertook the National Suicide Prevention Trial across 12 PHN sites. This trial was then evaluated with the findings implemented across all PHN regions across Australia by the Targeted Regional Initiatives for Suicide Prevention (TRISP) funding. In 2023, CESPHN commissioned Beacon Strategies to undertake a consultation and co-design project under TRISP.

The consultations and lived experience interviews identified the following areas of need:

1. Strengthen the **services that already exist** to make them more effective in responding to people's needs and preferences - particularly around being flexible, effective, compassionate and inclusive.

2. Increase **awareness** about what services and supports are available, what someone might expect when accessing them and who can help with navigating the system.
3. Easier **access** to the right type of services and supports, in the right place, at the right time - particularly pathways so people don't have to present to a hospital and can avoid barriers like eligibility criteria, travel and cost.
4. Acceptance and promotion of **non-clinical services** and approaches that focus on assisting people through the situations or difficulties that cause distress.
5. Increased engagement of people and groups in the community who have limited supports in place or experience **barriers to seeking help** based on their circumstances, identity or background - particularly making existing services more culturally appropriate for people from culturally diverse backgrounds and Aboriginal communities.
6. Increase effective **community engagement** to create support mechanisms outside of professional services (e.g. schools, workplaces), to reduce stigma in how people communicate about suicide, and train community gatekeepers to identify and respond to people in distress.
7. Effective mechanisms of **local collaboration, governance and networking** to plan and take collective action on suicide prevention.
8. Better engagement and involvement of people with **lived experience** centrally within the suicide prevention system, including more peer support.
9. Increase support to the suicide prevention **workforce to build the capacity, capability and confidence** to respond to people in distress, and to provide the training and professional support they need and have an increased tolerance of 'risk' (8).

In response to the identification of the above, CESPHN co-designed and commissioned a suite of initiatives and services throughout 2023-24 to address unmet needs with the aim of decreasing suicide in the region, with a particular focus on programs that target groups disproportionately affected by suicide.

Further consultation with CESPHN staff in 2024 has identified additional areas of need. These needs are both systems-level and service delivery needs. System level needs include:

1. Increased recognition that systemic issues are causing suicidal distress and attempts and the roles that holistic support can play to reduce this. Examples of systemic issues include but are not limited to:
    - being under financial distress or instability
    - experiences of racism
    - experiences of domestic and family violence
    - homelessness
    - LGBTIQA+ discrimination
2. More research needs to be undertaken on female suicide attempts and intentional self-harm. The data we have shows higher levels of deaths by suicide in males due to the lethality of means males use on average in comparison to females. However, the data also show that females attempt suicide and engage in intentional self-harm at a higher rate than males.
3. Further work needs to be undertaken in the multicultural space that recognises individual disparate cultural needs, including the needs of refugees and the impact of trauma on these communities
4. Continual reviewing, improvement, availability and communication of information about available services and how to navigate them for service users, their carers and people working across the system

5. Increased service integration to improve interface between primary care (particularly GPs) and acute/crisis mental health services.

Service level needs include:

1. An increase in publicly funded Dialectical behaviour therapy (DBT) therapy to build skills that don't require a diagnosis or admission into a broader program, and ideally located in community locations
2. Increased affordable accessibility to general practitioners. A reduction in bulk billing at general practices has decreased access to GPs and has impacts on both the creation and maintenance of Mental Health Care Plans.
3. Continued co-location of CESPHN funded Psychological Support Services (PSS) within culturally safe and engaging environments
4. Recruiting clinicians working in PSS who are capable and comfortable working with a person who is suicidal and across a range of presentations (e.g. clinical, trauma, situational stressors).

Workforce

The clinical workforce that works to support people experiencing suicidality is the mental health workforce. A detailed analysis of the composition of this workforce can be found in the mental health chapter of the Needs Assessment.

The non-clinical suicide prevention workforce consists of non-clinical community or support workers and the suicide prevention lived experience workforce. There has been significant focus on the lived experience workforce in recent years, as emerging research has evidenced the benefits of interventions from lived experience or peer workers.

Relevant documents demonstrating the importance and relevance of suicide prevention lived experience workforce, and the need to support its development, include the following:

- National Suicide Prevention Strategy 2025–2035 (10)
- The National Mental Health Commission National Lived Experience (Peer) Workforce Development Guidelines (11)
- LELAN Lived Experience Leadership for Organisation and System Change: A scoping review of concepts and evidence (12)
- Leading the Change, A Toolkit to Evaluate Lived Experience Inclusion and Development, Mental Health Commission of NSW (13)
- Roses in the Ocean's Suicide Prevention Peer Workforce paper (14)

CESPHN currently commissions the Suicide Prevention Lived Experience Workforce Development Initiative, enabling funding to be utilised for identified workforce development activities.

Opportunities to address health and service needs

Evidence-based service improvement opportunities:

- Enhance data and clinical document sharing between service providers
- Increase awareness of available services to reduce hospital emergency admissions
- Provide bilingual or culturally appropriate services to address diverse needs
- Build capacity, capability and confidence of the workforce to respond to people in distress and have a higher tolerance of suicide “risk”

Promote suicide prevention education:

- Increase the community’s awareness of suicide prevention and what resources are available

Partnerships and engagement including with people with lived experience:

- Continue to partner with people with lived experience to gain further suicide prevention insights, reduce stigma and improve services.
- Continue facilitating the CES Suicide Prevention Working Group, focusing on promotion, prevention, postvention, pathways, and aftercare and maintaining a strong connection with key agencies.
- Support regional oversight and coordination of regional, state, and federal suicide prevention strategies, including the NSW Ministry of Health’s Towards Zero Suicides initiatives and the Department of Health and Aged Care’s Targeted Regional Initiatives for Suicide Prevention.
- Drive work in Suicide Prevention Community Collaboratives in the region, bringing together people who work in the sector and people in the community with lived experience to work towards a shared purpose. Community Collaboratives aim to build resilience, support recovery from adversity and improve wellbeing. Collaboratives also provide systems-level responses to address incidents in the community.

Workforce:

- Continue to jointly review and update the Mental Health and Suicide Prevention Training and Professional Development resource with regional partners.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Use of Alcohol and Other Drugs

2025-2027 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

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Overview

Substance use, (including tobacco, alcohol, and illicit drugs) accounts for 16.1% of the nation's disease burden, with 1 in 3 Australians aged 14 and over engaging in alcohol consumption that puts their health at risk. In 2022-2023, 47% of Australians reported having used illicit drugs at some point in their lives (1).

The consequences of substance use are broad and can impact (directly and/or indirectly) on all Australian communities, families and individuals. Health impacts can range from injury and chronic conditions to preventable diseases and mental health disorders. Socially, substance use can exacerbate crime, domestic violence, childhood trauma, and strain on the criminal justice system. Economically, it can impose significant costs through healthcare, law enforcement, and lost productivity.

Within the CESPHN region, the primary drugs of concern are methamphetamines, alcohol, cannabinoids, and heroin.

Key issues

- Illicit drug use in the CESPHN region is predicted to continue to increase
- Instances of reported drug dealing are increasing
- The CESPHN region has higher hospitalisation rates for alcohol compared to other regions
- Priority populations remain the most impacted by AOD use including
    - Aboriginal and Torres Strait Islander people
    - Multicultural communities
    - Young people
    - LGBTQI+ communities
    - People experiencing homelessness
    - Individuals in contact with the criminal legal system.

Key gaps

- Limited access to holistic support and care coordination, as well as a lack of pathways for patients navigating AOD services.
- Absence of specific AOD Medicare Benefits Schedule (MBS) items for general practitioners to track service use.
- A need for additional prescribers to transition patients from public Opioid Treatment Programs (OTP) to private care.
- Insufficient services for priority populations, particularly women and multicultural communities.
- A shortage of residential rehabilitation beds.
- High prevalence of co-occurring mental health and substance use concerns, with a need for further capacity-building initiatives.
- Limited access to culturally appropriate rehabilitation for Aboriginal participants.
- Workforce shortages and the need for ongoing training and development.

Opportunities

To address these gaps, opportunities for CESPHN include:

- Gauge sector willingness and capacity to re-establish an AOD and mental health working group to enhance collaboration across services.
- Support the increase in the number of general practitioners (GPs), nurse practitioners, and pharmacists trained to prescribe opioid treatments.

- Encourage co-location of services, leveraging nurse practitioners to improve accessibility.
- Support the upskilling of peer workers to expand the AOD workforce.
- Support a review and alignment of the AOD Minimum Data Set (MDS) with the Primary Mental Health Care (PMHC) MDS for more integrated service monitoring and improvement.

Prevalence

Drug and alcohol services planning model

The national Drug and Alcohol Services Planning (DASP) model predicts that for every 100,000 people in a broadly representative population:

- 8,838 will have an alcohol use disorder
- 646 will have a methamphetamine use disorder
- 465 will have a benzodiazepine use disorder
- 2,300 will have a cannabis use disorder
- 793 will have a non-medical opiate (including heroin) use disorder.

The table below translates these rates to the current and future populations (aged 10 years and over) of the CESPHN region.(2) Higher prevalence rates are expected in areas that have higher than average numbers of people experiencing homelessness, people recently released from prison or people who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ).

Table 1: Estimated prevalence of drug disorders in the CESPHN region, 2023 and 2041

Drug disorder type	Standard rate (per 100,000 people)	2023 prevalence *	2041 prevalence **
Alcohol	8,838	142,480	150,562
Methamphetamine	646	10,414	11,005
Benzodiazepine	465	7,496	7,922
Cannabis	2,300	37,079	39,182
Non-medical opiate	793	12,784	13,509

*Sources: CESPHN 2020, *ABS 2024, **HealthStats 2022*

National drug strategy household survey

The National Drug Strategy Household survey asks people in Australia about their use and opinions of licit and illicit drugs. The most recent survey was conducted in 2022-23. Data for this survey is currently only available at a national level. It shows that nationally:

1 in 3 people (31%) drank **alcohol** in ways that put their health at risk

1 in 2 people (47%) have used an **illicit drug** in their lifetime, with **cannabis** being the most used (4.1%)[1]

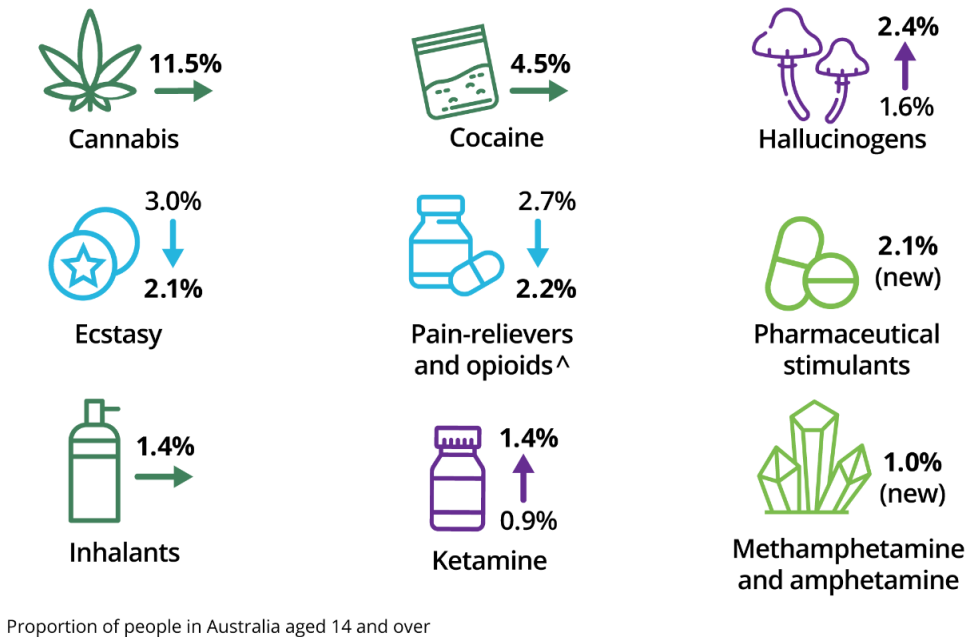
1 in 5 people (17.9%) had used an **illicit drug** in the previous 12 months in 2022-23. The changes in recent illicit drug use can be seen in the figure below.

Source: AIHW, 2024

Additionally, the daily tobacco smoking rate has dropped from 11.0% to 8.3% from 2019 to 2022-23 and the use of electronic cigarettes and vapes had nearly tripled between 2019 (2.5%) and 2022-23

(7.0%).(1, 3) Changes in illicit drug use from 2019 to 2022-23 saw increases in hallucinogens (1.6% to 2.4%) and ketamine (0.9% to 1.4%) (1, 3)

Figure 1: Changes to recent use of illicit drugs from 2019 to 2022-23

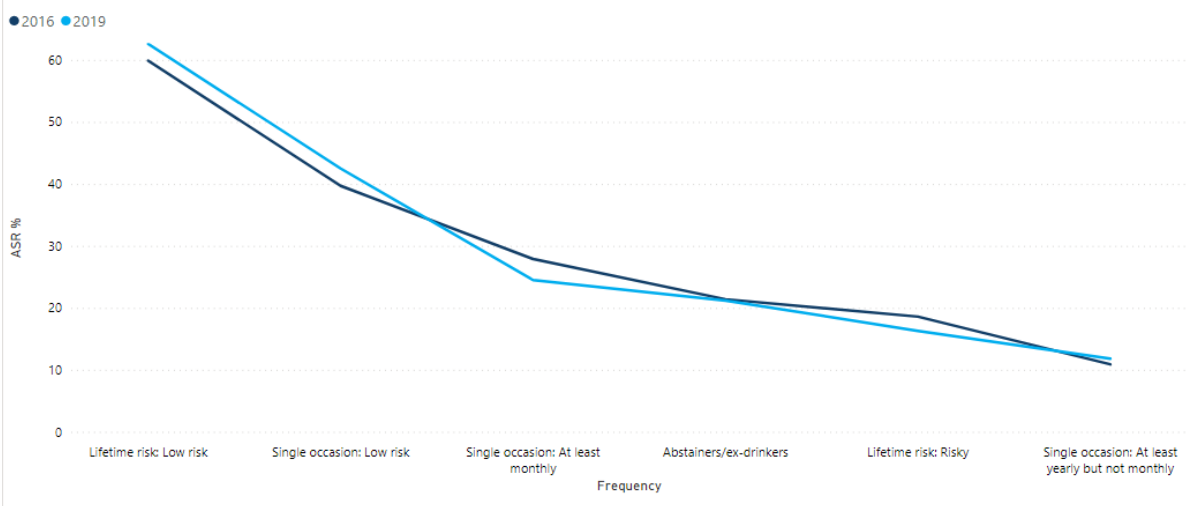


Source: AIHW 2024

The 2019 survey data is available at a PHN level. It showed that 24.5% of people aged 14 years and over in the CESPHN region drank at a risky level on a single occasion at least monthly, while 16.3% exceeded the lifetime risk guideline. Since 2016, the proportion exceeding the single occasion risk and lifetime risk guidelines has declined slightly (27.9% and 18.6% respectively).(4)

The illicit drug use among people aged 14 years and over within the CESPHN region has declined from 22.0% in 2016 to 18.7% in 2019.

Figure 2: Alcohol consumption and risk, CESPHN region, 2016 and 2019



Source: AIHW 2019

Illicit drug reporting system

The Illicit Drug Reporting System (IDRS) is a national illicit drug monitoring system intended to identify emerging trends of local and national concern in illicit drug markets. The data is reported at national level as well as capital cities around Australia. The 2024 Sydney IDRS sample comprised 150 people aged 18 years or older who injected illicit drugs ≥6 days in the preceding six months and resided in Sydney (5).

Three quarters (73%) of the Sydney sample reported recent (i.e., past six month) use of heroin, an increase from 67% in 2023. Among those who reported recent use, two fifths (43%) reported using heroin daily. The majority (83%) of the sample reported recent use of any methamphetamine in 2024, stable from 86% in 2023. Almost one third (29%) of the sample reported recent use of cocaine (16% in 2022). The use of methamphetamine has gradually been increasing while cocaine use has generally decreased since the beginning of monitoring. Two thirds (68%) of the Sydney sample reported non-prescribed cannabis and/or cannabinoid-related product use in the six months preceding interview in 2023 (65% in 2023), of which 61% reported daily use (56% in 2022). The most common non-prescribed pharmaceutical opioids recently used by participants were methadone (12%; 12% in 2023) and oxycodone (9%; 12% in 2023) and morphine (9%, 8% in 2023) (5).

Recent use of any new psychoactive substance was reported by 5% of participants, stable relative to 2023 (6% in 2022). One third (31%) of the Sydney sample reported recent use of any non-prescribed benzodiazepines, this was stable from 2023 (33%) in 2022.

The IRDS also identifies drug related harms and other behaviours:

- Almost two thirds (70%) of the sample reported using two or more drugs on the day preceding interview (excluding tobacco and e-cigarettes).
- Almost one fifth (17%) of the sample reported experiencing a non-fatal overdose in the 12 months preceding interview (17% in 2023), with ‘any opioids’ (10%) being the most common substance involved (12% in 2023).
- The majority (85%) of the sample reported awareness of the take-home naloxone program, a significant increase relative to 2023 (73%; p=0.016). Significantly more participants reported having obtained naloxone in the past year (60%; 47% in 2023; p=0.041).
- Five per cent of participants reported receptive needle sharing in the past month, stable relative to 2023 (n≤5).
- Twenty-nine per cent of the sample reported having an injection-related health issue in the month preceding interview (24% in 2023), most commonly any infection/abscess (16%).
- Fourty-six per cent of the sample reported currently being in some form of drug treatment at the time of the interview (39% in 2023), most commonly methadone treatment (27%; 22% in 2023).
- Among those who had recently used opioids and commented, 63% scored five or above on the Severity of Dependence (SDS) scale, indicating possible dependence. Of those who had recently used methamphetamine and commented, 51% scored four or above on the SDS scale, indicating possible dependence.
- The percentage of participants who reported having had a hepatitis C (HCV) antibody test in the last remained stable at 59% (58% in 2023).
- Half (52%) of the Sydney sample self-reported that they had recently experienced a mental health problem, with the most common reported problem being depression (64%). Almost one third (33%) of the Sydney sample scored 30 or more on the K10 scale (32% in 2023), indicating high psychological distress.
- The majority (94%) of participants reported accessing any health service for alcohol and/or drug support in 2023, with the most common service accessed being a NSP (83%; 86% in 2023), followed by GP (30%; 31% in 2023).

- Among those who had driven in the last six months, almost four fifths (78%) of participants reported driving within three hours of consuming an illicit or nonprescribed drug (63% in 2023).
- Twelve per cent of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the last year (7% in 2023).
- In 2024, almost half (47%) of the Sydney sample reported engaging in 'any' crime in the past month (47% in 2023; p=0.152).
- Three fifths (61%) participants reported a drug-related encounter with police which did not result in charge or arrest in the past 12 months (66% in 2023).
- In 2024, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face to-face (86%; 80% in 2023) (5).

Ecstasy and related drugs reporting system

The Ecstasy and Related Drugs Reporting System (EDRS) is a national monitoring system for ecstasy and related drugs that is intended to identify emerging trends of local and national interest in the markets for these drugs. The 2024 NSW EDRS sample comprised 100 people who regularly use ecstasy and other illicit stimulants in Sydney.(6) Participants are asked about their recent drug usage (in the past 6 months).

Just over one in four (28%) people in the NSW sample reported ecstasy as their drug of choice. Cannabis (20%) was the second most common drug of choice followed by cocaine (19%) and alcohol (less than 5%).

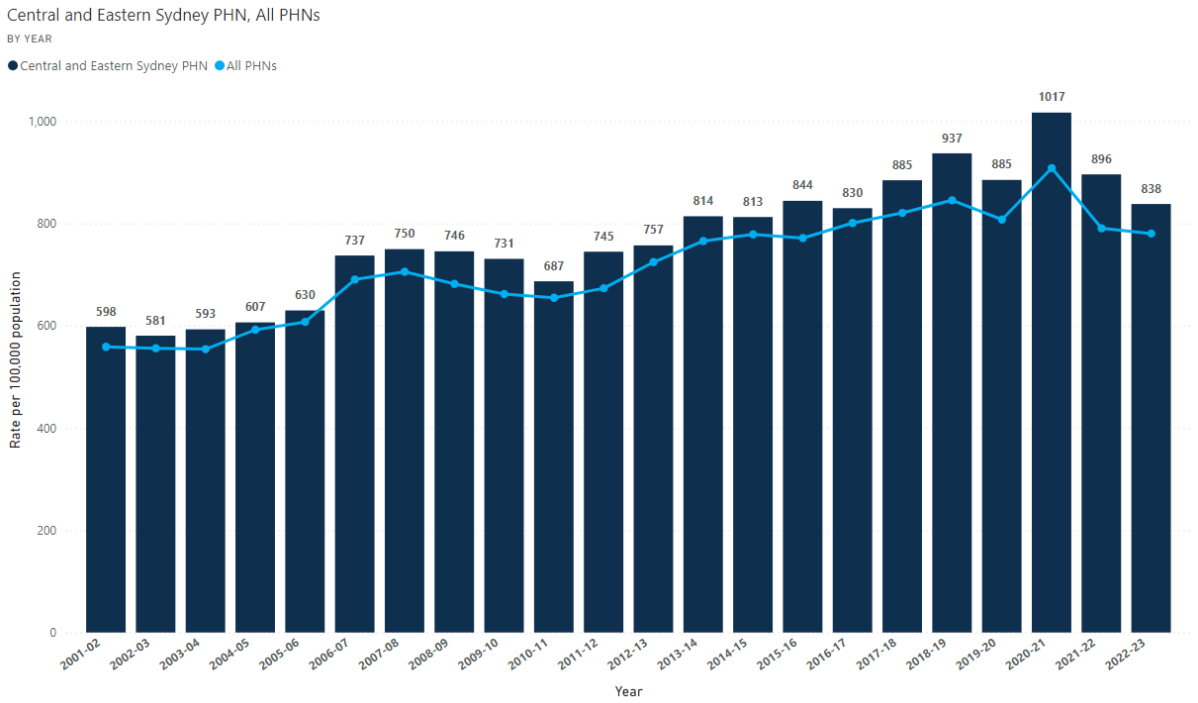
There was a decline in recent use of non-prescribed ecstasy between 2021-2022, however reported recent usage has returned to levels observed in 2020 and earlier with 96% of participants reporting recent use. (83%) and 2023 (99%) Capsules remained the most common form of ecstasy consumed in the six months preceding interview66%). This was followed by pills (57%), and crystal (53%).

Recent use of any methamphetamine has been declining since monitoring commenced in 2003. In 2024, one quarter (26%) of the sample reported recent use. The largest percentage of participants who had used methamphetamine in the six months preceding the interview reported using crystal methamphetamine (65%), followed by powder (38%).(6)

Hospitalisations

In 2022-23, there were 11,085 alcohol-related hospital admissions in the CESPHN region. CESPHN has a higher rate of hospitalisations (838.1 per 100,000 population) than the NSW rate (780.3 per 100,000 population) (7).

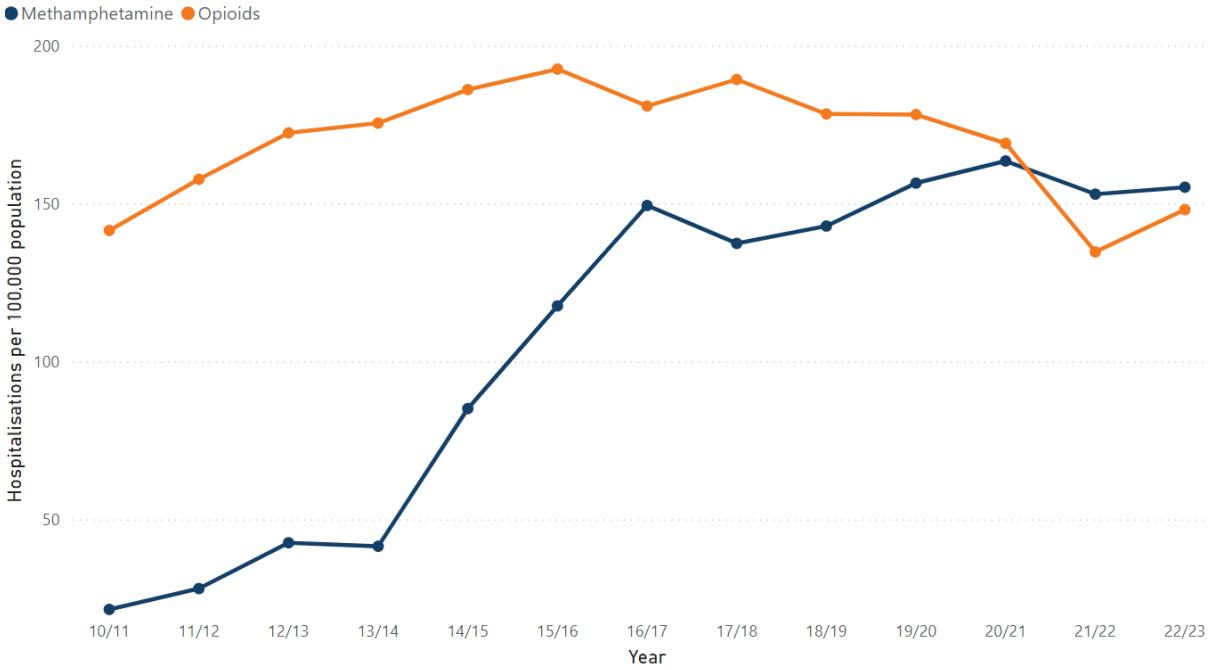
Figure 3: Alcohol related hospitalisations, CESPHN region, 2001-02 to 2022-23



Source: HealthStats NSW, 2025

In the central and eastern Sydney region hospitalisation rates for methamphetamine (155.2 per 100,000 population) have now overtaken hospitalisation rates for opioids (148.1 per 100,000 population). Opioid hospitalisations peaked in 2015-16 at 192.6 per 100,000 population and continue on a downward trend. Methamphetamine hospitalisations have remained stable since 2019-20. Rates in the CESPHN region are higher than the NSW rate both Methamphetamine and Opioid hospitalisation (140.4 per 100,000 population and 121.1 per 100,000 respectively) (7).

Figure 4: Hospitalisation rates for methamphetamine and opioids, CESPHN region 2010-11 to 2022-23



Source: HealthStats NSW, 2024

Treatment

There are two local health district (LHD) run specialist alcohol and other drug (AOD) programs in the CESPHN region, along with government services provided by the St Vincent's Health Network. There are also non-government organisations (NGOs) who have both widely applicable models of care and specifically targeted models of care. A list of NGOs and the type of service they provide are included in Table 2 below. In addition, there are alcohol and other drug interventions provided by general practice and community pharmacy, and some residents can access private treatment programs although these are mainly located outside the CEPHN region.

Finally, there are community drug action teams (CDAT's) and local drug action teams (LDAT), organised by interested members of the community, who undertake population style interventions. There is little difference in intent between CDATs and LDATs, however LDATs are supported by Commonwealth funding and policy frameworks and CDATs are supported by the NSW state Government.

Table 2: Non-government AOD providers in CESPHN region

Agency Name	Service Type
2Connect Youth and Community	AOD Counselling, Youth AoD service
ACON	AOD Counselling
Aboriginal Medical Service Redfern	AOD Counselling, Pharmacotherapies
Alf Dawkins Detoxification Unit (Inner city Detox)	Withdrawal service
Mission Australia AOD Hub Common Ground	AOD Counselling, Medical
Catholic Care Family Recovery (formerly Holyoake)	AOD Counselling
Sydney Children's Hospital - Cicada Centre	AOD Assessment, Counselling and Support
Clean Slate Clinic – Applied Recovery Co.	Withdrawal service

Co.As.It	AOD Counselling
Community Restorative Centre	AOD Counselling
Deadly Connections Community & Justice Services	Case Management
Foundation House	Residential Rehabilitation
Guthrie House	Residential Rehabilitation
Headspace	Youth AOD service
Jarrah House	Residential Rehabilitation, Withdrawal service and AOD Counselling
Kathleen York House	Residential Rehabilitation
Leichhardt Women's Community Health Centre	AOD Counselling
Lou's Place	Case Management
Mission Australia, Drug and Alcohol Program	AOD Counselling
Odyssey House Community Programs	Case Management, AOD Counselling
PALM East - Ted Noffs Foundation	AOD Counselling
Salvation Army Foundations Maroubra	Case Management
Phoebe House	Residential Rehabilitation
Rainbow Lodge Program	Case Management
Salvation Army Oasis Youth Services	Case Management, Youth AOD service and AOD Counselling
St George Family Support Services	Case Management
St Vincent De Paul Society - Frederic House	Case Management
St Vincent de Paul Society - Continuing and Coordinated Care Program Sydney	Case Management
St Vincent's Alcohol and Other Drug Service	Assertive Case Management, AOD Counselling, Youth AOD service and Withdrawal service
Sydney Women's Counselling Centre	AOD Counselling
Ted Noffs Foundation: PALM	Residential Rehabilitation, Youth AOD service
The Gender Centre	AOD Counselling
The Haymarket Foundation	Case Management, AOD Counselling and Residential Rehabilitation
The Rehabilitation Project	AOD Counselling
The Salvation Army William Booth Detoxification Unit	Withdrawal service
The Station Drug and Alcohol Service	AOD Counselling, Case Management
The Rev Bill Crews Foundation AOD Hub	AOD Counselling, Case Management
Uniting Supervised Injecting Centre (MSIC)	AOD Counselling, Case Management
Waverley Drug and Alcohol Centre	AOD Counselling, Case Management
WAYS Youth and Family	AOD Counselling, Case Management
We Help Ourselves (WHOS): Gunyah	Residential Rehabilitation
We Help Ourselves (WHOS): New Beginnings	Residential Rehabilitation
We Help Ourselves (WHOS): OSTAR	Residential Rehabilitation
We Help Ourselves (WHOS): RTOD	Residential Rehabilitation
Weave Youth and Community Services	AOD Counselling, Case Management, Youth AoD service
We Help Ourselves (WHOS) Hub Lilyfield	AOD Counselling, Case Management
The Salvation Army William Booth House: The Bridge Program	Residential Rehabilitation

Source: NSW Ministry of Health Centre for Alcohol and Other Drugs

Treatment need

The DASP model anticipates that the majority of those with only mild disorders will not seek treatment and will resolve the disorder without specialist intervention, that around 50% of those with a moderate disorder will require treatment and 100% of those with a severe disorder will require treatment. The table below estimates the treatment required for each drug type for the current CESPHN population (aged 10 years and over).{Central and Eastern Sydney PHN,, 2016}

Table 3: Estimated drug and alcohol treatment required in the CESPHN region

Drug type	Assumption of Use Treated rate Mild (%)	Mod (%)	Severe (%)	Assumption of overall prevalence Treated Rate (%)	Estimated quantum needed 2020
Alcohol	20	50	100	35	46,377
Amphetamine	0	50	100	95	9,201
Benzodiazepines	20	50	100	45	3,137
Cannabis	20	50	100	35	12,069
Opiates – non-medical use	0	50	100	95	11,295

Source: CESPHN 2016

The DASP modelling also provides estimates of population level requirements for screening of at-risk patients in the primary care setting. It does this through estimates of risk by drug type and age group. It is estimated for the CESPHN population (aged 10 years and over) there were:

- 219,148 people who needed screening and brief intervention for alcohol use in 2020, increasing to 262,891 people in 2036
- 13,433 who needed screening and brief intervention for amphetamines in 2020, increasing to 16,115 in 2036, and
- 138,982 people who needed screening and brief interventions for cannabis use in 2020, increasing to 166,724 in 2036.{Central and Eastern Sydney Primary Health Network,, 2020}

Table 4: Estimated number of screening interventions required in the primary care setting in the CESPHN region by drug type

Drug Type	Standard rate (per 100,000 people)	Estimated no. of screening interventions 2020	Estimated no. of screening interventions 2036
Alcohol	14,617	219,148	262,891
Amphetamine	896	13,433	16,115
Cannabis	9,270	138,982	166,724

Source: CESPHN 2019

Mellor *et al*, used the DASP model to predict bed estimates by LHD in NSW. The below table shows the bed estimates using the original DASP model unmodified parameters, these estimates do not consider potential differences in prevalence rates, severity distributions and treatment rates.{Mellor, Richard, 2019}

Table 5: DASP predicted bed numbers by LHD, bed type, CESPHN region, 2019

Bed type	Sydney LHD	South Eastern Sydney LHD
Detoxification	29	38
Residential rehabilitation	187	248
Inpatient	7	9
Total	222	294

Source: Mellor, R and Ritter, A, 2019. Note: the bed numbers reported here are rounded. Total estimates are calculated by summing the non-rounded bed numbers.

Government funded AOD treatment services

In 2023-24, there were 66 government funded AOD treatment services in the CESPHN region that provided 6,802 closed treatment episodes. This equates to 222.3 episodes or 137.4 clients per 100,000 population.

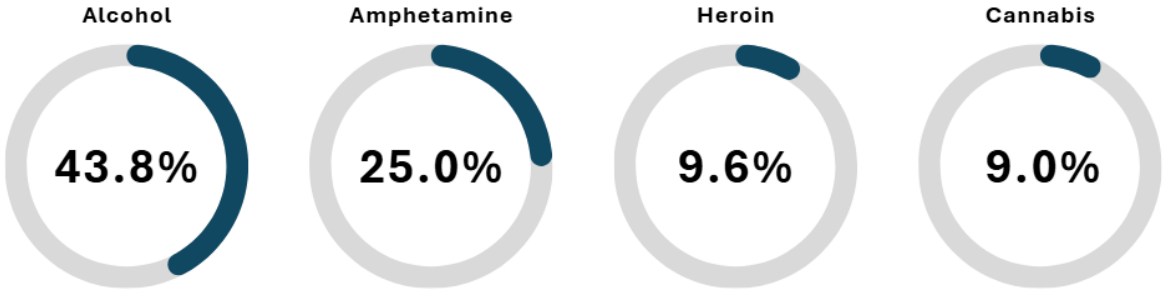
Client demographics

Of the publicly funded AOD treatment services in the CESPHN region in 2023-24:

- 98.0% of clients attended for their own drug use
- For those who attended for their own drug use:
  - 63.0% were male and 34.0% female, 3.0% undisclosed
  - 28.2% were aged 30-39 years, 26.4% aged 40-49 years, 19.1% aged 20-29 years, 15.3% aged 50-59 years, 4.1% aged 10-19 years and 7.0% aged 60+ years
  - 13.7% were Aboriginal and Torres Strait Islander people (here in referred to as Aboriginal people).{Australian Institute of Health and Welfare,, 2025}

Principal drug of concern

In 20223-24, the four most common principal drugs of concern for which clients sought treatment in the CESPHN region were:

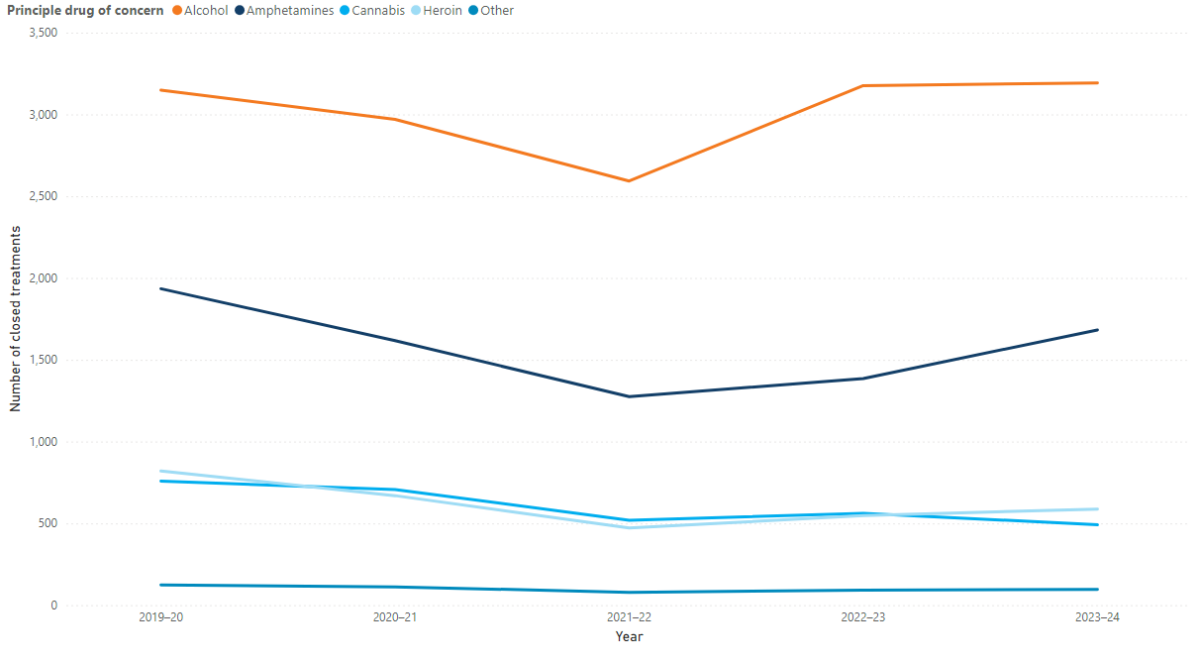


These were also the top four principal drugs of concern nationally – alcohol (40.2%), amphetamines (25.5%), cannabis (16.8%) and heroin (4.5%).{Australian Institute of Health and Welfare,, 2025}

Between 2019-20 and 2023-24, the number of closed treatment episodes with alcohol as the principal drug of concern increased overall by 1.4% (from ,3,149 to 3,192 episodes). This is despite a decrease in 2021-22 (2,593). Amphetamines were the second highest principal drug of concern and follow the same trend as alcohol.

Across all principal drugs of concern between 2019-20 and 2023-24 we saw a decrease in closed treatment episodes in 2021-22 (5,482 episodes) then an increase in both 2022-23 and 2023-24 (6,639 and 6,669 respectively).{Australian Institute of Health and Welfare,, 2025}

Figure 5: Number of closed treatment episodes by principal drug of concern, CESPHN region, 2019-20 to 2023-24

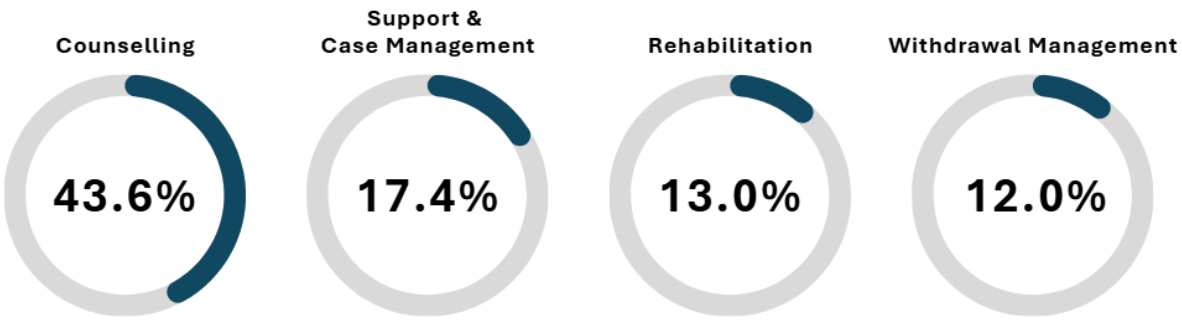


Source: AIHW, 2024

Stakeholders have confirmed that methamphetamines and alcohol are the two most commonly occurring sources of substance related concerns within the CESPHN region. Most commissioned service providers have stressed that alcohol is still the drug of primary concern and the source of greatest harm to their clients. Consultations also highlighted an emerging increase in Nitazene usage and overdoses, with a need to expand the take home Naloxone program.

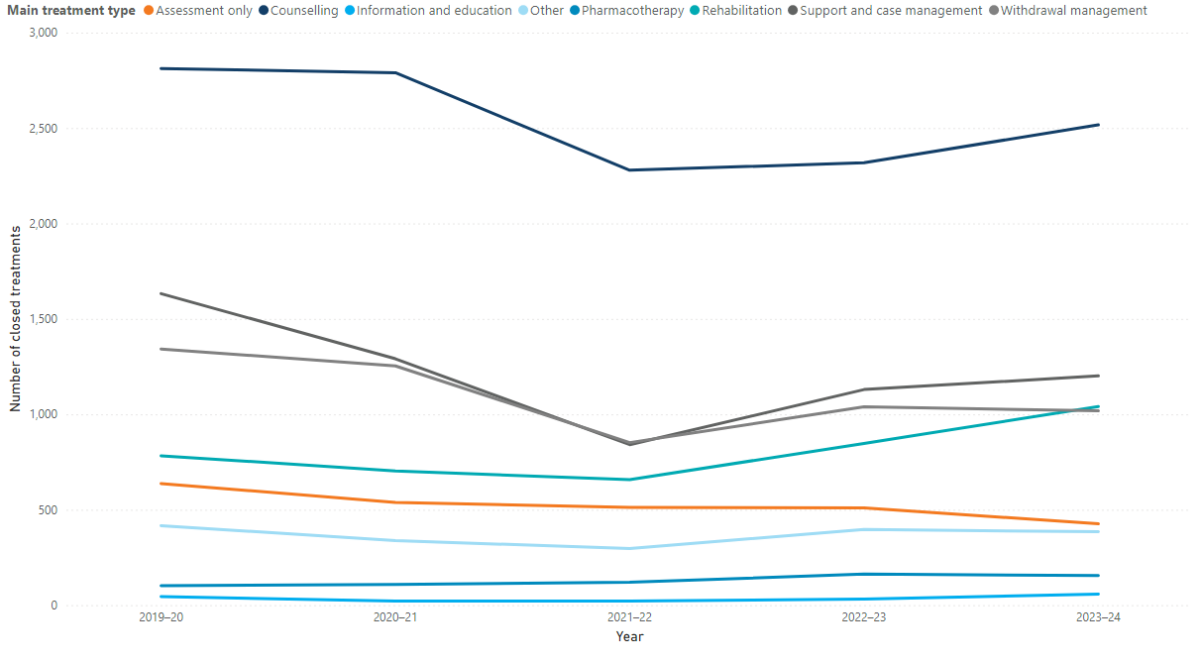
Treatment type

In 2023-24, the most common treatment types provided to clients in CESPHN were:



Compared to national figures, the CESPHN region had a much higher percentage of clients whose main treatment type was withdrawal management (12.0% compared to 6.2%) and rehabilitation (13.0% compared to 6.0%) (8).

Figure 6: Number of closed treatment episodes by main treatment type, CESPHN region, 2019-20to 2023-24



Source: AIHW, 2025

Source of referral

In 2023-24, over half (53.3 %) of all closed treatment episodes had a source of referral as self/ family. The next most common source of referral was a health service (19.4% of closed treatment episodes).{Australian Institute of Health and Welfare,, 2025}

Treatment setting

In 2022-23, the majority (74.4%) of closed treatment episodes were provided in non-residential treatment facilities, followed by residential facilities (25.1%). There were very low numbers of treatment episodes provided in outreach settings (0.2%) and in the client's home (0.1%).{Australian Institute of Health and Welfare,, 2025}

Primary care

There are no specific alcohol and other drug MBS items for general practice to quantify service use. While there are MBS items for addiction medicine specialists to provide care, this data is not available at the PHN level.

It is expected that most GPs would be seeing patients who have alcohol and other drug concerns in their day-to-day practice. With over 200,000 people estimated to need screening and brief intervention for alcohol use, this would require every GP in the CESPHN region to undertake almost 200 interventions per year.

Opioid Treatment Program (OTP) prescribers and dosing points

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides state-wide data on clients receiving pharmacotherapy treatment, dosing sites and prescribers but does not allow comparisons across PHNs. NSW Health advised in November 2025 that there were 197 OTP dosing points located in the CESPHN region, including 159 pharmacies.

In November 2025, NSW Health also advised that there were 304 unique OTP prescribers in the CESPHN region. Some prescribers prescribe at multiple locations. Further breakdown of prescriber groups can be seen in the table below.

Table 6:OTP Prescriber groups, CESPHN region, 2025

Prescriber group	Total Number	Unique Number
All prescribers: OTP accredited and not OTP accredited	415	327
OTP accredited and not OTP accredited prescribers - excluding registrars	395	313
OTP accredited prescribers only – excluding registrars	229	157

Source: Safescript NSW

For a prescriber to provide OTP to a patient they can prescribe unaccredited with limited capacity or complete the Opioid Dependence Treatment Education Program (OTEP) course followed by a half day clinical placement to become accredited with the NSW Ministry of Health Opioid Pharmacotherapy Subcommittee.

Stakeholder consultations in July 2024 highlighted that there is an ongoing need to increase the number of OTP prescribers in the region. It was highlighted that nurse practitioners and pharmacists also play an important role as OTP prescribers, and focus shouldn't only be on increasing GP numbers. This is coupled with previous consultations where it was identified that there is a need to safely transition clients from the public OTP clinics to the primary care sector (general practices, private practices and pharmacy). Strategies to improve rates of prescribing and administration could include:

- Training in shared care
- Communication with GPs and pharmacies
- Further investigating how to support depot buprenorphine being administered outside of public clinics
- Incentivising the uptake of clients on OTP for GPs who have recently completed the OTEP course
- Adequate renumeration (i.e., MBS) for what is often complex and time-consuming work
- Ongoing support, mentoring, peer group learning and CPD/training
- Stigma and discrimination training.

Priority populations

Priority populations within the Alcohol and Other Drug sector are similar to those across all areas of health. Within the AOD space, localised data for priority population groups is often unavailable but we are able to look at national level data to understand key issues and trends within these groups.

Aboriginal and Torres Strait Islander people

In 2018-19, an estimated 55.1% of the Aboriginal population in the CESPHN region exceeded the NHMRC guidelines for single occasion risk (short term alcohol consumption), ranking CESPHN highest amongst all PHNs. The rate was much lower for lifetime risk (long term alcohol consumption) at 19.4% of the Aboriginal population, ranking CESPHN 13th amongst all PHNs. (8)

In 2022-23, an estimated 22% of the Aboriginal population in NSW had used substance(s) in the previous 12 months (9).

Table 7: Aboriginal Substance use in NSW, 2022-23

Substance use	Males (%)	Females (%)	Total NSW (%)
Used substance(s) in last 12 months	32.4	13.9	22.1
Has not used substance(s) in last 12 months	67.0	84.1	76.6

Source: ABS, NATSIHS 2024

The proportion of Aboriginal clients receiving publicly funded treatment for their own drug use has increased nationally from 14% in 2015-16 to 17% in 2019-20. (8)

Further detail on Alcohol and Other Drug use in Aboriginal populations can be found in the Aboriginal and Torres Strait Islander peoples health and wellbeing section.

Multicultural communities

It is difficult to identify rates of alcohol and other drug use in multicultural communities as national surveys tend to be administered in English and there are limitations in the way data is collected.

While both the 2022-23 and the 2019 NDSHS suggests that overall AOD rates amongst culturally and linguistically diverse (CALD) respondents are lower than non-CALD communities, people from multicultural communities are underrepresented in AOD treatment and when in treatment are less likely to be connected to appropriate support services.(10) The 2022-23 NDSHS found that nationally:

- People with non-English speaking backgrounds are less likely to drink alcohol at risky levels with 43% of people born in non-main English-speaking countries having not consumed alcohol in the previous 12 months, compared to 18.5% of people born in Australia.
- People with diverse backgrounds are much less likely to have used illicit drugs.

There is a growing body of literature that discusses barriers faced by people from multicultural communities to accessing these services including stigma, limited health literacy and concerns about the cultural responsiveness of services. To improve the capacity of AOD treatment services to support multicultural communities, in 2021/22 CESPHN co-commissioned the Network of Alcohol and Other Drugs Agencies (NADA) to carry out the CALD Audit Project across four sites, of which two were in the CESPHN region. This pilot project aimed to devise, implement and evaluate an auditing process to enhance the cultural inclusion of mainstream AOD treatment services in supporting people from multicultural communities accessing treatment. The auditing process sought to optimise service experiences by identifying organisational factors that support best practice cultural inclusion. A rapid review of the role and importance of cultural inclusion in AOD services identified 16 recommendations and four key themes:

- Service delivery and the settings in which treatment is delivered: Flexible service delivery (including outreach) to match clients' help seeking preferences/behaviours; Offering longer timeframes for engagement and treatment; building capacity to navigate the AOD treatment landscape and associated support services; Responding to other language needs within treatment provision.
- Self and Community perception: Addressing the impact of particularly high levels of stigma surrounding AOD use in some communities at both an individual client and community level; Providing education on AOD-related health issues to help address generational attitudinal and knowledge differences within families that shape and support help seeking attitudes.
- Community engagement and service collaboration: Building relationships with cultural/religious leaders, key community members and CALD specific services.
- Workforce development and cultural competence of staff: the training of staff in cultural inclusion practices; Recruitment and use of skilled bi-cultural workers and translators.(11)

This project was evaluated by UNSW Centre for Social Research in Health in 2022 and assessed how AOD services fare in terms of cultural inclusion and to describe the acceptability of the cultural inclusion audit process from the perspective of staff and auditors at the four pilot sites. Overall, the evaluation demonstrated low levels of cultural inclusion across the various services. Although participants generally perceive both themselves and their services as culturally competent, the survey responses highlight significant gaps, showing that many services are not fully inclusive across several key service areas. On a positive note, the interview data revealed a strong acceptance of the audit process, with participants recognising areas where improvements are needed. Ultimately all services showed an improvement across all domains.

To further address these needs, in 2024/25 CESPHN commissioned a follow up Multicultural Audit Project which aimed to increase capacity of alcohol and other drugs (AOD) treatment services to support multicultural people and their communities in collaboration with the Network of Alcohol and other Drug Agencies Inc. (NADA). The primary outcome for this project was to further the work conducted in the audit above and to ultimately increase awareness and workforce capacity of generalist NGO AOD services in supporting clients from multicultural communities. This project took place across a further five sites within the CESPHN region.

The multicultural audit introduced several key innovations based on learnings from the earlier pilot, including pre-audit relationship-building sessions, extended implementation support, cross-level multicultural supervision, and the launch of the NADA Multicultural Alcohol and Other Drug Network. These elements helped services to move beyond assessment into genuine cultural reflection, practical action, and sustained change. All participating services engaged consistently in multicultural supervision and consultancy, using these sessions as platforms for reflective learning, skills development, and service improvement. Services translated audit recommendations into tangible actions— implementing practical, visible changes such as culturally inclusive welcome areas, updating environments, revising policies, introducing multilingual resources, and developing multicultural engagement strategies as part of core organisational planning. Services undertook deeper analysis of the cultural and linguistic diversity within their local communities, using this knowledge to guide service planning, improve client engagement, and strengthen culturally relevant service delivery. One of the most significant outcomes of Phase 2 has been the growth in each site's service-wide understanding and application of culturally inclusive practice. Beyond isolated initiatives, services now view cultural inclusion as an organisational responsibility that embeds in every part of their operations—from policy and leadership, to frontline practice, environment design, and community engagement. This shift in knowledge, confidence, and mindset means cultural responsiveness is no longer just an aspirational goal but is actively being embedded into the fabric of service delivery.
Research has highlighted that people who inject performance and image enhancing drugs (PIEDs) in Australia are a younger and more culturally and linguistically diverse group. People who inject IPEDs may be more vulnerable to blood-borne virus transmission and/or less likely to know their blood-borne virus status. From design to delivery, IPED harm minimisation strategies should pay attention to the needs of multicultural communities.(12) Northern Sydney PHN has developed a GP guide on harm minimisation that could be used for this community.(13)

Young people

In the 2022-23 NDSHS, at a national level young people (aged 14-24):

- 1 in 5 (20%) drank alcohol less than often monthly, and 16.3% had never had a full glass of alcohol (up from 7.5% in 2001)
- The proportion of daily drinkers and ex-drinkers among people aged 18–24 has remained stable since 2001 and did not change between 2019 and 2022–2023
- Between 2019 and 2022-23 there was an increase of 5% in females aged 18-24 consuming alcohol at risky levels (35% to 40%) narrowing the gap to males (47% in 2019 and 45% in 2022-23).
- The proportion of young people who drank alcohol monthly decreased from 34% to 29%

- Fewer younger people than reported smoking daily than ever before with a 50% decrease in young people aged 18-24 years smoking daily. Males aged 18-24 years were 1.4 times more likely to smoke cigarettes than females
- The use of vapes and electronic cigarettes has had a sharp increase from 2019 to 2022-23 with an increase from 1.8% to 9.7% in 14-17 year olds and an increase from 5.3% to 21% in 18-24 olds.
- Around 1 in 3 people aged 18-24 (35%) had used an illicit drug in the previous 12 months and almost 1 in 2 (49%) had done so at some point in their lifetime
- For the first time females aged 18-24 were just as likely to use illicit drugs as males
- Cannabis is the most commonly used illicit drug across all ages. Inhalants are the next most common in young people aged 14-17 and cocaine usage has increased to become the second most commonly used illicit drug among 18-24 year olds.(1)

Table 8: Most commonly used illicit drugs in the previous 12 months by young people, 2019 and 2022–2023

People aged 14-17 2019	People aged 14-17 2022-2023	People aged 18-24 2019	People aged 18-24 2022-2023
Marijuana/ cannabis (8.2%)	Marijuana/ cannabis (9.7%)	Marijuana/ cannabis (25%)	Marijuana/ cannabis (25.5%)
Inhalants (*1.8%)	Inhalants (*2.2%)	Ecstasy (10.8%)	Cocaine (11.3%)
Ecstasy (*1.2%)	Pain-relievers and opioids (*1.6%)	Cocaine (10.8%)	Ecstasy (6.7%)
Hallucinogens (*1.1%)	Pharmaceutical stimulants (*1.0%)	Hallucinogens (5.2%)	Hallucinogens (6.4%)
Tranquilisers/ Sleeping pills (*0.7%)	Hallucinogens (*0.9%)	Inhalants (5.2%)	Inhalants (5.2%)

** Estimate has a relative standard error between 25% and 50% and should be interpreted with caution.*
Source: AIHW 2024

Data from CESPHN commissioned service providers working with young people confirm that alcohol and cannabis remain the primary drugs of concern for young clients, followed by methamphetamine. Service providers have seen an increase in the use of benzodiazepines and inhalants in younger clients.

LGTBIQ+ communities

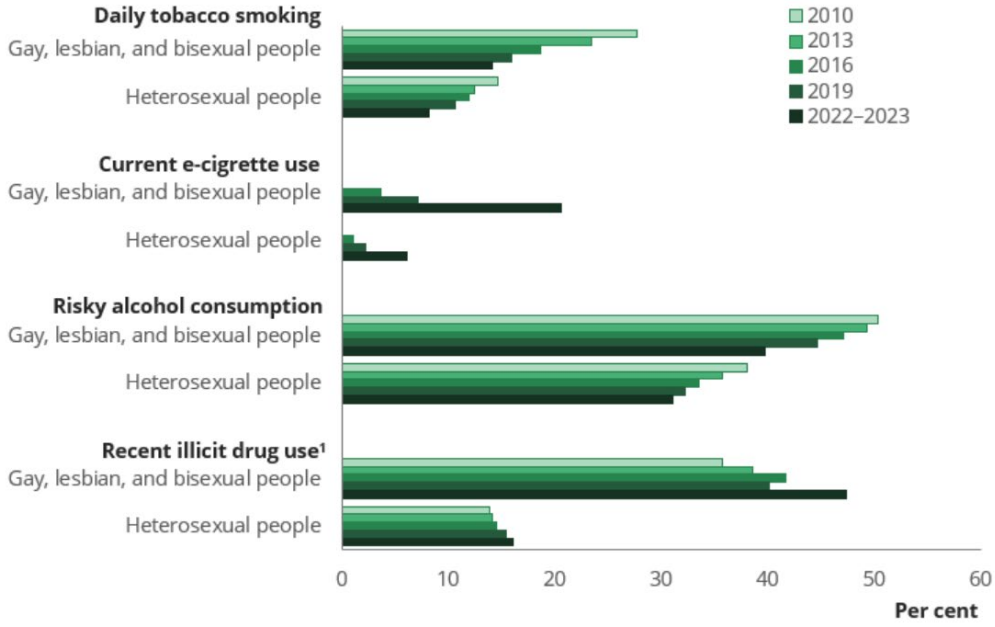
The NDSHS includes questions on gender and sex recorded at birth. Within the 2022-23 sample 5.1% of people aged 14 years and over reported that they were gay, lesbian or bisexual. The 2022-23 survey was the first to include questions representing people who are transgender or gender diverse, with 0.9% of people aged 14 and over reporting that they were trans or gender diverse. Findings for gay, lesbian, and bisexual people are grouped together for data quality purposes, but it is important to note that there are differences in substance use between each population. Similarly, transgender people and other gender diverse people are grouped together for data quality purposes.

For gay, lesbian and bisexual people:

- Rates of drug use across daily tobacco smoking, current e-cigarette use, risky alcohol consumption and recent illicit drug use are all higher than heterosexual people
- Daily tobacco smoking rates continue on a long-term decline from 28% in 2010 to 14.2% in 2022-23
- 1 in 5 people (21%) report using electronic cigarettes and vapes. This has tripled since 2019 (7.1%)
- The proportion of people drinking alcohol at risky levels has declined from 50% in 2010 to 40% in 2022-23

- In 2022-23 almost 1 in 2 people (47% has used an illicit drug in the previous 12 months, an increase from 40% in 2019.(1)

Figure 7: Drug use among people aged 14 and over, by sexual orientation, 2010 to 2022–2023



1. Used any illicit drug in the previous 12 months.

Source: AIHW, 2024

The most commonly used illicit drug is cannabis (33%) followed by cocaine (15.1%) and inhalants (11.0%).

For trans and gender diverse people:

- The use of tobacco, e-cigarettes and alcohol reflected use in the general population
- 1 in 3 trans and gender diverse people had used an illicit drug during the previous 12 months. After adjusting for differences in age, compared to cisgender people, trans and gender diverse people were 1.6 times as likely to have used any illicit drug in the previous 12 months.(1)

The Rainbow realities report (2024) commissioned by the Department of Health and Aged Care provides a synthesis of more than 50 new analyses derived from six surveys of LGBTQA+ populations in Australia. In relation to alcohol and other drugs the report found that:

- While only a relatively small proportion of LBQ+ women were currently using tobacco, those who were current smokers were more likely to have ever used or felt concern regarding drug consumption or who have felt concern in the past 12 months regarding alcohol consumption
- The concentration of reported vape use within younger age groups demonstrates a clear cohort effect
- The connections observed between vaping and prior drug and alcohol use among LBQ+ women may indicate a tendency among LBQ+ women to engage in polysubstance use and reflect social engagement within spaces where these are commonly occurring substances.

- Almost one-fifth of participants who held a preference for alcohol support service provider, expressed a preference for a service that catered specifically to LGBTQA+ people, with a further 55% holding a preference for a service that is mainstream but known to be inclusive of LGBTQA+ people (14).

One of the surveys synthesised as part of the Rainbow Realities report, the Sydney Women and Sexual Health (SWASH) Lesbian, Bisexual and Queer Women's Health Survey 2020 has collected data form the Sydney region. Respondents reported that they were more likely to drink alcohol (86%) and drink at levels that put them at risk of lifetime harm (48%), compared to women in general (71% and 25% respectively).(15)

Among current drinkers, 21% had been concerned about their alcohol use in the past year, and 5% had sought help to manage their alcohol use in the last 12 months. In 2020 more than half (54%) of respondents had used an illicit drug in the last six months, an increase from 47% in the 2018 survey.(15)

Recently, CESPHN funded ACON to produce LGBTIQ+ Inclusive Guidelines for AOD services. The purpose of the guidelines is to increase the understanding of AOD workers about the needs of LGBTIQ people and communities and how to provide an inclusive service response. The guidelines were launched in February 2023, coinciding with World Pride.

People experiencing homelessness

Within the CESPHN region, on census night in 2021, 12,799 people were experiencing homelessness. This was 10.4% of the national figure. There is a strong association between problematic alcohol or other drug use and experiences of homelessness. It can lock people into homelessness and compound the effects of limited-service engagement and increased social isolation.(16) Problematic alcohol or other drug use is related to several homelessness risk factors, including low socioeconomic status and family and domestic violence. Problematic drug and/or alcohol users are also at great risk of serious and preventable health issues and death, particularly those who are homeless.

The Specialist homelessness services annual report 2023-24 found that nationally, around 24,100 Specialist Homelessness Services (SHS) clients were clients with problematic drug or alcohol issues. This represented 8.6% of all SHS clients. Of this, 24,100clients:

- 33% identified as Aboriginal or Torres Strait Islander
- Nearly 4 in 5 (78% or 18,800) clients with problematic drug and/or alcohol use needed assistance with accommodation provision, higher than any other SHS client group
- 79% had previously been assisted by SHS at some point since July 2011
- 57.9% were homeless and 38.5% were at risk of experiencing homelessness.(16)

Additionally, people experiencing homelessness may not have access to mobile phones, data or technology to connect with services that provide support via telehealth. Many services have supported their clients to engage with their AOD counselling and case-management by providing data and credit on mobile phones to support clients to continue to engage.

People in contact with the criminal legal system

In 2024, 21,478 individuals were released from full time custody in NSW.(4) 51.5 per cent of those released had returned to corrective services within two years in 2021-22.(5) This number is significantly higher for people who have experienced prior imprisonment and is almost twice as high

for populations experiencing multiple and complex disadvantage including mental health and AOD issues, cognitive disability, and homelessness.

The relationship between alcohol and other drug use and incarceration is well established. The 2022 National Prisoner Health Data Collection found that:

- Almost 3 in 4 (73% of prison entrants) reported using illicit drugs in the previous 12 months before incarceration
- Almost one-third of prison entrants reported they had injected drugs at some stage in their lives
- People entering prison were more than 4 times as likely to report illicit drug use in the preceding 12 months as people in the general community.
- Almost 2 in 5 (37%) of prison discharges reported using illicit drugs in prison, this increases to 41% in Aboriginal and Torres Strait Islander dischargees
- About 1 in 7 (15%) of male dischargees and about 1 in 20 (6.2%) of female dischargees reported injecting substances in prison.(11) (17)

The Community Restorative Centre (CRC) – a provider of specialist throughcare, post-release, and reintegration programs for people transitioning from prison into the community in NSW – has raised that a number of their clients have cognitive impairments, intellectual disabilities, and acquired brain injuries that are sometimes first identified and diagnosed in prison. CRC staff have highlighted the importance of diagnosis because it can have a significant impact on how clients are treated and how they function in the community.

Previous consultation with service providers revealed:

- Clients are commonly using heroin and methamphetamines.
- The importance of culturally safe services, in particular to be staffed by people with lived experience of AOD and the criminal justice system in frontline positions.
- Cognitive functioning and offending history are often barriers to accessing withdrawal and residential rehabilitation programs. Clients on bail or without stable accommodation to return to following treatment are also barriers. Case management support is essential to assist clients to access these treatments.
- Relationships with local GPs and pharmacies who are willing to provide OTP and work together to support a client have enabled clients to receive the treatment they need and avoid returning to custody.
- Since the onset of the pandemic, OTP services have transferred large numbers of clients to depot buprenorphine treatment. There are also increasing numbers of people exiting custody who have been commenced on depot buprenorphine. This has been a positive change with clients not having to travel to attend regular appointments. There are, however, reports of residential rehabilitation services being reluctant to accept people who are on depot buprenorphine.
- People on OTP that were previously attending clinics for dosing have now had their collection point changed to a local pharmacy. This means that people can miss out on the comprehensive support that a clinic provides.
- The need for a phone service to provide connection and assist with case management needs would be beneficial.
- Funding is needed to prepare clients for release from custody such as cognitive remediation, communication, and other self-management skills to support clients to successfully engage in AOD treatment once exiting to community. Funds are also needed for inclusion of AOD programs within prisons, including individual counselling, psycho-educational programs,

group therapy, transitional assistance programs and harm reduction education like that in Victoria.

People with co-occurring mental health conditions

The relationship between substance use and mental health is complex and bidirectional. The 2022–2023 National Drug Strategy Household Survey (NDSHS) found that, compared with adults without a mental illness, those with a mental illness were:

- more likely to drink alcohol at risky levels (37% compared with 32%)
- twice as likely to smoke daily (15% compared with 7.4%)
- 1.8 times as likely to use any illicit drug (29% compared with 16%) (18)

A recent study of Australian general practice records (19) showed the rate of moderate to heavy drinking among patients with severe mental illness and/or long-term mental illness was 4.7%, more than double that for the population without (2.2%). The same study also showed almost half (47%) of people with severe or long-term mental illness are current or past smokers, compared with almost one third (30%) of the population without.(20)

Consultation with stakeholders heavily emphasised the need for better systems to be in place to address the needs and provide suitable treatment options people who have co-occurring substance use and mental health conditions.

People with other co-occurring conditions

It is well established that substance use can increase the risk of physical injury. Between 36% and 51% of hospital admissions for traumatic brain injury (TBI) are due to incidents that occurred while intoxicated.(21)

Between 48% and 68% of heroin users will experience at least one non-fatal overdose.16,17 A nonfatal opiate overdose is defined by a loss of consciousness and hypoventilation, which can result in hypoxic brain injury and severe cognitive impairment.(22, 23)

According to NSW emergency department records, 40-50% of admissions for seizures are alcohol-related (27). Seizures are common following withdrawal from alcohol and typically present 6-48 hours after discontinuation of use, but not all alcohol-related seizures are the result of withdrawal.(24) It has been suggested that with each additional episode of withdrawal in people with chronic alcohol dependence, seizures increase in both frequency and intensity causing permanent epileptogenic alterations in the brain that can result in recurring seizures long after the cessation of alcohol.(24)

Other conditions that are often found to co-occur with AOD use disorders are physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain.(25)
Consultations with stakeholders identified the challenges with collecting data around co-occurring conditions and how that impacts their ability to treat clients.

Older people

Consultation with stakeholder and service providers found that the age of people accessing local services is continuing to increase. With this increase in age, comes more complexities with both physical

and mental health issues that need to be treated simultaneously. The increased complexity can be a barrier to accessing care, in particular aged care services.

Service gaps

Service availability and navigation

Themes across consultations with stakeholders have been similar to consultations held in previous needs assessment processes. For people in this cohort, being able to access free primary health care to manage health concerns remains an issue and service gap. The concept of holistic support, with wraparound service provision for employment and education needs along with day to day living support were all acknowledged as positive aims. There remains a need for increased access to support services that addressed the multitude of problems generally associated with a significant substance use concern.

Care co-ordination and team-based service provision continue to be raised as models of care that should be pursued. Further enhancements of services are required to treat the full complexity of clients. In particular to be able to address the various intersectionalities of an individual client in one place by having access to a range of clinical services including psychology, nutrition, medical and social work were all necessary to provide holistic care. Co-location with mental health services, and the ability to benefit from the two funding steams working together would improve outcomes for clients. A role for pharmacists as potential treatment co-ordinators was also suggested. Services to support people experiencing gambling harm were noted by stakeholders as an emerging need.

Stakeholders also commented that there is often no funding available for follow-ups within the community, once clients leave a service there is no way knowing the status of that person and if further treatment is required.

A steadily rising need for opioid treatment was noted by stakeholders, with increasing demand placed on public health OTP clinics. This is exacerbated by large numbers of people exiting custody who have been placed on Long Acting Injectable Buprenorphine (LAIB) who need ongoing treatment, with limited options for community-based OTP.

Increased access to treatment is needed for people seeking to address their alcohol use given the large number of people requiring treatment as estimated by the DASP model. Treatment options should provide for those with mild to moderate needs through to more intensive supports.

To address some of the above needs, CESPHN has commissioned The Rehabilitation Project Connect-Discover-Recover program working extensively with people from culturally and linguistically diverse communities and particularly with the Islamic and Arabic-speaking community. In addition to this, CESPHN has also commissioned specialised Mandarin speaking multicultural AOD services at Odyssey House, specifically targeting areas such as the Chinese population in Hurstville, in the St George region.

Methamphetamine use and interventions

The effective treatment of problematic methamphetamine use involves the treatment of both the physical and psychological effects of its use, and the underlying causes of its use, which can include

comorbid mental health issues, trauma history, homelessness, unemployment.(22) However, most current services are constructed to deal with alcohol and heroin which have very different psychological and physical withdrawal profiles than stimulants. The lack of any substitution therapy for stimulant drugs was also noted.

In 2020 the report of the NSW Special Commission of Inquiry into the drug ice was released, with the NSW government committing to support 86 of the 109 recommendations. The NSW Ministry of Health Centre for Alcohol and Other Drugs is responsible for the implementation of these recommendations and progress against these recommendations is reported by NSW Health.
Implementation of the recommendations will address treatment gaps and improve health and social outcomes through a suite of cross-government initiatives, including:

- Evidence-based prevention, treatment, support and early intervention services.
- Integrated care for people with multiple and complex needs.
- Enhancing digital capability, system navigation and virtual healthcare.
- Enhancing the AOD workforce, including Aboriginal health practitioners and peers.
- Better utilisation of data and evidence to inform system priorities, management, monitoring and evaluation.
- Expanded justice initiatives.

Residential rehabilitation beds

The general lack of availability of residential rehabilitation beds across the state continues to be a concern. In addition, the need for culturally appropriate rehabilitation for Aboriginal people was raised in consultations. The length of waiting periods to access a bed and the poor service continuity with withdrawal services was frequently raised. Transitions between services could be improved between most service modalities however the withdrawal/rehabilitation link was the primary focus of most commentary.

Co-occurring conditions associated with substance use

Dealing with co-occurring mental health conditions in the context of AOD use continues to be a central theme. More than 1 in 3 with a substance use disorder have at least one mental health condition and the rates are even higher among people in substance use treatment (28). People with co-occurring mental health and substance use often have a variety of other medical, family, and social issues (e.g., housing, employment, welfare or legal concerns). Together, all these factors can impact a person's treatment and recovery progress. Because of this, there is a need for health practitioners to adopt a holistic approach to the management and treatment of co-occurring mental health and substance use disorders that focus on treating the person. Ongoing capacity building activities to support the local workforce understanding in co-occurring mental health and alcohol and other drug needs is important. In a survey of community organisations multiple AOD services identified co-occurring mental health conditions as a high area of concern for their clients.

Services for Aboriginal people

Previous consultation with Aboriginal service providers raised access issues in specific locales including La Perouse, Mascot and Botany. Difficulty accessing rehabilitation, and particularly accessing culturally appropriate rehabilitation was referenced by all Aboriginal participants. Since previous consultations there have been no additional Aboriginal AOD Service. Rehabilitation services should be culturally specific healing centres and include connection to community. There was a general preference for

medically supervised inpatient withdrawal services instead of withdrawal managed in the home, and greater access to detoxification services staffed by Aboriginal people.

Aboriginal service providers also previously highlighted the relationship between suicide and drug use and the need for specific service responses to this. This link was similarly emphasised by other stakeholders, with a reference to those aged 18-24 years in the context of the 'come down' from binge stimulant use. It was also noted that there are limited supports available for people who are exiting custody and a lack of culturally appropriate services for this group.

Addressing stigma associated with AOD use

There is often a lot of stigma associated with the use of alcohol and other drugs outside of recreational use. There is a need to not only reduce this stigma at a population level, but more specifically within frontline services who are engaging with the community outside of the service/treatment setting. Up to two-thirds of Australians entering AOD treatment services also experience post-traumatic stress disorder (PTSD) (29) and knowing how to identify this and manage this in a community setting may help with reducing the stigma associated with this cohort.

Workforce development

Workforce development and capacity building continues to remain an area of need for stakeholders within the AOD sector. The consultation process identified that an increase in the number of general practitioners who prescribe opioid treatments was required, as well as upskilling of nurse practitioners and pharmacies to provide opioid treatment as this is within their scope of practice.

The report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants recommends that all NSW government employees and NGO partners be trained in trauma-informed practice. Such training should be co-designed and delivered by people with lived experience of trauma, including Aboriginal people.

In August 2024, NSW Health released the NSW Alcohol and Other Drugs Workforce Strategy 2024-2032.(26)The aim of the strategy is that the AOD workforce meets the needs of the NSW community. The strategy lists the following areas in which the AOD sector are experiencing workforce challenges:

- shortages of suitably qualified and skilled staff
- burnout and change fatigue
- fewer entrants to the sector
- limits on professional development opportunities, training and education, particularly in regional settings
- absence of coordinated recruitment and retention strategies
- disparities in remuneration and employment conditions between public sector and nongovernment services.

CESPHN consultation with stakeholders within the AOD sector also identified these workforce challenges amongst the local workforce. Consultation also highlighted that:

- the local workforce found that networking opportunities have continued to decrease since COVID-19 where meetings moved online and have remained online and this has limited the ability to create meaningful relationships across the sector.

- The need for increased opportunities for cross-sector collaboration with the mental health workforce as clients often have co-occurring mental health conditions.

Lived and living experience workforce

External stakeholder consultations identified that there needs to be further support for the lived and living experience workforce. Whilst programs exist including ConnectedED from NSW Users and AIDS Association (NUAA) and NADA's Peer Worker Community of Practice to support lived and living experience workers, it was identified that a model of supervision within the workforce similar to clinical professions may enhance the capabilities of the workforce.

Opportunities to address health and service needs

- Support an increase in the number of general practitioners (GPs), nurse practitioners, and pharmacists trained to prescribe opioid treatments.
- Encourage co-location of services, leveraging nurse practitioners to improve accessibility.
- Continue to support provision of treatment services that address co-occurring mental health and AOD needs.
- Continue to address barriers to treatment faced by multicultural populations.
- Support networking opportunities among the local AOD workforce.
- Support the upskilling of peer workers to expand the AOD workforce.
- Provision of culturally appropriate rehabilitation for Aboriginal Torres Strait Islander clients.
- Support a review and alignment of the AOD Minimum Data Set (MDS) with the Primary Mental Health Care (PMHC) MDS for more integrated service monitoring and improvement.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Aboriginal and Torres Strait Islander Peoples' Health and Wellbeing

2025-2027 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples or people that identify as from the First Nations community. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

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Overview

There were an estimated 19,520 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2024, accounting for 1.2% of the total population. The areas where most Aboriginal people live are the Botany Bay IARE (2.3%), Randwick - La Perouse IARE (2.1%) and Sydney – City IARE (1.8%). More than half (54.5%) of the Aboriginal population within the CESPHN region is under 30 years of age.

The strength of Aboriginal communities in the CESPHN region is rooted in their rich cultural heritage, strong family and social networks, effective community leadership, and growing engagement in health, education, and economic development. While there are significant challenges, Aboriginal people continue to demonstrate remarkable resilience, empowerment, and unity in their efforts to address disparities and promote the wellbeing of their communities. Their ongoing work to preserve and celebrate culture, improve health outcomes, and advocate for social change is a testament to the strength of these communities.

Key issues

- The impact of past traumas and injustices and the effects of intergenerational trauma
- Aboriginal children in NSW are significantly over-represented in the child protection system
- Aboriginal adults in NSW are over-represented in the criminal justice system and the youth justice system
- Suicide is more than 3-times more prevalent in this population than the general population in the region
- Emergency department (ED) presentations and hospital admissions are high in the region
- 30% of all Aboriginal people in the CESPHN region, had at least one long-term health condition
- High rates of smoking at some time during pregnancy
- Aboriginal mothers are more likely to give birth to babies born with a low-birth weight compared with non-Aboriginal mothers (11.5% versus 6.5%)
- High numbers of carers of people with disabilities
- High rates of domestic violence and abuse
- The percentage of Aboriginal people living with overweight or obesity increased from 57% in 2014 to 72% in 2023.

Key gaps

- Continuity of healthcare transition from correctional facilities to general practice and other primary care services
- Reducing disparities in preventable health measures and trying to improve health outcomes
- Promote better use of Urgent Care Centres and primary care to the community to avoid ED and hospital admissions
- Appropriate culturally safe care throughout the health system that is tailored to the needs of this community
- Low uptake of 715 Health Assessments.

Background

Prior to the colonisation of Australia, the health and wellbeing of the Aboriginal and Torres Strait Islander population (herein referred to as Aboriginal people) was robust, holistic and centred around the balance between physical, emotional and spiritual wellbeing. Primary health care in the traditional sense consisted of traditional healers, bush medicine, healing songs and spiritual practices.(1)

Colonisation had a profound impact on the Aboriginal population including:

- Displacement from their land
- Introduction of European disease
- Intergenerational trauma
- Cultural and spiritual disconnection
- Violence and conflict.

These factors have contributed greatly to health disparities and challenges faced by Aboriginal peoples.

Many Aboriginal people in the CESPHN region maintain a strong connection to the land, or Country which is central to their identity and spirituality. This connection to land contributes to mental and physical health, as people draw strength from their ancestral ties and the natural environment. The local communities have a deep understanding of the land, passed down through generations, and engage in environmental stewardship as evidenced by the Gamay Rangers service in the La Perouse area. This relationship with nature helps promote sustainability and wellbeing within these communities.

Aboriginal communities in the CESPHN region are focused on engaging young people and providing opportunities for empowerment, education, and leadership development. Programs such as the La Perouse Strengthening Our Mob Program and Tribal Warrior's youth mentoring services help to foster a sense of pride in cultural heritage and can offer pathways to employment and education.

With the consultation and support of the Aboriginal Advisory committee, CESPHN Aboriginal health programs focus on providing care that respects cultural practices while addressing both physical and mental health needs. These initiatives play a critical role in tackling the health inequities faced by Aboriginal people, particularly in areas like chronic disease management, mental health, and preventative care.

Aboriginal elders and community leaders in the region continue to guide and advocate for their communities. Their leadership plays a critical role in ensuring that community members' needs are met and that their voices are heard in decision-making processes.

Communities continue to be deeply connected through extended family and kinship systems. These structures are vital in maintaining strong social cohesion and ensuring that families support each other. Family is central to Aboriginal culture, and these relationships are a key strength in community life.

Stolen Generations

The Stolen Generations refers to the Aboriginal children who were forcibly removed from their families by Australian federal and state government agencies and church missions between approximately 1910 and 1972. This policy aimed to assimilate these children into white society, often placing them in foster homes, orphanages, or institutions.(2)

The historical injustices and trauma inflicted upon Aboriginal communities through the forced removal of children, and the negative impacts this has had, not only on the individuals removed but on subsequent generations through intergenerational trauma needs to be understood by health care providers. Recognising these past wrongs is a vital step towards healing and reconciliation between Aboriginal and non-Aboriginal Australians.

Intergenerational trauma

Intergenerational trauma has had profound and lasting impacts on Aboriginal people in Australia. This is the transmission of trauma and its effects from one generation to the next. This can happen through various mechanisms, including genetic changes, behavioural patterns, and emotional responses.

Some of the effects that intergenerational trauma can have on Aboriginal people:

- Difficulty forming secure attachments
- Increased risk of poor mental health
- Suicidal ideation and self-harm
- Chronic health concerns due to prolonged stress
- Family and community disruption
- Loss of cultural identity
- Educational disadvantage
- Economic hardship.(3)

Programs that focus on cultural continuity and community-led healing are essential in supporting the recovery and wellbeing of Aboriginal peoples.(4-6)

Closing the Gap

Closing the Gap is an Australian government strategy aimed at reducing the disparities between Aboriginal peoples and non-Aboriginal persons across several key areas, including health, education, employment, and life expectancy. Closing the Gap is crucial for ensuring that Aboriginal peoples have equal opportunities to thrive and maintain their cultural heritage while achieving better life outcomes.(7)

Table 1: Closing the Gap targets that CESPHN contributes to

Target	CESPHN activity
Everyone enjoys long and healthy lives (Outcome 1)	Work with primary health services to ensure they provide services in a culturally sensitive way.
Children are born healthy and strong (Outcome 2)	General Practitioner (GP) Antenatal Shared Care Program.
Children thrive in their early years (Outcome 4)	Aboriginal young people's speech pathology program; Sydney Children's Hospital Integrated Team Care (ITC) program, place-based Healthy Schools program
Students achieve their full learning potential (Outcome 5)	Deadly Choices Program to promote healthy lifestyle initiatives.
Students reach their full potential through further education pathways (Outcome 6)	Youth health and wellbeing programs.
Young people are engaged in employment or education (Outcome 7)	Babana Aboriginal employment days.
Adults are not overrepresented in the criminal justice system (Outcome 10)	Community Restorative Centre Alcohol and Other Drug Transition Program
Aboriginal families and households are safe (Outcome 13)	Domestic and Family Violence (DFV) Assist Program.
People enjoy high levels of social and emotional wellbeing (Outcome 14)	Multiple mental health programs, I-ASIST training.
Cultures and languages are strong, supported and flourishing (Outcome 16)	Cultural awareness training program.

Source: Closing the Gap 2024

Geography and demographics

In 2024, an estimated 19,520 Aboriginal people lived within the CESPHN region, accounting for 1.2% of the total population.(8)

There are 12 Indigenous Areas (IARE) within the CESPHN region. The region's Aboriginal population is concentrated in Botany Bay IARE (2.3%), Randwick - La Perouse IARE (2.1%) Marrickville IARE and Sydney – City IARE (both 1.8%) and Sutherland Shire IARE (1.6%).(9)

Table 2: Usual resident population (URP) in the CESPHN region by IARE, 2024

Indigenous Area (IARE)	Aboriginal persons	% of IARE region
Botany Bay	1,337	2.3
Canterbury – Bankstown (part a)	1,335	0.9
Hurstville – Kogarah	1,207	0.8
Leichhardt	727	1.3
Marrickville	1,496	1.8
Randwick – La Perouse	2,881	2.1
Rockdale	1,010	0.9
Sutherland Shire	3,803	1.6
Sydney – City	3,806	1.8
Sydney Inner West	1,378	0.6
Woollahra – Waverley	540	0.4
CESPHN	**19,502**	**1.2**

Source: PHIDU 2025

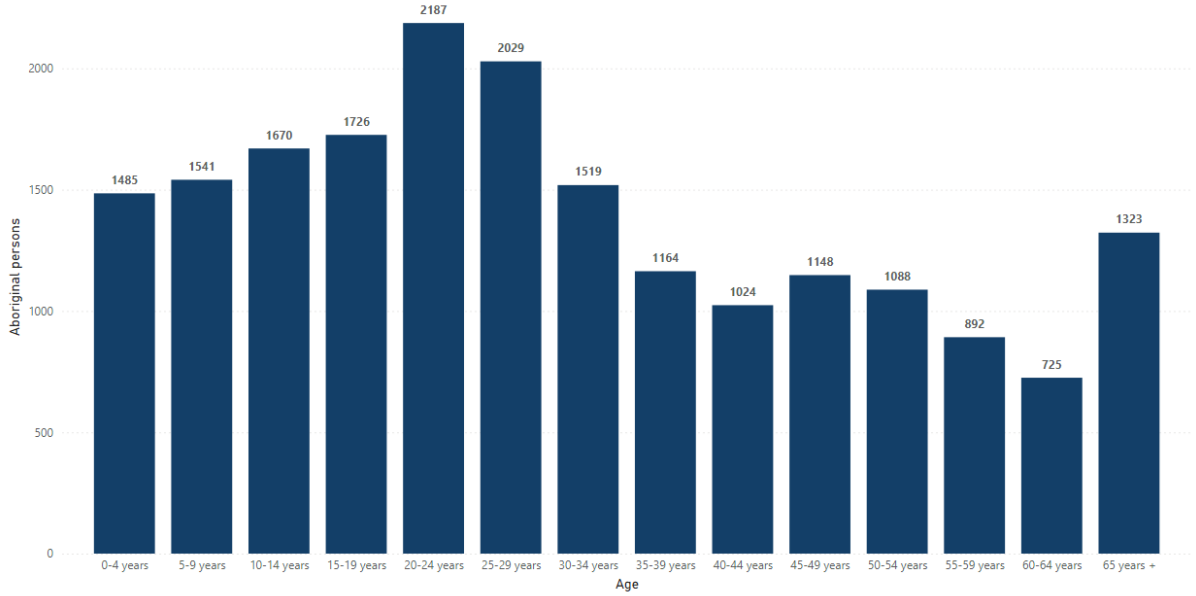
The La Perouse Aboriginal community is a vital and resilient community in the heart of Sydney, with a rich cultural history and strong connections to its land and traditions. La Perouse was one of the earliest places where Aboriginal people were settled by the British after colonisation, often because of displacement from their traditional lands. The community remains culturally strong. Through advocacy and cultural preservation, the community continues to foster a strong sense of identity and empowerment while working to overcome the barriers that have historically marginalised Aboriginal people.

The Redfern Aboriginal community remains one of the most significant and resilient urban communities established in Australia. It has a rich history of activism, cultural expression, and social justice advocacy. Despite the challenges posed by social disadvantage, housing issues, and systemic racism, the Redfern Aboriginal community continues to thrive through its strong networks, cultural pride, and ongoing efforts for empowerment and equality. The community serves as a model for urban Aboriginal life, showing the strength of identity, culture, and solidarity in the face of adversity.

Age

In 2024, more than half (54.5%) of the Aboriginal population within the CESPHN region is under 30 years of age. One in five (21.6%) Aboriginal people are aged between 20-29 years (4,216).(9)

Figure 1: Aboriginal population by 5-year-age groups, CESPHN region, 2024



Source: PHIDU 2025

Births

Aboriginal mothers who gave birth in the CESPHN region in 2022 accounted for 1.5% of births (NSW 5.5%). 1.9% of babies born in the region in 2022 identified as Aboriginal (NSW 7.4%).(10)

Determinants of health

Lifestyle risk factors

Diet

Dietary risk factors are one of the leading risk factors contributing to ill health and premature deaths after tobacco use, overweight and obesity in Australia. They contribute to coronary heart disease, bowel cancer, type 2 diabetes and stroke. Rates of long-term health conditions associated with risk factors such as these are disproportionately higher among Aboriginal Australians compared to non-Aboriginal Australians.(11)

Table 3: Dietary risk factors of Aboriginal residents by sex, NSW, 2022-23

Risk Factors	Sex	
	Males (%)	Females (%)
Did not meet recommended fruit guideline	69.9	65.3
Did not meet recommended vegetable guideline	96.6	91.3
Usually consumes sugar sweetened or diet drinks	78.1	71
Usually consumes sugar sweetened drinks	69.4	52.3
Usually consumes diet drinks	26.3	25.7

Source: ABS, NATSIHS 2024

Smoking

In 2023-24, the proportion of people in NSW who smoke daily were higher among the Aboriginal population (21.4%), compared to the non-Aboriginal population (7.1%).(10)

Despite this, the proportion of Aboriginal daily smokers has decreased by 35.7% since 2015-16 reflecting a strong focus on health and wellbeing within the community and the success of government initiatives.(10)

Reasons for high smoking rates in the Aboriginal community are multifaceted and include:

- Social norms constructed around smoking culture
- Socioeconomic disadvantage
- Coping mechanisms to combat life stressors such as housing concerns, poor mental health, grief and loss
- Community bonding and sharing of tobacco products.(12)

Vaping

Although there is no publicly available data regarding vaping in the Aboriginal population within the CESPHN region, anecdotally it has been reported from stakeholders that there has been an increase in vaping rates within both Aboriginal and non-Aboriginal communities.

Within the context of NSW, available evidence mirrors that of daily smoking rates. In 2023-24, the proportion of people who vape (occasionally or daily) were higher within the Aboriginal population (12.7%), compared to the non-Aboriginal population (7.4%) and higher than that of the NSW average (7.6%).(10)

CESPHN has funded the Tackling Indigenous Smoking program, 'Nah Joomelah', which is delivered through the La Perouse Local Aboriginal Land Council to provide smoking and vaping prevention and health promotion messaging across the CESPHN region. Feedback on additional needs in relation to this program is an acknowledgement of the support of traditional Nicotine Replacement Therapy (NRT) being more readily available than the supports to stop vaping, with a distinct lack of local GPs/ Pharmacies willing to provide access to vapes due to the updated regulations in Australia.

Socioeconomic disadvantage

The Centre for Aboriginal Economic Policy Research (CAEPR) developed the Indigenous Relative Socioeconomic Outcome (IRSEO) index to measure relative advantage or disadvantage at the Indigenous Area level, where a score of 1 represents the most advantaged area and a score of 100 represents the most disadvantaged area.

The IRSEO index for the CESPHN region reflects a relatively advantaged area (IRSEO = 10). None of the IAREs within the region have an IRSEO index equal to or lower than the national or NSW index. Canterbury–Bankstown (part a) IARE has the highest IRSEO score (meaning most disadvantaged) in the CESPHN region.(9)

While the CESPHN population is relatively advantaged in comparison to other areas, the high cost of living in the region and housing affordability are presenting as major issues. Approximately half of low-income Aboriginal households are under financial stress from their mortgage or rent.

Table 4: Indigenous Relative Socioeconomic Outcome (IRSEO) index score by IARE, 2021

Indigenous Area (IARE)	IRSEO Index score
Botany Bay	15
Canterbury – Bankstown (part a)	26
Hurstville – Kogarah	12
Leichhardt	7
Marrickville	5
Randwick – La Perouse	14
Rockdale	7
Sutherland Shire	3
Sydney – City	11
Sydney – Inner West	6
Woollahra – Waverley	1
CESPHN	**10**
New South Wales	**35**
Australia	**41**

Source: PHIDU, 2024

Contact with the criminal justice system

Adult imprisonment

In March 2025, there were 4,244 Aboriginal adults in custody in NSW, making up 32.4% of the adult prison population despite the Aboriginal population. This is up by 12.1% from March 2023.(13)

The over-representation of Aboriginal people in the criminal justice system is a significant concern and reflects:

- Social and economic disadvantage
- Systemic racism and discrimination
- Mental health and substance abuse concerns
- Lower levels of education and employment opportunities.(14)

The imprisonment rate in NSW for Aboriginal people continues to increase. In June 2025, the rate per 100,000 Aboriginal adults was 2,611.9, an 23.8% increase from 2022 (2,109.2).(15)

Community-based correction allows individuals convicted of crimes to serve their sentences outside of prison. As at June 2025, 22,049 Aboriginal persons were serving community-based correction orders in Australia, with 43.2% (9,521) being served in NSW.(15)

Youth justice

A large proportion of young people admitted to Youth Justice NSW identify as Aboriginal.

- 44.5% (493) young people attending Youth Justice conference
- 52.5% (2,262) young people under community supervision
- 55.1% (1,821) young people remanded in custody
- 66.9% (107) young people sentenced to detention.(16)

Consultations identified that cultural connection plays a significant role in reducing criminal involvement among Indigenous youth by fostering a sense of identity, belonging, and resilience through:

- Strengthening identity and self-esteem
- Improving mental health
- Building resilience
- Providing social support.(17)

The Youth Koori Court (YKC) in NSW is a specialised division within the Children's Court designed to address the over-representation of young Aboriginal people in the criminal justice system. The court operates in Surry Hills and involves Aboriginal elders and respected community members in the court process to provide cultural guidance and support to focus on underlying issues such as homelessness, substance abuse and disengagement from education to reduce reoffending. The Youth Koori Court is a great example of how community involvement and a holistic approach have a much more meaningful impact. (18)

Child protection

Aboriginal children in NSW are significantly over-represented in the child protection system.

In June 2023, 45% of children in out-of-home care were Aboriginal, despite Aboriginal children making up only about 7% of the child population in NSW. This highlights the urgent need for culturally sensitive and community-led approaches to child welfare.(19)

In NSW in 2022-23:

- Aboriginal children were three times more likely than non-Aboriginal children to be reported at risk of significant harm
- Approximately 6,500 Aboriginal children were in out-of-home care
- Approximately 25,000 reports about Aboriginal children were made to the helpline that reached the threshold for suspected risk of significant harm, which represented 22% of all reports made
- Approximately 1,000 Aboriginal children were deemed unsafe and entered out of home care, representing 44% of all children deemed unsafe
- Approximately 9,000 Aboriginal children were seen by a case worker, representing 31% of all children seen.(19)

The high rates of Aboriginal children in the child protection system and the trauma experienced by children removed from their families in past decades has been passed down through generations, influencing their health, wellbeing, and parenting practices. Ongoing involvement with child protection services can exacerbate this trauma by creating:

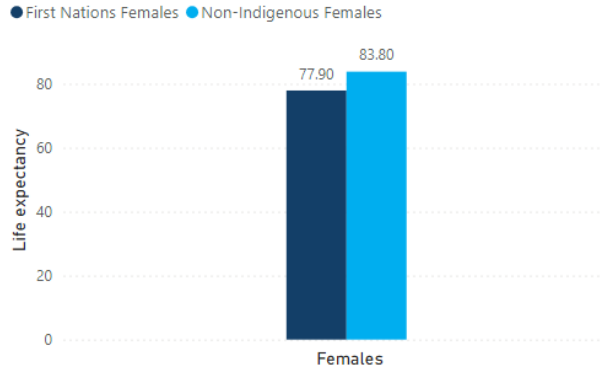
- Distrust of authorities
- Chronic stress
- Higher suicide risk
- Social Isolation
- Cultural disconnection
- Cultural barriers.(19)

Health status

Life expectancy

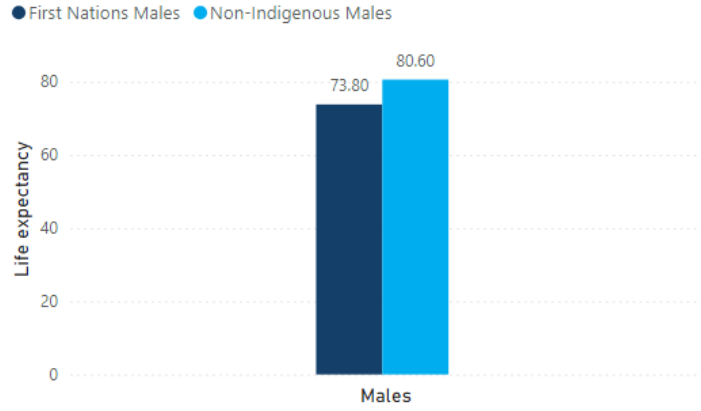
Aboriginal females born in NSW have a life expectancy of 77.9 years (5.9 years lower than non-Aboriginal residents in NSW) while males have a life expectancy of 73.8 years (6.8 years lower than non-Aboriginal residents in NSW). (20)

Figure 2: Life expectancy in females by Aboriginal status, NSW, 2020-22



Source: AIHW, Aboriginal and Torres Strait Islander Health Performance Framework 2024

Figure 3: Life expectancy in males by Aboriginal status, NSW, 2020-22



Source: AIHW, Aboriginal and Torres Strait Islander Health Performance Framework 2024

Median age at death

Within the CESPHN region, Aboriginal males have a median age at death of 60 years and females have a median age at death of 67 years. For females, this is consistent with the Greater Sydney and NSW median age at death, however for males the median age at death is 2 years lower than NSW.(9)

Table 5: Median age at death by gender and regions, 2018-22

Region	Females (yrs)	Males (yrs)
CESPHN	67	60
Greater Sydney	67	62
NSW	67	62
NSW, QLD, SA, WA & NT	64	59

Source: PHIDU 2024

Infant and child mortality

Perinatal mortality

Perinatal mortality is defined as deaths commencing from at least 20-weeks of gestation (foetal deaths or 'stillbirths') and deaths of live-born babies within the first 28 days after birth (neonatal deaths).(10)

In NSW there were 789 Aboriginal perinatal deaths in 2022 a rate of 12 per 1,000 births (non-Aboriginal babies' rate of 7.8).(10)

Addressing perinatal deaths requires a comprehensive approach that includes improving healthcare services, addressing social determinants of health, and ensuring equitable access to care for Aboriginal people.

Infant mortality

Infant mortality is defined by deaths in children under 1 year of age. Between 2017-21 there were 3.9 infant deaths per 1,000 Aboriginal live births, compared to 3.0 infant deaths per 1,000 non-Aboriginal live births across NSW.(9)

Child mortality

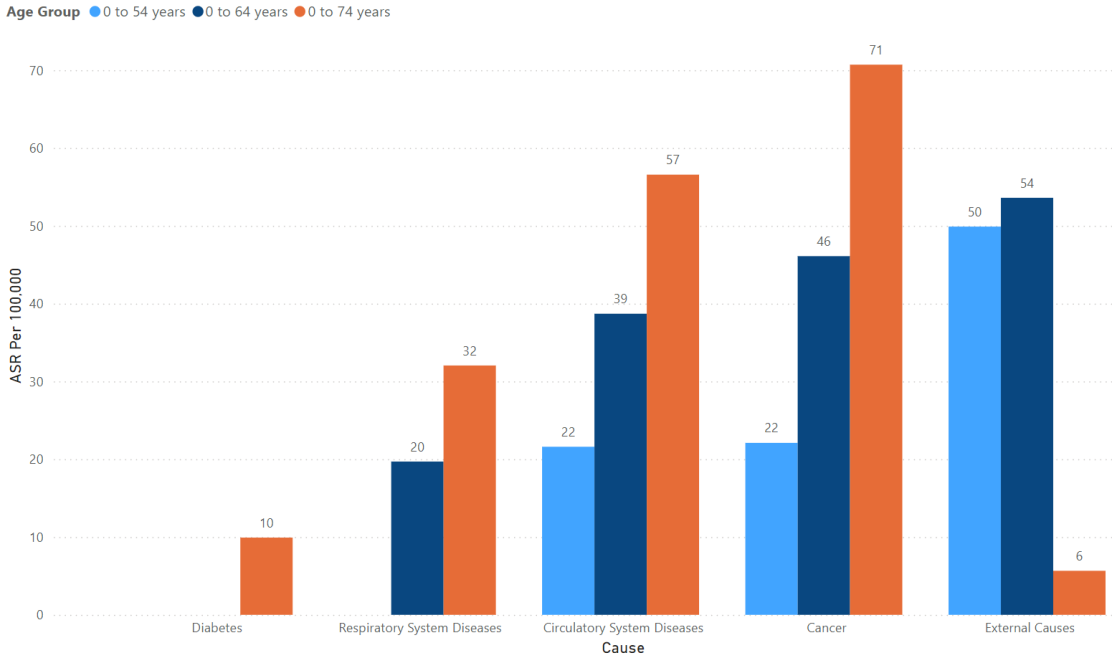
The child (0-4 years) mortality rate among Aboriginal children in NSW between 2017 and 2021 was 98.7 per 100,000 compared to 69 for non-Aboriginal children.(9)

Although the rate of child death was significantly lower for NSW in comparison to other states and territories, there is still substantial work that needs to be done to close the gap between Aboriginal and non-Aboriginal child mortality rates.(9)

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. The three main causes of preventable deaths that occurred in the CESPHN region were cancer, circulatory system diseases and respiratory system diseases.(9)

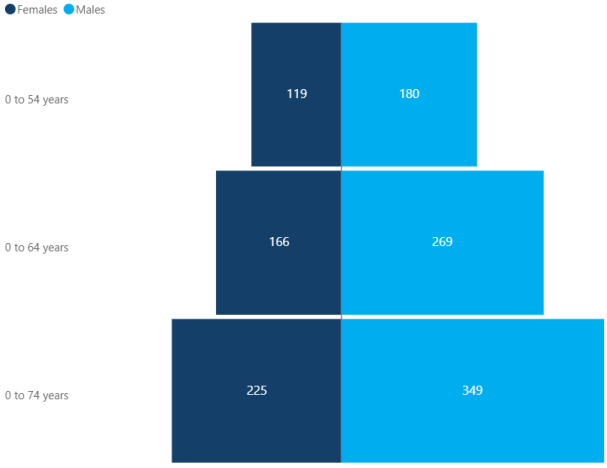
Figure 4: Premature deaths by age group and cause for Aboriginal people, CESPHN region, 2018-22



Source: PHIDU 2024

Males within all age groups had a higher age standardised rate (ASR) of premature deaths per 100,000 population than females. In the 0 to 64 years age group, the ASR of premature deaths in males was 1.3 times the rate of females.(9)

Figure 5: Premature deaths by age group and gender, CESPHN region, 2018-22



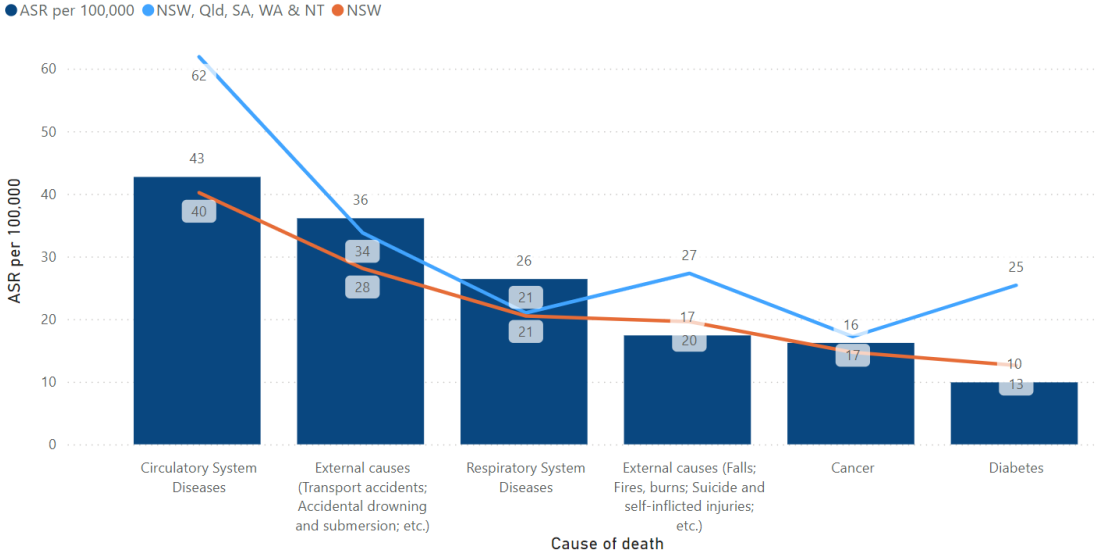
Source: PHIDU 2024

Avoidable deaths

Potentially avoidable deaths are deaths before the age of 75 years from conditions that are potentially preventable through primary or hospital care. The rate of potentially avoidable deaths was the lowest in NSW in comparison to the other states and territories in 2015-2019 at 149 per 100,000.(9)

Avoidable deaths from circulatory system diseases had the highest ASR in the CESPHN region (43 deaths per 100,000), followed by avoidable deaths from external causes (36 deaths per 100,000).(9)

Figure 6: Avoidable deaths by cause of death, CESPHN region, 2018-22



Source: PHIDU 2024

Long term health conditions

In the CESPHN region, just over 30% of all Aboriginal people had at least one long term health condition.(9)

Table 6: Percentage of Aboriginal people who self-reported long term health conditions, 2021

Number of selected chronic conditions	CESPHN (%)	NSW (%)	Australia (%)
No selected chronic conditions	59	54.6	56.9
One	21.4	22.3	20.6
Two	6.1	7.3	6.7
Three or more	3.3	4.4	4.0
Has one or more selected chronic conditions	30.8	34.1	31.3

Source: PHIDU 2024

CESPHN commissions the Sydney Local Health District (SLHD), South Eastern Sydney Local Health District (SESLHD) and Sydney Children's Hospital Network (SCHN) to deliver the Integrated Team Care (ITC) program to support Aboriginal people with chronic conditions. The program provides care coordination, outreach and supplementary services.

The Practice Incentives Program – Indigenous Health Incentive (PIP IHI) encourages health services to meet the health care needs of Aboriginal people with a chronic disease. Health services include general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services.

Disability

There were 1,180 Aboriginal people in the CESPHN region with a profound or severe disability according to the 2021 Census. Of those, 904 Aboriginal people were aged 0-64 years and 282 were 65 years or older. Approximately, thirteen percent (12.9%) of Aboriginal persons aged 15 years and over were providing unpaid assistance to people with a disability.(21)

NDIS participation

At June 2025, there were a total of 60,529 (8.2%) Aboriginal participants on the NDIS across Australia, with a growth rate of 13.9% since June 2023.(22)

In NSW, there were a total of 20,541 Aboriginal participants in June 2025, representing 33.9% of the total Aboriginal participants across Australia.(22)

Within the CESPHN region, a total of 1,038 NDIS participants identified as Aboriginal.(23)

Table 7: NDIS participants by Aboriginal status and service district, CESPHN region, 2024-2025

Region	Aboriginal	non-Aboriginal	Not stated
South Eastern Sydney	572	11,926	2,334
Sydney	466	6,552	1,326
Australia	60,529	577,989	100,895

Source: NDIS 2025

Hospital admissions

Across the CESPHN region, the rates of hospital admission were higher than NSW rates, but lower than the national for both genders.(9) Within the CESPHN region there were IAREs with admission rates higher than NSW rates:

- Botany Bay IARE, Leichhardt IARE, Marrickville IARE, Randwick – La Perouse IARE, Sydney – City IARE and Sydney – Inner West IARE had admission rates for females all higher than the CESPHN rate.
- Botany Bay IARE, Leichhardt IARE, Marrickville IARE, Randwick – La Perouse IARE, Sydney – City IARE, Sydney – Inner West IARE and Woollahra – Waverley IARE had admission rates for males all higher than the NSW rates.(9)

Table 8: Average annual hospital admission, ASR per 100,000 by gender and IARE, 2019-20 to 2022-23

Region	Female	Male
Botany Bay	32,941.6	29,484.2
Canterbury – Bankstown (part a)	30,533.2	22,212.2
Hurstville – Kogarah	28,732.1	21,763.8
Leichhardt	36,025.4	33,735.6
Marrickville	34,881.8	28,031.1
Randwick – La Perouse	38,421.1	38,437.2
Rockdale	23,126.4	18,649.0
Sutherland Shire	26,293.5	20,222.1
Sydney – City	40,494.9	35,525.3
Sydney – Inner West	31,812.2	27,238.8
Woollahra – Waverley	28,460.2	27,315.3
CESPHN	**33,201.1**	**28,744.2**
New South Wales	**31,335.4**	**23,590.3**
Australia	**41,807.5**	**30,139.3**

Source: PHIDU 2024

Emergency department presentations

The three main causes of ED presentations in 2022-23 were:

- injury poisoning and other causes (13,001 ASR per 100,000 population)
- mental and behavioural disorders (5,893.6 ASR per 100,000 population) and
- respiratory disease (4,796.7 ASR per 100,000 population).(9)

Rates of emergency department (ED) presentations for mental and behavioural disorders are well above the Greater Sydney and NSW rates suggesting a need for culturally safe alternatives to ED support.(9)

Table 9: ED presentations for mental and behavioural disorders for Aboriginal people, ASR per 100,000, by age groups and region, 2022-23

Age groups	CESPHN	Greater Sydney	NSW
15-24	5,022.2	3,768.5	4,779.6
25-44	10,279.1	5,357.1	6,252.9
45-64	11,394.4	4,631.7	4,388.2

Source: PHIDU 2024

Overall, ED presentations in the CESPHN region were higher than the rates for Greater Sydney and NSW.(9) Of note, is the rate of non-urgent ED presentations. Promotion of new urgent care services to the Aboriginal population will be important.

Table 10: ED presentations by triage category, ASR per 100,000, by region, 2022-23

Triage category	CESPHN	Greater Sydney	NSW
Resuscitation and emergency	10,785.8	10,778.7	10,284.8
Urgent	29,172.9	22,524.1	26,187.4
Semi-urgent	20,388.0	18,280.5	31,958.4
Non-urgent	3,184.8	3,129.1	8,854.6

Source: PHIDU 2024

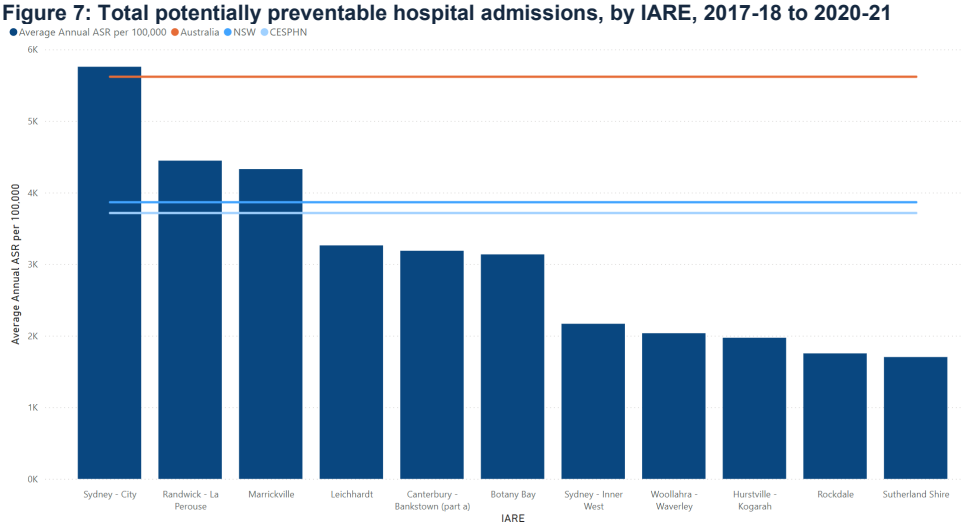
Potentially preventable hospitalisations (PPH)

Total potentially preventable hospitalisations

The rate of potentially preventable hospitalisations by IARE in the CESPHN region was 3,714.9 per 100,000 between 2017-18 and 2020-21. This was slightly lower than the NSW rate of 3,865.5 per 100,000.(9)

Within the CESPHN region, Sydney-City IARE, Randwick – La Perouse IARE and Marrickville IARE had higher rates than the state rate. Furthermore, Sydney – City IARE also had a higher rate than national rate.(9)

Figure 7: Total potentially preventable hospital admissions, by IARE, 2017-18 to 2020-21



Source: PHIDU 2024.
Note: There is no published data available for Lord Howe Island IARE.

Within the CESPHN region, the IAREs with the highest rate of potentially preventable hospitalisations (PPHs) were:

- Marrickville IARE for the 0 to 14-years, 15 to 24 years and 65 years and over age groups.
- Randwick-La Perouse IARE for the 25 to 44 years
- Sydney-City IARE for the 45-to-64-year age group.(9)

Table 11: Potentially preventable hospital admissions. by IARE and age group, 2017-18 to 2020-21

IARE/Region	0 to 14 years	15 to 24 years	25 to 44 years	45 to 64 years	65 years and over
Botany Bay	1,835.9	1,107.5	3,169.6	4,884.1	13,571.4
Canterbury - Bankstown (part a)	1,853.0	982.9	3,280.6	5,169.6	11,491.9
Hurstville - Kogarah	1,122.0	609.0	1,637.4	3,287.9	8,430.2
Leichhardt	2,507.4	1,229.8	2,502.1	6,171.5	10,169.5
Marrickville	3,750.3	2,913.1	2,977.0	6,589.5	16,019.4
Randwick - La Perouse	2,191.0	1,775.0	4,415.7	8,361.6	13,666.7
Rockdale	1,231.9	1,404.1	1,492.2	2,531.1	5,357.1
Sutherland Shire	953.8	934.9	1,490.5	2,353.6	7,532.8
Sydney - City	3,418.7	1,287.0	4,301.5	14,218.0	14,843.8
Sydney - Inner West	1,509.4	922.3	1,799.3	4,138.6	6,521.7
CESPHN	**1945.7**	**1299.8**	**2959.6**	**6873.7**	**11242.9**
Greater Sydney	**1895.9**	**1471.4**	**2372.1**	**4934.1**	**10555.3**
New South Wales	**2075.8**	**1658.3**	**2458.3**	**5354.3**	**11052.5**
Australia	**2810.1**	**2297.8**	**4397.8**	**9120.7**	**13239.7**

Source: PHIDU 2024
Note: Lord Howe Island IARE is not included as there is no published data available.

Acute potentially preventable hospital admissions

Acute dental conditions had the highest ASR of all acute PPH admissions (354.8 per 100,000 population) in the CESPHN region; higher than the NSW rate of admission (321.8 per 100,000).(9)

Table 12: Potentially preventable hospital admissions by acute condition, 2017-18 to 2020-21

Region	Acute cellulitis	Acute convulsions and epilepsy	Acute dental conditions	Acute ear, nose and throat infections	Acute urinary tract infections
CESPHN	349.9	300.9	354.8	268	273.8
Greater Sydney	266.3	259.5	298.8	276.1	259.5
New South Wales	285.2	272.9	321.8	288.8	264.8
Australia	515.5	404.8	402	385.4	402.8

Source: PHIDU, 2024

Chronic preventable hospital admissions

Chronic Obstructive Pulmonary Disease (COPD) had the highest ASR of all chronic PPH admissions in the CESPHN region (444.2 per 100,000 population).(9)

Table 13: Potentially preventable hospital admissions by chronic condition, 2017-18 to 2020-21

Region	Chronic angina	Chronic asthma	Chronic congestive cardiac failure	Chronic diabetes complications	Chronic Obstructive Pulmonary Disease (COPD)
CESPHN	89.4	206.3	154.5	274.6	444.2
Greater Sydney	55.8	167.7	131.1	239.6	421.5
New South Wales	72.4	155.4	145.3	294.2	457.9
Australia	134.5	189.8	222.6	419.3	536

Source: PHIDU, 2024

Preventive health

Immunisation

In 2023, immunisation rates amongst Aboriginal children aged 1-year-olds and 5-years-olds in the CESPHN region were above the target of 95% (95.4% and 96.5% respectively). However, the 2-year-olds age group remains below the target.(9)

Immunisation rates across all age groups were higher in the CESPHN region, when compared to the national rates.(9)

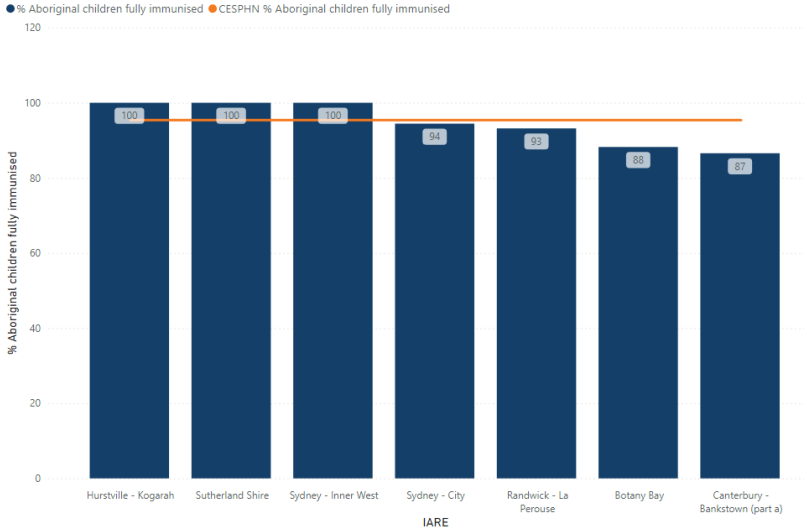
Table 14: Immunisation status of Aboriginal children, by age and region, 2023

Region	1-year-olds (%)	2-year-olds (%)	5-year -olds (%)
CESPHN	95.4	88.7	96.5
Greater Sydney	93.6	90.6	96.3
NSW	94.1	91.3	96.6
Australia	92.2	86.9	95.3

Source: PHIDU 2023

Sydney – City IARE, Randwick-La Perouse IARE, Botany Bay IARE and Canterbury-Bankstown (part a) IARE areas had 1-year-old immunisation rates below target (95%).(9)

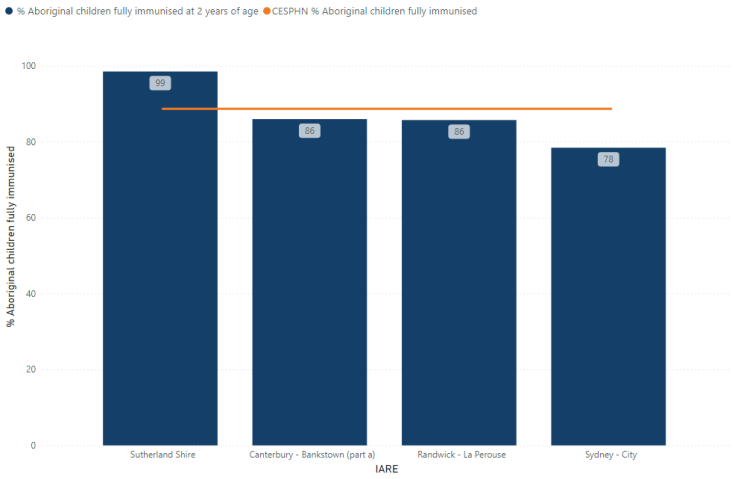
Figure 8: 1-year-olds fully immunised by IARE, CESPHN region, 2023



Source: PHIDU 2025
Note: data is not available for Leichhardt IARE, Marrickville IARE, Rockdale IARE or Woollahra - Waverly IARE.

Canterbury – Bankstown (part a) IARE, Randwick – La Perouse IARE and Sydney – City IARE areas had 2-year-old immunisation rates well below the national target (95%).(9)

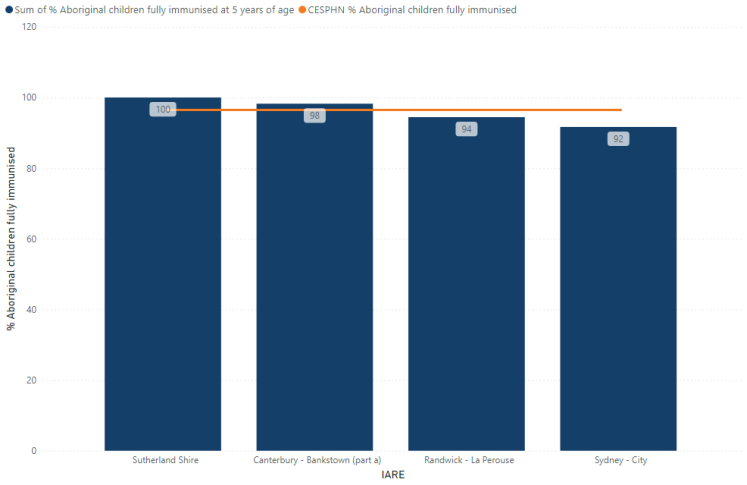
Figure 9: 2-year-olds fully immunised by IARE, CESPHN region, 2023



Source: PHIDU 2025
Note: data is not available for Botany Bay IARE, Hurstville – Kogarah IARE, Leichhardt IARE, Marrickville IARE, Rockdale IARE, Sydney – Inner West IARE or Woollahra - Waverly IARE.

Randwick – La Perouse IARE and Sydney – City IARE areas had 5-year-old immunisations rates below the national target (95%).(9)

Figure 10: 5-year-olds fully immunised by IARE, CESPHN region 2023



Source: PHIDU, 2025

Note: Data not available for Botany Bay IARE, Hurstville - Kogarah IARE, Leichhardt IARE, Sydney - Inner West IARE or Woollahra - Waverly IARE.

Potentially preventable hospitalisations (vaccine preventable)

Between 2017-18 and 2019-21, there were 511.5 per 100,000 population potentially preventable admissions for vaccine preventable conditions in the CESPHN region. This rate is lower than the national rate (597.8 per 100,000), however higher than the NSW rate (292.9 per 100,000).(9)

Within the CESPHN region, Sydney-City IARE had high rates for all vaccine preventable conditions. Rates per 100,000 population were:

- 1.9 times the national rate, and
- 3.9 times the NSW rate.(9)

Table 15: Potentially preventable hospitalisations, vaccine preventable per 100,000 population, by IARE, 2017-18 to 2020-21

IARE/Region	Pneumonia and influenza	Total
Botany Bay	90.6	506.0
Canterbury - Bankstown (part a)	134.3	311.8
Hurstville - Kogarah	-	139.4
Leichhardt	260.7	327.9
Marrickville	244.8	650.5
Randwick - La Perouse	216.7	639.8
Rockdale	-	-
Sutherland Shire	51.9	96.6
Sydney - City	263.4	1,133.6
Sydney - Inner West	105.0	276.6
CESPHN	**158.9**	**511.5**
Greater Sydney	**138.2**	**340.2**
New South Wales	**151.1**	**292.9**
Australia	**231.6**	**597.8**

Source: PHIDU, 2024
Note: Lord Howe Island IARE is not included as there is no published data available.

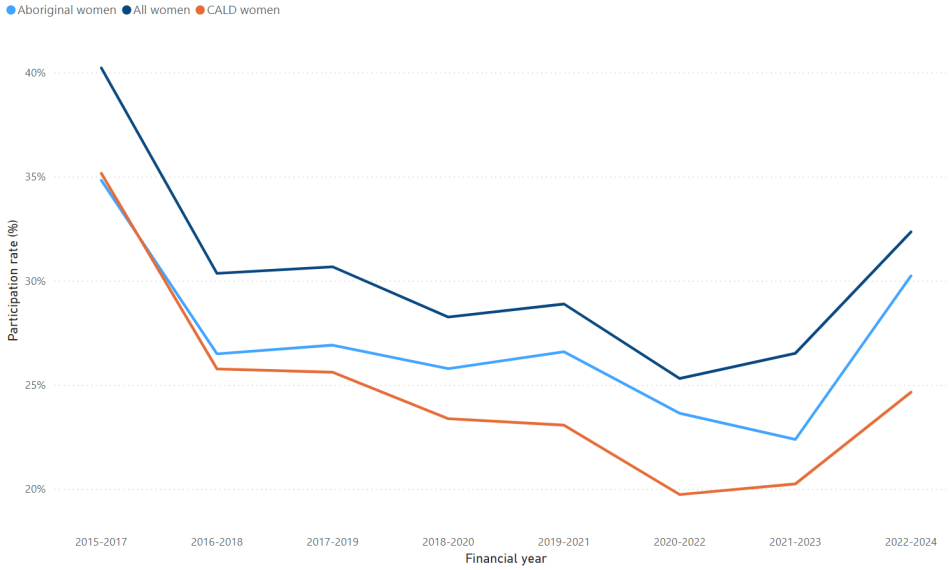
Cancer screening

There is limited local level data on cancer screening participation by Aboriginal people.

BreastScreen

Within the CESPHN region, breast screening participation rates for Aboriginal women aged 50-74 years have been consistently rising since 2021. However, screening rates are well below the rate for the eligible CESPHN population of 50.5%.(24)

Figure 11: BreastScreen participation rate, Aboriginal, CALD and all women, CESPHN region, 2020-24



Source: Cancer Institute NSW 2024

National Bowel Cancer Screening Program

In 2023, the annual bowel cancer screening participation rate for people aged 50-74 in the CESPHN region is 35.6%, slightly below the NSW rate of 37.5%. There is no recent screening participation data for Aboriginal people.(25)

Hearing screening

In 2018-19, 42.6% of Aboriginal people aged 7 years and older had a hearing impairment in one or both ears, with 22.7% having a hearing impairment in both ears. In NSW, the proportions were slightly lower, with 37.5% having a hearing impairment and 19.3% with an impairment in both ears. The proportion of people with a hearing impairment in one or both ears increased with age, those aged 15-24 years had the lowest proportion at 28.7%, those aged 55 years and over had the highest proportion at 81.8%.(11)

Maternal and child health

Aboriginal women and babies often face significant health challenges, including higher rates of maternal mortality, low birth weights, and early childhood health issues. Services like the Malabar Midwives in the CESPHN region are vital for addressing these disparities and improving the quality of care for Aboriginal mothers.

The Malabar Midwives Service provided by SESLHD and the SLHD Aboriginal Maternal Health Service offer a model of care that is culturally sensitive and designed to address the specific needs of Aboriginal mothers in Sydney. By combining midwifery care with Aboriginal health workers, the services improve outcomes for both mothers and babies through continuity of care, community involvement, and culturally safe services. This approach helps build trust and provides better support for Aboriginal women throughout pregnancy, birth, and postnatal care. The services take a holistic approach to care, addressing not just the physical health of the mother and child but also emotional, mental, and cultural wellbeing.

The focus is on preventive health and early intervention, aiming to address issues before they become more serious. Midwives work with other health professionals to monitor both maternal and fetal health during pregnancy.

Antenatal care

Note: Data for the Sydney Local Health District was not publicly available for this measure. Therefore, only data for the South Eastern Sydney Local Health District (SESLHD) has been included here.

In 2023, 83.7% of Aboriginal mothers in SESLHD attended their first antenatal visit by 14-weeks' gestation (compared to 81.7% non-Aboriginal mothers in SESLHD).(10)

In 2023, 91.9% of Aboriginal mothers within SESLHD attended their first antenatal visit by 20-weeks' gestation (compared to 96.1% non-Aboriginal mothers in SESLHD).(10) There is a need for additional health strategies and initiatives to close this gap.

Smoking during pregnancy

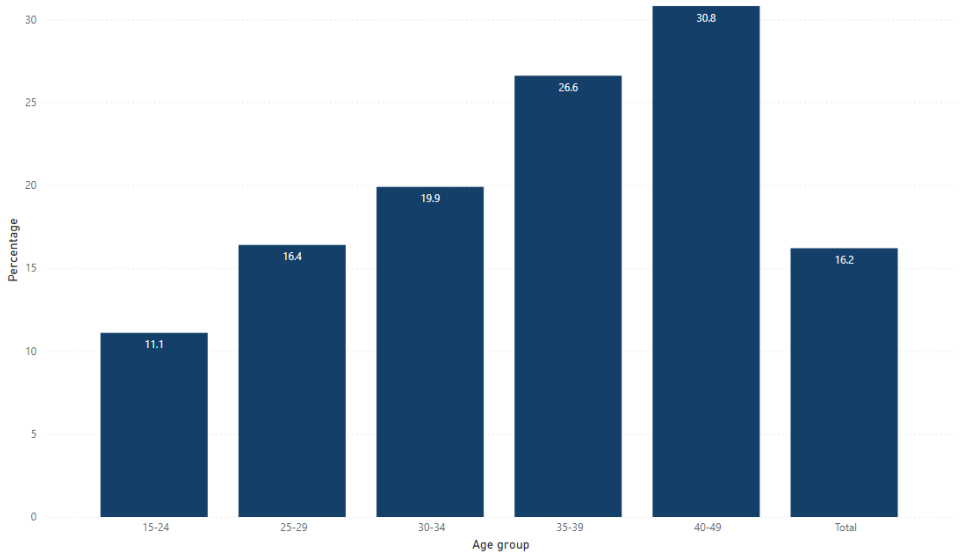
In 2023, 36.9% of Aboriginal mothers in NSW smoked at any time during their pregnancy. Within the CESPHN region, the rate was lower with 34.9% of Aboriginal mothers smoking at any point during their pregnancy.(10)

Gestational diabetes mellitus

In 2021-22, there were around 2,400 new cases of gestational diabetes among Aboriginal women, equating to 16.2% of Aboriginal women who gave birth in hospital in Australia. The incidence of gestational diabetes was slightly higher in the Aboriginal community (20.8%) in comparison with the non-Aboriginal community (17.8%).

The 40-49 age group had the highest incidence of gestational diabetes (30.8%).(26)

Figure 12: Incidence of gestational diabetes among Indigenous women nationally by age, 2020–21



Source: AIHW 2024

Low birthweight babies

In 2023, 11.5% of all babies born to Aboriginal mothers in the CESPHN region had a low birth weight; approximately double the proportion born to non-Aboriginal mothers (6.5%). Furthermore, this was also higher than the NSW rate for babies born with a low birth weight (6.8%).(10)

Breastfeeding

Across NSW in 2022, 55.8% of Aboriginal mothers were full breastfeeding their babies at discharge (from hospital, or discharge from home birth care), a decrease from 61.2% in 2018. This compares to 66.6% of non-Aboriginal mothers that were full breast feeding their babies at discharge in 2022.(27)

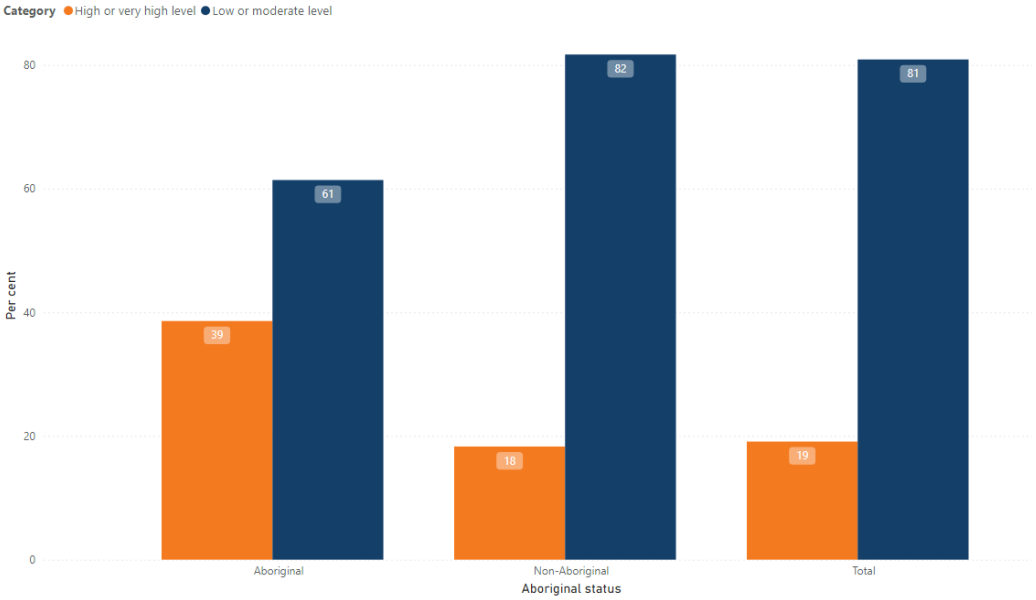
Within the CESPHN region, 54.9% of Aboriginal mothers were full breastfeeding and 26% were offering some level of breast feeding at time of discharge.(27)

Social and emotional wellbeing

Psychological distress

In 2024, the Aboriginal population in NSW had levels of very high psychological distress at twice the rate of the non-Aboriginal population (38.6% compared to 18.3%).(10)

Figure 13: Psychological distress experienced by Aboriginal status, NSW, 2024



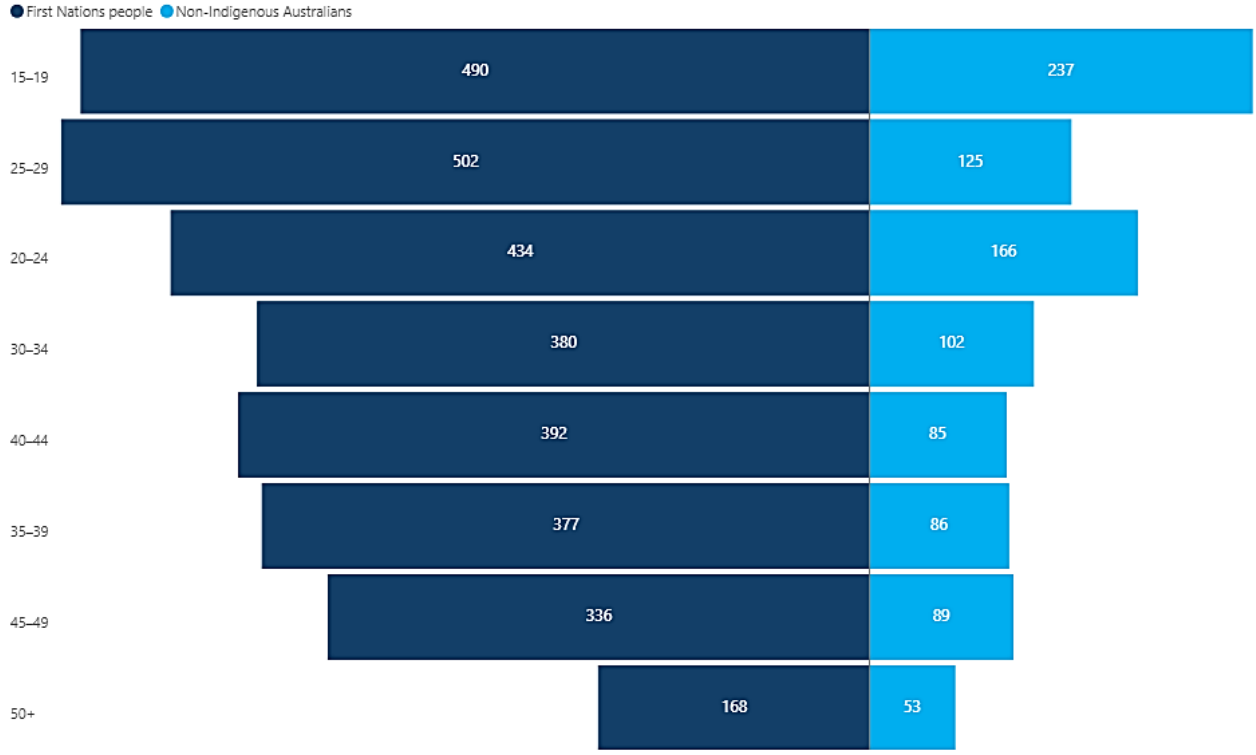
Source: HealthStats NSW 2025

CESPHN commissions a range of Aboriginal mental health and social and emotional wellbeing programs. These include Babana Aboriginal Health and Wellbeing Events, Yarning Circles, Youth Health and Wellbeing Programs at La Perouse, and in the inner city. In addition to these services the Psychological Support Services program provides free short-term psychological services.

Self-harm

Nationally, individuals aged 20-29 years have the highest rates per 100,000 population of intentional self-harm hospitalisations; the rate for Aboriginal persons is 4.0 times the rate of non-Aboriginal persons.(28)

Figure 14: Self-harm by age group per 100,000 population, Australia, 2023-24



Source: AIHW 2025

Females have a higher rate of intentional self-harm hospitalisations per 100,000 population than males (528.2 compared to 341.2). However, Aboriginal females have rates of intentional self-harm hospitalisations 2.9 times that of non-Aboriginal females and Aboriginal males have rates of intentional self-harm hospitalisations 4.2 times that of non-Aboriginal males.(28)

Suicide

In 2023, 5.1% of deaths in the Aboriginal population were by suicide, a rate which is more than three times that of the non-Aboriginal population (1.7%). The age-standardised rate (per 100,000 population) for those who died by suicide was more than twice as high in the Aboriginal population than the non-Aboriginal population (30.2 compared to 11.7).(28)

Table 16: Suicide rates, Aboriginal and non-Aboriginal, Australia, 2023

Measure	Aboriginal	non-Aboriginal
Number	239	2,085
Per cent of all causes of death	5.1	1.7
Age-standardised rate (per 100,000)	30.2	11.7

Source: AIHW 2025

In NSW, the rate of suicide across all age groups is significantly higher among the Aboriginal population with the 35-44 years age group having the highest ASR (46.2 per 100,000).(28)

Table 17: Suicide rate by age, Aboriginal and non-Aboriginal, NSW, 2019-23

Aboriginality and Age Group	Age-specific rate (per 100,000)	Deaths	Lower age specific rate (per 100,000)	Upper age specific rate (per 100,000)
				Aboriginal
0–24	8.3	74.0	6.4	10.2
25–34	35.0	84	27.5	42.5
35–44	46.2	79	36.0	56.3
45+	19.6	77	15.2	23.9
				non-Aboriginal
0–24	4.3	495	4.0	4.7
25–34	12.8	717	11.9	13.8
35–44	13.1	701	12.1	14.0
45+	13.9	2,279	13.3	14.4

Source: AIHW 2025

CESPHN commissions Tribal Warrior to deliver the Connector Service an Aboriginal-specific culturally safe care coordination service for Aboriginal people affected by suicide. The service is for those who have been bereaved by suicide or those who have a recent experience of suicidality.

Alcohol and substance use

Addressing alcohol and substance abuse is essential in order to address the underlying intergenerational trauma experienced by these individuals and the resultant health impacts, social and economic consequences, and the community's cultural and spiritual well-being.

Alcohol

Consultations identified that alcohol-related rehabilitation and detoxification services were a gap in care within the CESPHN region.

An estimated 15.9% of Aboriginal people in NSW did not consume alcohol in the twelve months preceding the National Aboriginal and Torres Strait Islander Health Survey – the rate was higher in the female population compared to the male population (16.9% compared to 14.7%). Males exceeded females in alcohol consumption that exceeded the guidelines by 29.3%.(11)

Table 18: Alcohol consumption status proportion, by gender, NSW, 2022-23

Alcohol consumption	Males (%)	Females (%)	Total NSW (%)
Exceeded guideline	54.9	25.6	39.6
Consumed alcohol less than 12 months ago but did not exceed guideline	25.4	49.0	38.0
Consumed alcohol 12 or more months ago	14.7	16.9	15.9

Source: ABS, NATSIHS 2024

Substance use

In 2022-23, an estimated 22.1% of the Aboriginal population in NSW had used substance(s) in the previous 12-months. The proportion of males that have used one or more substances within the prior 12 months was over two-folds greater than the female proportion, highlighting the need for gender-specific approaches to addressing substance abuse.(11)

Table 19: Substance use proportion, NSW, 2022-23

Substance use	Males (%)	Females (%)	Total (%)
Used substance(s) in last 12-months	32.4	13.9	22.1
Has not used substance(s) in last 12-months	67.0	84.1	76.6

Source: ABS, NATSIHS 2024

CESPHN commissions a range of drug and alcohol support services and programs. These include the Redfern Aboriginal Medical Service Drug and Alcohol Treatment Program, the Community Restorative Centre drug and alcohol program, Weave Youth and Community Services 'Speak Out' Dual Diagnosis Program, We Help Ourselves and Odyssey House.

Older people

Demographics

In 2024,21.9% of the CESPHN Aboriginal population were aged 50 years and over and 7.4% were aged 65 years and over.(9) Leichhardt IARE had the highest proportion of Aboriginal people aged 50 years and over (26.7%), followed by Sydney – City IARE (23.5%) and Marrickville IARE (22.7%).(9)

Table 20: Usual resident population (URP) aged 50 years and over, by IARE, 2024

IARE	50-54	55-59	60-64	65yrs +	Total	% Total IARE population
Botany Bay	73	71	53	70	267	21.1
Canterbury – Bankstown (part a)	70	60	53	100	283	22.2
Hurstville – Kogarah	50	56	47	86	239	20.8
Leichhardt	47	44	32	59	182	26.7
Marrickville	82	74	64	103	323	22.7
Randwick – La Perouse	148	134	105	225	612	22.3
Rockdale	63	44	35	70	212	21.9
Sutherland Shire	204	152	114	229	699	19.2
Sydney – City	256	181	159	256	852	23.5
Sydney Inner West	76	60	44	92	272	20.7
Woollahra – Waverley	19	16	19	33	87	16.6
CESPHN	**1,088**	**892**	**725**	**1,323**	**4,028**	**21.6**

Source: PHIDU, 2025

Aged care

Home care

In 2023-24 there were 97 admissions to home care in the CESPHN region who identified as Aboriginal.(29)

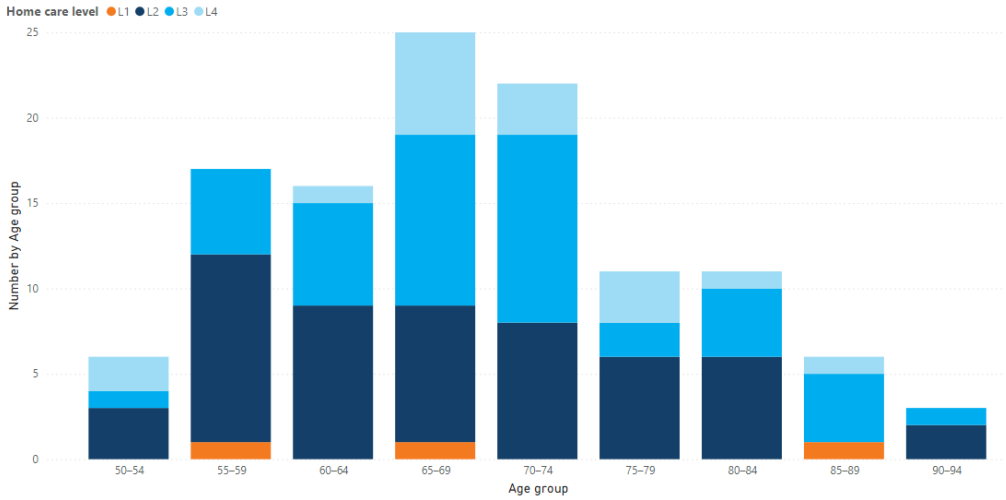
Table 21: Home care admissions by ACPR, 2023-24

Aged care planning region	Home care
Inner West	5
South East Sydney	92
CESPHN	97

Source: AIHW GEN 2025

The highest number of Aboriginal home care recipients were aged 65-69, followed by the 70-74 years old age group.(29) Wyanga, Guriwal and Kurranulla offer Aboriginal specific home care, transport and respite within the region.

Figure 15: Home care admissions by age group, CESPHN region, 2023-24



Source: AIHW GEN 2025

Residential care

In 2023-24, there were 73 residential care admissions for people who identified as Aboriginal in the CESPHN region. Approximately one third of these admissions were for permanent places.(29)

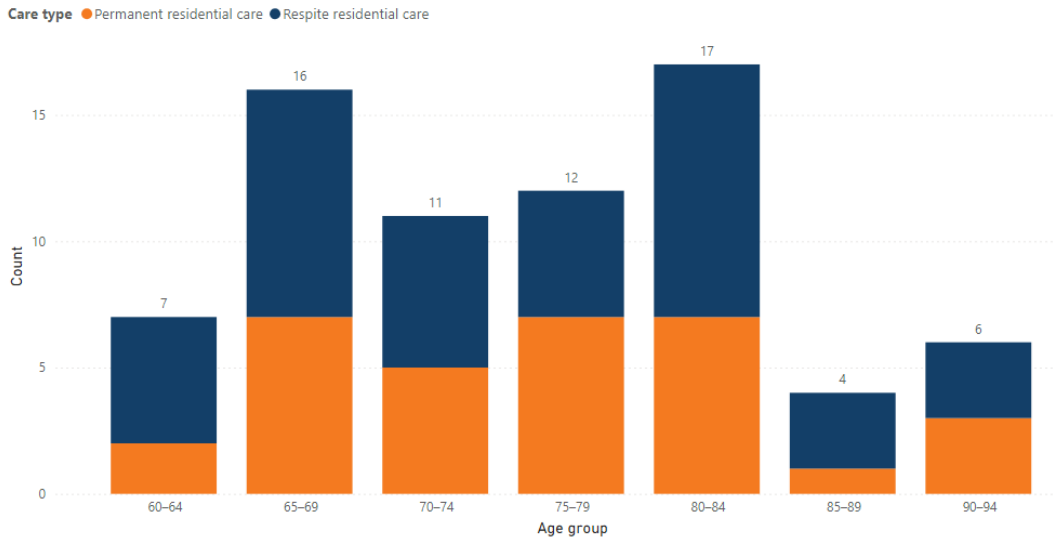
Table 22: Residential care admissions by ACPR, 2022-23

Aged care planning region	Permanent	Respite	Total residential care
Inner West	12	9	21
South East Sydney	20	32	52
CESPHN	32	41	73

Source: AIHW GEN 2023

Majority of residential care admissions were in the 65–69-year age group, followed by the 80–84-year age group.(29)

Figure 16: Residential care admissions, by admission type and age group, CESPHN region, 2023-24



Source: AIHW GEN 2025

The role of carers

Caring in Aboriginal communities is deeply influenced by historical and cultural factors. Many Aboriginal carers do not self-identify with the term "carer" and may be reluctant to access mainstream support services due to past experiences and cultural differences. Family structures and values also play a significant role, with extended family often involved in caregiving. The pressures of taking on caring roles with little formal support need to be recognised.

Access to primary care

There is one Aboriginal Community Controlled Health Service in the region located in Redfern. Aboriginal people access general practice care throughout the region with the largest numbers of patients in the Local Government Areas (LGA) of Sydney, Sutherland, Randwick, Inner West and Bayside.

There are 360 practices sharing data with CESPHN and among these practices there are approximately 14,500 active Aboriginal patients meaning they have attended the practice three or more times in the past two years. The number of active Aboriginal patients per general practice varies with close to 30% of practices having less than 10 patients and almost 50% of practices having between 11 and 50 active patients.

CESPHN works to support general practices within the region to provide culturally sensitive care. CESPHN regularly offers cultural awareness training for GPs followed up with practice support visits.

Table 23: Number of active Aboriginal patients in general practice, 2025

LGA	RACGP Active Patients	No. of Practices
Sydney	3,573	68
Sutherland Shire	2,616	50
Randwick	2,329	25
Inner West	1,730	42
Bayside	951	32
Georges River	887	33
Canterbury-Bankstown	898	41
Canada Bay	534	21
Waverley	361	18
Burwood	342	14
Woollahra	112	8
Strathfield	65	9
Total	**14,398**	**361**

Source: POLAR and PenCS, CESPHN held data, 2025

Table 24: Number of active Aboriginal patients by practice, 2025

Practices	10 or less	11-50	51-100	101-200	200+
Number	122	159	48	22	10
Percentage	34	44	13	6	3

Source: POLAR and PenCS, CESPHN held data, 2025

MBS item 715 health assessments

The MBS item 715 health assessment supports initial and ongoing engagement of Aboriginal people in primary healthcare in a culturally safe way. They are an important means to encourage early detection and treatment of common conditions. Aboriginal people are eligible for an annual health assessment as well as follow-up services for preventative health care and education between health assessments.

The proportion of the Aboriginal population in the CESPHN region who received an MBS 715 health assessment (14.3%) has remained relatively constant since 2019-20 and is the 6th lowest of all PHNs and well below the national rate of 25%.(30)

Table 25: Health assessment (MBS 715) by financial year, CESPHN region, 2019-20 – 2023-24

Year	Total (No.)	Total (%)
2019–20	2,412	14.1
2020-21	2,460	14.6
2021-22	1,699	9.9
2022-23	2,567	14.6
2023-24	3,050	14.3%

Source: AIHW 2025

The rate of follow up of patients who received a health assessment in the CESPHN region was 31.4% in 2023-24, 14th lowest of all PHNs. (30)

Despite considerable efforts to increase the uptake of MBS item 715 assessments the rate of assessments remains low. Barriers to greater uptake include:

- Many healthcare providers and community do not understand the benefits and availability of the 715 assessments
- System and process barriers to systematically identifying Aboriginal status, insufficient time and workforce resources, and complicated billing procedures
- 715 assessments can only be undertaken annually, which also impacts access to other health services.

After hours care

In 2021, 2.6% of calls to the HealthDirect After Hours Helpline from the CESPHN region were from callers who identified as Aboriginal.(31)

The after-hours period is broken down into 4 timeframes, based on practice incentive program (PIP) time periods.

- T1 = 6pm through to 11pm weeknights
- T2 = 11pm through to 8am weekdays
- T3 = outside 8am to 12 noon on Saturdays
- T4 = all day on Sunday and public holidays.

Table 26: Callers to HealthDirect After Hours Helpline, by PIP timeframe, Aboriginal and non-Aboriginal, CESPHN region, 2021

PIP timeframe	Aboriginal (%)	non-Aboriginal (%)	Total (%)
T1	0.8	31.3	32.1
T2	0.5	19.7	20.2
T3	0.4	17.1	17.5
T4	0.7	29.4	30.1
Total	**2.6**	**97.4**	**100.0**

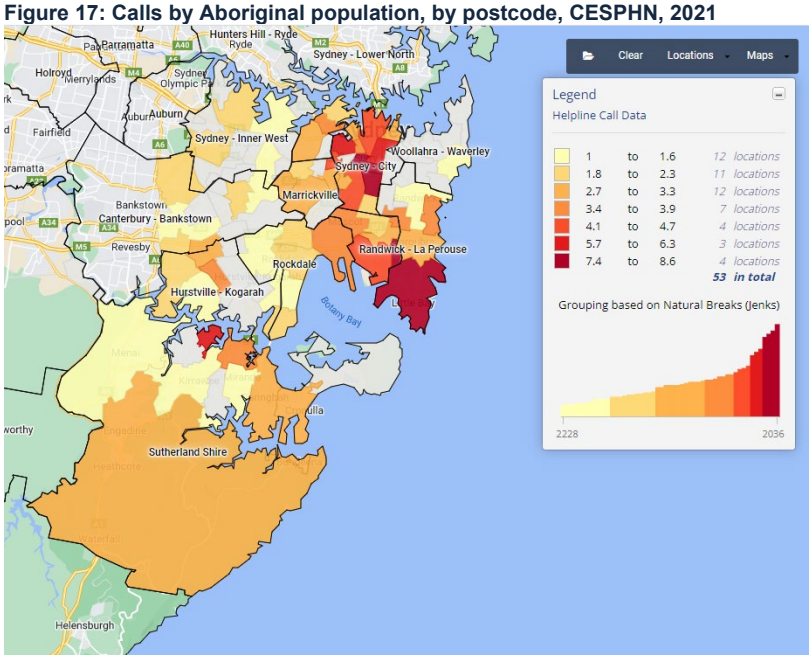
Source: HealthDirect Australia 2022

Within the CESPHN region, there were seven postcodes where 5% or more of calls to the After-Hours Helpline were by callers who identified as Aboriginal:

- 2036 (8.6%)
- 2008 (8.0%)
- 2016 (7.7%)
- 2017 (7.4%)
- 2037 (6.3%)
- 2010 (6.0%)
- 2225 (5.7%).

These postcodes predominantly fall under two IAREs (Randwick-La Perouse and Sydney-City).

Figure 17: Calls by Aboriginal population, by postcode, CESPHN, 2021



Source: HealthDirect Australia, 2022

Opportunities

- Continued support of programs addressing care of chronic conditions
- Continued focus on supporting the mental health and wellbeing of Aboriginal people
- Promotion of urgent care as an alternative to attending ED for non-urgent care
- Work with Justice Health to improve healthcare transition from correctional facilities to general practice and other primary care services
- Continued GP education to promote cultural safety and understanding of intergenerational trauma and ongoing impacts.
- Community education on:
  - Accessing relevant healthcare including MBS 715 health assessments
  - Domestic violence and sexual abuse resources
  - Mental health and resources
  - Antenatal care
- Stigma reduction campaigns: design culturally sensitive initiatives.
- Programs addressing impact of intergenerational trauma including supporting those impacted by child protection and out of home care.
- Alcohol and other drugs and mental health services for young Aboriginal people.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Health and Wellbeing of People from Multicultural Communities

202-2027 Needs Assessment
2025 Annual Review

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Definitions

Throughout this chapter the following terms will be used to describe different population groups within the broader definition of multicultural populations

Table 1: Key definitions

Term	Definition
Asylum seeker	An asylum seeker is someone who has left their country of origin, has applied for recognition as a refugee in another country and is awaiting a decision on their application
CALD	Culturally and Linguistically Diverse The appropriateness of the term culturally and linguistically diverse (CALD) is contested, and there are alternative terms which are preferred by some groups to highlight specific aspects of identity [4]. The term CALD cannot fully capture the richness of diverse cultural backgrounds which can include differences in cultural and ethnic identity, language, country of birth, national origin, heritage/ancestry, race and religion.
Migrant	A migrant is someone who chooses to move, and can return home safely
Multicultural	Relating to, reflecting, or adapted to diverse cultures
Refugee	A refugee is someone who has been forced to leave their country of origin due to war, natural disaster or to escape persecution because of their race, religion, nationality, membership of a particular group, or political opinion.

In-language focus group feedback

For primary health care to be responsive to the needs of this large proportion of the population, there is a need to better understand the experiences shaping health outcomes for multicultural communities. To gain a deeper insight into the health experiences of recently arrived communities (past five years) CESPHN engaged a specialist multicultural consulting organisation to conduct 11 in-language focus groups in person in June and July 2024. The focus groups engaged 125 participants across 7 languages: in Arabic (2x), Bengali (2x), Mandarin (2x), Nepali (2x), Urdu (1x) Mongolian women (1x), and a group held in English for people from an Indian background (1).

Although this sample is not representative, the quotes from the individuals involved have been integrated into this chapter and provide a lived-experience perspective to multicultural needs in the CESPHN region. They also provide a glimpse into the strengths of these communities, their understanding of the health care system and their experience.

> "We are spiritually connected, and our community is very helpful and has strong family ties. It is remarkable that the connection we maintain is very strong, even from thousands and thousands mile across."
>
> *Bengali-speaking resident of the CESPHN region*

Overview

The population of the Central and Eastern Sydney region is diverse and continually evolving with new migrants from different countries adding to the cultural mix.

The 2021 Census data showed that 40.7% of CESPHN residents were born overseas compared to the NSW average of 29.3%. Overall, 46.8% of the population speak a language other than English at home and 6.3% do not speak English well or at all. This shows the need for health services specifically tailored to meet the needs of multicultural residents, such as culturally safe spaces, more interpreters and translated health information to help make living in the CESPHN region easier for these residents.

Key health issues

- People from multicultural backgrounds don't access CESPHN commissioned mental health services at the same rate as other people.
- People from multicultural backgrounds attend services later, resulting in poorer health outcomes
- Less likely to access preventable screening
- International students in the CESPHN region needing support for health and wellbeing issues
- Impact of global events on local communities (e.g. war in Gaza).
- Higher prevalences for several long-term health conditions for people with a country of birth outside of Australia, including dementia, diabetes, heart disease, heart disease or stroke, kidney disease and stroke

Key service issues

- There is a need to better understand the experiences shaping health outcomes for multicultural communities
- Health navigation assistance can assist people to understand and access the complex health and social support system
- Need for culturally responsive care.

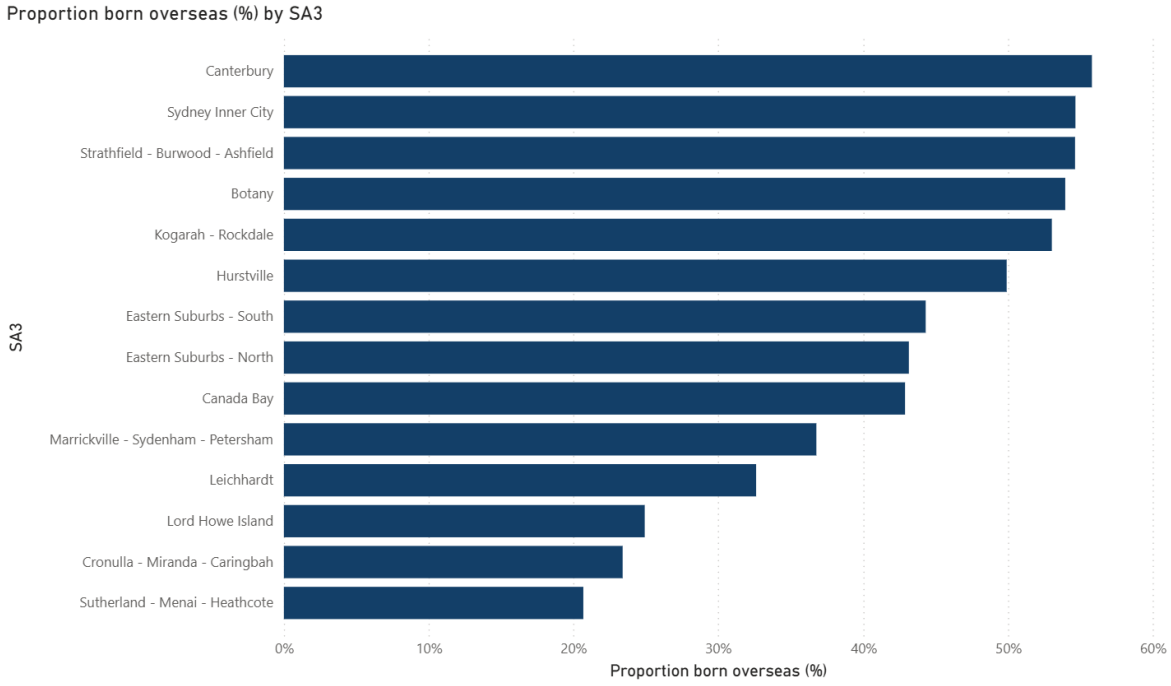
Demographics

Born overseas

There is significant cultural diversity across the CESPHN region, 2021 Census data shows that 40.7% of CESPHN residents were born overseas. Sydney Inner City SA3 had the highest number of people born overseas (n=217,795), followed by Strathfield -Burwood-Ashfield SA3 (n=161,666) and Kogarah-Rockdale SA3 (n=145,918)

The SA3s of Canterbury, Sydney Inner City, Strathfield-Burwood-Ashfield, Botany and Kogarah-Rockdale have more than 50% of their population born overseas compared to the NSW average of 29.3%.(1)

Figure 1: Total people born overseas by age-groups, CESPHN region, 2021



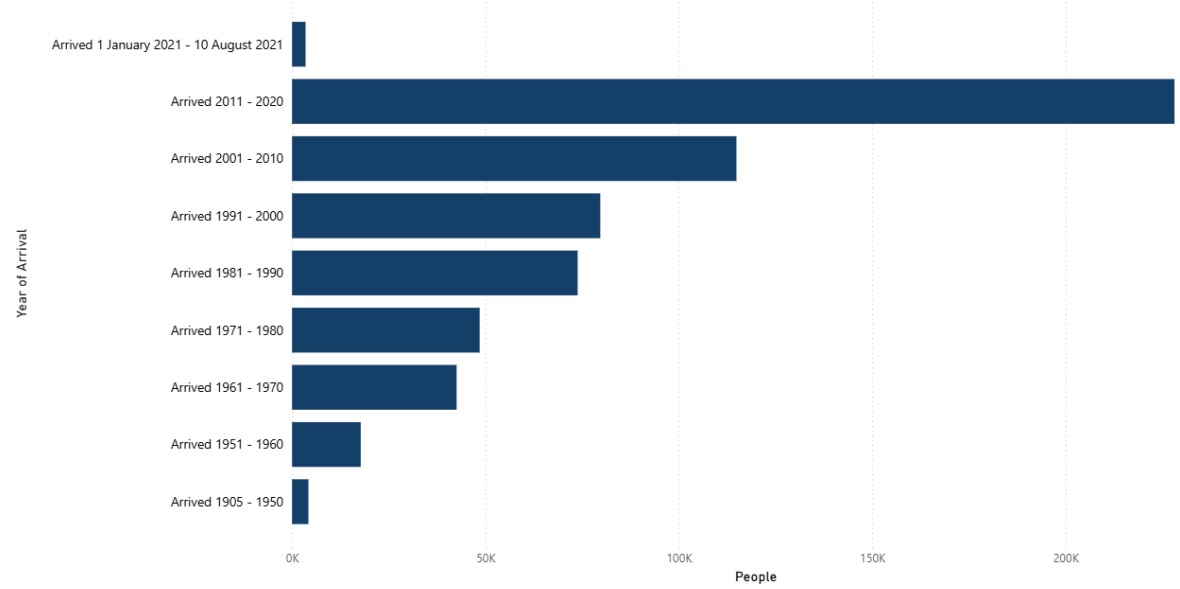
Source: ABS, 2022

People aged 25-39 years represent the highest number of people residing in the CESPHN region who were born overseas, accounting for one-third of this population group.(1)

Year of arrival

The population represents a mix of well-established generations of migrants in the region as well as newly arrived migrants, asylum seekers and international students. Census data shows that 613,070 people who were born overseas, now reside in the CESPHN region.(1) Over one-third (37.21%) of these arrivals occurred between 2011-2020 (n=228,141).

Figure 2: Count of people born overseas by year of arrival, CESPHN region, 2021

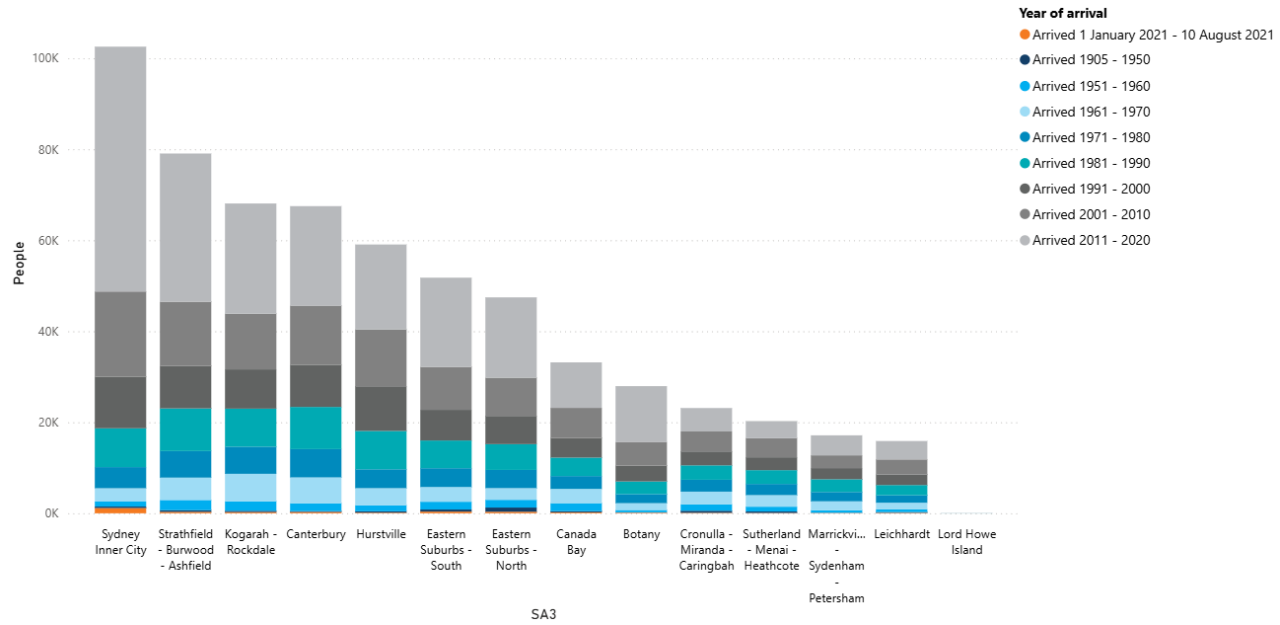


Source: ABS, 2022

Of those who arrived between 2011-2020, the majority are residing in:

- Sydney Inner City SA3 (n= 53,812, 23.6%)
- Strathfield-Burwood-Ashfield SA3 (n= 32,591, 14.3%)
- Kogarah – Rockdale SA3 (n= 24,219,10.6%)
- Canterbury SA3 (n= 21,863, 9.6%)
- Eastern Suburbs – South SA3 (n= 19,621,8.6%)

Figure 3: Count of people born overseas by year of arrival by SA3, CESPHN region, 2021



Source: ABS, 2022

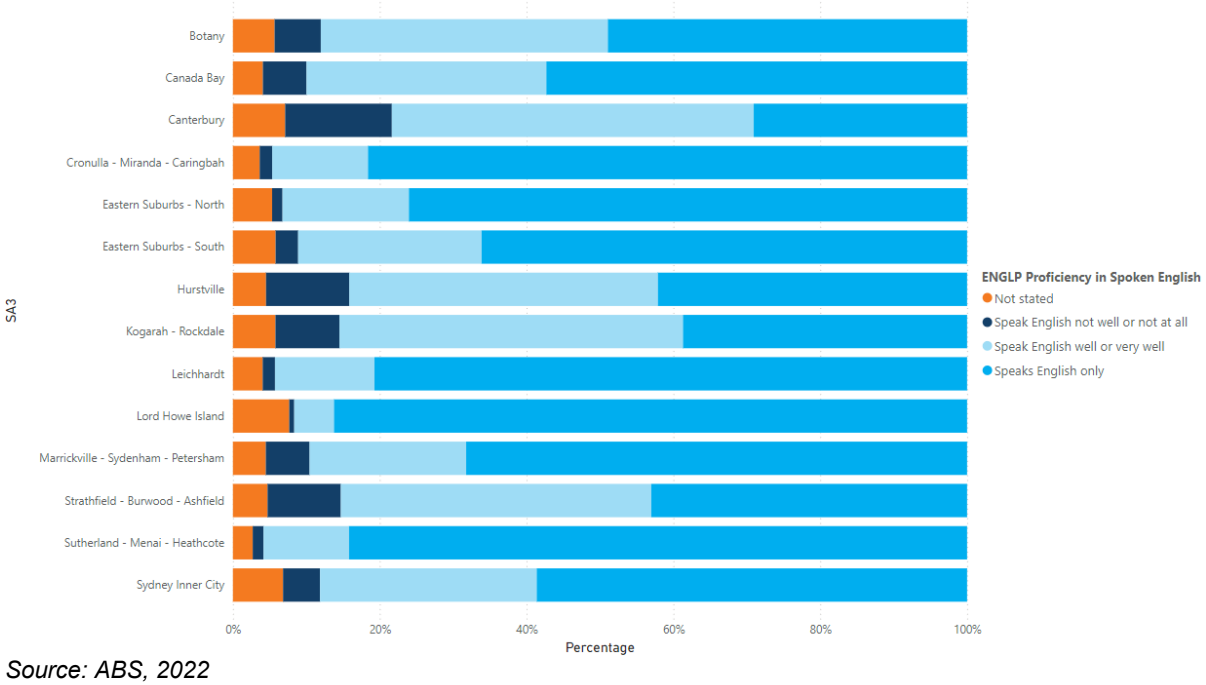
English proficiency

Overall, 46.8% of the population speak a language other than English at home and 6.3% do not speak English well or at all. The SA3s with the highest proportions of people who do not speak English well or at all are:

- Canterbury (14.5%),
- Hurstville (11.3%),
- Strathfield-Burwood-Ashfield (10.0%),
- Kogarah-Rockdale (8.7%) and
- Botany (6.3%),

These SA3s all have higher proportions of the population with poor English proficiency, than the NSW average of 4.5%.

Figure 4: English proficiency by SA3, CESPHN region, 2021



Source: ABS, 2022

Language spoken at home

The top four languages, other than English, spoken at home are Mandarin (17.2%), Cantonese (9.4%), Greek (8.7%) and Arabic (8.2%) (3).

Areas with a high concentration of speakers of these languages are:

- Mandarin:
  - 18.6% of Mandarin speakers live in Hurstville SA3,
  - 18.5% live in Sydney Inner City SA3 and
  - 18.3% live in Strathfield-Burwood-Ashfield SA3
- Cantonese:
  - 25% of Cantonese speakers live in Hurstville SA3,
  - 16.1% live in Strathfield-Burwood-Ashfield SA3 and
  - 12.6% live in Kogarah-Rockdale SA3
- Greek:
  - 22% of Greek speakers live in Canterbury SA3,
  - 21.6% live in Kogarah-Rockdale SA3 and

- 11.5% live in Hurstville SA3.
- Arabic:
  - 39.5% of Arabic speakers live in Canterbury SA3,
  - 21% live in Kogarah-Rockdale SA3 and
  - 11.2% live in Hurstville SA3.
- Nepali:
  - 31.8% of Nepali speakers live in Strathfield-Burwood-Ashfield SA3,
  - 26.2% live in Hurstville SA3 and
  - 23.9% live in Kogarah-Rockdale SA3. (4)

The 2021 Census showed that other commonly spoken languages across the CESPHN region include Spanish, Italian, Vietnamese, Indonesian, Portuguese, Korean, Bengali, Thai, Macedonian, Hindi, Russian, French, Tagalog, Urdu and Japanese (5).

Migration

Between 2000 and 10 August 2021, a total of 226,227 permanent migrants entered Australia and took up residence within the CESPHN region; this accounted for 14.6% of the total CESPHN population and was the ninth highest of all PHNs across Australia (ranging from 2.8% to 24.5%).(2) Over one third of these migrants took up residency in Homebush Population Health Area (PHA) (34%), followed by Riverwood PHA (23.9%) and Hurstville/Narwee – Beverly Hills PHA (23.2%).(2)

These migrants arrived through one of three migration programs as outlined below.

Offshore Humanitarian Program

Between 2000 and 10 August 2021, 6,022 permanent migrants entered Australia under the Offshore Humanitarian Program and took up residence within the CESPHN region. Of these migrants, 3.1% took up residency within the Lakemba/Punchbowl/Wiley Park – part a PHA, followed by 1.3% in Riverwood PHA, and 1.0% in both Belmore - Belfield/ Canterbury (South) – Campsie PHA and Homebush PHA.(2)

Family stream visa

90,042 permanent migrants under the Family stream visa took up residency within the CESPHN region between 2000 and 10 August 2021; accounting for 5.8% of the CESPHN population. The highest proportion of migrants on Family stream visas took up residency in Riverwood PHA (12.7%), followed by Homebush PHA (11.1%) and Hurstville/Narwee – Beverly Hills PHA (10.9%).(2)

Skill stream visa

More than 70,000 permanent migrants entered Australia under the Skill stream visa and took up residency within the CESPHN region between 2000 and 10 August 2021. More than one in five took up residency in Homebush PHA (21.9%), followed by Haymarket/ Millers Point/ Sydney PHA (14.1%) and both Canada Bay – West and Chippendale/ Redfern/ Waterloo PHAs (13.2%).(2)

The PHAs mentioned in this section equate to pockets within SA3s, when rounding up to SA3 levels, we see that Strathfield-Burwood-Ashfield SA3, Hurstville SA3, Canterbury SA3 and Sydney Inner City SA3 are notable pockets of settlement for permanent migrants residing the CESPHN region.

Refugees and asylum seekers

In March 2022, 451 people who came seeking asylum by boat, and were granted a Bridging Visa E, resided in the CESPHN region (9). Approximately 70.2% resided in Canterbury SA3, 14.9% in Strathfield-Burwood-Ashfield SA3 and 14.9% in Botany SA3. Asylum seekers could be on a range of visa types and might not always have access to Medicare which has implications for access to health services and the health status of this population group.

International students

Between January and April 2023, there were more than 900,000 international students studying in Australia split evenly between universities and other educational institutions.(3) As there are many major universities based in the Central and Eastern Sydney region, we host many international students.

According to the most recently available data, there were 258,766 international students enrolled across NSW with 76.2% studying in the CESPHN region.(4) The top five countries international students came from were China, Nepal, India, Indonesia and Thailand. International students at the time of this data might still have been impacted by COVID restrictions in commencing their studies.(4)

Table 2: Enrolments and commencements of international students, CESPHN region, 2021

Nationality	Enrolments	Commencements
China	71,364	26,531
Nepal	22,241	6,497
India	14,168	4,052
Indonesia	8,231	3,171
Thailand	8,037	3,337
Korea, Republic of (South)	909	412
Hong Kong	818	283
Brazil	741	320
Philippines	200	62

Source: Department of Education, Skills and Employment, 2021

Health status of multicultural communities

Health risk factors

Data from the National Health Survey in 2022, highlights variations in health risk factors by several population characteristics; we have included characteristics looking at:

- Country of birth
- Migrant status, and
- Main language spoken at home

against the health risk factors of:

- Smoking and electronic cigarette/vaping device use
- Physical activity
- Alcohol consumption
- Daily consumption of fruit and vegetables
- High blood pressure

It should be acknowledged that the data collected was self-reported and collected via survey or face-to-face interviews with an ABS interviewer – this may impact results, especially for answers related to main language as proxy interviews were accepted where language was a difficulty.

Smoking and electronic cigarette / vaping device use

Data shows that smoking rates are higher for people born in Australia compared to people born overseas, however for people born overseas we see an increase in smoking rates for people who arrived more than 10 years ago compared to people who arrived in the last 10 years. Smoking rates are also higher for people whose main language spoken at home is English.

There is less variation in daily e-cigarette/vaping device use between people born in Australia and people born overseas, however people born overseas and arrived in the last 10 years are 2.5 times more likely to use daily e-cigarette/vaping device than people born overseas and arrived over 10 years ago. (5)

Table 3: Proportion of population aged 18 years and over, who smoke or vape by population characteristics, Australia, 2022

Population characteristics	Current daily smoker (%)	Current daily e-cigarette / vaping device use (%)
Born in Australia	12.0	3.4
Born overseas	8.4	2.4
Born overseas and arrived over 10 years ago	8.5	1.8
Born overseas and arrived in the last 10 years	7.3	4.3
Main language spoken at home: English	11.3	3.2
Main language spoken at home: Other language	7.2	2.3

Source: ABS, 2023

Physical activity

There is minimal variation between people born in Australia and people born overseas regarding meeting physical activity guidelines, with approximately three-quarters of each population group not meeting physical activity guidelines. A slightly higher proportion of people born overseas and arrived over 10 years ago did zero minutes of physical activity than people born overseas and arrived in the last 10 years. There was also a slightly higher proportion not meeting physical activity guidelines for people whose main language spoken at home was not English. (5)

Table 4: Proportion of population aged 18 years and over, who meet physical activity guidelines by population characteristics, Australia, 2022

Population characteristics	Did not meet 2014 physical activity guidelines (%)	Zero minutes of physical activity (%)	Did not meet 2014 physical activity guidelines excluding workplace activity (%)	Zero minutes of physical activity excluding workplace (%)
Born in Australia	74.9	12.3	75.8	15.1
Born overseas	75.9	11.8	76.6	14.1
Born overseas and arrived over 10 years ago	76.0	12.5	76.6	15.0
Born overseas and arrived in the last 10 years	75.1	9.9	76.8	11.6
Main language spoken at home: English	74.1	12.0	75.0	14.7
Main language spoken at home: Other language	81.0	12.8	81.9	15.3

Source: ABS, 2023

Alcohol consumption

Alcohol consumption rates were higher for people born in Australia compared to people born overseas, with consumption guidelines being exceeded by more than twice the proportion of people born overseas. Similar variations are seen between people born overseas and arrived over 10 years ago and people born overseas and arrived in the last 10 years. When comparing main language spoken at home, people whose main language was English has 6 times the proportion of the population exceeding guidelines compared to people whose main language was not English.(5)

Table 5: Proportion of population aged 18 years and over, alcohol consumption pattern by population characteristics, Australia, 2022

Population characteristics	Australian Adult Alcohol Guideline 2020 – Exceeded guideline (%)	Consumed more than 10 drinks in the last week (%)	Consumed 5 or more drinks on any day in the last 12 months at least monthly (%)
Born in Australia	33.0	22.7	25.8
Born overseas	16.0	11.2	11.3
Born overseas and arrived over 10 years ago	18.1	13.1	12.0
Born overseas and arrived in the last 10 years	10.6	5.7	9.3
Main language spoken at home: English	31.2	21.7	24.0
Main language spoken at home: Other language	5.5	3.5	3.9

Source: ABS, 2023

Daily consumption of fruit and vegetables

Data regarding daily consumption of fruit and vegetables shows minimal variation between people born in Australia and people born overseas. A slightly lower proportion of people born overseas did not meet fruit consumption recommendation compared to people born in Australia, however we see a reduction in the proportion not meeting fruit consumption recommendations for those born overseas and arrived more than 10 years ago compared to those who arrived in the last 10 years, which is not

in-line with results of other health risk factors where we have generally seen negative changes in the data.(5)

Table 6: Proportion of population aged 18 years and over, fruit and vegetable consumption pattern by population characteristics, Australia, 2022

Population characteristics	Daily consumption of fruit — Did not meet recommendation	Daily consumption of vegetables — Did not meet recommendation
Born in Australia	58.1	92.6
Born overseas	51.9	94.9
Born overseas and arrived over 10 years ago	50.8	94.9
Born overseas and arrived in the last 10 years	55.3	95.0
Main language spoken at home: English	56.5	93.0
Main language spoken at home: Other language	52.5	95.9

Source: ABS, 2023

High blood pressure

High blood pressure results show minimal difference between people born in Australia compared to people born overseas. However, for people born overseas, there is a higher proportion of people with high blood pressure in people who arrived over 10 years ago compared to people who arrived in the last 10 years. There is also a slightly higher proportion of people with high blood pressure in people whose main language spoken at home is English.(5)

Table 7: Proportion of population aged 18 years and over, with high blood pressure by population characteristics, Australia, 2022

Population characteristics	High blood pressure (≥140 / 90 mmHg) (%)
Born in Australia	23.7
Born overseas	22.5
Born overseas and arrived over 10 years ago	26.3
Born overseas and arrived in the last 10 years	13.0
Main language spoken at home: English	24.3
Main language spoken at home: Other language	18.9

Source: ABS, 2023

Participation in screening programs

Screening programs are designed to detect diseases before a person begins to show symptoms. In Australia, there are 6 population-based screening programs:

- Newborn Bloodspot Screening
- Newborn Hearing
- BreastScreen Australia
- National Bowel Cancer Screening
- National Cervical Screening
- National Lung Cancer Screening (no data publicly available as yet)

Unfortunately, data on these programs is limited, especially when exploring specific population groups such as those from multicultural backgrounds.

BreastScreen NSW:

There are low participation rates in screening for breast cancer by women from culturally and linguistically diverse (CALD) backgrounds aged 50-74. Data from the Cancer Institute shows that the total CESPHN participation rate in breast cancer screening is lower than the State participation rate,

rates are then lower again within the population group who identify as CALD. The data consistently shows lower participation rates in CALD population groups within the Sydney LHD compared to South Eastern Sydney LHD.(6)

For the past two reporting periods the LGA of Inner West, within the Sydney LHD, has had the lowest participation rates, and within the South Eastern Sydney LHD area, Sydney LGA has had the lowest participation rates for people who identify as CALD, highlighting them as areas of focus in promotion. (6)

Table 8: BreastScreen NSW, participants aged 50-74 years who identify as culturally and linguistically diverse, CESPHN region, 2019-20 to 2023-24

Biennial period	Women screened (#)	Participation rate (%)	CESPHN total participation (%)	NSW total participation (%)
2019-20	28,653	39.7	46.1	49.9
2020-21	23,312	32.1	38.3	43.4
2021-22	26,379	35.5	43.0	46.8
2022-23	31,111	40.6	50.0	51.9
2023-24	31,262	40.3	49.5	51.6

Source: Cancer Institute NSW, 2025

National Bowel Cancer Screening:

A 2025 monitoring report of the National Bowel Cancer Screening Program compared participation rates, screening positivity rates, diagnostic assessment rates and time between positive screen and diagnostic assessment for those who preferred a language other than English at home compared with English speakers. The results showed a lower participation rate and lower diagnostic assessment follow-up in those who prefer a language other than English at home. There was also a reported longer median time between positive screen and diagnostic assessment.(7)

Table 9: NBCS summary of performance indicators for English speakers and those who prefer a language other than English at home, Australia, 2025

Indicator	LOTE	English	Summary of performance indicators
Participation rate	24.3–31.1%	44.0–46.8%	Lower participation rate
Screening positivity rate	6%	6%	Same screening positivity rate
Diagnostic assessment rate	80%	87%	Lower diagnostic assessment follow-up rate
Time between positive screen and diagnostic assessment	66 days	62 days	Longer median time

Source: AIHW, 2025

National Cervical Screening:

The National Cervical Screening Program records both “Main language other than English spoken at home” and “country of birth” to help identify people from multicultural backgrounds; unfortunately, the data in these fields is insufficiently populated to estimate participation of people from multicultural backgrounds.(8)

Long-term health conditions

The year of arrival in Australia and level of English proficiency are interacting factors that relate to the prevalence of many long-term health conditions for people born overseas.

Country of birth

People born in Australia had the highest prevalence (age standardised percentages) of one or more long-term health conditions (35.55%) compared with people living in Australia who were born in one of the top twenty countries of birth as reported by the AIHW. (9)

For arthritis, asthma, cancer, dementia, heart disease, heart disease or stroke, kidney disease, lung conditions, mental health conditions and stroke, the Australian-born population had a similar or higher age-standardised prevalence than that of the overseas born population.(9)

Table 10: Long-term health conditions by country of birth, Australia, 2021

Country of Birth	One or more long-term health condition(s)	Arthritis	Asthma	Cancer	Dementia	Diabetes	Heart disease	Heart disease or stroke	Kidney disease	Lung condition	Mental health condition	Stroke	Any other long-term health condition(s)
Australia	35.55	8.43	10.50	2.83	0.61	3.99	3.59	4.17	0.86	1.76	11.74	0.84	8.92
China	14.91	2.28	1.59	1.38	0.57	3.72	2.08	2.45	0.58	0.42	1.79	0.55	5.37
England	31.29	7.61	7.99	2.62	0.55	3.51	3.12	3.62	0.68	1.58	9.73	0.74	7.88
Germany	25.22	6.32	5.03	2.37	0.61	3.03	3.08	3.58	0.65	1.22	6.77	0.75	7.33
Greece	24.69	6.10	4.46	1.95	0.72	4.62	3.23	3.72	0.72	0.90	6.37	0.72	7.09
Hong Kong (SAR of China)	20.91	2.80	4.50	1.81	0.43	3.91	2.06	2.36	0.52	0.40	3.49	0.42	7.20
India	19.54	4.20	2.91	1.17	0.49	7.81	3.22	3.57	0.64	0.59	1.80	0.55	4.80
Iraq	28.56	7.25	5.28	1.43	0.83	7.52	4.01	4.69	1.32	0.78	5.47	1.16	11.91
Italy	22.50	6.32	4.07	2.28	0.94	4.69	3.30	3.78	0.86	1.00	5.02	0.83	5.57
Korea, Republic of (South)	16.06	2.35	1.78	1.35	0.53	4.27	1.48	1.88	0.48	0.33	2.33	0.52	5.86
Lebanon	26.43	7.20	4.45	1.76	0.69	7.47	3.67	4.24	1.06	1.07	5.25	0.90	8.15
Malaysia	20.46	3.65	4.58	1.70	0.46	4.38	2.37	2.75	0.53	0.45	3.03	0.52	6.45
Nepal	15.23	2.02	2.02	0.52	0.00	6.22	1.80	2.24	0.29	0.46	1.20	0.49	4.30
New Zealand	30.87	7.04	9.68	2.75	0.52	3.72	3.43	3.99	0.79	1.67	7.82	0.83	6.91
Pakistan	23.90	5.49	3.96	1.31	0.52	9.41	4.60	5.01	0.97	0.62	2.82	0.71	5.94
Philippines	25.16	5.60	6.37	1.67	0.56	7.31	2.62	3.05	0.96	0.53	2.84	0.62	7.39
Scotland	31.03	7.20	7.76	2.60	0.64	3.50	3.29	3.83	0.70	1.73	9.24	0.77	7.97
South Africa	27.42	5.38	6.64	2.42	0.50	3.51	2.90	3.26	0.58	0.84	7.33	0.53	7.29
Sri Lanka	25.46	4.44	6.73	1.32	0.52	8.97	3.89	4.21	0.74	0.55	2.94	0.52	5.73
United States of America	31.12	6.59	7.77	2.74	0.48	3.06	2.83	3.28	0.60	1.23	10.58	0.64	9.09
Vietnam	19.17	3.21	3.74	1.23	0.77	5.03	1.88	2.42	0.76	0.50	2.67	0.71	6.36

Source: AIHW, 2023

There were higher prevalences for several long-term health conditions for people with a country of birth outside of Australia, these include dementia, diabetes, heart disease, heart disease or stroke, kidney disease and stroke.

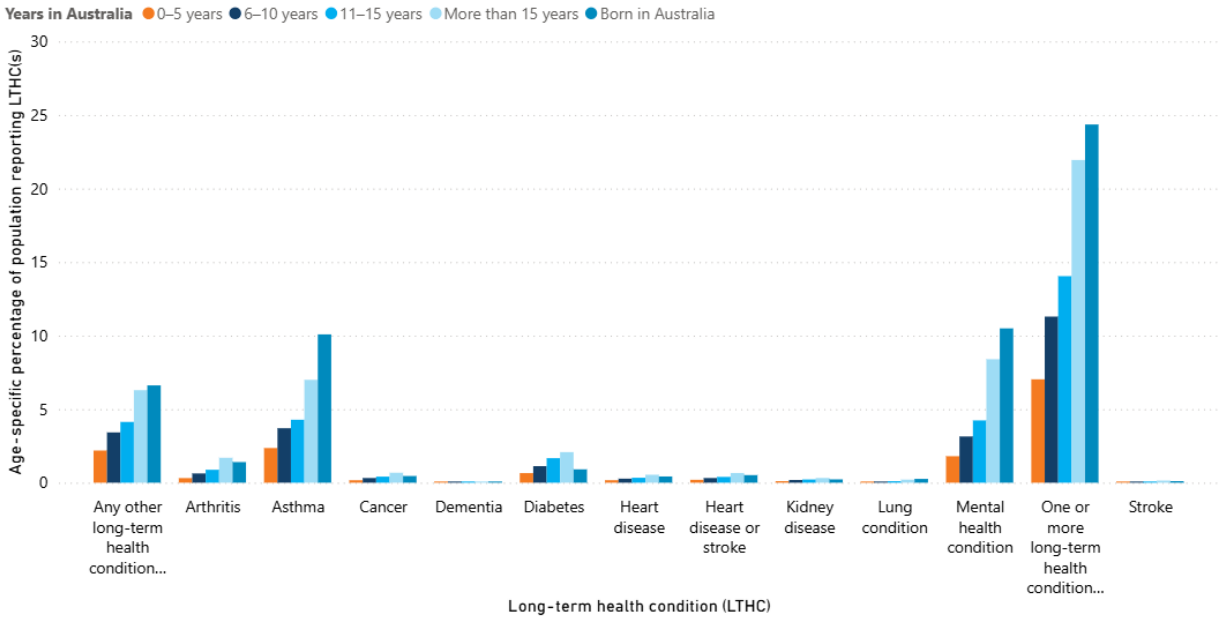
- Prevalence of dementia was highest in people born in Italy (0.94%), Iraq (0.83%), Vietnam (0.77%) and Greece (0.72%); compared to people born in Australia (0.61%)
- Prevalence of diabetes was highest in people born in countries of south Asia (Pakistan, Sri Lanka, India) and southeast Asia (Philippines and Vietnam) and pockets of the middle east (Lebanon and Iraq); compared to people born in Australia (3.99%)
- Prevalence of heart disease and heart disease or stroke was highest in people born in countries of south Asia (Pakistan and Sri Lanka) and the middle east (Iraq and Lebanon); compared to people born in Australia (3.59% and 4.17% respectively)
- Prevalence of kidney disease was highest in people born in Iraq (1.32%), Lebanon (1.06%), Pakistan (0.97%) and Philippines (0.96%); compared to people born in Australia (0.86%)
- Prevalence of stroke was highest in people born in Iraq (1.16%) and Lebanon (0.9%); compared to people born in Australia (0.84%).(9)

Year of arrival

A higher age-standardised prevalence of arthritis, asthma, mental health and lung condition was observed among people who first arrived in Australia more than 10 years ago, particularly for those with low English proficiency. This points to the need for interpreter use and information in other languages to be made available for these communities.

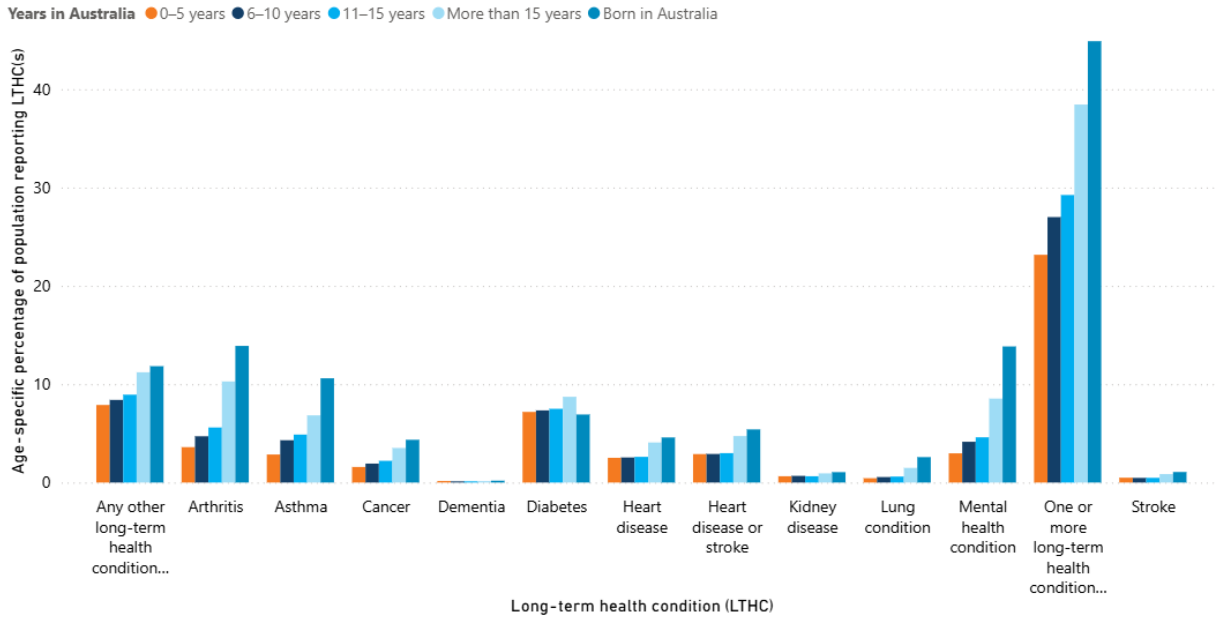
The prevalence of chronic health conditions increased with time since migration across all conditions and age groups for most countries of birth. However, Iraq had a higher prevalence among more recent arrivals for multiple conditions, including dementia, heart disease and kidney disease. (9)

Figure 5: Long term health condition by years in Australia, 0-44 years old, Australia, 2021



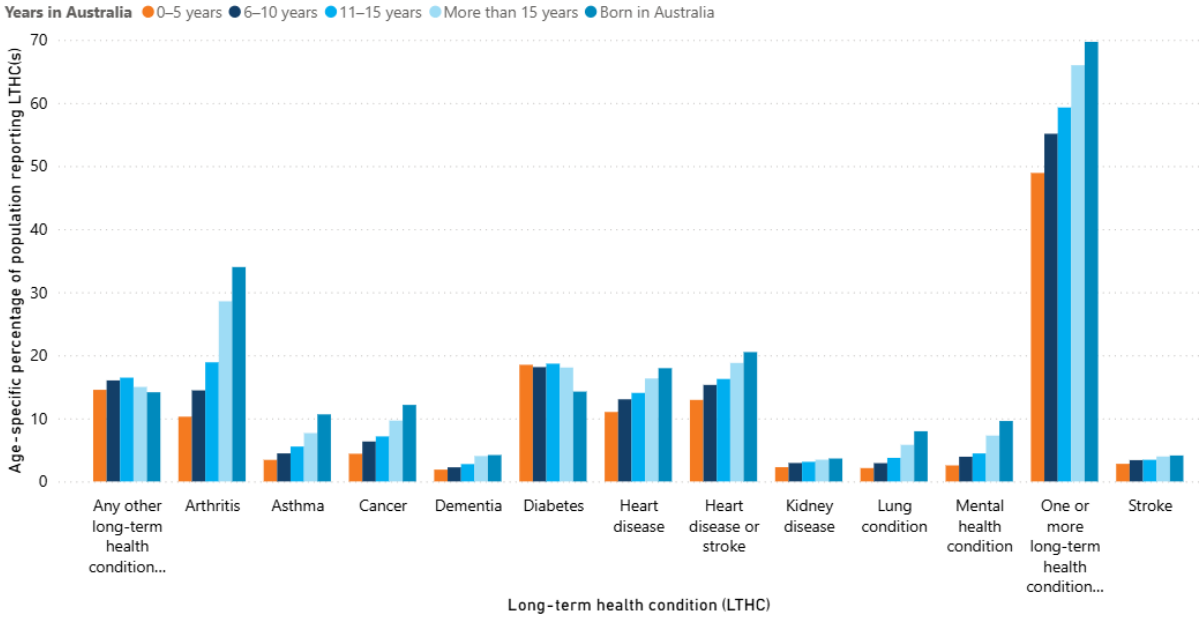
Source: AIHW, 2023

Figure 6: Long term health condition by years in Australia, 45-64 years old, Australia, 2021



Source: AIHW, 2023

Figure 7: Long term health condition by years in Australia, 65 years and older, Australia, 2021



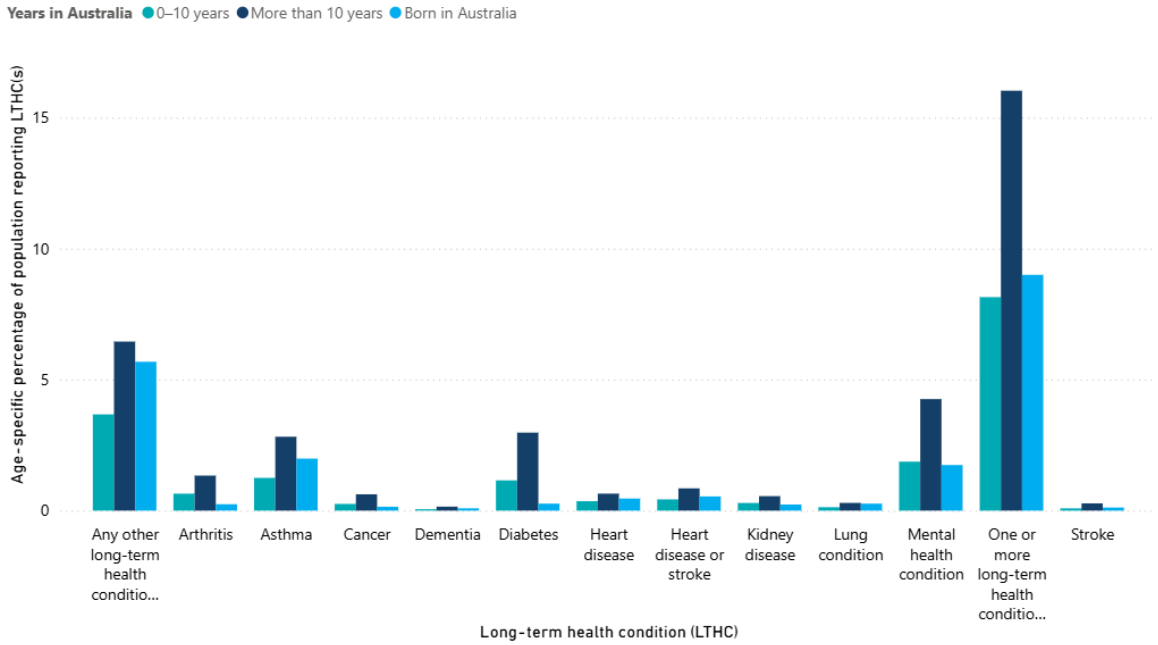
Source: AIHW, 2023

Just over one percent (1.22%) of residents in the CESPHN region are living with chronic Hepatitis B (CHB). This prevalence is higher than the national average (0.78%). Overseas born residents account for 70% of all cases of CHB. In the CESPHN region, people born in China, Vietnam and Greece are most represented in overseas born people affected by CHB.

English Proficiency

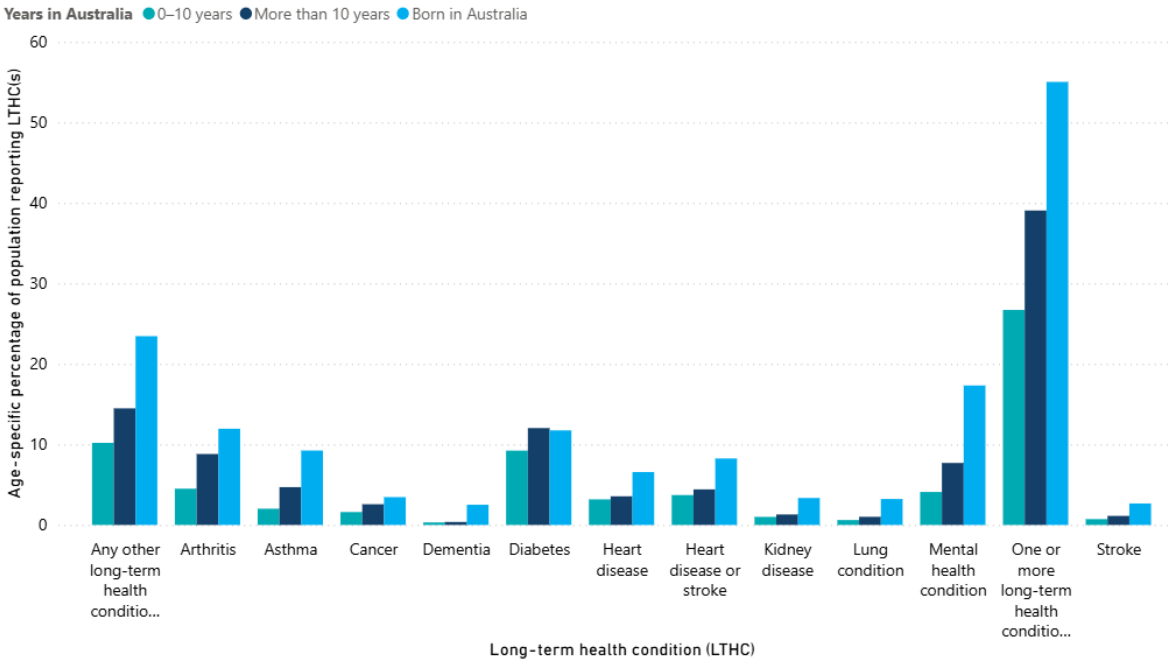
Individuals with poor English proficiency who were born overseas and have been living in Australia for more than 10 years had the highest age-specific percentage of the population reporting one or more long term health conditions. These results were also seen for any other long term health condition, arthritis, asthma, cancer, diabetes and mental health condition.(9)These results were not replicated in the older age cohorts of 45-64 years and 65 years and over; where we see those born in Australia often with a higher age-specific percentage of the population reporting long term health conditions. Of particular note is the increased rate of dementia for people born in Australia with poor English proficiency in the older age cohorts.

Figure 8: Long term health condition by years in Australia, 0-44 years old who speak English not well or not at all, Australia, 2021



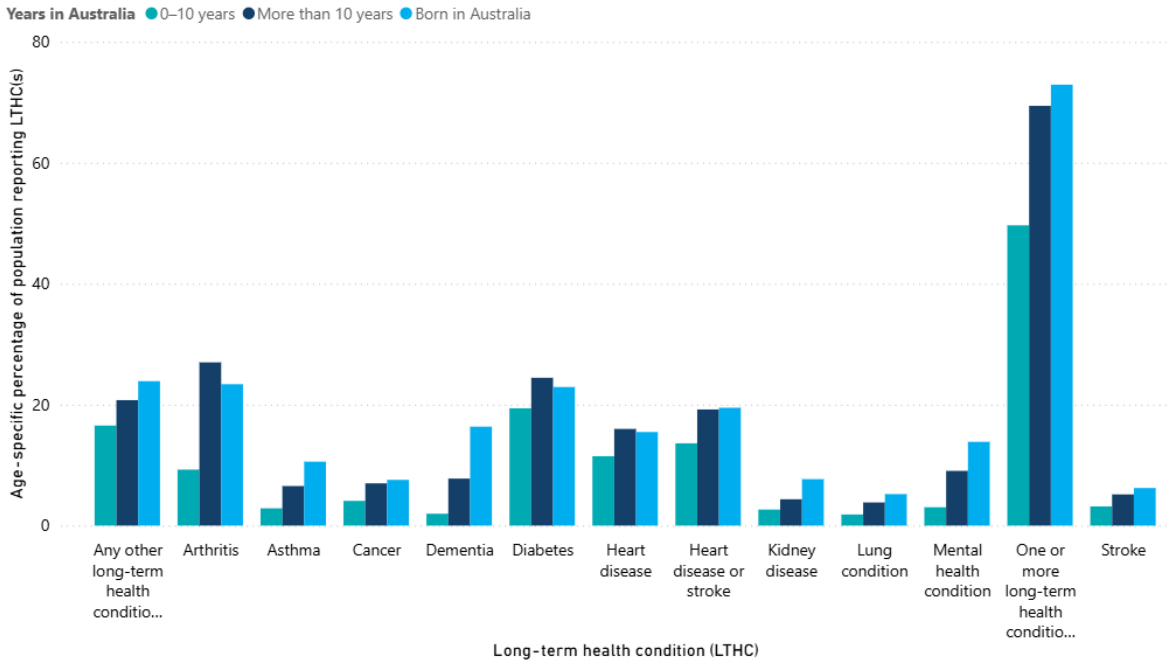
Source: AIHW, 2023

Figure 9: Long term health condition by years in Australia, 45-64 years old who speak English not well or not at all, Australia, 2021



Source: AIHW, 2023

Figure 10: Long term health condition by years in Australia, 65 years and older who speak English not well or not at all, Australia, 2021



Source: AIHW, 2023

Age at arrival

Some long-term health conditions have been shown to be more likely, dependent on a person's age at arrival in Australia.(10) Unadjusted data from the AIHW, shows that individuals who were aged 65

years or older had a higher likelihood of at least one long-term health condition, two or more long term health conditions, heart disease, and arthritis for both males and females. Results showed that any 'age at arrival' did not have a higher likelihood of asthma or mental health condition for either males or females, however all 'age at arrival' groupings had significantly higher likelihood of diabetes. (9)

Health of Refugees and Humanitarian Entrants

The Australian Institute of Health and Welfare 'Health of Refugees and Humanitarian Entrants Report 2023' shows that humanitarian entrants had different long-term health conditions compared with other migrants (17). These were:

- 40% decrease in cancers
- 50% increase in mental health conditions
- 130% increase in kidney disease
- 70% increase in diabetes.

People from the above communities are also at higher risk of hospitalisation for certain diabetes-related conditions when compared to people born in Australia. In 2021, 7.6% of humanitarian entrants reported having diabetes compared with 4.3% of the rest of the population.(11) CESPHN commissions the Community Diabetes Education Program to educate and promote early intervention for people at high risk of developing type 2 diabetes, people living with type 2 diabetes and people who care for people at risk or living with type 2 diabetes, who speak Arabic, Bengali, Cantonese, Greek, Indonesian, Nepali, Mandarin, or Vietnamese.

Almost 9 in 10 humanitarian entrants had a GP attendance in 2021, highlighting the opportunity in primary care to promote prevention and early intervention. In addition, accidental drowning deaths of humanitarian entrants were 2.4 times as high as the rest of the population in 2007-2020, this is significant for CESPHN given the Central and Eastern Sydney region is fringed by a coastline.(11)

> "Back in Nepal mental health is not considered a big thing. But when I came to Australia, it was a huge thing. If you talk about it [in Nepal], you are considered 'crazy'. Here [in Australia] we have help but we don't use it."
>
> Nepali speaking resident

> "If anyone hears someone is facing mental health problems the first thing they say is perform prayers [and] everything will be solved. There is nothing called mental health issues, those are foul talk."
>
> Bengali speaking resident

> "Mental health is a luxury, only rich people talk about it but we as people who are working hard to just be able to pay rent and food, there is no time to think about mental health, we just need to keep going."
>
> Arabic speaking resident

Health of International Students

The in-language focus groups contained international students of all ages. Responses showed that whilst health insurance is mandatory for all students studying in Australia, there is a lack of understanding of how to access primary health care and a lack of understanding in navigating the health system.

> "For the first 2 years as a student, I did not go to any healthcare/medical facility as I was concerned about cost of accessing healthcare."
>
> Indian background participant

> "I had a good experience at my university medical centre when I was suffering from fever. However, the prescription they provided was very expensive. So instead, I used similar medicines I was carrying from India."
>
> Indian background resident

A 2024 International Students Roundtable held at the University of Sydney highlighted the challenges faced by students which are often more pronounced or serious for international students, including:

- Social isolation, loneliness, homesickness
- Cultural adaptation and language proficiency challenges
- Personal finances
- Precarious housing
- Discrimination, racism and exploitation
- Dealing with authority figures and 'systems'
- Wage-theft, underpayment in part-time/casual employment
- Health and mental health issues
- Access to concessional travel.

The 2020 Productivity Commission inquiry into mental health recommended strengthening the accountability of tertiary education providers to include expanded mental health support to their students, including international students, such as ensuring that counselling services are able to meet the language and cultural diversity needs of their international students.(12)

International students fall under the headspace priority group of young people from a refugee or migrant background and as such in recent years headspace National has developed resources for headspace services to improve access to health care for international students. In the CESPHN region, our headspace centres are equipping themselves with the resources they need to support students with Overseas Student Health Cover (OSHC) access the support they need. Other CESPHN commissioned services including the Psychological Support Services program and The Way Back NSW support service, have seen an increase in the number of international students accessing care.

Impacts of International conflicts

A Healthed article has highlighted GPs observing "a rise in patient distress levels related to global conflicts". Results from a survey conducted on GPs demonstrated that more than 10% of respondents "reported observing a significant increase in distress or other medical concerns they attribute to conflicts in places such as Palestine, Ukraine and Sudan."

In 2024, CESPHN consulted with community leaders, NGO's, mental health services and government services to understand the key supports required by the Palestinian, Muslim and Arabic communities and the Jewish community due to the current conflict in Gaza. These consultations identified that communities urgently needed safe, non-clinical spaces to express distress, and faced barriers to mental health care due to unmet basic needs like food, housing, and healthcare. They expressed a need for service navigation support, mental health literacy and proactive help-seeking skills, and access to services designed and offered by organisations who understand and have experience supporting communities affected by conflict.

Access to services

National level data shows that humanitarian entrants consistently had a higher proportion of the population who had at least one GP attendance in 2021 compared to other permanent migrants, irrespective of their time since arrival in Australia. The same was seen for diagnostic imaging, other MBS services, pathology and other allied health.(11)

Table 11: Health service use by humanitarian entrants, Australia, 2021

Broad Types of Service group	Proportion of the population with at least one service in 2021					
	Less than 5 years since arrival in Australia		5 – 10 years since arrival in Australia		More than 10 years since arrival in Australia	
	Humanitarian entrant	Other permanent migrants	Humanitarian entrant	Other permanent migrants	Humanitarian entrant	Other permanent migrants
Anaesthetics	1.9	4.3	2.2	4.9	3.1	5.8
Diagnostic imaging	41.3	35.0	41.7	35.1	41.7	35.1
GP attendances	89.7	82.9	90.1	79.7	87.7	76.5
Obstetrics	2.1	5.1	2.0	3.5	2.4	1.3
Operations	6.6	8.6	7.2	9.3	8.4	11.0
Optometry	20.2	23.7	18.8	25.9	18.5	29.5
Other allied health	12.7	8.8	14.3	10.0	13.4	11.6
Other MBS services	12.8	9.2	12.8	10.3	12.7	12.0
Pathology	67.9	67.3	70.2	64.9	71.6	64.1
Radiotherapy and nuclear medicine	0.1	0.1	0.1	0.1	0.1	0.1
Specialist attendances	23.8	21.0	23.7	21.6	22.3	23.9

Source: AIHW, 2023

Data from 2021, shows that humanitarian entrants had a higher proportion of the population cohort with at least one GP service (88.8%) compared to other permanent migrants (78.5%) and the rest of the Australian population (79.2%).(11)Data by age group shows that humanitarian entrants consistently had a higher proportion of the population with at least one GP attendance compared to other cohort groups.(11)

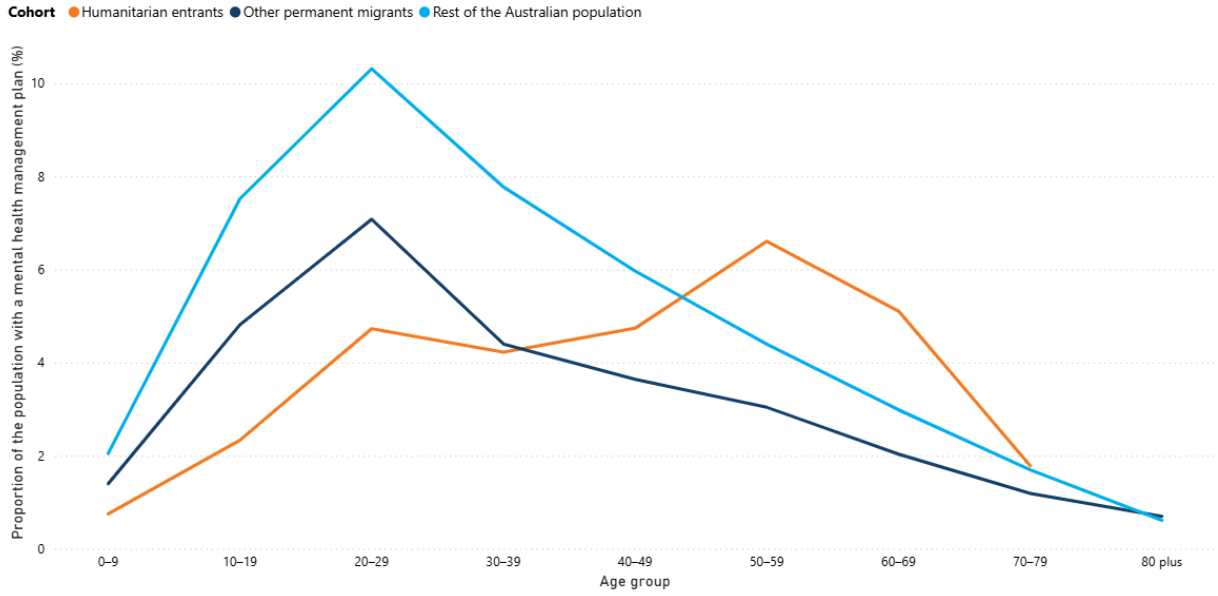
Table 12: Proportion of population with at least one GP attendance by cohort, Australia, 2021

Age Group	Humanitarian entrants	Other permanent migrants	Rest of the Australian population
0-9 years	85.1	80.2	82.5
10-19 years	81.1	74.9	76.5
20-29 years	87.6	80.0	80.0
30-39 years	90.2	81.3	75.0
40-49 years	92.2	76.8	78.7
50-59 years	93.7	77.5	81.9
60-69 years	94.6	76.6	85.4
70-79 years	92.9	76.6	86.2
80plus	86.4	71.7	61.5
All ages	**88.8**	**78.5**	**79.2**

Source: AIHW, 2023

In 2021, the proportion of population cohorts with a mental health management plan varied across age groups. Humanitarian entrants had lower uptake between 0-30 years, with a gradual increase between 30-39 years and 50-59 years. Whereas other permanent migrants and the 'rest of the Australian population' had higher uptake between 0-9 and 20-29 years, followed by gradual decline in older age brackets. (11)

Figure 11: Proportion of population cohorts with mental health management plan by age groups, Australia, 2021



Source: AIHW, 2023

Multicultural communities are underrepresented in the use of CESPHN commissioned mental health services relative to the general population. Country of birth, self-identified cultural background and language spoken at home is data that is routinely collected by our commissioned mental health services.

CESPHN's 2024 in-language focus groups revealed the barriers which can prevent multicultural residents from seeking medical care when necessary. This delay in help seeking and prevention can lead to more acute presentations and may be due to a range of factors. Participants in the focus groups in 2024 provided a lived experience perspective confirming barriers such as:

- Language
- Lack of use of interpreters*

- Difficulty navigating the health system
- Risk of re-traumatisation
- Fear of not being granted resident status if they are unwell
- Not having access to Medicare funded health care
- Financial hardship
- Limited trust of health service providers
- Not knowing the costs involved
- Believing that health care was better in their home country
- Stigma associated with certain conditions

Feedback from the in-language focus groups also highlighted that many communities are used to visiting a pharmacist as a first port of call rather than a local doctor (GP). CESPHN resources both GPs and pharmacists to play this role in the community by keeping them informed of relevant services in the area.

Consultations with CESPHN's stakeholders in 2024 reaffirmed the need for increased support with system navigation and health literacy for multicultural communities, especially recently arrived residents. In 2025 CESPHN commissioned a multicultural navigator service to support patients in Mandarin, Cantonese, Arabic, Korean and Nepali to engage more easily with health and community services.

> "I came to Australia over five months pregnant, and there were cases where my appointments were cancelled at the hospital because there were no available Mongolian interpreters. It's not easy for a pregnant person to come and go again and again."
>
> Mongolian speaking resident

Current work

- Access to interpreting services for allied health professionals' program:
  - This program supports multicultural service users who have low proficiency in English by enabling private allied health professionals in the CESPHN catchment area to access free interpreting services through TIS National. Registered professionals can use immediate, pre-booked phone, or on-site interpreting, with phone interpreting encouraged for mild to moderate needs due to capped funding. The program is administered locally to improve communication and access to care for multicultural communities.
- Implementation of PHN Multicultural Health Framework:
  - This framework provides guidance for CESPHN to develop a responsive approach aimed at increasing health system access and equity for multicultural communities. CESPHN's implementation plan has been developed to address the actions below as a quality improvement process with the collaboration of all CESPHN teams:
    - Identifying needs
    - Supporting commissioned providers to deliver culturally appropriate care
    - Improving access to care
    - Commissioning coordinated and integrated care
    - Ensuring a culturally responsive approach across all CESPHN activities.
- Multicultural health navigator service:
  - The Multicultural Health Navigator service offers one-on-one bilingual support to help residents with limited English proficiency in Canterbury, Strathfield-Burwood-Ashfield, and Rockdale-Kogarah-Hurstville access health and social services. Navigators who speak Mandarin, Cantonese, Arabic, Korean, or Nepali offer tailored support by helping clients

understand and access health and social services that meet their individual needs, including mental health, housing, employment, and physical health.

- Community Diabetes Education Program:
  - CESPHN commissions the Community Diabetes Education Program (CDP) to provide in-language diabetes education to people at high risk of developing type 2 diabetes, people living with type 2 diabetes, and carers who speak Arabic, Bengali, Cantonese, Greek, Indonesian, Nepali, Mandarin, or Vietnamese. The program delivers education through interactive workshops addressing the types of diabetes, signs and symptoms, risk factors, and prevention and management strategies including healthy living and the annual cycle of care, as well as available support services.
- Diabetes Education in Pregnancy Program:
  - CESPHN commissions the Diabetes Education in Pregnancy program to provide diabetes education to pregnant women in multicultural communities. The program aims to increase awareness of risk factors for diabetes, promote healthy living, improve knowledge of diabetes management during and after pregnancy, and support use of available diabetes-related services and resources
- Gaza conflict community support programs:
  - CESPHN has worked with Northern Sydney PHN, Western Sydney PHN and South Western Sydney PHN to distribute funds to community organisations who work directly with these communities. Some of the activities commissioned were healing circles, tailored health education for new arrivals to the region, or training religious leaders in mental health to better support their congregations.

Opportunities

- Ensure multicultural community members are involved in co-design for new services
- Ongoing cultural competency training for GPs, allied health and commissioned service providers
- Support the role of pharmacists, which was identified often as the first point of call for some communities
- Develop culturally sensitive health outcome measures.
- Trauma informed care training offered to GPs
- Initiatives to increase rate of cancer screening and immunisation
- Data collection and research:
  - Investigate health disparities and inequities
  - Assess cultural competency in healthcare settings
  - Evaluate effectiveness of multicultural health programs
  - Identify best practices in multicultural healthcare

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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Older People

2025-27 Needs Assessment
2025 Annual Review

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

Older People

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Older People

Overview

The Central and Eastern Sydney Primary Health Network (CESPHN) region is experiencing a significant demographic shift, with older Australians forming an increasingly large proportion of the population. Currently, 14.9% of the estimated resident population are aged 65 years and over, with this proportion set to increase by 43.6% between 2024 and 2041. The most substantial growth will occur among those aged 85 years and over, with this cohort expected to more than double - an increase of 101.8% over the same period.

Within the region, Lord Howe Island SA3 had the highest proportion of people aged 65 years and over (21.7%), followed closely by Cronulla – Miranda – Caringbah SA3 (20.2%). Socioeconomic indicators highlight that nearly half (47.6%) of older residents receive the Age Pension, and 14.8% have a Commonwealth Seniors Health Card. These figures underscore the financial vulnerability of many older Australians and the need for accessible, affordable health and aged care services.

As the older population continues to grow in number in the region, so does the increase in demand for services and access to preventative care and early intervention, and integrated health and social support services. Meeting these needs will require a coordinated approach across primary care, aged care, and community services.

Key health issues

Older people in the CESPHN region face a range of health and wellbeing challenges:

- Social isolation: 23.3% of older people live alone, with 2.7% of this cohort having poor English proficiency, increasing vulnerability to mental health issues and cognitive decline.
- Falls and injury: fall related hospitalisations remain high, especially among males aged 65 years and over.
- Preventative health gaps: influenza immunisation rates among people aged 65 years and over are increasing but remaining lower than the state average.
- Chronic disease burden: a significant proportion of people aged 65 years and over reported having one or more chronic condition, with high rates of this population reporting heart disease, diabetes and mental health conditions.
- Disability and functional limitations: high numbers of people in this age group are living with a mild or moderate and/or severe core activity limitation and a profound or severe disability, particularly in Kogarah – Rockdale SA3.

Key service gaps

Despite positive experiences with general practice care, several gaps exist:

- Low uptake of health assessments: Only 28.5% of persons aged 75 years and over received a GP health assessment, lower than both state and national averages.
- Mental health and cultural appropriateness: access to mental health services and culturally tailored care remains limited for this age group.
- Navigation and access to age care services: many people aged 65 years and over struggle to access and navigate aged care services, compounded by long waitlists for home care packages (Levels 2-4).
- Residential aged care demand: GP attendances per residential aged care patients, higher than the national average, indicating complex health needs.
- Digital health barriers: telehealth service uptake is hindered by low digital literacy among older populations, limiting access to virtual care options.

Population

In 2024, 14.8% of the estimated resident population (ERP) in the CESPHN region were aged 65 years and over, and 7.2% were aged 75 years and over.(1) The number of people aged 65 years and over is expected to increase by 30.4% between 2024 and 2041.(2) Furthermore, the number of people aged 85 and over is expected to increase by 101.8% between 2024 and 2041 (n=38,895 compared to n=78,505).(2)

Lord Howe Island SA3 had the highest proportion of people aged 65 years and over (21.7%), followed by Cronulla – Miranda – Caringbah SA3 (20.2%) and Sutherland – Menai – Heathcote SA3 (18.0%).(1)

Table 1: Estimated resident population (ERP) aged 65 years and over by SA3, CESPHN region, 2024

SA3	Age group (years)						% Total SA3 population
	65-69	70-74	75-79	80-84	85+	Total	
Botany	2,121	1,774	1,539	1,051	994	7,479	12.0
Canada Bay	4,229	3,834	3,198	2,164	2,321	15,746	17.5
Canterbury	6,160	4,924	4,216	3,077	3,423	21,800	14.9
Cronulla – Miranda – Caringbah	6,697	5,621	4,983	3,527	4,077	24,905	20.2
Eastern Suburbs – North	5,023	4,564	4,784	3,039	3,389	20,799	15.6
Eastern Suburbs – South	5,486	4,803	4,286	2,984	3,238	20,797	14.4
Hurstville	7,301	5,870	4,700	3,199	3,762	24,832	17.9
Kogarah – Rockdale	6,541	5,624	4,819	3,387	3,809	24,180	15.5
Leichhardt	2,488	2,296	1,904	965	944	8,597	14.8
Lord Howe Island	28	28	19	16	6	97	21.7
Marrickville – Sydenham – Petersham	1,938	1,723	1,375	987	1,019	7,042	12.3
Strathfield – Burwood – Ashfield	6,668	5,542	4,375	3,165	4,118	23,868	13.9
Sutherland – Menai – Heathcote	5,878	5,001	4,297	2,731	2,628	20,535	18.0
Sydney Inner City	6,673	5,764	4,423	2,627	2,565	22,052	9.0
CESPHN	**67,231**	**57,368**	**48,918**	**32,919**	**36,293**	**242,729**	**14.8**
NSW	**430,070**	**370,619**	**309,188**	**197,592**	**192,618**	**1,500,087**	**17.7**
Australia	**1,359,467**	**1,174,229**	**973,264**	**612,072**	**581,499**	**4,700,531**	**17.3**

Source: ABS ERP 2025

At June 2024, of the CESPHN population aged 65 years and over:

- 47.6% were receiving the Age Pension. Canterbury SA3 had the highest rate of recipients (64.7%) followed by Botany SA3 (61.1%) and Marrickville – Sydenham – Petersham SA3 (57.9%).(3)
- 14.8% were receiving the Commonwealth Seniors Health Card (CSHC), which provides recipients with benefits such as cheaper medicines under PBS and bulk billed doctor visits (doctors discretion). Cronulla – Miranda – Caringbah SA3 had the highest proportion of CSHC recipients (20.4%), followed by Sutherland – Menai – Heathcote SA3 (19.3%) and Canada Bay SA3 (19.1%).(3)

Table 2: DSS recipients by SA3, CESPHN region, at June 2024

SA3	Age Pension	Age Pension (%)	Commonwealth Seniors Health Card	Commonwealth Seniors Health Card (%)
Botany	4,570	61.1	690	9.2
Canada Bay	6,360	40.4	3,005	19.1
Canterbury	14,110	64.7	1,740	8.0
Cronulla – Miranda – Caringbah	10,435	41.9	5,075	20.4
Eastern Suburbs – North	5,150	24.8	2,895	13.9
Eastern Suburbs – South	8,965	43.1	3,660	17.6
Hurstville	13,175	53.1	3,760	15.1
Kogarah – Rockdale	13,895	57.5	3,075	12.7
Leichhardt	3,025	35.2	1,445	16.8
Lord Howe Island	30	30.9	10	10.3
Marrickville – Sydenham – Petersham	4,080	57.9	750	10.7
Strathfield – Burwood – Ashfield	12,165	51.0	3,365	14.1
Sutherland – Menai – Heathcote	10,245	49.9	3,970	19.3
Sydney Inner City	9,405	42.6	2,575	11.7
CESPHN	**115,610**	**47.6**	**36,015**	**14.8**
NSW	**820,395**	**54.7**	**186,570**	**12.4**
Australia	**2,667,380**	**56.7**	**544,780**	**11.6**

Source: Department of Social Services 2025, ABS 2025

Aboriginal and Torres Strait Islander population

In 2024, 21.9% of the CESPHN Aboriginal and Torres Strait Islander population (herein referred to as Aboriginal people) were aged 50 years and over and 7.4% were aged 65 years and over.(4) Leichhardt IARE had the highest proportion of Aboriginal people aged 50 years and over[1] (26.7%), followed by Sydney – City IARE (23.5%) and Marrickville IARE (22.7%)[2].(4)

[1] Aboriginal people are considered 'older' at age 50 and over instead of 65 years and over due to a lower life expectancy and earlier onset of health issues and poorer health outcomes.
[2] For more information regarding the Aboriginal population in the CESPHN region, please refer to the Aboriginal peoples' health and wellbeing report.

Table 3: Usual resident population (URP) aged 50 years and over, by IARE, 2024

IARE	50-54	55-59	60-64	65yrs +	Total	% Total IARE population
Botany Bay	73	71	53	70	267	21.1
Canterbury – Bankstown (part a)	70	60	53	100	283	22.2
Hurstville – Kogarah	50	56	47	86	239	20.8
Leichhardt	47	44	32	59	182	26.7
Marrickville	82	74	64	103	323	22.7
Randwick – La Perouse	148	134	105	225	612	22.3
Rockdale	63	44	35	70	212	21.9
Sutherland Shire	204	152	114	229	699	19.2
Sydney – City	256	181	159	256	852	23.5
Sydney Inner West	76	60	44	92	272	20.7
Woollahra – Waverley	19	16	19	33	87	16.6
CESPHN	1,088	892	725	1,323	4,028	21.6

Source: PHIDU 2025
Data note: The Canterbury – Bankstown (part a) IARE boundaries partially overlaps with the CESPHN region boundary. No data is available for Lord Howe Island IARE.

Health status

Social isolation

Social isolation and loneliness have significant health repercussions that can contribute to poor mental health and wellbeing and lead to cognitive decline and dementia among older people. In the CESPHN region, almost a quarter of older people (23.3%) live alone and 2.7% of older people living alone have poor English proficiency.(5) Canterbury SA3 had the highest proportion of people aged 65 years and older living alone with poor English proficiency (5.4%), followed by Marrickville – Sydenham – Petersham SA3 (4.9%).(5)

Table 4: Social isolation indicators by SA3, CESPHN region, 2021

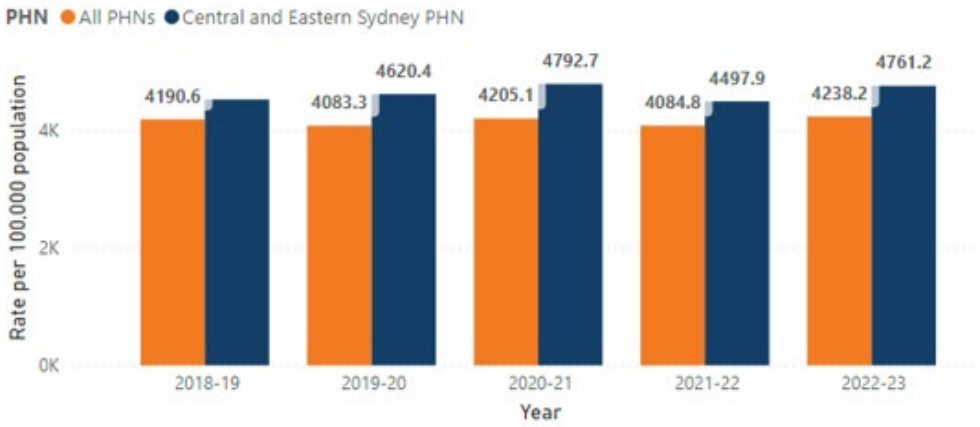
SA3	Population 65 year +	Population 65 years+ living alone	Population 65+ living alone with poor English proficiency
Botany	7,136	1,738	260
Canada Bay	14,952	3,190	380
Canterbury	20,895	3,950	1122
Cronulla – Miranda – Caringbah	23,445	5,272	111
Eastern Suburbs – North	20,705	5,677	149
Eastern Suburbs – South	20,937	5,418	439
Hurstville	23,448	4,617	798
Kogarah – Rockdale	23,726	5,011	816
Leichhardt	8,201	2,265	104
Lord Howe Island	109	15	0
Marrickville – Sydenham – Petersham	7,052	1,648	347
Strathfield – Burwood – Ashfield	23,261	4,949	893
Sutherland – Menai – Heathcote	19,703	3,634	72
Sydney Inner City	20,615	7,074	762
CESPHN	**234,185**	**54,503**	**6,253**

Source: ABS 2023

Falls

The rate of fall-related injury hospitalisations (excluding rehabilitation admissions) in those aged 65 years and over has remained relatively consistent across the five years to 2022-23, both within NSW PHNs and CESPHN. In 2022-23, males within the CESPHN region had fall-related hospitalisations 1.05 times the rate of females (4,866.8 compared to 4,644.1 respectively).(2)

Figure 1: Fall-related hospitalisations in the CESPHN region, 2018-19 to 2022-23

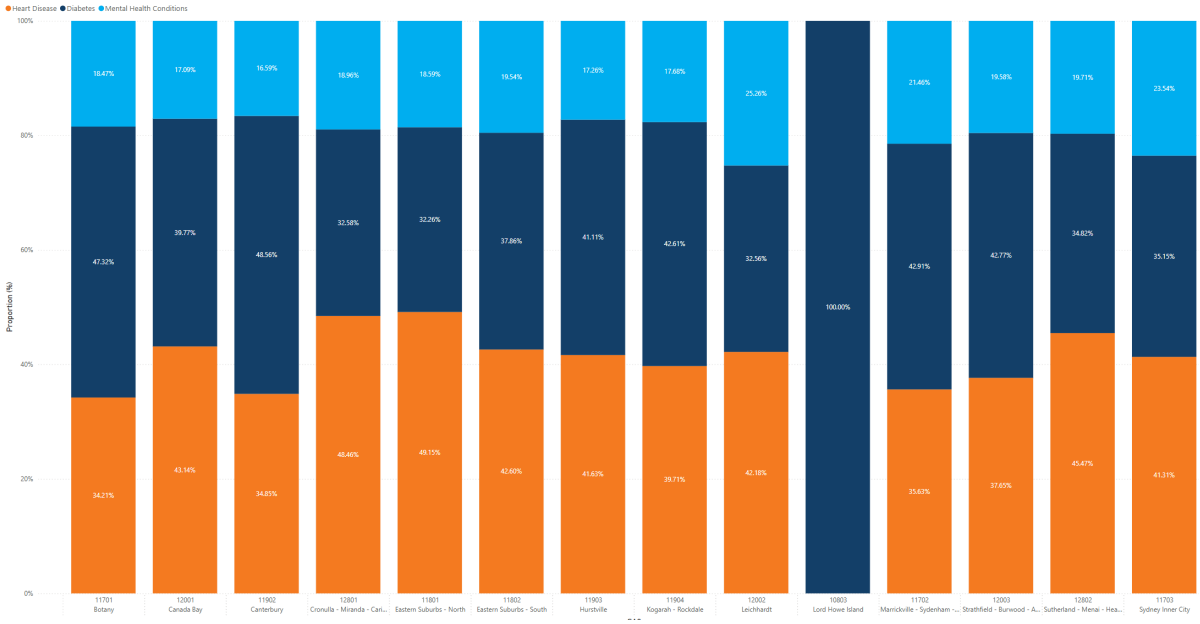


Source: HealthStats NSW, 2025

Long-term health conditions

In 2021, Canterbury SA3 had high levels of people aged 65 years and older reporting diabetes as a long-term health condition (48.6%).(5) Eastern Suburbs – North SA3 had the highest proportion of people aged 65 years and older who reported having heart disease (49.2%), followed by Cronulla – Miranda – Caringbah SA3 (48.5%). Similar proportions of people reporting mental health conditions across the SA3s in the CESPHN region.(5)

Figure 2: People aged 65 years and older who reported a long-term health condition by SA3, CESPHN region, 2021



Source: ABS 2022
Data note: No published data available for Lord Howe Island SA3 regarding heart disease and mental health conditions.

Dementia

In 2022, there was an estimated 372,815 people aged 65 years and over living with dementia in Australia. This is expected to increase by 39.6% to 520,340 by 2031.(6) Based on national rates, we estimate that 22,547 people aged 65 years and over in the CESPHN region have dementia, accounting for 15.4% of this population group.(7)

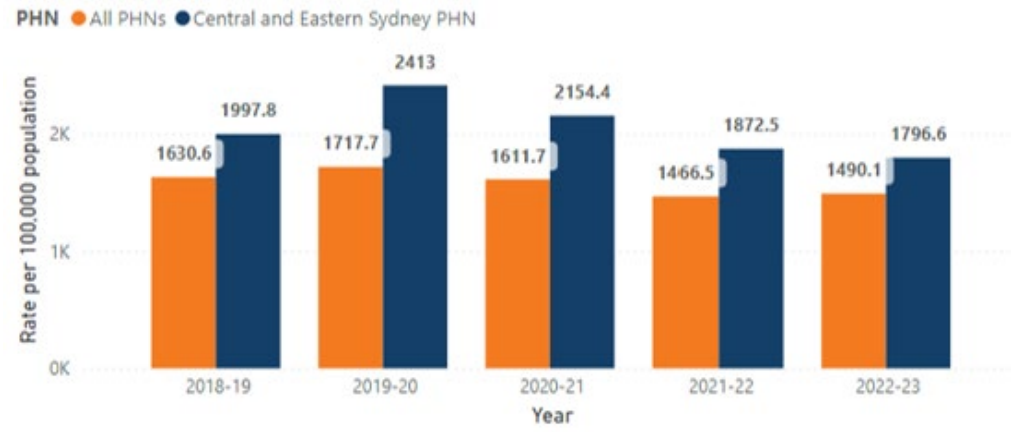
Table 5: Estimated prevalence of dementia, by age group, CESPHN region, 2022

Age group (years)	Estimated people with dementia	
	Number per 1,000 nationally	Number estimated CESPHN
65–69	24.8	1,762
70–74	40.9	2,469
75–79	70.6	3,398
80–84	123.2	4,078
85+	295.47	10,840
Total	**15.4**	**22,547**

Source: AIHW 2023 and ABS 2023

In 2022-23, there was a decrease in the rate of dementia-related hospitalisations for those aged 65 years and over within CESPHN. Dementia related hospitalisations across the CESPHN region were higher for males than females (2,196.8 compared to 1,477. per 100,000 population respectively).(2)

Figure 3: Dementia-related hospitalisations in the CESPHN region, 2018-19 to 2022-23



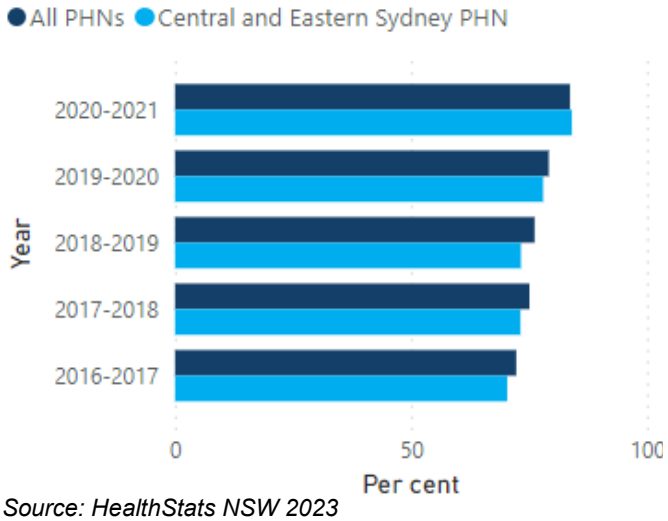
Source: HealthStats NSW 2025

Influenza and pneumonia

Data note: Regional level data regarding influenza rates is no longer reported via HealthStats NSW. Therefore, Figure 4 and the accompanying text have not been updated.

In the five years to 2020-21, individuals aged 65 years and over within the CESPHN region have had influenza immunisation rates slightly lower than or on par with NSW PHN rates. CESPHN rates have risen slightly over this period, with rates increasing from 70.4% to 84.1% over the past 5 years.(8)

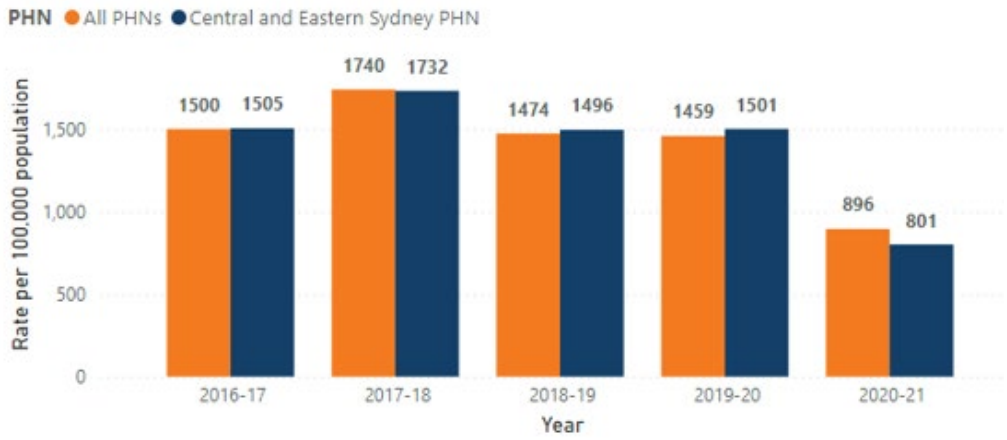
Figure 4: Influenza immunisation rates by year, CESPHN region, 2016-17 to 2020-21



Source: HealthStats NSW 2023

Between 2016-17 and 2019-20, CESPHN rates of influenza and/or pneumonia hospitalisations were equal to or slightly higher than NSW PHNs rates. However, there has been a continued decline in hospitalisation rates since 2017-18. In 2020-21, CESPHN hospitalisation rates were lower than NSW PHN rates (801 to 896 per 100,000 population respectively).(2)

Figure 5: Influenza and/or pneumonia hospitalisation rates by year, CESPHN region, 2016-17 to 2020-21



Source: HealthStats NSW 2025

Disability

Overall, the likelihood of experiencing disability increases with age. This means the longer people live, the more likely they are to experience some form of disability. Knowing how many people are living with a disability, and their characteristics can assist with primary care service planning.

In 2021, Kogarah – Rockdale SA3 had high numbers of people living with a disability. Specifically, the highest number of people aged 65 years and older with a moderate or mild core activity limitation (5.7%), the second highest number of people with profound or severe core activity limitation (5,1%), and the second highest number of people with a profound or severe disability (6%) in the CESPHN region.(9)

In the CESPHN region (2021), Cronulla – Miranda – Caringbah SA3 had the highest number of people aged 65 years and older living with a profound or severe core activity limitation (5.5%), with Strathfield – Burwood – Ashfield SA3 having the highest number of people living with a profound or severe disability (7.8%).(9)

Table 6: People living with a disability, 65 years and over by SA3, CESPHN region, 2021

SA3	People with moderate or mild core activity limitation	People with a profound or severe core activity limitation	People with profound or severe disability
Botany	1,104	1,404	1,486
Canada Bay	1,779	2,742	2,686
Canterbury	2,376	3,066	4,023
Cronulla – Miranda – Caringbah	2,442	5,115	3,636
Eastern Suburbs – North	1,799	3,007	2,506
Eastern Suburbs – South	2,548	3,891	3,667
Hurstville	3,115	4,925	4,928
Kogarah – Rockdale	3,360	4,685	5,338
Leichhardt	873	1,531	1,292
Lord Howe Island	0	0	7
Marrickville – Sydenham –Petersham	1,115	1,532	1,746
Strathfield – Burwood – Ashfield	3,046	3,940	6,918
Sutherland – Menai – Heathcote	1,955	4,151	2,780
Sydney Inner City	2,419	3,892	3,262
CESPHN	**58,917**	**92,498**	**88,845**

Source: ABS 2022

Access to services

GP health assessment

In 2023-24, 55,999 health assessments were completed in the CESPHN region – 47.4% of these were for people aged 75 years and over, equating to OVER one-quarter of individuals aged 75 years and over living in the CESPHN region (28.5%). National and state figures show a higher proportion of health assessments were for people aged 75 years and over (54.6% and 53.7% respectively), as well as a slightly higher proportion of people aged 75 years and over had a health assessment completed (39.1% and 39% respectively).(1, 10)

Marrickville – Sydenham – Petersham SA3 had the highest proportion of their population aged 75 years and over with a completed heath assessment (40.4%), followed by Canada Bay SA3 (35%) and Cronulla – Miranda – Caringbah SA3 (34.6%).(1, 10)

Table 7: Proportion of population 75 years and over who had a health assessment completed, CESPHN, 2023-24

SA3	Health Assessments^	Population*	Proportion with Health Assessment completed (%)
Botany	269	3,584	7.5
Canada Bay	2,691	7,683	35.0
Canterbury	2,244	10,716	20.9
Cronulla – Miranda – Caringbah	4,358	12,587	34.6
Eastern Suburbs – North	2,194	11,212	19.6
Eastern Suburbs – South	2,774	10,508	26.4
Hurstville	3,887	11,661	33.3
Kogarah – Rockdale	3,184	12,015	26.5
Leichhardt	1,232	3,813	32.3
Lord Howe Island	n.p.	41	n.p.
Marrickville – Sydenham – Petersham	1,365	3,381	40.4
Strathfield – Burwood – Ashfield	3,578	11,658	30.7
Sutherland – Menai – Heathcote	3,194	9,656	33.1
Sydney Inner City	2,721	9,615	28.3
CESPHN	**33,691**	**118,130**	**28.5**

*Source: ^Department of Health 2025; *ABS ERP 2025*

Patient experience of older people

Nationally, 75.8% of people aged 65 years and over had seen a GP in the last 12 months.

Patient experience in healthcare for people aged 65 years and over is generally better than for people aged 15 years and over – a higher proportion of people aged 65 years and over feel their GP listens, shows respect and spends enough time with them, and a lower proportion had difficulty accessing their preferred GP or waited longer than acceptable.(11)

Table 8: Patient experience measures by age group, Australia, 2023-24

Patient experience measure	Percent 15 years and over	Percent (65 years and over average)
Percentage of adults who felt their GP always or often listened carefully in the preceding 12 months, by age and sex	90.5	93.9
Percentage of adults who felt their GP always or often showed respect for what they had to say in the preceding 12 months	93.7	96.1
Percentage of adults who felt their GP always or often spent enough time in the preceding 12 months	87.8	93.2
Percentage of adults who saw a GP in the preceding 12 months	66.4	75.8
Percentage of adults who could not access their preferred GP in the preceding 12 months	33.6	24.2
Percentage of adults who felt they waited longer than acceptable to get an appointment with a GP	28	18
Percentage of adults who did not see or delayed seeing a GP due to cost in the preceding 12 months	2.4	8.8

Source: ABS 2024

Aged care

The aged care target population is defined as all people aged 65 years and over and Aboriginal and Torres Strait Islander Australians (here in referred to as Aboriginal people) aged 50–64 years. Aged care is delivered through a variety of programs:

- Commonwealth Home Support Programme (CHSP) - provides entry-level home support services (such as personal care, transport, and assistance with food preparation and meals) to help people stay independent and in their homes and communities for longer.
- Residential aged care - provides a range of care options and accommodation on a permanent or respite basis for people who are unable to continue living independently in their own homes.
- Home Care Packages Programme (Home Care) - offers packages of services at four levels of care to enable people to live at home for as long as possible.
- Flexible care - Transition Care is the largest of the flexible care programs, providing support for people to return home after a hospitalisation.

Royal Commission into Aged Care Quality and Safety

In February 2021, the Royal Commission into Aged Care Quality and Safety delivered its final report which outlined 148 recommendations for reforming the aged care system in Australia.(12) The Commission found that people receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need including GP visits, mental health services, oral and dental health care, and preventative care. It also found that there is often poor clarity about health care responsibilities and communication between aged care providers and health care providers. The report also highlighted gaps that occur when older people transition between multiple health and social care systems.

A report commissioned by the Department of Health in response to issues identified by the Royal Commission found the need for services that:

- support people accessing information and navigating the aged and health care systems
- focus on prevention and early intervention
- are culturally safe for Aboriginal people, people from multicultural communities, refugees, and LGBTIQA+ communities
- support information sharing to facilitate clinical handover between aged care and health care providers.(13)

In response to the Commission's recommendations, the Australian Commonwealth Government will boost funding to reform the aged care system within Australia, including a focus on meeting older peoples preferences to age in place and the development and implementation of a new support at home program.(14) The five pillar aged care reform plan includes:

1. Home care – at home support and care based on assessed needs
2. Residential aged care services and sustainability – improving service suitability that ensures individual care needs and preferences are met
3. Residential aged care quality and safety – improving access to and quality of residential care
4. Workforce – growing a bigger, more skilled, caring and values-based workforce; and
5. Governance – new legislation and stronger governance.

Aged Care Act 2024

The new Aged Care Act commenced 1 November 2025 and covers 58 recommendations from the Royal Commission. It will do this through:

- a Statement of Rights ensuring older people remain active care system participants in their own care
- the new Support at Home program, improving access to services, products, equipment and home modifications
- strengthened Aged Care Quality Standards improving the quality of care
- new regularly model encouraging stronger working relationships, transparency and engagement
- simplifying the registration process and giving clear provider obligations
- funding culturally safe, trauma-aware and healing-informed services for older Aboriginal people
- updating digital systems to support high-quality, better-connected care.(15)

Every provider will be registered under a new regulatory model and required to meet strengthened Aged Care Quality Standards to ensure every older person receives the best care possible.

Home support services

As at 30 June 2024, the rate of home support recipients per 1,000 people aged 65 years and over was lower in the CESPHN region than state and national rates.(16)

Table 9: Rate of home support recipients, CESPHN region, at 30 June 2024

Region	Rate of home support recipients per 1,000 people aged 65 years and older
CESPHN	142.7
NSW	153.9
Australia	176.1

Source: AIHW GEN 2025

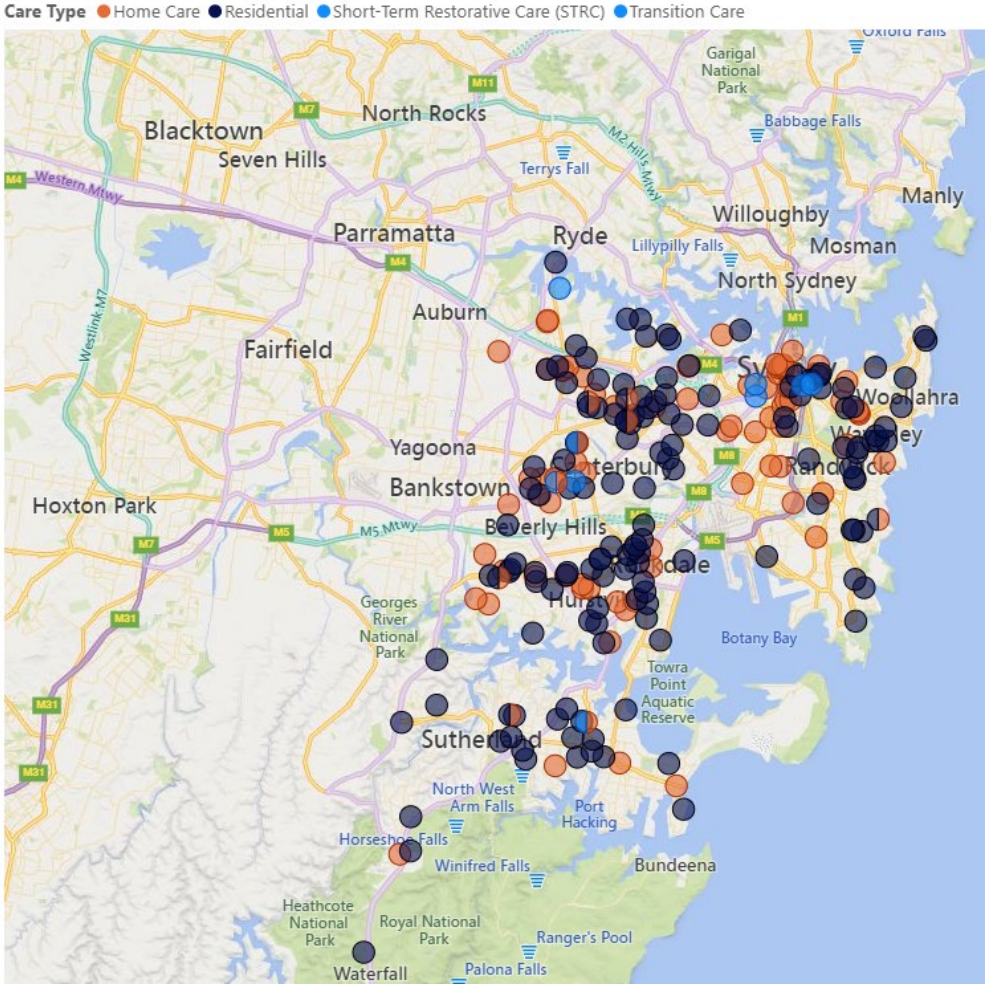
Across 2023-24, there were 217 home support outlets across the CESPHN region. Transport was the most commonly used home support service in the CESPHN region throughout 2023-24.(17)

Residential care, home care and transition care

As at 30 June 2024, in the CESPHN region, there were:

- 145 RACFs offering 12,533 places (n=10,727 places filled by those aged 65 years and over)
- 89 services providing home care packages (n=18,133 people at 30 June 2024)
- 3 services providing transition care
- 6 short-term restorative care, and
- 1 multi-purpose centre.

Figure 6: Number and location of aged care services, by service type, CESPHN region, as at June 2024

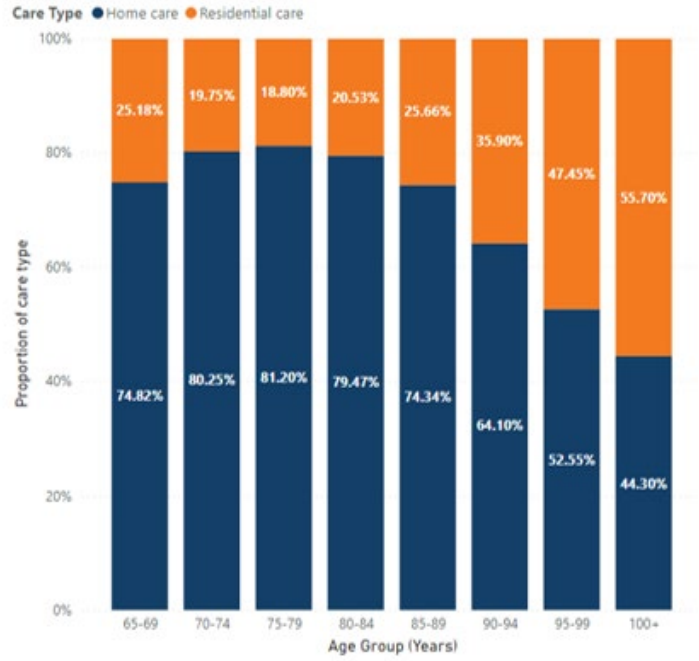


Source: AIHW GEN 2025

As at 30 June 2024, CESPHN was relatively well supplied with permanent residential aged care places (n=12,533) compared to state (n=72,572) and national averages (n=223,691).(17)

Data shows that up until 90-94 years of age, a higher proportion of aged care recipients in the CESPHN region utilised home care. As people age, the proportion of people using residential care increases.(16)

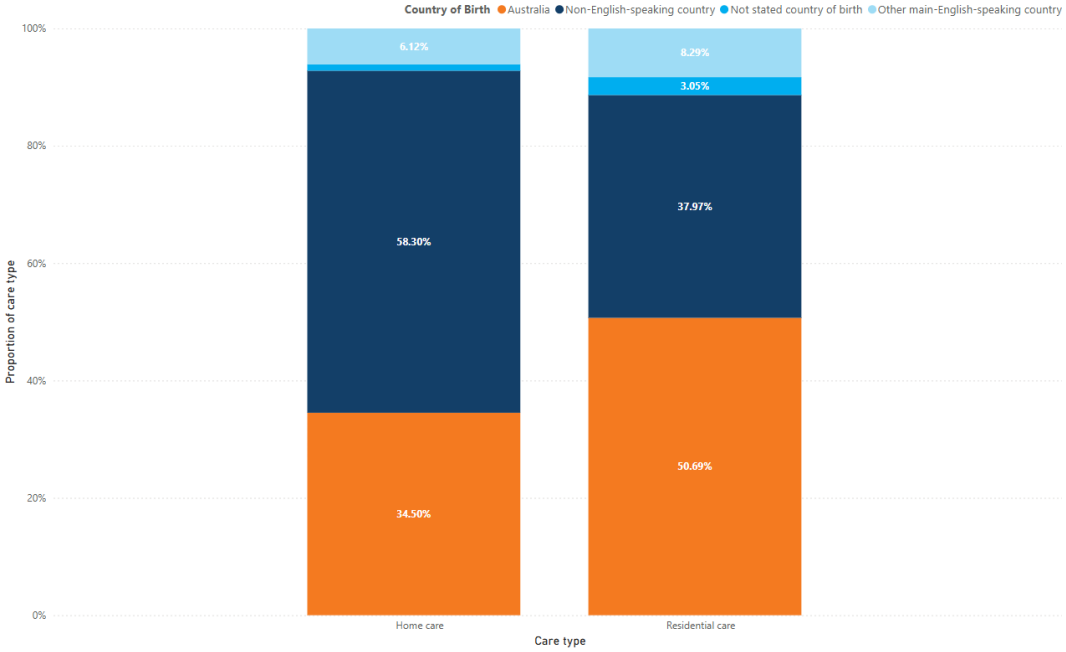
Figure 7: Care type by age group, CESPHN region, 2023-24



Source: AIHW GEN 2025

Over 30% of all residential places (34.5%) and 58.3% of home care places were filled by people born in non-English speaking countries. (16)

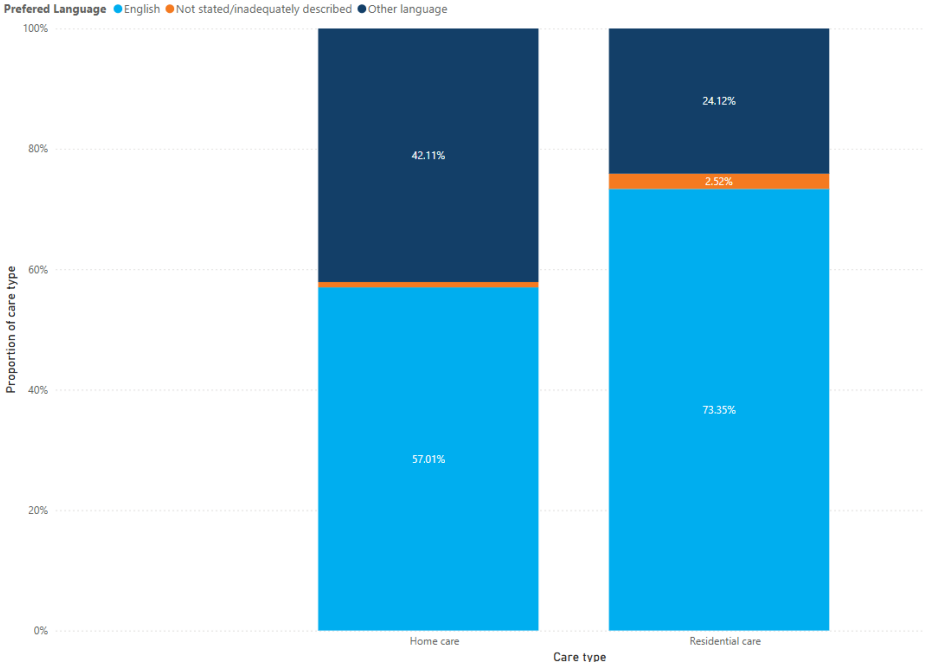
Figure 8: Country of birth by care type, CESPHN region, 2023-24



Source: AIHW GEN 2025

The CESPHN region has a higher proportion of older people with a preferred language other than English (37.8%) compared to NSW (20.7%).(16) Home care packages are more frequently used by this group with 42.1% of people using these services reporting a preferred language other than English.(16)

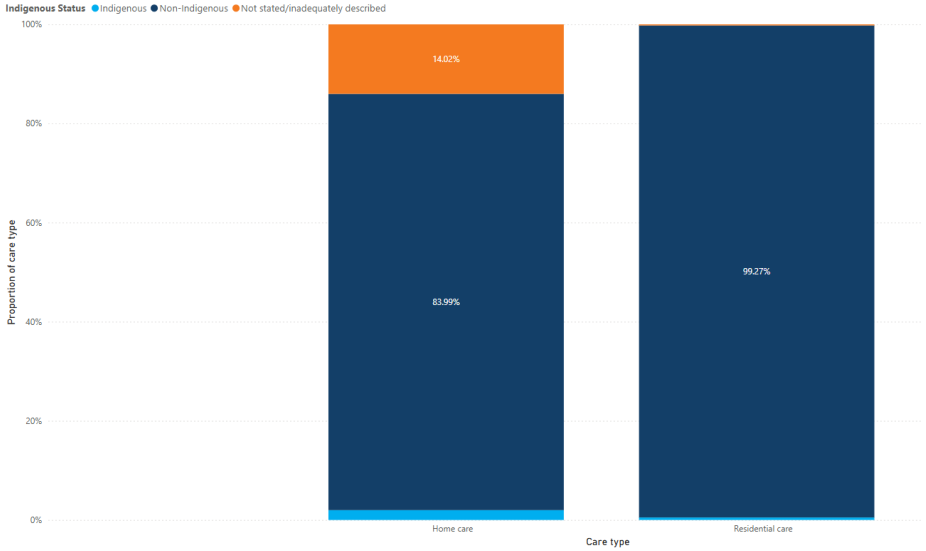
Figure 9: Preferred language by care type, CESPHN region, 2023-24



Source: AIHW GEN 2025

1.9% of individuals aged 50 years and over, using aged care services in the CESPHN region identified as Aboriginal.(16)

Figure 10: Indigenous status by care type, CESPHN region, 2023-24



Source: AIHW GEN 2025

Residential care

As at 30 June 2024, CESPHN had a rate of permanent residential care recipients per 1,000 people aged 70 years and over slightly higher than both the state and national rates.(17)

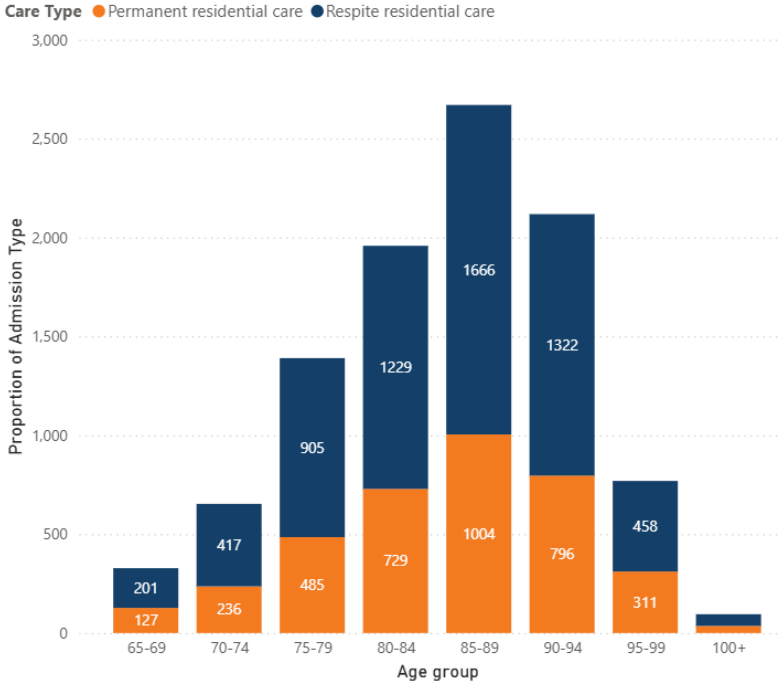
Table 10: Rate of permanent residential care recipients, CESPHN region, as at June 2024

Region	Rate of residential care recipients per 1,000 people aged 70 years and older
CESPHN	69.0
NSW	67.7
Australia	67.7

Source: AIHW GEN 2025

In 2023-24, there were 9,981 places filled by individuals aged 65 years and over – 3,724 of these places were identified as permanent admissions and 6,257 respite places.(16) Over half (57.6 %) of the 65 years and over residential care population were female, just over half of residents (56.6%) were aged 85 years and over.(16)

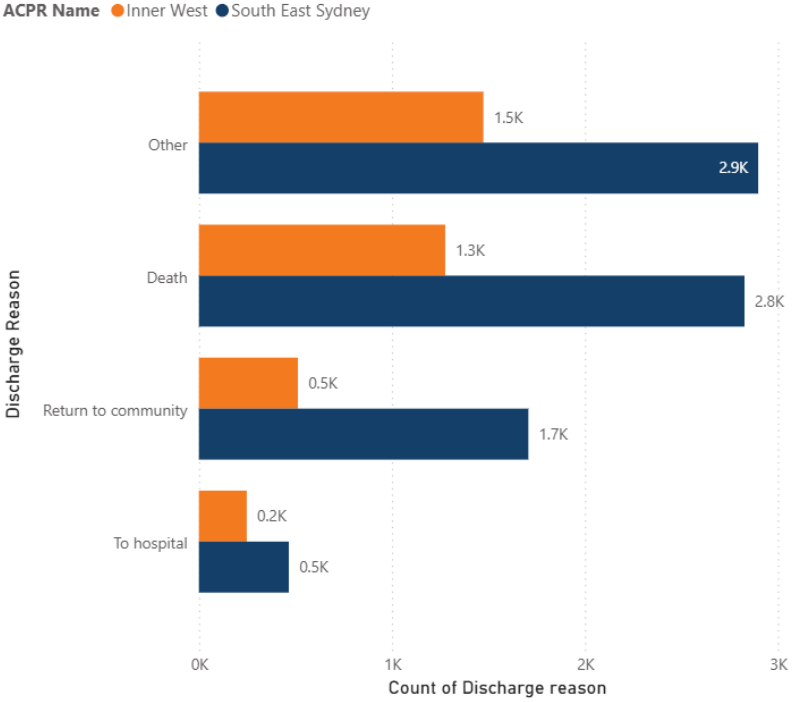
Figure 11: Residential care places by care type and age group, CESPHN region, 2023-24



Source: AIHW GEN 2025

In 2023-24, there were 11,409 exits from residential care in the CESPHN region for people aged 65 years and over. Over one-third of exits (35.9%) were due to death.(18)

Figure 12: Discharge reason by Aged Care Planning Region (ACPR), CESPHN region, 2023-24



Source: AIHW GEN 2025

Young people in residential care

The Australian Government is working to reduce the number of younger people (under the age of 65 years) going into residential aged care, and to help younger people who are already in residential aged care to move into age-appropriate accommodation with the supports they need.

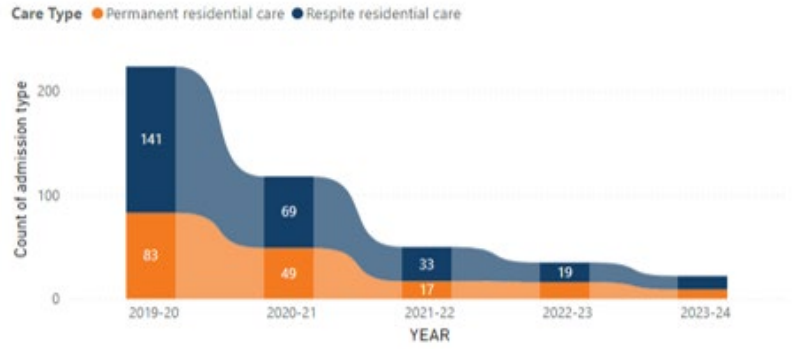
The Younger People in Residential Aged Care Strategy 2020–25 sets out to achieve this goal through the following targets, apart from in exceptional circumstances:

- no people under the age of 65 entering residential aged care by 2022
- no people under the age of 45 living in residential aged care by 2022
- no people under the age of 65 living in residential aged care by 2025.

As at 30 June 2024, 53 individuals aged under 65 years were in residential aged care in the CESPHN region; 36 were permanent residents. Of the 36 residents, 11 identified as Aboriginal, three of which were in permanent care, eight were in respite care and all aged 50 years and older.(16)

In 2023-24, there were 9 people aged under 65 years admitted to permanent residential care across the CESPHN region – a 90.8% decrease since 2019-20. Similarly, there has also been a 89.2% decrease in the number of people aged under 65 years entering respite care in this period.(19)

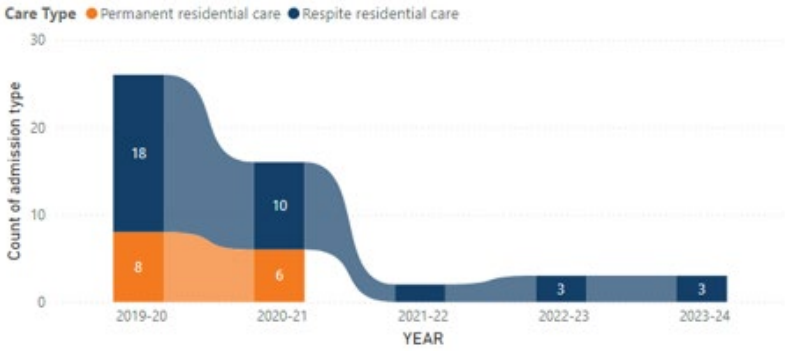
Figure 1313: Young people (under 65 years) entering residential aged care, CESPHN region, 2023-24



Source: AIHW GEN 2025

In 2023-24, there were three people aged under 50 years admitted to respite care across the CESPHN region - an 83.3% decrease since 2019-20. There has been no updated data available regarding admissions into permanent residential care for people aged under 50 years during this period since 2021-22.(19)

Figure 14: Young people (under 50 years) entering residential aged care, CESPHN region, 2023-24



Source: AIHW GEN 2025
Note: Data is not available for permanent residential admissions in the CESPHN region for the under 50 years age group in the 2021-22, 2022-23 and 2023-24 period.

Home care packages

On 30 June 2024, CESPHN had a rate of home care recipients per 1,000 people aged 65 years and over higher than both the state and national rates.(20)

Table 11: Rate of home care recipients, CESPHN region, as at June 2024

Region	Rate of residential care recipients per 1,000 people aged 65 years and older
CESPHN	70.8
NSW	59.6
Australia	58.5

Source: AIHW GEN 2025

In 2023-24, 6,958 people aged 65 years and over were admitted to home care packages within the CESPHN region, with a total of 101,834 people aged 65 years and over accessing a home care package in Australia at 30 June 2024.(19)

Forty-two percent (42.3%) of admissions into home care packages in 2023-24 were for level 2 home care packages, another 32% of admissions to home care packages in the CESPHN region were for level 3.(19)

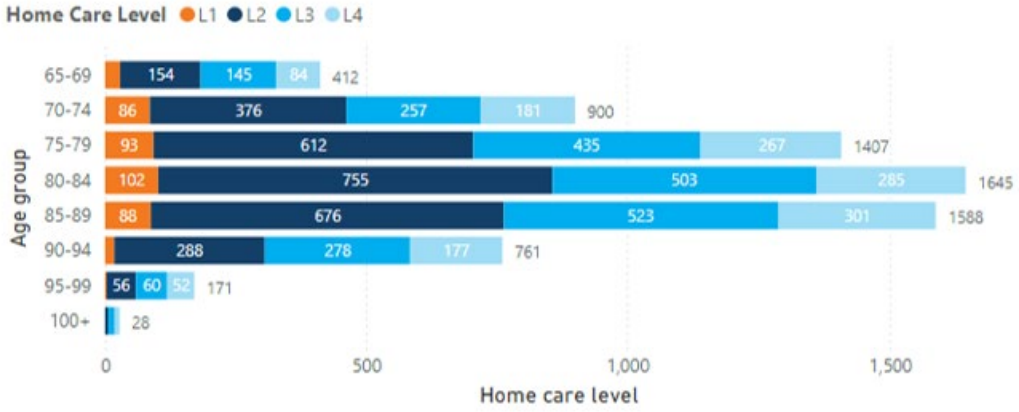
Figure 15: Home care admissions by home care level and ACPR, CESPHN region, 2023-24

Source: AIHW GEN 2025

In the CESPHN region, 65.8% of admissions into home care packages in 2023-24 were females.(19) Similarly at the national level 61.5% of all recipients of home care packages were females.(16)

Approximately one quarter of admissions (23.8%) into home care packages in 2023-24 were aged 80-84 years, and a further 23% were aged 85-89 years.(19) Similar proportions were seen nationally for all people receiving home care packages, with 23.7% of all recipients at 30 June 2024 aged 85-89 years and a further 21.0% aged 80-84 years.(16)

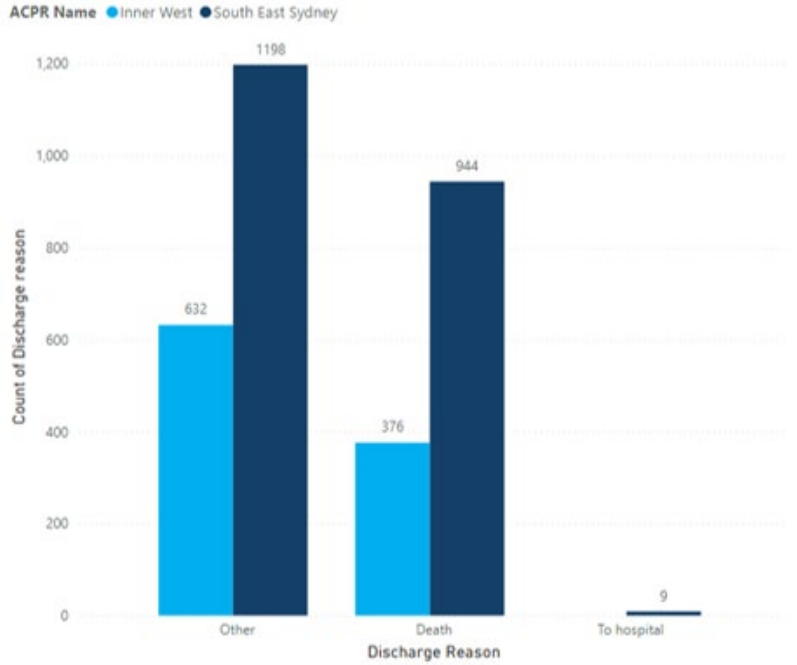
Figure 16: Home care admissions by age group and care level, CESPHN region, 2023-24



Source: AIHW GEN 2025

In 2023-24, 3,159 people were discharged from home care packages in the CESPHN region. Fifty eight percent (57.9%) of the discharges were for 'other' reasons, with 65.5% of these residential care admissions occurring in the South East Sydney Aged Care Planning Region (ACPR).(18)

Figure 17: Discharges from home care packages by ACPR, CESPHN region, 2023-24



Source: AIHW GEN 2025

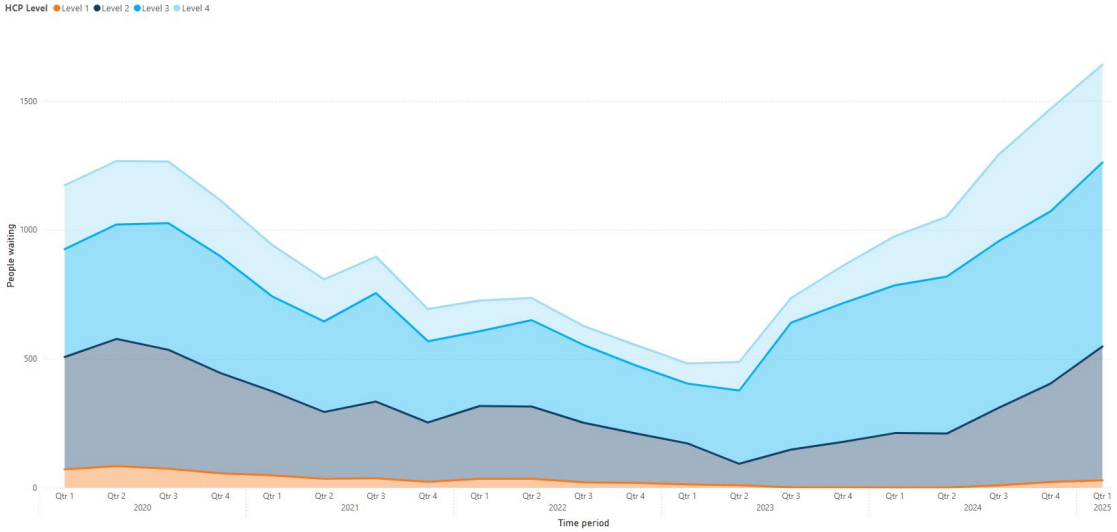
Home care package waitlists

The Royal Commission into Aged Care highlighted the need to meet preferences to age in place, which includes the provision of at home support and care based on assessed need, as such the waitlists for home care packages is an area of focus over the coming years.

From March 2020 to March 2025, the wait lists for home care packages have:

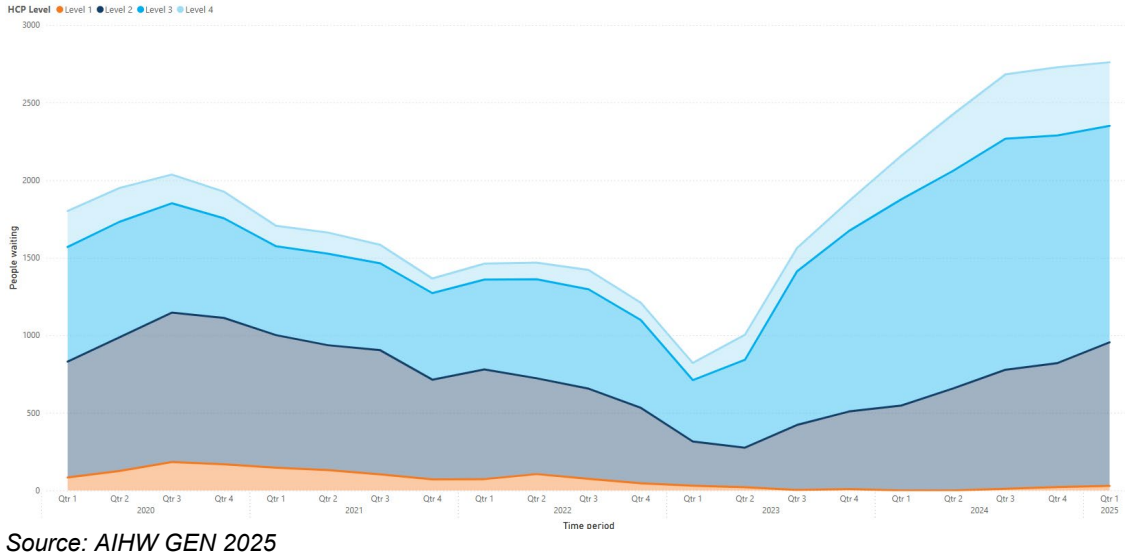
- generally decreased for level 1 – there are now 58 people waiting across the CESPHN region
- fluctuated overall, but saw a general increase in both ACPRs from Q2 2023 for level 2 – there are now 1,445 people waiting
- reduced for levels 3 and 4 up until 2023 and then continued to increase - there are now 2,108 people waiting for level 3 and 790 people waiting for level 4.(20)

Figure 18: Wait list for home care packages by care level, Inner West ACPR, March 2020 - March 2025



Source: AIHW GEN 2025

Figure 19: Wait list for home care packages by care level, South East Sydney ACPR, March 2020 - March 2025



Source: AIHW GEN 2025

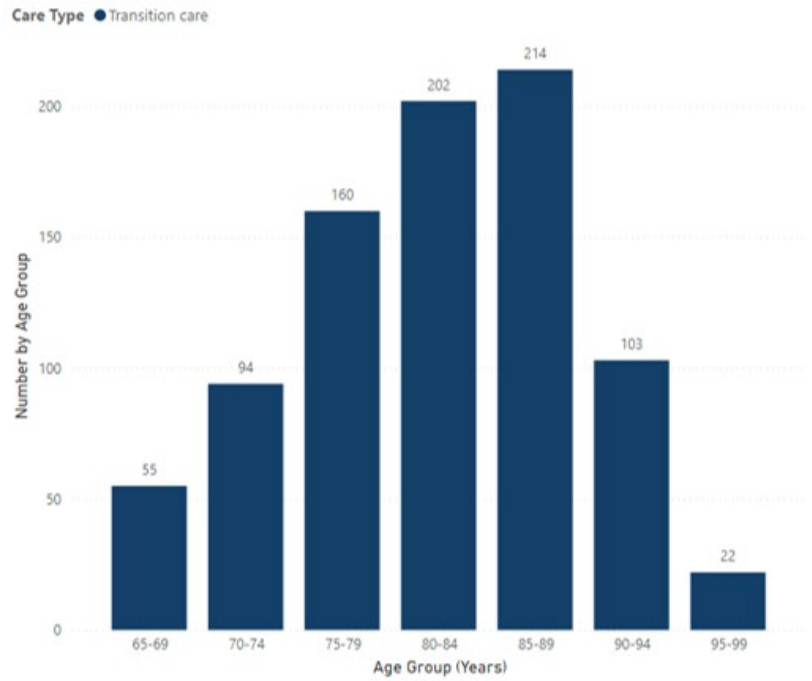
Transition care

In 2023-24, 850 people aged 65 years and over were admitted to transition care within the CESPHN region.(19)

Over half (55.2%) of the admissions into transition care in 2023-24 were females.(21) Approximately fifty percent (48.9%) of all admissions in 2023-24 were aged 80-89 years, and a further 18% were aged 75-79 years.(19)

The majority (83.3%) of exits from transition care were people entering home/community care, followed by to hospital which made up 13.2% of exits.(18)

Figure 20: Admissions into transition care by age group, CESPHN region, 2023-24



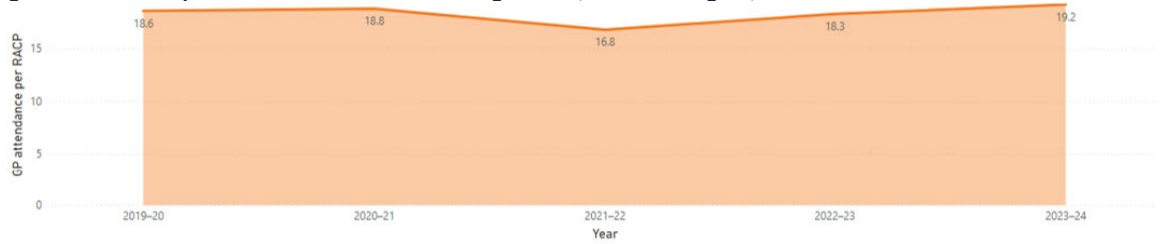
Source: AIHW GEN 2025

GPs in RACFs

GP consultations

In 2023-24, there were 310,104 GP residential aged care attendances in the CESPHN region to 16,189 residents giving a rate of 19.2 GP attendances per residential aged care patient. This is higher than the national rate of 18.4 GP attendances per residential aged care patient.(22)

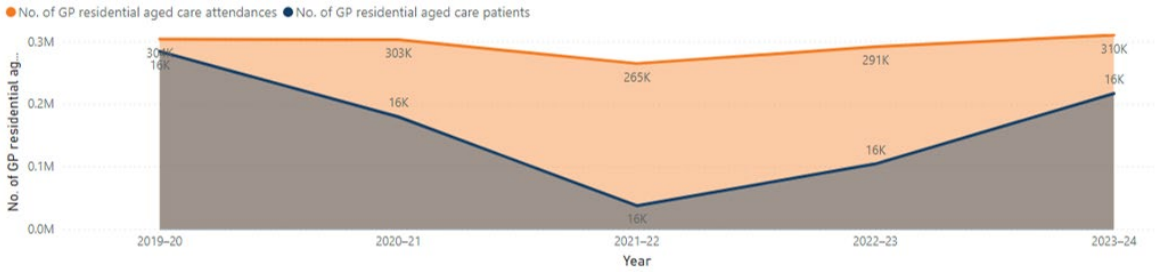
Figure 21: General practitioners' attendances in aged care, CESPHN region, 2023-24



Source: AIHW 2025

In the five years to 2023-24, there has been a 13.6% increase in the number of GP residential aged care attendances in the CESPHN region, with a 0.4% increase in the number of GP residential aged care patients.(22)

Figure 22: General practitioner attendances and patients in aged care, CESPHN region, 2023-24

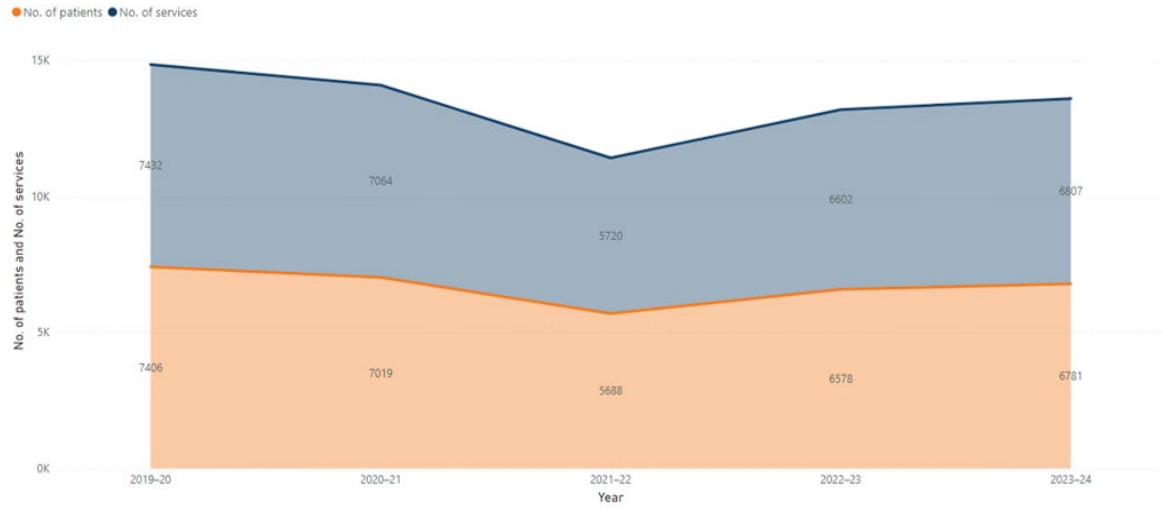


Source: AIHW 2025

Medication review

In 2023-24, there were 6,807 medication management reviews (residential) for 6,781 patients in the CESPHN region. This is similar to the national rate of 1.0 medication management reviews (residential) per patient.(22)

Figure 23: Medication management reviews, CESPHN region, 2023-24



Source: AIHW 2025

Carers

Nationally, an estimated 11.9% of the population are carers; with 4.5% identifying as a primary carer. Almost one in five (19.2%) individuals aged 65-74 years of age identified as a carer in 2022.(23)

In NSW, 17.5% of people aged 65 years and over identified as a carer, with almost half being a primary carer (8.2%); this is approximately 1.5 times as many as those in NSW aged 0-64 years, where 10.8% identify as a carer.(23)

Across Australia, almost one-third (31.9%) of all primary carers aged 65 years and over live in the same household as those they are providing care for; the majority of these carers are the partner of the care recipient (26.9%). Approximately two-thirds (62.2%) of primary carers aged 65 years and over were born in Australia, and most (87.9%) have English as the main language spoken at home. (23)

Almost half of primary carers aged 65 years and over live in the lowest two quintiles of relative socio-economic disadvantage (48.4%). This highlights the significant proportion of this population group who are both potential users of the health system, as well as providing a caring role to another person.(23)

CESPHN's current work

Healthy Ageing Strategy and Hubs

CESPHN's Healthy Ageing Strategy focuses on enabling older people to live active, connected, and independent lives through inclusive communities and integrated health and social services.

- Commissioning three Healthy Ageing Hubs in neighbourhood centres to provide practical support, service navigation, and social connection
- Offering referral pathways for health professionals to connect socially isolated patients with community supports
- Empowering older people and carers with information and guidance to maintain wellbeing

Care Finder Program

CESPHNs Care Finder Network is supporting vulnerable older Australians who require intensive assistance to navigate aged care and other services. This work includes:

- Face-to-face support for accessing My Aged Care and arranging assessments
- Assistance with completing forms, shortlisting providers, and understanding service agreements
- Linking clients to broader supports such as mental health, housing, and community groups

After-Hours Action Plans for RACHs

CESPHN is assisting RACHs to implement structured after-hours care plans to reduce unnecessary hospital transfers and improve resident safety.

- Development of clear protocols for urgent care outside business hours.
- Collaboration with GPs and after-hours services to ensure continuity of care.
- Education for RACH staff on escalation pathways and emergency management.

GP Connect

CESPHN's GP Connect initiative is designed to strengthen communication and collaboration between general practitioners and RACHs. This program aims to improve continuity of care, reduce fragmentation, and ensure timely clinical decision-making for older residents.

- Facilitates secure messaging and information sharing between GPs and RACH staff.
- Supports integration with My Health Record for accurate and up-to-date patient information.
- Provides training and technical assistance to practices and aged care facilities to adopt digital tools.
- Enhances coordination of care plans, medication management, and follow-up appointments.
- Reduces unnecessary hospital transfers through better GP engagement and proactive care.

Aged Care and Dementia Pathways and Consumer Resources

CESPHNs aged care and dementia pathways provide clinical and consumer pathway information to guide care for older people and those living with dementia. This work includes:

- Evidence-based pathways for diagnosis, management, and referral.
- Consumer-friendly resources to support informed decision-making.
- Inclusion of culturally appropriate materials and links to local services

MyMedicare GP Aged Care Incentive (GPACI)

CESPHN supports practices to participate in MyMedicare and GP ACI to improve continuity of care. This includes:

- Education and engagement with general practices on incentive benefits.
- Integration of GP ACI into aged care planning and service delivery.
- Monitoring uptake and supporting practices with implementation challenges.

Aged Care Onsite Pharmacist Measure

CESPHN is working to improve medication safety and quality use of medicines in RACHs through onsite pharmacist support. This involves:

- Engaging with RACHs and pharmacists to facilitate program uptake.
- Providing education on medication safety, deprescribing, and polypharmacy management.
- Supporting collaboration between pharmacists, GPs, and nursing staff.
- Aligning with eNRMC and My Health Record for accurate documentation.

Vaccination Coverage Projects for RACH Residents

CESPHN leads initiatives to increase vaccination rates among aged care residents and staff. This includes:

- Targeted campaigns for influenza, COVID-19, and other recommended vaccines.
- Data monitoring and reporting to identify coverage gaps.
- On-site vaccination support and education for RACH staff and residents.

Immunisation Quality Improvement Activities in General Practice

CESPHN works with practices to boost immunisation rates among older adults.

- Data audits and targeted patient recall.
- Education for clinicians on best practice vaccination protocols.
- Support for implementing quality improvement cycles in practices.

Telehealth and Digital Health Support to RACHs

CESPHN is supporting the enablement of telehealth and remote monitoring to improve access, quality and efficiency of care for older people and reduce potential need for hospital transfers. This includes:

- Grants to RACHs to expand their telehealth capacity.
- Training RACH staff in telehealth technology and workflows.
- Providing technical assistance and troubleshooting support.
- Implementation and training support on the use of My Health Record for information sharing and accurate documentation.
- Potential future integration of remote monitoring tools for chronic disease management.

iREADI Dementia Program Expansion

CESPHN is expanding the Integrated Rehabilitation for Early-Stage Dementia (iREADi) Dementia Program, which focuses on improving the lives of people living with dementia and their carers through early identification, education, and integrated support.

- Providing training for GPs and aged care staff on dementia recognition and management.
- Developing consumer resources to support families and carers.
- Strengthening referral pathways to specialist dementia services and community supports.

- Promoting best-practice models for dementia care across primary and aged care settings.

Emotional Wellbeing of Older Persons (EWOP) Program

CESPHN is working to address the mental health needs among older Australians through:

- Commissioning psychological and counselling services.
- Access to programs that reduce loneliness and social isolation.
- Integration of the EWOP program with primary care and community supports.

Action Areas

Digital Health Enablement

- Expand telehealth and remote monitoring for older adults, especially in RACHs.
- Develop digital literacy programs for older people to improve uptake of My Health Record and virtual care.
- Partner with tech providers for digital cognitive training platforms to support dementia prevention and wearable health devices and fall detection systems.

Integrated Care Models

- Pilot Hospital in the Home (HITH) for older people living in the community with acute and chronic conditions.
- Strengthen multidisciplinary care teams linking GPs to allied health, and aged care providers.
- Explore shared care plans between primary care and residential aged care facilities.

Workforce Capacity Building

- Create training pathways for residential aged care nurses and GPs in geriatric care and dementia management.
- Support intergenerational volunteer programs to address social isolation and workforce gaps.
- Develop clinical leadership programs for aged care managers.

Preventive Health & Early Intervention

- Expand awareness of falls prevention programs and home safety assessments for older people living in the community.
- Increase screening for frailty, cognitive decline, and mental health in general practice and primary care.
- Continue to promote nutrition and physical activity programs tailored for older adults.

Social Connection & Community Engagement

- Build healthy ageing community hubs for older people offering health, social, and digital services.
- Partner with local councils for age-friendly community initiatives.
- Support peer-led programs to assist raise awareness, provide connection to health and well – being services, reduce loneliness and improve mental wellbeing.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Maternal and Child Health and Wellbeing

2025-2027 Needs Assessment
2025 Annual Review

Maternal and child health and wellbeing

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Maternal and child health and wellbeing

Overview

Experiences from conception and throughout the early years of a child's life can have lasting impacts on physical and mental well-being. What happens during this time of early development can influence a child's future social, emotional and intellectual development. (REF) A key health service aim of early childhood years is to eliminate or mitigate the risk factors of adverse health effects and identify children at risk.

This chapter reviews some of the risk factors that can compromise childhood development. It is acknowledged that these indicators are not comprehensive. Further, the indicators reported here, such as maternal age, maternal health behaviours, birthweight and maternal access to early antenatal care narrow the focus on proximal causes of adverse child health-related outcomes. These indicators are useful because these are easily measured and have direct effects on outcomes. By addressing these risk factors through integrated, place-based and population-level action, CESPHN and its partners can achieve multiple impacts: optimising healthy childhood development, reducing the burden of chronic disease, improving quality of life, and strengthening system sustainability. Insofar as these indicators arise from broader socio-economic determinants of health, it follows that improving the social determinants of health can bring positive changes to mothers' and children's standards of living and wellbeing.

Key health issues

- Pockets of high levels of socio-economic disadvantage within the CESPHN region align with high numbers of 0–4-year-olds, and higher proportion of children who were born overseas or speak a language other than English at home
- The proportion of women with their first antenatal visit recorded during the first 14 weeks of gestation is below the NSW average
- Coverage rate of fully immunised children in several regions within the CESPHN region are less than the national target with some areas falling below 90% coverage
- There is a disparity in fully immunised coverage rates between all children and Aboriginal children
- Pockets of developmental vulnerability in one or more domains within the CESPHN region, with trends also showing reductions in rates of children developmentally on track
- Lower proportion of Aboriginal babies born within a healthy weight range compared with non-Aboriginal babies (88% versus 95%)

Key gaps

- Treatment delays for children newly diagnosed with a disability
- Access to affordable paediatric care

Demographics

Maternal demographics

Maternal age

The Australian Institute of Health and Welfare (AIHW) states that

> ***"The age of mothers when they give birth can have implications for their experience of pregnancy and birth….mothers aged under 20 and mothers aged over 40 have an increased risk of complications and adverse pregnancy outcomes"(1)***

In the ten years between 2014 and 2023, we have seen a shift in maternal age both at the state level (NSW) and nationally. The proportion of mothers aged 20 years or younger has almost halved in NSW and nationally, decreases are also seen in the proportion of women aged between 20 and 29 years, while there is an increase in all age groups aged 30 years and over.

Table 1: Number and proportion of women giving birth by age groups, NSW and Australia, 2014 and 2023

	NSW				Australia			
Maternal age	2014 (number)	2014 (%)	2023 (number)	2023 (%)	2014 (number)	2014 (%)	2023 (number)	2023 (%)
Under 20	2,630	2.7	1,235	1.4	9,332	3.0	4,504	1.6
20-24	11,697	12.2	7,724	8.9	39,904	13.0	26,058	9.3
25-29	25,995	27.1	20,957	24.1	85,296	27.7	68,985	24.5
30-34	33,298	34.7	32,354	37.2	105,300	34.2	103,717	36.9
35-39	17,939	18.7	20,077	23.1	54,890	17.8	63,278	22.5
40 and over	4,357	4.5	4,705	5.4	13,102	4.3	14,541	5.2

Source: AIHW, 2025

Birth and fertility rates

In 2023, 279,319 women gave birth across Australia; 31.7% of women who gave birth in 2023 lived in NSW (n=88,531). Within the CESPHN region, the AIHW calculated a rate of 39.6 births per 1,000 women of reproductive age (15-44 years) in 2023, which is the lowest for all PHNs across Australia. Across the SA3s within the CESPHN region, Sutherland-Menai-Heathcote SA3 had the highest birth rate in 2023, calculated at 54.5 per 1,000 women of reproductive age, followed by Cronulla-Miranda-Caringbah at 53.0 per 1,000 women of reproductive age and Leichhardt SA3 at 52.0 per 1,000 women of reproductive age.

The fertility rate shown in Table 3, is calculated by averaging the number of registered births per woman aged 15-49 years and therefore gives a different measure to birth rates mentioned above. However, we see the same SA3s with the highest birth and fertility rates.

Table 2: Births by SA3, CESPHN region, 2020 to 2024

SA3	2020	2021	2022	2023	2024	% Change
Botany	720	875	846	706	654	▼-9.2%
Canada Bay	1,006	1,132	1,019	873	908	▼-9.7%
Canterbury	2,081	1,867	1,836	1,761	1,753	▼-15.8%
Cronulla - Miranda - Caringbah	1,300	1,441	1,425	1,255	1,237	▼-4.8%
Eastern Suburbs - North	1,602	1,782	1,513	1,285	1,303	▼-18.7%
Eastern Suburbs - South	1,501	1,734	1,625	1,463	1,373	▼-8.5%
Hurstville	1,324	1,375	1,280	1,209	1,224	▼-7.6%
Kogarah - Rockdale	1,801	2,030	1,846	1,754	1,647	▼-8.6%
Leichhardt	721	824	746	642	625	▼-13.3%
Lord Howe Island	5	5	4	6	6	▲20.0%
Marrickville - Sydenham - Petersham	596	674	623	573	549	▼-7.9%
Strathfield - Burwood - Ashfield	1,740	1,808	1,632	1,514	1,426	▼-18.0%
Sutherland - Menai - Heathcote	1,149	1,362	1,279	1,171	1,130	▼-1.7%
Sydney Inner City	2,175	2,447	2,087	1,871	1,740	▼-20.0%
CESPHN	17,721	19,356	17,761	16,083	15,575	▼-12.1%

Source: ABS, 2025

Table 3: Fertility rates by SA3, CESPHN region,2020 to 2024

SA3	2020	2021	2022	2023	2024	% Change
Botany	1.4	1.4	1.4	1.4	1.2	▼-16.0%
Canada Bay	1.5	1.5	1.4	1.4	1.3	▼-10.3%
Canterbury	2.0	1.9	1.9	1.8	1.7	▼-17.7%
Cronulla - Miranda - Caringbah	1.8	1.8	1.8	1.8	1.7	▼-7.7%
Eastern Suburbs - North	1.4	1.4	1.4	1.3	1.1	▼-19.7%
Eastern Suburbs - South	1.4	1.4	1.4	1.4	1.2	▼-9.5%
Hurstville	1.5	1.4	1.4	1.4	1.3	▼-12.4%
Kogarah - Rockdale	1.5	1.5	1.5	1.4	1.3	▼-13.9%
Leichhardt	1.6	1.6	1.6	1.6	1.4	▼-12.5%
Marrickville - Sydenham - Petersham	1.2	1.2	1.1	1.1	1.0	▼-15.0%
Strathfield - Burwood - Ashfield	1.2	1.2	1.2	1.1	1.0	▼-19.0%
Sutherland - Menai - Heathcote	1.8	1.8	1.8	1.9	1.7	▼-2.2%
Sydney Inner City	0.9	0.9	0.9	0.8	0.7	▼-18.9%
CESPHN (average)	1.4	1.3	1.3	1.3	1.2	▼-13.0%

Source: ABS, 2025

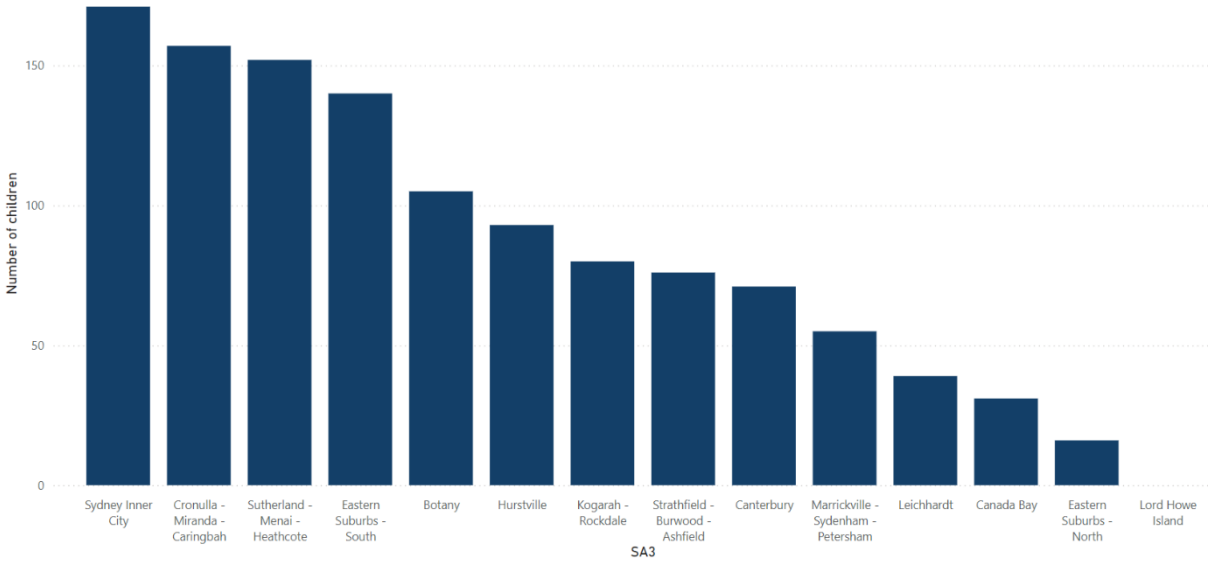
0-4 years

In 2024, there were an estimated 77,093 children aged between 0 to 4 years in the CESPHN region.(2) Numbers are expected to grow at a rate of 0.31% annually reaching 87,493 by 2041.. Canterbury SA3 had the highest number (n=8,598), accounting for 11.2% of children 0-4 years across the CESPHN region, followed by Kogarah-Rockdale SA3 (n=8,122) accounting for 10.5% and Sydney Inner City (n=7,688), accounting for 10.0% of the CESPHN 0-4 year population.(2)

Population aged 0-4 years who identify as Aboriginal

In 2021, there were 1,186 children aged 0-4 years who identify as Aboriginal in the CESPHN region. Sydney Inner City was the SA3 with the highest number of children identifying as Aboriginal (N=171), accounting for 14.4% of Aboriginal children in the CESPHN region followed by Cronulla-Miranda-Caringbah SA3 (N=157) and Sutherland-Menai-Heathcote SA3 (N=152).(3)

Figure 1: Number of children aged 0-4 years who identify as Aboriginal by SA3, CESPHN region, 2021

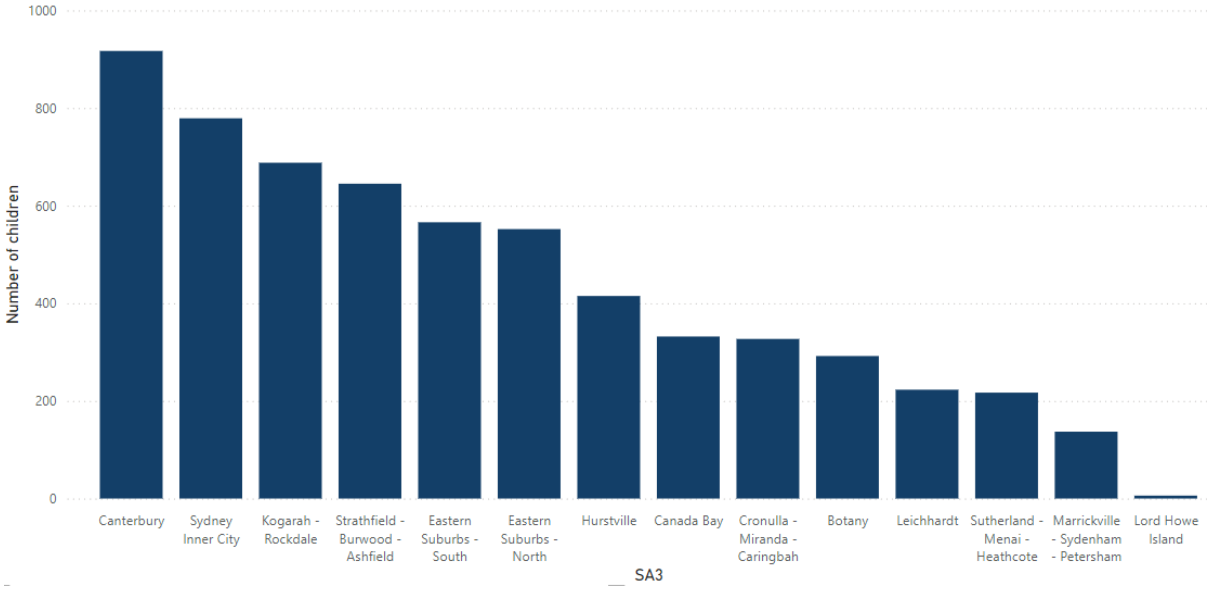


Source: ABS, 2022

Population born overseas or have parents who were born overseas

In 2021, 6,096 children residing in the CESPHN region between the ages of 0 to 4 were born overseas. Canterbury, Sydney Inner City and Kogarah-Rockdale SA3s had the highest numbers of overseas born children <5 years.(3)

Figure 2: Number of children aged 0-4 years born overseas by SA3, CESPHN region, 2021

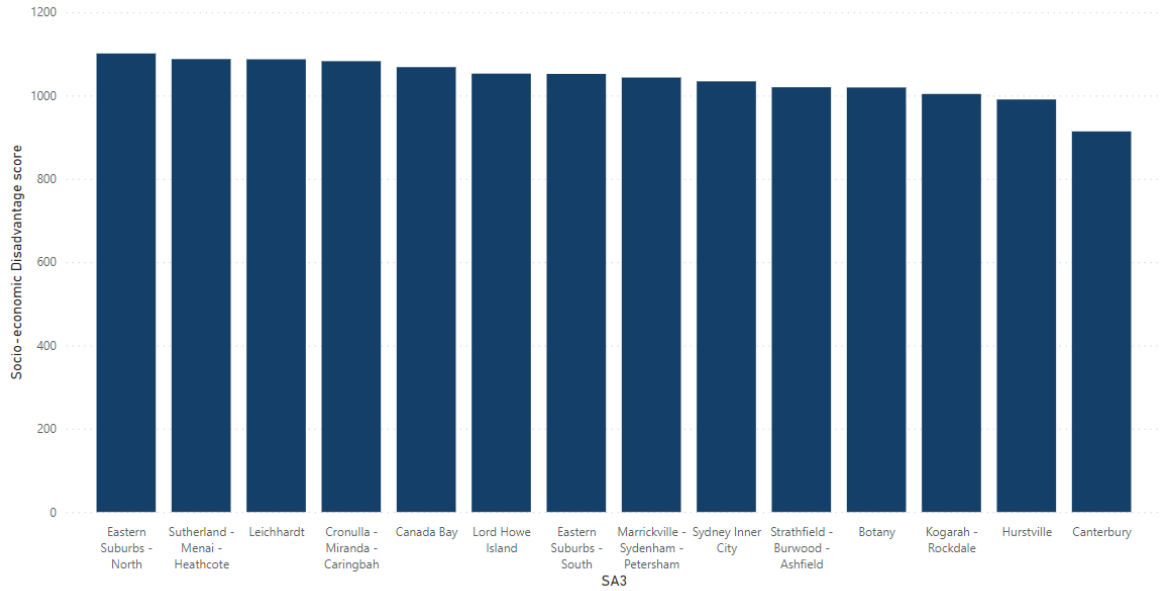


Source: ABS, 2022.

Socio-economic disadvantage

Twelve out of fourteen SA3s in the CESPHN region ranked above 1,000 on the SEIFA Index of Relative Socioeconomic Disadvantage rankings, meaning the areas have a lower proportion of relatively disadvantaged people than the Australian average. Two SA3s ranked below 1,000: Hurstville SA3 (990.6) and Canterbury SA3 (913.9) - highlighting pockets of relative disadvantage in the CESPHN region.(4)

Figure 3: Socio-economic disadvantage score by SA3, CESPHN region, 2021



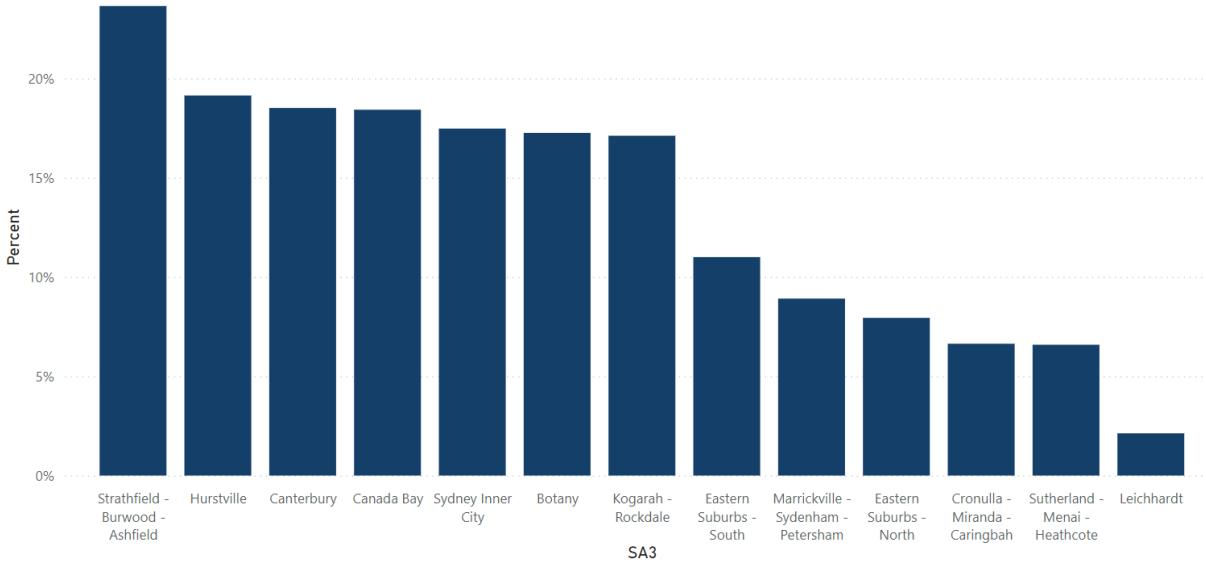
Source: ABS, 2022

English proficiency

Over thirty percent (31.6%) of children across the CESPHN region speak a language other than English at home with more than half of children (58.6%) in the Canterbury SA3 speaking a language other than English at home (58.6%). Almost half of children younger than 5 years residing in Kogarah - Rockdale SA3 (49.7%) and Hurstville SA3 (47.6%) speak a language other than English at home respectively.(3)

In 2021, 4.2% of children aged 0-4 years in the CESPHN region did not speak English well or at all. This proportion is highest in Botany SA3 (7.4%), followed by Strathfield-Burwood-Ashfield SA3 (7.4%) and Canterbury (6.9%).(3)

Figure 4: Proportion of children aged 0-4 years born in non-English speaking countries with reported low English proficiency by SA3, CESPHN region, 2021



Source: ABS, 2022

Health status

Maternal health

Antenatal care

There is strong evidence to support the efficacy of routine antenatal care on childhood outcomes particularly the first trimester.(5) Antenatal care offers opportunities for education around life-style modifications, such as smoking, the early detection of pregnancy complications and vaccination during pregnancy.

Data from the Australian Institute of Health and Welfare highlights variations in antenatal care at a national level by demographic groupings to 2023.(5) The data indicates:

- Women aged 30-34 years had the highest proprotion of antenatal care viists in the first trimester for all women giving birth (81.5% in 2023)
- Women in the least disadvantaged quintile had the highest rates of antenatal visits in the first trimester for all women giving birth (85.3% in 2023; compared to 74.9% in lowest quintile)
- Age-standardised rate for Aboriginal and Torres Strait Islander women is lower Nationally than for non-Indigenous women (70.5% compared to 78.3%)
- Women in remote and very remote areas have significantly lower rates of antenatal care in the first trimester compared to women in major cities, inner regional and outer regional areas.

Within the CESPHN region, the proportion of women receiving antenatal care within the first trimester of pregnancy is below the NSW and National rates, with 67.8% of women in CESPHN meeting this National Core Maternity Indicator compared with 80.4% in NSW and 80.0% Nationally.(5)This proportion was higher in 2019, (74.9%), dropping to two-thirds (66.5%) in 2020, and has remained relatively steady since. In contrast, the overall NSW estimate did not show variation between 2019 and 2023.

Table 4: Proportion of women receiving antenatal care during the first trimester of pregnancy, 2019 to 2023

Year	CESPHN (%)	NSW (%)	Australia (%)
2019	74.9	80.2	76.6
2020	66.5	80.7	79.1
2021	67.2	80.9	79.6
2022	66.3	80.3	78.7
2023	67.8	80.4	80.0

Source: AIHW, 2025

Differences in this core indicator are evident across the CESPHN region. High proportions of women receive their first antenatal care visit during the first trimester of pregnancy in Sutherland-Menai-Heathcote (84.6%), Cronulla-Caringbah-Miranda (83.8%), and Eastern Suburbs North (83.1%) SA3 regions. Low proportions are seen in Canterbury (40.7%), Strathfield-Burwood-Ashfield (44.6%) and Marrickville-Sydenham-Petersham (46.1%) SA3 regions.(5)

Table 5: Proportion of women receiving antenatal care during the first trimester of pregnancy, by SA3, 2021-2023

SA3	% receiving care
Botany	79.7
Canada Bay	57.3
Canterbury	40.7
Cronulla - Miranda – Caringbah	83.8
Eastern Suburbs – North	83.1
Eastern Suburbs – South	80.7
Hurstville	71.6
Kogarah – Rockdale	70.6
Leichhardt	59.1
Marrickville - Sydenham – Petersham	46.1
Strathfield - Burwood – Ashfield	44.6
Sutherland - Menai – Heathcote	84.6
Sydney Inner City	62.0

Source: AIHW, 2025

CanterburyAS3, Strathfield-Burwood-Ashfield SA3 and Marrickville-Sydenham-Petersham SA3 are all areas with high cultural diversity, with pockets of disadvantage and high growth projected. CESPHN's GP Antenatal Shared Care (ANSC) Program partners with local hospitals to co-ordinate three GP ANSC programs – RPA Women and Babies/Canterbury (RPA/Canterbury), The Royal Hospital for Women (RHW) and St George/Sutherland (STGS).

These programs aim to improve maternal and child wellbeing by supporting clinicians in the provision of integrated antenatal and postnatal care, particularly in areas and demographics of need. As at July 2023, there were 1,319 GPs registered and actively participating in a program. (6)GPs can be registered in a single local hospital or with multiple local hospitals.

Table 6: GP registrations and births in the CESPHN region by GP ANSC program, 2025

GP ANSC program	No. GPs registered	No. of births with GP ANSC as model of care (2022)	Proportion of total hospital births with GP ANSC as model of care (2022) (%)
Royal Hospital for Women	445	1,620	51.4
RPA Women and Babies and Canterbury Hospital	577	225	4.6
St George and Sutherland Hospital	318	187	2.8

Source: CESPHN database, 2024

Smoking during pregnancy

There are variations in smoking rates in the first 20 weeks of pregnancy across demographic groups nationally:

- Smoking rates decrease as maternal age increases; almost one-third (28.5%) of women younger than 20 years smoke in the first 20 weeks of pregnancy compared to 5.4% of women aged 40 and over
- Smoking rates decrease as level of disadvantage decreases; 14.4% of women in the most disadvantaged quintile smoked in the first 2 weeks of pregnancy, compared to 2.1% in the least disadvantaged quintile
- Age-standardised rate for Aboriginal and Torres Strait Islander women is higher Nationally than for non-Indigenous women (38.4% compared to 9.2%)

- Women in remote and very remote areas have significantly higher rates of smoking in the first 20 weeks of pregnancy compared to women in major cities, inner regional and outer regional areas.(5)

Within the CESPHN region, there is a significantly lower proportion of women smoking in the first 20 weeks of pregnancy (2.2%), compared to NSW (7.2%) and national rates (7.6%). Data also shows that less than 50% of women who smoked in the first 20 weeks of pregnancy continued to smoke after the first 20 weeks (45.9%), compared to 65.7% in NSW and 69.2% nationally.(5)

Table 7: Proportion of women smoking in the first 20 weeks of pregnancy, CESPHN region, 2019 to 2023

Year	CESPHN	NSW	Australia
2019	3.1	8.4	9.0
2020	2.9	8.2	8.8
2021	n.a.	n.a.	8.6
2022	n.a.	n.a.	8.3
2023	2.2	7.2	7.6

Source: AIHW, 2025

Maternal medical conditions

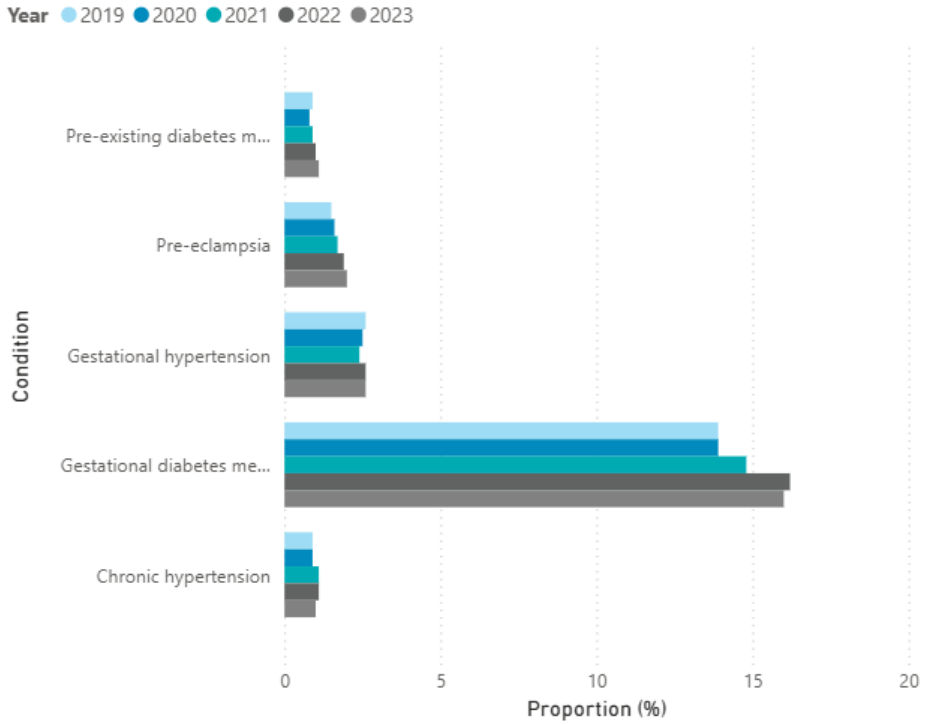
The prevalence of common maternal medical conditions is lower than that seen in other NSW PHN regions yet provides an indicator of women requiring specialist antenatal care and closer monitoring during pregnancy. Gestational diabetes was the most prevalent condition in CESPHN mothers in 2023 (13.8%), compared to 16.0% for all NSW mother's.(7)

Diabetes in pregnancy increases the risk of adverse outcomes for the mother and baby including large birth weight, stillbirth and pre-term birth. For mothers, gestational diabetes is a risk factor for cardiovascular risk in later life and does not always resolve after delivery. Rates peaked in 2022, with 14.9% of mothers in the CESPHN region reportedly having gestational diabetes, and 16.2% across NSW. (7)

With almost one in eight pregnancies affected, the burden of care on antenatal specialist services is substantial.

Rates by Aboriginal status of mothers according to PHN are not available from NSW Health. In 2022, the NSW prevalence of gestational diabetes for all Aboriginal mothers was 14.3%, compared with 16.4% for all mothers.(7) However, lower rates of testing in Aboriginal women may account for this difference and under-reporting of Aboriginal status may also obscure differences, although these explanations are speculative in the absence of informative data.

Figure 5: Proportion of women with identified maternal medical conditions, CESPHN region, 2019 - 2023



Source: HealthStats NSW, 2025

Overweight and obesity in pregnancy

Obesity is associated with an increased risk of pregnancy complications and adverse pregnancy outcomes. According to the most recent data from NSW Health, 34.2% of women residing in the SLHD catchment were obese or overweight during the first trimester of gestation, compared with 31.4% of women living in the South Eastern Sydney Local Health District boundaries.(7)

Birth and development

Healthy birth weight

Birth weight is a predictor of future health. A healthy baby is born between 2,500 and 4,499 grams. The National Agreement on Closing the Gap has set a target that by 2031 91% of Aboriginal and Torres Strait Islander babies are born within the healthy weight range.(1)

In 2022, 95.1% of non-Aboriginal babies within CESHN were born within a healthy weight range, a proportion that has been stable over time. However, only 88.2% of Aboriginal babies within the CESPHN region were born at a healthy weight. This below target proportion is lower than that recorded for Aboriginal babies in 2019 (92.3%) (1)

Population aged 0-4 years who need core activity assistance

Data from the 2021 census showed that 711 children aged 0-4 years required core activity assistance in the CESPHN region, representing 0.9% of this population group in the region. Canterbury SA3 had

the highest number of children aged 0-4 years requiring core activity assistance (N=103), followed by Sutherland - Menai - Heathcote SA3 (N=86) and Kogarah - Rockdale SA3 (N=77).(3)

Table 8: Number of children aged 0-4 years who need core activity assistance by SA3, CESPHN region, 2021

SA3	Number of children who need core activity assistance	Proportion of children requiring core activity assistance
Botany	29	0.8%
Canada Bay	41	0.9%
Canterbury	103	1.1%
Cronulla - Miranda – Caringbah	48	0.7%
Eastern Suburbs – North	50	0.8%
Eastern Suburbs – South	52	0.8%
Hurstville	70	1.1%
Kogarah – Rockdale	77	0.9%
Leichhardt	20	0.6%
Marrickville - Sydenham – Petersham	20	0.8%
Strathfield - Burwood – Ashfield	62	0.8%
Sutherland - Menai – Heathcote	86	1.3%
Sydney Inner City	53	0.7%
CESPHN	711	0.9%

Source: ABS, 2022
Note: data for Lord Howe Island was not publishable

Immunisation

At June 2025, annual immunisation rates in the CESPHN region were below the target of >95% for 1-, 2- and 5-year-olds. Rates were lower in Aboriginal children compared with rates for all children aged 1 and 2 years old and were slightly higher in Aboriginal children at 5 years of age.(8)

When compared with 2019 rates (pre-Covid), rates of fully immunised children are similar in the twelve months to June 2025, indicating a return to pre-pandemic levels. However, for Aboriginal children, current rates are below pre-pandemic levels and are markedly below pre-pandemic levels for 1-year olds (86.3% versus 95.1%) and 5-year-olds (93.2% and 97.7%). The rate of fully immunised Aboriginal children in CESPHN are lower than the NSW average for Aboriginal children.(8)

Table 9: Percentage of children fully immunised (uptake of National Immunisation Program funded vaccines), by region and age, January to December 2019 (pre-Covid) and July 2024 to June 2025

	1 year olds		2 year olds		5 years olds	
	CESPHN	NSW[a]	CESPHN	NSW[a]	CESPHN	NSW[a]
2019						
All	93.8%	94.2%	90.4%	91.3%	92.4%	94.7%
Aboriginal	95.1%	94.4%	90.4%	92.0%	97.7%	97.9%
2025						
All	92.5%	91.8%	90.5%	90.0%	92.5%	93.3%
Aboriginal	86.3%	91.3%	88.7%	89.3%	93.2%	95.1%

Source: Australian Government: Department of Health, Disability and Ageing, 2025

There were no SA3s in the CESPHN region with rates of fully immunised children across 1-year, 2-year and 5-year-old age groups at June 2025. However, there were pockets across our region with fully immunised children:

- more than 95% of 1-year olds within Leichhardt and Marrickville-Sydenham-Petersham SA3s were fully vaccinated.
- more than 95% of 2-year-olds within the Marrickville-Sydenham-Petersham SA3 were fully vaccinated
- more than 95% of 5-year-olds within the Sutherland-Menai-Heathcote SA3 were fully vaccinated

Of concern, in three SA3 regions, fewer than 90% of children were fully immunised at 2 years of age- Canterbury (86.8%), Eastern Suburbs-South (88.5%) and Kogarah-Rockdale (88.4%).(8)

In the Eastern Suburbs North SA3 and Sydney Inner City SA3, only 89.1% and 89.6% of 5-year-olds, respectively, were fully immunised. The variability in demographic characteristics across the CESPHN region suggests that the barriers may differ for different SA3 regions and public health interventions will likely need to be tailored to redress area-specific barriers.(8)

Table 10: Percentage of fully immunised children by CESPHN SA3

SA3	% Fully Vaccinated		
	1 year-olds	2 year-olds	5-year olds
Botany	91.7	90.5	91.5
Canada Bay	93.6	90.5	94.6
Canterbury	89.2	86.8	92.8
Cronulla - Miranda – Caringbah	94.0	91.4	94.0
Eastern Suburbs – North	92.8	90.0	89.1
Eastern Suburbs – South	93.3	88.5	91.2
Hurstville	90.7	91.3	93.2
Kogarah – Rockdale	90.8	88.4	92.1
Leichhardt	95.4	92.6	94.1
Marrickville - Sydenham – Petersham	97.3	96.0	94.3
Strathfield - Burwood – Ashfield	93.1	92.1	93.1
Sutherland - Menai – Heathcote	94.3	93.2	95.5
Sydney Inner City	94.9	90.5	89.6

Source: Department of Health, Disability and Ageing, 2025

Research from surveys of Australian parents demonstrate that vaccine hesitancy has increased since the COVID-19 pandemic.(9)(10) The National Vaccination Insights Project identifies barriers to childhood vaccination as reported by parents. Parents of children who do not receive vaccinations are more likely to cite concerns about safety and doubts about the scientific efficacy of vaccination than parents of fully or partially vaccinated children.

Parents of partially vaccinated children are more likely to cite practical difficulties in arranging vaccination appointments and financial barriers.(11) Local data from within the CESPHN SA3 regions may assist in identifying reasons for less vaccination uptake and better target strategies to the needs of the community.

Childhood development

The Australian Early Development Census (AEDC) is completed every three years by teachers in children's first year of school. Five domains are assessed:

1) physical health and wellbeing,
2) social competency,
3) emotional maturity,
4) communication skills and general knowledge, and
5) language and cognitive skills.

The most recent AEDC was conducted from May to July inclusive, 2024. Across the five domains, there have been changes in the proportion of children who were developmentally on track, developmentally vulnerable and/or developmentally at risk across the CESPHN region. Six of the thirteen SA3s we have data for, show that from 2018 to 2024 there has been either an increase or no change in the proportion of children who were developmentally on track for all domains (meaning their scores were in the top 75% of scores).There are also areas within the CESPHN region, where we can see a decrease in the proportion of children who were developmentally on track for five domains; the largest shifts are seen in Canada Bay SA3 (down 16.8%), Eastern Suburbs-South SA3 (down 13.4%) and Leichhardt SA3 (down 10.1%).(12)

Table 11: Proportion of children developmentally on track, by SA3, 2018 to 2024

SA3	Developmentally on track for five domains			
	2018	2021	2024	Change over time
Botany	53.1	57.3	59.8	▲12.6%
Canada Bay	68.6	60.7	57.1	▼-16.8%
Canterbury	51.9	47.6	51.6	▼-.6%
Cronulla - Miranda – Caringbah	65.2	63.8	65.2	unchanged
Eastern Suburbs – North	60.9	65.5	72.5	▲19.0%
Eastern Suburbs – South	67	55.9	58	▼-13.4%
Hurstville	55.5	57.4	54.5	▼-1.8%
Kogarah – Rockdale	53.7	56.8	54.3	▲1.1%
Leichhardt	69.1	71.4	62.1	▼-10.1%
Marrickville - Sydenham – Petersham	65.6	63.6	67.8	▲3.4%
Strathfield - Burwood – Ashfield	58.8	54.7	55.5	▼-5.6%
Sutherland - Menai – Heathcote	63	59.6	59.9	▼-4.9%
Sydney Inner City	59.5	60.7	62.6	▲5.2%

Source: AEDC, 2025

Data that highlights where children are developmentally vulnerable on one or more, or two or more domains shows pockets across the CESPHN region where higher proportions of children are classified as vulnerable in one or more of the five domains.

When looking at children who are vulnerable on one or more domains, in the CESPHN region, Canterbury SA3 had the highest proportion of children in 2024 (24.0%), followed by Kogarah-Rockdale SA3 (21.1%) and Hurstville SA3 (20.8%). However, we see that the greatest change between 2018 and 2024 was in Leichhardt SA3 (43.4% increase), followed by Canada Bay (40.4% increase) and Eastern Suburbs-South SA3 (25.0% increase) highlighting areas of potential future risk.(12)

Similar trends were seen in the children who are vulnerable on two or more domains, in the CESPHN region, Canterbury again had the highest proportion of children in 2024 (11.1%), followed by Hurstville SA3 (10.5%) and Kogarah-Rockdale SA3 (9.7%). However, again the greatest changes over time were seen in other SA3s. Leichhardt SA3 had the greatest percentage change between 2018 and 2024, of

children who are vulnerable on two or more domains (28.3% increase), followed by Eastern Suburbs-South SA3 (27.9%) and Cronulla-Miranda-Caringbah (23.6% increase).(12)

Table 12: Proportion of children vulnerable on one or more, or two or more domains, by SA3, 2018 to 2024

SA3	Vulnerable on one or more domains			Vulnerable on two or more domains		
	2018	2021	2024	2018	2021	2024
Botany	21.8	16.8	18.2	10.5	7.5	8.9
Canada Bay	13.6	14.8	19.1	6.5	7.2	6.8
Canterbury	24.5	24.7	24.0	12.3	12.3	11.1
Cronulla - Miranda – Caringbah	15.1	15.6	13.8	5.5	7.7	6.8
Eastern Suburbs – North	16.4	14.3	8.5	7.7	5.9	3.6
Eastern Suburbs – South	13.6	19.7	17.0	6.1	7.7	7.8
Hurstville	20.0	18.4	20.8	9.4	7.8	10.5
Kogarah – Rockdale	22.4	18.0	21.1	9.6	8.3	9.7
Leichhardt	9.9	12.4	14.2	4.6	6.4	5.9
Marrickville - Sydenham – Petersham	15.2	15.7	15.0	7.2	6.9	6.9
Strathfield - Burwood – Ashfield	18.0	22.4	19.6	8.5	10.2	9.2
Sutherland - Menai – Heathcote	14.0	15.0	13.8	5.7	7.7	5.3
Sydney Inner City	17.7	17.7	15.2	8.4	8.8	7.2

Source: AEDC, 2025

While historically, we see that some SA3s continue to have higher proportions of children developmentally at risk on one or more domains, we can also see trends where proportions of children developmentally on track on all domains is decreasing in some regions and conversely the proportion of children developmentally vulnerable is increasing in these same regions; current data shows that Leichhardt SA3, Eastern Suburbs-South SA3 and Canada Bay SA3 have seen the greatest changes in vulnerable children in the past 6 years.(12)

Between 2021-23, CESPHN was a primary partner in the NHMRC partnership funded grant – Strengthening Care for Children (SC4C) project. The project trialled a new general practitioner (GP) – paediatrician integration model of care designed to:

- reduce the need for paediatric referrals to hospital services
- support and improve GP confidence to manage a broad range of child health concerns, and
- strengthen primary relationships and trust with family and/or care givers to deliver high quality of paediatric care close to home.

The project also sought to develop relationships between GPs and paediatricians, with ongoing support and education opportunities provided to GPs from the SC4C project team over a 12-month period. This included:

- GP-led co-consultation with SC4C paediatricians (weekly for six months, fortnightly for the following six months)
- SC4C paediatricians led monthly case discussions, and
- SC4C paediatrician weekday phone and email support.

Key indicators against which needs were identified include participation in antenatal care, health behaviours during pregnancy (namely smoking and alcohol intake), incidence of preventable pregnancy complications (gestational diabetes), and birth outcomes (birth weight) and breastfeeding.
Issues raised during the external consultations conducted by CESPHN with clinical and community leaders included:

- Treatment delays for children newly diagnosed with a disability
- Growing concerns about identifying and managing children with speech delays due to missed preventive health care assessments
- The impact of maternal mental health on child development.

CESPHN's current work

CESPHN is actively engaged in improving the health and wellbeing of children and have commissioned a range of services and supported integration activities that include:

- GP Antenatal Shared Care
- Diabetes Education in Pregnancy program
- Early intervention speech pathology for Aboriginal children and other priority populations.
- Schools based care coordination program in four local public primary schools.
- CESPHN's work in immunisation assists general practices to identify children 0-5 years overdue for scheduled vaccination and provide ongoing vaccination support to GPs
- Supporting Outreach program, where a Nurse Practitioner provides place-based care to women and children living in domestic and family violence refuges. This includes holistic preventative care and health service provision to children to meet their developmental milestones and optimise their health.

Opportunities

- Promote the importance of the early years of life and antenatal care to primary care providers and the community
- Increase childhood immunisation rates through continued support to primary care providers in identifying and following up children overdue for scheduled vaccinations, as well as education and awareness to support conversations with vaccine hesitant families.
- Support primary care providers to complete a range of screenings and checks to improve health outcomes during the perinatal period and early years, including for postnatal care; childhood development; mental health; domestic, family, and sexual violence; and alcohol and other drugs use.
- Support primary care providers to complete appropriate follow up of concerns identified during screenings and checks, including knowledge of services and supports, clear referral pathways and education. Increase resources for school-aged children who have missed the early-childhood screening and developmental checks.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Health and Wellbeing of People with Disability

2025-2027 Needs Assessment
2025 Annual Review

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Overview

Summary

People with disability experience high unmet health needs and poor health outcomes. Just over 18% (over 180,000) of people live with a disability within the central and eastern Sydney region. Providing appropriate and relevant primary care to people living with a disability is a key focus for CESPHN.

This chapter identifies the specific health requirements, barriers to accessing services, and the support systems necessary for enhancing the quality of life for people with disabilities and their care supports.

Key services issues/gaps

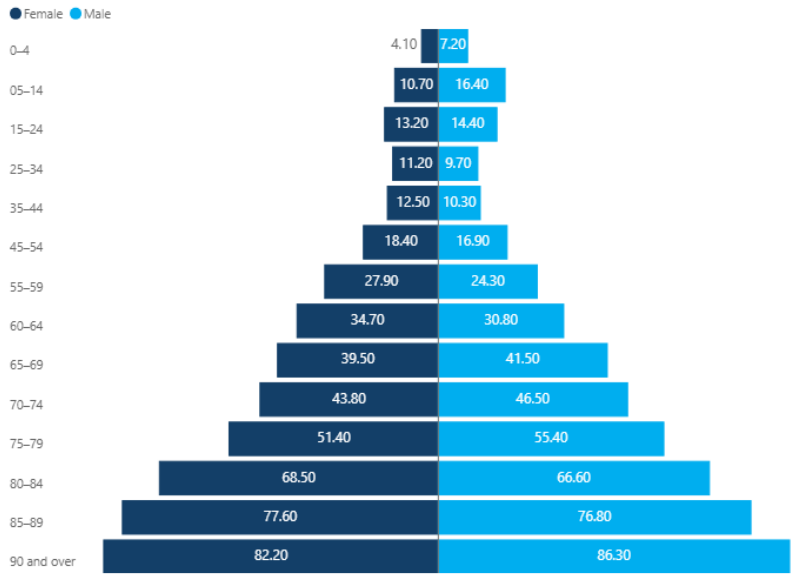
- Access to well-coordinated care between primary, secondary and tertiary for people with disability
- Lower participation in preventive health and screening services by people with disability
- Limitations in Medicare funding models to adequately remunerate GPs for the time required to provide complex medical and psychosocial care, including long consults, home visits to group homes, and care plan preparation.
- Variable capability and confidence among primary care providers and a lack of tools and resources to support patients with a disability.
- People with disability who intersect with other priority groups often experience compounded barriers to accessing care, including lower health literacy and economic disadvantage.
- Gaps in the intersection between aged care and disability, including limited palliative care options in group homes and loss of NDIS supports for those entering residential aged care after age 65.
- Limited targeted mental health support for adolescents with a disability, including those experiencing suicidal distress.
- Lack of service navigation support tailored to the needs of people with intellectual disability
- Limited access to appropriately supported dental care for people with disability.
- Lack of community-based child behavioural management programs for people with ADHD, and autism and other developmental conditions
- Inadequate support for carers in managing their own health needs and wellbeing.
- Need for sustained investment in ongoing patient-centred, multidisciplinary and integrated models of care
- Limited mental health services available for people with intellectual disability with poor mental health
- Limited access to NDIS and psychosocial services for people suffering from severe mental health illnesses
- Disruption to care and support for people with a disability exiting the custodial system.

Population

Prevalence

In 2022, approximately 5.5 million Australians had a disability, giving an age-standardised rate of 19.2%. The prevalence of disability increases with age with 7.6% of children aged 0–14 having a disability while 50% of people aged 65 and over have a disability. About 1 in 4 (23%) reported a mental or behavioural disorder as their main condition (the condition causing them the greatest impact) and 3 in 4 (77%) reported a physical disorder as their main condition while 1 in 3 (32%) had severe or profound disability. (1)

Figure 1: Proportion of the Australian population with disability by age and gender, 2022



Source: ABS, 2024

Disability free life expectancy

Since 2003, females and males in Australia have both seen an increase in expected years of life without disability, with females now expected to have 66.2 years of life without disability and males expected to have 63.7 years. Conversely, the number of expected years of life with disability has reduced for both genders, with females expected to have 18.7 years (down from 20.7 years), and males expected to have 17 years (down from 18.6 years). (1)

These trends are also seen when looking at expected years of life without severe or profound disability. However, this is slightly different for males when looking at expected years of life with severe or profound disability where the years have remained relatively constant between 2003 and 2018 (5.4 years to 5.5 years).(1)

Table 1: Expected years of life at birth, by disability status, females in Australia, 2003 to 2018

Disability status	Expected years of life (females)				
	2003	2009	2012	2015	2018
With disability	20.7	19.6	19.8	19.3	18.7
Without disability	62.2	64.3	64.5	65.2	66.2
With severe or profound disability	8.3	7.5	7.8	7.5	7.2
Without severe or profound disability	74.6	76.4	76.5	77.1	77.7
Total life expectancy at birth	**82.8**	**83.9**	**84.3**	**84.5**	**84.9**

Source: AIHW, 2024

Table 2: Expected years of life at birth, by disability status, males in Australia, 2003 to 2018

Disability status	Expected years of life (males)				
	2003	2009	2012	2015	2018
With disability	18.6	17.7	17.5	17.3	17.0
Without disability	59.1	61.6	62.4	63.0	63.7
With severe or profound disability	5.4	5.5	5.6	5.4	5.5
Without severe or profound disability	72.3	73.9	74.2	75.0	75.2
Total life expectancy at birth	**77.8**	**79.3**	**79.9**	**80.4**	**80.7**

Source: AIHW, 2024

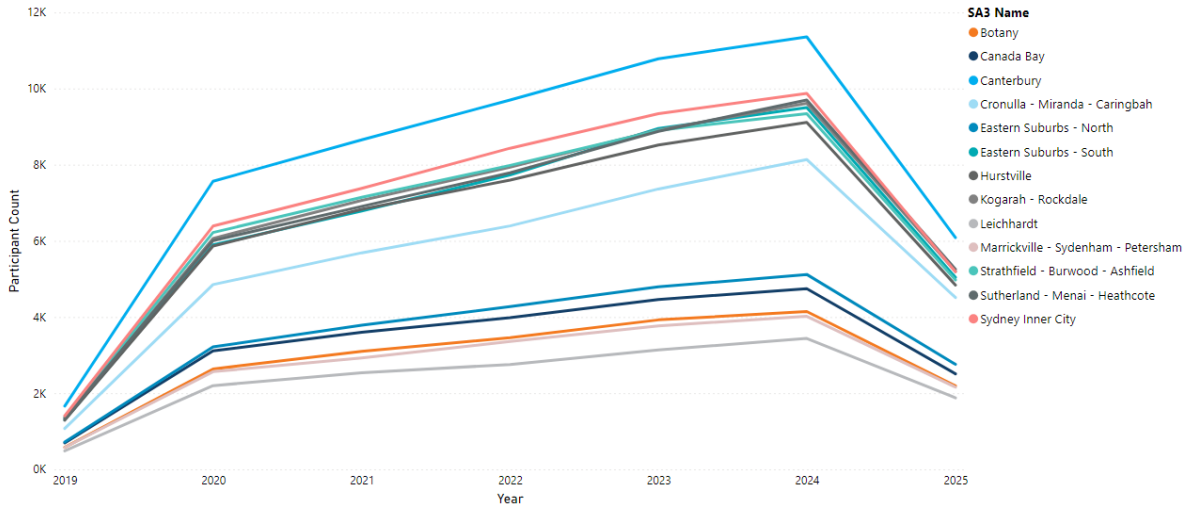
National Disability Insurance Scheme (NDIS) participants

At June 2025, there were 739,413 active participants in the NDIS across Australia, almost one third of these participants are within NSW (n=217,911) and approximately 3% (n=23,176) reside in central and eastern Sydney; with 14,832 within South Eastern Sydney service district and 8,344 within Sydney service district.(2) NDIA projections data shows that across the South Eastern Sydney and Sydney service districts, there is a projected 141% increase in NDIS participant numbers between June 2025 and June 2034.(3)

The highest NDIS participant count across CESPHN SA3s is within the Canterbury SA3 (n=6,086), followed by Sutherland-Menai-Heathcote SA3 (n=5,254) and Kogarah-Rockdale SA3 (n=5,195); these SA3s have had some of the highest participant numbers for the CESPHN region each year since 2019.

The visual below illustrates a significant decline in NDIS participant numbers across all SA3s in the CESPHN region; this aligns to commentary regarding access difficulties to NDIS especially for people with psychosocial disability.(4)

Figure 2: Active participant count by SA3, CESPHN region, 2019 to 2025



Source: NDIS, 2025

Of all active participants in the CESPHN region in 2024-25, the highest proportion of participants are within the 0-14 aged groups (n=8,946); this accounts for 38.6% of all NDIS active participants in the CESPHN region. More than one quarter of active NDIS participants in the CESPHN region are 0–14-year-olds living within the South Eastern Sydney service district (26.7%). Of all active participants in the central and eastern Sydney region at 30 June 2025, the primary disabilities included autism (n=8,279), psychosocial disability (n=3,135) and intellectual disability (n=2,691), jointly accounting for 60.9% of active participants.

At 30 June 2025, there were a total of 60,529 NDIS active participants across Australia who identified as having an Indigenous background, representing 8.2% of active participants nationally. Less than one in ten (9.4%) of NSW active participants identified as having an Indigenous background, and 4.4% of active participants in the CESPHN region identified as having an Indigenous background.(2)

Table 3: Number of active NDIS participants by service district and Indigenous status, CESPHN region, 2025

Service district	Indigenous	Non-Indigenous	Not stated
South Eastern Sydney	572	11,926	2,334
Sydney	446	6,552	1,326
CESPHN total	*1,018*	*18,478*	*3,660*
NSW	20,539	158,647	38,725
Australia	60,529	577,989	100,895

Source: NDIS, 2025

At 30 June 2025, there were a total of 64,697 NDIS participants that identified as having a culturally and linguistically diverse (CALD) background across Australia, representing 8.7% of active participants nationally. One in ten (10.6%) of NSW active participants identified as having a CALD background, and 15.8% of active participants in the CESPHN region identified as having a CALD background(2)

Table 4: Number of active NDIS participants by service district and CALD status, CESPHN region, 2025

Service district	CALD	Non-CALD	CALD status not stated
South Eastern Sydney	2,170	12,217	445
Sydney	1,481	6,637	226
CESPHN total	*3,651*	*18,854*	*671*
NSW	23,189	187,179	7,543
Australia	64,697	643,066	31,650

Source: NDIS, 2025

Demographic data shows that within our service districts we have higher proportions of culturally and linguistically diverse (CALD) participants compared to the national and State proportions, however a lower proportion of participants who identify as Aboriginal and/or Torres Strait Islander.(3)

Supported independent living participants

Supported Independent Living (SIL) is a type of support funded by the National Disability Insurance Scheme (NDIS) in Australia. SIL is designed for individuals with higher support needs who require significant assistance throughout the day, including overnight support. This support can include help with personal care, cooking, cleaning, and other daily activities. SIL funding is typically used for:

- Personal care: Assistance with bathing, dressing, and grooming;
- Household tasks: Help with cooking, cleaning, and laundry;
- Skill development: Support to build independence in daily activities.

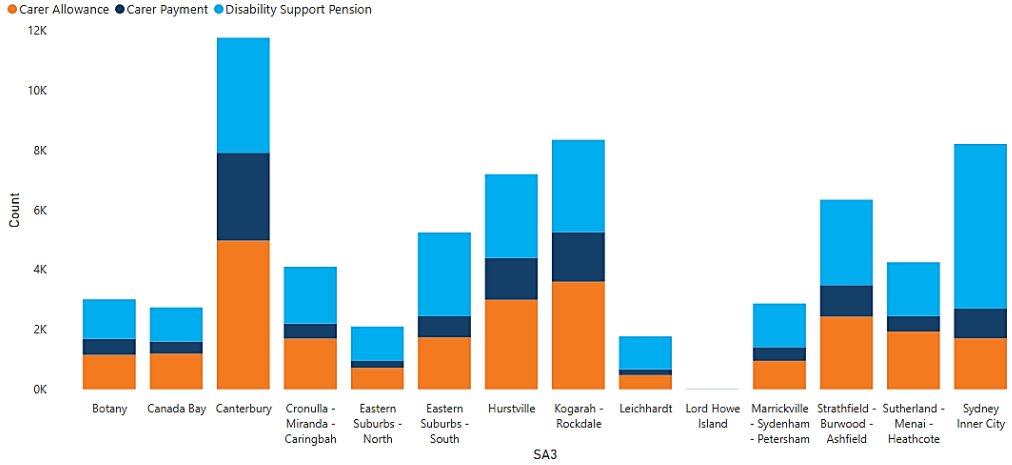
As of June 2025, there were a total of 1,275 participants living in SIL facilities across the CESPHN region, growing by a rate of 6.3% annually from 2019 (5). The largest change has been seen in the South Eastern Sydney service district, which has had a 66.3% increase in SIL participant numbers from 2019 to 2025 (507 and 843 respectively); Sydney service district has seen a 14.0% increase in participant numbers in this same period (379 and 432 respectively).(2)

Support pensions and allowances

At June 2025, there were approximately 30,805 individuals within the CESPHN region receiving a disability support pension, 25,550 individuals receiving a carer allowance and 11,615 individuals receiving a carer payment.(5) Across the CESPHN region, Sydney Inner City SA3 had the highest number of recipients of disability support pensions (5,510), followed by Canterbury SA3 (3,850) and Kogarah-Rockdale SA3 (3,090). (5)

Canterbury SA3 had the highest number of recipients of carer payments and carer allowance (2,940 and 4,975 respectively), followed by Kogarah-Rockdale SA3 (1,660 and 3,600 respectively).(5)

Figure 3: Count of DSS recipients by payment type, by SA3, 2025



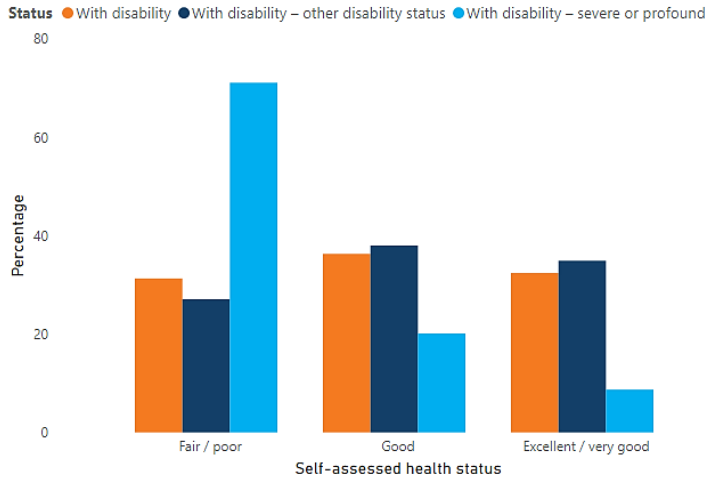
Source: DSS, 2025

Health status and risk factors

Self-reported health status

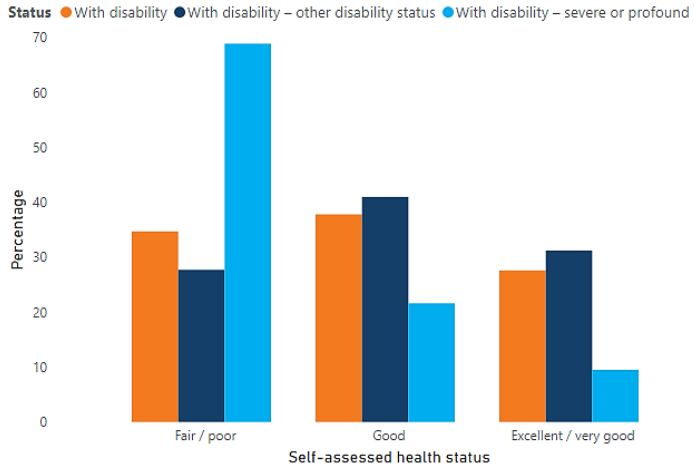
Those with severe or profound disability report poorer health status than all people with disability and those with other disability status. This is true for both 18-64 year old age group and 65 years+ age group.(1)

Figure 4: Self assessed health status by disability status, 18-64 year olds, nationally, 2022



Source: ABS, 2024

Figure 5: Self-assessed health status by disability status, 65 years and over, nationally, 2022



Source: ABS, 2024

Persons aged 18-64 years with severe or profound disability have higher levels of psychological distress (K10 scores) compared to persons aged 65 years and over with severe or profound disability.(1)

Table 5: Psychological distress by age and disability severity group, Australia, 2022

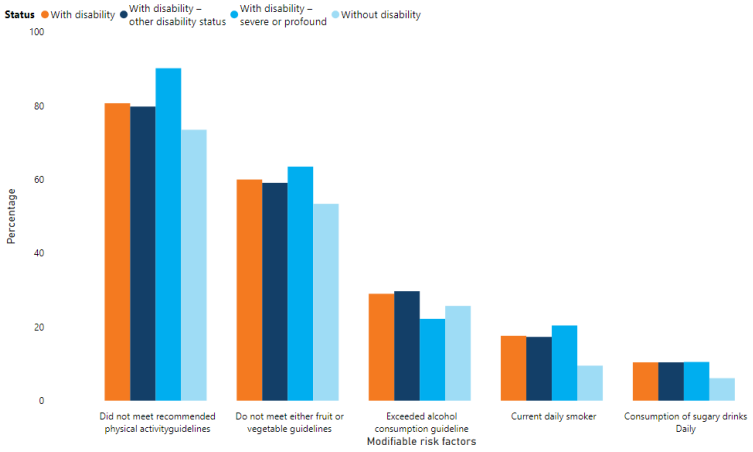
	18-64 years			65 years +		
Psychological distress level	All disability	With disability – other disability status	With disability – severe or profound	All disability	With disability – other disability status	With disability – severe or profound
Low distress level	34.9	*36.6*	**18.4*	57.4	*62.7*	*29.2*
Moderate distress level	24.0	*24.6*	*20.9*	23.9	*23.6*	*27.9*
High distress level	23.1	*22.5*	*28.6*	12.9	*9.7*	*31.6*
Very high distress level	17.8	*16.1*	*37.1*	5.8	*4.0*	*14.5*

Source: AIHW, 2024

Modifiable risk factors

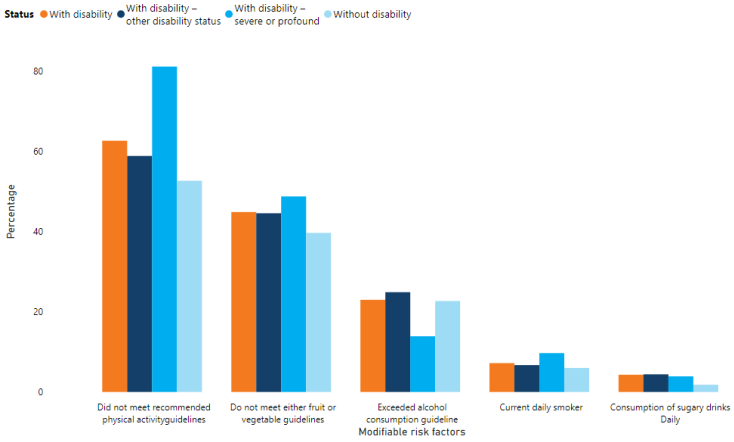
Individuals with a disability have higher rates of modifiable risk factors across all age groups and genders compared to people without disability, with the exception of exceeding alcohol consumption guidelines.(1)

Figure 6: Modifiable risk factors 18-64 years by disability status, Australia, 2022



Source: AIHW, 2024

Figure 7: Modifiable risk factors 65 years and over by disability status, Australia, 2022



Source: AIHW, 2024

Access

Assistance with activities

Nationally, an estimated 3.2 million people living with disability needed assistance with core activities.(6)

Approximately 669,000 people aged 0-64 years with a reported disability, required assistance with health care, 524,000 people received assistance, and 169,000 people did not have their health care assistance needs fully met. Approximately 898,000 people aged 65 years and over with a reported disability, required assistance with health care, 771,000 people received assistance, and 181,000 people did not have their health care assistance needs fully met. .(6)

Table 6: Estimated assistance needs for individuals with profound core activity limitation, nationally, by age group, 2022

Core activities	Aged 0–64 years			Aged 65+ years		
	Needed (%)	Received (%)	Not fully met (%)	Needed (%)	Received (%)	Not fully met (%)
Self-care	59.0	44.0	17.6	63.4	49.6	18.5
Mobility	81.3	70.0	33.6	85.0	76.5	30.3
Communication	61.9	48.6	25.7	39.6	30.4	7.9
Cognitive or emotional tasks	71.9	65.5	34.2	34.1	31.0	10.1
Health care	58.9	46.0	16.0	82.3	73.5	21.3
Reading or writing tasks	26.4	22.6	8.0	36.2	33.4	4.4
Transport	41.5	36.0	12.4	73.1	66.9	17.4
Household chores	38.3	33.3	18.9	74.2	67.5	30.5
Property maintenance	36.2	28.4	16.3	72.9	66.6	29.8
Meal preparation	30.7	26.8	10.2	46.3	43.1	10.6

Source: ABS, 2024

Care providers for core activity limitations

Approximately 2.8 million people with disability received assistance for core activities; equating to approximately 89.7% of those needing assistance. .(6)
People with disability receiving assistance with core activities receive care though both informal and formal care providers. Informal providers in this data include relatives including spouse/partner, parent, child, sibling, grandchildren and other relatives not elsewhere specified.

Nationally, three- quarters of all people with a reported disability needing assistance are receiving assistance from informal providers (75.7%), an estimated 57% are receiving assistance from formal providers. Informal assistance/care is being provided predominantly for tasks such as reading or writing, meal preparation, transport and mobility; whereas formal care/assistance is more common for health care and cognitive or emotional tasks.

Spouse/parters are providing approximately one-third of informal care for all needing assistance, with child providing care to parent accounting for approximately one-quarter and a further one in five being a parent providing informal care/assistance to a child.

Table 7: Proportion of people with disability recieving informal and/or formal assistance for core activitiy limitations, nationally, 2022

Core activities	Informal care for all with reported disability (%)	Formal care for all with reported disability (%)
Self-care	63.4	17.5
Mobility	76.5	25.9
Communication	67.3	28.7
Cognitive or emotional tasks	72.3	51.7
Health care	43.9	55.9
Reading or writing tasks	80.5	13.2
Transport	78.2	21.9
Household chores	66.8	36.9
Property maintenance	63.3	32.6
Meal preparation	78.8	18.4
All needing assistance	75.7	57.0

Source: ABS, 2024

Access to health services

Through CESPHN's internal and external consultations, accessibility to primary and acute care systems was identified as a crucial need in the care of people with a disability.

Data from the national Disability, Ageing and Carers survey in 2018 highlighted some access issues faced by people living with a disability who are living in households:

- 6% aged 64 years and under with a severe or profound disability delayed seeing or did not see a GP due to cost with 5% not seeing a medical specialist because of cost
- 11% aged 64 years and under with a severe or profound disability who attended a hospital emergency department thought the care could have been provided by a GP
- 5.7% aged 64 years and under with a severe or profound disability attended a hospital emergency department because their GP does not have required equipment/facilities
- 26.4% aged 64 years and under, with a severe or profound disability, who saw 3 or more health professionals for the same condition felt the health professional did not help coordinate care
- 26.8% aged 15-64 years with a severe or profound disability waited longer than they felt acceptable to see a GP, with 38.3% waiting longer than they felt acceptable to see a medical professional with 21.5% delaying or not seeing a dental professional because of cost
- 12.8% aged 5 to 64 years with a severe or profound disability had difficulty accessing medical facilities (including GP, dentist, hospital) (7)

Younger people aged under 65 with a disability in aged care facilities

At 30 June 2024, 88 individuals aged under 65 years were in residential aged care in the CESPHN region; 82 were permanent residents and six (6) were in respite care.(8) Seven of the 82 residents (8.0%) identified as Aboriginal, all of whom were aged 50 years and older; five were in permanent care and two were in respite care.(8) While we have seen the total number of individuals aged 0-64 years living in residential care in the CESPHN region halve between 2022 and 2024, there are still a number of people under 65 needing permanent residential care.

MBS utilisation

Of NDIS participants 95.6% used at least one MBS service in 2019-20, compared to 87.1% of the total population. NDIS participants whose primary disability was multiple sclerosis had the highest proportion of MBS use (99.6%), followed by participants whose primary disability was stroke (98.7%) (7) (7).

NDIS participants had an average of 21 MBS subsidised visits in 2019-20, compared to 18.4 MBS subsidised visits for the total population. NDIS participants whose primary disability was psychosocial had, on average, 40.5 MBS subsidised services in 2019-20, followed by participants whose primary disability was multiple sclerosis with 38.1 visits (7) (7).

National Disability Insurance Scheme Providers

Within the CESPHN region, there were a total of 22,373 NDIS providers active at 30 June 2025. Fifty seven percent (57.2%) of providers were located within the South Eastern Sydney service district, proportional to the total number of active participants in the area.(2) Provider growth reflects numbers of providers receiving higher payments over the period whereas provider shrinkage reflects those receiving payments that are 25% or less than the previous period.

Table 8: Number of active NDIS providers, provider growth and provides shrinkage by service district, CESPHN, 2024

Service district	Active providers	Provider growth (%)	Provider shrinkage (%)
South Eastern Sydney	12,796	3	61
Sydney	9,577	4	61
CESPHN total			
NSW	93,225	3	62
Australia	311,744	3	63

Source: NDIS, 2025

CESPHN's current work

The provision of primary care that is relevant and responsive to people with a disability is a key focus area of CESPHN. Our current work includes implementing Project GROW. CESPHN launched Project GROW in 2021 as part of the Primary Care Enhancement Program (PCEP) to address barriers to equitable health care faced by people with intellectual disability. The PCEP is an initiative under the National Roadmap for Improving the Health of People with Intellectual Disability.

The activities in Project GROW aim to:

- increase the capacity of primary care providers to deliver accessible and inclusive, quality healthcare to patients with intellectual disability
- increase health literacy and participation of the community and disability support sectors in preventative health measures and primary care initiatives for people with intellectual disability
- establish mechanisms to improve primary care data, and data collection to advance service planning and delivery for people with intellectual disability.

The Connect and Thrive program led by Flourish Australia supports people with severe mental illness and reduced psychosocial functional capacity who are not receiving support through the NDIS with one-on-one psychosocial support and group support programs.

Opportunities

- Continued investment in programs to improve health literacy and service knowledge for people with disability and their supports.
- Continued development of patient-centred, multidisciplinary and integrated models of care
- Workforce development and training to increase primary care capability in disability-inclusive healthcare.
- Development of targeted strategies to address health inequity
- Strategies to address needs of people with disability who experience additional vulnerabilities, including those who are older, members of multicultural communities, impacted by alcohol and other drugs or exiting the Justice system.
- Increase the availability and capacity of mental health service providers for people with intellectual disability with poor mental health
- Lead an annual disability roundtable: to bring together key stakeholders in health and primary care and the broader disability sector to showcase progress and highlight areas to prioritise for further intervention
- Advocate for disability needs during development of the Single Digital Patient Record
- Leverage opportunities arising from NDIS reforms, including Thriving Kids, to strengthen partnerships, develop local initiatives, establish referral pathways, and build capacity of primary care providers.
- Strengthen disability-inclusive dental care through collaboration with general dental practices to improve accessibility, communication and coordinated care for people with intellectual disability.
- Develop shared model of care between local specialist services and general practice for people with intellectual disability, autism and ADHD.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Health and Wellbeing of People Affected by Domestic, Family and Sexual Violence

2025-2027 Needs Assessment
2025 Annual Review

Contents

List of Tables

Content warning: The following chapter contains information that may be distressing. Please consider your wellbeing and reach out to services and supports as required.

Domestic and family violence is a complex, multifaceted issue; while our aim is to provide a thorough assessment of domestic and family violence in central and eastern Sydney, it should be noted that not all aspects of this area are addressed by this needs assessment.

Health and wellbeing of people affected by domestic, family and sexual violence

Overview

Domestic, Family and Sexual Violence (DFSV) has increased over the 12-month period to 30 June 2025 across NSW. Furthermore, in the CESPHN region, approximately 6,000 domestic violence related assault incidents were recorded between July 2024 and June 2025, with the Canterbury-Bankstown LGA recording the highest number of incidents.

People with disabilities, older people, Aboriginal and Torres Strait Islander peoples, and LGBTIQA+ people experience increased risk, severity and frequency of DFSV and other types of abuse as well as challenges in accessing support due to the context of oppression and discrimination in which they live.

Key issues/needs

- Need for continuous DFSV education and support for primary care
- Service design and delivery needs to prioritise children and young people

Key gaps

- Fragmented support for the intersecting issues of Sexual Violence and Child Sexual Abuse.
- Support for children impacted by DFSV
- Wider range of service options that reduce DFSV
- Lack of dedicated prevention and early intervention activities to stop DFSV before it occurs

Prevalence

New South Wales Health defines DFSV as:

> ***"any behaviour by a person directed against another person with whom they have a domestic relationship that is:***
>
> - ***violent or threatening behaviour***
> - ***behaviour that coerces or controls the other person***
> - ***behaviour that causes the other person to fear for their safety or wellbeing, or the safety and wellbeing of others"(1)***

Domestic relationships can include intimate partner relationships, family relationships or kinship relationships. DFSV includes but is not limited to physical abuse, sexual abuse, financial abuse, emotional abuse, spiritual abuse, medical neglect, technology-facilitated abuse and stalking.(1, 2)

Intimate partner violence is a leading contributor to the burden of disease among females aged 15–54 , consistently ranking within the top five risk factors across these age groups.(1) DFSV can also lead to mental health issues, substance abuse, homelessness and impact a person's employment and participation in society. Legislation criminalising coercive control came into effect in NSW in July 2024, serving to recognise the impact of non-physical and sexual forms of DFSV.

Data from the first year of collection shows that the five most reported types of controlling behaviours across NSW are:

- harassment, monitoring or tracking
- threats or intimidation
- financial abuse
- shaming, degrading or humiliating, and
- social isolation and cultural abuse.(2)

Across NSW in 2024-25, there were 38,169 domestic violence related assaults recorded by NSW police, a rate of 457.5 per 100,000 population, the highest number and rate in the past 10 years. Thirty-three domestic violence related murders were recorded by NSW police in 2024-25; 14 were adult females, 11 were children and 8 were adult males.(2)

These figures illustrate a gradual increase since 2021-22 where there were 24 domestic violence related murders recorded by NSW police. There has been a decrease in the number of adult males killed as a result of domestic violence related murder (50% reduction), while there has been a 40% increase in women killed because of domestic violence related murder and a 50% increase in children killed as a result of domestic violence related murder across NSW since 2021-22.(2)

Women and children experience DFSV more than men:

- An estimated 1.1 million women in New South Wales (37%) have experienced violence (physical or sexual) since the age of 15, including:
  - 21% (640,200) who experienced sexual violence
  - 29% (911,800) who experienced physical violence
- Sexual assault rates experienced by women have also increased across Australia, with the largest increase in NSW (up 2,296 victims or 19%) in 2023.
- An estimated 524,200 women in New South Wales (17%) have experienced abuse (physical and/or sexual) by an adult before the age of 15, including:
- 11% (343,300) who experienced sexual abuse
- 9.1% (285,500) who experienced physical abuse
- Child abuse and neglect experienced during childhood is the leading risk factor contributing to the burden of disease for 15-44 year old women.(3)

An estimated 486,700 women in New South Wales (16%) witnessed violence towards a parent by a partner before the age of 15(4)

In the central and eastern Sydney region, approximately 6,000 domestic violence related assault incidents were recorded between July 2024 – June 2025. Canterbury-Bankstown LGA ranked highest in the CESPHN region with 1,688 recorded incidents (444.4 per 100,000 population) and ranked 67 out of 130 LGAs in NSW. Sutherland Shire LGA has seen a 21.5% increase per year over the past two years and is ranked 98 out of 130 LGAs. Conversely, the Randwick LGA saw a two-year decrease of 12.1%, while other LGAs remained stable over this period.(5)

Table 1: Number, rate and ranking of recorded domestic violence related assault incidents by Local Government Area, 2024-25

LGA	No. of incidents	Rate per 100,000 population	CESPHN Rank	NSW Rank	Two-Year Trend (%)
Bayside	602	329.0	3	89	Stable
Burwood	135	317.7	4	90	Stable
Canada Bay	152	166.3	11	109	Stable
Canterbury-Bankstown*	1,688	444.4	1	67	Stable
Georges River	472	298.6	5	92	Stable
Inner West	525	278.8	7	100	Stable
Randwick	333	234.8	9	102	⬇ 12.1%
Strathfield	167	349.2	2	82	Stable
Sutherland Shire	672	285.9	6	98	⬆ 21.5%
Sydney	1,202	520.2	12	nc	Stable
Waverley	196	274.5	8	101	Stable
Woollahra	111	203.1	10	105	Stable
NSW	38,169	457.5	n/a	n/a	Stable

Source: BOCSAR, 2025
**Note: CESPHN region only covers a proportion of the Canterbury-Bankstown LGA*

Sexual Violence

Nationally, 22% of women (2.2 million) and 6.1% of men (582,400) have experienced sexual violence since the age of 15(4) and in 2023, there were 36,318 recorded victims of sexual assault, an 11% increase from the previous year, with 84% of victims being female and 41% aged 10–17 years.(4) Sexual assault reports increased 42.1% (up 9.2% per year on average), rising in 10 of the 13 NSW regional locations and 14 of the 15 Greater Sydney locations(5), indicating a growing need for trauma-informed services. RPA Hospital, located in Camperdown, provides a 24/7 crisis response including forensic medical care and counselling for sexual assault survivors aged 14 and over, serving as a critical hub for the region.

Child Sexual Abuse

Child sexual abuse prevalence remains alarmingly high, with the Australian Child Maltreatment Study reporting that 28.5% of Australians experienced sexual abuse during childhood, including 37.3% of girls and 18.8% of boys.(6). Child abuse and neglect experienced during childhood is the leading risk factor contributing to the burden of disease for women aged 15–44 year.(3) The CESPHN region is home to the Sydney Children's Hospitals Network (SCHN), which operates Child Protection Units at Randwick and Westmead. These tertiary services provide 24-hour crisis counselling, forensic medical assessments, psychosocial support, and ongoing therapeutic care for children and families following allegations of sexual abuse.

Factors driving DFSV

Our Watch, the peak Australian body on the prevention of gender-based violence, identifies the following gendered drivers:

- Condoning of violence against women
- Men's control of decision-making and limits to women's independence in public and private life
- Rigid gender stereotyping and dominant forms of masculinity
- Male peer relations and cultures of masculinity that emphasise aggression, dominance and control (5).

There are also reinforcing factors including:

- Condoning of violence in general
- Experience of, and exposure to, violence
- Factors that weaken prosocial behaviour such as financial stress
- Resistance and backlash to prevention and gender equality efforts

Intersections of forms of violence

Sexual Violence and Child Sexual Abuse often intersect with Domestic and Family Violence; however, support continues to be fragmented. An integrated approach to addressing sexual forms of violence is necessary to provide the best possible holistic support for impacted families.

Emerging research highlights that an under-reported form of assault that has enormous medical impacts is non-fatal strangulation. In addition to immediate and ongoing risks such as injury to the larynx and anoxic brain injury, women who have been strangled by their partner are 7.5 times more likely to be killed by the same partner.

Anecdotally, DFSV Assist has seen an increase in disclosures to primary care providers in the region with patients having experienced non-fatal strangulation and sexual choking.

Intersectionality with other priorities

- People with disabilities, older people, Aboriginal and Torres Strait Islander people and LGBTIQA+ people experience increased risk, severity and frequency of DFSV and other types of abuse as well as challenges to accessing support due to the context of oppression and discrimination in which they live. Women and children on precarious visas are particularly vulnerable with many services not offering support to this cohort, increasing their risk of homelessness.
- DFSV is the leading cause of homelessness for women and girls. In Australia, in 2022-23, 38% of all clients in specialist homelessness services identified family and domestic violence as the cause of their homelessness.
- The reduction of general practices in the region offering bulk billing as well as waiting times are affecting access to primary healthcare.

- Subject matter expert consultations discussed how a key issue is women and children that do not have timely access to housing support services in the CESPHN region.
- Lack of prevention activities that support healthier relationships and positive behaviours for men

The role of primary healthcare

Intimate partner violence is a leading contributor to the burden of disease among females aged 15–54, consistently ranking within the top five risk factors across these age groups.

In Australia, it is estimated that a full-time GP will unknowingly see five women a week who have experienced DFSV. GPs are second only to friends and family members, in relation to receiving disclosures of current partner violence (Safer Families evidence brief #2: Identifying and responding to domestic abuse and family violence: Implications for the health sector).

Accordingly, there has been a policy-level shift towards enhancing primary care's role in prevention and early intervention in DFSV. The NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026 recognises that primary care is often the first port of call for people in the community and, therefore, has a role in recognising DFSV and ensuring appropriate action and care is provided to people experiencing it.

The Strategy calls for a more coordinated approach between primary care and domestic violence support services, increased training and support provided to primary care services to respond better to DFSV, and provide trauma informed and culturally safe care to victims.

Gaps and needs

Need for continuous DFSV education and support for primary care

GPs and other primary and community care professionals have an important role to play in addressing DFSV in the Central and Eastern Sydney region as they are often the first point of contact for people experiencing domestic violence due to physical injuries and mental health issues resulting from the violence.

In early 2021, Central and Eastern Sydney PHN facilitated 15 key informant interviews and distributed a survey to GPs, allied health professionals, practice nurses and practice managers to gather information about their professional experiences related to domestic and family violence. The largest barrier to supporting patients experiencing DFSV was a lack of knowledge, followed by the presence of a partner or child and lack of time. Feedback from GPs also reported that their behaviour is often driven by:

- a reluctance to interfere
- wanting to avoid victim-blaming attitudes
- fear of offending patients
- not knowing what to do
- having inadequate training
- experiencing a lack of time
- a lack of referral options or limited knowledge of referral options
- victims are accompanied by a child or partner
- language and cultural barriers.

In an ongoing Sax Institute baseline survey offered to primary care providers in CESPHN prior to attending DFSV training, of 113 respondents, 47.5% of respondents mentioned they have not received any training in relation to recognising and responding to DFSV. However, on a scale of 0 to 10, respondents scored an average of 8.5 when asked whether they agree the primary care sector has a role to play in identifying and supporting patients experiencing DFSV.

To support primary care with the capability to intervene early and mitigate risk, training and education to health professionals on the following needs to be provided:

- Creating a safe environment for disclosure
- How to recognise the signs of DFSV
- How to start the conversation
- How to respond to disclosures appropriately
- An understanding of the support available and referral pathways.

Given the lack of time and remuneration for GPs and other health care providers to engage in this work, navigating the DFSV service sector in order to seek support for a patient can be challenging. Health professionals need one simple, streamlined referral pathway to access support for patients.

Service design and delivery need to prioritise children and young people

During a consultation facilitated by Central and Eastern Sydney PHN in July 2024, subject matter experts noted that people who use violence often have a history of witnessing or experiencing DFSV as a child. Working with children, in healing and recovery, in and of itself is prevention work as it has the potential to reduce the prevalence of intergenerational trauma.

The consultation also reinforced links established between DFSV and developmental delays, which can be addressed through better integration between the DFSV sector, primary care and community health, particularly as specialist costs and waiting times can be prohibitive.

CESPHN's current work

DFSV Assist and DFSV Health Assist Services

CESPHN delivers two initiatives to strengthen the health sector's response to domestic, family, and sexual violence (DFSV): DFSV Assist and DFSV Health Assist.

DFSV Assist focuses on building the capacity of primary healthcare professionals through training and navigation support for Domestic and Family Violence, Sexual Violence and Child Sexual Abuse.

CESPHN was one of six PHNs initially funded by the Australian Government Department of Health, Ageing and Disability to address DFSV; this work has recently expanded to include another six PHNs nationwide. The region's DFSV Assist service provides training to GPs, allied health professionals and practice staff to enhance their capacity to identify and appropriately respond to DFSV presentations from patients. Training is free and is offered in-practice, online as well as through continuing professional development (CPD) events.

DFSV Assist also provides a navigation support service exclusively for health professionals to better support their patients experiencing DFSV through:

- Local referral support, accessible by phone, email or secure messaging.
- Providing secondary consultations (guidance and advice for supporting specific patients).
- Improving connection and coordination between primary care and DFSV services to support health professionals to provide seamless support to victims
- Closing the feedback loop and providing (with consent) referral outcome information to referring practitioners.

The Navigation service has enabled better outcomes for patients experiencing abuse as its singular referral pathway limits the risk of re-traumatisation due to retelling stories to multiple agencies to seek various types of support.

Primary healthcare professionals also have ready access to the DFSV pathways on HealthPathways.

DFSV Health Assist is a place-based outreach healthcare initiative designed to improve health outcomes for women and children living in refuges or short-term accommodation, particularly those on temporary visas who face significant barriers to accessing care. This program was established under the national pilot grant, *Supporting Outreach Healthcare for Victim-Survivors of Domestic, Family and Sexual Violence*, which funds PHNs to develop innovative models of care for people escaping violence.

The service delivers free, trauma-informed primary healthcare directly within refuges, ensuring that women and children can access essential health support without the challenges of navigating traditional systems. Care is led by a Nurse Practitioner who provides health screening, early intervention, and referrals to specialist services. A dedicated Coordinator supports service navigation, appointment scheduling, and manages brokerage funds help to cover unavoidable costs.

Opportunities

There are several strategic opportunities to enhance CESPHN's role in supporting victim-survivors and improving system integration. These opportunities build on current initiatives and align with state and national priorities for prevention and early intervention.

The subject matter expert consultation noted the need to commence DFSV-related training earlier in healthcare professional career pathways. For example, training should commence during medical school or during GP registrar training. This is an area DFSV Assist has begun to explore and will continue in 2026.

The introduction of new MBS Level E consultation item numbers for consultations lasting 60 minutes or more could help improve outcomes by allowing more time to be spent supporting patients impacted by DFSV. DFSV Assist training modules will continue education about this MBS item.

In addition, CESPHN can leverage the following opportunities:

- Continue our engagement with other agencies and strengthen these relationships, for example through participation in regional interagencies, to better connect primary care with the DFSV sector.
- Invest in targeted prevention activities that align with the NSW Strategy for the Prevention of Domestic, Family and Sexual Violence 2024-2028.
- Increase CESPHN's community engagement activities and participation in key community events, for example with councils and local organisations.
- Support capacity-building initiatives for local organisations and community leaders to strengthen their ability to respond to DFSV and connect with primary care services.
- Strengthen engagement in early intervention for problematic and harmful sexual behaviours (PHSB), recognising this as a critical opportunity to prevent escalation and reduce long-term harm.
- Leverage our outreach health clinics in refuges as an opportunity to strengthen integrated care pathways, expand partnerships with local providers, and embed sustainable models for trauma-informed primary care.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Health and wellbeing of LGBTIQA+ communities

2025-2027 Needs Assessment
2025 Annual Review

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Overview

The Lesbian, Gay, bisexual, transgender and gender diverse, intersex, queer and asexual community (LGBTIQA+) is a diverse cohort. The acronym includes significant variations in gender identities and expression, sexual orientation and bodily diversity. The acronym LGBTIQA+ will be used throughout this document as appropriate, apart from quoting data sources where a different acronym is used.

Individuals who have multiple intersecting identities often face marginalisation resulting in additional barriers to their physical or mental health. This chapter will capture the health priorities, gaps, barriers and opportunities for the LGBTIQA+ community.

Key issues

- LGBTIQA+ people experience higher levels of mental distress and poor mental health
- LGBTIQA+ people drink more alcohol and use illegal drugs at higher levels than non-LGBTIQA+ people
- Can have higher instances of sexually transmitted diseases, though PReP use remains high amongst gay men
- High levels of loneliness and social isolation, especially amongst older adults (see mental health chapter of this Needs Assessment)
- Vulnerability amongst LGBTIQA+ people who are members of priority population groups
- The community can experience harassment, stigma and discrimination in their daily lives.

Service gaps

- Easy access to gender affirming care for transgender patients
- Services that understand the social and health needs of intersex people
- Delivery of trauma-informed care and sexual diversity training for clinical staff and community services.
- Access to mental health supports.

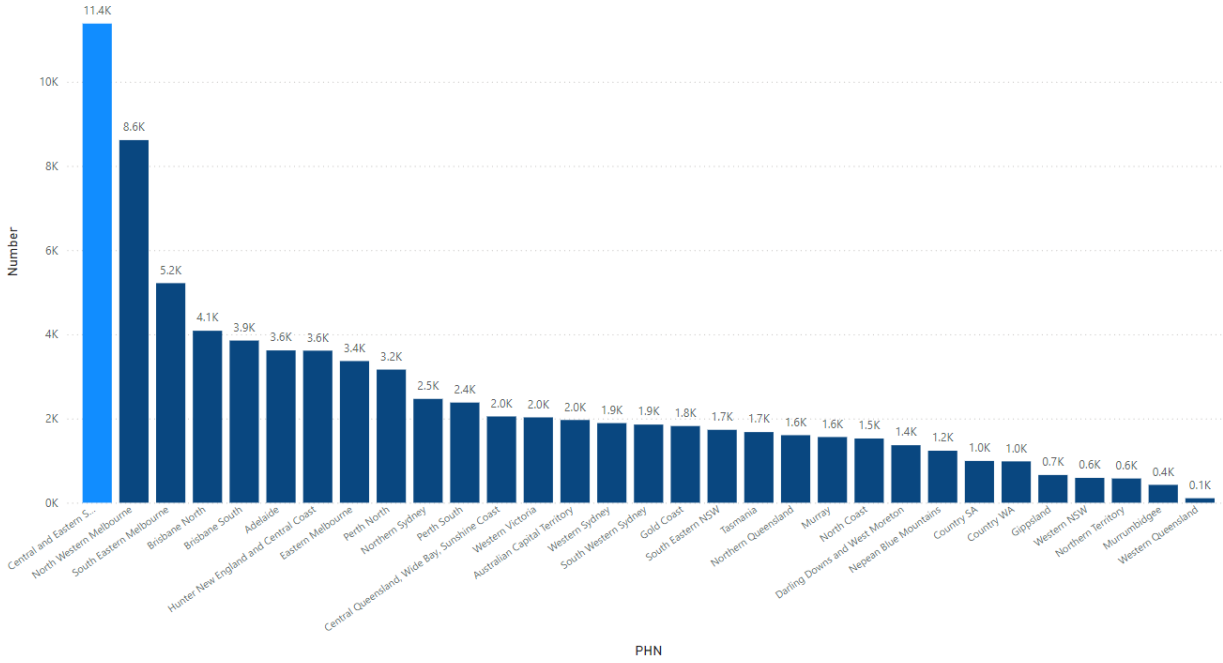
Demographics

Census

The 2021 Census captures the number of same sex couples who live together in Australia. The Central and Eastern Sydney PHN region has a high number of same sex couples living together (n=11,382), representing 14.5% of same sex couples living together in Australia. By comparison, the CESPHN region comprises 6% of the total Australian population'.(1)

However, this information does not provide detailed information on individuals who may be single, in relationships with the same sex but do not cohabitate, or members of the LGBTIQA+ community who do not have relationships with the same sex. It can be assumed that this high number of people within the CESPHN region compared to other parts of Australia is consistent with where the rest of the LGBTIQA+ community reside.

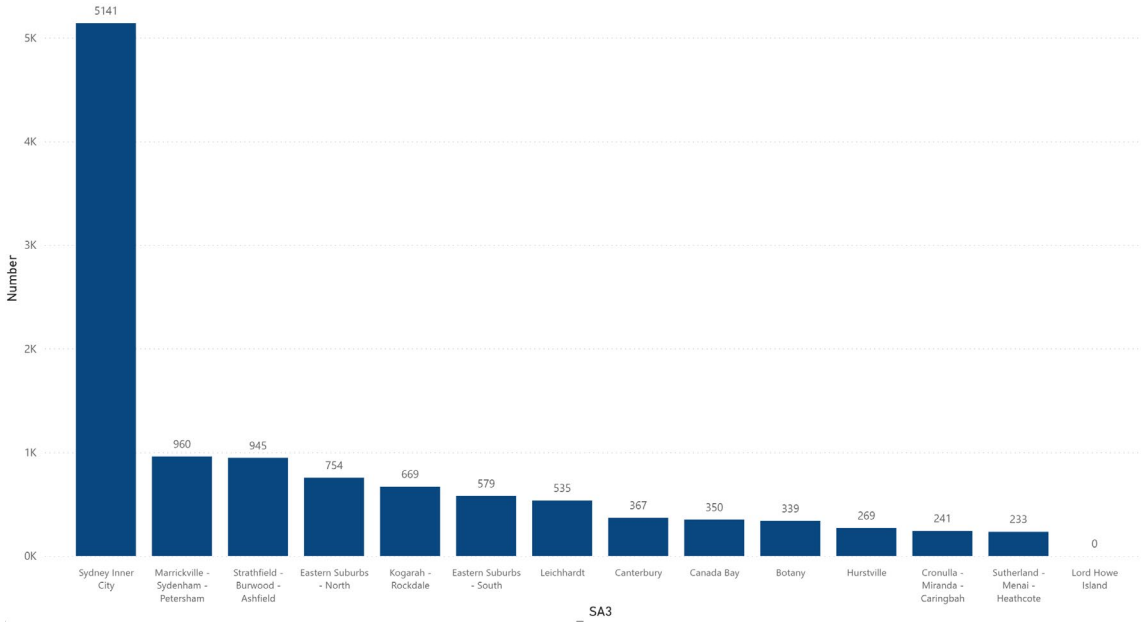
Figure 1: Distribution of Same sex couples across Australia, 2021 by PHN



Source: ABS, 2022

CESPHN's demographic data shows that the highest concentration of same sex couples reside within Sydney Inner City SA3 area. This area had the highest number of same sex couples for both male and female, representing 68.3% of same sex couples in the CESPHN region. (1)

Figure 2: Distribution of same sex couples across the CESPHN region by SA3. 2021



Source: ABS, 2022

Census data does not capture trans and gender diverse or intersex peoples living within the region and is likely to significantly underestimate the number of LGBTIQA+ people. It is estimated that between 1% to 2% of people in Australia are intersex.(2)

LGBTIQA+ people as a priority population

Data collection and the availability of data for the health and wellbeing needs of LGBTIQA+ people is very limited and not available for CESPHN region. This is a limitation within this Health Needs Assessment. To understand the health and wellbeing needs of LGBTIQA+ people within the CESPHN region we can look at national level research as well as plans and strategies where LGBTIQA+ people are at the centre. Current examples include:

- The NSW LGBTIQ+ Health Strategy 2022-2027.(2)
- The National Action Plan for the health and Wellbeing of LGBTIQA+ People 2025-2035.(3)

LGBTIQA+ peoples are defined as priority populations within numerous physical, social and mental health strategies, frameworks, action plans and reforms. The below strategies are examples of areas that highlight the community as a priority population.

National strategies

- The Australian Government's National Mental Health and Suicide Prevention Plan
- The Fifth National Mental Health and Suicide Prevention Plan
- National Drug Strategy 2017-2026
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-29
- The National Palliative Care Strategy 2018
- Commonwealth Department of Health and Aged Care Diversity Framework
- National Dementia Action Plan 2024–2034
- Ninth National HIV Strategy 2024-2030
- Australian Cancer Plan

NSW focused strategies

- NSW Youth Health Framework 2017-2024
- Strategic Framework for Suicide Prevention in NSW 2022-2027
- NSW Alcohol and Other Drugs Workforce Strategy 2024-2032

Health and wellbeing of lesbian, gay, bisexual and queer people

The section refers to the health and wellbeing outcomes of Lesbian, Gay, Bisexual and Queer (LGBQ+) cohorts under the LGBTIQA+ umbrella.

Mental health

Data collated from the National Study of Mental Health and Wellbeing 2020-2022 reports on modelled prevalence for LGBTQ+ Australians. In general, LGB+ people were more likely to experience a mental disorder than heterosexual people. Three in four (74.5%) LGB+ individuals had experienced a mental illness at some time in their life – compared with 41.7% of heterosexual people (4). This includes:

- 63.5% of gay or lesbian people
- 80.1% of bisexual people
- 93.1% of people who used a different term to describe their sexual orientation.(4)

Nearly three in five (58.7%) LGB+ people had experienced a 12-month mental disorder, in comparison to 19.9% of heterosexual people including:

- 42.8% of gay or lesbian people
- 64.4% of bisexual people (4)

The sexually diverse cohort experience higher rates of poor mental health that is linked to experiences of discrimination due to their sexual orientation, bullying, violence, exclusion and devaluation of their identity and their relationships both interpersonally and within broader social discourse.(5) These experiences may lead to challenges with work, relationships, finances and housing.

Poor mental health is not innate to LGBQ+ experience, and is influenced by social and cultural factors, which often compound over the lifespan.

Suicidality and suicide prevention

LGBQ+ people have significantly higher rates of suicidality than their heterosexual counterparts. An analysis of the 2020-2021 Private Lives 3 National Survey of 5,174 cisgender LGBQ participants aged 18+ years across Australia found that over one-third (37.2%) of participants reported having experienced suicidal ideation in the past 12 months and 3.9% of the participants reported a suicide attempt within the 12-month time frame.(6)

Data from the 2020-2022 National Study of Mental Health and Wellbeing indicates that half of LGB+ people (43.9%) had high or very high levels of distress. In comparison, 15.4% of heterosexual people experienced this level of distress. One in four (28.6%) lesbian or gay individuals or one in two (51.5%) bisexual people had high or very high levels of psychological distress. Nearly half of LGB+ people (47.8%) had seriously considered suicide at some point within their lifetime compared to 15.3% of heterosexual people (4).

Non-suicidal self-harm rates (including suicide attempts) are also significantly higher within the cohort, 41.2% had self-harmed compared to 7.4% of heterosexual people. This includes 27.1% of gay or lesbian people and 47.5% of bisexual people.

Alcohol and other drug use

Alcohol and other drug use rates amongst LGBQ+ people are significantly higher than their heterosexual counterparts. The below data on Alcohol and Other Drug Use has been extracted from the Rainbow Realities Report from 2023 (7).

Alcohol

Alcohol use is higher within LGBQ+ communities, with risk factors including:

- Age 35-54 years
- Earned income in the highest brackets ($1,000+ net weekly income)
- Had been sexually assaulted
- Had been treated unfairly based on their LGBQ+ identity in the past 12 months
- Had ever experienced homelessness
- Reported high or very high levels of psychological distress

The Private Lives 3, Pride and Pandemic survey characterised alcohol use patterns of LGBTQA+ adults (20). It found that:

- 26.8% (n = 1,815) of LGBTQA+ adults reported drinking monthly or less
- 27.5% (n = 1,866) drinking 2-4 times per month
- 18.7% (n = 1,268) drinking 2-3 times per week and
- 13.3% (n = 902) drinking four or more times per week

Of those who reported drinking alcohol:

- 71.6% (n = 4,183) reported ever drinking six or more drinks on one occasion
- 16.4% (n = 960) of these individuals reported drinking six or more drinks monthly
- 12.4% (n = 727) weekly and 2.1% (n = 123) daily

In terms of impact on daily life, 16.9% (n = 991) reported that they had struggled to manage their alcohol use or that it negatively impacted their everyday life in the past 12 months:

- 18.3% (n = 182) of those who expressed some struggle with alcohol consumption had sought professional support. 68.5% (n = 135) of those had sought support from a mainstream service that is not known to be LGBTQA+-inclusive, 33.0% (n = 65) from a mainstream service that is known to be LGBTQA+-inclusive, and only 7.6% (n = 15) from a service that caters only to LGBTQA+ people.
- 46.0% (n = 1,198) of LGBTQA+ adults who consumed alcohol during the Covid-19 pandemic reported their drinking had increased during the pandemic and 25.1%, (n = 654) reported drinking less during the pandemic.
- 17.4% (n = 432) of LGBTQA+ adults reported struggling to manage their alcohol consumption or where it negatively impacted their life during the pandemic (7).

Nicotine use

Data collated from the 2020 Private Lives 3 survey (6) reports the following breakdown of current cigarette smokers:

- 21.9% gay

- 21.1% queer
- 20.7% pansexual
- 20.7% bisexual
- 14.6% lesbian

This compares to 15.2% current smokers, with 13.8% daily smokers, in the general Australian population. (6)

The National Drug Strategy Household Survey (NDSHS) 2022-23 (8) found that:

- more than 21% of gay, lesbian and bisexual people reported currently using electronic cigarettes and vapes
- The proportion of people using electronic cigarettes and vapes tripled between 2022 -2023 from the 2019 (7.1%) survey
- 46% of gay, lesbian, and bisexual people had used e-cigarettes at some point in their lifetime

Illicit drug use

The NDSHS 2022-23 found that gay, lesbian, and bisexual people were 2.4 times more likely than heterosexual people to have used any illicit drug in the previous 12 months.(8) This higher rate of overall use was evident in almost all individual illicit drugs reported. Differences between gay, lesbian and bisexual people can be seen in the table below:

Table 1: Most commonly used illicit drugs in the previous 12 months, by sexual orientation, 2022–2023

Gay, lesbian, and bisexual people	Heterosexual people
Cannabis (33%)	Cannabis (10.4%)
Cocaine (15.1%)	Cocaine (4.0%)
Inhalants (11.0%)	Hallucinogens (2.1%)
Ecstasy (9.6%)	Pain-killers/pain-relievers and opioids* (2.0%)
Hallucinogens (8.0%)	Ecstasy (1.7%)

*Used for non-medical purposes.
Source: AIHW 2024

The 2020 SWASH report (9), which focuses on LBQ+ women who reside in Sydney, reported that

- 54.0% of LBQ+ women had ever used illicit drugs.
- 4% reported injecting drug use ever in their lifetimes.
- 54% reported poly drug use (2 or more on one occasion) in the last 6 months.
- 17% indicated they have been concerned about their drug use or felt that it negatively impacted their life, and 7% said they had sought help to manage their use.

Sexual health

The Gay Community Periodic Survey: Sydney 2023 reported the proportion of non-HIV-positive participants who reported testing for HIV in the previous 12-months increased sharply between 2022 and 2023 (to 73.1% from 61.6%).(10)

Awareness of pre-exposure prophylaxis (PrEP) increased among all survey participants between 2019 and 2023 (from 91.7% in 2019 to 95.1% in 2023), with the proportion of non-HIV-positive participants who reported using PrEP in the six months prior to the survey also increasing over the same period (31.0%, 45.5%).(10)

Testing rates for sexually transmitted infections (STIs) declined between 2019 and 2023 for both non-HIV-positive (79.3%, 73.4%) and HIV-positive participants (87.2%, 83.1%). COVID-19 is likely to have affected STI testing frequency since 2020, however this effect remained in 2023.(10)

In 2023, non-HIV-positive participants commonly reported that their last HIV test was at a general practice (50.2%) or a sexual health clinic or hospital (36.9%). The proportions of non-HIV-positive persons who most recently tested at a general practice or at home increased between 2019-2023, while the proportions who last tested at a sexual health clinic, hospital or community-based service decreased.(10)

Health and wellbeing of trans and gender diverse people

Mental health

Trans and gender diverse people in Australia have significantly poorer mental health outcomes than cisgender heterosexual people and LGBQ+ cohorts.

The Rainbow Realities NSW Briefing paper: LGBTQA+ Mental Health and Suicidality identifies that among trans and gender diverse peoples high or very high psychological distress was more likely to be reported by Private Lives 3 (PL3) participants who had a disability compared to those without a disability, and also among trans and gender diverse participants compared with cisgender participants.(11)

Anglo-Celtic and multicultural participants did not differ on levels of psychological distress. In Writing Themselves In 4 (WTI4), the rates of reporting high or very high psychological distress were significantly elevated for trans and gender diverse young people (compared with cisgender participants), as well as for young LGBTQA+ participants with a disability (compared to those without).(11)

Suicidality and suicide prevention

Trans Pathways is the largest study ever conducted of the mental health and care pathways of trans and gender diverse young people in Australia (859 participants). It is also the first Australian study to incorporate the views of parents and guardians of trans young people (194 participants). The report found that:

- 48.1% of trans and gender diverse young people reported having ever attempted suicide
- 74.6% reported having been diagnosed with depression
- 60.1% reported that they felt isolated from mental health support services(11)

Trans and gender diverse Private Lives 3 participants were more likely to report both recent and lifetime suicidal ideation than cisgender participants. Similarly, trans and gender diverse young people from WTI4 were more likely than their cisgender counterparts to have either recently or in their lifetime had suicidal ideation.(11)

Alcohol and Other Drugs

The NHSHS 2022-23 found that the use of tobacco, e-cigarettes and alcohol in trans and gender diverse people reflected the use in the general population. However, 1 in 3 trans and gender diverse people had used an illicit drug during the previous 12 months. After adjusting for differences in age, compared to cisgender people, trans and gender diverse people were 1.6 times as likely to have used any illicit drug in the previous 12 months (8).

Gender affirming health care

Gender affirming care is a non-judgemental, respectful, shared-decision making model that tailors support based on the individual and their health goals. Gender affirming can care include any single

or combination of a number of social, psychological, behavioural or medical interventions designed to explore, support and affirm an individual's gender identity.(12)

Gender affirming care is a practice that should be available to all trans or gender diverse people within the region. Whist there is currently no way to measure access to gender affirming care, it is reported that trans and gender diverse people often report misgendering and that there is a lack of basic awareness of primary care services around gender affirming practices. There is also a reported lack of understanding from primary care professionals about the availability and accessibility of specialist gender affirming services.

Consultation with stakeholders also found that trans and gender diverse people are often not presenting to primary care professionals for health concerns either related or unrelated to their gender identity out of fear of misgendering or stigma associated their identity.

Autism

A growing body of research has identified an overrepresentation of autism spectrum diagnosis (ASD) or autistic traits among trans and gender diverse individuals. This provides additional challenges with access to mental, physical and disability healthcare.
At present research is limited in an Australian context, but UK data set analysis conducted in 2020 titled ‘ Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals.” explored five independently recruited datasets of 641,860 individuals who provided information on their gender, neurodevelopmental and psychiatric diagnoses including autism, and measurements of autistic traits (self-report measures of autistic traits, empathy, systemizing, and sensory sensitivity). These studies concluded that on average trans and gender diverse individuals on average score more highly on self-report measures of autistic straits, systemizing and sensory sensitivity than their cis-gender counterparts. From this research, trans and gender diverse individuals were approximately 3.03-6.36 times as likely to be autistic than their cisgender counterparts. Whilst this research has been provided from a UK context, this is a newly emergent area of interest within Autism and Trans and Gender Diverse research.(13)

Sexual health

The 2018 Australian Trans and Gender Diverse Sexual Health Survey **(14)** reported that 69.3% of respondents had ever been tested for STIs, of whom 57.6% had been tested in the year prior to this survey. People who experienced gender insensitivity within sexual health care were less likely to have been tested recently and reported testing less often (14)

Health and wellbeing of intersex people

There is limited data available to identify the cohort of the intersex population in Australia. The most recent data source; Intersex: Stories and statistics from Australia (15), released in 2016, details findings from 272 people with intersex variations who participated in the ‘Australians born with Congenital Variations in Sex Characteristics (Intersex/DSD/hormonal, chromosomal or other biological variations/conditions)’ project. The findings show that:

- A majority of people with intersex variations considered themselves to be moderately to extremely healthy at the time of the survey.
- Most participants (60%) reported that they had experienced a medical treatment intervention related to their intersex variation.
- On average, they had experienced at least two interventions. The most commonly reported interventions were hormonal treatments and genital surgeries of varying kinds.

- Over half of all treatments were delivered to participants when they were aged under 18yrs.
- One fifth of the participants had been given no information at all about any surgical or hormonal treatments they had received and the majority were not told about risks related to the interventions, their right to not have these often life-changing treatments or other related information.
- Participants reported various physical, mental and psychological impacts from treatments.
- Most participants considered their mental health as good (or positive) at the time of the survey. The most frequently reported mental health diagnoses included depression, anxiety and PTSD.
- Wellbeing risks were high – 42% of participants had thought about self-harm and 26% had engaged in it; 60% had thought about suicide and 19% had attempted it – specifically on the basis of issues related to having a congenital sex variation.
- The group mostly attributed their wellbeing risks to negative social responses from others, difficulties around having undergone interventions or issues around gender/identity.
- Overall their mental health service experiences were mixed. 44% of the group reported receiving counselling/ training/pressure from institutional practitioners (doctors, psychologists etc.) on gendered behaviour; and 43% from parents. Many participants desired improvements in training for mental health services/workers.(15)

Service utilisation/access

Consultation with external stakeholders and consultation findings shared from Sydney Local Health District have identified the following service utilisation and access issues within the primary care sector for LGBTIQ+ peoples:

- Barriers to accessing services include the cost to access a GP, as often multiple consultations are required initially to find a GP who has the knowledge and understanding to work with the patient.
- The limited number of experienced providers are fully booked, people need to find alternatives and there is often no continuity of care.
- Experienced providers are burning out due to overwhelming numbers trying to seek their services. These GPs need to be provided with greater support.
- There is a need for primary care intake forms to be consistently updated to include all areas of the community. Improvements also need to be made to medical software used in general practice
- Social workers and peer workers could be further utilised in this sector as part of a Multidisciplinary Team Care approach.
- A large proportion of aged care services and providers are affiliated with religious organisations impacting older LGBTIQ+ people's anxiety around accessing services
- There needs to be upskilling of translation services to avoid bias (either conscious or unconscious) when providing services
- A need for access to wrap around services, particularly for trans and gender diverse people.

Other issues raised by the community in consultations:

- Trauma associated from earlier in the lifespan
- HIV and aging is complex with limited housing options
- People going back into the closet when they access hospital or aged care
- Partners not being recognised as their support person
- Forms not allowing for connections not from next of kin/family

- Bisexual people mistaken by health providers as straight

Opportunities to address health and service needs

- Provision of training and education for primary care and mental health workforce on LGBTQIA+ inclusive care
- Support upskilling of aged care workforce and adoption of LGBTQIA+ person-centred approaches
- Promote gender affirming care
- Provision of greater support for transgender children and adolescents
- Support adoption of trauma informed care approach
- CESPHN to support ACON in the development of an integrated general practice specializing in LGBTIQA+ health
- Promotion of LGBTIQA+ services in CESPHN service directories and HealthPathways
- Ensure commissioned services are accessible for LGBTQIA+ people.

Definitions

Below is a breakdown of the acronym with broad definitions used within the cohort. These definitions are sourced from the Australian Institute of Family Studies and are used across Australian Government reports and resources.

- **Lesbian:** an individual who identifies as a woman and is sexually and/or romantically attracted to other people who identify as women.
- **Gay:** an individual who identifies as a man and is sexually and/or romantically attracted to other people who identify as men. The term gay can also be used in relation to women who are sexually and romantically attracted to other women.
- **Bisexual:** an individual who is sexually and/or romantically attracted to people of the same gender and people of another gender. Bisexuality does not necessarily assume there are only two genders.
- **Transgender/Trans:** This is an umbrella term which refers to people whose sex at birth does not match with their gender identity. Trans people may choose to live their lives with or without modifying their body, dress or legal status, and with or without medical treatment and surgery. Trans people may use a variety of terms to describe themselves including but not limited to: man, woman, trans woman, trans man, non-binary, agender, genderqueer, genderfluid, trans guy, trans masculine/masc, trans feminine/femme.
- **Intersex:** Intersex is an umbrella term that refers to individuals who have anatomical, chromosomal and hormonal characteristics that differ from medical and conventional understandings of male and female bodies There are at least 40 different variations that may be apparent at different life stages or may remain unknown to the individual and their medical practitioners. Some people with an intersex variation are LGBTQ, many are heterosexual and most are cisgender.
- **Queer:** a term used to describe a range of sexual orientations and gender identities. Although once used as a derogatory term and still considered derogatory by many older LGBTIQA+ people, the term queer now encapsulates political ideas of resistance to heteronormativity and homonormativity and is often used as an umbrella term to describe the full range of LGBTIQA+ identities.
- **Asexual/ace**: a sexual orientation that reflects little to no sexual attraction, either within or outside relationships. People who identify as asexual can still experience romantic attraction across the sexuality continuum. While asexual people do not experience sexual attraction, this does not necessarily imply a lack of libido or sex drive.
- **+ (Plus):** Represents other identities that fall outside of the cohorts listed within the acronym, and captures experience of individuals who have sex, gender or sexual orientations that does not align with endosex, cisgender or heteronormative experience.

Other acronyms may be found where they are referencing a specific published report.(16)

- **AFAB/AMAB:** an acronym for Assigned or presumed Female/Male at Birth. Often used as a description of the lived experience of Trans and Gender Diverse peoples.
- **Dysphoria:** the distress or unease sometimes experienced from being misgendered and/or when someone's gender and body personally don't feel connected or congruent. Many trans people do not experience gender dysphoria at all and, if they do, they may cease with access to gender affirming healthcare and/or peer support. With or without the presence of gender dysphoria, being trans is not a mental illness. Gender dysphoria does not equal being trans.(17)

- **Dead name:** an informal way to describe the former name a person no longer uses because it does not align with their current experience in the world or their gender. Some people may experience distress when this name is used.
- **Endosex:** a term used to describe people whose innate sex characteristics meet medical and conventional understandings of male and female bodies.(17)
- **Gender affirmation:** the personal process or processes a trans person determines is right for them in order to live as their defined gender and so society recognises this. This may involve social, medical and/or legal steps that affirm a person's gender. A trans person who hasn't medically or legally affirmed their gender is no less the man, woman or non-binary person they've always been. A person's circumstances may inhibit their access to steps they want to take to affirm their gender.(18)
- **Gender:** Using the ABS's nominal definition of Gender (19)'Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, woman or non-binary person. Non-binary is an umbrella term describing gender identities that are not exclusively male or female. Gender includes the following concepts:
    - Gender identity is about who a person feels themself to be
    - Gender expression is the way a person expresses their gender. A person's gender expression may also vary depending on the context, for instance expressing different genders at work and home
    - Gender experience describes a person's alignment with the sex recorded for them at birth i.e. a cis experience or a trans experience.
- **Sex:** a classification that is often made at birth as either male or female based on a person's external anatomical characteristics. However, sex is not always straightforward, as some people may be born with an intersex variation, and anatomical and hormonal characteristics can change over a life span.
- **Sex characteristics:** a term used to refer to physical parts of the body that are related to body development, regulation and reproductive systems. Primary sex characteristics are gonads, chromosomes, genitals and hormones. Secondary sex characteristics emerge at puberty and can include the development of breast tissue, voice pitch, facial and pubic hair, etc.
- **Sistergirl and Brotherboy**: terms used for trans people within some Aboriginal or Torres Strait Islander communities. How the words Sistergirl and Brotherboy are used can differ between locations, countries and nations. Sistergirls and Brotherboys have distinct cultural identities and roles. Sistergirls are Indigenous people assigned male at birth but who live their lives as women, including taking on traditional cultural female practices.(5) Brotherboys are Indigenous people assigned female at birth but are a man or have a male spirit.(20)

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CENTRAL AND EASTERN SYDNEY
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Health and Wellbeing of People Experiencing or at Risk of Homelessness

2025-2027 Needs Assessment
2025 Annual Review

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Health and wellbeing of people experiencing or at risk of homelessness

Overview

The CESPHN region has the highest proportion of people experiencing homelessness in NSW with large numbers of people sleeping rough in the City of Sydney and Inner West council regions. The CESPHN region also has the highest number of boarding houses in NSW along with some of the highest numbers of people from the list of National priority homelessness cohorts, which include youth, older adults, and Aboriginal and Torres Strait Islander peoples.

In 2021, 11,496 people experienced homelessness in the CESPHN region, equating to 35% of the state's homeless population.(1) Homelessness is influenced by a complex interplay of social, economic, and health-related drivers and contributes to poorer health, exacerbation of mental and emotional health issues, an increased risk of injury due to violence, and greater difficulty in managing chronic health conditions.

The Specialist Homelessness Services program is the primary NSW government response to homelessness, providing a wide range of supports to people experiencing, or at risk of homelessness. In 2022-23, Specialist Homelessness Services in the CESPHN region provided support to over 8,000 people experiencing, or at risk of homelessness, representing approximately 13% of all Specialist Homelessness Services delivered across NSW.(2)

Feedback from stakeholder consultation with peak bodies in June 2024 revealed that the region is experiencing issues with services being at capacity, and complex cases in which clients are experiencing multiple health and social issues. Additionally, specialist homelessness services also told of increased uptake by women between the ages of 18 to 24.

The following key needs and gaps for the CESPHN region were identified:

Key issues

- Access to affordable primary health care services
- Upskilling of the primary care workforce to meet the needs of people experiencing homelessness
- Enhanced data capture methodologies are required to record clients, prioritise needs, and improve the overall service system.
- Strengthened collaboration between housing providers, specialist homelessness service providers and health service providers based around a housing first approach
- Embedding of primary health care services with housing and specialist homelessness support services
- Need for more localised place-based responses for priority homelessness cohorts, e.g. Aboriginal people and those leaving correctional centres.

Key gaps

- Integration of the health, housing and homelessness service system
- Access to homelessness friendly GPs, pharmacists, allied health, dentistry, mental health, and alcohol and other drugs and support services
- Access to post-crisis mental health and community based and residential alcohol and other drug support services
- Capacity of workforce to deliver respectful and person-centred care
- Geographic location and spread of Specialist Homelessness Services with most providers working in the inner-city regions.
- Access to ongoing coordinated chronic care management

CESPHN homelessness profile

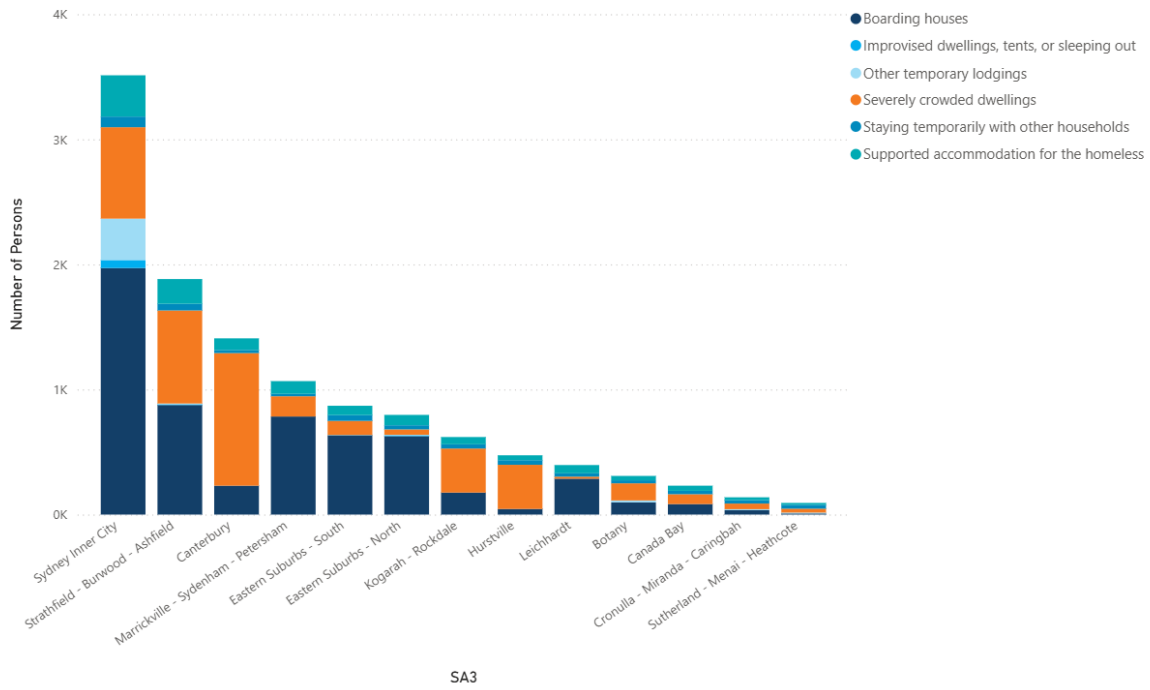
On Census night in 2021, approximately 11,496 people were experiencing homelessness in the central and eastern Sydney region. This equates to approximately 34% of the State's homeless population of 34,982 people, and just under 10% of the National homeless population of 122,494.(3)

The highest numbers of people experiencing homelessness were in Sydney Inner City SA3 (3,505 people), followed by Strathfield-Burwood-Ashfield SA3 (1,882 people) and Canterbury SA3 (1,408 people).(3)

When looking at the breakdown of people experiencing homelessness across the CESPHN region we see the following:

- There were 5,855 people living in boarding houses (approximately 50% of all people experiencing homelessness) within the CESPHN region, accounting for 66.2% of all NSW boarding house residents and 26.4% of boarding house residents across Australia.
- People living in improvised dwellings, tents or sleeping out was most common in the Sydney Inner City SA3 (but makes up only 0.7% of people experiencing homelessness in the CESPHN region.
- Approximately ten percent (9.8%) of those experiencing homelessness across the region were residing in supported crisis accommodation on the night of the Census
- People living in 'severely' overcrowded dwellings was the second highest homeless operational group in the CESPHN region; accounting for approximately one-third of people experiencing homelessness. Two-thirds of people living in severely crowded dwellings were in the SA3s of:
  - Canterbury (27.4%)
  - Strathfield-Burwood-Ashfield (19.2%) and
  - Sydney Inner City (18.9%). (1)

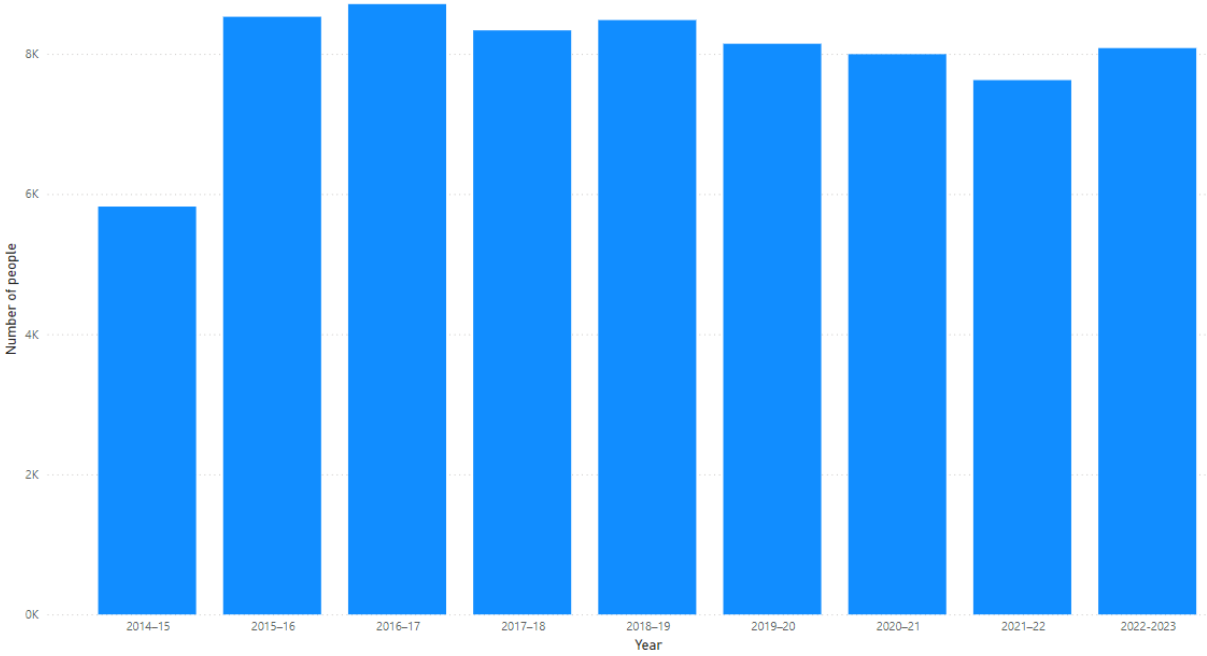
Figure 1: Number of people experiencing homelessness in the CESPHN region, by homeless operational groups and SA3, 2021



Source: ABS, 2023

The number of people experiencing homelessness in the CESPHN region has remained relatively stable over the period 2015-16 to 2022-23.

Figure 2: Number of people experiencing homelessness in the CESPHN region by year, 2014-15-2022-23



Source: AIHW, 2023

Drivers of homelessness

The key drivers of homelessness in NSW are (1):

- Poverty and financial disadvantage accounting for 21% of homelessness in NSW
- Undersupply of affordable and appropriate housing
  - Rising rental prices that have seen many low-income households spend over 30% of their income on housing cost. A lack of affordable housing is pushing more people into homelessness with reports of increasing numbers of people in our region living out of cars.
- Social housing
  - The supply of social housing has been outpaced by the population growth and need for affordable and suitable housing.
- Employment
  - Unemployment in different areas in the region is high and may be attributable to economic factors that contribute to homelessness
- Socioeconomic status
  - CESPHN contains some of the lowest socio-economic status regions in Sydney. The link of association between risk of homelessness and SES is high and provide an indication of risk of homelessness
- Domestic violence
  - In 2023-2024 people experiencing family and domestic violence were the largest cohort of Specialist Homelessness Service clients, making up over 39% of all clients.
- Mental health and alcohol and other drugs
  - People living with a mental health condition, alcohol and other drug dependence, family or relationship breakdown, people experiencing minority stress due to their gender or sexuality, and people who experience other harms such as gambling are more likely to experience homelessness, and homelessness can increase the risk of mental illness.

Priority populations experiencing homelessness

People experiencing homelessness are often members of priority populations, whose needs may not be fully met by current services. Priority populations within the CESPHN region include:

Aboriginal and Torres Strait Islander people

- This group is overrepresented in homelessness services, with 20% all people experiencing homelessness identifying as Aboriginal and Torres Strait Islander (3)and 30% of people accessing SHS identifying as Aboriginal

People from multicultural backgrounds

- This group is particularly overrepresented in severely overcrowded dwellings such as Boarding Houses in the inner west region.(4)
- The hardships and trauma endured by many refugees prior to resettlement coupled with their lack of financial resources means that they are often vulnerable to housing stress, insecurity and homelessness.(5)

People with a disability

- Those with a disability experience much higher levels of persistent homelessness.(6)(7)

LGBTIQ+ people

- People who identify as LGBTIQ+ are more than twice as likely to experience homelessness than the rest of the population(8)

Older people

- The number of people aged 65 and older who are experiencing homelessness has been increasing, exacerbated by increasing cost of housing and rent. One in seven people (16 per cent) experiencing homelessness were aged 55 years and over.(3) Women are represented in this population group more than men.

People experiencing Family and Domestic Violence

- Family and domestic violence is the main reason women and children leave their homes in Australia (AHURI 2021). 43.8% of women accessing Specialist Homelessness Services in 2024 had experienced domestic or family violence.(9)

Homelessness health services

Primary care is a critical site for preventative health care, early diagnosis and management of acute and chronic disease and access to specialist health care. Primary health care providers play a key role in coordinating the health care provided to individuals with complex needs, enabling people to access the right care at the right time and place. There are a range of primary care services in the CESPHN region with a dedicated focus in providing holistic care to people experiencing homelessness. These include:

- General Practices (providing patient centred care for homelessness)
- Homeless Health Service at St Vincent's Hospital
- Aboriginal Medical Service Redfern
- Kirketon Road Centre
- Mission Australia Clinic
- Streetside Medics
- Primary health care clinics at the Matthew Talbot Hostel and the Exodus Foundation
- Primary health care outreach clinics into crisis accommodation shelters

There are several local public health initiatives in place for people experiencing homelessness. These include annual programs to:

- distribute influenza vaccines,
- targeted initiatives to address strategic priorities (e.g. hepatitis C health promotion), and
- responses to extreme weather, and
- local arrangements for managing public health emergencies such as outbreaks of communicable diseases in specialist homelessness services.

Potential exists to increase the capacity of homelessness health primary care services in our region. This includes improved access to homelessness friendly general practices, allied health, mental health and alcohol and other drug practitioners working with the homeless population particularly in areas further afield from the inner-city region.

Specialist homelessness services

The Specialist Homelessness Service workforce specialist supports services for people experiencing or at risk of homelessness. These include:

- Specialist Homelessness Service providers delivering services to both specific target groups such as older women, people experiencing family and domestic violence, refugee and migrants, youth and Aboriginal and Torres Strait Islander people
- A range of more general Specialist Homelessness Services assisting people facing housing crises

Many Specialist Homelessness Services in our region provide integrated access to primary care mental health and drug and alcohol support workers. They also report ongoing issues linking clients without a GP to a homelessness friendly GP practice for ongoing affordable primary care, particularly those who are rough sleeping.

The CESPHN region contains 66.2% of NSWs' boarding house population. Newtown Neighbourhood centre provides case management support to people residing in boarding houses.

Specialist Homelessness Services across NSW provide a variety of services to assist people who are experiencing homelessness or who are at risk of homelessness, ranging from general support and assistance to immediate crisis accommodation.
(6)

Table 1: NSW SHS clients by client group, June 2025

Row Labels	Female	Male	Total
Number of clients accommodated in short-term/emergency accommodation	1,299	954	2,253
Number of clients who are at risk of homelessness	7,035	3,842	10,877
Number of clients who are homeless	7,358	5,269	12,627
Number of clients who have experienced family and domestic violence	6,702	2,249	8,951
Number of clients with a current mental health issue	5,306	2,896	8,202
Number of clients with problematic drug or alcohol issues	911	908	1,819
Number of Indigenous clients	5,138	3,165	8,303
Number of nights in short-term/emergency accommodation	28,141	20,813	48,954

Source: Australian Institute of Health and Welfare, 2024

The total number of clients who received support from the Specialist Homelessness Services each month in NSW has slowly increased to 24,179 clients in June 2025, with women making up 61.3% of clients during this period.(2) Data from the Specialist Homelessness Service sector shows that:

- 45.1% of women accessing Specialist Homelessness Services had experienced domestic or family violence
- 33.9% of all clients had a current mental health issue
- 7.5% of clients had problematic drug or alcohol issues

The highest proportion of clients accessing Specialist Homelessness Services in the region are in the Inner City SA3 (36.4%), followed by Strathfield-Burwood-Ashfield SA3 (15.1%). Specialist Homelessness Services are operating in the inner-city region and the need for greater access to services further from the inner-city region has been reported.

Table 2: SHS clients by SA3, 2023-24

SA3	No. clients
Botany	223
Canada Bay	177
Canterbury	588
Cronulla - Miranda - Caringbah	260
Eastern Suburbs - North	281
Eastern Suburbs - South	495
Hurstville	428
Kogarah - Rockdale	544
Leichhardt	304
Marrickville - Sydenham - Petersham	328
Strathfield - Burwood - Ashfield	1,208
Sutherland - Menai - Heathcote	239
Sydney Inner City	2,904

Source: AIHW, 2025

Housing

Social and supported housing providers within the CESPHN region include Homes NSW, the Aboriginal Housing Office, and a diverse range of Community housing providers. Within the CESPHN region access to social housing consists of:

- Approximately 29,000 public housing residential dwellings and almost 10,000 community housing residential dwellings accounting for approximately 30% and 18% of all NSW Public and Community housing residential dwellings, respectively.(10)
- The Aboriginal Housing Office and several Aboriginal housing providers operate within the region to provide culturally appropriate and affordable housing, and rental assistance for the Aboriginal people in the region.

The main Community housing providers of social and affordable housing in the region include:

- Bridge housing,
- Metro community housing,
- St George community housing,
- Mission Australia housing
- Women's Housing Company

In 2024, there were 6,602 general applicants for housing and 1,869 applicants for priority housing across the CESPHN region. , The highest numbers of general applicants originated from the St George (n=1,421), Inner West (n=1,256) and Leichhardt/Marrickville (n=1,092) allocation zones.(10) These allocation zones also had the highest number of priority applicants, with 363 in Leichhardt/Marrickville, 356 in Inner West and 327 in St George allocation zones.

Table 3: Applicants on NSW Housing register, CESPHN region, at 30 June 2024

Allocation zone	General Applicants, 2024	Priority Applicants, 2024
Inner City	521	195
Eastern Suburbs	894	292
Leichhardt/Marrickville	1,092	363
Canterbury	711	147
Inner West	1,256	356
Sutherland	578	168
St George	1,421	327
Riverwood	129	20
CESPHN total	6,602	1,869
NSW	**46,904**	**9,428**

Source: Communities and Justice, 2024

Wait times for social housing remain high. Of general housing applicants, there is an expected minimum 5 to 10 years wait for a social housing property for all allocation zones within the region, with most having a 10+ years expected wait time.

Table 4: Expected wait-times for general housing applicants, by allocation zone CESPHN region, 30 June 2024

Allocation zone	Expected wait times for general applicants			
	Studio/1-bedroome property	2-bedroom property	3-bedroom property	4+ bedroom property
Canterbury	10+ years	10+ years	10+ years	10+ years
Eastern Suburbs	5 to 10 years	10+ years	10+ years	10+ years
Inner City	5 to 10 years	10+ years	10+ years	10+ years
Inner West	10+ years	10+ years	10+ years	10+ years
Leichhardt/Marrickville	10+ years	10+ years	10+ years	10+ years
Riverwood	10+ years	10+ years	10+ years	10+ years
St George	10+ years	10+ years	10+ years	10+ years
Sutherland	10+ years	10+ years	10+ years	10+ years

Source: Communities and Justice, 2024

There are several programs that provide rapid access to temporary accommodation for homeless people in the region. These include:

- The Homelessness Outreach Support Team (HOST) and the Homelessness Assertive Response Team (HART) street-based patrols fast tracking clients into temporary accommodation
- The Together Home Program which allocates high needs housing support packages to people with complex needs, including those with severe mental health conditions
- Implementation of No Exits from Government Services into Homelessness framework, which work to coordinate and focus efforts across government agencies to prevent exits into homelessness

Of note, 6 out of 10 people in social housing where a movement from social housing to another status was recorded returned to some form of homelessness. Reported contributing factors include(16):

- A lack of ongoing access to homelessness support services once a person is placed into social housing
- A disconnect from social networks that often occurs with people being placed in locations away from their longer standing community and support networks.

The CESPHN region contains approximately 67% of NSW's boarding houses.

Access to primary healthcare

Key barriers to accessing primary healthcare include(1)

Cost of services

- Lack of awareness and confusion over which GPs and general practices bulk bill is impacting access and desire to engage with general practice and other primary care services. The limited access to affordable GP services also extends to allied health services.

Cost of medications

- Upon discharge from a general practitioner, people experiencing homelessness find it hard to follow the prescribed treatment protocol due to the cost of medications and living conditions.

Wait lists

- Longer wait times to see a bulk-billing general practitioner were highlighted as a key barrier across the region. This limited access to GP services also extends to allied health services.

Digital health literacy

- Online booking systems are identified as a barrier to accessing general practitioner services if no alternative booking mode is available, as people experiencing homelessness may not have access to a charged digital device or the ability to make an online booking

Transport

- People experiencing homelessness may not have access to a car or be able to afford petrol and public transport to attend medical appointments.

Shame and stigma

- People experiencing homelessness report shame in accessing a GP due to issues such as personal hygiene and clothing. Stigma from general practice staff, in particular reception staff, has been highlighted by service providers and consumers as a barrier to access.

Lack of understanding and awareness of services

- Many people who are experiencing homelessness lack understanding of the health system and the skills to navigate it. This often results in presentations to Emergency Departments for issues that could be addressed in primary care.

Lack of care coordination

- Providers have identified difficulty in engaging with GPs and general practices to arrange referrals and coordination of care for their clients.

Identified needs, gaps and opportunities

Access to timely and affordable primary health care services

- Greater access to crisis supports and support for people experiencing secondary and tertiary homelessness (Improved access to mobile primary care clinics and GP Homelessness friendly practices)
- Codesign and coproduction of strategically placed Homelessness friendly GP practices supported by business models that subsidise the use of longer consultation times (Item C and D MBS items) and health assessment plans for the management of chronic and complex conditions and reduction of persistent homelessness
- Strengthened collaboration and integration of GP homelessness friendly practices with health, housing, and homelessness sectors, in particular case workers facilitating patient attendance and follow up with GP clinics

- Stakeholder consultations highlighted the need for general practices to be better equipped to provide care to Aboriginal and Torres Strait Islander people and young people experiencing homelessness.
- Commissioning to support expansion of existing primary care outreach clinics and services into homelessness crisis accommodation and shelters (GP's, nurses, mental health and drug and alcohol practitioners, sexual health workers, peer support workers, Aboriginal and multicultural health workers, allied health workers)

Coordinated chronic care management

- Prioritised connection with a regular GP and general practice for people transitioning from shelter accommodation to independent housing or post discharge from government agencies such as hospitals and the criminal justice systems to improve general health and chronic disease management
- Prioritised health assessments and chronic disease management plans in general practice for the management of chronic and complex conditions which can lead to recurring or. persistent homelessness
- Greater use of case management services and peer support networks and other integrated approaches in general practice to assist follow up primary care and strengthen community support networks for people at risk of or experiencing homelessness.
- The codesign and coproduction of homelessness friendly GP practices needs to incorporate a plan to promote the integration of these new models of primary care, through the building of strong relationships across the housing homelessness and health system that facilitate referrals to the services
- Providing access to ongoing support from the appropriate range of services including mental health, psychosocial and housing providers
- Improved care coordination to help people to navigate health, homeless and housing services to receive the support they need

Workforce development

- Upskilling of the primary care workforce working with people at risk of homelessness
- More GPs qualified and trained in the provision of trauma informed care, including the use of GP trainees
- More GPs trained in the early detection and management of family and domestic violence
- Expanded employment and use of Aboriginal and multicultural health workers in existing homelessness health outreach services and clinics
- Provision of education and training to GP reception staff to help build trust and reduce shame and stigma experienced by people who are homeless.
- Training of GPs and practice staff to identify people at risk of homelessness, linking people to the care they need at the earliest opportunity

Geographic location of services

- It has been reported that the service environment can be difficult to navigate and access, and services lack flexibility to respond to other areas in the CESPHN region
- Opportunity exists to review and map the homelessness and primary health care supports across the CESPHN region to help inform, shape, and coordinate services to meet the needs of more marginal and underserved regions, where access to homelessness and primary health care.

Collaborative partnerships

- There are multiple health housing and homelessness service providers and other community organisations such as councils, emergency services, charities, real estate agencies and community managed organisations providing services to people experiencing or at risk of homelessness
- Opportunity exists to collaborate with a broader range of partners, including Homes NSW, community housing providers and community managed organisations such as hot meal

service providers to embed primary health care services including, health assessments and clinics
- Opportunity exists to scaling up existing work addressing the needs of people residing in crisis accommodation and in Boarding Houses
- Opportunity exists to build on evolving multi-agency service models and approaches to improve service coordination and improve access to primary healthcare across the spectrum (i.e. prevention, early intervention, crisis and post crisis care and assistance)
- Further opportunities exist to target delivery of mental health and drug and alcohol detox and support services for people experiencing homelessness through provider partnerships, use of existing commissioned service providers, and expanded presence of mental health and alcohol and other drug practitioners in existing homelessness services.
- Opportunity exists for more innovative localised place-based responses for priority homelessness cohorts, e.g. Aboriginal people and those leaving correctional centres and mental health services.

Improved data collection and use

- An opportunity exists to expand collaboration and use of Advance to Zero - End Street Sleeping Collaboration framework and build on collection of real-time data and insights created through the by-name list registry of the Sydney Zero project.
- The purpose of the by-name list register is for those who are homeless to be known by name and for their housing, health and social needs to be recognised to facilitate the organisation of local services to assist people into permanent housing with necessary supports. Potential exists to explore expanding access to the register for GPs and primary care practitioners whose work focuses on homelessness

PHN Homelessness Access Program

- CESPHN is the lead agency for a new national PHN Homelessness Access Program
- and has been working with the Australian Alliance to End Homelessness to strategically improve PHN responses to improving access to primary health care for people who are homeless or at risk of homelessness. Key initiatives include commissioning of services, and PHN participation in a national intersectoral health, housing and homelessness community of practice to assist enhance collaboration and capacity between sectors. In partnership with the Alliance we have developed the PHN Homelessness Health Framework.
- provides a national approach to addressing these challenges. The Framework outlines principles to assist guide PHNs in designing, commissioning, and supporting trauma-informed health services that are inclusive and responsive to the unique needs of people experiencing homelessness.

Regional Intersectoral Homelessness Health Strategy 2020-2025

- CESPHN is a partner in a Intersectoral Homelessness Health Strategy which is a joint initiative between South Eastern Sydney Local Health, Sydney Local Health District, St Vincent's Health Network, Central and Eastern Sydney Primary Health Network, Department of Communities and Justice - Sydney, South Eastern Sydney and Northern Sydney District and City of Sydney.
  This Strategy identifies five priority areas for improving health outcomes for people experiencing or at risk of homelessness within region; Improving access to the right care at the right time, Strengthening prevention and public health, Increasing access to primary care, building workforce capacity, and establishing collaborative governance and shared planning.

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CENTRAL AND
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An Australian Government Initiative

Primary Care Workforce

2025-2027 Needs Assessment
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Summary

The primary healthcare workforce is the cornerstone the health system in Australia. They are the first point of contact when entering the health system and provide a wide range of services from preventative health to chronic disease management through a person-centred approach. Having a robust and dynamic primary health care workforce is essential for delivering services to keep people well and out of hospital.

The central and eastern Sydney region has one of the largest primary care workforces in Australia with over 2,200 general practitioners and over 14,000 registered allied health professionals across 12 professions.

The primary care workforce is facing many challenges including there being a reduction in the number of general practitioners working in the region. This is compounded by the cohort getting older, planning to retire sooner and working less hours compared to New South Wales and National rates. As Australians live longer, and have increased health needs, the reliance on the primary care workforce increases and workforce rates need to reflect these demographic changes.

Key issues

- There is a low practice accreditation rate with 29% of practices in the region not accredited. This means that many patients and GPs cannot access the benefits that come with accreditation.
- There are a high number of solo practices in the region
- The workforce is ageing, and high numbers of GPs plan to retire in the next 5 years, with a high proportion of these GPs located in areas of socio-economic disadvantage and high health needs
- There have been a high number of practice closures, with 41 practices over a two-year period and another 20 with plans to close in the next five years
- There is a low rate per 100,000 population of primary care nurses in the region, and of which 53.3% plan to retire in the next 10 years, this is despite having a much younger primary care nurse workforce than NSW and Aus rates.
- Changes in public funding (NDIS and MBS linked MDT care plans) may disproportionately impact viability of allied heath

Key gaps

- There is an uneven distribution of GPs across the region ranging from 64.2 per 100,000 population in Botany SA3 to 223.0 per 100,000 population in Sydney Inner City SA3
- Reduction in number of GP registrars, with only one in four practices accredited to undertake registrar training
- There is an expected ongoing reduction in GP workforce when measured against numbers, FTE and years intending to work against the expected increase in health service needs as the population increases and ages

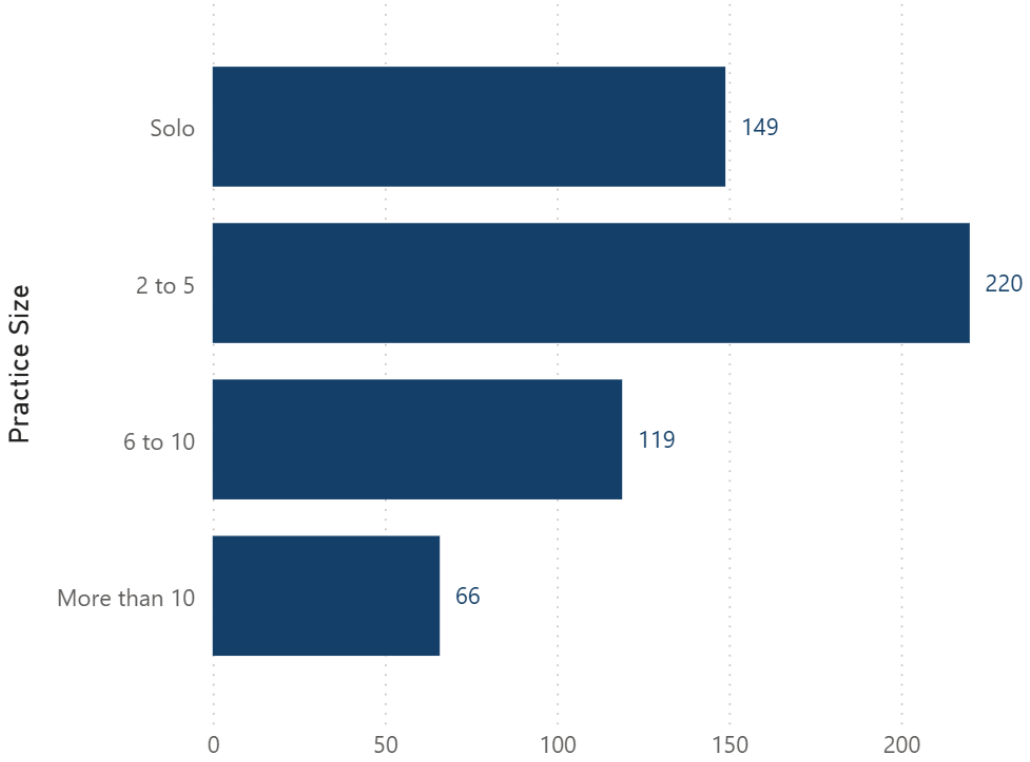
General practice

As of September 2025, there were 554 general practices (1) operating within the central and eastern Sydney region, a slight reduction compared to the 564 practices in the region in September 2024. This includes one Aboriginal Medical Service in Redfern.

Practice composition

Across the central and eastern Sydney region, general practices with two to five GPs are most common with 39.7% of practice making up this composition. This is followed by solo practices which represent 26.9% of general practices. There has been a shift in the composition of general practice in the last five years, where in 2021, 36.2% of practices had two to five GPs, and 34.4% of practices were solo GPs (1).

Figure 1: General practice size in central and eastern Sydney region, September 2025



Source: CESPHN CRM, 2025

Accreditation

Over two-thirds (71.0%) of general practices within the central and eastern Sydney region were accredited or registered for accreditation in September 2025 (1). This rate is low among PHNs in metropolitan areas, where the average accreditation rate was 78% in 2020-21.(2) 85.1% of GPs in the central and eastern Sydney region have an accredited (or registered for accreditation) practice as their primary organisation (1). The low accreditation rate could be attributed to the large proportion of solo/small practices as well as the ageing GP workforce in the central and eastern Sydney region.

Table 1: Accreditation status of general practices by SA3, central and eastern Sydney region, September 2025

SA3	Accredited	Registered for Accreditation	Not accredited	Total
Botany	7	2	6	15
Canada Bay	21	0	1	22
Canterbury	39	0	12	51
Cronulla - Miranda - Caringbah	24	2	3	29
Eastern Suburbs - North	28	0	17	45
Eastern Suburbs - South	28	1	9	38
Hurstville	33	2	10	45
Kogarah - Rockdale	36	0	22	58
Leichhardt	15	0	8	23
Marrickville - Sydenham - Petersham	9	0	10	19
Strathfield - Burwood - Ashfield	43	1	19	63
Sutherland - Menai - Heathcote	27	1	6	34
Sydney Inner City	71	4	36	112
Lord Howe Island	0	0	1	1
CESPHN	381	13	160	555

Source: CESPHN CRM, 2025

Looking at the composition of the non-accredited practices in the central and eastern Sydney region compared to accredited practices, non-accredited practices are more likely to be solo practices (66.5%), less likely to have a practice manager (35.5% compared to 76.8%), and have a very limited number of practice nurses (11.6% of practices compared to 76.3%). Only six non-accredited practices have allied health on the same premises compared to 127 accredited practices across the region.

Looking at the distribution of non-accredited practices across the region, more than half of the practices in Botany and Marrickville-Sydenham-Petersham SA3s are not accredited (53.3% and 52.6% respectively), with another four SA3s having more than a third of practices not accredited (Kogarah-Rockdale - 37.9%, Eastern Suburbs – North 37.8%, Sydney Inner City 35.7% and Leichhardt 34.8%). Canada Bay SA3 has the lowest proportion of non-accredited practices (4.5%)

Accreditation provides benefits to patients and practice through access to funding streams and additional educational opportunities to GPs. Many of these SA3s with high proportions of non-accredited practices are also in low socio-economic areas, have high numbers of multicultural communities and have low rates of general practitioners per 100,000 population.

A 2024 consultation with non-accredited practices stated reasons for not considering accreditation included impending GP retirements or practice closures.

Table 2: Practice composition of accredited and non-accredited practices, CESPHN region, 2025

Practice size	Accredited practices (%)	Non-accredited practices (%)
Solo Practice	9.5	66.5
2-5 GPs	42.7	32.4
6+ GPs	47.8	1.2
Practice Manager	76.8	35.3
Practice Nurse	5.3	11.6
Allied health on the same premise	33.5	3.5

Source: CESPHN CRM, 2025

Table 3: Composition of non-accredited practices (not accredited and registered for accreditation practices), by SA3, September 2025

SA3	Computerised	Non-computerised	Solo Practice	2-5 GPs	6+ GPs	Practice Manager	Practice Nurse	Allied health
Botany	8	0	6	2	0	3	2	0
Canada Bay	1	0	1	0	0	0	0	0
Canterbury	11	1	10	2	0	1	1	0
Cronulla - Miranda - Caringbah	4	1	3	2	0	3	2	0
Eastern Suburbs - North	17	0	11	5	1	7	1	1
Eastern Suburbs - South	9	1	8	2	0	2	0	1
Hurstville	11	1	8	4	0	3	0	0
Kogarah - Rockdale	21	1	14	8	0	12	2	0
Leichhardt	5	3	5	3	0	1	2	0
Marrickville - Sydenham - Petersham	9	1	7	3	0	4	0	1
Strathfield - Burwood - Ashfield	18	2	12	8	0	6	0	2
Sutherland - Menai - Heathcote	6	0	3	3	0	6	1	0
Sydney Inner City	31	10	26	14	1	13	8	1
Lord Howe Island	1	0	1	0	0	0	1	0
CESPHN	152	21	115	56	2	61	20	6

Source: CESPHN CRM, 2025

Practice viability

Between July 2023 and April 2025, 41 general practices have closed (CESPHN 2025) for financial reasons and due to GP retirements (1). Consultation with non-accredited practices in the CESPHN region revealed that at least 20 GPs plan to close their practices soon or within the next five years. Some GPs who have closed their practices are now working part-time in other practices as they

transition to retirement. In many catchments, general practices have moved from bulk billing to mixed and private billing, highlighting the increased difficulty in sustaining a general practice.

General practitioners

Distribution

In 2023 there were 2,202 general practitioners (GPs) working in the Central and Eastern Sydney region (1,898.0 FTE) giving a rate of 134.2 per 100,000 population (115.87 FTE per 100,000 population), higher than state and national rates per 100,000 population. (118.2 and 121.1 respectively) (3).

Table 4: GPs by region, 2022

Measure	CESPHN	NSW	Australia
Number of practitioners	2,202	10,020	32,929
Number of practitioners (rate per 100,000 population)	134.2	118.2	121.1
FTE total	1,898.0	9,078.8	29,367.9
FTE total (rate per 100,000 population)	115.7	107.1	108.0
FTE clinical	1,759.1	8,474.6	27,388.6
FTE clinical (rate per 100,000 population)	107.2	99.9	100.7

Source: HWD, 2025

The distribution of GPs across the region is very uneven. Across the Central and Eastern Sydney region in 2024, the SA3s of Botany (64.2), Marrickville-Sydenham-Petersham 71.1), and Kogarah-Rockdale (86.1) have lowest rates of GPs per 100,000 population, all of which are well below the NSW (118.2) and national (121.1) rates per 100,000 population. At the opposite end of the spectrum, the SA3s of Sydney Inner City (223.0), Eastern Suburbs-North (185.3), and Leichhardt (178.5) all have rates per 100,000 population well above the state and national rates. The same trend across SA3s is seen across the FTE total per 100,000 population and FTE Clinical per 100,000 population (3).

Table 5: GPs by SA3, central and eastern Sydney region, 2024

SA3	No. of practitioners (rate per 100,000)	FTE total (rate per 100,000 population)	FTE clinical (rate per 100,000 population)
Botany	64.2	60.0	54.9
Canada Bay	159.0	125.3	117.1
Canterbury	113.4	107.7	98.6
Cronulla-Miranda-Caringbah	115.3	104.9	99.8
Eastern Suburbs – North	185.3	147.6	132.5
Eastern Suburbs – South	133.5	115.8	108.0
Hurstville	100.1	88.8	83.9
Kogarah-Rockdale	86.1	78.9	73.9
Leichhardt	178.5	144.3	134.9
Marrickville-Sydenham-Petersham	71.7	67.1	62.4
Strathfield-Burwood-Ashfield	105.7	92.0	86.5
Sutherland-Menai-Heathcote	110.3	98.6	92.6
Sydney Inner City	223.0	187.2	171.5
CESPHN	134.2	115.7	107.2
NSW	118.2	107.1	99.9
Australia	121.1	108.0	100.7

Source: HWD, 2025

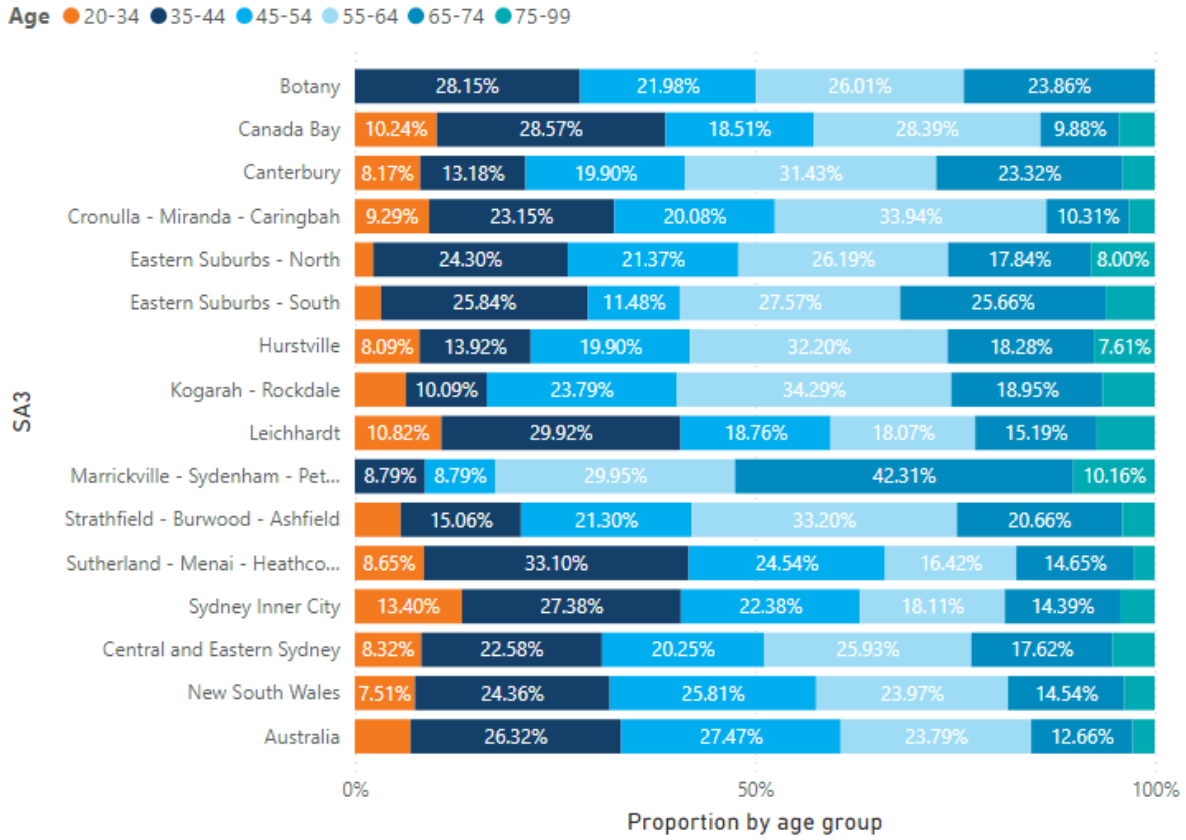
***Lord Howe Island figures have been excluded due to data suppression rules*

Demographics

Just over half (51.2%) of GPs working across the central and eastern Sydney region in 2024 were female while representing 46.0% of the region's FTE. Marrickville-Sydenham-Petersham had the highest FTE proportion of male GPs with 83.3 % of the FTE workforce, followed by Botany (65.8%) and Kogarah-Rockdale (64.6%) (3).

The CESPHN GP workforce continues to remain considerably older than state and national averages. In 2024, just under half of FTE GPs across the central and eastern Sydney region were aged 55 years or older (48.9%), this is higher than both the state and national rates of 42.31% and 39.24% respectively. Marrickville-Sydenham-Petersham SA3 (82.42%),Kogarah-Rockdale SA3 (59.7%) Eastern Suburbs – South SA3 (59.4%) had the highest rates of GPs aged 55 years and over across the central and eastern Sydney region (3). Both Marrickville-Sydenham-Petersham and Kogarah-Rockdale already have low rates of GPs per 100,000 population, therefore an aging workforce will compound the likelihood of GP shortages in these regions.

Figure 2: Proportion of FTE GP workforce by age group, SA3, CESPHN, New South Wales and Australia, 2024



Source: HWD, 2025

Years intend to work

Of the central and eastern Sydney region's SA3s, Marrickville - Sydenham – Petersham SA3 has the highest percentage of GPs who do not intend to work more than five years (38.5%). Across the region 27.2% of GPs only intend to work another five years or less which is higher than the New South Wales and Australia proportions which are both at 24.1%.

Table 6: GP years intended to work by SA3, central and eastern Sydney region, 2024

Geography	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	23.7	28.9	10.5	13.2	15.8	7.9	0.0
Canada Bay	26.7	21.5	8.9	14.8	23.0	5.2	0.0
Canterbury	25.5	24.2	7.9	17.6	16.4	6.1	2.4
Cronulla-Miranda-Caringbah	25.2	18.7	12.9	14.4	18.7	10.1	0.0
Eastern Suburbs - North	32.1	21.5	12.2	14.2	14.2	3.3	2.4
Eastern Suburbs - South	32.6	23.7	11.6	13.7	12.6	3.7	2.1
Hurstville	30.7	21.9	12.4	15.3	13.1	4.4	2.2
Kogarah - Rockdale	30.1	28.6	15.0	12.0	12.0	2.3	0.0
Leichhardt	20.6	21.6	12.7	8.8	29.4	6.9	0.0
Marrickville - Sydenham - Petersham	38.5	38.5	0.0	12.8	10.3	0.0	0.0
Strathfield - Burwood - Ashfield	31.3	25.1	8.4	13.4	15.6	3.9	2.2
Sutherland - Menai - Heathcote	24.4	11.4	8.1	21.1	22.8	7.3	4.9
Sydney Inner City	22.8	19.1	9.8	16.6	22.8	6.8	2.1
Central and Eastern Sydney	27.2	21.7	10.5	15.0	18.2	5.4	2.0
New South Wales	24.1	20.1	12.3	17.3	19.8	4.9	1.4
Australia	24.1	19.2	12.6	18.1	20.7	4.2	1.1

Source: HWD, 2025

Hours worked per week

In 2024, on average GPs in Australia worked 35.7 total hours per week, slightly higher than NSW (36.2 total hours per week). In the Central and Eastern Sydney region, GPs worked 34.5 total hours per week. Average weekly working hours ranged from 38.0 hours per week in Canterbury SA3 to 31.5 hours per week in Canada Bay SA3 (3).

In 2024, on average GPs in Australia worked 33.3 clinical hours per week, slightly lower than NSW where GPs worked on average 33.8 clinical hours per week. GPs in the Central and Eastern Sydney region have a lower average, working 32.0 clinical hours per week (3). Across the region average weekly clinical hours ranged from 34.8 hours in both Canterbury and Marrickville – Sydenham – Petersham SA3s to 28.6 hours per week in Eastern Suburbs – North SA3 (3).

Figure 3: General practitioner mean hours worked per week by SA3, central and eastern Sydney region, 2024

Source: HWD, 2025

Using the Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool, the GP full-time equivalent in the region has decreased in recent years despite the increase in population. Analysis of FTE between 2021 and 2023 shows a peak of 1,903.9 FTE in 2021 and a reduction to 1,730.4 FTE in 2023, a decrease of 9.1 percent despite the 4.5% PHN-wide population growth during the same period. Botany decreased by 31%, the largest change in the region, followed by Kogarah-Rockdale at 19.4%. Given Botany and Kogarah-Rockdale make up the Bayside LGA, which has the second-highest housing target, the area is considered underserviced (4).

Direct engagement with GPs and consultation as part of the workforce prioritisation program (WPP) identified factors attributed to the reduction in FTE, including the ageing GP workforce transitioning to part-time arrangements, and younger GPs prioritising work-life balance.

Table 7: General practitioner fulltime equivalent (FTE), Central and Eastern Sydney region, 2021-23

SA3	2021	2022	2023
Botany	54.2	46.8	41.4
Canada Bay	117.1	118.9	111.6
Canterbury	183.3	183.9	168.3
Cronulla - Miranda - Caringbah	133.5	124	117
Eastern Suburbs - North	166.2	149.4	147.3
Eastern Suburbs - South	143.3	135.5	129.7
Hurstville	150.9	154.9	147.7
Kogarah - Rockdale	155.9	151.4	143.4
Leichhardt	78.8	70.5	66
Marrickville - Sydenham - Petersham	51.7	49.5	46
Strathfield - Burwood - Ashfield	203.6	198.4	188.6
Sutherland - Menai - Heathcote	151.2	147.5	139.7
Sydney Inner City	322.5	304.6	291.3

Source: HeaDS UPP, 2025

GP Registrars

The Central and Eastern Sydney region had 272 Australian General Practice Training (AGPT) registrars in 2024 a decrease from 319 in 2019 (4). This 14.7% decrease in registrars between 2019 and 2024, combined with older GPs planning to retire in the next five years poses a challenge for the central and eastern Sydney region, especially given its projected population increase of 9.3% by 2041 that will increase pressure on general practice to maintain access.

Table 8: Number of GP trainees, central and eastern Sydney region, 2019 to 2024

Year	2019	2020	2021	2022	2023	2024
No. Registrars	319	269	293	260	238	272

*Source: HeaDS UPP, 2025;*GP trainees includes participants on the Australian General Practice Training Program*

Distribution

GP registrars can only undertake their training at practices who are accredited to undertake GP registrar training. Across the CESPHN region there are 138 practices (24.9% of all practices) who are accredited. The Engadine-Heathcote GP catchment region (Sutherland-Menai-Heathcote SA3) is categorised as an outer metro area and consistently receives the highest number of registrars and recently benefited from the RACGP EOI for training accreditation. It also has the highest proportion of practices in the region who are accredited for registrar training (18 practices, 52.9% of practices). Consultations with GPs from other catchments, particularly Marrickville-Sydenham-Petersham, Botany, Caringbah-Miranda-Cronulla, Kogarah-Rockdale, and Eastern Suburbs South, have highlighted the need for more training practice opportunities due to an ageing GP workforce and a high number of practice closures (1).

Table 9: Number of practices accredited for GP registrar training, by SA3, 2025

SA3	Number of practices
Botany	3
Canada Bay	8
Canterbury	10
Cronulla - Miranda - Caringbah	10
Eastern Suburbs - North	9
Eastern Suburbs - South	8
Hurstville	12
Kogarah - Rockdale	9
Leichhardt	8
Marrickville - Sydenham - Petersham	2
Strathfield - Burwood - Ashfield	12
Sutherland - Menai - Heathcote	18
Sydney Inner City	29
CESPHN	138

Source: CESPHN CRM, 2025

Primary Care Nurses

Primary care nursing refers to nurses whose main area of work is in a primary care setting, such as a general practice. In 2025, in the CESPHN CRM, there was a reported 727 primary care nurses working in the Central and Eastern Sydney region. As of November 2025, 43.7% of general practices in CESPHN do not employ a practice nurse. 19.9% employ one nurse and 36.4% employ more than one nurse (1).

Distribution

In 2024, the national health workforce dataset showed 511 (428.7 FTE) primary care nurses in the Central and Eastern Sydney region, giving a rate of 31.1 per 100,000 population (26.1 FTE per 100,000 population (3).

Whilst the primary care nursing workforce continues to increase within the region, rates are still well below the NSW and national rates (41.2 per 100,000 population and 46.7 per 100,000 population respectively) (3). Low rates of primary care nurses in our region could be linked to a high proportion of solo GP practices, lower pay rates in practice nursing compared to hospital settings, and nurses not working to their full scope of practice.

Table 10: Primary care nurses by region, 2023

Measure	CESPHN	NSW	Australia
Number of Practitioners	511	3,496	12,712
Number of Practitioners (rate per 100,000 population)	31.1	41.2	46.7
FTE Total	428.7	2,841.2	10,613.5
FTE Total (rate per 100,000 population)	26.1	33.5	39.0
FTE Clinical	409.0	2,714.7	10,087.2
FTE Clinical (rate per 100,000 population)	24.9	32.0	37.1

Source: HWD, 2024

The distribution of primary care nurses is uneven throughout the region. The lowest rates across the region are in Marrickville-Sydenham-Petersham SA3 (14.0 per 100,000 population), Hurstville SA3 (16.1 per 100,000 population), and Strathfield-Burwood-Ashfield SA3 (16.8 per 100,000 population). Sydney Inner City SA3 has the highest rate of primary care nurses in the region (65.6 per 100,000 population) followed by Eastern Suburbs – South SA3 (48.4 per 100,000 population), which are both above the national rate (46.7 per 100,000 population) (3).

Notably, this is the same trend across General Practitioner rates within SA3s with Marrickville-Sydenham-Petersham, Botany, and Kogarah-Rockdale SA3s having the lowest rates per 100,000 population. The number of nurses in primary and community settings has increased substantially in recent years, by 23.7% between 2020 and 2024 (4).

Table 11: Number of nurses in primary and community settings, central and eastern Sydney region, 2018-2023

	2020	2021	2022	2023	2024
Number of nurses	3,285	3,859	3,809	3,924	4,065

Source: HeaDS UPP, 2025

Years intend to work

In 2024, 53.3% of primary care nurses in the Central and Eastern Sydney region intended to only work up to another 10 years. This is despite 42.9% of nurses in CESPHN falling within the 20 to 34 age group, which is significantly higher than New South Wales and Australia at 28.6% and 28.7%, respectively (3).

Table 12: Primary care nurses years intended to work by SA3, central and eastern Sydney region, 2023

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	40.0	30.0	30.0	0.0	0.0	0.0	0.0
Canada Bay	25.9	29.6	11.1	22.2	11.1	0.0	0.0
Canterbury	17.9	25.0	10.7	10.7	25.0	10.7	0.0
Cronulla-Miranda-Caringbah	29.4	29.4	8.8	8.8	14.7	8.8	0.0
Eastern Suburbs – North	36.4	36.4	9.1	9.1	9.1	0.0	0.0
Eastern Suburbs – South	27.8	20.3	8.9	17.7	19.0	6.3	0.0
Hurstville	16.7	12.5	12.5	25.0	20.8	0.0	12.5
Kogarah-Rockdale	27.3	22.7	18.2	13.6	18.2	0.0	0.0
Leichhardt	30.0	25.0	15.0	15.0	15.0	0.0	0.0
Marrickville-Sydenham-Petersham	50.0	50.0	0.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	42.1	0.0	0.0	31.6	26.3	0.0	0.0
Sutherland-Menai-Heathcote	45.7	11.4	0.0	8.6	17.1	8.6	8.6
Sydney Inner City	29.2	26.6	9.1	15.6	9.7	7.8	1.9
CESPHN	29.7	23.6	9.1	15.2	14.5	5.7	2.2

Source: HWD, 2024

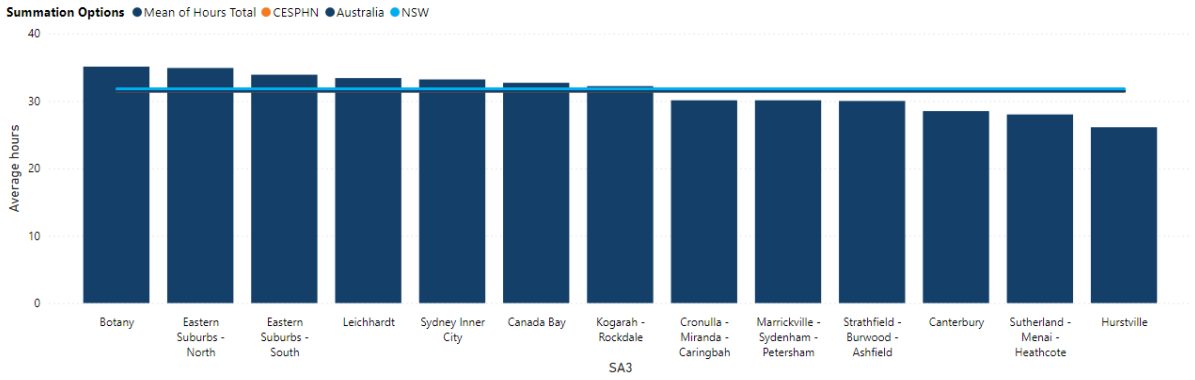
*** Lord Howe Island figures have been excluded due to data suppression rules*

Hours worked per week

Total hours

In 2024, on average primary care nurses in Australia worked 31.9 total hours per week, slightly higher than NSW where primary care nurses worked on average 31.1 total hours per week. Across the Central and Eastern Sydney region, on average primary care nurses work more hours with 32.0 total hours per week. Across the region, average weekly total hours ranged from 35.1 hours in BotanySA3 to 26.1 in Hurstville SA3 (3).

Figure 4: Primary care nurses mean hours worked per week by SA3, central and eastern Sydney region, 2024



Source: HWD, 2024

Clinical hours

In 2024, on average total clinical hours worked by primary care nurses was similar across Australia (30.2 clinical hours per week), NSW (29.5 clinical hours per week), and the Central and Eastern Sydney (30.4 clinical hours per week) (3).

Allied Health Professionals

In 2023, there were 14,280 Australian Health Practitioner Regulation Agency (AHPRA) registered allied health professionals (AHPs), across 12 professions working in the central and eastern Sydney region (12,951.4 FTE), giving a rate of 870.5 practitioners per 100,000 population (789.5 FTE per 100,000 population). (3) Psychologists had the highest rate of AHPs per 100,000 population (179.3), followed by physiotherapists (152.1) and dental practitioners (112.2) (3).

Demographics

Almost two in three (64.4%) AHPRA registered FTE AHPs working across the CESPHN catchment in 2023 were female. This reflects national proportions, where 65.9% of AHPRA registered FTE AHPs were female (3).

In 2023, 63.2% FTE AHPs across the central and eastern Sydney region were aged 20-44 years old; this is slightly lower than both the state and national rates of 65.0 and 67.7% respectively (3).

Table 13: Proportion of FTE AHP workforce by age groups, CESPHN, 2023

AHP	20-34 years (%)	35-44 Years (%)	45-54 Years (%)	55-64 Years (%)	65-74 Years (%)	75-99 Years (%)
Chinese Medicine Practitioners	7.6	14.3	26.3	31.4	16.6	3.9
Chiropractors	34.1	27.7	23.2	11.1	4.0	0.0
Dental Practitioners	28.4	26.8	18.4	16.3	8.7	1.4
Medical Radiation Practitioners	49.0	25.8	13.1	8.7	3.2	0.3
Occupational Therapists	58.9	22.1	11.8	5.9	1.1	0.2
Optometrists	39.3	20.0	17.2	14.1	9.3	0.0
Osteopaths	15.9	17.7	27.4	18.6	16.8	3.5
Paramedicine Practitioners	52.6	21.5	17.2	7.3	1.3	0.0
Pharmacists	38.8	31.1	15.1	9.7	4.0	1.3
Physiotherapists	55.9	19.7	12.6	8.6	3.0	0.2
Podiatrists	49.3	21.9	13.4	11.7	2.9	0.9
Psychologists	22.5	29.1	24.4	14.0	7.6	2.4

Source: HWD, 2025

Hours worked per week

In 2023 across all AHPs, paramedicine practitioners had the highest average clinical hours a week at 44.0 hours, followed by podiatrists (37.1 hours) and physiotherapists (35.9 hours) Chinese medical practitioners on averaged worked the lowest clinical hours a week at 29.5 hours (3).

Across the region, pharmacists, optometrists and psychologists all worked, on average a lower number of clinical hours than the national and state averages for their profession (3).

Issues impacting the primary care workforce

Aging GP workforce

The central and eastern Sydney region has an older GP workforce than the NSW or Australian average. In a survey conducted in 2022 of all GPs who visited RACFs in central and eastern Sydney, 50% stated they intend on either decreasing or stopping their visits to RACFs in the next two years. New initiatives to attract GPs to visit aged care facilities may not be enough to encourage GP attendance and new GPs are increasingly unlikely to visit aged care facilities because of the low remuneration, lack of IT interoperability and the increased administration.

Changing work arrangements for GPs

The working arrangements of GPs have evolved over time, The number of GPs working part-time compared with the conventional full-time schedule has significantly increased. After a steady FTE ratio of 0.7 between 2018 and 2022, the average FTE per GP dropped to 0.6 in 2023 (4). This could be attributed to several factors. As GPs near retirement, they also transition to part time. It is critical that we work to maintain GP participation and that includes supporting those working part time.

Utilisation of primary care nurses working in general practice

Utilisation of primary care nurses in the region has been limited by traditional perception of the role and the MBS item system, as items need to be billed under GPs. Furthermore, remuneration is generally less attractive when compared with nursing in secondary care. Additional aspects identified in the CESPHN Practice Nurse Strategy 2025-2028 include the need for leadership in general practice to drive quality improvement, and more opportunities are needed to support career progress.(5)

Effective use of primary care nurses could work to address workforce shortages in primary care. This could involve allowing the role to take on more responsibilities and provide more high-quality care. This could be most impactful in areas of chronic disease management and education. Additionally, utilising nurses could reduce costs for patients accessing primary care and provide better professional opportunities and career opportunities for nurses. The Central and Eastern Sydney region is well positioned for this as the number of nurses in primary and community settings is increasing year by year.

Low practice accreditation rate

The low practice accreditation rate (69.5% of general practices within the central and eastern Sydney region when compared with the metropolitan average of 78% in 2020-21) is attributed to multiple factors, including large numbers of solo practices. The introduction of MyMedicare, which aims to improve the relationship between patient and practice, and the General Practice Aged Care Incentive (GPACI) could offer additional reasons for practices to register for accreditation.

CESPHN's current work

- Accreditation and Practice Incentives Programs (PIP): CESPHN continues to offer support to general practices achieving and maintaining Accreditation against the RACGP 5th edition Accreditation Standards. Along with accreditation, support is offered on registration to the PIP programs including Quality Improvement (QI), where support on driving QI activities if offered.
- MyMedicare, GP Aged Care Incentive (GPACI), Bulk Billing Incentive Program (BBPIP): CESPHN provides support and guidance to general practices and healthcare providers on all aspects of these programs, including facilitation of registration for MyMedicare, GPACI, and BBPIP.
- Encouraging innovation by provision of grants to general practices and allied health providers to help improve digital health capabilities and further embed quality improvement.
- Chronic Conditions Management (CCM) and Better Access MBS Updates: CESPHN offers resources and advisory services to general practices, nurses, and other providers to help them understand and implement changes in chronic disease management and Better Access MBS items and care plans.
- Workforce Development:
  - CESPHN has developed targeted strategies including GP Workforce, practice manager, practice nurse, and allied health to drive collaboration and strengthen workforce capacity across the region. A digital health strategy has also been developed to support the workforce in the region
  - The General Practice Workforce Planning and Prioritisation (WPP) Program provides independent, evidence-based advice to inform the geographic distribution and placement of GP Registrars to meet the community's current and future GP workforce needs. This program is led by ACT PHN (Capital Health Network). Consultation with CESPHN stakeholders, workforce, population and environmental data contributes to this program.
  - CESPHN delivers ongoing guidance and coordination for GP Registrars and Supervisors through orientation programs, education sessions, and networking opportunities. Additionally, CESPHN is facilitating succession planning initiatives to assist GPs in preparing for future workforce needs.
  - Deliver tailored support to smaller and solo general practices (1–5 GPs) in developing business and financial plans with a focus on succession planning strengthen the long-term sustainability of general practices by enhancing their capacity for effective business planning, financial management, and leadership transition..

Opportunities

- Upcoming Accreditation Standards: The introduction of the RACGP 6th Edition Standards in 2026 presents an opportunity to support non-accredited practices in achieving accreditation, improving quality and safety across the region.
- Expansion of MyMedicare and GPACI Registrations: Increasing registrations for MyMedicare and GPACI among general practices and patients will strengthen continuity of care and enhance patient engagement.

- Chronic Conditions Management Changes: The July 2025 updates to CCM offer the potential to expand and reinforce the role of practice nurses, improving chronic disease management and team-based care.
- Innovative Workforce Models: Opportunity to support the general practice workforce in adopting multidisciplinary, team-based care models, fostering collaboration and efficiency.
- Scope of Practice: Enable GPs and nurses to work to their full scope of practice, optimising skills and improving patient outcomes.
- Integration of Artificial Intelligence (AI): Explore AI solutions tailored for general practice to enhance operational efficiency and patient care delivery.
- Practice Nurses: The continuation of the Practice Nurse Strategy and implementation plan will include the establishment of a Practice Nurse Advisory Group, designed to drive collaboration, provide leadership, and support effective implementation of the strategy across the region.
- Practice Managers: The implementation of the Practice Manager Strategy will ensure practice managers are well-supported and connected through the development of an advisory group, tailored in-practice guidance, comprehensive resources, and access to education and professional development opportunities.
- Training Pathways for Future Practitioners: Collaborate with the RACGP, universities, local health districts, and health networks to develop and strengthen training pathways, ensuring a sustainable GP workforce.
- Workforce Wellbeing and Connectivity: Continue to support primary care professionals in self-care and professional networking, promoting resilience and collaboration.

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CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Access and Coordinated Care

2025-2027 Needs Assessment
2025 Annual Review

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Overview

Summary

Access to primary care services is a major key in improving and maintaining population health, with more than 70% of the CESPHN population seeing a a Medicare-subsidised GP in 2023-24. Coordinated care focuses on ensuring seamless and integrated healthcare services across various providers and stages of care. This approach emphasises the importance of maintaining consistent and coherent care over time, which is particularly crucial for patients with chronic conditions or complex health needs.

Key issues

- Reduced bulk billing across primary care and increasing out of pocket expenses
- Low health literacy for identified populations and locations:
- Lack of coordinated care between systems, particularly among vulnerable and priority groups including:
  - Veterans
  - People leaving the criminal justice system
  - People living with a disability
  - People experiencing family and domestic violence
  - Older people.
- Workforce scope of practice and lack of system interoperability, which impacts providers identifying appropriate services and connecting with other providers
- The NSW Health implementation and rollout of the Single Digital Patient Record across NSW over the next five years
  - Though this has the potential to improve communications between general practice, acute and virtual care services.

Key gaps

- More effective communication and information sharing among healthcare providers, including system interoperability that enables continuity of care across primary, secondary and tertiary care
- Increased multidisciplinary teamwork
- Increased patient-centred care that respects individual preferences and needs
- Utilisation of My Health Record.

Accessing health care

Access

GPs are the first point of contact for most people seeking health care, with 77.0% of the population in the Central and Eastern Sydney region seeing a Medicare-subsidised GP in 2023-24 This is lower than the Australian average over the same period, at 84.4%.(1)

In 2023-24, there were 9,083,677 GP attendances in the Central and Eastern Sydney region. This equates to an age-standardised rate of 6.4 services per 100 people, slightly lower than the national average of 6.5 services per 100 persons.(1)

For Medicare-subsidised GP attendances, the highest number of services per 100 people were attributed to the Sutherland-Menai-Heathcote and Canterbury SA3s in 2023-24 (681.3 and 676.8 services per 100 people); areas with notably high proportions of individuals aged 65+.(1)

Table 1: Medicare-subsidised GP attendances by SA3, central and eastern Sydney region, 2023-24

SA3	No. services	Services per 100 people
Botany	298,496	481.45
Canada Bay	562,761	634.23
Canterbury	980,349	676.77
Cronulla-Miranda-Caringbah	761,399	627.71
Eastern Suburbs – North	701,713	534.40
Eastern Suburbs – South	743,693	524.35
Hurstville	834,459	612.35
Kogarah-Rockdale	912,090	600.11
Leichhardt	317,534	553.03
Marrickville-Sydenham-Petersham	311,516	552.98
Strathfield-Burwood-Ashfield	945,868	560.92
Sutherland-Menai-Heathcote	770,937	681.28
Sydney Inner City	988,138	415.44
CESPHN Average	**769,337**	**622.40**
National	**163,543,539**	**613.70**

Source: AIHW, 2025

** No data published for Lord Howe Island*

Medicare-subsidised care through GP bulk billing reduces the financial barrier for people needing to access GP care. However, over the last 1 - 2 years, the number of GP practices and primary care services offering bulk billing as an option has decreased. CESPHN's lower bulk-billing rate is largely explained by a structural mismatch between high operating costs and the current Medicare rebate, combined with demographic factors and market dynamics that reduce the viability and demand for 100% bulk-billing models. The region's practice mix, workforce pressures, and complex patient needs further reinforce the shift toward mixed and private billing.

In 2024-25, the average cost per standard GP consultation across the CESPHN region was $87.14, a 4.7% increase over the previous twelve months. The average cost per long consultation was $138.90, a 3.8% increase over the previous twelve months. Moreover, the percentage of practices that bulk bill

all services in the region reduced from 31.4% to 25.7% between 2023-24 and 2024-25. Canterbury SA3 is the only area within the CESPHN region where more than 50% of practices bulk bill all services (53.8%). Marrickville-Sydenham-Petersham SA3 has 47.4% of practices who offer bulk billing for all services, followed by Hurstville SA3 with 37.5%. Data shows that no practices within Botany SA3 offer bulk billing for all services (down from 7.7% in the previous 12 months), followed by Eastern Suburbs-North SA3 with 4.8% offering bulk billing.

Table 2: Bulk billing clinics and average cost per consultation by SA3, 2024-25, CESPHN region

SA3	Bulk Billing Clinics	Average Cost (Standard Consultation)	Average Cost (Long Consultation)	Bulk Billing %	Change in bulk billing from previous year (%)
Botany	0	$81.40	$128.91	0.0	-100.0
Canada Bay	2	$85.30	$131.53	9.1	-39.4
Canterbury	28	$82.60	$134.59	53.8	-9.6
Cronulla - Miranda - Caringbah	4	$91.26	$145.71	13.8	-40.2
Eastern Suburbs - North	2	$108.81	$174.69	4.8	-2.4
Eastern Suburbs - South	4	$87.20	$135.05	12.9	-30.3
Hurstville	15	$80.36	$130.27	37.5	0.0
Kogarah - Rockdale	16	$80.68	$126.86	30.2	0.6
Leichhardt	6	$95.59	$153.35	30.0	50.0
Marrickville - Sydenham - Petersham	0	$82.23	$130.61	47.4	-10.5
Strathfield - Burwood - Ashfield	9	$79.32	$127.20	30.4	-44.2
Sutherland - Menai - Heathcote	17	$83.54	$136.24	25.0	-20.5
Sydney Inner City	9	$94.55	$150.66	19.5	-17.0
CESPHN	**129**	**$87.14**	**$138.90**	**25.7**	**-18.2**

Source: Cleanbill, 2025

From the above information average out of pocket costs per service generally correspond to SEIFA scores across the CESPHN region. Strathfield-Burwood-Ashfield SA3 and Kogarah-Rockdale SA3 had some of the lowest average out-of-pocket costs for both standard and long consults and some of the lowest SEIFA values for our region (7 of the 32 SA2s with IRSD under 1,000).

Canterbury SA3 has 9 of the lowest SEIFA scores in our region and has the 6th lowest out of pocket expenses for standard consultation and 7th lowest for long consultations. However, some areas with high SEIFA scores pay significantly different amounts. Sutherland-Menai-Heathcote and Leichhardt differ in SEIFA scores by only one point, however residents in Sutherland-Menai-Heathcote on average pay substantially less in out of pocket costs.

The decrease in general practices that bulk bill means people are expected to pay a larger out-of-pocket expense to access primary care, which in turn influences health-seeking behaviours, especially for those who are financially struggling or unable to afford a consult.

Allied Health Professionals

Rates for other Medicare-subsidised services (allied health and diagnostic imaging) in the central and eastern Sydney region were similar to national rates as shown in the following table. Data shows, however, higher specialist attendances in the CESPHN region compared to national figures in 2023-24.(1)

Table 3: Medicare-subsidised services per 100 people (age standardised), central and eastern Sydney region, 2023-24

Medicare-subsidised service	CESPHN	Metropolitan (greater capital city)	Australia
Allied health attendances (total)	97.95	101.53	100.23
Diagnostic imaging (total)	100.37	105.60	107.25
Specialist attendances (total)	123.60	100.59	97.60

Source: AIHW, 2025

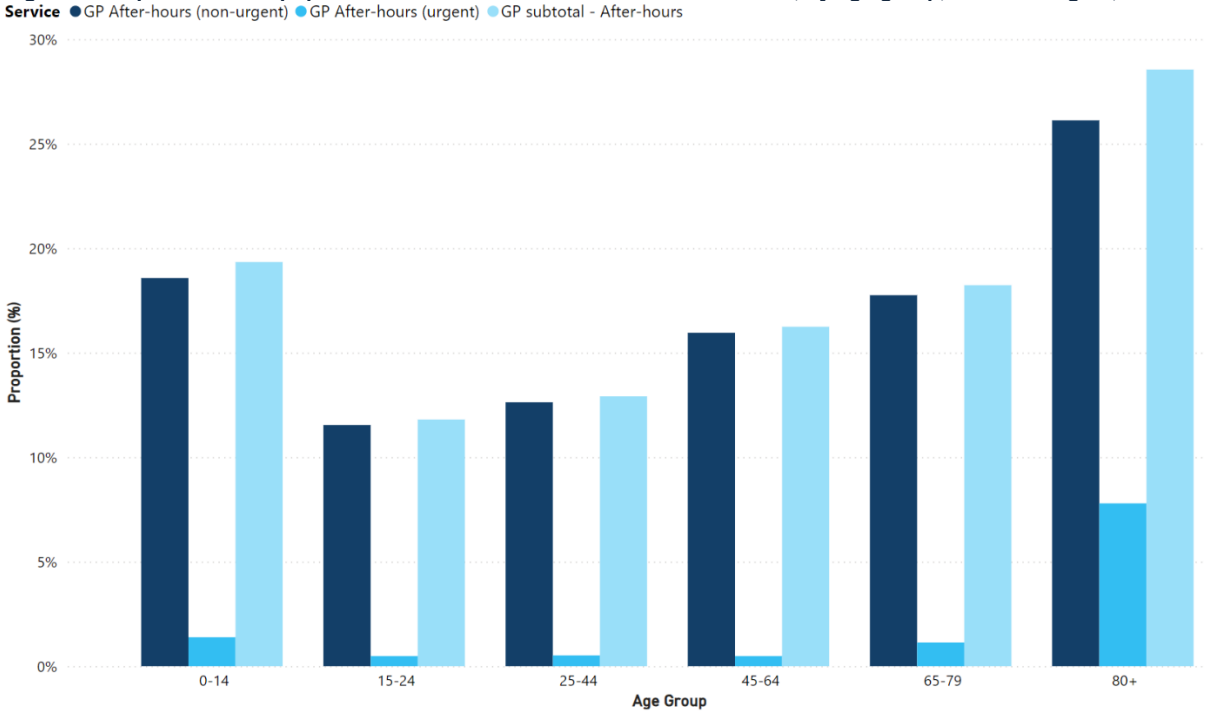
After Hours

After Hours GP services

In 2023-24, 233,592 people (14.6% of the population) in the CESPHN region received an after-hours GP service; slightly lower than the proportion of the population nationally (15.7%) People were more likely to receive a non-urgent after-hours GP service (14.2%) than an urgent after-hours GP service (0.7%). A higher proportion of females received an after-hours GP service than males (15.4% compared to 13.7%).(1)

People aged 80 years and over were most likely to receive an after-hours GP service (28.1%) followed by 14 years and younger (19.5%) and then 65-79 years old (17.8%). In 2023-24, there were 479,563 after-hours GP services provided in the CESPHN region, equivalent to 29.9 services per 100 people. People aged 80+ years received the highest number of services per 100 people (131.8), followed by those aged 65-79 years (44.9 services per 100 people).(1)

Figure 1: Proportion of the population who received an after hours GP service, by age group, CESPHN region, 2022-23



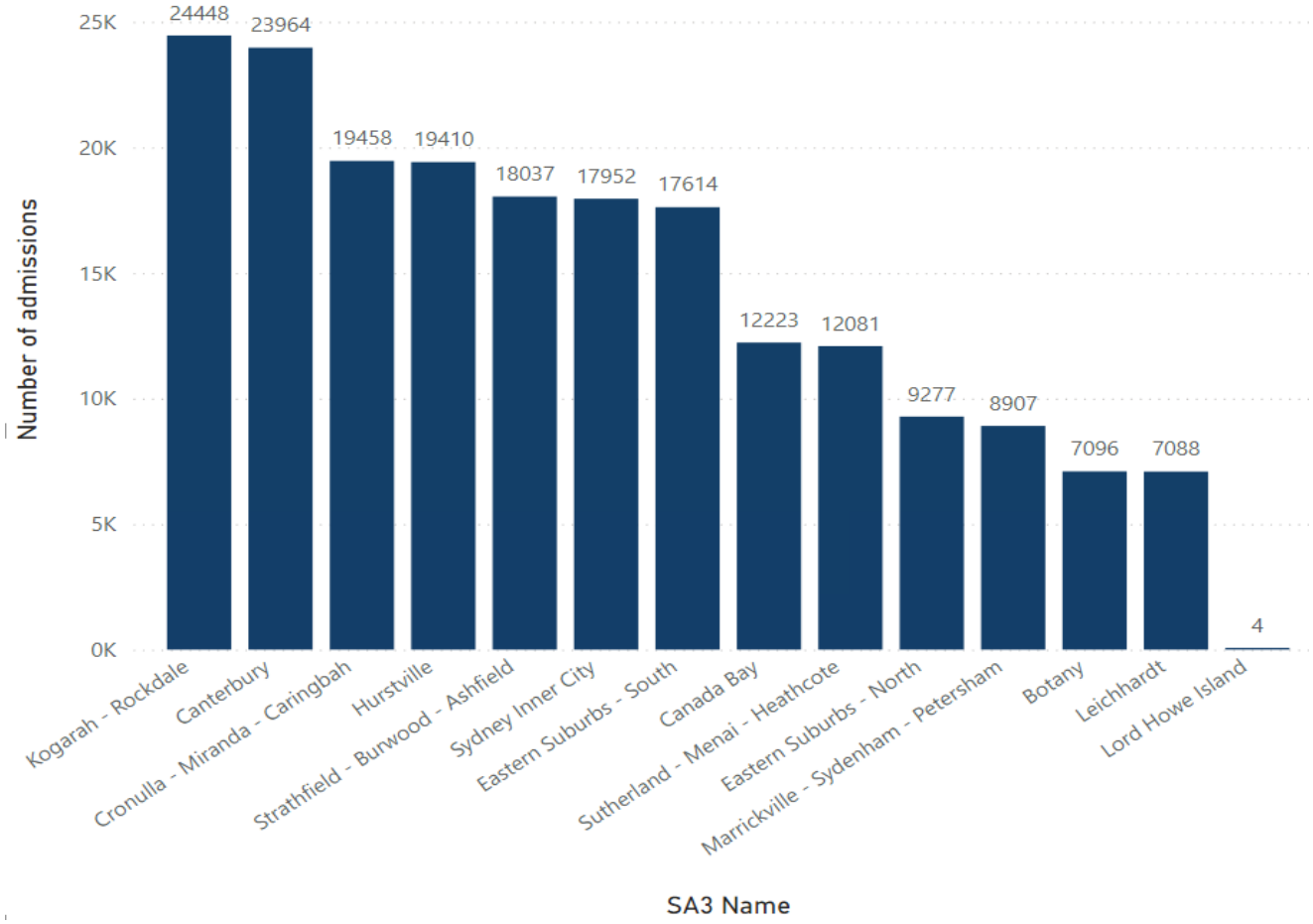
Source: AIHW, 2023

Emergency Department admissions

The Lumos program provides insights on the patient journey through the NSW health system by linking general practice and NSW Health data. Of the general practices in the region participating in Lumos the highest number of emergency department admissions between January 2024 and December 2024 is in the Sydney Inner City SA3 at 80,676, which has two major hospitals (Royal Prince Alfred Hospital and St Vincent's Hospital) within the region. This is followed by Kogarah – Rockdale (which contains St George Hospital) at 55,609 and Eastern Suburbs – South at 55,278 (which contains Prince of Wales Hospital).(2)

The highest number of ED admissions in 2024 were attributed to residents living in the Kogarah – Rockdale SA3, followed by the Canterbury SA3.(2)

Figure 2: ED admissions by SA3 of patient residence, CESPHN region, 2024

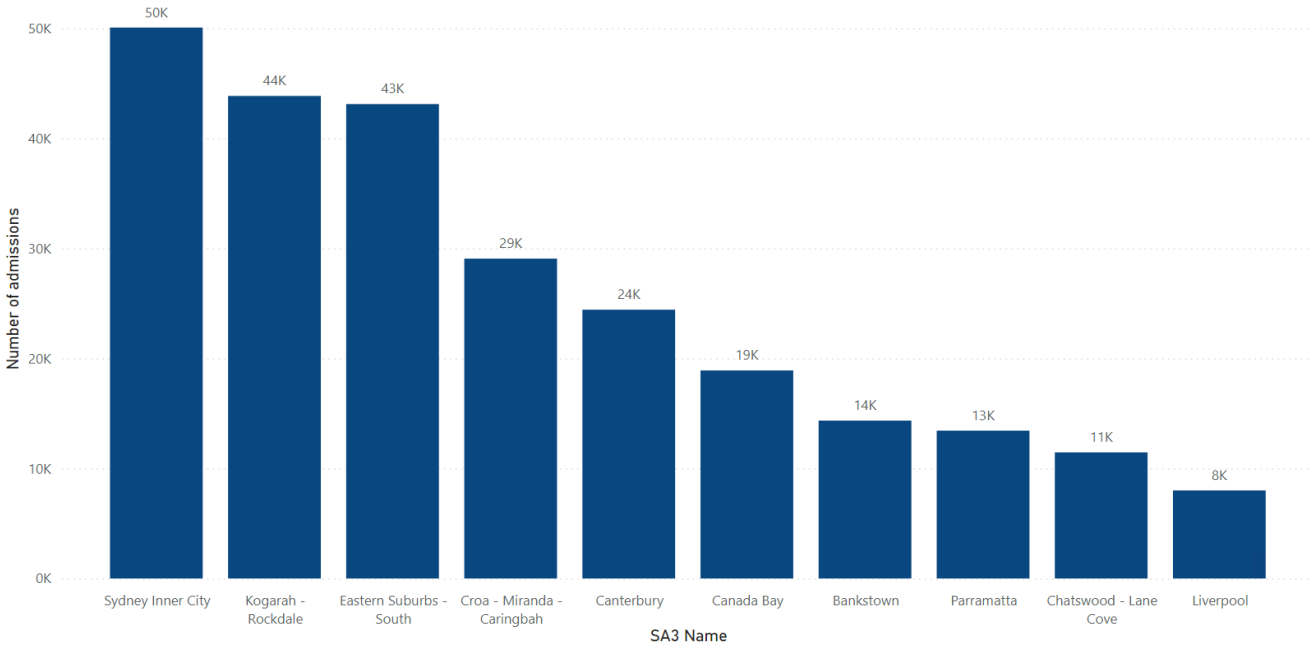


Source: Lumos, 2025

Admissions by SA3 broadly correlate with the region's population distribution. A notable exception is the Kogarah – Rockdale SA3 which, despite representing 9.4% of the region's population, had an ED admission rate of nearly 13%.(2)

There were 14,349 patients in the Bankstown SA3 who had visited a participating practice and were admitted to a hospital in the Central and Eastern Sydney region in 2023. This is followed by the Parramatta and Chatswood – Lane Cove SA3s at 13,436 and 11,459, respectively.(2)

Figure 3: Top 10 ED admission by facility SA3, 2024



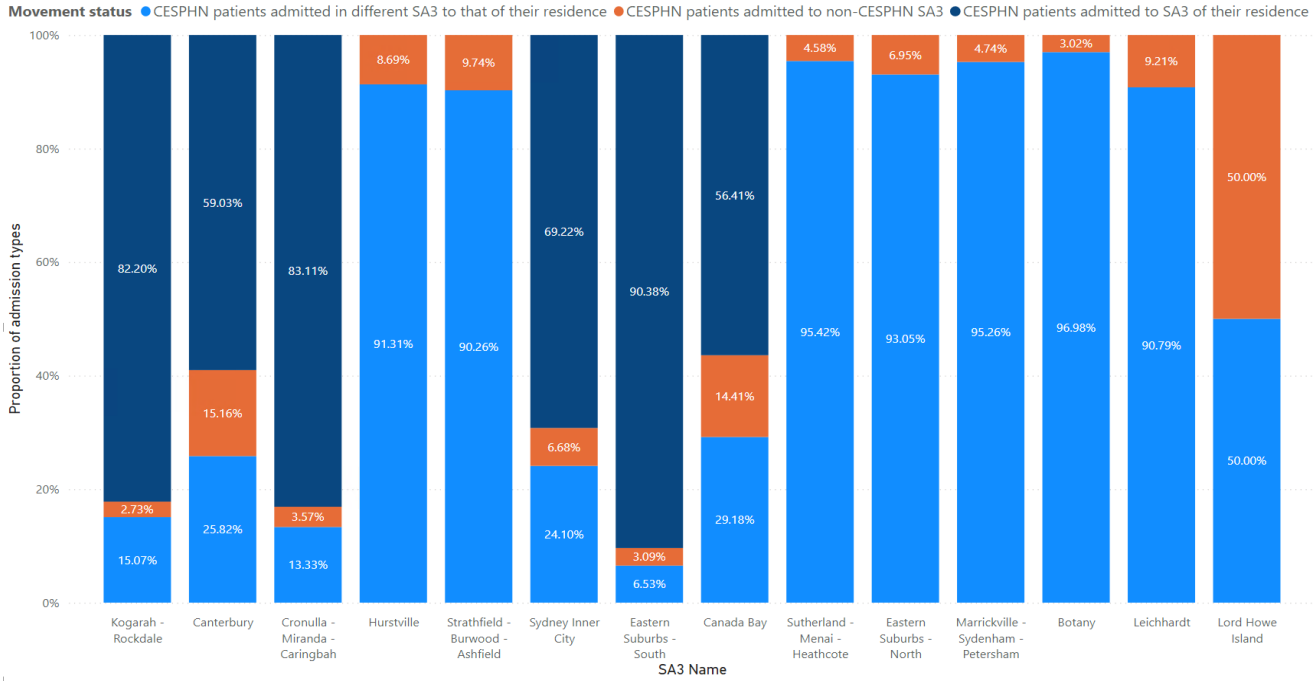
Source: Lumos, 2025

When comparing the SA3s where patients reside to the SA3s where they were admitted, it was found that most patients in the following SA3s were admitted within the same SA3 during the 2024 calendar year:

- Sydney Inner City
- Kogarah – Rockdale
- Eastern Suburbs – South
- Cronulla – Miranda – Caringbah
- Canterbury
- Canada Bay

This can be attributed to each of the SA3s containing one or more major hospital. However, Canterbury and Canada Bay ranked relatively low, at 59.0% and 56.4% respectively, suggesting there may be opportunities to improve the local capacity of these areas.(2)

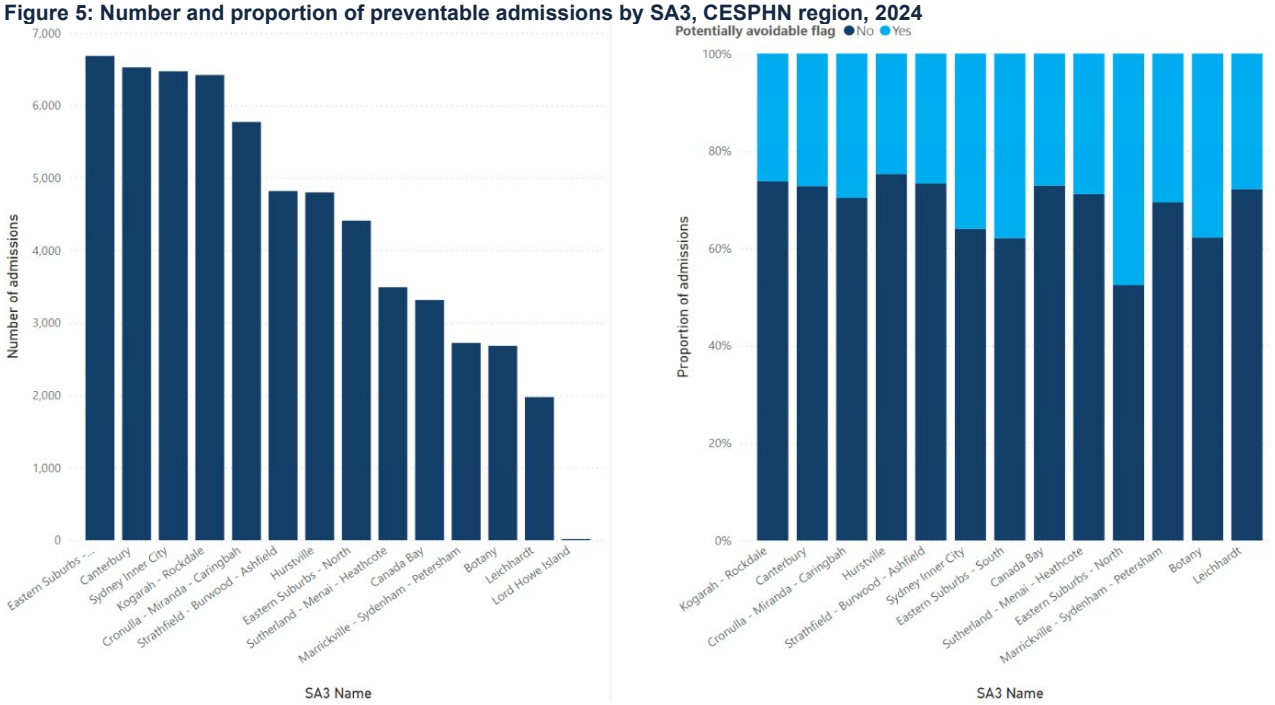
Figure 4: Comparison of patient SA3 to SA3 movement for ED admission, CESPHN region, 2024



Source: Lumos, 2025

Of the region's SA3s, Eastern Suburbs – North has the highest percentage of preventable admissions as determined by the admitting hospital, at 47.5%. The Maroubra UCC is well positioned to reduce the burden of the local hospital by addressing the needs of patients who would otherwise present to the ED.(2)

Figure 5: Number and proportion of preventable admissions by SA3, CESPHN region, 2024



Source: Lumos, 2025

Urgent Care Clinics

NSW Health and the Commonwealth Department of Health, Disability and Ageing have funded CESPHN to commission urgent care clinics (UCC) /services across the region, increasing access to primary care and easing the demand for emergency services. Urgent care services enable people to receive GP led care for urgent but non life-threatening conditions and support nearby hospital emergency departments. UCC clinics include doctors, nurses, and other specialists who provide care across extended hours and offer bulk-billed services, making them affordable and accessible for people who face financial barriers to accessing health care and would otherwise present to ED. Urgent care services are open every day of the year (including public holidays).

At November 2025, there are five active UCC facilities in the CESPHN region. These are in:

- Belmore
- Caringbah
- Carlton
- Green Square, and
- Maroubra

CESPHN Has been funded by the Department of Health, Disability and Ageing to open an additional two UCCs, which will open in December 2025 and will be located in:

- Marrickville, and
- Burwood

At November 2025, the five active clinics are seeing approximately 1,300 patients per week in total with the number of presentations the highest on weekends and Mondays. The busiest times at the clinics are in the mornings (8am-12pm) and evenings (12-pm -4pm). Highest usage of urgent care is among children aged 0-14 years, with approximately 30% of presentations.

Dental care

In 2021-22, per capita spending on dental services in Australia amounted to $432.(3) NSW Health provides safety net dental services for eligible NSW residents. Public dental clinics are usually located in public hospitals and community health centres. All children (0-18 years of age) who are NSW residents are eligible for public dental services in NSW. Adult NSW residents must be eligible for Medicare and be listed on one of the following Australian Government concession cards: Health Care Card, Pensioner Concession Card or Commonwealth Seniors Health Card.

Data from the 2022-23 Patient Experience Survey shows that, in the twelve months prior to the survey:

- two-thirds of people between the ages of 45 and 64 years needed to see a dental professional, those aged 85 years and older had the lowest proportion needing to see a dental professional (51.4%)
- two-thirds of people with a long-term health condition needed to see a dental professional,
- 72.3% of those living in the least disadvantaged areas needed to see a dental professional, compared to 54.7% in the most disadvantaged areas(4)

Access to affordable dental care was a need highlighted in our stakeholder consultations. Nationally in 2022-23, approximately 1 in 6 people delayed or did not see a dental professional; when they needed to, due to cost. More than one quarter (26.1%) of people who at least once delayed seeing or did not see a dental professional when needed – due to cost, lived in the most disadvantaged areas on the index of relative socio-economic disadvantage (IRSD) (3) 11.1% of those who lived in the most disadvantaged areas (IRSD), were placed on a public dentistry waiting list, and 1 in 5 (20.1%) of those who lived in the most disadvantaged areas (IRSD) received public dental care.(3)

In October 2024, NSW Health streamlined processes for access to public dental services; one improvement was combining the current assessment and treatment waiting lists, meaning patients can be seen for urgent dental treatment whilst waiting for routine care. At 30 June 2025, across NSW, 96% of patients had been waiting less than the maximum recommended waiting time for public dental services. For LHDs within the CESPHN region, the proportions were 99% for Sydney LHD and 94% for South Eastern Sydney LHD.(5)

Access to dental care is even more difficult for people that live in aged care facilities or are homeless.

Service navigation

Community and stakeholder consultations identified the following key issues impacting the ability to navigate health services in the CESPHN region:

- Low health literacy
- Provider and consumer challenges with identifying and navigating services.

Health literacy

Health literacy is a determinant of health and is defined by the World Health Organization (WHO) as

> ***"representing the personal knowledge and competencies that accumulate through daily activities, social interactions and across generations. Personal knowledge and competencies are mediated by the organizational structures and availability of resources that enable people to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being for themselves and those around them."(6)***

Low health literacy is associated with a range of factors including poorer health outcomes, limited engagement with the healthcare sector, limited ability to navigate the healthcare system, limited knowledge, and uptake of preventive actions, as well as impaired self-management and increased use of emergency care, hospitalisations, and mortality rates. The combination of low health literacy and complex health needs amplify the difficulties patients experience when navigating a fragmented health care system.

In 2018, the ABS conducted the Health Literacy Survey (HLS) across Australia on previous respondents of the National Health Survey (2017-18), using the Health Literacy Questionnaire (HLQ). The HLQ consists of 44 questions across 9 health literacy domains:

- Domain 1: Feeling understood and supported by healthcare providers
- Domain 2: Having sufficient information to manage my health
- Domain 3: Actively managing my health
- Domain 4: Social support for health
- Domain 5: Appraisal of health information
- Domain 6: Ability to actively engage with healthcare providers
- Domain 7: Navigating the healthcare system
- Domain 8: Ability to find good health information
- Domain 9: Understand health information well enough to know what to do(7)

Results of the domains were analysed across several population characteristics, geographical groups and health risk factors and health status.

Population characteristics

Across domains 1-5, those born overseas generally reported lower disagreement with questions than those who were born in Australia; similar results were seen for those whose main language spoken at home was a language other than English compared to those whose main language spoken at home was English. However, across domains 6-9, those born overseas generally had greater difficulty in being able to actively engage with healthcare providers, navigate the healthcare system and/or

understand health information well enough to know what to do, compared to those born in Australia. Individuals whose main language spoken at home was a language other than English, had significantly higher proportion of respondents claiming difficulty with navigating the healthcare system and/or understanding health information well enough to know what to do compared to those whose main language spoken at home was English.(7)

Geographical groups

Based on the Index of Relative Socio-Economic Disadvantage (IRSD), those living in the lowest two quintiles (i.e. areas of relatively greater disadvantage and lack of advantage in general), had higher proportions of respondent disagreement with 'actively managing my health', 'social support for health' and 'appraisal of health information'. These groups also had greater difficulty in 'ability to find good health information' and 'understand health information well enough to know what to do'.(7)

Health risk factors and health status

Respondents with fair/poor self-assessed health status had much higher disagreement responses across domains 2-5, compared to those with excellent/very good self-assessed health status. The same pattern was seen in respondents with 3 or more chronic health conditions compared to respondents with no selected chronic conditions. Respondents with high or very high levels of psychological distress had higher disagreement responses across domains 1-5 than those with low levels of psychological distress. Across domains 6-9, respondents with fair/poor self-assessed health status, 3 or more chronic conditions and/or high/very high psychological distress all had greater difficulty than those with excellent/very good self-assessed health status, no selected chronic conditions and/or low levels of psychological distress.(7)

These results show the impacts of population characteristics, geographical groupings and health risk factors and health status on health literacy and highlight areas where improvement can be targeted in health service design and provision, as well as public health strategies to improve access to health information and health services.

Supporting consumer health literacy and service navigation

Nationally Healthdirect operate a website and phone line that provides 24-hour health advice. The website includes information on individual general practice, pharmacy and allied health services. People calling the phone line are directed to the most appropriate health service for their condition. Community awareness of this service is still relatively low and greater promotion would be beneficial.

CESPHN has developed a health and community services directory and a mental health services directory to assist people and providers find services within the region. Headstart is a mental health service directory aimed at helping community members find mental health support.

Eight NSW PHNs are co-funding a Medicare Mental Health Phone Line whose aim is to direct people to the right mental health services and support and avoid people having to re-tell their story multiple times. The phone line provides 24 hour support.

Tools to support service provider service navigation

Identification and navigation of services most appropriate to a patient's needs is a challenge for providers, particularly when their patients have complex health needs. CESPHN, SLHD, SESLHD and

SVHN jointly fund HealthPathways, an online health information portal to support local GPs and health professionals. It provides clinical decision support frameworks on how to assess and manage medical conditions and how to appropriately refer patients to local services and specialists.

Specific care coordination challenges

We have identified a range of groups within the CESPHN population who would benefit from improved care coordination. These include veterans, people exiting the justice system, people with a disability and people experiencing family and domestic violence.

Veterans

Service members are taught to prioritise service above their own needs. This can lead to issues in accessing health and mental health support, such as feelings of shame, worry about letting the team down, and a sense of loss upon discharge. There is significant underreporting among members; the 2020-2022 National Study of Mental Health Wellbeing found that veterans were less likely to have reported a mental health disorder in the previous 12 months when compared with non-veterans, at 17% and 22%, respectively. PTSD is often underreported, minimised, or not coded appropriately, and there are high levels of suicide ideation among veterans.(8) According to the 2021 Census, a total of 152,170 individuals have served or are serving in New South Wales of which 18,007 are currently serving in the regular service and 6,506 are currently serving in the reserves service.(9)

Primary care providers can struggle to support veterans because they do not have access to medical histories from within the military. Although veterans are given their medical history and a handover letter, they do not always share these with primary care providers. Serving members or veterans might not link their service history to their medical presentations, but if clinicians ask, it can lead to better understanding and potentially more entitlements to health checks and other benefits. A new system is being developed to link military medical history with civilian history, which should be released soon.

People leaving the criminal justice system

NSW has the largest prisoner population with 12,897 adults and 209 juveniles in custody as of September 2024, 12-month increases of 5.1% and 6.1% respectively.(10) There is an overrepresentation of Aboriginal persons (31.3% of adults and 50% of juveniles in custody).(11)

The prisoner population is fluid with people constantly entering and being released from the system. This constant movement means that the health issues of people in custody become the health issues of the community. Over the 12-month period to September 2024, 1,388 adults and 16 juveniles in NSW were discharged due to their sentence expiring.(10) By December 2023, 43.6% of adults and 73.6% of juveniles who were released from sentenced custody had reoffended within 12 months of discharge.(12)

Although the Justice Health and Forensic Mental Health Network has implemented several projects aiming to better support people when they leave prison, such as reminders to collect their medications and health summaries, these projects can be challenging due to the ad-hoc nature and constant movement of people. For example, a large number of prison departures may not be planned. The Single Digital Patient Record (SDPR) system may overcome some of these issues however this is also dependent on the capability of SDPR to integrate with primary care systems.

Mental health and alcohol and other drug support services are delivered through Community Corrections, a division within Corrective Services NSW that manages and supervises offenders sentenced to various types of community-based orders by the courts or released from prison on parole to complete the remainder of their sentence in the community. Often these are people with very complex needs that often end up sleeping rough and experiencing recidivism.

People living with a disability

There are approximately 180,000 people living with a disability in the CESPHN region. There is a need for improved coordination between primary care and disability services and multidisciplinary, integrated models of care. AIHW data indicates that 26.4% of people with a severe or profound disability who saw 3 or more health professionals for the same condition felt the health professional did not help coordinate care. CESPHN hosts a Disability Network that includes a broad range of stakeholders including people with a lived experience, disability providers and primary care providers. This group provides an opportunity to strengthen coordination. CESPHN also delivers training to primary care providers on how to best support people with an intellectual disability and the importance of working together with the person's Disability Support Team.

People experiencing family and domestic violence

Primary care has a role in recognising domestic and family violence (DFV) and providing trauma informed and culturally safe care to victims. There is a need for a more coordinated approach between primary care and domestic violence support services as well as increased training and support provided to primary care services to respond better to DFV. Navigating the DFV service sector to seek support for a patient can be challenging and CESPHN has established DFV Assist to provide a navigation service for health professionals to better support their patients experiencing DFV.

Older people

As people age their care typically becomes more complex and reliant on a range of service providers including community aged care, residential aged care, primary care and acute care. It is currently very difficult to share information between these various providers creating delays and inefficiencies in the system. CESPHN has provided telehealth equipment to residential aged care homes to enable telehealth consultations with their GPs and other health care providers. Further work needs to occur to better integrate community aged care providers.

Joint planning

Joint planning between primary health networks, local health districts, and other consumer and provider organisations can assist to improve care coordination.

CESPHN participates in numerous partnership committees with the local health districts and speciality health networks in our region that cover mental health, alcohol and other drugs, disability, sexual health and viral hepatitis, diabetes and aged care.

There are a number of regional plans that have been developed with partners including the Joint Regional Mental Health and Suicide Prevention Plan, the Intersectoral Homelessness Health Strategy and the Inner West Child Health and Wellbeing Plan.

Digital health and interoperability

The COVID-19 pandemic accelerated the rollout of technologies that streamline the flow of relevant patient information between service providers, however ensuring the consistent and meaningful use of these tools is a continuing challenge for the region. Consultations with GPs, allied health professionals, hospitals and local health districts demonstrated that the use of digital health technologies by clinicians and services were related to the level of digital health maturity within each setting, as well as the interoperability between digital health systems across service providers and between acute and primary care.

NSW Health has commenced rolling out the Single Digital Patient Record (SDPR) program across the state and this system has the capacity to share data between providers as well as with patients. Primary health networks are advocating strongly for the involvement of primary care in the design of the SDPR and especially the portal between general practice and acute care.

Between 2024 and 2025, the number of computerised general practices decreased from 96.8% to 96.2%. My Health Record uptake remained stable at 84.2% of general practices, while the number of practices registered for secure messaging decreased from 94.5% to 93.5%.(13)

Table 4: Digital health initiatives in the CESPHN region, as at September 2025

Digital health initiatives	No. of general practices 2024	No. of general practices 2025	% of computerised practices 2024	% of computerised practices 2025	% of general practices 2024	% of general practices 2025
Computerised practices (clinical software)	537	535	100.0	100.0	96.8	96.2
Registered to access MyHR	470	470	87.9	91.1	85.7	84.2
Use secure messaging solution	522	529	97.2	98.9	94.5	93.5

Source: CESPHN CRM database, 2025

*** % of computerised practices value is against the aggregate number of computerised practices*

My Health Record

Meaningful use of My Health Record (MyHR) can improve health outcomes by supporting the sharing of patient information between providers across the health system, which can reduce duplication of services, lessen medication errors and increase patient participation in their care. As organisations decommission faxes, MyHR offers a suitable enhancement for the transfer of patient data. MyHR statistics generally demonstrate increases in views and uploads by various health care services in the CESPHN region, largely propelled by software vendors continuing to integrate MyHR functionality. As of September 2025, 438 out of 464 pharmacies were MyHR registered.(13)

Despite the high rate of general practice MyHR registration in the CESPHN region, uptake has slowed and few practices upload at least one summary per week indicating that more work is required to integrate MyHR into daily practice activity. As the upload of shared health summaries is one of the

requirements of the Practice Incentive Program eHealth Incentive (ePIP), with the required number being a proportion of the practice's standard whole patient equivalent (SWPE), uploads are often performed to meet the requirement rather than utilise the MyHR system for its intended purpose. As such, the viewing and uploading of documents that are not associated with incentives demonstrates legitimate use of the system.

From an allied health perspective, technology integration with MyHR is poor. Most platforms used by allied health are not able to integrate with MyHR, and the National Provider Portal only facilitates viewing and downloading, not uploading. To date, 617 allied health practices are registered in our region.

Secure messaging

Secure messaging is a core capability for safe, seamless, secure, and confidential provider-to-provider communication, enabling electronic access to patient information. It has not reached its potential in terms of application, however the introduction of online solutions such as the MyHealthLink Portal has helped increase uptake by providers that would otherwise be ineligible due to their software configuration. Furthermore, the industry-wide push for interoperability is continuing to increase the efficiency of secure messaging, particularly between general practices using differing platforms. The need for improved access to patient information from hospitals is continually raised by GPs. The rollout of the Single Digital Patient Record (SDPR) in NSW presents an opportunity to address this long-running issue. Until more permanent solutions are implemented CESPHN continues to work closely with the local health districts and specialty health networks to resolve specific problems.

Smart forms and eReferrals

Smart Forms and eReferrals allow for documents to be pre-filled with clinical data and transmitted point-to-point. As with secure messaging, the promotion of technologies that facilitate the efficient transfer of information between service providers has resulted in a significant increase in the number of providers configured to send Smart Forms and eReferrals. However, medical specialist practice adoption remains low, which can be attributed to ongoing interoperability issues and the high cost of secure messaging services, which limits secure messaging to those who are both able to afford the service and have the digital health maturity to use it. The recent acquisition of Argus by Healthlink will help with increasing adoption by medical specialist practices.

As of June 2025, 531 general practices and 1,248 medical specialist practices were configured to send Smart Forms and eReferrals. Between July 2024 and June 2025, 67,112 eReferrals were received by LHDs in the CESPHN region.

Electronic prescribing

Electronic prescribing provides an option for prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme (PBS) prescription in place of a paper prescription and is delivered via a prescription exchange service. As of September 2025, 90.5% of pharmacies were able to dispense electronic prescriptions and 71.8% of computerised general practices were able to issue electronic prescriptions.

Table 5: Electronic prescribing capable practices in the CESPHN region, September 2025

Type	No. of practices
General practice	386
Pharmacy	420

Source: CESPHN CRM database, 2025

Shared Care

CESPHN and the local health districts are working together on a ranged of shared care initiatives to ensure coordinated care for people requiring complex care. These initiatives exist in mental health, antenatal care, cancer care and alcohol and other drugs. Having an electronic shared health care plan would further streamline the delivery of shared care but this has proven problematic given system interoperability issues.

MyMedicare

MyMedicare is a voluntary patient registration model that provides incentives for both general practices and patients when patients register with a particular practice. This link between patients and their preferred general practice has the possibility to lead to greater continuity of care. As of September 2025, 379 general practices in the central and eastern Sydney region have enrolled in the MyMedicare program.

Disaster management

Primary care needs to be better integrated in disaster management plans. CESPHN has established a Primary Care Emergency Response Team to ensure continuity of access to primary care when there is a disaster or critical incident and to support the emergency response by addressing immediate health needs in a disaster situation or an unexpected event. The team includes GPs, practice nurses, pharmacists and mental health professionals. Once the team is established, we will look to integrate further with local councils and other key stakeholders.

The types of events that may require an emergency response could include:

- Natural events – bushfires, heatwaves, severe storms, flooding, earthquake
- Public safety threats and major transport accidents
- Hazardous materials accidents
- Major public health threats.

Key issues impacting access

Increasing out of pocket GP consultation costs

The increasing out of pocket cost of GP consultations, combined with the reducing number of practices that offer bulk billing, imposes financial strain on residents in the Central and Eastern Sydney region and may result in patients not receiving timely care. This issue was raised as a major health concern in every consultation held as part of the development of this needs assessment. The increase in out-of-pocket expenses is disproportionate across the region.

Poor care coordination for specific population groups

Groups most impacted by lack of coordinated care include veterans, people leaving the criminal justice system, people living with a disability, people experiencing family and domestic violence and older people. Further work needs to occur with partners to improve care for these groups of people.

Low uptake and utilisation of My Health Record

While a large number of general practices in the region are registered for My Health Record, allied health and medical specialist organisations are lagging due to incompatible vendor software. General

practice uploads of data to My Health Record are low. Furthermore, patient awareness has not been a key focus since the end of the opt-out period for My Health Record registration in January 2019.

Need for more connection between general practice and allied health

There is a need to provide a more holistic approach to care that acknowledges the connection to mental and physical health and the impact of social determinants that affect people's health. For this to occur, there needs to be a continued focus on designing models of service delivery where GP services work closely with allied health, either via outreach models, co-location, or joint care plans. There are small scale pilots being undertaken by CESPHN attempting to offer models for multidisciplinary team care.

Central and Eastern Sydney PHN has an Allied Health Engagement Strategy that focuses on increasing participation of allied health professionals through various avenues, including an allied health network providing professional connections and training, promoting the adoption of digital health tools so that there is consistency between allied health professionals and with general practice, supporting with quality improvement activities and creating professional development and recognition pathways.

Need for improved information sharing between primary and acute care

Improving system integration between primary and acute care provides many advantages for continuity of care, including more effective and efficient treatment in the hospital setting and, in turn, a reduction in preventable hospitalisations. Health system interoperability is the key to addressing this issue.

Supporting care transition across the lifecycle

As people transition through life they receive support from different care providers. There is an opportunity to improve this transition process such as when a child receiving care through local paediatric services over many years becomes an adult and has to receive care under different protocols and by different providers. Similarly, the care needs of someone aged 20-65 is likely to be very different to that of people aged 70 years and over, requiring aged care support. Patient education, improving health literacy and working with service providers will help facilitate this transition.

CESPHN's current work

- CESPHN commissions urgent care services in our region: There are currently 5 active UCCs in the CESPHN region (Maroubra, Carlton, Caringbah, Green Square and Belmore), with two new urgent care services due to open in December 2025 (Marrickville and Burwood)
- MyMedicare and GP Aged Care Incentive (GPACI): supporting general practices and providers to register for MyMedicare and GPACI. CESPHN will offer ongoing support to non-accredited general practices to achieve accreditation so they can participate in MyMedicare and GPACI.
- CESPHN supports general practices with quality improvement (QI) activities in line with the requirements of the PIP QI incentive and to promote a team approach to QI in general practice.
- Over the next four years, CESPHN will commission the GP+ program. This program will support smaller general practices to connect to local allied health providers, improve health outcomes through a multidisciplinary approach and enhance patient experiences in primary care
- Service navigation: CESPHN commissions a Multicultural Health Navigator Service to assist people within the region with limited or no English proficiency who speak Mandarin, Cantonese, Arabic, Korean or Nepali to navigate health and related services.
- Service navigation and referrals: CESPHN jointly funds two HealthPathways programs within the CESPHN region with SLHD, SESLHD and SVHN. The HealthPathways program provides clinical decision support frameworks on how to assess and manage medical conditions and how to appropriately refer patients to local services and specialists
- Service navigation: CESPHN has developed a health and community services directory and a mental health services directory to assist people and providers find services within the region.
- Mental health service navigation: CESPHN is one of eight NSW PHNs co-funding a Medicare Mental Health Phone Line whose aim is to direct people to the right mental health services and support and avoid people having to re-tell their story multiple times. The phone line provides 24 hour support.
- CESPHN has developed a digital health strategy to drive the support it provides to health professionals in the region.

Opportunities

- The changes to Medicare Benefits Schedule items for chronic disease management in July 2025 could also help strengthen the practice nurse role.
- Incentivise retention and recruitment
- Promote virtual care services
- Exploring artificial intelligence (AI) systems that are being tailored to general practice to optimise efficiency and patient care
- Continued focus on improving usage of digital tools among general practices
- Supporting care transitions across the lifecycle.
- Ensure follow up and handover of care to a GP for people leaving justice system
- Improved identification and support of veterans in primary care
- Continued focus on supporting better integration of primary care with disability services
- Work to facilitate improved care coordination between primary care and community aged care
- Implementation of a centralised mental health intake and assessment model to combine intake, assessment, and referral services
- Consumer education on digital solutions and how to navigate the health system
- Promotion of service directories and Healthdirect
- Incentivise allied health and specialist adoption of My Health Record
- Re-engage general practices on the My Health Record, providing them with updates on new features

- Facilitate communication between GPs and acute care via access to Single Digital Patient Record and an electronic shared care plan
- Improved engagement of primary care in disaster management.

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