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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Our region

2022-2024 Needs Assessment

15 November 2021

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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Geography

CESPHN covers an area of 626 square kilometres that includes central and eastern Sydney and the remote Norfolk and Lord Howe islands. The boundaries align with those of the South Eastern Sydney Local Health District (SESLHD) and Sydney Local Health District (SLHD).

Population

CESPHN is the second largest of the 31 PHNs across Australia by population, with an estimated resident population (ERP) of 1.67 million in 2020.(1) This includes 17,468 Aboriginal people.

CESPHN also has a large non-resident population with over 0.4 million people entering the region each day to work, and many more to visit or study, inevitably making use of a range of health services.(2)

The highest concentration of the population live in the Statistical Area 3 (SA3) of Sydney Inner City (15.3%), followed by Strathfield-Burwood-Ashfield (10.2%).(1) The majority of SA3s have densities above 4,000 people per square kilometre (sq km) which rises to over 10,000 per sq km in Sydney Inner City. Seven of the ten most densely-populated SA2s in Australia can be found in the CESPHN region surrounding the central business district.(2) Conversely our region also includes the remote communities on Norfolk Island and Lord Howe Island.

Table 1: Estimated resident population (ERP) in the CESPHN region by SA3, 2020

SA3	Total persons	% of region	Density (per sq km)
Botany	56,550	3.4	2,034.2
Canada Bay	93,775	5.6	4,760.2
Canterbury	147,127	8.8	4,920.6
Cronulla-Miranda-Caringbah	119,365	7.1	2,143.0
Eastern Suburbs - North	139,479	8.3	5,323.6
Eastern Suburbs - South	156,609	9.4	4,987.5
Hurstville	138,993	8.3	4,100.1
Kogarah-Rockdale	156,283	9.3	4,977.2
Leichhardt	61,764	3.7	5,772.3
Lord Howe Island	403	0.02	24.7
Marrickville-Sydenham-Petersham	60,171	3.6	4,737.9
Norfolk Island	1,734	0.1	50.5
Strathfield-Burwood-Ashfield	171,112	10.2	5,003.3
Sutherland-Menai-Heathcote	112,576	6.7	468.7
Sydney Inner City	256,105	15.3	10,162.9
CESPHN region	1,672,046	100.0	2,654.5

Source: ABS 2020 ERP

Our population is characterised by:

- Cultural diversity: 40% of the community were born outside Australia, 38% speak a language other than English at home and 7% do not speak English well or at all.
- A high concentration of same sex couples: around 1 in 5 of all those living in Australia.
- High numbers of people experiencing homelessness or at risk of homelessness:

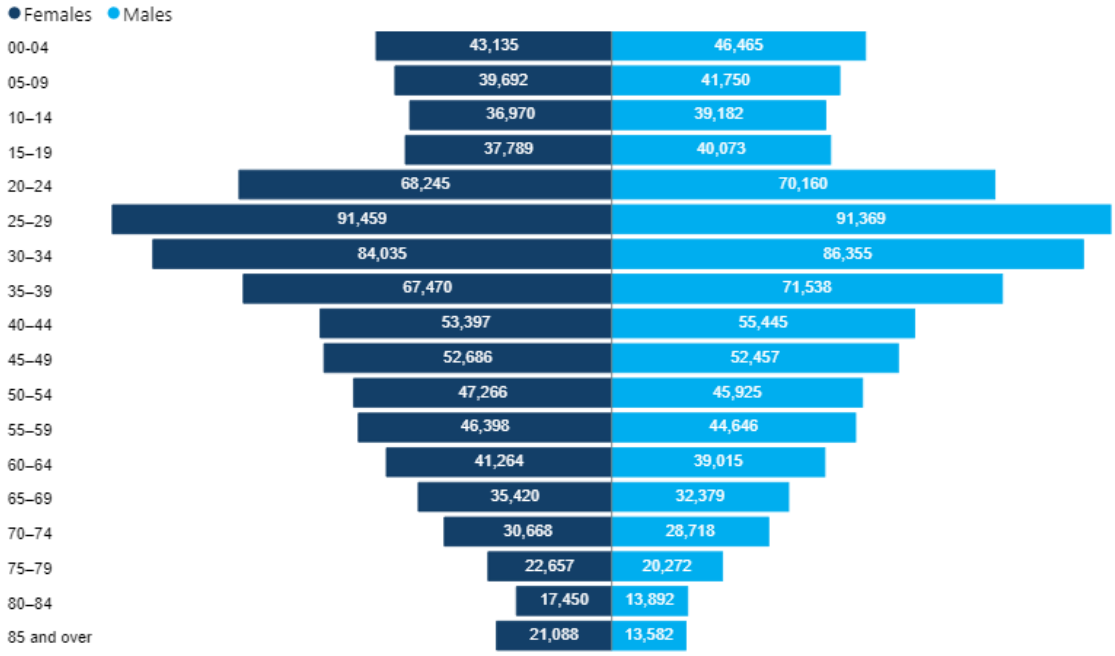
- 35% of the NSW homeless population
- 65% of NSW boarding house residents
- 22% of NSW social housing residential dwellings and long waitlists for general applicants.[1]

The overall level of advantage in the CESPHN region is above that of the Australian average, however there are pockets of disadvantage in the SA3 of Botany, Canterbury, Hurstville, Kogarah-Rockdale, Strathfield-Burwood-Ashfield, Sydney Inner City, and Eastern Suburbs-South.

Age and gender

Comparison of 5-year age groups shows the highest proportion of the CESPHN population are aged 25-29 years (10.9%). Adults aged 25-64 years constitute 63% of the CESPHN region, while 14% of the region is aged 65 years and over. There are 837,089 females (50.1%) and 833,223 males (49.9%) in the region, which is consistent with national rates.(1)

Figure 1: Age breakdown by gender, CESPHN region, 2020



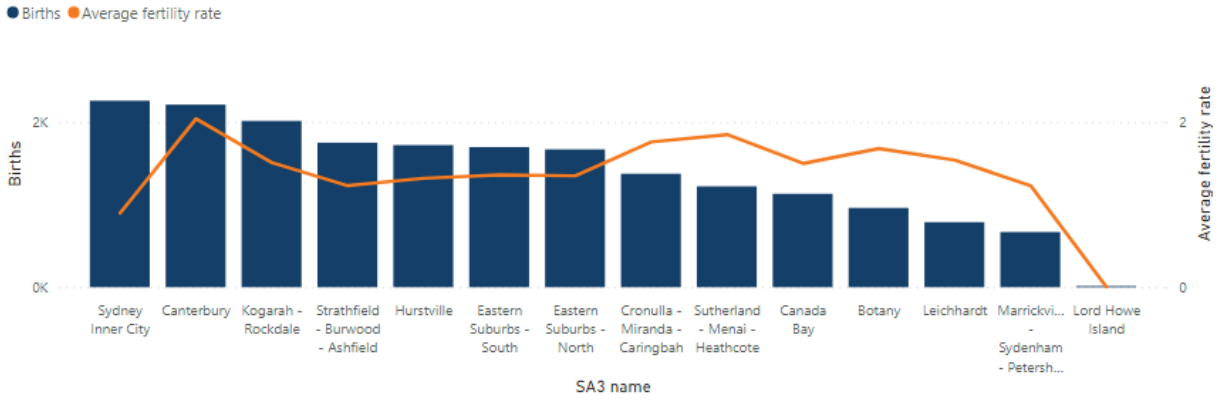
Source: ABS 2020 ERP
Note: This does not include Norfolk Island, as ERP by age group was not provided by the ABS.

Births

In 2019, there were 19,481 live births in the CESPHN region. The highest number of births were in the SA3 of Sydney and Inner city (2,260), followed by Canterbury (2,212) and Kogarah- Rockdale (2,015).(3) The total fertility rate was highest in SA3 of Canterbury (2 babies per woman) and lowest in Sydney Inner City (less than 1 baby per woman).(3)

[1] See Regional Priority Population Groups for a further description of these priority groups.

Figure 2: Number of live births and fertility rate in the CESPHN region by SA3, 2019



Source: ABS, 2019 Births

Population growth

Between 2016 and 2036, the population in the CESPHN region is expected to increase by 28.7% to 2,020,750 residents. The greatest population growth is expected in the 85 years and over age group (101.4% increase).(4) These projections are based on assumptions about future trends in fertility, mortality and migration.

Table 2: Population projections by age groups, CESPHN region, 2016 - 2036

Age group	2016	2036	% change
0-14 years	240,703	321,450	33.6
15-64 years	1,120,672	1,346,670	20.2
65+ years	209,106	352,630	68.6

Source: HealthStats NSW, 2020

Botany SA3 had two of the highest growth SA2s within the CESPHN region between 2016 and 2020, Banksmeadow SA2 had a 976.2% increase in ERP (2016 ERP n=21, 2020 ERP n=226), and Botany SA2 (18.6% increase in ERP). Arncliffe-Barwell Valley SA2 had the second highest growth in ERP (24.5%), followed by Waterloo-Beaconsfield SA2 (23.9%) and Homebush SA2 had the fifth highest growth in the CESPHN region (18.4%).(5, 6) Key development projects in our region that will impact our resident and non-resident population include Green Square, Waterloo and the Redfern North Eveleigh precinct renewal.

References

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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, 2017-2019

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

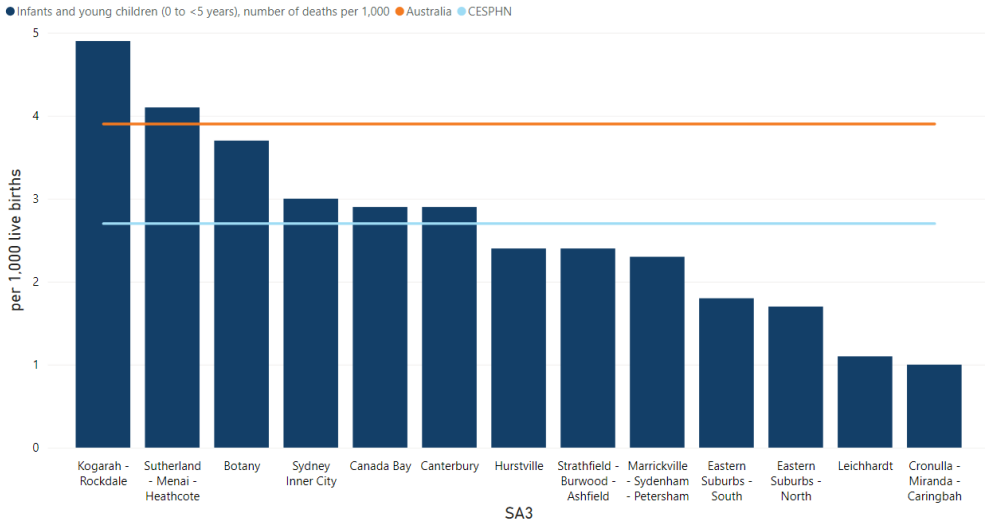
Source: AIHW 2019

Infant and young child mortality

The 2014-2016 mortality rate for infants and young children aged less than 5 years was lower in the CESPHN region (2.7 deaths per 1,000 live births) compared to the national rate (3.9 deaths per 1,000 live births).(2)

Kogarah-Rockdale (4.9 per 1,000 live births) and Sutherland-Menai-Heathcote (4.1 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, 2014-2016



Source: AIHW 2018

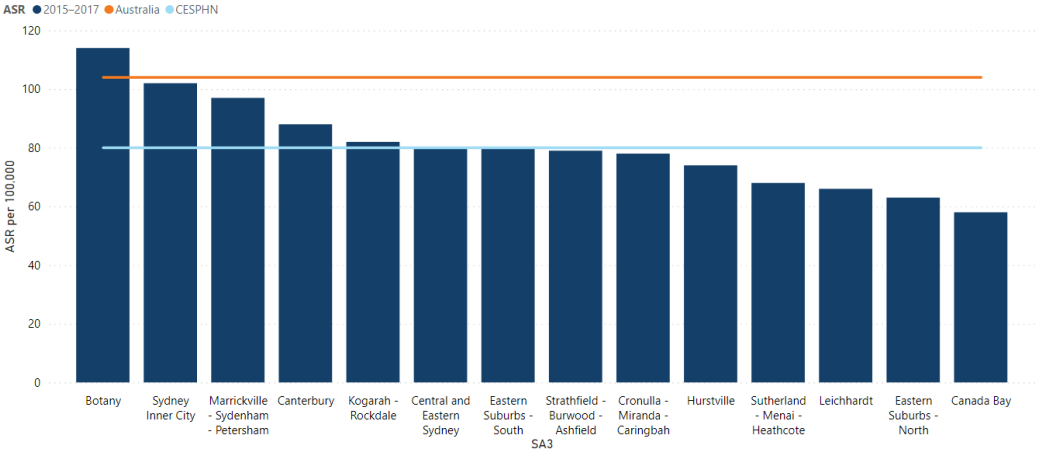
Potentially avoidable deaths

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

In 2017-2019, the age-standardised rate (ASR) of potentially avoidable deaths in the CESPHN region (78.4 per 100,000 people) was lower than both the NSW (100.2 per 100,000) and national rates (104.2 per 100,000 people).The rate for males (103.7 per 100,000 people) was much higher than the rate for females (53.9 per 100,000 people) in the CESPHN region.(1)

In 2015-2017, Botany (114.3 per 100,000 people) had the highest rate of potentially avoidable deaths. Most SA3s have seen the same national downward trend in potentially avoidable deaths, except for Canterbury which has seen an increase over time.

Figure 2: Potentially avoidable deaths in the CESPHN region (ASR per 100,000) by SA3, 2015-2017



Source: AIHW 2019

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. In 2014-2018, premature mortality rates in the CESPHN region (192.5 per 100,000 people) were lower than both NSW (238.1 per 100,000 people) and national rates (237.2 per 100,000 people).(3)

The male rate (242.6 per 100,000 people) was much higher than the female rate (142.2 per 100,000 people) in the CESPHN region. Botany (248.2 per 100,0000 people) had the highest rate of all SA3s for both genders.(3)

The three highest causes of premature mortality were from cancer (84.2 per 100,000), circulatory system diseases (33.8 per 100,000) and external causes (22.1 per 100,000).(3) Botany had higher premature mortality rates for cancer (103.1 per 100,000) and circulatory disease (44.6 per 100,000) than state and national rates.

Table 2: Premature mortality per 100,000 people by cause by SA3, 2014-2018

SA3	Cancer	Cerebrovascular disease	Circulatory disease	COPD	Diabetes	External causes	Ischaemic heart disease	Respiratory system disease	Road traffic	Suicide
Botany	103.1	9.8	44.6	11.7	7.2	25.4	19.6	17.7	2.1	11.8
Canada Bay	68.7	5.4	27.5	3.9	3.1	17	11.7	5.9	1.9	7.4
Canterbury	86.3	8.7	42.2	6.6	7.4	21.4	18.6	13.1	2.1	5.9
Cronulla - Miranda - Caringbah	78.3	5.8	28.4	3.9	3.4	21.3	14.4	8.1	2.1	9.7
Eastern Suburbs - North	71.6	5.4	25.2	2.1	2.2	18.5	12.6	5.6	2	9
Eastern Suburbs - South	91.5	7.5	34.9	6.3	4.3	21.7	16.5	11.2	1	8.6
Hurstville	82.3	7.8	33.1	6	5.4	17.5	14.4	10.6	0	7.3
Kogarah - Rockdale	91.9	7.5	34	4.7	7	17.7	15.6	9.2	1.9	6.1
Leichhardt	87.5	5.8	29.7	4.8	3.1	24.4	13.7	10.6	3.6	8.5
Marrickville - Sydenham - Petersham	91.2	10.1	44.5	8.2	8.2	26.9	18.5	15	2.8	11.1
Strathfield - Burwood - Ashfield	80.6	10.5	36	5.6	5.2	18.4	15.9	11.8	0	7.3
Sutherland - Menai - Heathcote	80.3	6.5	29.2	5.4	4.8	18.5	13.9	12.7	2.1	8.5
Sydney Inner City	92.1	7.5	39	10.8	4.4	32.9	19.2	17.3	1.6	12.7
CESPHN	84.2	7.5	33.8	5.9	4.9	22.1	15.6	11.1	1.7	8.8
NSW	99.1	8.3	43.2	10.1	6.7	27.8	21.2	16.8	3.4	11
Australia	98.4	7.9	43.1	9.7	6.5	30.1	22.0	16.1	4.5	12.4

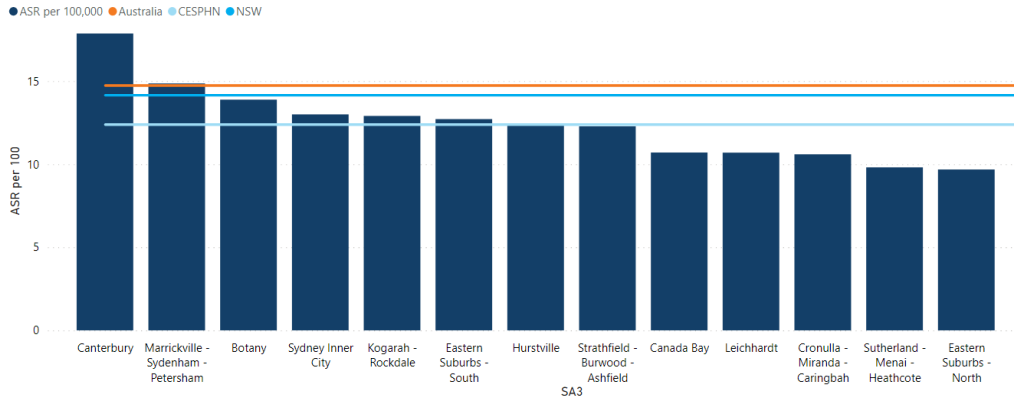
Source: PHIDU 2021

Self-assessed health status

In 2017-18, a lower percentage of people living in the CESPHN region (12.4%) reported fair or poor health compared to the NSW (14.1%) and national average (14.7%).(3)

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 2017-18 show Canterbury (17.9 per 100 people) had the highest rate of fair or poor self-assessed health in the region.(3)

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, 2017-2018



Source: PHIDU 2021

Psychological distress

In 2017-2018, the rate of people experiencing high or very high psychological distress in the CESPHN region (10.4 ASR per 100 people) was lower than the NSW (12.4 ASR per 100) and national rate (12.9 ASR per 100).(3) Please refer to Mental Health report for further analysis.

Chronic disease

Cancer incidence

In 2017, there was a total of 7,848 new cases for all cancers in the CESPHN region. Incidence was higher in males (534.2 ASR per 100,000 males) than females (423.9 ASR per 100,000 females). In terms of number of cases, the 60–69-year age group had the highest number (1,915). However, the 80+ year age group had the highest rate (2,500.1 ASR per 100,000 persons).(4)

Table 3: Incidence of Cancer in the CESPHN region by age group, 2013-2017

Age group	Number of cases	ASR per 100,000
0-49	1,211	107.4
50-59	1,299	716.5
60-69	1,915	1,379.5
70-79	1,908	2,146.7
80+	1,515	2,500.1

Source: Cancer Institute NSW 2021

Prostate cancer was the most common type of cancer in the CESPHN region (15.4% of all cases), whereas lung cancer contributed to the highest proportion of deaths (18.8% of cancer deaths) from 2013 to 2017.(4)

Table 4: Most common cancer types in the CESPHN region, 2013-2017

	% of cases		% of deaths
Prostate	15.4	Lung	18.8
Breast	13.7	Colon	7.2
Melanoma of skin	9.1	Pancreatic	6.9
Lung	8.3	Breast	6.7
Colon	7.4	Prostate	6.0

Source: Cancer Institute NSW 2021

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. Please refer to the sexual health section for more information on viral hepatitis.

Overall, males in the CESPHN region have seen a faster increase in new liver cancer cases and in 2017 had a higher incidence rate (11.1 ASR per 100,000 males) compared to females (4.0 ASR per 100,000 females). Similarly to all cancer data, number of cases was highest in persons aged 60-69 years and highest rate was in those aged 80+.(4)

Five out of 13 LGAs in the CESPHN region have a higher liver cancer incidence rate compared to the NSW rate, with Randwick and Sydney LGAs having the highest rate (11.0 ASR per 100,000 people).(4)

Table 5: Incidence of liver cancer in the CESPHN region by LGA, 2013-2017

LGA	ASR per 100,000
Botany Bay	7.9
Burwood	10.2
Canada Bay	9.1
Canterbury-Bankstown	9.9
Georges River	7.5
Inner West	9.7
Randwick	11.0
Rockdale	8.3
Strathfield	8.5
Sutherland Shire	7.6
Sydney	11.0
Waverley	4.4
Woollahra	4.3
NSW	8.3

Source: Cancer Institute NSW 2021

Cancer management

Cancer care in the CESPHN region is provided by Sydney Local Health District (SLHD), South East Sydney Local Health District (SESLHD) and St Vincent's Hospital Network (SVHN). In 2019,

approximately 1,743 patients from these service providers completed an outpatient cancer clinic survey which identified that more than half of surveyed patients did not have a current or ongoing cancer management plan.(6) That same year CESPHN conducted a review that resulted in GPs identifying a lack of confidence in cancer management of patients due to access barriers to specialist communication. This is an important gap to address as research supports the need of general practices to be more involved at all stages of cancer care.(7)

Diabetes

In 2019, the prevalence for diabetes in the CESPHN region (9.1%) was less than the NSW percentage (11.1%). However, females in the region had a higher prevalence (9.7%) compared to the state rate (9.1%).(8) There were 67,570 National Diabetes Services Scheme (NDSS) (4% of the CESPHN population) in 2021. The majority of registrants have Type 2 diabetes (84.1%), followed by Type 1 (11.2%), gestational (3.7%), and other (1.0%).(9)

From 2013-2017, incidence of insulin-treated Type 1 diabetes was highest in Sutherland-Menai-Heathcote (12.3 per 100,000 people) and Type 2 diabetes was highest in Eastern Suburbs-North (9,333.9 per 100,000 people).(10)

The annual diabetes cycle of care is for patients with established diabetes and includes diabetes management and general health checks. In 2020-21, 4,544 patients in the CESPHN region received an annual diabetes cycle of care (0.27 per 100 people compared to 0.57 per 100 people nationally). Canterbury had the highest rate of people receiving this MBS item (0.49 per 100 people).(11)

Chronic kidney disease

In 2011-12, the modelled prevalence of chronic kidney disease (CKD) in the CESPHN region was 5.5% for persons aged 18-54 years. This was below both the NSW (5.6%) and national rate (6.1%).(12) However, it is important to note that Aboriginal and Torres Strait Islander people (here in referred to as Aboriginal people) are twice as likely to have CKD.(13) This can be evidenced in the rate of chronic kidney disease hospitalisations during 2016-17, where the rate for Aboriginal people (1,974.1 per 100,000 people) was more than double the non-Aboriginal rate (923.2 per 100,000 people).(8)

Other chronic diseases

2017-18 modelled prevalence estimates of other chronic conditions showed that rates in the CESPHN region were below both state and national rates for all conditions, except for osteoporosis.(3)

Table 6: Rate of people aged 18 years and over with selected chronic diseases, ASR per 100, by SA3, 2017-2018

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

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 2017-18, there were 14,735 PPHs for chronic conditions, equivalent to 872 per 100,000 people. This was lower than the national rate of 1,233 per 100,000 people. The most common PPH was for congestive cardiac failure (179 per 100,000 people), with an average length of stay of 7.2 days.(14)

Table 7: PPHs for chronic conditions in the CESPHN region by condition, 2017-2018

PPH condition	PPH per 100,000 (ASR)	No. of PPH	Average length of stay (days)
Angina	109	1,809	1.8
Asthma	99	1,423	2.5
Bronchiectasis	18	312	6.8
COPD	166	2,835	6.4
Congestive cardiac failure	179	3,352	7.2
Diabetes complications	116	1,922	6.7
Hypertension	33	572	2.4
Iron deficiency anaemia	137	2,273	1.6
Nutritional deficiencies	3	58	n.p
Rheumatic heart disease	11	178	8.8
Total chronic	872	14,735	4.9

Source: AIHW 2019

Lifestyle risk factors

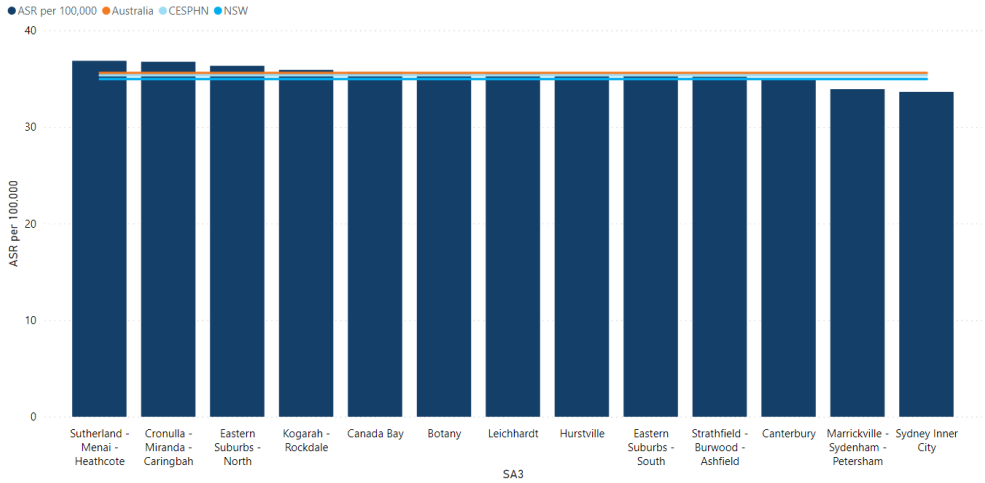
Overweight and obesity

Adults

2017-18 PHIDU modelled estimates demonstrate that the male population was more likely to be overweight (41.6%) compared to the female population (29.4%), while obesity rates were similar in both genders.(3)

Four SA3s had rates above the state (35.0%) and national (35.6%) rates – Sutherland-Menai-Heathcote (36.8%), Cronulla-Miranda-Caringbah (36.8%), Eastern Suburbs-North (36.3%) and Kogarah-Rockdale (35.9%).(3)

Figure 4: Rate of people aged 18 years and over who were overweight (ASR per 100) by SA3, 2017-2018



Source: PHIDU 2021

Obesity rates in CESPHN SA3s were all below the state (30.9%) and national (31.3%) rates. Sutherland-Menai-Heathcote had the highest rate (29.0%).(3)

Children

Between 2017-18, the estimated rate of children (2-17 years) in the CESPHN region considered overweight was 16.9%, which was similar to the state (17.0%) and national rate (16.7%). Overweight rates were similar across SA3s. However, rates for obese children in CESPHN (4.9%) was much lower than state (7.4%) and national rates (8.2%). Eastern Suburbs – South (6.9%) had the highest rate of obese children.(3)

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 – Eastern Suburbs – North (59.1%) and Marrickville – Sydenham – Petersham (48.8%).
- Current smokers – Canterbury (15.3%) and Leichhardt (8.7%).
- Low, very low or no exercise in past week – Canterbury (74.3%) and Eastern Suburbs – North (49.7%).
- More than two standard alcoholic drinks per day **–** Eastern Suburbs – North (20.3%) and Canterbury (7.8%).(3)

Table 8: Health behaviour rates of people aged 18 years and over by SA3 (ASR per 100), 2017-2018

SA3	Adequate fruit intake	Current smokers	Low, very low or no exercise	More than two alcoholic drinks per day
Botany	52.0	14.5	68.9	11.4
Canada Bay	54.6	10.0	60.6	14.2
Canterbury	56.8	15.3	74.3	7.8
Cronulla - Miranda - Caringbah	54.8	11.7	59.0	19.5
Eastern Suburbs - North	59.1	9.0	49.7	20.3
Eastern Suburbs - South	55.8	12.1	60.7	14.9
Hurstville	52.5	12.4	65.6	12.1
Kogarah - Rockdale	54.0	13.7	68.4	10.3
Leichhardt	50.5	8.7	55.6	18.5
Marrickville - Sydenham - Petersham	48.8	14.2	61.3	14.7
Strathfield - Burwood - Ashfield	53.7	13.1	65.0	10.2
Sutherland - Menai - Heathcote	53.2	9.3	61.5	19.0
Sydney Inner City	50.3	13.5	58.1	15.3
CESPHN	53.7	12.3	62.0	14.3
NSW	52.5	14.4	65.3	15.5
Australia	51.3	15.1	66.1	16.1

Source: PHIDU 2021

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.(15)

Preventive health

Immunisation

Childhood coverage

As at March 2021, fully immunised rates in the CESPHN region were above state and national rates for 1-year-olds, while 2 and 5-year-olds were below both rates. The 2 year old age group had the lowest fully immunised rates, which is a common trend across the state and nationally due to the number of strains counted as 'fully immunised'.(16)

The Aboriginal and Torres Strait Islander fully immunised rate for the 5 year age group was above the national 95% target.(16)

Table 9: Fully immunised rates, by region and age group, as at March 2021

	1-year-olds			2-year-olds			5-year-olds		
Children	CESPHN	NSW	National	CESPHN	NSW	National	CESPHN	NSW	National
All	95.0	94.9	94.9	91.3	92.3	92.5	92.9	95.0	95.2
Aboriginal	92.5	94.6	93.7	90.3	92.9	91.7	98.4	97.7	97.2

Source: Department of Health 2021

As at March 2021, the SA3s with the lowest fully immunised rates were:

- Eastern Suburbs – North for the 1- year -old age group
- Canterbury and Sydney Inner City for the 2-year-old age group
- Sydney Inner City for the 5-year-old age group.(16)

There are a multitude of reasons for lower immunisation rates in these SA3s, including: lack of follow-up with a GP motivated by reduction in welfare payment, transient populations, and transmission errors from practice software to the Australian Immunisation Register (AIR).

Table 10: Fully immunised children rates in the CESPHN region by age group and SA3, as at March 2021

SA3	1-year-olds	2-year-olds	5 -year-olds
Botany	95.9	90.7	91.7
Canada Bay	95.0	91.5	94.4
Canterbury	94.7	89.9	94.5
Cronulla - Miranda - Caringbah	94.8	92.9	94.5
Eastern Suburbs - North	93.2	90.3	89.7
Eastern Suburbs - South	94.6	91.1	89.7
Hurstville	95.0	90.5	94.2
Kogarah - Rockdale	94.0	90.9	92.8
Leichhardt	97.0	92.0	93.5
Marrickville - Sydenham - Petersham	97.0	93.5	93.5
Strathfield - Burwood - Ashfield	94.9	91.5	93.2
Sutherland - Menai - Heathcote	97.6	95.0	96.8
Sydney Inner City	94.4	89.9	88.7

Source: Department of Health 2021

Adolescent coverage

NSW Health works in partnership with schools to deliver the NSW School Vaccination Program to offer vaccines recommended for adolescents under the National Immunisation Program (NIP).

Human papillomavirus (HPV) vaccination is recommended for people aged 12 to 13 years to prevent HPV, a common virus spread through sexual contact that can result in genital warts and various cancers. In 2018, the HPV immunised rates (first dose) for females and males in the CESPHN region were higher than the NSW rates.(8)

Quadrivalent Meningococcal ACWY (4vMenCV) vaccine protects against four serogroups of Meningococcal: A, C, W and Y. In 2017, the NSW government funded the addition of 4vMenCV to the School Vaccination program for students in years 11 and 12. In 2019, this vaccination was added to the NIP, now given to students in year 10.

Table 11: Percentage of first dose adolescent vaccination coverage rates by school year, 2018

LHD	HPV Female (Year 7) (%)	HPV Male (Year 7) (%)	4vMenCV (Year 12) (%)
SLHD	90	85	79
SESLHD	89	89	78
National	85	83	70

Source: HealthStats NSW 2021

Potentially preventable hospitalisations

Total vaccine preventable PPHs in the CESPHN region have increased from 121 per 100,000 people in 2013-14 to 355 per 100,000 people in 2017-18. Since 2014-15, the total vaccine preventable PPH rates in the CESPHN region have been consistently above the national rates.(14)

Pneumonia and influenza contributed to 61% of the total vaccine preventable PPHs in 2017-18. Since 2016-17, rates in the CESPHN region for pneumonia and influenza have exceeded national rates.(14)

Table 12: Age-standardised rate of vaccine-preventable PPHs per 100,000 people, 2013-14 to 2017-18

Category	Region	2013-14	2014-15	2015-16	2016-17	2017-18
Pneumonia and influenza	CESPHN	35	79	74	116	212
	National	49	81	92	109	207
Other vaccine preventable conditions	CESPHN	86	107	134	137	145
	National	80	95	107	105	108
Total vaccine preventable	CESPHN	121	185	208	251	355
	National	128	175	199	213	313

Source: AIHW 2019

Marrickville-Sydenham-Petersham had the highest rate of pneumonia and influenza PPHs (303 per 100,000 people), followed by Canterbury (249 per 100,000 people).(14)

Hurstville had the highest rate of other vaccine preventable PPHs (265 per 100,000 people), followed by Kogarah-Rockdale (204 per 100,000 people).(14)

Table 13: Age-standardised rate (ASR) of vaccine-preventable PPHs per 100,000 people, by SA3, 2017-18

	Pneumonia and influenza		Other vaccine-preventable conditions	
Region	ASR	No. of PPH	ASR	No. of PPH
Botany	235	121	167	83
Canada Bay	208	229	83	82
Canterbury	249	387	179	261
Cronulla - Miranda - Caringbah	171	287	99	131
Eastern Suburbs - North	198	334	82	123
Eastern Suburbs - South	197	326	125	191
Hurstville	177	305	265	386
Kogarah - Rockdale	230	411	204	330
Leichhardt	217	126	40	26
Marrickville - Sydenham - Petersham	303	171	131	75
Strathfield - Burwood - Ashfield	212	385	152	253
Sutherland - Menai - Heathcote	181	234	66	77
Sydney Inner City	245	401	187	359
CESPHN	212	3,706	145	2,372
National	207	57,198	108	28,329

Source: AIHW 2019

Screening

In 2018-19, the CESPHN region was below NSW and national rates for bowel and breast cancer screening. Cervical screening in the CESPHN region was just above the NSW rate but below the national rate. Canterbury had the lowest bowel cancer screening rate (34.1%), Sydney Inner City the lowest breast screening rate (44.4%) and Kogarah – Rockdale the lowest cervical screening rate (38.3%).(17)

Table 14: Percentage of screening participation by cancer type and SA3, 2018-2019

SA3	Bowel (%)	Breast (%)	Cervical (%)
Botany	n.p.	n.p.	n.p.
Canada Bay	40.9	51.1	47.4
Canterbury	34.1	46.4	41.1
Cronulla - Miranda - Caringbah	42.3	57.4	46.8
Eastern Suburbs - North	34.3	44.9	51.9
Eastern Suburbs - South	38.0	53.9	47.6
Hurstville	38.8	52.8	42.6
Kogarah - Rockdale	35.9	50.9	38.3
Leichhardt	40.9	54.5	53.6
Marrickville - Sydenham - Petersham	37.7	50.2	46.5
Strathfield - Burwood - Ashfield	37.0	49.2	42.9
Sutherland - Menai - Heathcote	43.7	59.3	50.2
Sydney Inner City	35.7	44.4	39.4
CESPHN	37.8	50.9	44.6
NSW	40.5	53.8	44.4
National	43.5	54.8	46.5

Source: AIHW 2021

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 2019-2020, CALD women had the lowest rate, followed by Aboriginal women and then all women.(4)

Table 15: Percentage of breast screening participation by population group, CESPHN region, 2019-2020

Population group	Breast (%)
Aboriginal	40.9
Culturally and linguistically diverse	35.7
All women	45.5

Source: Cancer Institute NSW 2021

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.(18)

Maternal and child health

Conception and pregnancy

Antenatal care

Routine antenatal care, particularly in the first trimester (before 14 weeks), is known to have better child and maternal health outcomes as it provides opportunities for mothers to receive effective health interventions and address necessary lifestyle modifications (e.g. smoking during pregnancy).(19)

In 2019, the percentage of mothers who had an antenatal visit before 14 weeks was lower in the CESPHN region for both all mothers (74.3%) and Aboriginal mothers (61.9%) compared to the respective NSW rates (79.6% and 75.3%). Data is from both NSW public and private hospitals.(8)

Table 16: Percentage of mothers with first antenatal visits before 14 weeks by LHD, 2019

Region	All mothers (%)	Aboriginal mothers (%)
Sydney LHD	77.1	61.7
South Eastern Sydney LHD	71.9	62.1
CESPHN	74.3	61.9
NSW	79.6	75.3

Source: HealthStats NSW 2021

In 2017-2019 the LGAs below the NSW rate included Botany Bay, Canterbury-Bankstown, Georges River, Randwick, Rockdale, Sydney, Waverly, and Woollahra. Many of these LGAs are characterised by a large CALD population.(8)

It is important to note that although there is no regional data available for antenatal visits before 14 weeks for mothers born in non-English speaking countries, both Sydney (SLHD) and South Eastern Sydney LHD (SESLHD) have a large percentage (38% in SLHD and 25% in SESLHD) of mothers from Asia, Middle East and Africa.(20) A mother's cultural background and experiences (e.g., migration status) can contribute to perinatal outcomes.(21)

Table 17: Percentage of all mothers with first antenatal visit before 14 weeks by LGA, 2017-2019

LGA	%
Botany Bay	68.4
Burwood	83.6
Canada Bay	82.4
Canterbury Bankstown	69.7
Georges River	65.2
Inner West	80.6
Randwick	71.0
Rockdale	64.4
Strathfield	80.2
Sutherland Shire	81.3
Sydney	74.8
Waverly	74.0
Woollahra	76.9
NSW	76.8

Source: HealthStats NSW 2021

The Australian Pregnancy Care Guidelines recommend 10 antenatal care visits for first-time mothers with uncomplicated pregnancies and seven for subsequent uncomplicated pregnancies. In 2019, CESPHN had a higher percentage (97.1%) of mothers attending five or more antenatal care visits compared to the national rate (94.7%).

Despite this, there are several SA3s that were below the CESPHN rate (97.1%), including: Canterbury, Cronulla – Miranda – Caringbah, Hurstville, Kogarah – Rockdale, Sutherland – Menai –

Heathcote.(19) Several of these SA3s are known to have diverse population groups. Identifying as an Aboriginal person, having a CALD background, migrant status (e.g., asylum seekers, refugees), and difficulty with reading and speaking the English language can lower access rates to antenatal visits.(21)

Table 18: Percentage of all mothers who attended 5 or more antenatal care visits by SA3, 2019

Region	%
Botany	97.7
Canada Bay	97.8
Canterbury	96.8
Cronulla – Miranda – Caringbah	95.8
Eastern Suburbs – North	98.0
Eastern Suburbs – South	97.3
Hurstville	95.1
Kogarah – Rockdale	95.8
Leichhardt	98.6
Marrickville – Sydenham – Petersham	98.8
Strathfield – Burwood – Ashfield	98.6
Sutherland – Menai – Heathcote	95.7
CESPHN	97.1
National	94.7

Source: AIHW 2019

CESPHN's Antenatal Shared Care (ANSC) Program partners with local hospitals to co-ordinate three ANSC programs – RPA Women and Babies/Canterbury (RPA/Cant), 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 of August 2021, there were 960 GPs registered and actively participating in a program. GPs are registered in a single local hospital or with multiple local hospitals.

Table 19: GP registrations in the CESPHN region by ANSC program, as of August 2021

ANSC program	No. GPs registered	No. of births with ANSC as model of care (2020)	Proportion of total hospital births with ANSC as model of care (2020) (%)
Royal Hospital for Women	389	1,991	53
RPA Women and Babies and Canterbury Hospital	613	789	13
St George and Sutherland Hospital	318	142	6.3

Source: CESPHN database 2021

Smoking during pregnancy

Smoking during pregnancy is associated with poorer perinatal health outcomes, including low birthweight, pre-term birth and perinatal death.(19) The CESPHN rate is below the NSW rate for all

mothers and Aboriginal mothers. However, disparity between these two groups are significant, with Aboriginal mothers having a much higher rate of smoking during pregnancy.(8)

Table 20: Percentage of mothers smoking during pregnancy, all mothers and Aboriginal mothers, 2019

Region	All mothers	Aboriginal
CESPHN	3.1	34.7
NSW	8.8	43.2

Source: HealthStats NSW 2021

Diabetes in pregnancy

Diabetes in pregnancy increases the risk of adverse outcomes for the mother and baby. It is important to identify and assess a woman's risk of diabetes in pregnancy early.(21)

From 2015 to 2019, the prevalence of mothers with diabetes (pre-existing and gestational) in the CESPHN region has seen a steep rise.(8) A number of factors are likely to have affected this trend including the introduction of new diagnostic guidelines and increasing risk factors in the population.

Table 21: Prevalence of diabetes in pregnancy (pre-existing and gestational), 2015 and 2019

Region	2015	2019
CESPHN	9.0	14.3
NSW	9.8	14.8

Source: HealthStats NSW 2021

In 2019, the rate of maternal diabetes for Aboriginal mothers (10.9%) was lower than all mothers rate (13.9%) in NSW. However, it is important to note that this may be due to under-detection and/or under-reporting.(8)

Canterbury and St George Hospital have both reported high rates of gestational diabetes and late presentation of pregnant women residing in surrounding areas to health professionals. Both hospitals service areas with high percentages of socioeconomically disadvantaged, as well as culturally and linguistically diverse persons, which is a risk factor for gestational diabetes.(22)

Overweight and obesity in pregnancy

Obesity is an increasingly important challenge in pregnancy. Its impact begins prior to conception (e.g. reducing fertility) and increases risks for negative health outcomes throughout a woman's pregnancy.(23) In 2019, 30.6% of mothers in SLHD were overweight or obese and 28.2% in SESLHD. This was lower than the NSW rate of 40.3%.(8)

Birth and development

Low birth weight

Low birth weight is an important predictor of newborn wellbeing and survival and can also be an indicator of poor health in pregnancy. In 2019, the percentage of low birth weights for the CESPHN region was slightly below the NSW rate for all children and above for Aboriginal children.(8)

Table 22: Percentage of low-birth weight, 2019

Region	All children	Aboriginal children
CESPHN	4.6	10.8
NSW	4.7	8.8

Source: HealthStats NSW 2021

Breastfeeding

Breastfeeding promotes healthy growth and development and protects children against infectious diseases or poor health conditions later in life.(1) Rate of breastfeeding at discharge after birth in SLHD is lower than the NSW rate, whereas SESLHD is higher. However, it is well documented that exclusive breastfeeding rates decline significantly with time.(20)

Table 23: Percentage of women fully breastfeeding at discharge, 2019

LHD	%
Sydney	69.7
South Eastern Sydney	75.2
NSW	71.1

Source: NSW Mothers and Babies 2019

Vulnerable children

Increasing evidence demonstrates that early childhood experiences impact an individual's health and wellbeing throughout their lifespan. Children who are exposed to vulnerability and live with socioeconomic disadvantage are more likely to experience poorer health outcomes. Measures for vulnerability range from mothers smoking during pregnancy to parents interacting with the justice system.

There is a number of vulnerable children within the CESPHN region, with the largest vulnerability group being young children aged 0 to 5 years.(24)

Table 24: Number of vulnerable children by LHD, 2018

Vulnerability group	SLHD	SESLHD
Young children (0 to 5 years)	14,823	14,747
Children aged under 15 and affected by mental illness	10,344	10,782
Children and young people aged 15 to 18 and affected by mental illness	2,587	3,167
Total	27,754	28,696

Source: TFM 2018

LGAs with the highest percentage of vulnerable children are(24):

- 0 to 5 years: Canterbury-Bankstown (26%), Bayside (24%), Georges River (24%).
- Children aged under 15 years and affected by mental illness: Inner West (12%), Randwick (11%), Bayside (10%), Sydney (10%), Burwood (10%).
- Children and young people aged 15 to 18 years and affected by mental illness: Sydney (16%), Randwick (15%), Inner West (13%).

Childhood development

The Australian Early Development Census (AEDC) measures developmental vulnerability through five domains: 1) physical health and wellbeing, 2) social competency, 3) emotional maturity, 4) communication skills and general knowledge, and 5) language and cognitive skills. These domains are important as they measure progress on a child's developmental journey (e.g., on track or at risk) and predict likelihood of good health, education, and social outcomes.

In 2018, the SA3s with the highest developmental vulnerability in one or more domains and that were above the NSW rate (19.9%) were Canterbury (24.5%), Kogarah-Rockdale (22.4%) and Botany (21.8%). AEDC data shows that some SA3s have seen an increase in language vulnerability, mainly Canterbury, Hurstville, Sydney Inner City, and Eastern Suburbs-South.(25)

Sexual health

Sexually transmissible infections (STIs)

The CESPHN region continues to have the highest rates of chlamydia, gonorrhoea, and infectious syphilis notifications in NSW. In 2020, the region made up 36% of chlamydia, 50% of gonorrhoea and 54% of infectious syphilis NSW notifications. In 2018, LGAs with the highest notification rates for chlamydia and gonorrhoea were Sydney, Inner West and Randwick.(26)

Table 25: Number of chlamydia, gonorrhoea, and syphilis notifications in the CESPHN region by LHD, 2020

LHD	Chlamydia	Gonorrhoea	Syphilis
Sydney	4,071	2,065	517
South Eastern Sydney	5,563	2,781	746

Source: NSW Health 2021

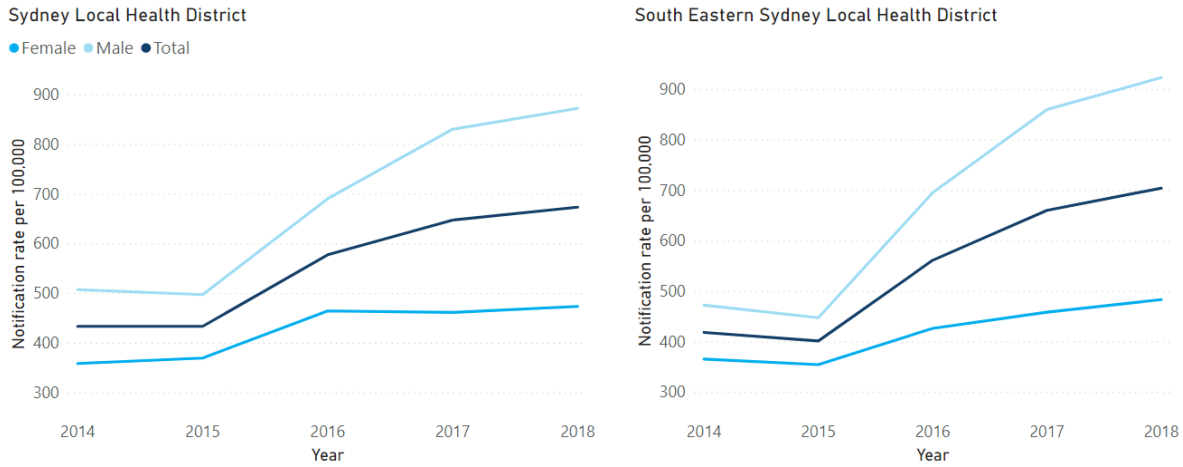
Age groups

- Forty per cent of chlamydia notifications in SLHD were represented by the 25–34-year age group, and 52% in SESLHD by the 20-29 year age group.(27, 28)

Gender

- Chlamydia infections increased from 2015 to 2018 in males (75.3% in SLHD and 106.3% in SESLHD) and females (28.1% in SLHD and 36.3% in SESLHD).(27, 28)

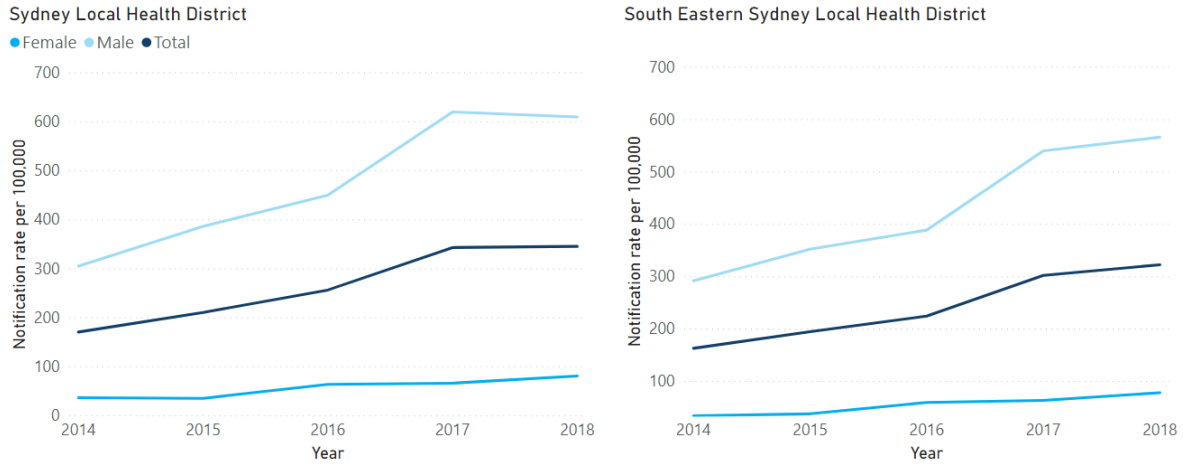
Figure 5: Chlamydia notification rates per 100,000 people by LHD, 2014 to 2018



Source: SLHD 2018, SESLHD 2018

- Gonorrhoea infections increased from 2014 to 2018 in males (99.6% in SLHD and 93.8% in SESLHD) and females (119.7% in SLHD and 127.8% in SESLHD).(27, 28)

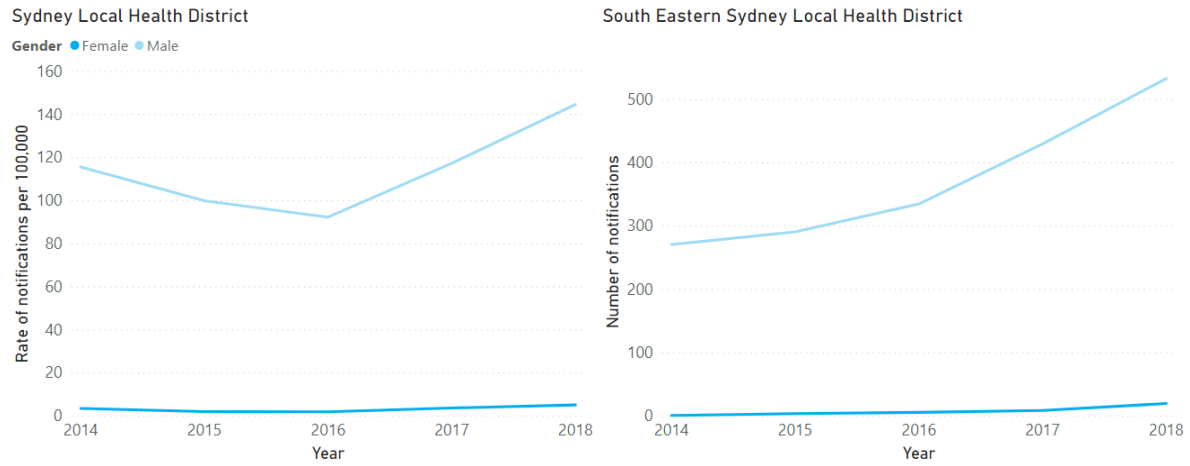
Figure 6: Gonorrhoea notification rate per 100,000 people by LHD, 2014-2018



Source: SLHD 2018, SESLHD 2018

- SESLHD's rate of male syphilis notifications continues to increase. This reflects the region's larger population of men who have sex with men (MSM), as enhanced surveillance in 2018 found that 81% of infectious syphilis notifications were in this population.(28)
- Although syphilis notifications in females are lower than males, there was a 60% increase in syphilis notifications in women under 46 years in NSW from 2017 to 2018 and these have remained elevated in 2019.(27) Further to that, the number of congenital syphilis cases have increased from one reported case each year from 2017-2019 to double that in the first half of 2020 alone. There were no congenital syphilis cases reported in the Aboriginal community from January 2015 to June 2020.(29)

Figure 7: Infectious syphilis notification rate per 100,000 people by LHD, 2014-2018



Source: SLHD 2018, SESLHD 2018

HIV

In 2020, the number of newly diagnosed human immunodeficiency virus (HIV) cases (n=206) in NSW decreased by 33% compared to the average for the last five years. Additionally, 31% of cases showed that infection occurred in the 12-months preceding diagnosis – a 47% reduction in the last five years.(30) However, rates for newly diagnosed HIV notification in the CESPHN region remained the highest in NSW, making up 41.6% of all notifications in the state.(30)

Of the 206 NSW cases, 75% occurred among MSM. In this group 49% were Australian born and 51% overseas born.(30) Overseas born, particularly CALD MSM, remain a priority population as there was a 32% increase in late diagnosis, compared to the 47% decline for Australian born MSM from 2015 to 2019. Declines in HIV notifications in inner Sydney, where approximately ≥20% gay-identified men live, were larger compared to those living in outer suburban areas.(31)

The number of HIV tests in publicly funded sexual health clinics decreased by 38% compared to the same period in 2019. This is likely due to the impact of COVID-19 in reducing casual sex activity, decreasing attendance at clinics, and increasing use of telehealth and other online services.(30)

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.(32) Despite increased longevity, older PLHIV also experience an increased burden of non-communicable age-associated comorbidities.(32) 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.(33)

Hepatitis B

The prevalence of hepatitis B in the CESPHN region is third highest (1.3%) in Australia. Nine SA3s had a chronic hepatitis B (CHB) prevalence rate above the national average (0.9%) with the highest rate being in Hurstville (2.0%).(34)

The highest absolute numbers of people living with CHB are in Sydney Inner City (4,150), Strathfield Burwood-Ashfield (3,186) and Hurstville (2,841).

The average proportion of people living with CHB receiving recommended monitoring and care in CESPHN is 26.1%, which is lower than other Sydney metro PHNs. Cohorts more likely to have hepatitis B are people from CALD backgrounds, particularly those born in countries with moderate to high rates.

Table 26: Prevalence of CHB and percentage receiving care and treatment by SA3, 2020

SA3	CHB prevalence (%)	CHB treatment (%)	CHB care (%)
Botany	1.4	10.1	18.4
Canada Bay	1.5	12.1	24.5
Canterbury	1.7	17.8	40.0
Cronulla – Miranda – Caringbah	0.6	11.1	20.7
Eastern Suburbs – North	0.7	8.4	17.3
Eastern Suburbs – South	1.2	6.6	12.9
Hurstville	2.0	20.4	39.7
Kogarah – Rockdale	1.5	16.2	30.9.
Leichardt	0.7	8.1	17.3
Marrickville – Sydenham – Petersham	1.1	17.4	34.6
Strathfield – Burwood – Ashfield	1.8	13.3	29.3
Sutherland – Menai – Heathcote	0.6	10.7	21.4
Sydney Inner City	1.6	7.0	15.9

Source: National Viral Hepatitis Mapping Project 2021

Hepatitis C

CESPHN's prevalence (0.91%) of chronic hepatitis C (CHC) is above the national average (0.78%). However, the proportion of people receiving CHC treatment (39.6%) is on par with the national average (39.5%).(34) Treatment of hepatitis C is crucial for the prevention of liver cancer.

The burden of CHC is highest in Sydney Inner City (2.4%), Marrickville-Sydenham-Petersham (1.3%), Leichhardt (1.2%) and Eastern Suburbs-South (1.1%). The highest absolute numbers of people living with CHC are in Sydney Inner City (5,253), Eastern Suburbs-South (1,663) and Strathfield-Burwood-Ashfield (1,056). Of these areas, Sydney Inner City has the lowest treatment rate at 33.4%.

Table 27: Prevalence of CHC and percentage receiving treatment by SA3, 2016-2020

SA3	CHC prevalence (%)	CHC treatment (%)
Botany	0.6	64.0
Canada Bay	0.4	45.5
Canterbury	0.8	42.0
Cronulla – Miranda – Caringbah	0.4	58.4
Eastern Suburbs – North	0.6	43.1
Eastern Suburbs – South	1.1	36.0
Hurstville	0.5	42.6
Kogarah – Rockdale	0.6	41.4
Leichardt	1.2	42.0

Marrickville – Sydenham – Petersham	1.3	45.1
Strathfield – Burwood – Ashfield	0.7	39.5
Sutherland – Menai – Heathcote	0.3	58.6
Sydney Inner City	2.4	33.4

Source: National Viral Hepatitis Mapping Project 2021

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 CHC (Egypt, Pakistan, the Mediterranean and Eastern Europe, Africa, and Southern Asia) represent a priority population with low uptake of CHC treatment.

Management and treatment

Antimicrobial resistance

Antimicrobial resistance 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.(35) 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.(36)

S100 prescribing for HIV

In a 2018 survey of 181 GPs in the CESPHN region, only 4% had completed S100 HIV prescriber training. Fifty-eight per cent said they would manage a newly diagnosed patient with HIV if they were supported appropriately – this may be a significant opportunity for increasing GP HIV management capacity. Twenty-four per cent were willing but see this as "*too complicated*". This indicates a continuing need for ongoing education to improve GP confidence in the management of HIV, thereby ensuring HIV patients feel comfortable and supported by their GPs.

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.(37)

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.(37)

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Aboriginal peoples

2022-2024 Needs Assessment

15 November 2021

Aboriginal peoples

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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Population

Geography and demographics

There was an estimated 17,468 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2019, accounting for 1.1% of the total population.(1)

There are 12 Indigenous Areas (IARE) within the CESPHN region. Sydney-City IARE has the highest proportion of Aboriginal people within the CESPHN region, accounting for 20% of this population group. Sutherland Shire IARE and Randwick-La Perouse IARE each have 16.7% and 16.1% of the region's Aboriginal population respectively.(2)

Table 1: Estimated resident population (ERP) in the CESPHN region by IARE, 2019

Indigenous Area (IARE)	Aboriginal persons	% of region
Botany Bay	1,016	5.8
Canterbury -Bankstown (part a)	1,254	7.2
Hurstville-Kogarah	975	5.6
Leichhardt	753	4.3
Marrickville	1,526	8.7
Randwick-La Perouse	2,808	16.1
Rockdale	934	5.3
Sutherland Shire	2,922	16.7
Sydney-City	3,511	20.1
Sydney Inner West	1,179	6.7
Woollahra-Waverley	590	3.4
CESPHN	17,468	1.1

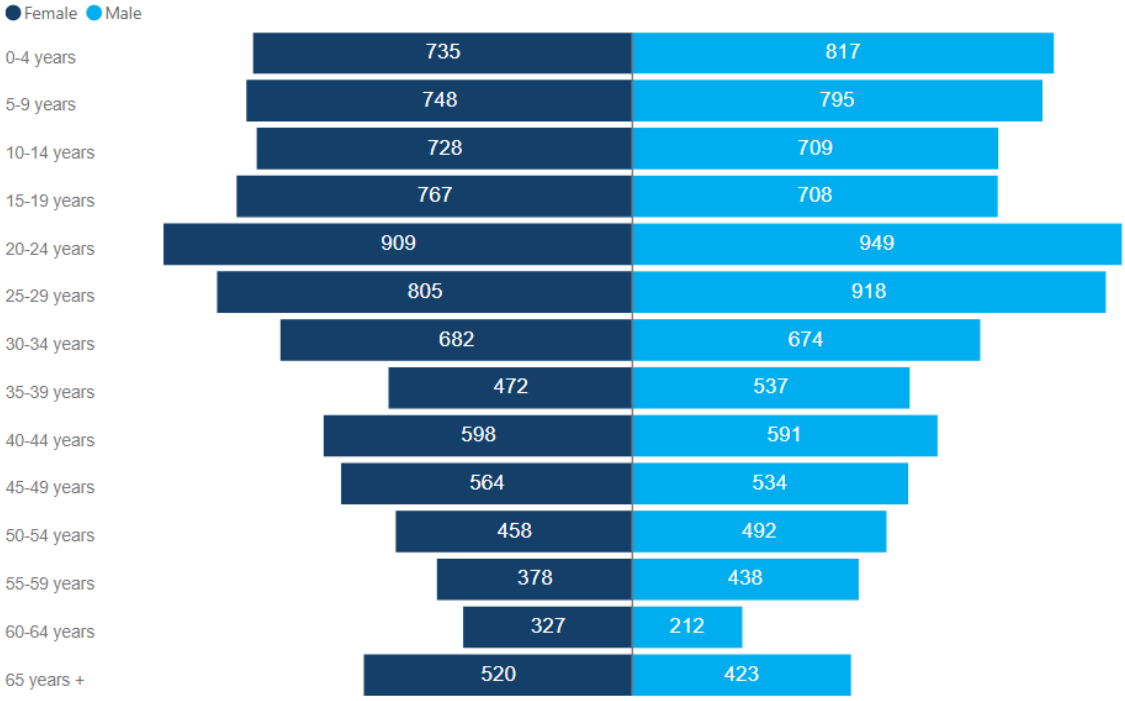
Source: PHIDU, 2020

Note: Lord Howe Island IARE data is not included due to low numbers, Norfolk Island does not have a IARE or associated data

Age and gender

One in five (20.5%) Aboriginal people within the CESPHN region are aged between 20-29 years (n= 3,581). More than half (54.8%) of the Aboriginal population within the CESPHN region is under 30 years of age.(1)

Figure 1: Gender by 5-year age groups, CESPHN region, 2016 ERP



Source: PHIDU, 2021

Births

In NSW, Aboriginal mothers accounted for 4.7% (4,479) of births in 2019. The proportion was lower in the Local Health Districts (LHD) within the CESPHN region – 1.4% (109 births) in Sydney LHD and 1.3% (135 births) in South Eastern Sydney LHD.(3)

In NSW, 6.6% (6,291) of babies born in 2019 identified as Aboriginal. The proportion was lower in the LHDs within the CESPHN region – 1.7% (129 babies) in Sydney LHD and 1.9% (197 babies) in South Eastern Sydney LHD.(3)

Table 2: Births by mother's and baby's Aboriginality, by LHD, 2019

Aboriginality	South Eastern Sydney LHD	Sydney LHD	NSW LHDs
	Mother (%)		
Aboriginal	1.3	1.4	4.7
Non-Aboriginal	98.2	98.2	94.9
Not stated	0.5	0.3	0.4
	Baby (%)		
Aboriginal	1.9	1.7	6.6
Non-Aboriginal	95.6	97.6	91.8
Not stated	2.5	0.7	1.6

Source: HealthStats NSW, 2021

Determinants of health

Lifestyle risk factors

Smoking

In 2018-19, almost 4 in 10 Aboriginal people in NSW were current smokers, 38.7% were daily smokers, and a further 25% were ex-smokers. These rates are consistent across males and females.(4)

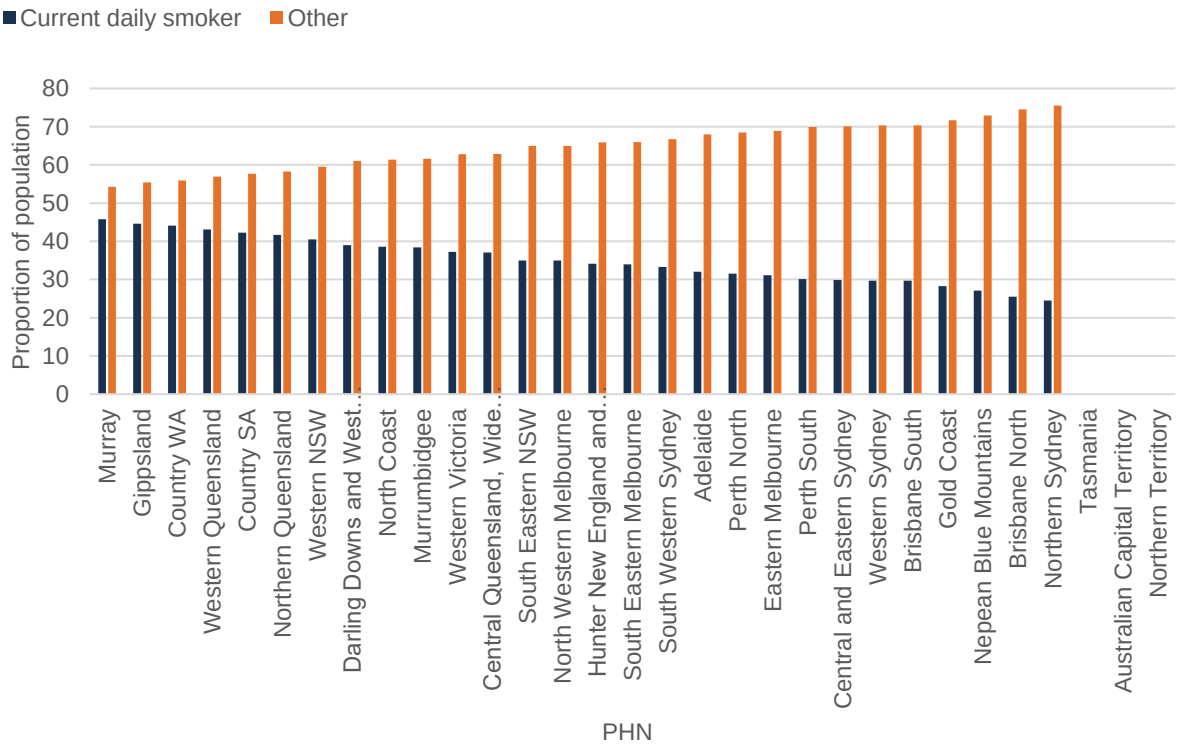
Table 3: Smoking status by gender, NSW 2018-19

Smoker status	Males (%)	Females (%)	Total NSW (%)
Current smoker	40.1	40.5	39.9
Daily	38.4	39.1	38.7
Ex-smoker	24.3	26.5	25.2
Never smoked	36.5	34.8	34.3

Source: ABS, NATSIHS 2019

Estimates at the PHN level show that approximately 3 in 10 Aboriginal people in the CESPHN region were current daily smokers in 2018-19, the 7th lowest rate for PHNs with available data.(4)

Figure 2: Smoking status by PHN, 2018-19



Source: ABS, NATSIHS 2019

Nutrition

An estimated 5.5% of the Aboriginal population aged 2-17 years in NSW had both adequate daily fruit and adequate daily vegetable consumption. Adequate fruit consumption was almost 12 times the proportion of adequate vegetable consumption among this age group (68.2% compared to 5.7%).(5)

An estimated 2.9% of the Aboriginal population aged 18 years and over in NSW had both adequate daily fruit and adequate daily vegetable consumption. Adequate daily fruit consumption was approximately 8 times the proportion of adequate daily vegetable consumption among this age group (40.9% compared to 5.0%).(5)

Table 4: Adequacy of fruit and vegetable intake, by group, NSW, 2018-19

Daily fruit and vegetable consumption (2013 NHMRC Guidelines)	2-17 years	18+ years
Adequate daily fruit consumption	68.2	40.9
Adequate daily vegetable consumption	5.7	5.0
Adequate daily fruit or adequate daily vegetable consumption	*68.8*	*43.0*
Adequate daily fruit *and* adequate daily vegetable consumption	5.5	2.9
Inadequate daily fruit and/or vegetable consumption	94.4	96.5

Source: ABS, NATSIHS 2019

Physical activity

Nationally, an estimated 89% of the Aboriginal population aged 15 years and older did not meet physical activity guidelines. The proportion is highest in the 15-17-year age group, where an estimated 93% did not meet physical activity guidelines. For most age groups, it is estimated that a higher proportion of males than females meet the physical activity guidelines, with the exception of the 15-17 year age group and 45-54 year age group.(5)

Table 5: People meeting physical activity guidelines, by age group, gender, Australia, 2018-19

2014 Physical Activity Guidelines	15–17	18–24	25–34	35–44	45–54	55 years and over	Total 15 years and over	Total 18 years and over
	Males							
Met guidelines	3.8	15.4	15.5	10.5	11.4	13.3	12.5	13.2
Did not meet guidelines	93.9	85.7	84.9	89.2	90.6	86.7	87.4	86.6
	Females							
Met guidelines	6.9	8.7	10.3	8.1	12.0	9.9	9.7	10.1
Did not meet guidelines	94.6	89.9	89.7	92.5	86.8	90.8	90.2	89.9
	Persons							
Met guidelines	4.8	12.1	12.8	9.0	12.4	11.3	11.0	11.6
Did not meet guidelines	93.0	87.6	87.6	91.4	86.7	89.2	89.0	88.4

Source: ABS, NATSIHS 2019

Overweight/obesity

An estimated 42.1% of the Aboriginal population aged 2-17 years in NSW were overweight/obese. A slightly higher proportion of males than females were overweight/obese (44.9% compared to 40.3% respectively).(5)

Table 6: BMI level by gender, aged 2-17 years, NSW, 2018-19

BMI	Males	Females	Total NSW
Underweight/ normal weight	57.7	59.5	58.2
Overweight/ obese	44.9	40.3	42.1

Source: ABS, NATSIHS 2019

An estimated 76.4% of the Aboriginal population aged 18 years and over in NSW were overweight/obese, of these almost two-thirds were considered obese (46.8%).(5)

Table 7: BMI level by gender, aged 18 year and over, NSW, 2018-19

BMI	Males	Females	Total NSW
Underweight/normal (BMI less than 25)	*20.3*	*25.1*	*23.2*
Normal weight (BMI 18.50–24.99)	18.8	22.2	21.1
Overweight/obese (BMI 25.00 or higher)	*79.3*	*75.8*	*76.4*
Overweight (BMI 25.00–29.99)	33.8	25.8	29.7
Obese (BMI 30.00 or higher)	43.9	49.8	46.8

Source: ABS, NATSIHS 2019

An estimated 72.4% of the Aboriginal population aged 18 years and over in NSW were at increased risk of developing chronic diseases due to their waist circumference risk level. The proportion of

females is approximately 1.3 times the proportion of males (81.6% compared to 62.2% respectively).(5)

Table 8: Waist circumference risk, by gender, aged 18 years and over, NSW, 2018-19

Waist circumference risk level	Males	Females	Total NSW
At increased risk of developing chronic diseases	62.2	81.6	72.4
Not at risk	37.2	18.4	27.7

Source: ABS, NATSIHS 2019

Socioeconomic index

The Centre for Aboriginal Economic Policy Research (CAEPR) developed the Indigenous Relative Socioeconomic Outcome (IRSEO) index that reflects 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 = 9). None of the IAREs within the CESPHN region have an IRSEO index equal to or lower than the national or NSW index. Within the CESPHN region, Canterbury-Bankstown (part a) has the highest IRSEO score (21) indicating the least advantaged IARE within the CESPHN region, followed by Randwick-La Perouse with an IRSEO index of 19.(6)

Table 9: Indigenous Relative Socioeconomic Outcome (IRSEO) index score by IARE, 2016

Indigenous Area (IARE)	IRSEO Index score
Botany Bay	10
Canterbury - Bankstown (part a)	21
Hurstville - Kogarah	6
Leichhardt	5
Lord Howe Island	n.a.
Marrickville	6
Randwick - La Perouse	19
Rockdale	3
Sutherland Shire	2
Sydney - City	12
Sydney - Inner West	4
Woollahra - Waverley	1
CESPHN	9
New South Wales	36
Australia	43

Source: PHIDU, 2020

Contact with the criminal justice system

Adult imprisonment

In 2019, NSW had an age-standardised imprisonment rate for Aboriginal adults of 1,684.2 per 100,000 population, with a 32.3% increase since 2006. The rate ratio between Aboriginal adult and non-Aboriginal adult imprisonment rates was 9.3.(7)

In 2020, 19,866 individuals were released from NSW adult correctional centres, and more than 50% of this cohort will return to prison within two years.(8) Our stakeholders have advised that prison inmates are often released with no medical plan and have low access to health services. 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.

Youth justice supervision

In 2017-18, NSW had a reported 123.4 Aboriginal young people (aged 10-17 years) under supervision on an average day; a rate 13.7 times that of non-Aboriginal young people. This was lower than the Australian rate, which had 170.2 Aboriginal young people under supervision on an average day, with a rate ratio of 15.8.(7)

Of the young Aboriginal people released from sentenced supervision in 2016-17, 26.3% returned to sentenced supervision within 6 months and 51.1% within 12 months. Of those released from detention, more than half (58.9%) returned to sentenced supervision within 6 months and four out of five (80.6%) returned to sentenced supervision within 12 months.(7)

Table 10: Young people released from sentenced supervision who returned to sentenced supervision, by time period and gender, Australia, 2016-17

	Released from community-based supervision		Released from detention	
	Returned to sentenced supervision within 6 months (%)	Returned to sentenced supervision within 12 months (%)	Returned to sentenced supervision within 6 months (%)	Returned to sentenced supervision within 12 months (%)
Females	27.4	53.9	59.0	80.6
Males	22.9	42.5	57.9	80.7
Total	26.3	51.1	58.9	80.6

Source: AIHW, 2020

Child protection

In 2018, there were 54.3 per 1,000 Aboriginal children in out-of-home care across Australia, compared to 5.3 per 1,000 non-Aboriginal children. The rate for Aboriginal children has increased by 55.6% since 2009.(7)

There was 62.3 per 1,000 Aboriginal children who were on care and protection orders in 2018 across Australia, compared to 6.8 per 1,000 non-Aboriginal children.(7) Data regarding substantiated child protection notifications (children in substantiations) is unavailable for 2018 due to the change in reporting in NSW.

Table 11: Child protection rates for Aboriginal children (per 1,000), Australia, 2009 to 2018

Year	Children in out-of-home care	Children in substantiations	Children on care and protection orders
2009	35.2	27.5	34.3
2010	37.8	27.7	37.7
2011	40.2	26.9	39.9
2012	42.7	32.5	42.6
2013	44.3	35.1	45.9
2014	47.1	35.6	48.8
2015	48.1	36.5	52.6
2016	51.9	39.9	56.7
2017	54.0	42.2	60.1
2018	54.3	n.a.	62.3

Source: AIHW, 2020

From 30 June 2018, there was 7,626 Aboriginal children in NSW on care and protection orders. Thirty-five per cent of these children were aged 10-14 years, followed by 30.9% aged 5-9 years. A further 6,766 Aboriginal children were in out-of-home care, giving a rate of 60.8 per 1,000 population and a rate ratio of 9.5 when compared to non-Aboriginal children.(7)

Health status

Life expectancy

Between 2015-17, Aboriginal females born in NSW had a life expectancy of 75.9 years (1.5 years higher than national Aboriginal life expectancy) while males had a life expectancy of 70.9 years (0.9 years higher than the national Aboriginal life expectancy).(7)

Table 12: Life expectancy at birth by gender, NSW, 2015-17

	Females	Males
NSW	75.9	70.9
Australia	74.4	70.0

Source: AIHW, 2020

Estimates for life expectancy by current age in 2015-17 show that individuals living in major cities have a slightly longer life expectancy each year of life than national estimates.(7)

Table 13: Life expectancy by age group and gender, Australia, and Major Cities, 2015-17

Age Group	Australia		Major Cities	
	Males	Females	Males	Females
0	70.0	74.4	72.1	76.5
1–4	69.5	74.0	71.6	75.8
5–9	65.6	70.0	67.7	71.9
10–14	60.6	65.1	62.7	66.9
15–19	55.7	60.1	57.8	62.0
20–24	50.9	55.3	52.9	57.1
25–29	46.3	50.5	48.2	52.2
30–34	41.8	45.7	43.7	47.3
35–39	37.5	41.1	39.3	42.6
40–44	33.2	36.6	35.0	38.1
45–49	29.2	32.2	30.8	33.7
50–54	25.5	28.0	27.0	29.4
55–59	21.8	24.0	23.2	25.2
60–64	18.2	20.0	19.5	21.2
65–69	14.9	16.3	16.1	17.3
70–74	11.7	12.9	12.7	13.7
75–79	9.0	9.8	9.8	10.6
80–84	6.7	7.1	7.1	7.6
85 years and over	4.3	4.5	4.4	4.6

Source: AIHW, 2020

Median age at death

Within the CESPHN region, Aboriginal males have a median age at death of 58 years and females have a median age at death of 63 years. For males, this is consistent with the Greater Sydney and NSW median age at death, however for females the median age at death is 2 years lower than Greater Sydney and NSW.(2)

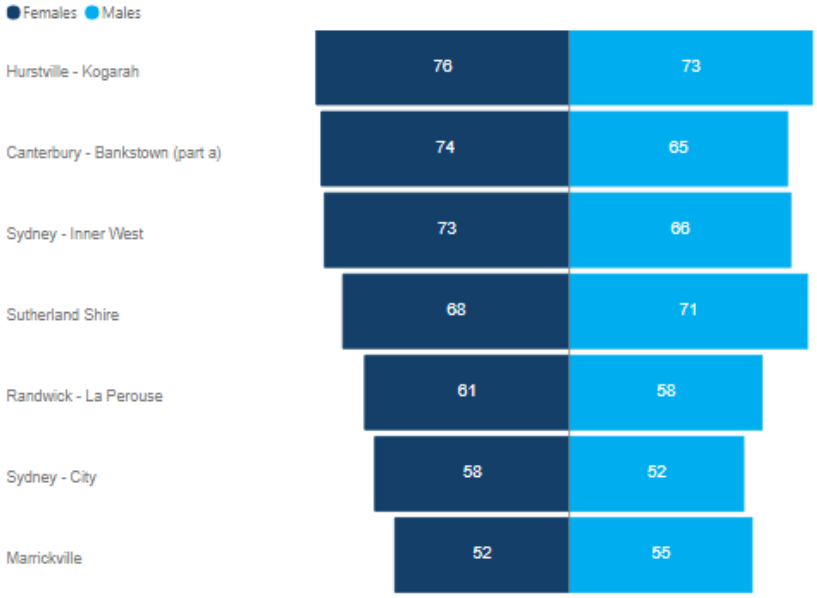
Table 14: Median age at death by gender and regions, 2013-17

Region	Females (yrs)	Males (yrs)
CESPHN	63	58
Greater Sydney	65	58
NSW	65	58
NSW, QLD, SA, WA & NT	61	56

Source: PHIDU, 2020

Within the CESPHN region, the Marrickville IARE and Sydney-City IARE have a younger median age at death for both males and females compared to the CESPHN average.(2)

Figure 3: Median age at death by gender and IARE, 2013-17



Source: PHIDU, 2020

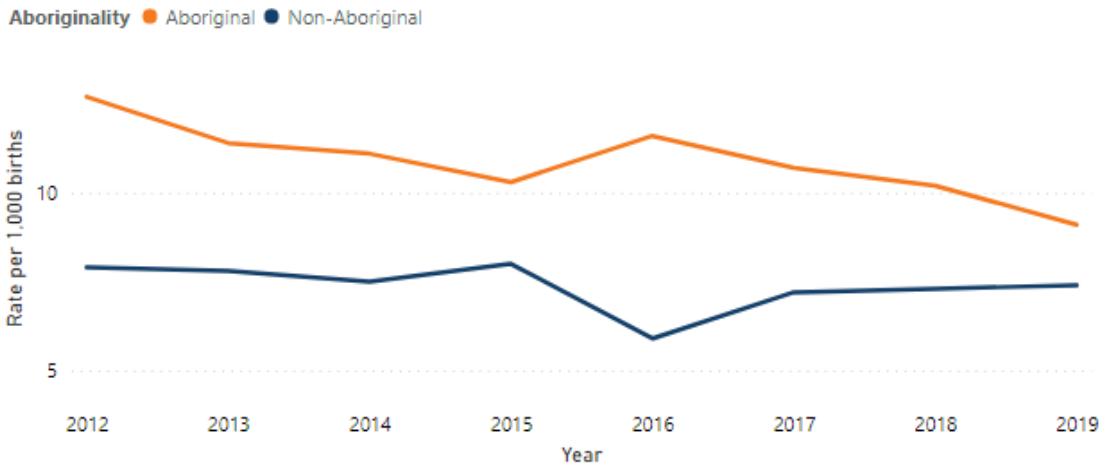
Note: data not available for Botany Bay IARE, Leichhardt IARE, Lord Howe Island IARE, Rockdale IARE or Woollahra-Waverley IARE

Infant and child mortality

Perinatal mortality

Perinatal mortality is defined as deaths commencing from at least 20 weeks of gestation (fetal deaths or 'stillbirths') and deaths of live-born babies within the first 28 days after birth (neonatal deaths).(7) In the eight years to 2019, there has been a slight decline in the rate of perinatal deaths per 1,000 Aboriginal live births. In 2019, rates of perinatal deaths in Aboriginal children was 9.1 per 1,000 live births, compared to 7.4 per 1,000 births in non-Aboriginal children.(3)

Figure 4: Perinatal deaths, NSW 2012 to 2019

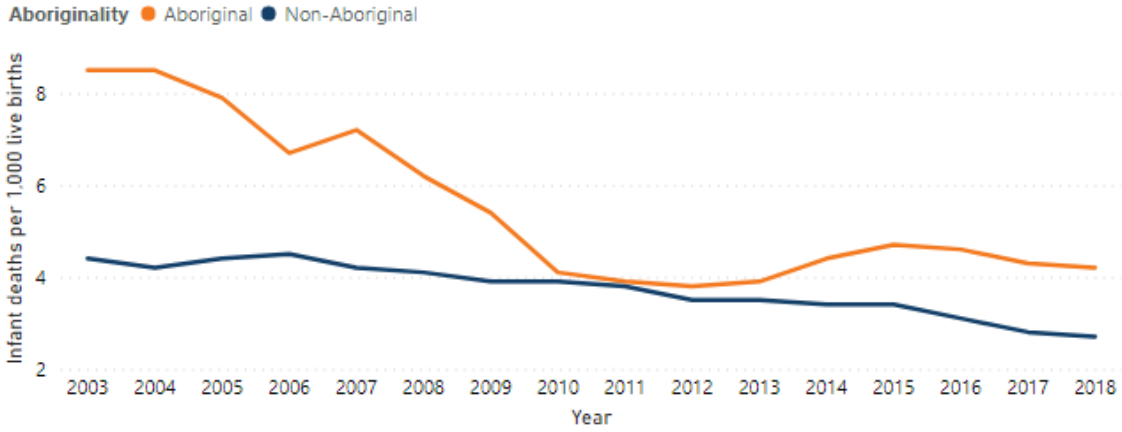


Source: HealthStats, 2021

Infant mortality

Infant mortality is defined by deaths in children under 1 year of age. Since 2003, there has been a decline in the rate of infant deaths per 1,000 live births for both Aboriginal and non-Aboriginal children. In 2018, there was 4.2 infant deaths per 1,000 Aboriginal live births, compared to 2.7 infant deaths per 1,000 non-Aboriginal live births across NSW.(3)

Figure 5: Infant mortality, NSW, 2003 to 2018



Source: HealthStats, 2021

Child mortality

Between 2014-2018, there were 603 deaths among Aboriginal children aged 0-4 years and a rate ratio of 2.0 when comparing Aboriginal child mortality to non-Aboriginal child mortality.(7)

Table 15: Aboriginal child mortality by sex, NSW, Qld WA, SA and NT, 2014-2018

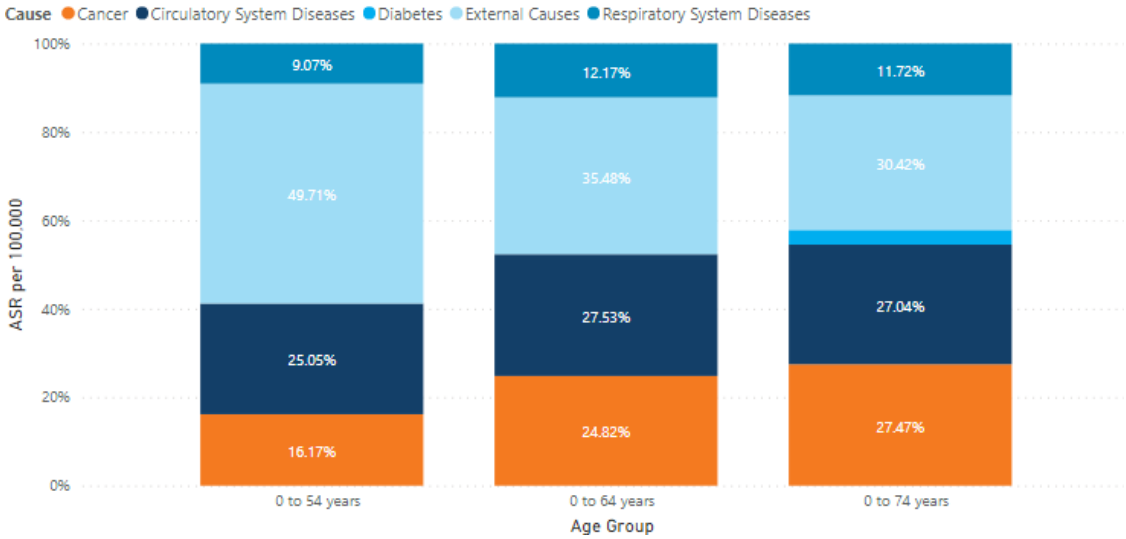
Year	Deaths (no.)	Deaths (%)	Rate per 100,000	Rate ratio	Rate difference
Child mortality (0-4)					
Males	339	56.2	159.1	2.1	81.6
Females	264	43.8	131.4	2.0	66.0
Total children (0-4)	603	100	145.6	2.0	74.1
Early childhood (1-4)					
Males	51	57.3	30.0	1.9	13.8
Females	38	42.7	23.7	1.8	10.6
Total children (1-4)	89	100	26.9	1.8	12.2

Source: ABS, 2021

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. Between 2013-17, almost half (49.71%) of all premature deaths in 0-54 year old's were due to external causes and a further 25% were caused by circulatory system diseases in the CESPHN region.(6) As the age groups broaden, external causes form approximately one-third of all premature deaths, and cancer and circulatory disease contribute approximately a quarter of causes each.

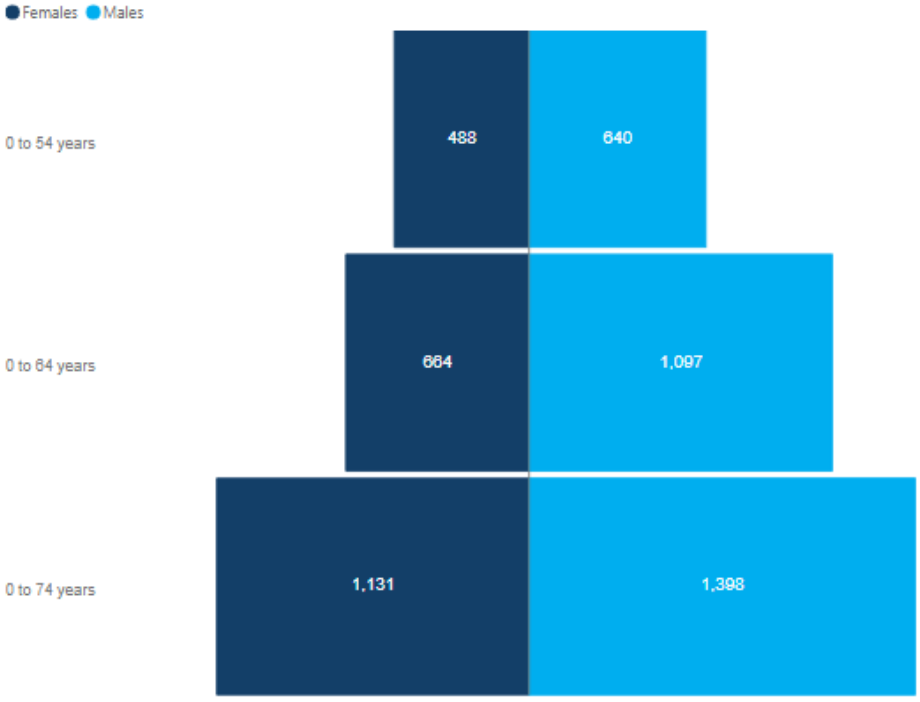
Figure 6: Premature deaths by age group and cause, CESPHN region, 2013-17



Source: PHIDU, 2020

Males within all age brackets have a higher age standardised rate of premature deaths per 100,000 population than females. In the 0 to 64 years age bracket, the ASR of premature deaths in males is 1.7 times the rate for females.(6)

Figure 7: Premature deaths by age group and gender, CESPHN region, 2013-17



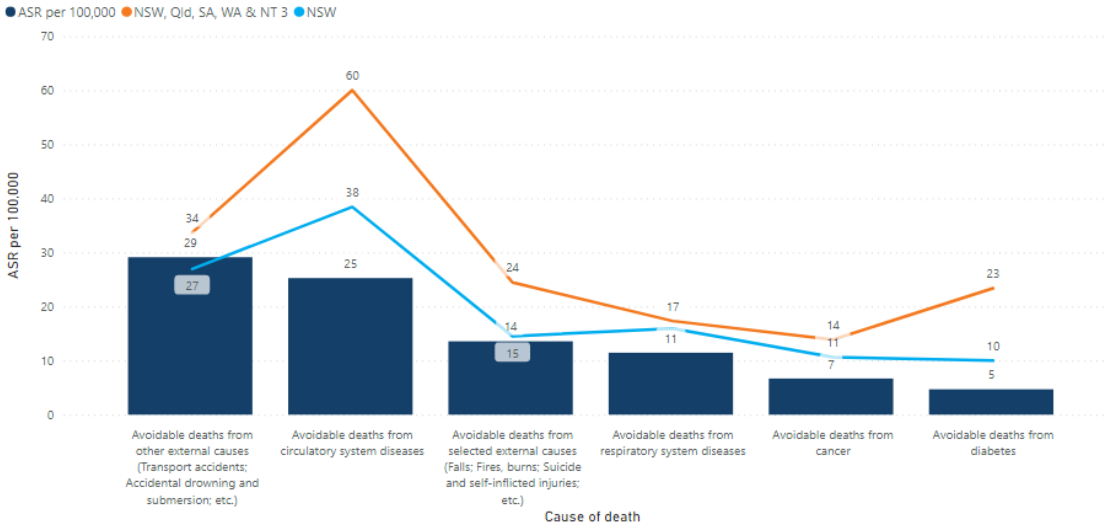
Source: PHIDU, 2020

Avoidable deaths

Potentially avoidable deaths are deaths below the age of 75 years from conditions that are potentially preventable through primary or hospital care. Between 2013-17, the rate of avoidable deaths per 100,000 population was 1.3 times higher for males than females across the CESPHN region (117 compared to 88 respectively).

Avoidable deaths from other external causes (such as transport accidents, accidental drowning, and submersions) had the highest age standardised rate (ASR) within the CESPHN region (29 deaths per 100,000), followed by avoidable deaths from circulatory system diseases (25 deaths per 100,000). Conversely the highest rates for cause of avoidable deaths across NSW and NSW, Qld, SA, WA and NT combined was due to circulatory system diseases (38 and 60 per 100,000 respectively) followed by other external causes (27 and 34 per 100,000 respectively).(6)

Figure 8: Avoidable deaths by cause of death, CESPHN region, 2013-17



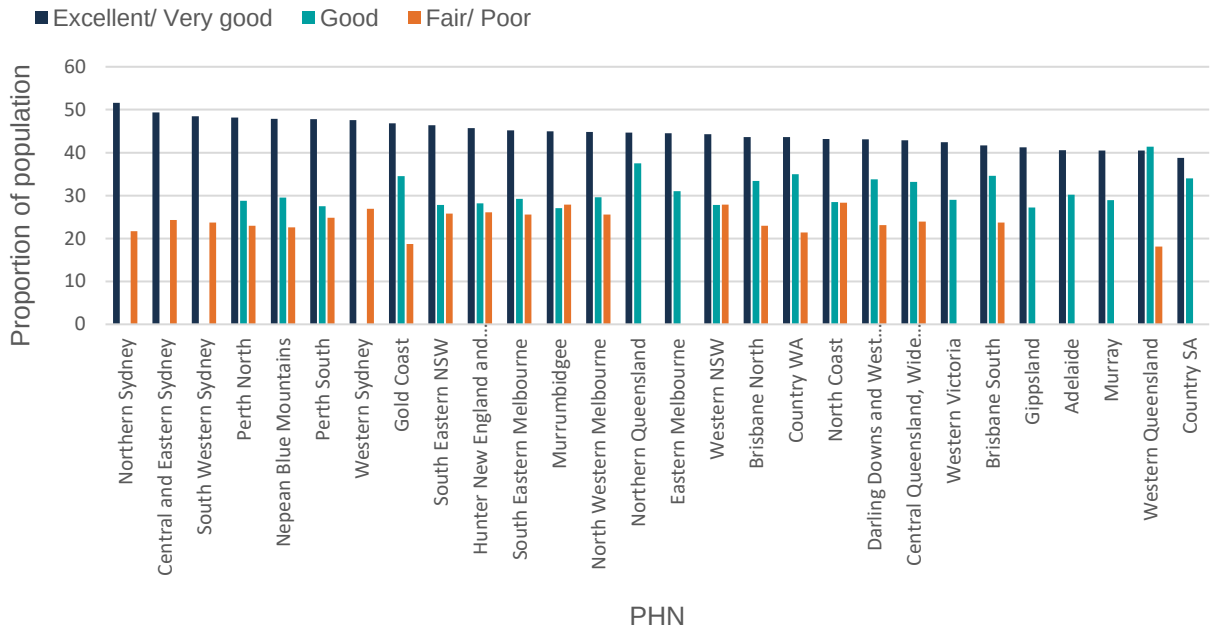
Source: PHIDU, 2020

Self-assessed health status

Nationally in 2018-19, 44.5% of Aboriginal people rated their health status as excellent/very good, up from 39.2% in 2012-13. In NSW, the proportion who rated their health as excellent/very good was slightly higher at 46.5%.(4)

The CESPHN region has the second highest proportion (49.4%) of Aboriginal people who rate their health as excellent/very good when looking at all PHN regions. Almost one in four (24.3%) Aboriginal people within the CESPHN region rated their own health as fair/poor.(4)

Figure 9: Self-assessed health status by PHN, 2018-19



Source: ABS, NATSIHS 2019

Long term health conditions

In NSW, 7 in 10 Aboriginal people had current long-term health conditions, this is consistent across genders. A higher proportion of males than females had only one or two current long-term health conditions, whereas females had a higher proportion than males with three or more current long-term health conditions.(4)

Table 16: Current long-term health conditions, by gender, NSW 2018-19

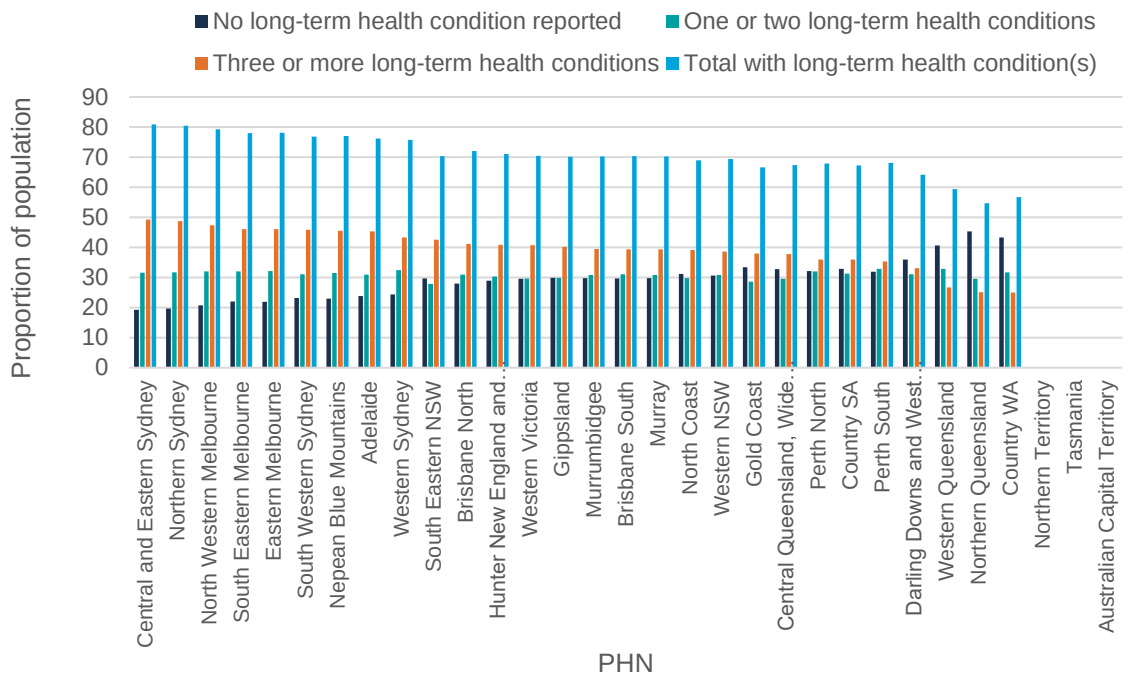
Number of current long-term health conditions*	Males (%)	Females (%)	NSW (%)
No current long-term health condition	29.9	28.6	29.5
One	18.9	13.4	16.3
Two	16.6	11.1	13.6
Three or more	34.5	46.4	40.3
Total with current long-term health condition	69.5	70.8	70.6

Source: ABS, NATSIHS 2019

**Persons who have a current medical condition which has lasted, or is expected to last, for 6 months or more.*

In 2018-19, an estimated 80.8% of the Aboriginal population in the CESPHN region had current long-term health conditions, ranking the highest of all PHNs. Almost half of Aboriginal people within our region were estimated to have three or more long term health conditions (49.2%), again the highest estimate for all PHNs.(4)

Figure 10: Long term health conditions by PHN, 2018-19



Source: ABS, NATSIHS 2019

Chronic conditions

In NSW, just over half of all Aboriginal people (51.1%) had at least one chronic condition.(4)

Table 17: Selected chronic conditions, by gender NSW 2018-19

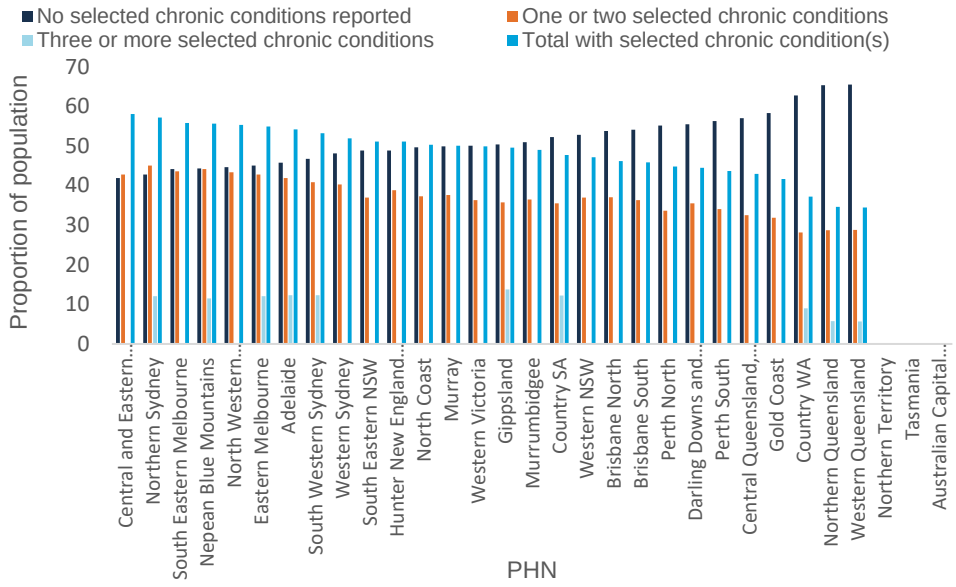
Number of selected chronic conditions*	Males (%)	Females (%)	NSW (%)
No selected chronic conditions	50.9	47.3	49.3
One	28.7	25.7	27.4
Two	10.2	13.8	11.7
Three or more	9.5	13.1	11.8
Has one or more selected chronic conditions	49.4	52.5	51.1

Source: ABS, NATSIHS 2019

**Selected chronic condition consists of arthritis, asthma, back problems (dorsopathies), cancer (malignant neoplasms), chronic obstructive pulmonary disease (COPD), diabetes mellitus, heart, stroke and vascular disease, kidney disease, mental and behavioural conditions and osteoporosis.*

In 2018-19, an estimated 58.1% of the Aboriginal population in the CESPHN region had selected chronic condition(s), ranking the highest of all PHNs.(4)

Figure 11: Selected chronic conditions, by PHN, 2018-19



Source: ABS, NATSIHS 2019

**Selected chronic condition consists of arthritis, asthma, back problems (dorsopathies), cancer (malignant neoplasms), chronic obstructive pulmonary disease (COPD), diabetes mellitus, heart, stroke and vascular disease, kidney disease, mental and behavioural conditions and osteoporosis.*

Disability

The 2018 Survey of Disability, Ageing and Carers (SDAC) estimates that 29.3% of the Aboriginal population in Australia has a disability compared to 15.5% of the non-Aboriginal population (age standardised). The proportion was highest in the 55 years and over age group for both the Aboriginal population and the non-Aboriginal population and across genders.(9)

Table 18: Disability, by age and gender, Australia, 2018

	Aboriginal			Non-Aboriginal		
Age group (years)	Has disability	Does not have disability	Total	Has disability	Does not have disability	Total
	Males					
0–14	19.5	83.2	100.0	9.1	90.8	100.0
15–34	10.9	86.1	100.0	7.9	92.1	100.0
35–54	32.5	65.9	100.0	11.7	88.3	100.0
55 years and over	52.4	47.6	100.0	37.6	62.5	100.0
Total Males	*23.7*	*76.8*	*100.0*	*17.0*	*83.0*	*100.0*
	Females					
0–14	13.3	86.4	100.0	5.2	94.7	100.0
15–34	16.2	83.3	100.0	8.0	92.0	100.0
35–54	37.4	62.2	100.0	12.8	87.2	100.0
55 years and over	52.1	52.1	100.0	36.7	63.3	100.0
Total Females	*24.3*	*75.1*	*100.0*	*16.8*	*83.2*	*100.0*
	Persons					
0–14	16.3	83.7	100.0	7.2	92.8	100.0
15–34	15.3	84.4	100.0	8.0	92.1	100.0
35–54	33.3	65.0	100.0	12.3	87.7	100.0
55 years and over	53.5	45.6	100.0	37.1	62.9	100.0
Total 15 years and over	28.2	71.7	100.0	19.1	80.9	100.0
Total	*24.0*	*75.9*	*100.0*	*16.9*	*83.1*	*100.0*
Total, Age standardised	29.3	70.7	100.0	15.5	84.5	100.0

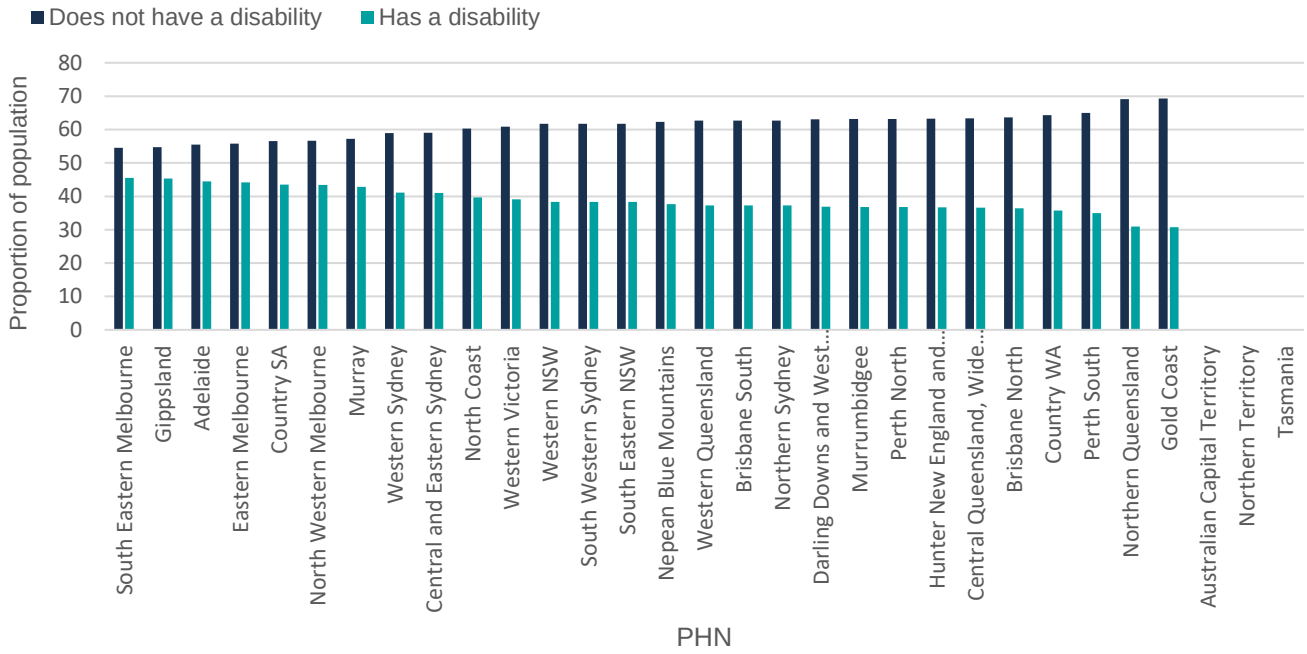
Source: ABS, 2021

Estimates from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) at the PHN level, show that an estimated 41% of the Aboriginal population within the CESPHN region had a disability, this ranks us 9th across all PHNs.(4)

It is important to recognise the SDAC and NATSIHS use different definitions of disability:

- SDAC: a person is living with disability if they report they have a limitation, restriction, or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities
- NATSIHS: refers to people with a profound or severe limitation when performing at least one selected task related to mobility, communication, or self-care.

Figure 12: Disability status, by PHN, 2018-19



Source: ABS, NATSIHS 2019

NDIS participation

There are low reported NDIS Aboriginal participants in both South Eastern Sydney and Sydney service districts, both within the CESPHN region. The Aboriginal participation rate in these service districts is approximately half of the national benchmark figure (3.5% each compared to 6.6%).(10) There is also a higher than national rate of unstated Aboriginal status.

Table 19: NDIS participants by Aboriginal status and service district, CESPHN region, 2020

Aboriginal status	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES Relative to benchmark	Sydney Relative to benchmark
Aboriginal	3.5	3.5	6.6	0.5	0.5
Non-Aboriginal	71.9	71.0	75.0	1.0	1.0
Not stated	24.6	25.5	19.0	1.3	1.4

Source: NDIS, 2020

The proportion of Aboriginal participants who reported they choose who supports them through NDIS activities is slightly lower in South Eastern Sydney than the national benchmark.(10)

Table 20: Outcome framework choice measure by Aboriginal status and service district, CESPHN region, 2020

Aboriginal status	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES Relative to benchmark	Sydney Relative to benchmark
Aboriginal	40	56	54	0.7	1.0
Non-Aboriginal	45	45	53	0.9	0.9
Not stated	40	43	49	0.8	0.9

Source: NDIS, 2020

Overall, Aboriginal participants within the CESPHN region reported that the NDIS has helped with choice and control in line with the national benchmark.(10)

Table 21: NDIS participants with more choice and control by Aboriginal status and service district, CESPHN region, 2020

Aboriginal status	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES Relative to benchmark	Sydney Relative to benchmark
Aboriginal	68.8	69.0	71.8	1.0	1.0
Non-Aboriginal	73.2	74.0	72.1	1.0	1.0
Not stated	74.3	77.0	72.6	1.0	1.0

Source: NDIS, 2020

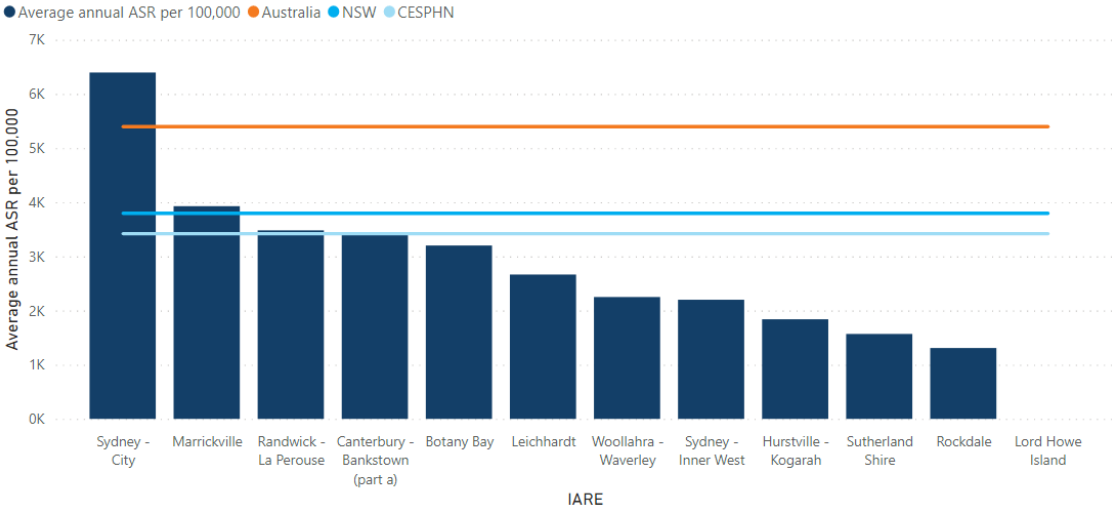
Potentially preventable hospitalisation (PPH)

Total potentially preventable hospitalisations

Between 2015-16 and 2017-18, there were 3,420.3 admissions for potentially preventable conditions per 100,000 Aboriginal persons within the CESPHN region (annual average age standardised rate). This rate is lower than both the NSW (3,795.4) and national rate (5,395.2).

Within the CESPHN region, Sydney-City IARE and Marrickville IARE had rates higher than NSW (6,395.9 and 3,927.7 per 100,000 Aboriginal persons respectively), with Sydney-City rates also higher than national rates. Randwick-La Perouse IARE and Canterbury-Bankstown IARE had rates slightly higher than the CESPHN region (3,481 and 3,449.4 per 100,000 Aboriginal people respectively).(6)

Figure 13: Total potentially preventable hospital admissions, by IARE, 2015-16 to 2017-18



Source: PHIDU, 2021

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

- Botany for the 0-to-14-year age group.
- Sydney-City for the 15 to 24 years, 15 years and over and 45-to-64-year age groups.
- Marrickville for the 65 years and over age group.(6)

Table 22: Potentially preventable hospital admissions. by IARE and age group, 2015-16 to 2017-18

IARE/Region	0 to 14 years	15 to 24 years	15 years and over	25 to 44 years	45 to 64 years	65 years and over
Botany Bay	2,870.7	2,196.9	2,327.2	1,360.0	6,554.3	10,221.4
Canterbury - Bankstown (part a)	1,346.8	1,187.8	2,942.1	3,240.2	8,060.3	12,110.5
Hurstville - Kogarah	-	-	1,534.7	-	2,585.7	7,976.1
Leichhardt	2,777.2	1,769.9	1,878.9	1,363.2	5,463.9	7,697.6
Lord Howe Island	-	-	-	-	-	-
Marrickville	2,490.8	2,311.4	3,090.7	2,306.5	7,960.9	17,205.8
Randwick - La Perouse	2,367.8	1,528.2	2,699.4	2,754.6	7,727.4	10,500.4
Rockdale	-	-	1,010.6	-	1,443.1	8,126.9
Sutherland Shire	752.7	587.6	1,302.7	1,940.2	3,019.8	4,695.3
Sydney - City	2,748.6	3,070.9	5,238.2	4,966.5	16,641.9	15,317.7
Sydney - Inner West	1,874.2	99.0	1,636.6	1,784.1	4,213.0	6,753.2
Woollahra - Waverley	1,402.5	1,803.4	1,776.0	1,525.4	4,153.7	9,137.5
CESPHN	1,811.0	1,655.6	2,767.0	2,817.4	7,792.3	10,372.5
Greater Sydney	2,202.3	1,813.6	2,635.0	2,879.7	6,241.5	11,946.4
New South Wales	2,414.7	2,053.3	2,965.5	3,110.3	6,733.9	14,982.7
Australia	3,250.3	2,517.7	4,278.3	5,159.0	10,375.0	17,713.4

Source: PHIDU, 2021

Acute potentially preventable hospital admissions

Acute cellulitis had the highest ASR of all acute PPH admissions (409.4 per 100,000 population) in the CESPHN region; it is also the only condition where CESPHN rates are higher than the NSW rate of admission (372.6 per 100,000).

Within the CESPHN region:

- Botany Bay IARE had the highest rate of acute PPH for acute ear, nose and throat infections and acute urinary tract infections.
- Sydney-City IARE had the highest rate of acute PPH for acute cellulitis and acute convulsions and epilepsy.
- Leichhardt IARE had the highest rate of PPH admissions for acute dental conditions.(6)

Table 23: Potentially preventable hospital admissions by acute condition and IARE, 2015-16 to 2017-18

IARE/Region	Acute cellulitis	Acute convulsions and epilepsy	Acute dental conditions	Acute ear, nose and throat infections	Acute urinary tract infections
Botany Bay	340.9	..	354.1	451.8	412.7
Canterbury - Bankstown (part a)	280.2	295.4	198.1	283.6	177.4
Hurstville - Kogarah	231.9	..	405.8	..	190.9
Leichhardt	272.3	..	662.0	..	0
Lord Howe Island	..	..	..	..	0
Marrickville	473.4	438.7	298.6	297.4	248.7
Randwick - La Perouse	301.3	411	404.1	305.9	202.2
Rockdale	..	..	301.7	..	193.9
Sutherland Shire	143.6	100.7	165.5	218.8	118.2
Sydney - City	985.3	864.1	457.4	183.3	372.8
Sydney - Inner West	..	241	251	312.7	272.5
Woollahra - Waverley	377.9	..	..	..	0
CESPHN	*409.4*	*356.7*	*330.3*	*243.8*	237.3
NSW	372.6	374.4	343.9	348.4	297.1
Australia	602.0	483.9	440.4	449.4	426.08

Source: PHIDU, 2021

Chronic preventable hospital admissions

Chronic Obstructive Pulmonary Disease (COPD) had the highest ASR of all chronic PPH admissions in the CESPHN region (379.4 per 100,000 population).

Within the CESPHN region:

- Leichhardt IARE had the highest rate of PPH admissions for chronic asthma.
- Marrickville IARE had the highest rate of PPH admissions for COPD.
- Randwick – La Perouse IARE had the highest rate of PPH admissions for chronic angina.

- Sydney IARE had the highest rate of PPH admissions for chronic congestive cardiac failure and chronic diabetes complications.(6)

Table 24: Potentially preventable hospital admissions by chronic condition and IARE, 2015-16 to 2017-18

IARE/Region	Chronic angina	Chronic asthma	Chronic congestive cardiac failure	Chronic diabetes complications	Chronic Obstructive Pulmonary Disease (COPD)
Botany Bay	..	260.4	158.3	429.7	133.1
Canterbury - Bankstown (part a)	..	244.3	214.5	286.6	693.5
Hurstville - Kogarah	..	203.6	..	304	..
Leichhardt	..	346.3	..	215.1	294.1
Lord Howe Island	..	..	..	..	..
Marrickville	..	220.1	121.4	311.1	758.6
Randwick - La Perouse	246.7	298.9	147.9	136.7	290.3
Rockdale	..	..	..	..	246
Sutherland Shire	110.3	..	165.8	73.4	67.9
Sydney - City	128.4	289.6	311.7	507.2	672.5
Sydney - Inner West	..	..	..	..	254.9
Woollahra - Waverley	..	..	..	..	291.5
CESPHN	*114.9*	*210.9*	*160.8*	*253.3*	*379.4*
NSW	111.2	209.7	163.7	319.0	540.1
Australia	177.8	243.8	247.7	420.9	583.4

Source: PHIDU, 2021

Preventive health

Immunisation

Table 25: Immunisation status, by age and region, 2018

Region	1-year-olds	2-year-olds	5-year-olds
CESPHN	91.7	91.1	96.6
Greater Sydney	94.5	90.6	97.2
NSW	94.3	91.0	97.3
Australia	92.6	88.1	96.7

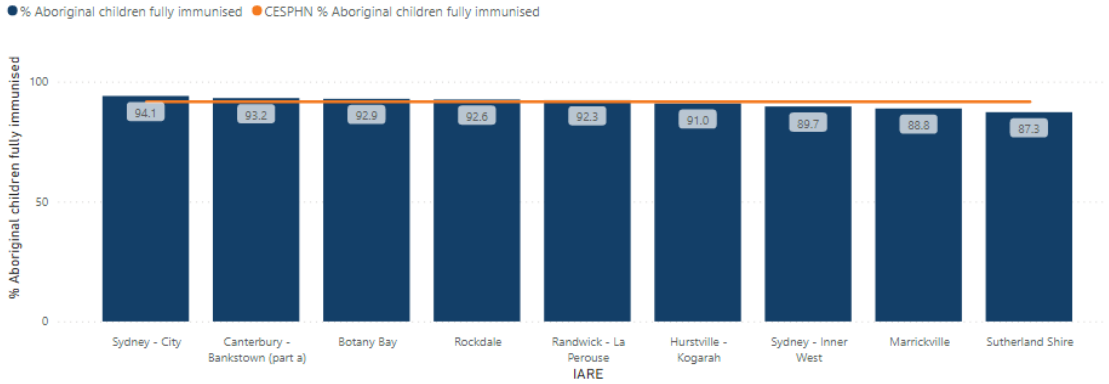
Source: PHIDU, 2021

In 2018, immunisation rates amongst Aboriginal children aged 1 or 2 years old in the CESPHN region were below the target of 95% (91.7% and 91.1% respectively).

No IAREs had immunisation rates at or above 95% for the 1-year-old age group. The Randwick-La Perouse IARE was the only area to have immunisation rates above 95% for 2-year-olds. All IAREs

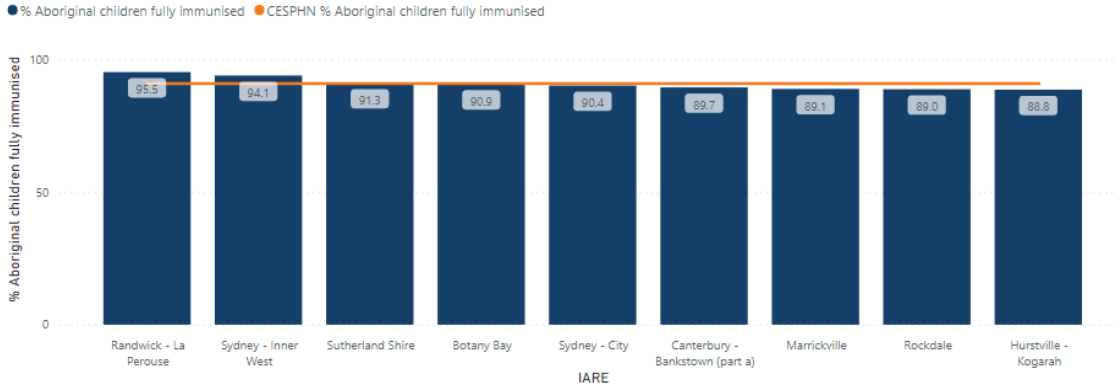
with the exception of Leichhardt and Randwick-La Perouse had immunisation rates above the 95% for 5-year-olds.(6)

Figure 14: 1-year-olds fully immunised by IARE, 2018



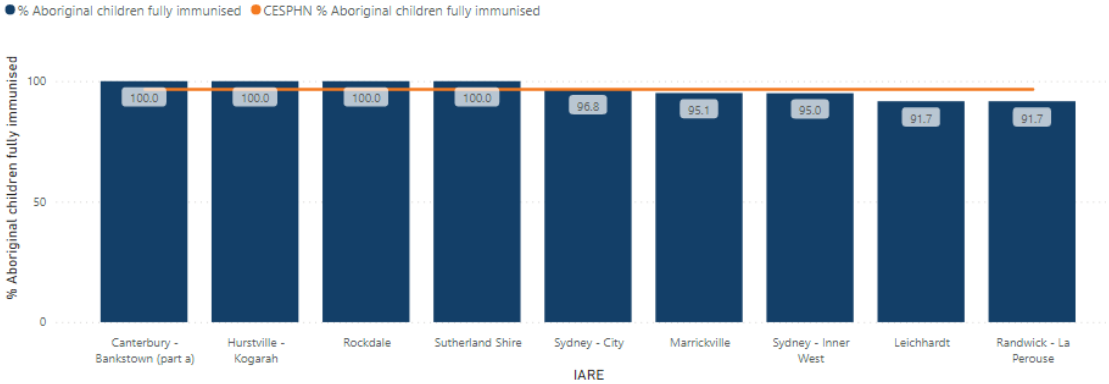
Source: PHIDU, 2021

Figure 15: 2-year-olds fully immunised by IARE, 2018



Source: PHIDU, 2021

Figure 16: 5-year-olds fully immunised by IARE, 2018



Source: PHIDU, 2021

Potentially preventable hospitalisations (vaccine preventable)

Between 2015-16 and 2017-18, there were 535.2 per 100,000 population potentially preventable admissions for vaccine preventable conditions in the CESPHN region. This rate is lower than the national rate (701.2 per 100,000), however higher than the NSW rate (362.9 per 100,000).

Within the CESPHN region, Sydney-City IARE had rates higher than NSW and national rates for all categories of vaccine preventable PPHs. Rates in Sydney-City IARE were:

- 1.2 times the national rate for pneumonia and influenza,
- 2.0 times the national rate for 'other' vaccine preventable conditions, and
- 1.7 times the national rate for all vaccine preventable conditions.(6)

Table 26: Potentially preventale hospitalisations, vaccine preventable, by IARE, 2015-16 to 2017-18

IARE/Region	Pneumonia and influenza	Other	Total
Botany Bay	..	..	176.1
Canterbury - Bankstown (part a)	174.5	234.6	409.4
Hurstville - Kogarah	..	156.5	252.3
Leichhardt	..	244.4	321.2
Lord Howe Island	..	..	..
Marrickville	172.5	378.5	552.2
Randwick - La Perouse	240.7	277.8	517.1
Rockdale	..	..	..
Sutherland Shire	73.9	169	242.8
Sydney - City	297.3	912.3	1,222.8
Sydney - Inner West	124.7	167.4	291.1
Woollahra - Waverley	..	..	374.1
CESPHN	171.8	362.8	535.2
Greater Sydney	179.6	263.4	443.1
New South Wales	176.5	185.6	362.9
Australia	242.5	458.7	701.2

Source: PHIDU, 2021

Cancer screening

There is limited local level data on cancer screening participation for Aboriginal people.

BreastScreen

Nationally, Aboriginal females have a much lower participation rate in breast cancer screening programs than non-Aboriginal females (37.3% compared to 53.2% respectively). The proportion of participants recalled to assessment is comparable between Aboriginal and non-Aboriginal females nationally.(11)

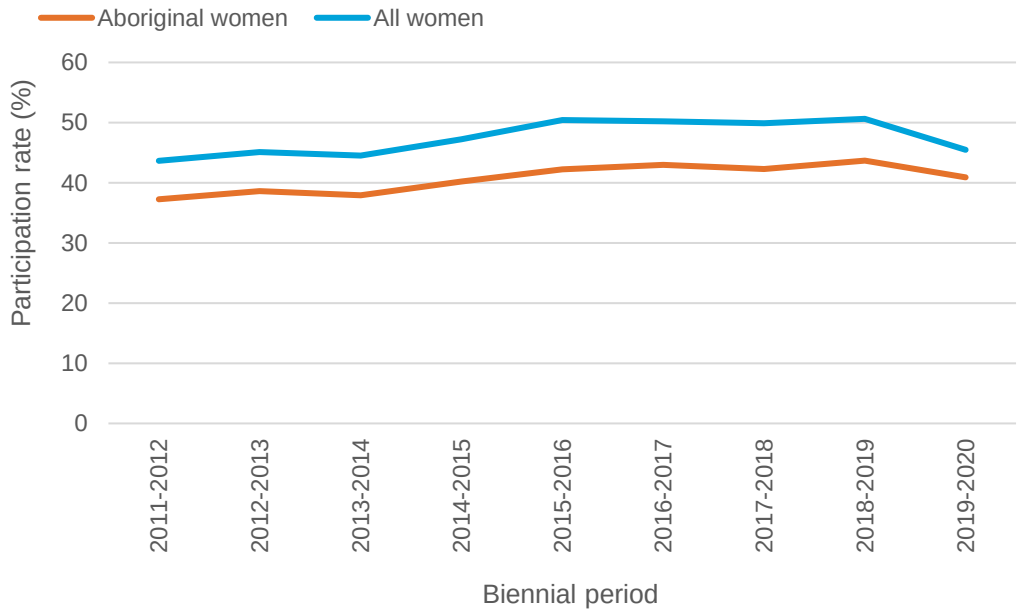
Table 27: BreastScreen participation by Aboriginality, Australia, 2014-15

Measure	Aboriginal	Non-Aboriginal
Participation rate (%) by Aboriginality	37.3	53.2
Recall to assessment (1st screening round) (%) by Aboriginality	11.3	11.9
Recall to assessment (2nd screening round) (%) by Aboriginality	3.7	3.8

Source: AIHW, 2018

Within the CESPHN region, breast screening participation rates for Aboriginal women aged 50-74 years have been consistently around 40% since 2011-12. All women (aged 50-74 years) in our region have had screening participation rates between 45-50% over this time period.(12)

Figure 17: BreastScreen participation rates by Aboriginality, CESPHN region, 2011-20



Source: Cancer Institute NSW, 2021

National Bowel Cancer Screening Program

Nationally, Aboriginal people have had lower participation rates in bowel screening programs than non-Aboriginal people (23.5% compared to 40% respectively). Data shows that the rate of positive iFOBT results in Aboriginal participants is 1.4 times the rate of non-Aboriginal participants, and diagnostic assessment following a positive screen is 0.8 times the rate. Approximately 2 in 5 Aboriginal people (42.6%) are not assessed following a positive bowel cancer screen.(11)

Table 28: National Bowel Cancer Screening Program participation by Aboriginality, Australia, 2014-16

Measure	Aboriginal	Non-Aboriginal
Participation rate (%) by Aboriginality	23.5	40
Number of positive iFOBT results by Aboriginality	408	39,395
iFOBT positivity rate (%) by Aboriginality	11.3	8.2
Diagnostic assessment rate (colonoscopy) (%)	57.4	70.9
Not assessed following a positive screen (%)	42.6	29.1

Source: AIHW, 2018

Hearing screening

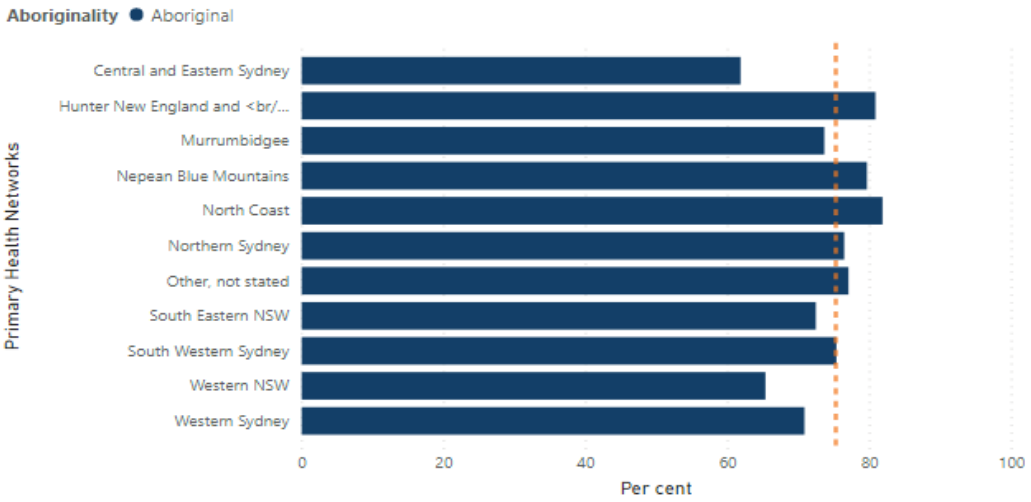
In 2018-19, 42.6% of Aboriginal people aged 7 years and older had hearing impairment in one or both ears, with 22.7% had hearing impairment in both ears. In NSW, the proportions were slightly lower, with 37.5% having a hearing impairment and 19.3% with impairment in both ears. The proportion of people with hearing impairment in one or both ears increases 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%.(5)

Maternal and child health

Antenatal care

In 2019, 75.3% of Aboriginal mothers across NSW attended their first antenatal visit by 14 weeks gestation. Within the CESPHN region, only 61.9% of Aboriginal mothers had attended their first antenatal visit by 14 weeks gestation.(3)

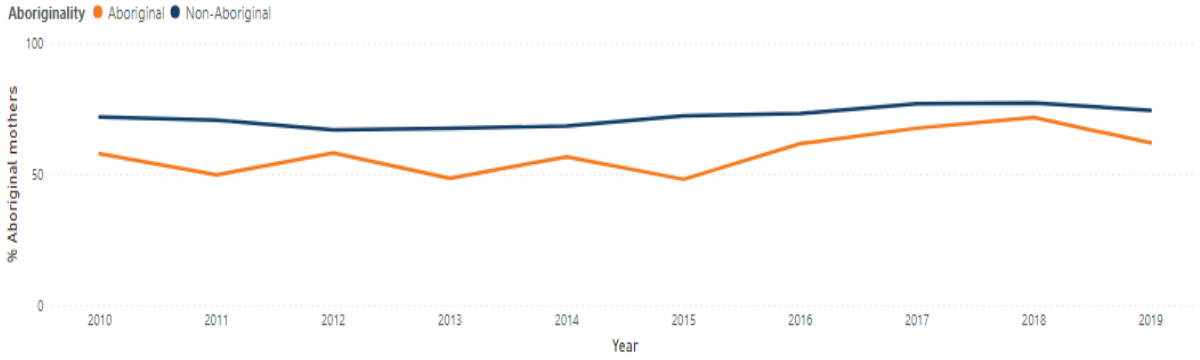
Figure 18: First antenatal visit by 14 weeks, by PHN NSW, 2019



Source: HealthStats NSW, 2021

Within the CESPHN region, Aboriginal mothers have consistently had a lower proportion attending their first antenatal visit by 14 weeks gestation compared to non-Aboriginal mothers. While the proportion has steadily increased since 2015, there has been a slight decrease between 2018 and 2019.(3)

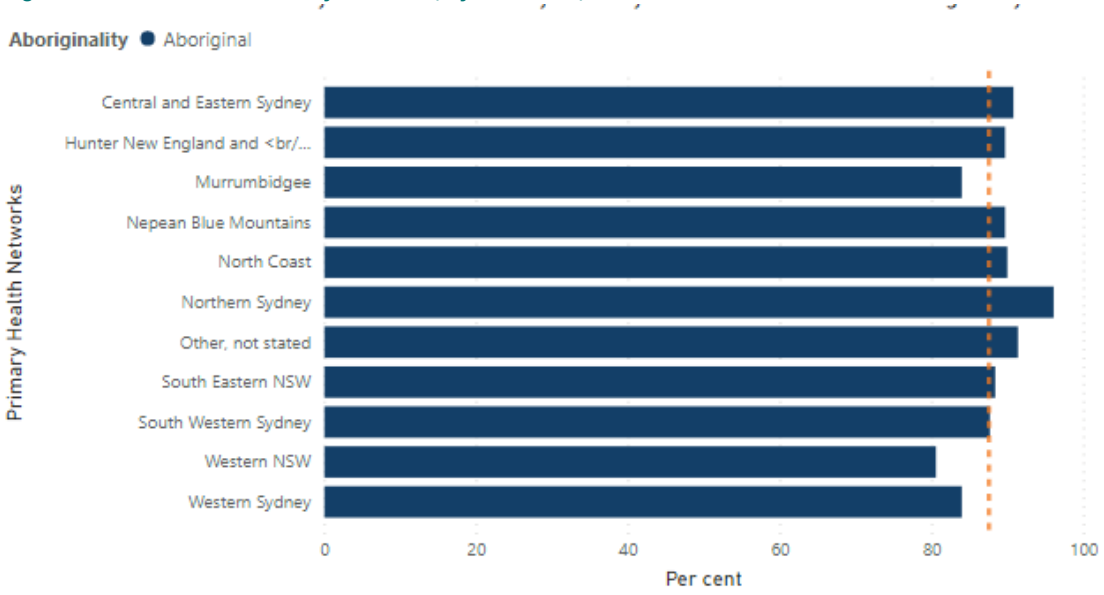
Figure 19: First antenatal visit by 14 weeks, CESPHN region, 2010-2019



Source: HealthStats NSW, 2021

In 2019, 87.6% of Aboriginal mothers across NSW attended their first antenatal visit by 20 weeks gestation. Within the CESPHN region the proportion increased to 90.8% of Aboriginal mothers.(3)

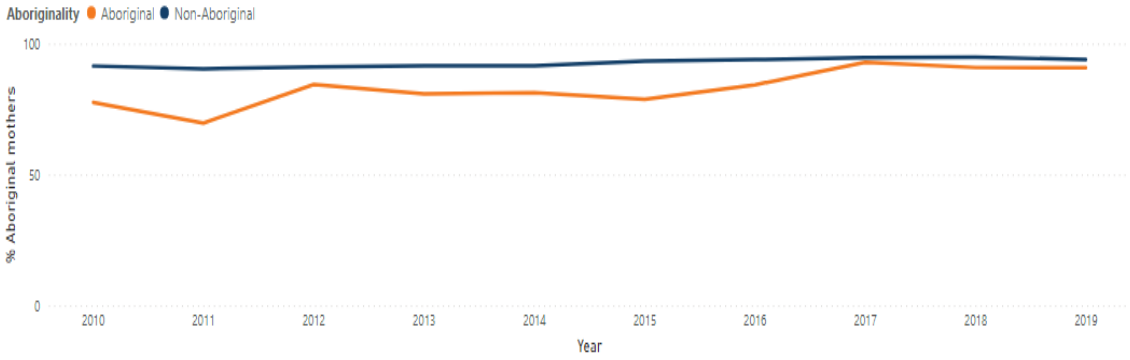
Figure 20: First antenatal visit by 20 weeks, by PHN NSW, 2019



Source: HealthStats NSW, 2021

Within the CESPHN region, Aboriginal mothers have consistently had a lower proportion attending their first antenatal visit by 20 weeks gestation compared to non-Aboriginal mothers, however the difference has been much smaller since 2017.(3)

Figure 21: First antenatal visit by 20 weeks, CESPHN region, 2010-2019

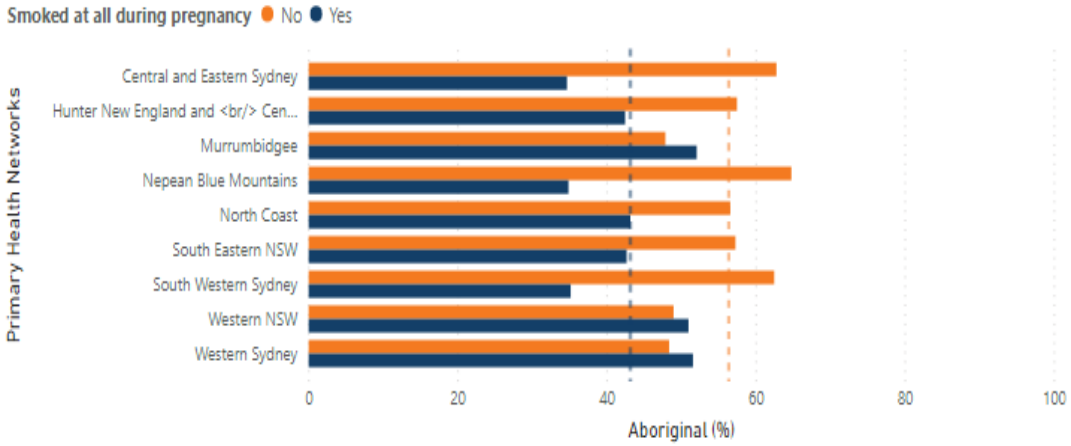


Source: HealthStats NSW, 2021

Smoking during pregnancy

In 2019, 43.2% of Aboriginal mothers in NSW smoked at any time during their pregnancy. Within the CESPHN region, the rate was lower with only 34.7% of Aboriginal mothers smoking at any point during their pregnancy.(3)

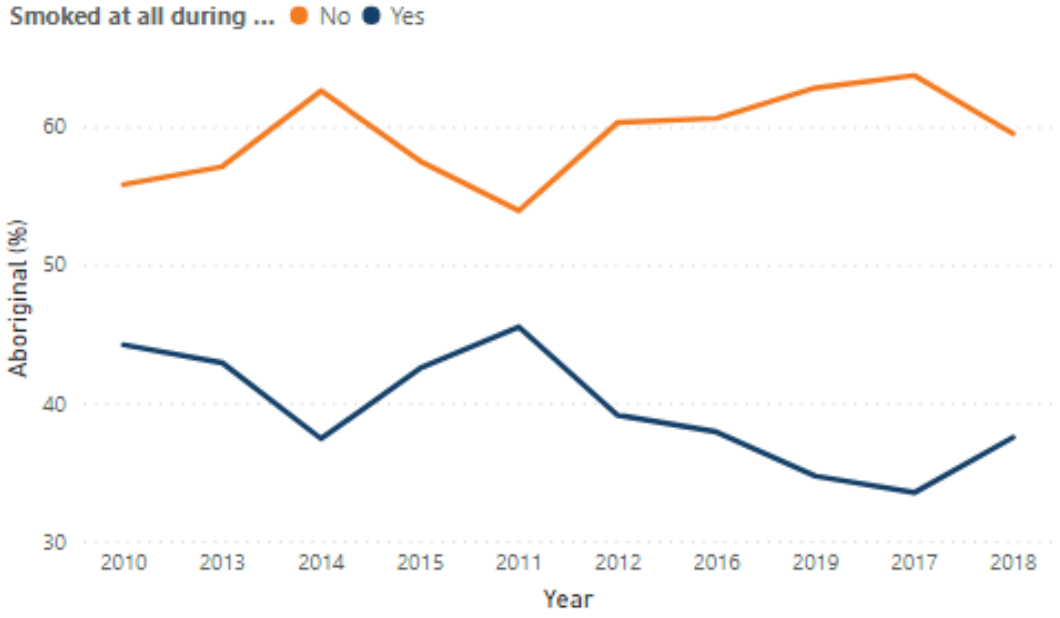
Figure 22: Smoking during pregnancy by NSW PHNs, 2019



Source: HealthStats NSW, 2021

Within the CESPHN region, there has been a decline since 2011 in the proportion of Aboriginal mothers smoking during pregnancy, however between 2017 and 2018 we have seen a slight increase in the proportion of Aboriginal mothers smoking at any point during their pregnancy.(3)

Figure 23: Smoking during pregnancy, CESPHN region, 2010-2019



Source: HealthStats NSW, 2021

Gestational diabetes mellitus

In 2017, 15.5% of Aboriginal mothers nationally who gave birth had gestational diabetes and 3.4% had pre-existing diabetes (compared with 12.5% and 1% of non-Aboriginal mothers, respectively).(7)

Table 29: Gestational diabetes status by Aboriginality, Australia, 2017

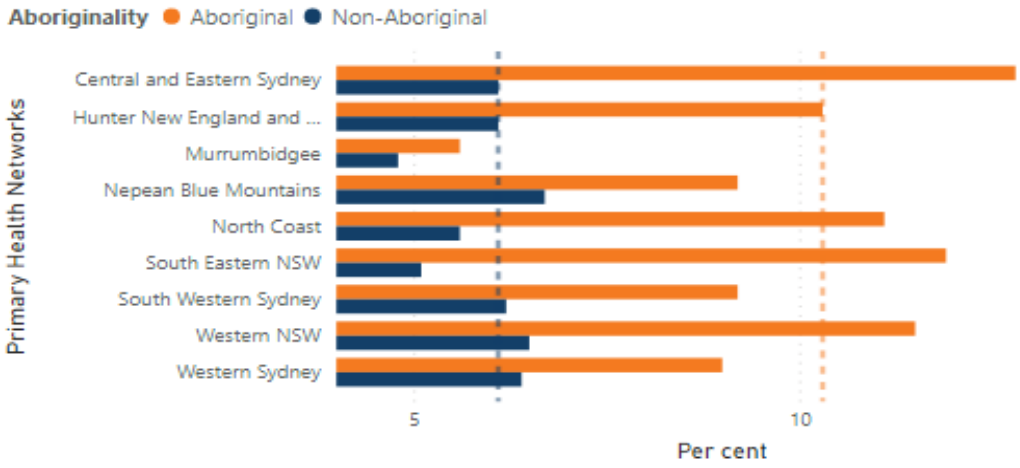
Health condition	Aboriginal (no.)	Non-Aboriginal (No.)	Aboriginal (AS%)	Non-Aboriginal (AS%)	Rate ratio	Rate difference
Pre-existing diabetes	274	2,066	3.4	1.0	3.4	2.4
Gestational diabetes	1,467	26,714	15.5	12.5	1.2	3.0
No diabetes	10,767	180,650	81.1	86.5	0.9	-5.4

Source: AIHW, 2020

Low birthweight babies

In 2019, 12.8% of all live birth babies born to Aboriginal mothers in the CESPHN region had a low birth weight; this is more than double the proportion born to non-Aboriginal mothers (6.1%) (3) and is higher than the reported National rate for 2017 of 11%.(7)

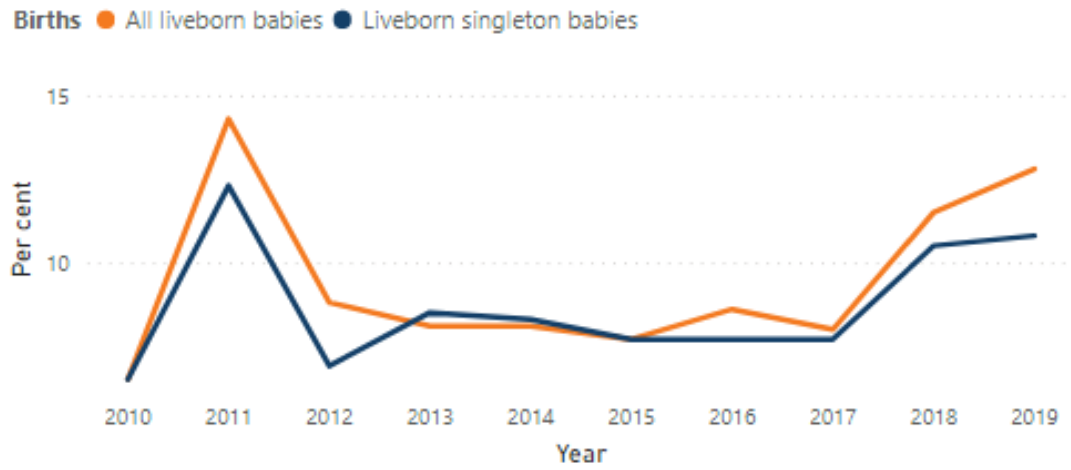
Figure 24: Low birth weight babies by Aboriginal mothers, by PHN NSW, 2019



Source: HealthStats NSW, 2021

Within the CESPHN region, we have seen an increase from 2017 in the proportion of babies born to Aboriginal mother with a low birth weight. In 2019, 12.8% of all liveborn babies and 10.8% of all live born singleton babies were of low birth weight, up from 2017 rates of 8% and 7.7% respectively.(3)

Figure 25: Low birth weight babies born to Aboriginal mothers, CESPHN region, 2010-2019



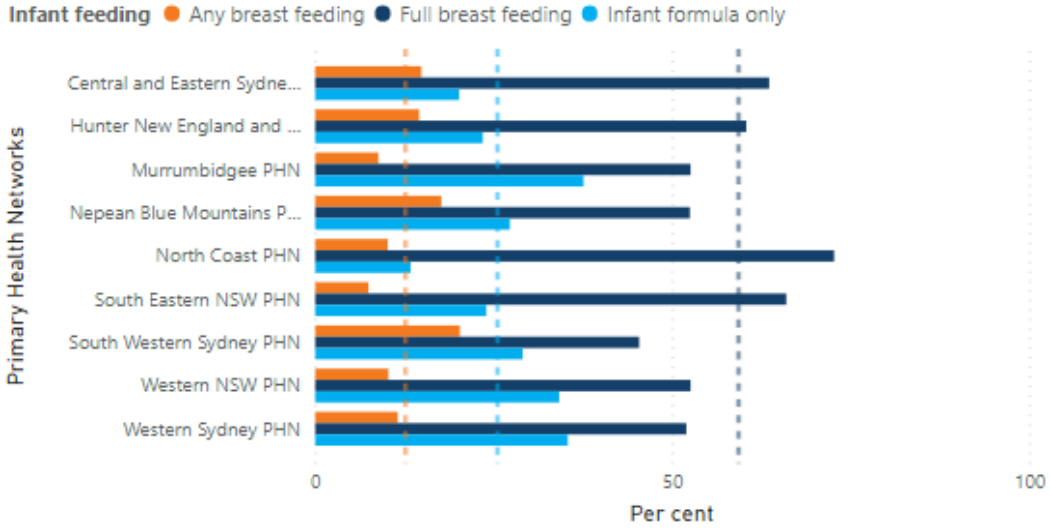
Source: HealthStats NSW, 2021

Breastfeeding

Across NSW, 59.3% of Aboriginal mothers were full breast feeding their babies at discharge (from hospital, or discharge from care for home births), a further 12.7% were offering any level of breast feeding and 25.6% were offering infant formula only.

Within the CESPHN region, we had higher proportion of Aboriginal mothers full breast feeding (63.6%) and/or offering any level of breast feeding (14.9%) at time of discharge compared to NSW.(3)

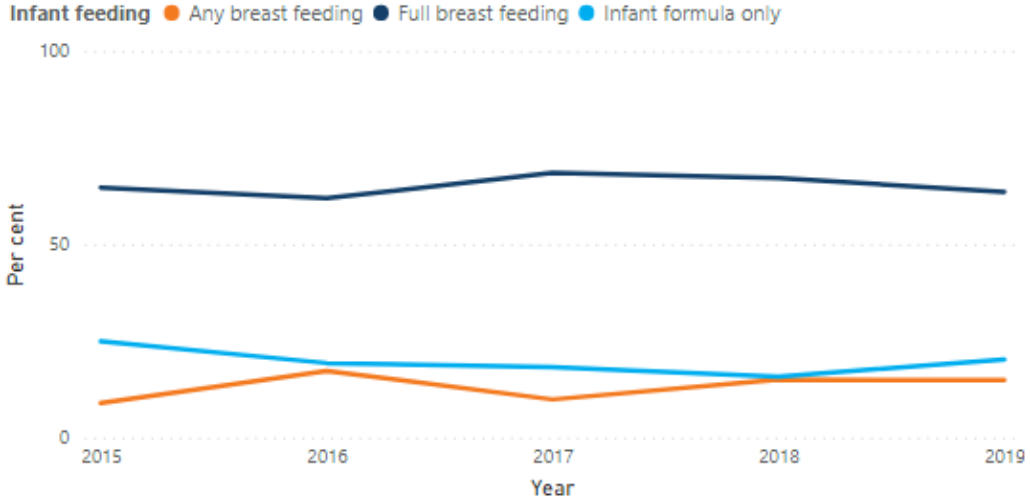
Figure 26: Infant feeding at discharge, all PHNs NSW, 2019



Source: HealthStats NSW, 2021

Infant feeding patterns at time of discharge have remained relatively constant across the CESPHN region for Aboriginal mothers since 2015.(3)

Figure 27: Aboriginal mothers infant feeding at discharge, CESPHN region, 2015-2019



Source: HealthStats NSW, 2021

Social and emotional well-being

Psychological distress

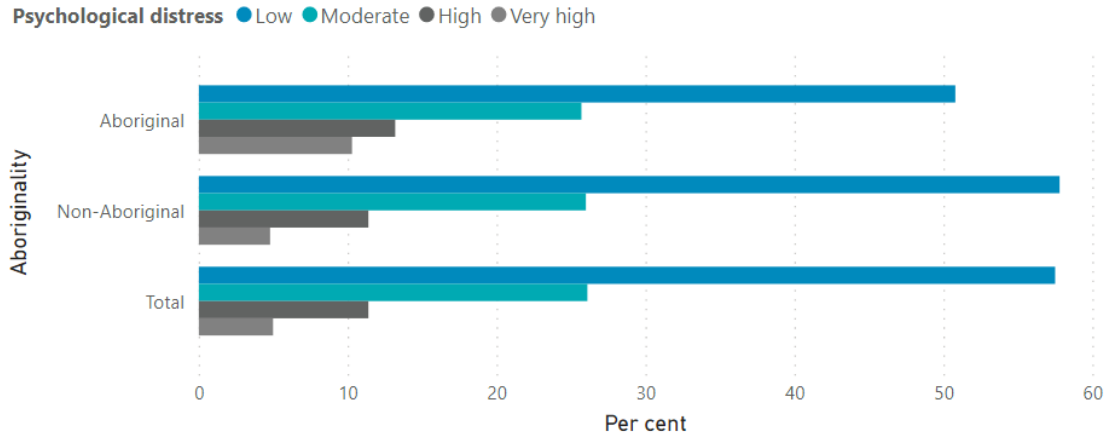
NSW data shows that the Aboriginal population has consistently reported higher levels of psychological distress than the non-Aboriginal population. Both groups have seen an increase in the proportion of the population experiencing psychological distress between 2013 to 2019.(3)

Figure 28: Psychological distress by Aboriginality, NSW, 2003-2019

Source: HealthStats NSW, 2021

Between 2017-19, the Aboriginal population in NSW had levels of very high psychological distress at twice the rate of the non-Aboriginal population (10.3% compared to 4.8%); the rate of high psychological distress was 1.2 times the rate on non-Aboriginal individuals.(3)

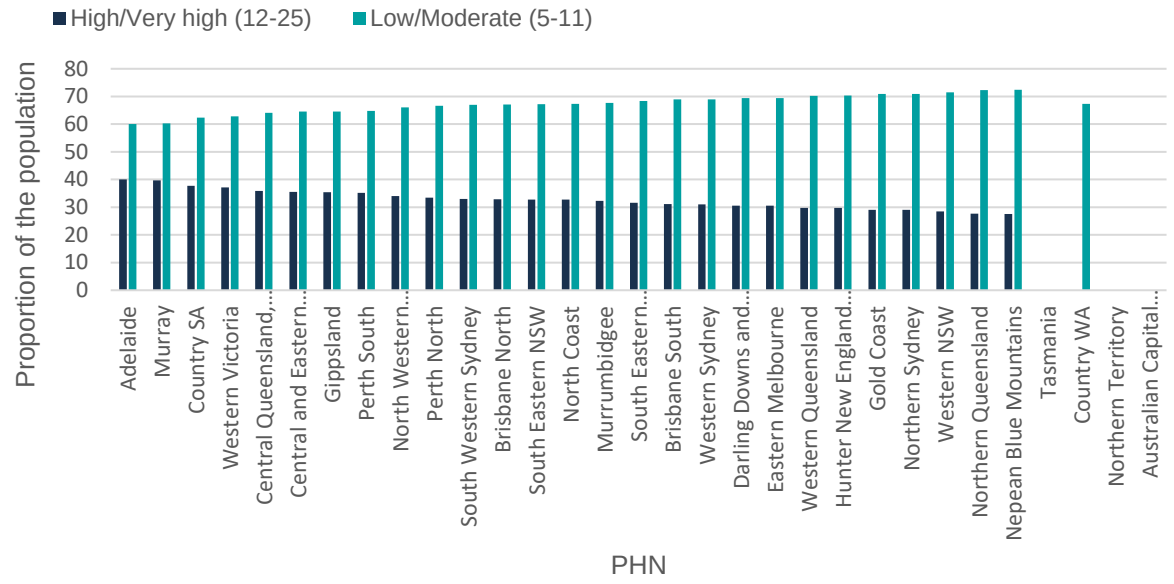
Figure 29: Distress level by Aboriginality, NSW, 2017-19



Source: HealthStats NSW, 2021

Estimates at the PHN level show that an estimated 35.5% of the Aboriginal population within the CESPHN region experienced high/very high levels of psychological distress in 2018-19, ranking 6th highest out of all PHNs and highest in NSW.(4)

Figure 30: Psychological distress by PHN, 2018-19

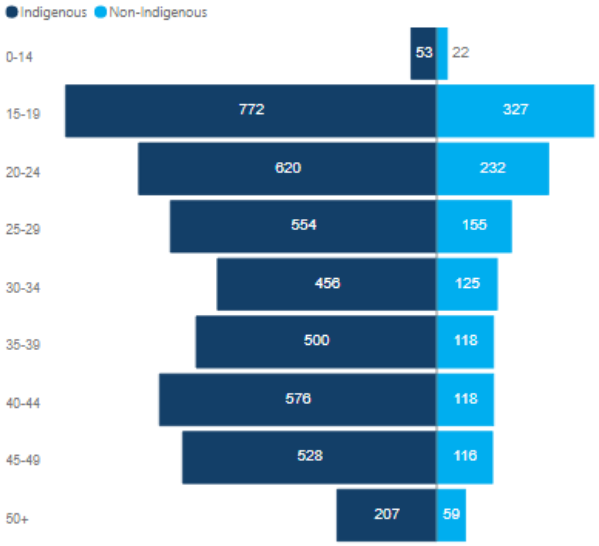


Source: ABS, NATSIHS 2019

Self-harm

Nationally, individuals aged 15-19 years have the highest rates per 100,000 population of intentional self-harm hospitalisations; the rate for Aboriginal persons is 2.4 times the rate of non-Aboriginal persons.(13)

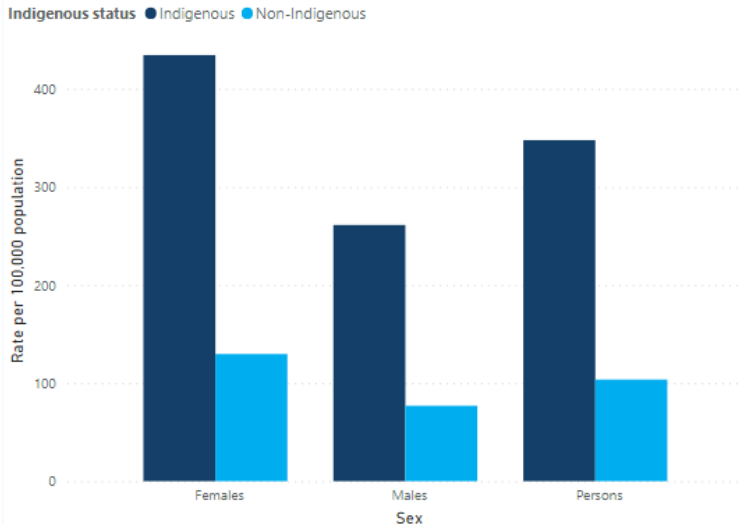
Figure 31: Self-harm by Aboriginality and age group, Australia, 2019-20



Source: AIHW, 2021

Females have a higher rate of intentional self-harm hospitalisations per 100,000 population than males (434.6 compared to 261.3). However, Aboriginal females and males both have rates of intentional self-harm hospitalisations 3.4 times non-Aboriginal females and males.(13)

Figure 32: Self-harm by Aboriginality and sex, Australia, 2019-20



Source: AIHW, 2021

Suicide

In 2019, 16.7% of deaths in the Aboriginal population were by suicide, a rate which is almost three times as high as the non-Aboriginal population (5.7%). 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 (81.7 compared to 38.3).(13)

Table 30: Suicide rates by Aboriginality, Australia, 2019

Measure	Aboriginal	Non-Aboriginal
Number	195.0	2,202.0
Per cent of all causes of death	5.7	1.9
Age-standardised rate (per 100,000)	27.1	12.7

Source: AIHW, 2021

Between 2014 and 2018, 796 Aboriginal people in Australia died by suicide, more than two-thirds of these deaths were for people aged under 35 years (67.1%). In NSW, similar proportions were seen with 193 Aboriginal people dying by suicide and 60.1% of these deaths were individuals under 35 years of age.(13)

The age-specific rate per 100,000 population is higher in the Aboriginal population than the non-Aboriginal population both at the national level (117.0 compared to 53.6) and NSW level (80.2 compared to 45.1). The 25-34 years age group has the highest age-specific rate for the Aboriginal population at both national and NSW levels (47.1 and 33.3 per 100,000 respectively).(13)

Table 31: Deaths by age, Aboriginality, NSW and Australia, 2014 to 2018

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)
	Australia			
Aboriginal	117	796	100.2	133.8
0–24	15.7	297	13.9	17.5
25–34	47.1	237	41.1	53.1
35–44	39.5	154	33.3	45.7
45+	14.7	108	11.9	17.5
Non-Aboriginal	53.6	10,293	51.4	55.8
0–24	5	1,281	4.7	5.3
25–34	14.9	1,806	14.2	15.6
35–44	18.1	1,996	17.3	18.9
45+	15.6	5,210	15.2	16
	NSW			
Aboriginal	80.2	193	57.1	103.3
0–24	7.9	57	5.9	9.9
25–34	33.3	59	24.8	41.8
35–44	23.8	33	15.7	31.9
45+	15.2	44	10.7	19.7
Non-Aboriginal	45.1	4,009	42.1	48.1
0–24	4.3	494	3.9	4.7
25–34	11.9	660	11	12.8
35–44	15.2	763	14.1	16.3
45+	13.7	2,092	13.1	14.3

Source: AIHW, 2021

Alcohol and substance use

Alcohol

An estimated 23.3% 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 (28.2% compared to 18.1%). Males exceeded both the single occasion risk guidelines and lifetime risk guidelines more than females.(4)

Table 32: Alcohol consumption status, by gender, NSW, 2018-19

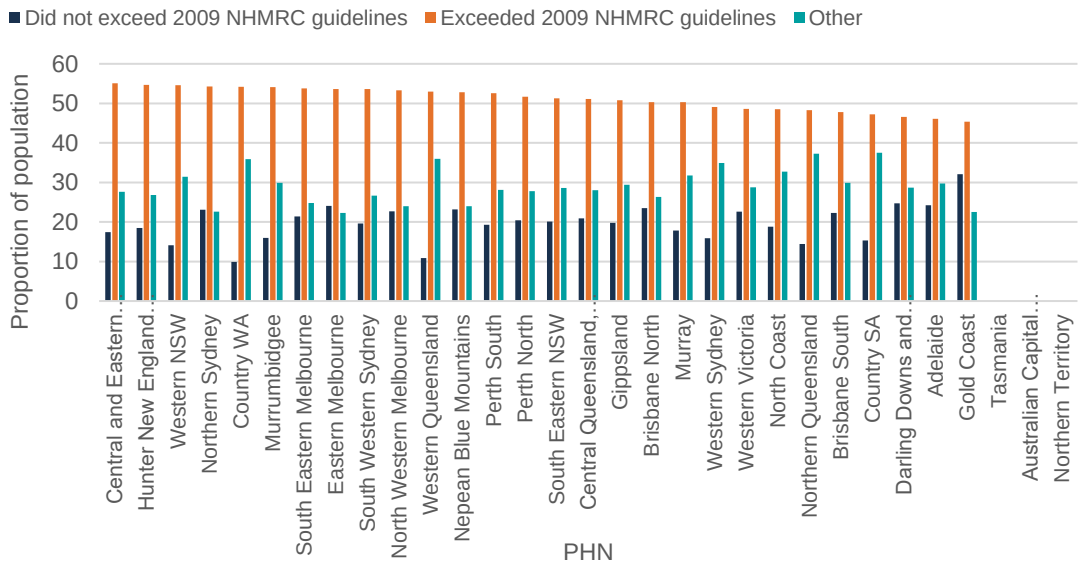
Alcohol consumption	Males	Females	Total NSW
Did not consume alcohol in the last 12 months/have never consumed	18.1	28.2	23.3
Consumed alcohol in the last 12 months	78.9	68.8	74.0
Did not exceed single occasion risk guidelines	14.3	24.8	20.1
Exceeded single occasion risk guidelines	64.0	44.9	53.8
Consumed alcohol in the last week	55.4	38.9	47.4
Did not exceed lifetime risk guidelines	26.9	27.3	27.4
Exceeded lifetime risk guidelines	28.6	12.2	19.8

Source: ABS, NATSIHS 2019

Single occasion risk

Within the CESPHN region, an estimated 55.1% of the Aboriginal population exceeded the NHMRC guidelines for single occasion risk (short term alcohol consumption), ranking CESPHN highest amongst all PHNs. An estimated 17.4% did not exceed the NHMRC guidelines.(4)

Figure 33: Short term alcohol consumption status, PHN, 2018-19



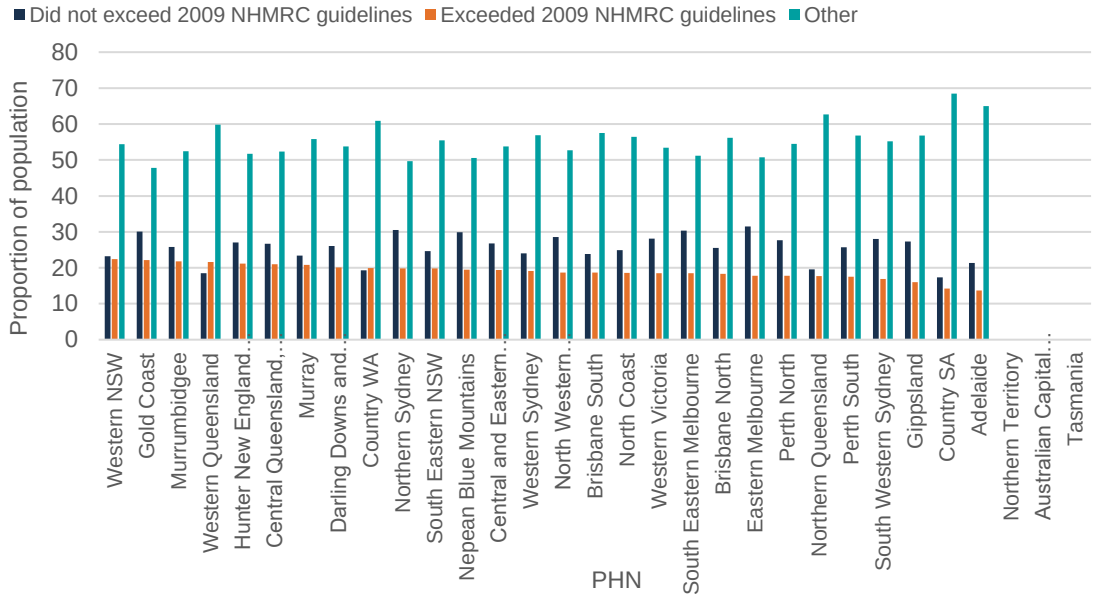
Source: ABS, NATSIHS 2019

**other Includes persons who did not consume alcohol in the last week, including those who never consumed alcohol, those for whom alcohol intake could not be determined, and those who could not remember when they had last consumed alcohol.*

Lifetime risk

Within the CESPHN region, an estimated 19.4% of the Aboriginal population exceeded the NHMRC guidelines for lifetime risk (long term alcohol consumption), ranking CESPHN 13th amongst all PHNs. An estimated 26.8% did not exceed the NHMRC guidelines.(4)

Figure 34: Long term alcohol consumption, PHN, 2018-19



Source: ABS, NATSIHS 2019

Substance use

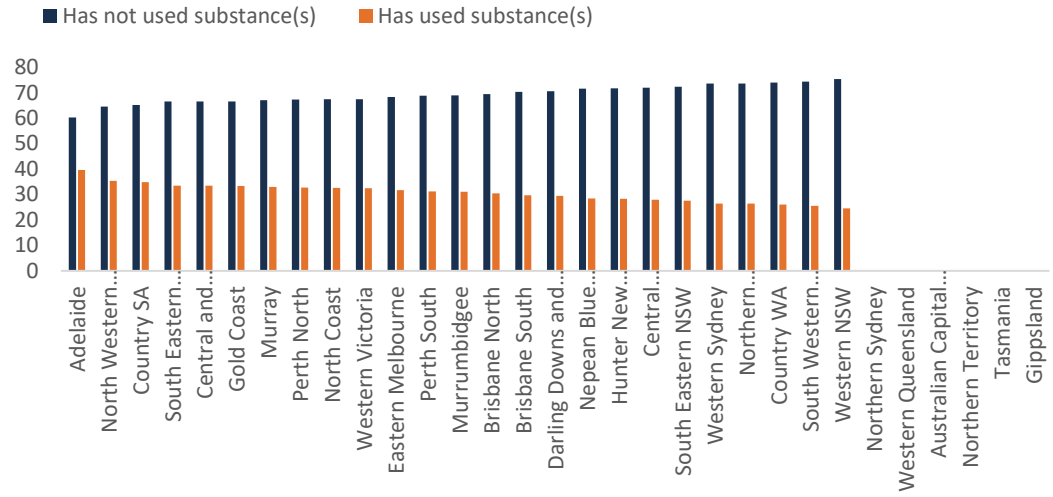
In 2018-19, an estimated 26.7% of the Aboriginal population in NSW had used substance(s) in the previous 12 months. Modelled estimates at the PHN level suggests that 33.5% of the CESPHN Aboriginal population had used substance(s) in the previous 12 months; placing our PHN equal 4th in terms of proportion of the population estimated to have used substances in the past 12 months, and highest in NSW.(5)

Table 33: Substance use in NSW, 2018-19

Substance use	Males (%)	Females (%)	Total NSW (%)
Used substance(s) in last 12 months	33.2	21.6	26.7
Has not used substance(s) in last 12 months	65.9	76.6	72.5

Source: ABS, NATSIHS 2019

Figure 35: Substance use by PHN, 2018-19



Source: ABS, NATSIHS 2019

Older people

Demographics

Population estimates show that 18.3% of the CESPHN Aboriginal population were aged 50 years and over and 6.5% were aged 65 years and over. Leichhardt IARE had the highest proportion of Aboriginal persons aged 50 years and over (24.0%), followed by Botany Bay IARE (21.4%) and Sydney-City IARE (19.7%).(6)

Table 34: Estimated resident population aged 50 years and over, by IARE, 2016

IARE	50-54	55-59	60-64	65yrs +	Total	% Total IARE population
Botany Bay	99	26	41	51	217	21.4
Canterbury -Bankstown (part a)	92	29	50	68	239	19.1
Hurstville-Kogarah	88	21	24	52	185	19.0
Leichhardt	77	41	19	45	182	24.0
Marrickville	110	39	46	102	297	19.4
Randwick-La Perouse	175	53	85	153	466	16.6
Rockdale	73	18	23	53	167	17.9
Sutherland Shire	216	53	85	154	508	17.4
Sydney-City	329	67	106	192	694	19.7
Sydney Inner West	86	23	37	71	217	18.4
Woollahra-Waverley	43	6	5	23	77	13.3
CESPHN	1,422	438	212	1,128	3,200	18.3%

Source: PHIDU, 2021

Note: Lord Howe Island IARE is not included due to low numbers

Aged care

Home care

In 2019-20 there were 53 individuals in home care or transition care in the CESPHN region who identified as Aboriginal, accounting for 1.0% of residents using home care or transition care services in the CESPHN region.(14)

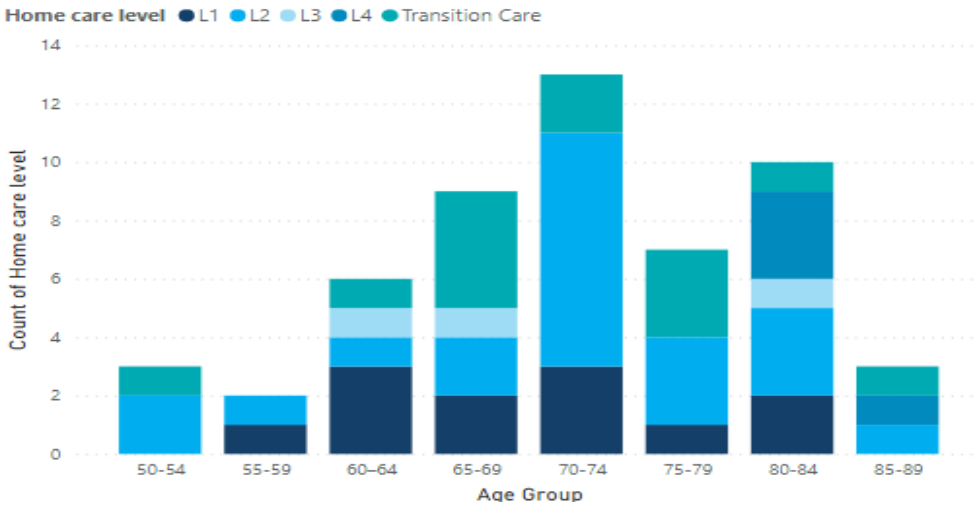
Table 35: Home care or transition care by ACPR, 2019-20

Aged care planning region	Home care	Transition care	Total home care
Inner West	12	6	18
South East Sydney	28	7	35
CESPHN	40	13	53

Source: GEN, 2021

Individuals aged 70-74 years old had the highest number of home care recipients, with 61.5% of them receiving Level 2 Home Care package. Those aged 65-69 years old had the highest number of transition care recipients (n=4; 30.8% of transition care recipients).(15)

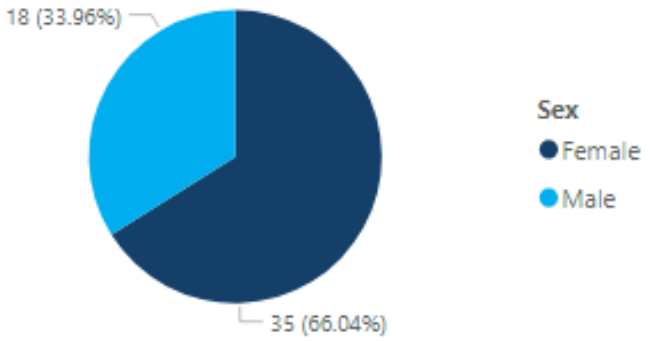
Figure 36: Home and transition care admissions by age group, CESPHN region, 2019-20



Source: GEN, 2021

Two-thirds of admissions to home care support were for females in 2019-20.(15)

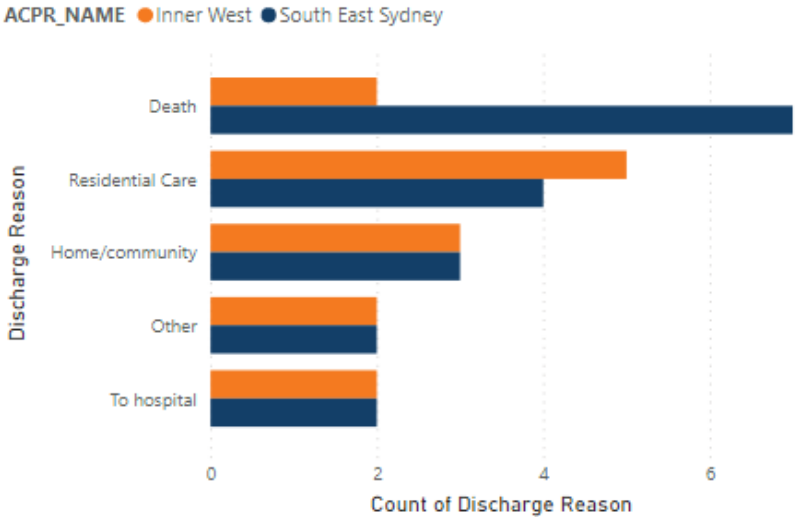
Figure 37: Home care admissions by gender, CESPHN region, 2019-20



Source: GEN, 2021

Thirty-two individuals were discharged from home care supports in 2019-20 – 28% of these discharges were due to death and a further 28% entered residential care.(16)

Figure 38: Home care discharges, by discharge reason, by ACPR, CESPHN region, 2019-20



Source: GEN, 2021

Residential care

In 2019-20, there were 83 residential care admissions for people who identified as Aboriginal in the CESPHN region, accounting for 0.9% of all residential care places. Almost 4 in 10 (38.6%) of these admissions were for permanent places.(15)

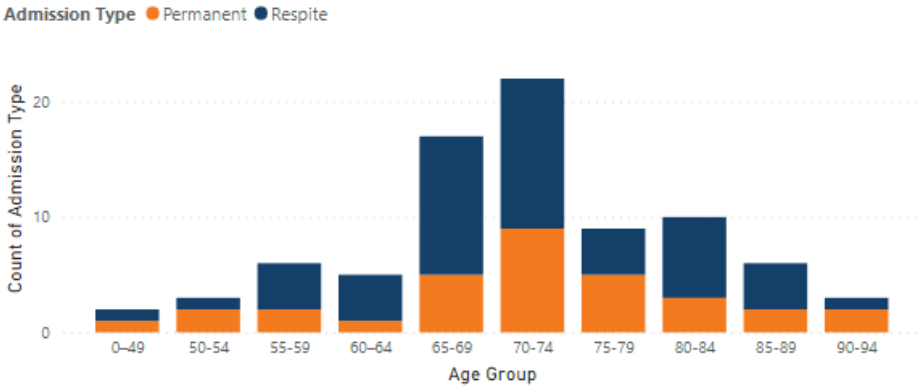
Table 36: Residential care places by ACPR, 2019-20

Aged care planning region	Permanent	Respite	Total residential care
Inner West	10	14	24
South East Sydney	22	37	59
CESPHN	32	51	83

Source: GEN, 2021

The majority of residential care admissions were in the 70-74 year age group (n=22), comprising 13 respite admissions and 9 permanent admissions.(15)

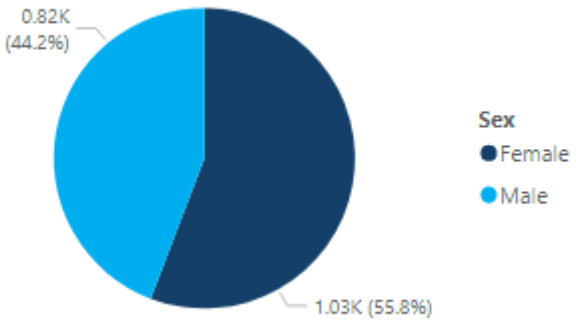
Figure 39: Residential care admissions, by admission type and age group, CESPHN region, 2019-20



Source: GEN, 2021

In 2019-20, admissions to residential care were relatively evenly split between males and females who identified as Aboriginal.(15)

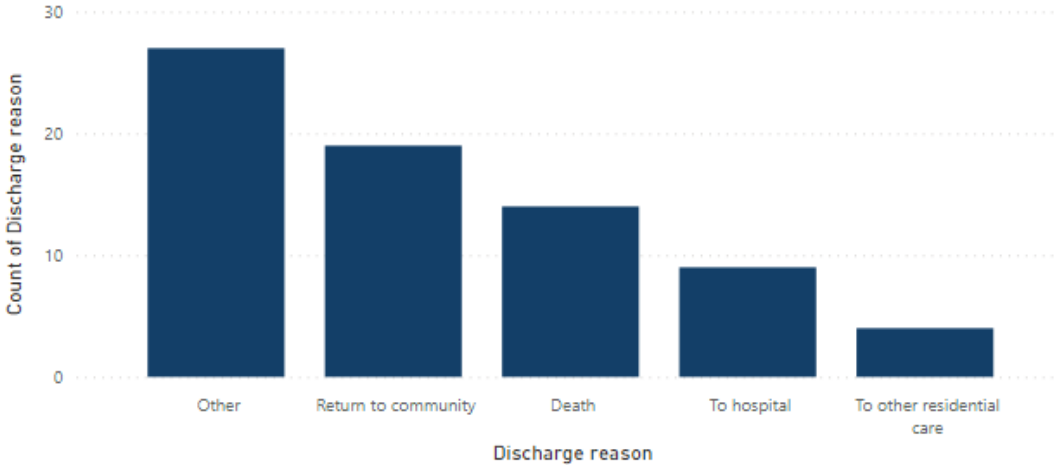
Figure 40: Proportion of residential care admissions by gender, CESPHN region, 2019-20



Source: GEN, 2021

In 2019-20, of the 73 individuals who identified as Aboriginal and exited residential care across the CESPHN region, approximately one-quarter (26%) of these discharges were due to the resident returning to the community.(16)

Figure 41: Exits from residential care by discharge reason, CESPHN region, 2019-20



Source: GEN, 2021

Hospitalisations

Demographics

Gender

Across the CESPHN region the rates of admission by gender were lower than both NSW and Australian rates. However, within the CESPHN region there were IAREs with admission rates higher than NSW rates:

- Randwick-La Perouse, Sydney-City and Woollahra-Waverley IAREs had admission rates for females all higher than the NSW rates
- Botany Bay, Randwick-La Perouse and Sydney City IAREs had admission rates for males all higher than the NSW rates.

Table 37: Average annual ASR per 100,000 by gender and IARE, 2016-17 to 2018-19

Region	Female	Male
Botany Bay	30,874.9	25,696.5
Canterbury - Bankstown (part a)	26,722.6	23,191.9
Hurstville - Kogarah	18,613.6	17,881.7
Leichhardt	26,799.0	23,576.0
Lord Howe Island	..	-
Marrickville	32,793.6	23,355.3
Randwick - La Perouse	39,384.0	28,092.0
Rockdale	22,528.1	15,636.9
Sutherland Shire	23,449.2	16,520.4
Sydney - City	36,793.2	32,744.0
Sydney - Inner West	23,464.8	18,170.9
Woollahra - Waverley	40,226.6	17,079.4
Central and Eastern Sydney	30,467.0	25,242.2
New South Wales	33,286.9	25,454.3
Australia	41,955.6	30,831.4

Source: PHIDU, 2021

0-14 years

Leichhardt IARE had the highest ASR of hospital admissions for 0–14-year-olds where the cause was digestive system disease and skin and subcutaneous tissue diseases (1,789.6 and 1,055.3 per 100,000 population respectively). These rates were higher than both NSW and national rates.

Randwick-La Perouse and Sydney-City IAREs had hospital admission rates for 0–14-year-olds for injury, poisoning and other external causes (3,278.0 and 2,892.2 per 100,000 population respectively), higher than rates across Australia (2,194 per 100,000 population).

Marrickville IARE and Sydney Inner West IARE had hospital admissions for 0–14-year-olds for respiratory system diseases higher than state rates (3,440.6 and 3,434.6 respectively compared to 3,116.3 per 100,000population).

Table 38: Hospital admissions by cause, 0–14-year-olds, by IARE, 2016-17 to 2018-19

IARE	Digestive system diseases	Injury, poisoning and other external causes	Respiratory system diseases	Skin and subcutaneous tissue diseases
Botany Bay	1,343.8	1,870.4	2,265.1	871.3
Canterbury -Bankstown (part a)	1,029.0	1,071.8	1,844.6	..
Hurstville-Kogarah	..	1,242.0	2,763.9	..
Leichhardt	1,789.6	1,105.0	2,316.4	1,055.3
Marrickville	1,535.0	1,979.8	3,440.6	640.8
Randwick-La Perouse	916.5	3,278.0	2,381.6	811.5
Rockdale	1,476.0	1,087.3	1,695.2	..
Sutherland Shire	929.1	742.9	1,982.1	235.6
Sydney-City	1,262.2	2,892.2	2,217.1	980.8
Sydney Inner West	664.4	557.1	3,434.6	..
Woollahra-Waverley	1,232.1	1,236.2	2,598.7	..
CESPHN	1,091.6	1,730.9	2,348.8	530.7
NSW	1,208.4	1,743.4	3,116.3	446.4
Australia	1,381.4	2,194.0	3,756.2	902.4

Source: PHIDU, 2021

15 years and older

Randwick La Perouse IARE and Sydney-City IARE had some of the highest ASR of hospital admissions for individuals aged 15 years and older for:

- digestive system diseases (3,491.4 and 3,313.2 per 100,000 population respectively),
- injury, poisoning and other external causes (5,401.9 and 4,697.7 per 100,000 population respectively),
- respiratory system diseases (2,715.7 and 2,943.6 per 100,000 population respectively) and

Marrickville IARE and Sydney-City IARE had hospital admission rates for skin and subcutaneous tissue diseases (1,953.5 and 1,911.9 per 100,000 population respectively) higher than both state (1,061.3 per 100,000 population) and national rates (1,627.8 per 100,000 population respectively).

Botany Bay IARE had hospital admission rates for individuals aged 15 years and over (1,502.3 per 100,000 population) higher than both state (772.6 per 100,000 population) and national rates (1,095.5 per 100,000 population); Sydney-City IARE had rates (1,046.7 per 100,000 population) higher than state.(6)

Table 39: Hospital admissions by cause, 15 years and older, by IARE, 2016-17 to 2018-19

IARE	Digestive system diseases	Infectious and parasitic diseases	Injury, poisoning and other external causes	Respiratory system diseases	Skin and subcutaneous tissue diseases
Botany Bay	2,363.00	1,502.30	3,997.80	1,519.20	600.4
Canterbury -Bankstown (part a)	3,006.10	907.8	3,571.20	2,127.80	..
Hurstville-Kogarah	..	..	2,629.80	1,186.20	..
Leichhardt	2,652.00	..	3,817.20	1,845.90	587.2
Marrickville	2,716.3	741.9	3,543.0	2,917.2	1,953.5
Randwick-La Perouse	3,491.4	622.9	5,401.9	2,715.7	876.3
Rockdale	2,175.0	..	3,181.4	1,789.4	..
Sutherland Shire	2,839.0	392.3	2,335.2	827.3	699.2
Sydney-City	3,313.2	1,046.7	4,697.7	2,943.6	1,911.9
Sydney Inner West	1,959.3	..	3,186.6	1,346.3	..
Woollahra-Waverley	1,309.2	..	1,557.3	1,246.7	..
CESPHN	2,872.9	781.7	3,793.8	2,061.5	1,134.5
NSW	3,789.0	772.6	4,035.6	2,502.6	1,061.3
Australia	4,122.1	1,095.5	5,565.6	3,386.4	1,627.8

Source: PHIDU, 2021

Principal diagnosis

External causes

Randwick-La Perouse IARE had hospital admission rates per 100,000 population for falls, exposure to inanimate mechanical forces, intentional self-harm and total diagnosis of injury or poisoning above both NSW and Australia rates. Of particular note are the rates for intentional self-harm, which are 2.2 times the rates for Australia.(6)

Sydney-City IARE had hospital admission rates per 100,000 population for falls, intentional self-harm and total diagnosis of injury or poisoning above both NSW and Australia rates. Of particular note are the rates for falls, which are 1.4 times the rates for Australia. (6)

Table 40: Hospital admissions by external causes, by IARE, 2016-17 to 2018-19

IARE	Falls	Expose to inanimate mechanical forces	Intentional self-harm	Total diagnosis of injury or poisoning
Botany Bay	940.2	380.3	268.4	2,460.7
Canterbury -Bankstown (part a)	636.7	503.0	344.4	2,385.8
Hurstville-Kogarah	321.0	467.3	..	1,389.0
Leichhardt	595.5	465.9	..	2,096.3
Marrickville	692.3	456.9	191.4	2,132.3
Randwick-La Perouse	922.9	654.4	721.2	3,528.5
Rockdale	441.5	271.4	259.0	1,432.0
Sutherland Shire	351.0	249.2	135.7	1,418.5
Sydney-City	1,127.1	445.5	424.2	3,484.5
Sydney Inner West	358.3	302.7	232.1	1,893.0
Woollahra-Waverley	570.5	..	230.5	1,204.8
CESPHN	704.0	421.9	335.5	2,440.8
NSW	610.1	398.0	270.4	2,338.3
Australia	785.5	477.5	326.5	3,403.0

Source: PHIDU, 2021

Emergency department presentations

There has been a continual increase in the number of ED presentations by Aboriginal people in the CESPHN region since 2014-15 (6,954) to 2019-20 (10,670), with the same pattern seen in mental health related ED presentations.(17)

Table 41: ED Presentations by Aboriginality, CESPHN region, 2014-15 to 2019-20

Year	Mental health related ED presentations	Total ED presentations
2014-15	524	6,954
2015-16	731	7,430
2016-17	637	7,662
2017-18	682	8,172
2018-19	917	9,891
2019-20	933	10,670

Source: AIHW, 2021

Access

In 2018-19, Aboriginal persons aged 15 years and over who are the most disadvantaged (1st quintile in SEIFA) were:

- 12.5 times more likely to have accessed health care
- 17.3 times more likely to have been admitted to hospital
- 16 times more likely to have visited casualty/emergency/outpatients/day clinic
- 11 times more likely to have consulted a doctor
- 8.3 times more likely to have consulted a dentist
- 8.8 times more likely to have consulted other health professionals

compared to Aboriginal persons aged 15 years and over who are most advantaged (5th quintile in SEIFA).(7)

Indigenous health PIP

The Indigenous Health Incentive (IHI) supports general practices and Aboriginal health services to provide better health care for Aboriginal patients with chronic disease. In 2018, 127 practices in the CESPHN region received an IHI payment. This has increased from 104 practices in 2015. The uptake of new practices signing up to the program was zero at the beginning of 2018 (latest available data).(18)

MBS item 715

The proportion of the Aboriginal population in the CESPHN region who have received a health assessment by a GP (MBS Item 715) in the last two years has remained stable.(19)

Table 42: Health assessment (MBS 715) by financial year, CESPHN region

Financial Year	Total (No.)	Total (%)
2018–19	2,393	13.0
2019–20	2,416	12.9

Source: AIHW, 2021

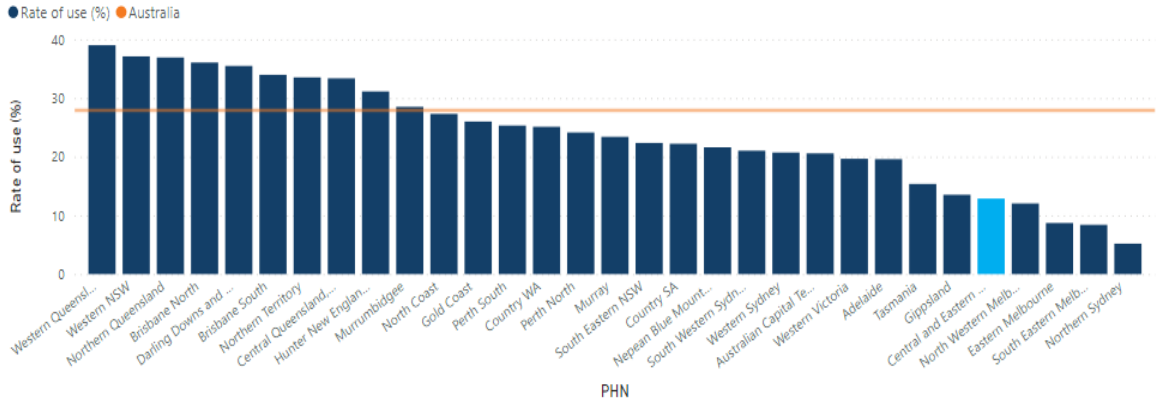
In 2019-20, CESPHN continued to have a low proportion of the population who received a health assessment (12.9%) compared to the national rate (27.9%); 11.5% (n=2,174) of these health assessments were face-to-face consultations and 1.4% (n=269) were telehealth consultations.(19)

The CESPHN and national rates are well below targets that have been set in the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023:

- 0-4 years: 69%
- 5-14 years: 46%
- 15-24 years: 42%
- 25-54 years: 63%
- 55 years and over: 74%.

The rate of follow up of patient who received a health assessment in the CESPHN region was 35.5% in 2019-20, 11th lowest of all PHNs.

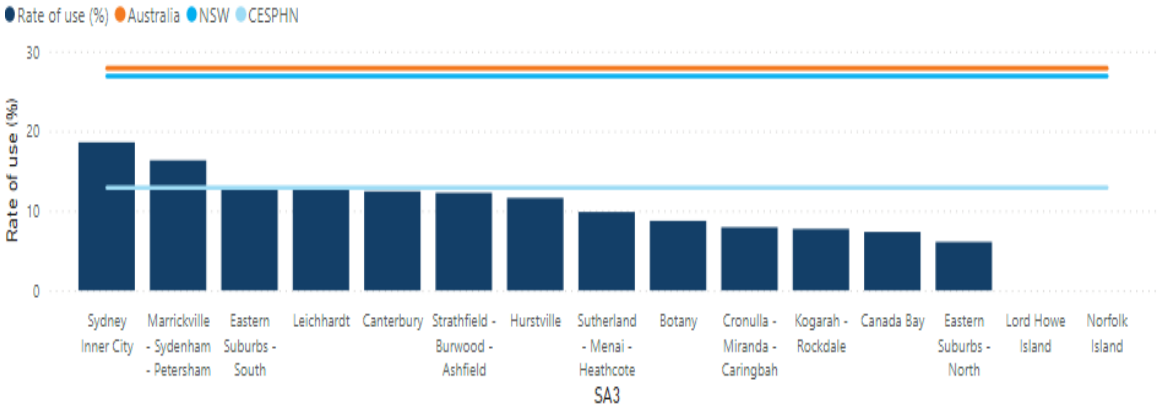
Figure 42: Health assessment (MBS 715) by PHN, 2019-20



Source: AIHW, 2021

Within the CESPHN region, all SA3s had MBS item 715 uptake rates lower than national and NSW rates. Sydney Inner City SA3, Marrickville-Sydenham-Petersham SA3 and Eastern Suburbs-South SA3 were the only SA3s within our region whose rates for MBS item 715 were higher than the CESPHN rate (18.59%, 16.33% and 12.99%).(19)

Figure 43: Health assessment (MBS 715) by SA3, 2019-20



Source: AIHW, 2021

After hours

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.

In 2020, 2.5% of calls to the After Hours Helpline from the CESPHN region were from callers who identified as Aboriginal.(20)

Table 43: Callers to HealthDirect After Hours Helpline, by Aboriginality and PIP timeframe, CESPHN region, 2019-20

PIP timeframe	Aboriginal (%)	Non-Aboriginal (%)	Grand Total (%)
T1	0.9	30.9	31.8
T2	0.6	20.1	20.7
T3	0.4	17.7	18.1
T4	0.6	28.8	29.4
Grand Total	2.5	97.5	100.0

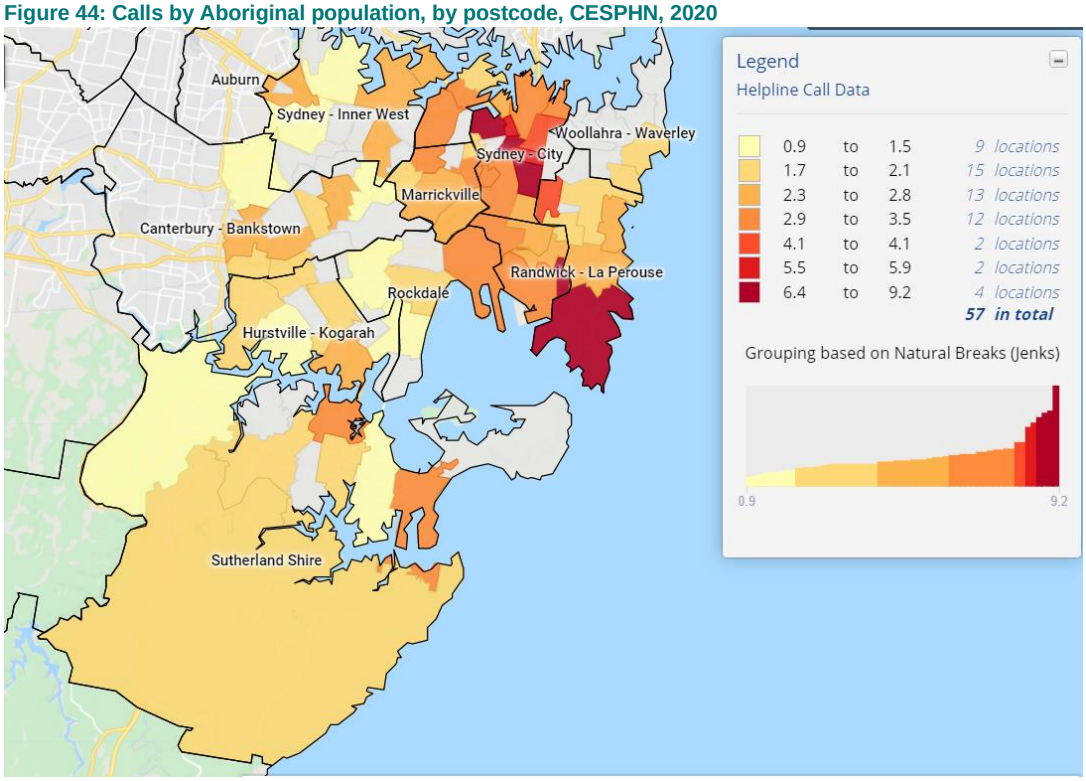
Source: HealthDirect Australia, 2020

Within the CESPHN region, there were six postcodes where 5.5% or more of calls to the After Hours Helpline were by callers who identified as Aboriginal:

- 2017 (9.2%)
- 2037 (7%)
- 2036 (6.8%)
- 2008 (6.4%)
- 2016 (5.9%)
- 2007 (5.5%)

These postcodes predominantly fall under two IAREs (Randwick-La Perouse and Sydney-City).

Figure 44: Calls by Aboriginal population, by postcode, CESPHN, 2020



Source: HealthDirect Australia, 2020

These trends in call areas were seen across the four PIP timeframes, with postcode 2017 consistently having the highest proportion of calls for each timeframe.

Table 44: Calls by timeframe and postcode, CESPHN, 2020

PIP Timeframe	Postcode with highest % calls	Postcode with 2nd highest % calls	Postcode with 3rd highest % calls	Postcode with 4th highest % calls	Postcode with 5th highest % calls
T1	2017 (11.1)	2036 (7.5)	2037 (7.1)	2010 (4.9)	2230 (3.8)
T2	2017 (14.3)	2037 (11.4)	2036 (7.5)	2010 (6.1)	2131 (5.8)
T3	2017 (9.3)	2036 (7.9)	2000 (4.1)	n.p	n.p
T4	2017 (10.5)	2016 (6.5)	2037 (6.4)	2036 (5.3)	2034 (5.1)

Source: HealthDirect Australia, 2020

The highest number of general practices open at any point during the after hours period was in the Sydney-City IARE (n=61), accounting for 22% of all practices open at any point during the after hours period. Of note, Randwick-La Perouse IARE had some of the lowest number of practices open in each of the PIP timeframes.(20)

Table 45: Practices open by after hours timeframes, by IARE, 2020

IARE	No. General Practices open at any time after hours	No. General Practices open in T1	No. General Practices open inT2	No. General Practices open in T3	No. General Practices open in T4
Botany Bay	18	10	1	15	7
Canterbury-Bankstown*	43	19	6	41	24
Hurstville-Kogarah	33	13	2	29	15
Leichhardt	15	9	2	11	7
Marrickville	14	6	1	11	4
Randwick-La Perouse	19	8	3	13	8
Rockdale	26	11	2	22	10
Sutherland Shire	28	12	5	24	11
Sydney-City	61	22	7	49	22
Sydney-Inner West	55	26	6	48	20
Woollahra-Waverley	26	10	3	22	8
Total	282	120	32	241	115

Source: HealthDirect Australia, 2020

*Note: This data includes the whole of the Canterbury-Bankstown IARE, not just CESPHN portion.

Lower urgency emergency department (ED) presentations

Lower urgency ED presentations are presentations to a public hospital ED with a triage category of 4 (semi-urgent) or 5 (non-urgent), where the patient did not arrive by ambulance, or police or correctional vehicle and was not admitted to the hospital, not referred to another hospital, or did not die.

In 2017-18, there were 3,278 lower urgency ED presentations in the CESPHN region for Aboriginal persons, 2,788 were semi-urgent presentations and 490 were non-urgent. This was equivalent to 15,734.0 per 100,000 population (semi-urgent) and 2,674.1 per 100,000 population (non-urgent). Both rates were lower than the national rate of 25,838.3 per 100,000 population (semi-urgent) and 6,644.6 per 100,000 population (non-urgent).

Table 46: Lower urgency ED presentations by IARE, 2017-18

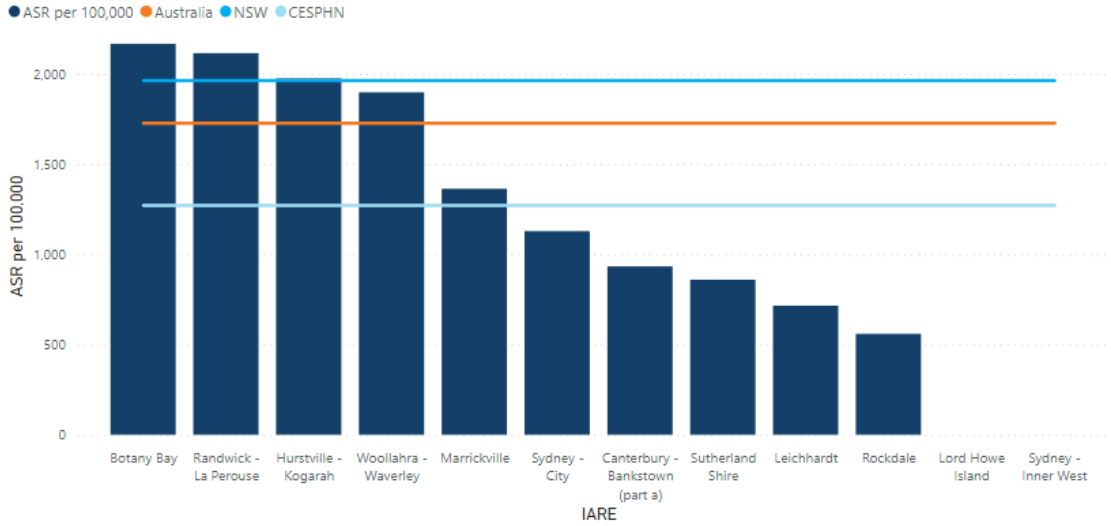
IARE	Non-urgent Presentations - Total, Aboriginal persons	Semi-urgent Presentations - Total, Aboriginal persons
Botany Bay	3,121.4	23,241.6
Canterbury - Bankstown (part a)	2,435.0	14,345.1
Hurstville - Kogarah	3,001.0	15,195.8
Leichhardt	2,230.7	11,576.76
Marrickville	2,329.0	13,058.5
Randwick - La Perouse	3,023.6	19,594.0
Rockdale	2,649.0	12,725.8
Sutherland Shire	2,011.9	9,882.5
Sydney - City	3,651.98	21,169.0
Sydney - Inner West	1,135.6	9,891.6
Woollahra - Waverley	1,897.2	12,775.5
Central and Eastern Sydney	2,674.1	15,734.0
New South Wales	10,833.7	31,068.5
Australia	6,644.6	25,838.3

Source: PHIDU, 2021

The breakdown of lower urgency ED presentations in 2017-18 show that there were IAREs within the CESPHN region where rates of presentation were higher than NSW and/or Australia.

Semi-urgent and non-urgent ED presentations for certain infectious and parasitic diseases in Botany Bay IARE, Randwick-La Perouse IARE, Hurstville-Kogarah IARE and Waverley-Woollahra IARE were higher than Australian and NSW rates in 2017-18.(6)

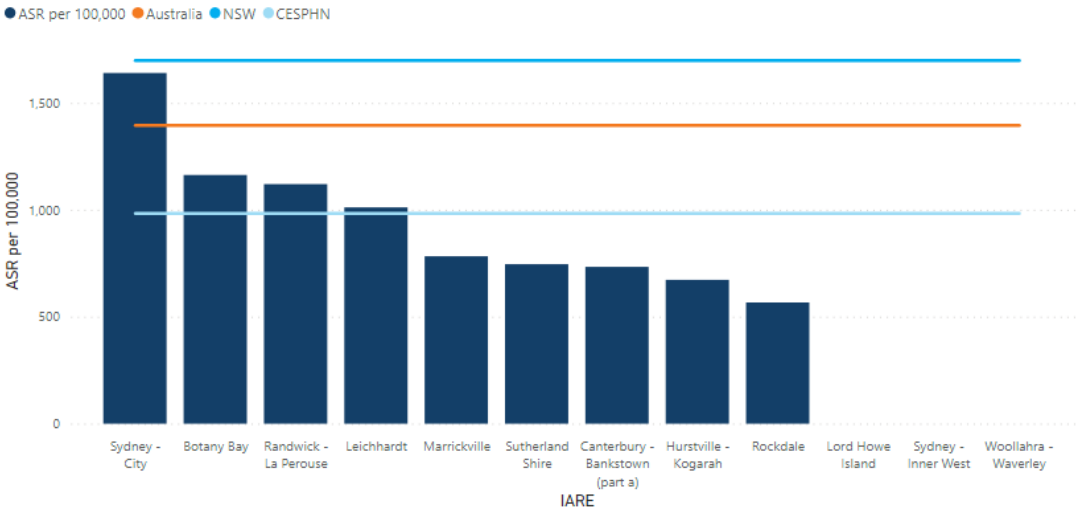
Figure 45: Lower urgency ED presentations for certain infectious and parasitic diseases, by IARE, 2017-18



Source: PHIDU, 2021

Semi-urgent and non-urgent ED presentations for mental and behavioural disorders in Sydney-City IARE were higher than national rates in 2017-18.(6)

Figure 46: Lower urgency ED presentations for mental and behavioural disorders, by IARE, 2017-18



Source: PHIDU, 2021

Patient experience

Communication

In 2018-19, 88.8% of Aboriginal patients in non-remote Australia felt their doctor listened carefully always/often when seeking health care, an increase from 79.5% in 2014-15. In non-remote NSW, similar rates were seen with 92.0% of patients feeling that their doctor listed carefully always/often when seeking health care. A higher proportion of males than females felt their doctor listened carefully always/often (90.0% compared to 87.7% respectively). Patients in older age groups reported a higher

proportion of patients who felt their doctor listened carefully always/often (87% for 15-24 years, increasing to 90.5% for those aged 55 years and older).(7)

In 2018-19, 87.9% of Aboriginal patients in non-remote Australia felt their doctor(s) always/usually explained things in a way that could be understood. In NSW the proportion was slightly higher at 89.2%. A slightly higher proportion of males reported their doctor(s) always/usually explained things in a way that could be understood compared to females (89.8% compared to 86.6% respectively). Patients aged 55 years and older had the highest proportion of respondents who reported their doctor(s) always/usually explained things in a way that could be understood (92.2%).

Aboriginal Medical Services/Community clinics and Doctor/GP service types had the highest proportion of individuals who felt their doctor(s) always/usually explained things in a way that could be understood (88.4%).(7) Those with no usual GP/medical service reported slightly lower agreement regarding doctor(s) explaining things in a way that could be understood (81.2%), and hospital settings had the lowest proportion of people who felt their doctor(s) explained things in a way that could be understood (74.2%).

Treated respectfully

In 2018-19, 91.0% of Aboriginal patients in non-remote Australia felt their doctor(s) showed respect always/often, this has increased from 85.0% in 2014-15. Patients in NSW reported similar levels, where 91.9% of patients felt their doctor(s) showed respect always/often. There was minimal difference between age groups, with the 35-44 year age group having the lowest proportion at 89.3% and those aged 55 years and older reporting the highest proportion of respect always/often at 93.6%.(7)

Unfair treatment and cultural barriers

Almost a quarter of a million Aboriginal patients across Australia did not access a health service when needed in 2018-19, with approximately one third not accessing a service because it was not culturally appropriate (32.0%). The proportion of patients who did not access a service because it was not culturally appropriate is consistently at around one-third irrespective of gender and age group. The same is seen for residents who live in non-remote settings and those respondents from NSW.(7)

Left against medical advice

Nationally, between July 2015 and June 2017, Aboriginal patients left hospital against medical advice/discharged at own risk at a rate 6.1 times that of non-Aboriginal patients. The rate ratio for NSW was slightly lower at 3.6 times that of non-Aboriginal patients.(7)

The highest age-standardised proportion in NSW was for Aboriginal patients whose principal diagnosis was *diseases of the skin and subcutaneous tissue* (4.9% of patients). The largest rate ratio in NSW was for patients whose principal diagnosis was *diseases of the musculoskeletal system and connective tissue* (rate ratio = 6.2).(5, 7)

Service gaps

Nationally, 67.7% of organisations funded to provide primary health care for Aboriginal persons identified mental health/social and emotional health and wellbeing as a service gap in the community they served, 54.0% identified youth services and 44.9% identified alcohol, tobacco and other drugs as health service gaps.(7) Our stakeholders advise that Aboriginal youth access to mental health services have long waiting times.

Table 47: Identified health service gaps in organisations funded for primary health care, 2017-18

Health service gap	% of respondents who identified the gap
Mental health/social and emotional health and wellbeing	67.7
Youth services	54.0
Alcohol, tobacco and other drugs	44.9
Prevention/early detection of chronic disease	43.9
Environmental health services (including housing)	41.9
Dental services	37.4
Access to health services (including transport)	33.3
Early childhood development and family support	31.3
Services to support healthy ageing	27.3
Disability services	26.8
Maternal and child health	25.8
Nutrition services (including lack of access to affordable healthy food)	25.3
Palliative care	15.2
Treatment of injury and illness	8.1
Pharmacy services	5.6

Source: AIHW, 2020

Recruitment, training and support of Aboriginal staff was identified as the main health service challenge in organisations funded for primary health care (71% of respondents), followed by staffing levels (63.1%) and staff retention/turnover (53.5%).(7) Our stakeholders have advised that there is a shortage of Aboriginal health workers during weekends at major hospitals.

Figure 47: Identified health service challenges in organisations funded for primary health care, 2017-18

Health service challenges	% of respondents who identified the gap
Recruitment, training and support of Aboriginal staff	71.2
Staffing levels	63.1
Staff retention/turnover	53.5
Coordination of clinical care with other providers (e.g. hospitals)	47.0
Appropriate health service infrastructure	45.5
Access to specialist medical services	44.4
Information technology	32.8
Staff housing	31.3
Access to allied health services	28.3
Provision of care in a cross-cultural environment	21.2
Corporate services/administration	9.1
Availability/maintenance of equipment	8.1
Financial management	4.5

Source: AIHW, 2020

Aboriginal health workforce

Across the CESPHN region, there were 253 AHPRA registered health professionals who identified as Aboriginal, giving a rate of 15.2 per 100,000 population and accounting for 0.6% of AHPRA registered health professionals. This is noticeably lower than the state and national rates per 100,000 population (29.0 and 25.1 respectively).(21)

Variations to NSW and Australian rates of Aboriginal health professionals are seen in the following professions:

- Aboriginal and Torres Strait Islander health practitioner: there are none registered in the CESPHN region
- Chinese medicine practitioners: there are less than 4 registered in the CESPHN region, therefore exact number are withheld from reporting
- Nurses and midwives: the rate across the CESPHN region is approximately half of the national rate per 100,000 population and approximately 40% of the NSW rate
- Occupational therapists: the rate across the CESPHN region is approximately half of both state and national rates
- Paramedicine practitioners: the rate is approximately 70% of the national rate and less than half of the state rate
- Physiotherapists: the rate across the CESPHN region is almost double that of the national rate.

Table 48: Aboriginal health professionals, CESPHN region, 2020

Health Profession	Number of Practitioners (rate per 100,000)			FTE Total (rate per 100,000)			FTE Clinical (rate per 100,000)		
	CESPHN	NSW	AUS	CESPHN	NSW	AUS	CESPHN	NSW	AUS
Aboriginal and Torres Strait Islander health practitioner	-	1.3	2.0		1.4	2.2		1.2	2.0
Chinese medicine practitioners	-	0.1	0.1	-	0.1	0.1	0.2	0.1	0.1
Chiropractors	0.2	0.1	0.1	-	0.1	0.1	-	0.1	0.1
Dental practitioners	0.4	0.4	0.4	0.3	0.4	0.4	0.3	0.4	0.4
Medical practitioners	2.0	2.1	1.8	2.1	2.3	2.0	1.9	2.1	1.8
General practice	*0.2*	*0.3*	*0.3*	*0.2*	*0.3*	*0.3*	*0.2*	*0.2*	*0.3*
Medical radiation practitioners	0.4	0.5	0.4	0.4	0.4	0.3	0.4	0.4	0.3
Nurses and midwives	8.4	19.4	16.5	7.6	17.9	15.0	7.3	17.3	14.3
Occupational therapists	0.2	0.5	0.5	0.2	0.5	0.5	0.2	0.4	0.4
Optometrists	-	0.0	0.0	-	0.0	0.0	-	0.0	0.0
Osteopaths	0.2	0.1	0.1	-	0.1	0.1	-	0.0	0.1
Paramedicine practitioners	0.8	1.7	1.1	0.9	2.1	1.3	0.9	2.0	1.3
Pharmacists	0.2	0.3	0.3	0.2	0.3	0.3	0.2	0.3	0.3
Physiotherapists	1.4	1.2	0.8	1.4	1.1	0.7	1.3	1.0	0.7
Podiatrists	-	0.2	0.1	0.2	0.2	0.1	-	0.2	0.1
Psychologists	1.0	1.0	0.8	0.9	0.9	0.7	0.7	0.7	0.6
Total	15.2	29.0	25.1	14.3	27.6	23.8	13.5	26.3	22.4

Source: HWA, 2021

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Older Australians

2022-2024 Needs Assessment

15 November 2021

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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List of figures

Population

In 2020 an estimated 14.1% of the CESPHN population were aged 65 years and over, and 6.5% were aged 75 years and over.(1) The number of people aged 65 years and over is expected to increase by 68.6% between 2016 and 2036.(2)

Cronulla-Miranda-Caringbah SA3 had the highest proportion of people aged 65 years and over (18.6%), followed by Lord Howe Island (17.9%) and Hurstville SA3 (16.4%).(1)

Table 1: CESPHN estimated resident population aged 65 years and over by SA3, 2020

SA3	Age group (years)					Total	% Total SA3 population
	65-69	70-74	75-79	80-84	85+		
Botany	2,026	1,708	1,320	1,015	916	6,985	12.4
Canada Bay	4,150	3,774	2,607	1,999	2,290	14,820	15.8
Canterbury	5,981	4,863	3,926	2,967	3,197	20,934	14.2
Cronulla-Miranda-Caringbah	5,977	5,295	4,087	3,132	3,736	22,227	18.6
Eastern Suburbs – North	5,695	5,929	4,161	2,892	3,517	22,194	15.9
Eastern Suburbs – South	5,818	5,300	3,925	2,870	3,124	21,037	13.4
Hurstville	6,486	5,552	4,002	3,124	3,635	22,799	16.4
Kogarah-Rockdale	6,707	5,781	4,238	3,295	3,727	23,748	15.2
Leichhardt	2,786	2,389	1,554	883	848	8,460	13.7
Lord Howe Island	19	17	11	13	12	72	17.9
Marrickville-Sydenham-Petersham	2,270	1,977	1,412	1,055	1,069	7,783	12.9
Strathfield-Burwood-Ashfield	6,679	5,498	4,129	3,286	3,734	23,326	13.6
Sutherland-Menai-Heathcote	5,543	4,875	3,451	2,177	2,294	18,340	16.3
Sydney Inner City	7,662	6,428	4,106	2,634	2,571	23,401	9.1
CESPHN	**67,799**	**59,386**	**42,929**	**31,342**	**34,670**	**236,126**	**14.1**
NSW	**404,034**	**355,280**	**253,241**	**174,990**	**179,095**	**1,366,640**	**16.7**
Australia	**1,257,859**	**1,104,741**	**773,575**	**528,344**	**527,471**	**4,191,990**	**16.3**

Source: ABS, 2020 ERP

As at March 2021, of the CESPHN population aged 65 years and over:

- 49.8% were receiving the Age Pension – Canterbury SA3 had the highest rate of recipients (67.9%) followed by Botany SA3 (67.4%) and Kogarah-Rockdale SA3 (59.3%).(3)
- 11.9% 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) – Lord Howe Island had the highest proportion of CSHC recipients (19.4%), followed by Cronulla-Miranda-Caringbah SA3 (18.0%) and Sutherland-Menai-Heathcote SA3 (16.3%).(3)

Table 2: DSS recipients by SA3, June 2021

SA3	Age Pension	Age Pension (%)	Commonwealth Seniors Health Card	Commonwealth Seniors Health Card (%)
Botany	4,713	67.5	524	7.5
Canada Bay	6,510	43.9	2,212	14.9
Canterbury	14,205	67.9	1,459	7.0
Cronulla-Miranda-Caringbah	10,549	47.5	4,064	18.3
Eastern Suburbs – North	5,484	24.7	2,534	11.4
Eastern Suburbs – South	9,661	45.9	2,916	13.9
Hurstville	12,627	55.4	3,024	13.3
Kogarah-Rockdale	14,033	59.1	2,589	10.9
Leichhardt	3,117	36.8	1,007	11.9
Lord Howe Island	29	40.3	15	20.8
Marrickville-Sydenham-Petersham	4,363	56.1	600	7.7
Norfolk Island	244	24.4	56	5.6
Strathfield-Burwood-Ashfield	12,379	53.1	2,566	11.0
Sutherland-Menai-Heathcote	10,200	55.6	3,025	16.5
Sydney Inner City	9,166	39.2	1,786	7.6
CESPHN	117,280	49.7	28,377	12.0
NSW	806,610	59.0	148,405	10.9
Australia	2,592,597	61.8	430,447	10.3

Source: Department of Social Services, 2021, ABS ERP 2020

*Norfolk Island data calculated using ABS “Regional population by age and sex, 2020 summary statistics by SA2 and above”

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, two in five older people (40%) live alone and 5% of older people living alone have poor English proficiency.(4)

Table 3: Social isolation indicators by SA3, 2016

SA3	Population 65 year +	Population 65 years+ living alone	Population 65+ living alone with poor English proficiency
Botany	6,985	3,098	221
Canada Bay	14,820	5,375	297
Canterbury	20,934	6,461	765
Cronulla-Miranda-Caringbah	22,227	9,315	57
Eastern Suburbs-North	22,194	10,241	141
Eastern Suburbs-South	21,037	9,329	382
Hurstville	22,799	8,158	502
Kogarah-Rockdale	23,748	8,425	523
Leichhardt	8,460	3,570	111
Lord Howe Island	72	35	0
Marrickville-Sydenham-Petersham	7,783	2,662	274
Norfolk Island	425	231	0
Strathfield-Burwood-Ashfield	23,326	8,141	669
Sutherland-Menai-Heathcote	18,340	6,028	43
Sydney Inner City	23,401	11,239	642
CESPHN	236,126	92,308	4,627

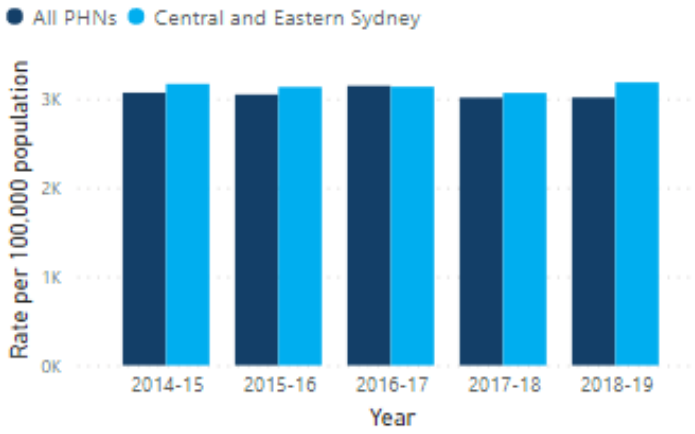
Sources: ABS, 2016, and ABS 2020 ERP

Note: *All values for Norfolk Island are from 2016 Census, other SA3 Population aged 65 years+ are from 2020 ERP*

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 2018-19, both within NSW PHNs and CESPHN. In 2018-19, females within the CESPHN region had fall-related hospitalisations 1.4 times the rate of males (3,646.3 compared to 2,615.3 respectively).(2)

Figure 1: Fall-related hospitalisations in the CESPHN region, 2014-15 to 2018-19



Source: HealthStats NSW, 2020

Dementia

In 2021, there are an estimated 358,398 people aged 65 years and over living with dementia in Australia. This is expected to increase by 36.8% to 490,326 by 2031.(5) Based on national rates, we estimate that 17,507 people aged 65-84 years in the CESPHN region have dementia, accounting for 7.4% of this population group.(5)

Table 4: Estimated prevalence of dementia, by age group, CESPHN region, 2021

Age group (years)	Estimated people with dementia	
	Number per 1,000 nationally	Number estimated CESPHN
65–69	23.7	1,605
70–74	39.3	2,336
75–79	68.3	2,933
80–84	118.3	3,709
85-89	199.7	6,924
90+	399.0	
Total	**14.7**	**17,507**

Source: AIHW, 2021 and ABS, 2020 ERP

Note: data for 85 years and over has been calculated using the National estimated rate for 85–89-year-olds and therefore we expect the number estimated for CESPHN region to be underestimated

People living with dementia, especially those in the community, are shown to generally have a higher use of health services than those without dementia. Nationally, in 2016-17, people living with dementia had a higher number of GP consultations per year (19.7) than those living without dementia (7.7), this was especially true for people living in the community.(5) In 2016-17, 48.7% of people living with dementia had a GP service, compared to 39.7% of people without dementia.

Table 5: Average number of GP consultations by dementia status, Australia, 2016-17

Place of residence	With dementia	Without dementia
Living in residential aged care	23.7	25.2
Living in the community	13.9	7.6
Total	19.7	7.7

Source: AIHW, 2021

People living with dementia also had higher rates of both chronic disease plans and geriatrician referred plans per 100 people than people without dementia; there is a greater difference in plans per 100 people for those living in the community, than those in residential care.(5)

Table 6: Plans per 100 people by place of residence and dementia status, Australia, 2016-17

Place of residence plan	With dementia	Without dementia
Living in residential aged care	133.3	137.2
Chronic disease plans (per 100)	121.5	130.1
Geriatrician referred plans (per 100)	11.8	7.1
Living in the community	169.6	56.1
Chronic disease plans (per 100)	145.4	54.8
Geriatrician referred plans (per 100)	24.3	1.4
Total	148.0	56.5
Chronic disease plans (per 100)	131.1	55.1
Geriatrician referred plans (per 100)	16.8	1.4

Source: AIHW, 2021

In 2016-17, individuals living with dementia had:

- Higher rates of medication management reviews than those without dementia (25.9 per 100 people compared to 3.7 per 100 people).(5)
- Higher rates accessing the following specialist services compared to people without dementia:
  - Geriatric medicine service (14.7% compared to 1.1%),
  - General medicine (10.1% compared to 6.1%),
  - Neurology (4.0% compared to 2.3%%), and
  - Haematology (21.8% compared to 19.4%).
- Higher utilisation rates per 100 people of allied health services, diagnostic imaging services, other MBS services and pathology tests than those without dementia.(5)

Table 7: Allied health, diagnostic and pathology services per 100 people by place of residence and dementia status, Australia, 2016-17

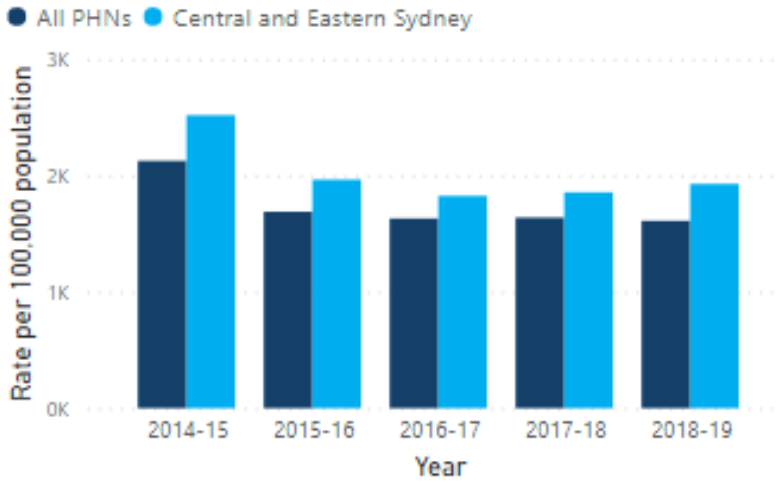
Place of residence	With dementia	Without dementia
Living in residential care	1,290.3	1,838.0
Allied health services (per 100)	151.4	164.3
Diagnostic imaging services (per 100)	117.3	190.9
Other MBS services (per 100)	88.1	125.7
Pathology tests (per 100)	933.5	1,357.1
Living in the community	1,633.1	849**.3**
Allied health services (per 100)	137.7	68.1
Diagnostic imaging services (per 100)	245.5	154.9
Other MBS services (per 100)	153.3	63.5
Pathology tests (per 100)	1,096.5	562.8
Total	1,429.1	854.1
Allied health services (per 100)	145.9	68.5
Diagnostic imaging services (per 100)	169.2	155.1
Other MBS services (per 100)	114.5	63.8
Pathology tests (per 100)	999.5	566.7

Source: AIHW, 2021

There has been a decline in the rate of dementia-related hospitalisations for those aged 65 years and over both within NSW PHNs and CESPHN. In 2018-19, males within the CESPHN region had

dementia hospitalisation rates 1.3 times the rate of females (2,214.5 compared to 1,700.6 respectively).(2)

Figure 2: Dementia-related hospitalisations in the CESPHN region, 2014-15 to 2018-19

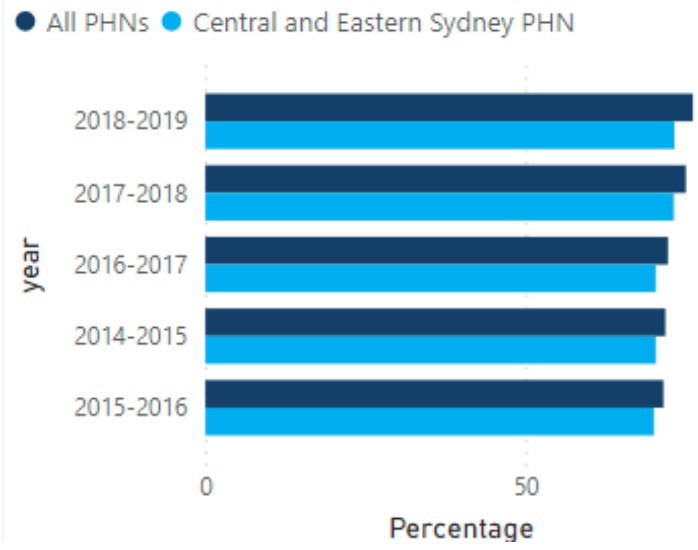


Source: HealthStats NSW, 2020

Influenza and pneumonia

In the five years to 2018-19, individuals aged 65 years and over within the CESPHN region have had influenza immunisation rates slightly lower than NSW PHN rates. CESPHN rates have remained relatively stable, with rates sitting between 70.4% and 73.3% over the past 5 years.(2)

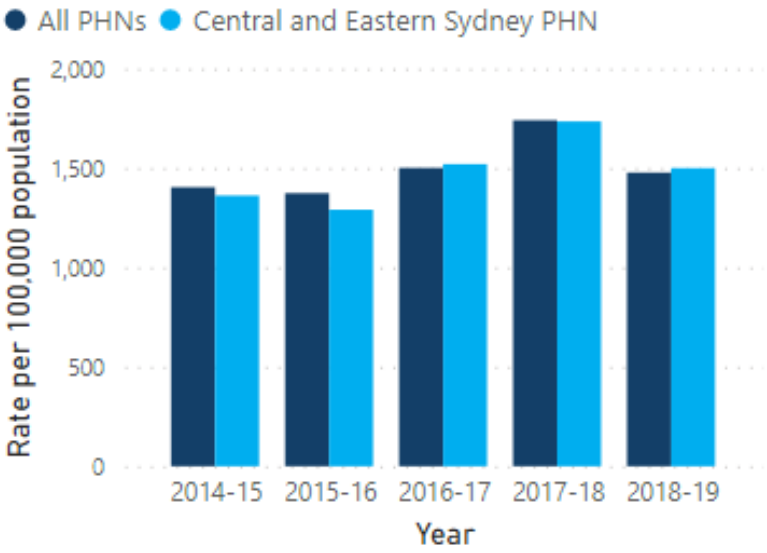
Figure 3: Influenza immunisation rates by year, CESPHN region, 2018-19



Source: HealthStats NSW, 2020

Since 2016-17, CESPHN rates of influenza and pneumonia hospitalisations have been equal to or slightly higher than NSW PHNs rates. There was an increase in the rate of hospitalisations from 2015-16 to 2017-18 (1,290.3 to 1,734.4 per 100,000 population respectively), followed by a decline in the rate from 2017-18 to 2018-19 (1,734.4 to 1,499.4 per 100,000 population respectively).(2)

Figure 4: Influenza and pneumonia hospitalisation rates by year, CESPHN region, 2018-19



Source: HealthStats NSW, 2020

GP health assessment

In 2020 42,779 health assessments were completed in the CESPHN region – 62.9% of these were for people aged 75 years and over, equating to approximately one-quarter of individuals aged 75 years and over living in the CESPHN region. Marrickville-Sydenham-Petersham SA3 had the highest proportion of their population aged 75 years and over with a completed heath assessment (38.0%), followed by Sutherland-Menai-Heathcote SA3 (32.7%) and Kogarah-Rockdale SA3 (30.2%).(1, 6)

Table 8: Proportion of population 75 years and over who had a health assessment completed, CESPHN region, 2020

SA3	Health Assessments^	Population*	Proportion with Health Assessment completed
Botany	262	3,251	8.1%
Canada Bay	2,057	6,896	29.8%
Canterbury	2,276	10,090	22.6%
Cronulla-Miranda-Caringbah	2,925	10,955	26.7%
Eastern Suburbs – North	1,390	10,570	13.2%
Eastern Suburbs – South	2,276	9,919	22.9%
Hurstville	3,143	10,761	29.2%
Kogarah-Rockdale	3,404	11,260	30.2%
Leichhardt	949	3,285	28.9%
Lord Howe Island	-	36	0.0%
Marrickville-Sydenham-Petersham	1,342	3,536	38.0%
Norfolk Island**	17	165	10.3%
Strathfield-Burwood-Ashfield	2,495	11,149	22.4%
Sutherland-Menai-Heathcote	2,589	7,922	32.7%
Sydney Inner City	1,874	9,311	20.1%
CESPHN	26,925	108,941	24.7%

*Source: ^Department of Health, 2021; *ABS, 2020 ERP; **ABS, Quickstats 2016*

Patient experience of older people

Nationally, 96.4% of people aged 65 years and over had seen a GP in the last 12 months, 71.5% reported excellent, very good or good health and 86.6% reported having a long-term health condition.

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.(7)

Table 9: Patient experience measures by age group, Australia, 2019-20

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	92.3	94.8
Percentage of adults who felt their GP always or often showed respect for what they had to say in the preceding 12 months	94.6	96.5
Percentage of adults who felt their GP always or often spent enough time in the preceding 12 months	90.9	94.6
Percentage of adults who saw a GP in the preceding 12 months	83.5	96.4
Percentage of adults who could not access their preferred GP in the preceding 12 months	28.0	19.9
Percentage of adults who felt they waited longer than acceptable to get an appointment with a GP	18.6	12.5
Percentage of adults who did not see or delayed seeing a dentist, hygienist or dental specialist due to cost in the preceding 12 months	19.1	7.7
Percentage of adults who reported excellent, very good or good health	87.5	71.5
Percentage of adults who reported having a long–term health condition	51.6	86.6

Source: AIHW, 2021

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.(8) 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 and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, refugees, and LGBTIQ+ communities
- support information sharing to facilitate clinical handover between aged care and health care providers.(9)

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.(10) 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.

Home support services

In 2019-20, the rate of home support recipients per 1,000 people aged 70 years and over was lower in the CESPHN region than state and national rates.(11)

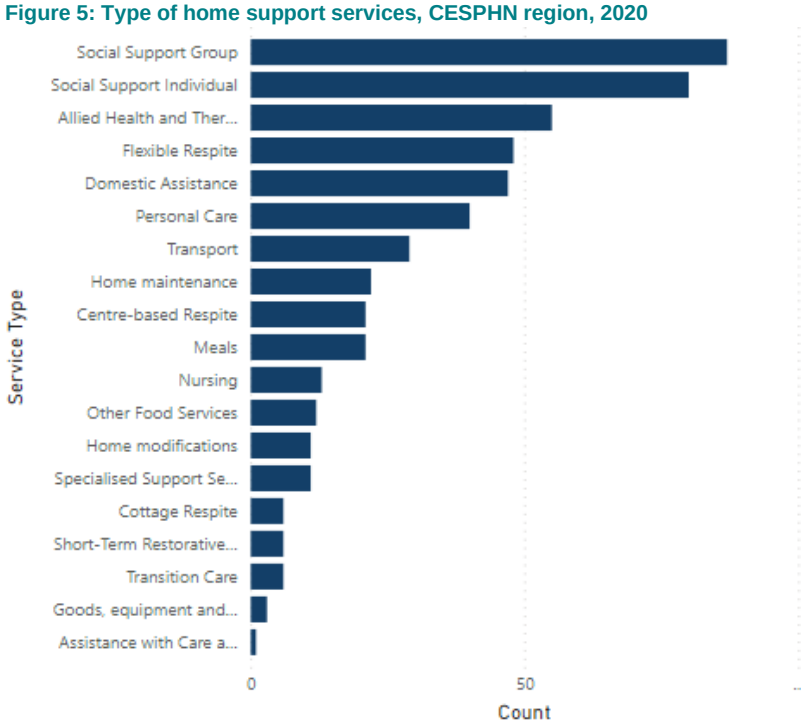
Table 10: Rate of home support recipients, CESPHN region, 2020

Region	Rate of home support recipients per 1,000 people aged 70 years and older
CESPHN	221.0
NSW	239.0
Australia	289.9

Source: AIHW, 2021

In June 2021, there were 205 organisations providing home support services across the CESPHN region. Social support services, both group (n=87) and individual (n=80), were the most common types of home support services.(11)

Figure 5: Type of home support services, CESPHN region, 2020



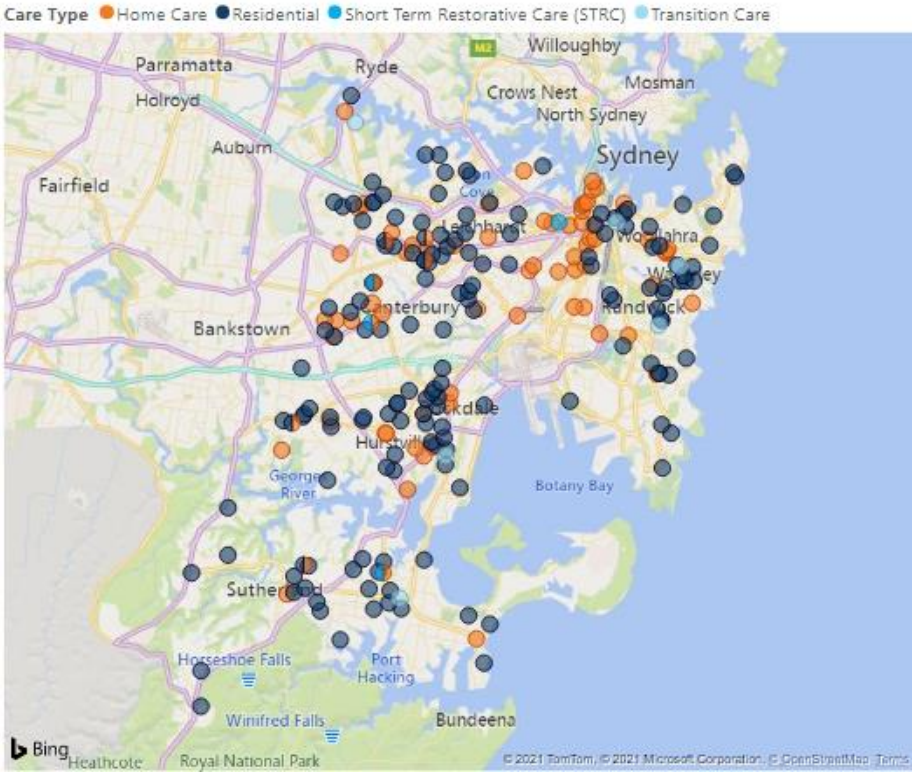
Source: AIHW, 2021

Residential care, home care and transition care

In the CESPHN region, there were:

- 161 RACFs offering 13,163 places (11,055 places filled by those aged 65 years and over)
- 127 services providing home care packages (7,641 people at 30 June 2020)
- 6 services providing transition care linked to six public hospitals.
- 4 short-term restorative care, and
- 2 multi-purpose centres.

Figure 6: Number and location of aged care services, by service type, CESPHN region, 2020

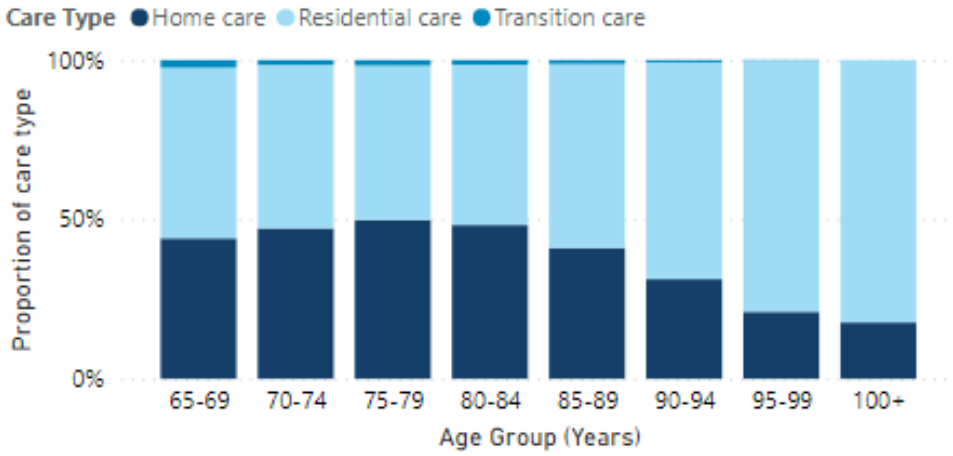


Source: AIHW, 2021

In June 2020, CESPHN was relatively well supplied with residential aged care places (80.3 places per 1,000 people aged 70 and over) compared to state (75.5 places per 1,000 people) and national averages (74.8 places per 1,000 people). However, places in residential care per 1,000 people aged 70 years and over in the CESPHN region have decreased each year since 2017, where it was 85.6 per 1,000.(11)

Data shows that up until 80-84 years of age, there is an almost 50:50 split between home care and residential care within the CESPHN region. As people age, the proportion using residential care increases.(12)

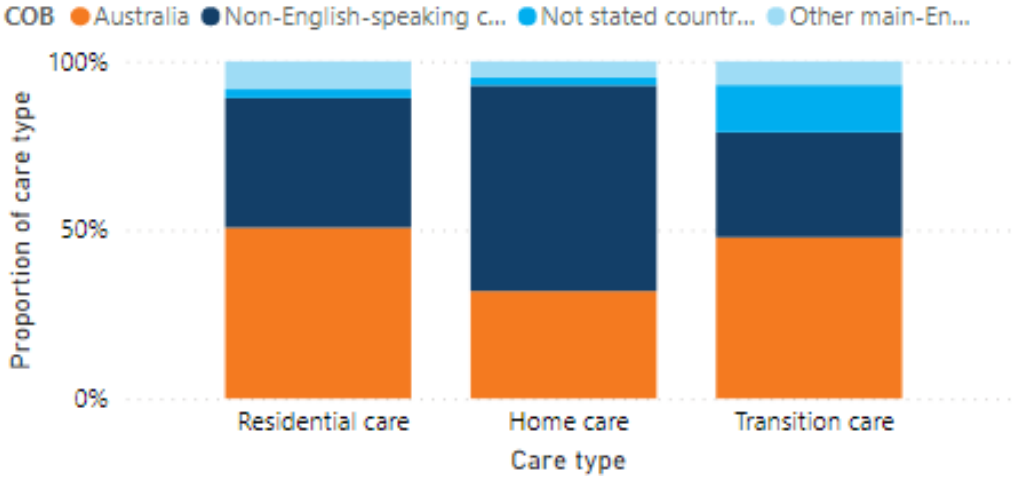
Figure 7: Care type by age group, CESPHN region, 2020



Source: AIHW, 2021

Over 30% of all residential and transition care places (38% and 31% respectively) and 61% of home care places were filled by people born in non-English speaking countries.(12)

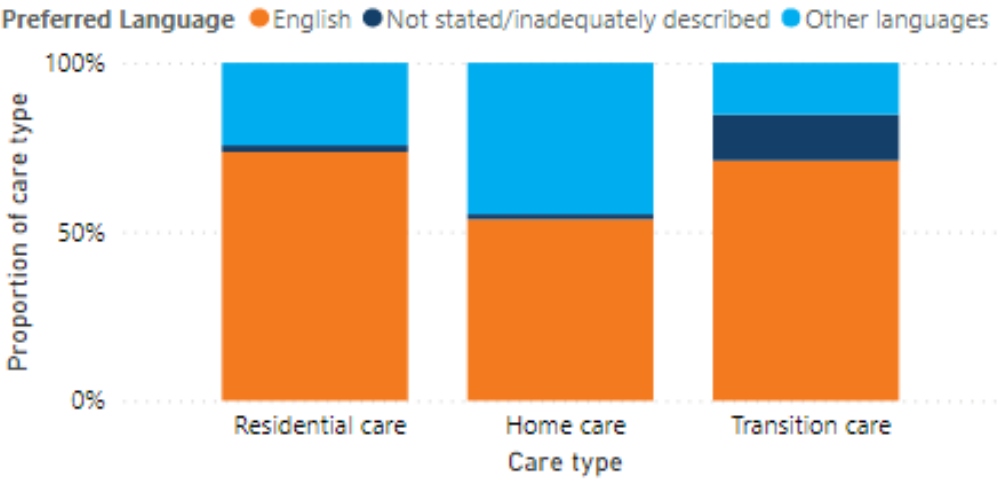
Figure 8: Country of birth by care type, CESPHN region, 2020



Source: AIHW, 2021

The CESPHN region has a much higher proportion of older people with a preferred language other than English (32.5%) compared to NSW (13%).(12) Home care packages are more frequently used by this group with 45% of people using these services reporting a preferred language other than English.(12)

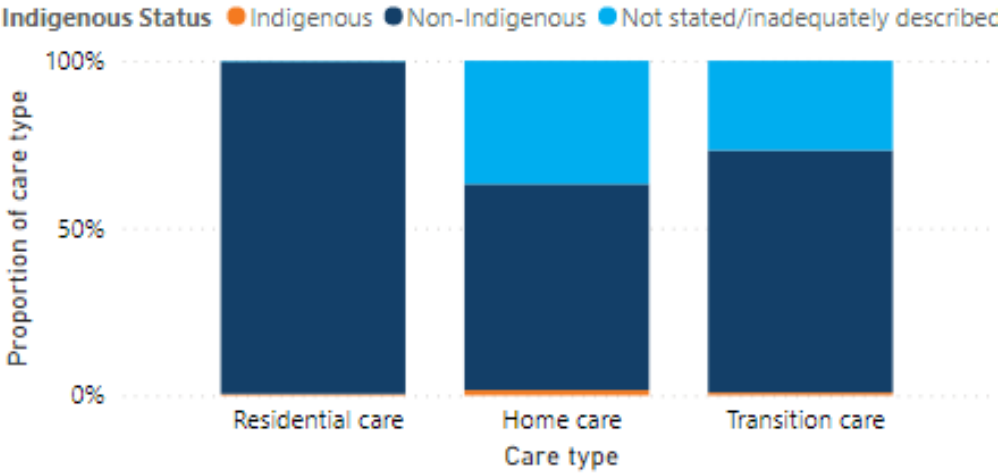
Figure 9: Preferred language by care type, CESPHN region, 2020



Source: AIHW, 2021

Less than 1% of individuals aged 50 years and over, using aged care services in the CESPHN region identified as Aboriginal.

Figure 10: Indigenous status by care type, CESPHN region, 2020



Source: AIHW, 2021

Residential care

On 30 June 2020, CESPHN had a rate of residential care recipients per 1,000 people aged 70 years and over slightly higher than both the state and national rates.(11)

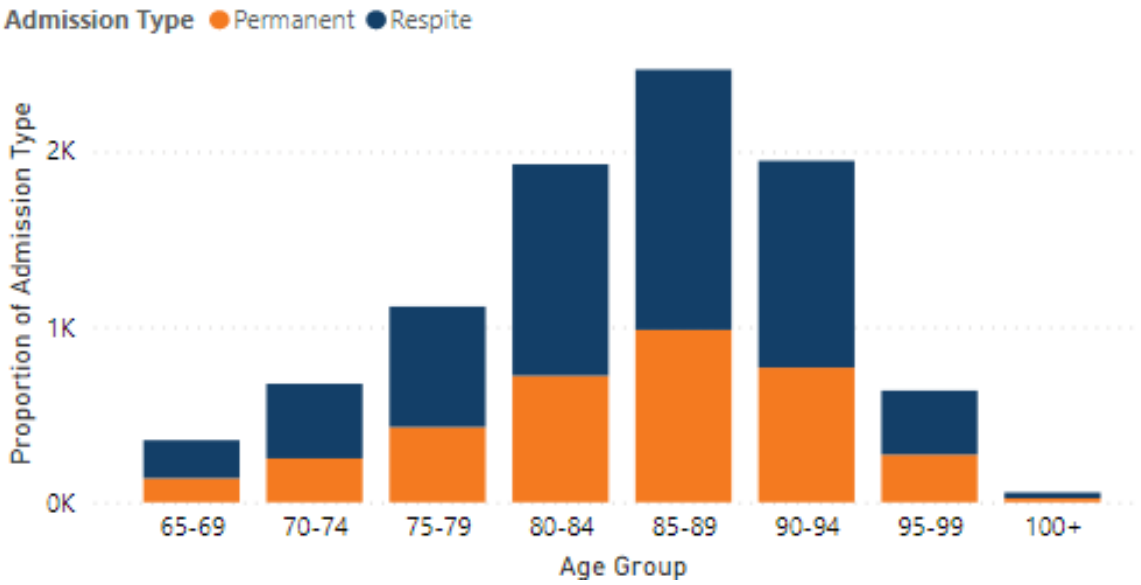
Table 11: Rate of residential care recipients, CESPHN region, 2020

Region	Rate of residential care recipients per 1,000 people aged 70 years and older
CESPHN	69.5
NSW	65.7
Australia	65.6

Source: AIHW, 2021

In 2020, there were 11,055 places filled by individuals aged 65 years and over – 10,592 of these places were identified as permanent admissions and 463 respite places.(12) Two-thirds (65.4%) of the 65 years and over residential care population were female, more than half of residents (58.2%) were aged 85 years and over.

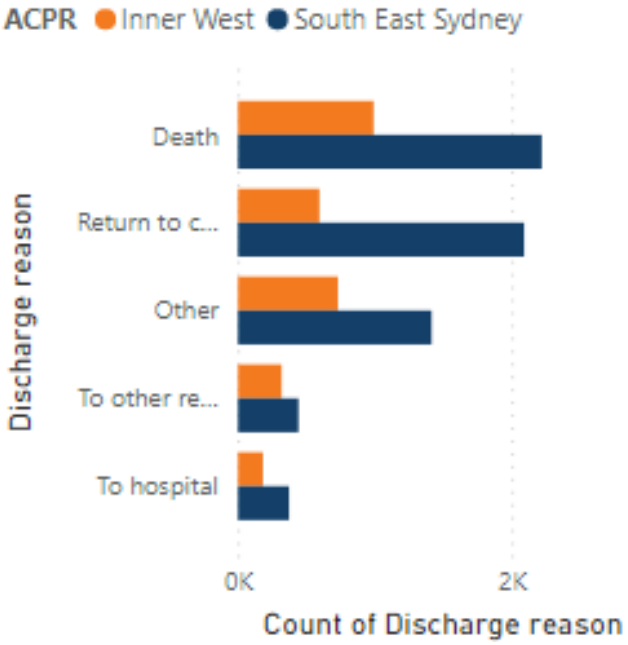
Figure 11: Residential care places by care type and age group, CESPHN region, 2020



Source: AIHW, 2021

In 2019-20, there were 9,376 exits from residential care in the CESPHN region for people aged 65 years and over. Over one-third of exits (34.3%) were due to death.(13)

Figure 12: Discharge reason by Aged Care Planning Region (ACPR), CESPHN region, 2020



Source: AIHW, 2021

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.

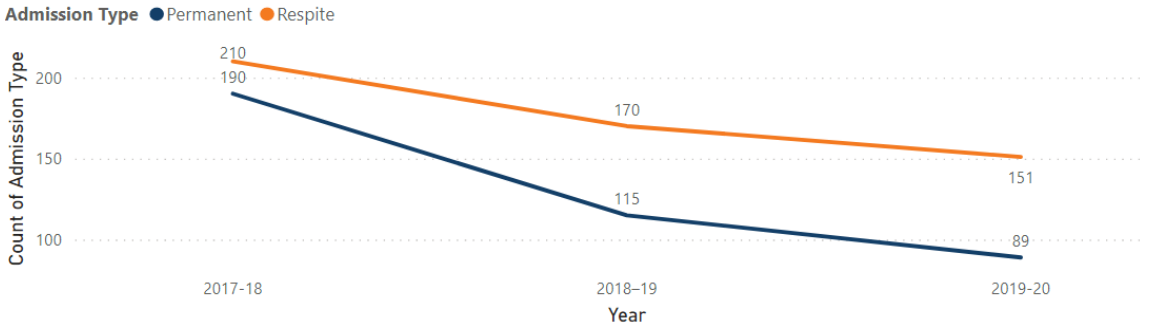
The Younger People in Residential Aged Care Strategy 2020–25 sets out to achieve this goal through the following targets, apart from in exceptional circumstances:

- 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.

At 30 June 2020, 329 individuals aged under 65 years were in residential aged care in the CESPHN region; 319 were permanent residents.(12) 15 of the 329 residents (4.6%) identified as Aboriginal , 14 were aged 50 years and older (11 in permanent care and 3 in respite), an additional resident in permanent care identified as Aboriginal and was aged 0-49 years.(12)

In 2019-20, there were 89 people aged under 65 years admitted to permanent residential care across the CESPHN region – a 53.2% decrease since 2017-18. There has also been a 28.1% decrease in the number of people aged under 65 years entering respite care in this period.(14)

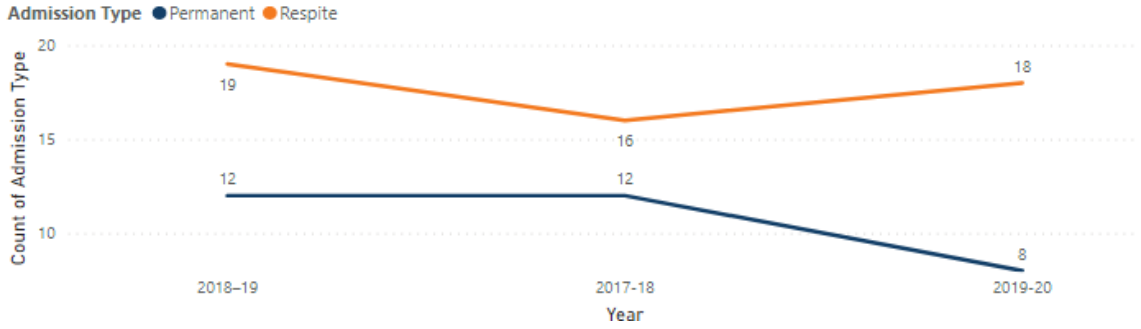
Figure 13: Young people (under 65 yrs) entering residential aged care, CESPHN region, 2019-20



Source: AIHW, 2021

In 2019-20, there were 8 people aged under 50 years admitted to permanent residential care across the CESPHN region – a 33.3% decrease since 2017-18. There has also been a 5.3% decrease in the number of people aged under 50 years entering respite care in this period.(14)

Figure 14: Young people (under 50 yrs) entering residential aged care, CESPHN region, 2019-20



Source: AIHW, 2021

Home care packages

On 30 June 2020, CESPHN had a rate of home care recipients per 1,000 people aged 70 years and over lower than both state and national rates.(11)

Table 12: Rate of home care recipients, CESPHN region, 2020

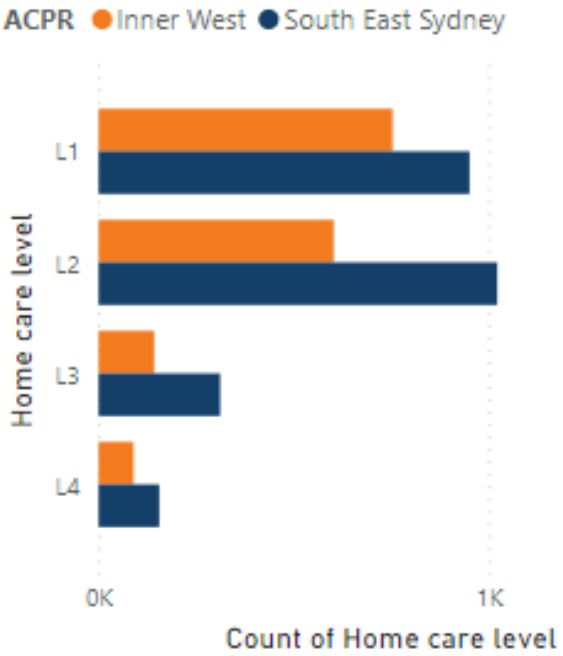
Region	Rate of residential care recipients per 1,000 people aged 70 years and older
CESPHN	46.8
NSW	51.8
Australia	48.2

Source: GEN, 2021

In 2019-20, 4,031 people aged 65 years and over were admitted to home care packages within the CESPHN region,(14) with a total of 7,641 people accessing a home care package at 30 June 2020.(12)

Approximately 4 in 10 admissions (42.3%) were for level 1 home care packages, and overall, 41.2% of home care packages in the CESPHN region were for level 2.

Figure 15: Home care admissions by home care level and ACPR, CESPHN region, 2019-20

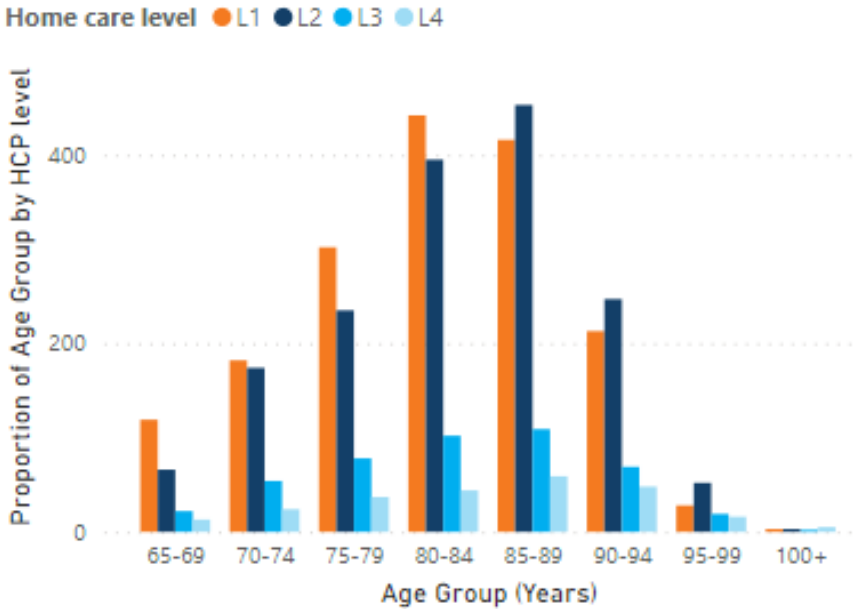


Source: AIHW, 2021

Almost 64% of admissions into home care packages in 2019-20 were females, while 66.8% of all recipients of home care packages on 30 June 2020 were females.

One quarter of admissions (25.7%) into home care packages in 2019-20 were aged 85-89 years, and a further 24.4% were aged 80-84 years. Similar proportions were seen for all people receiving home care packages, with 25.4% of all recipients at 30 June 2020 aged 85-89 years and a further 24.2% aged 80-84 years.

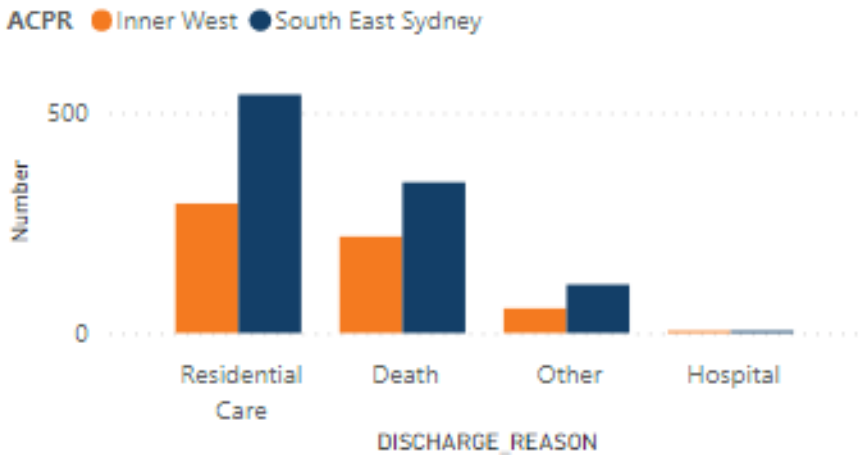
Figure 16: Home care admissions by age group and care level, CESPHN region, 2019-20



Source: AIHW, 2021

In 2019-20, almost 1,569 individuals were discharged from home care packages in the CESPHN region. Half of the discharges (53.2%) were for people entering residential care, with 64.8% of these residential care admissions occurring in the South East Sydney ACPR.(13)

Figure 17: Discharges from home care packages by ACPR, CESPHN region, 2019-20



Source: AIHW, 2021

Home care package waitlists

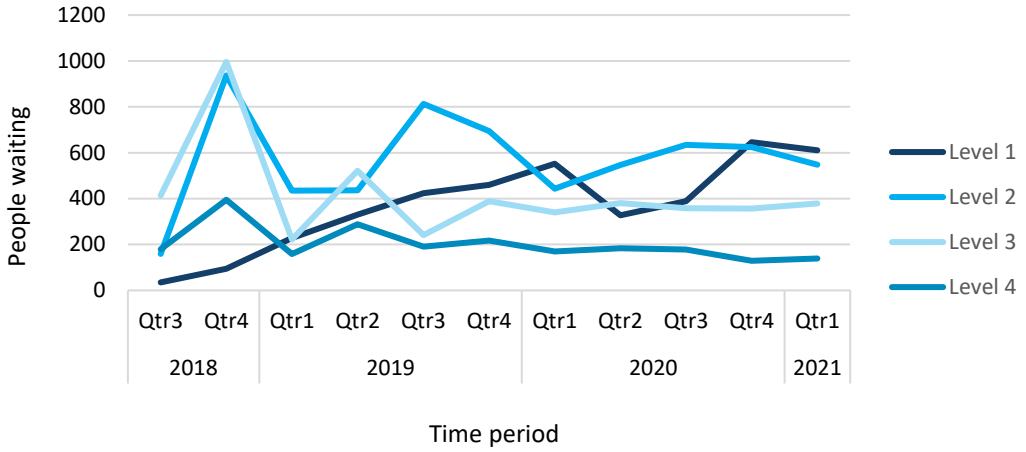
The Royal Commission into Aged Care highlighted the need to meet preferences to age in place, which includes the provision of at home support and care based on assessed need, as such the waitlists for home care packages is an area of focus over the coming years.

From June 2018 to March 2021, the wait lists for home care packages have:

- generally increased for level 1 – there are now 988 people waiting

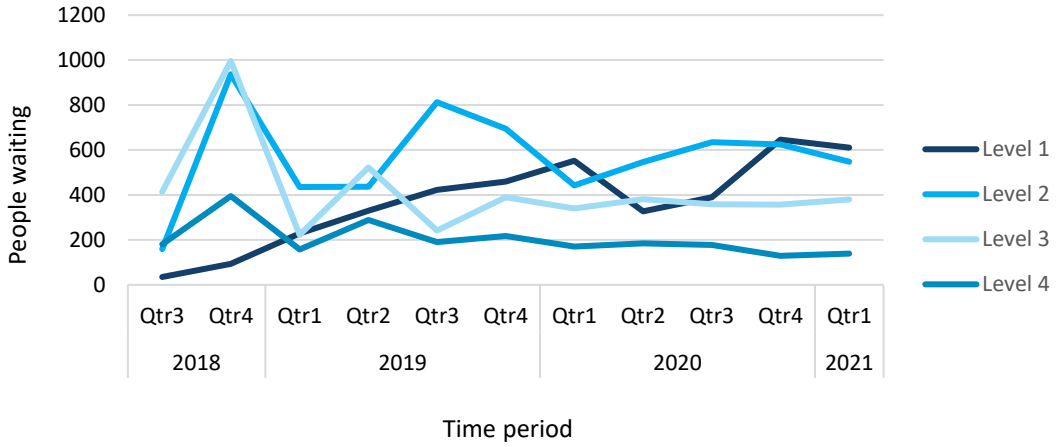
- fluctuated but remained relatively stable for level 2 – there are now 934 people waiting
- reduced for levels 3 and 4 – there are now 699 people waiting for level 3 and 270 people waiting for level 4.(15)

Figure 18: Wait list for home care packages by care level, Inner West ACPR, 2020



Source: AIHW, 2021

Figure 19: Wait list for home care packages by care level, South East Sydney ACPR, 2020



Source: AIHW, 2021

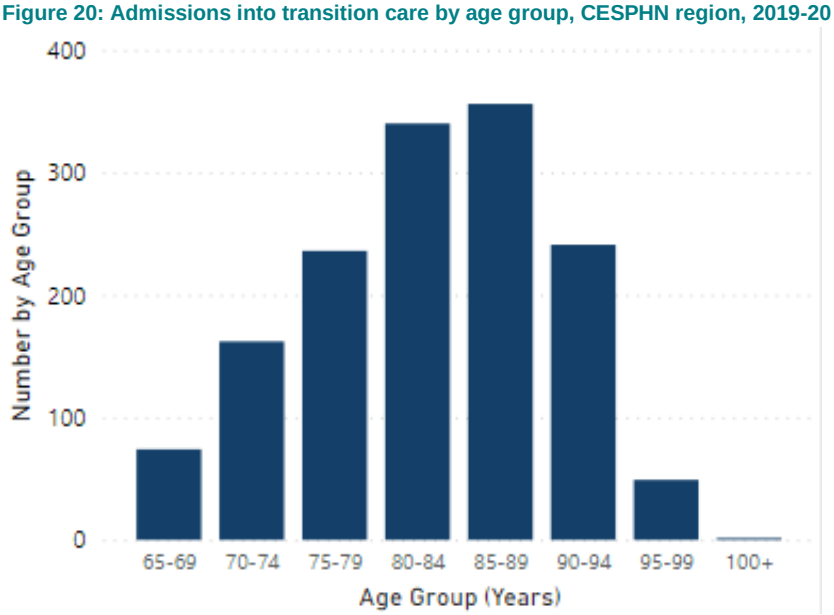
Transition care

In 2019-20, 1,459 people aged 65 years and over were admitted to transition care within the CESPHN region, (14) with a total of 2,278 people accessing transition care at 30 June 2020.(12)

Approximately 6 in 10 (60.3%) admissions into transition care in 2019-20 were females, and 59.6% of all recipients of transition care at 30 June 2020 were females. Half (49.6%) of all admissions in 2019-20 were aged 80-89 years, and a further 18.4% were aged 75-79 years.(14)

The majority (66.6%) of exits from transition care were people entering home/community care, followed by hospital which made up one-quarter of exits (25.6%).(13)

Figure 20: Admissions into transition care by age group, CESPHN region, 2019-20



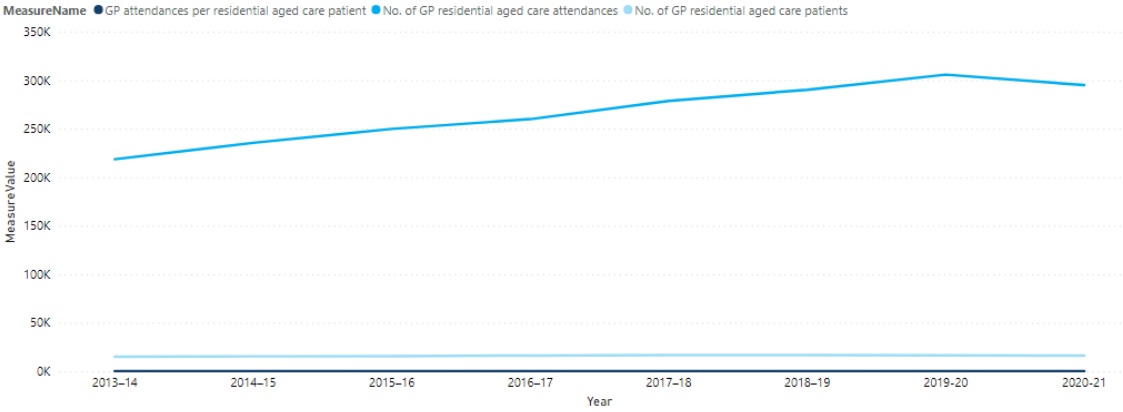
Source: AIHW, 2021

GPs in RACFs

GP consultations

In 2020-21, there were 295,010 GP residential aged care attendances in the CESPHN region to 16,156 residents giving a rate of 18.3 GP attendances per residential aged care patient. This is similar to the national rate of 17.8 GP attendances per residential aged care patient. In the eight years to 2020-21, there has been a 34.9% increase in the number of GP residential aged care attendances in the CESPHN region, however only a 7.0% increase in the number of GP residential aged care patients.(16)

Figure 21: General practitioners in aged care, CESPHN region, 2020-21

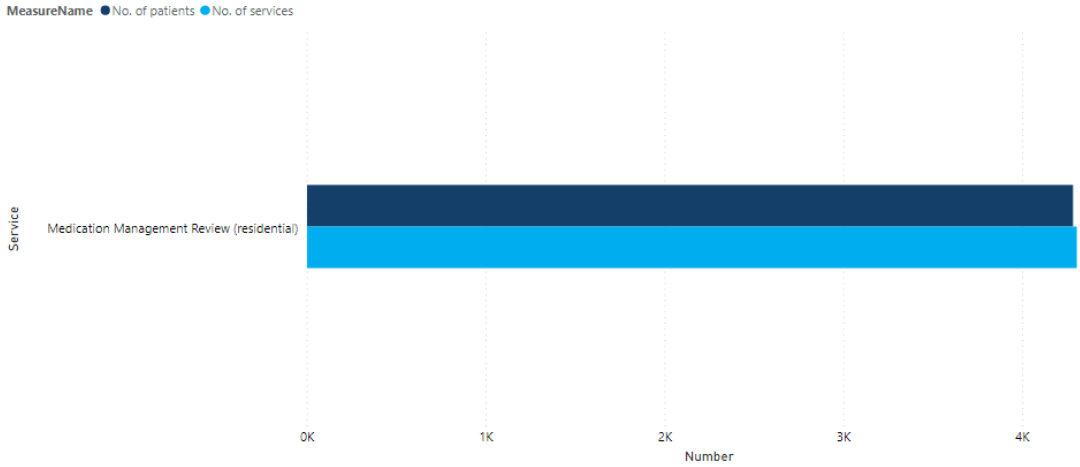


Source: AIHW, 2021

Medication review

In 2020-21, there were 4,306 medication management reviews (residential) for 4,285 patients in the CESPHN region. This is similar to the national rate of 1.01 medication management reviews (residential) per patient.(16)

Figure 22: Medication management reviews, CESPHN region, 2020-21



Source: AIHW, 2021

End of Life Care

Advance care planning

Despite evidence indicating the benefits to end of life care, it is estimated that less than 30% of Australians have completed an advance care plan.(17) This could be due to poor patient experience and psychological distress associated with this phase. Other barriers for uptake of advance care plans may be due to lack of infrastructure and time for discussions to be had and limited workforce capacity in addressing difficult end of life conversations.(18) This is important to note, as people do not usually return home after admission to RACFs.

Additionally, patient attitudes, cultural differences, and clinician self-efficacy regarding establishing plans have been highlighted as barriers and should be considered when implementing strategies.

A recent CESPHN survey highlighted the barriers faced by RACFs in preparing advance care plans for their residents. The largest barrier is ‘language and cultural’ at 32%, followed by ‘family/ relative reluctance’ at 29%, ‘capacity - cognitive impairment/ mental illness preventing informed decision’ and ‘too early to discuss’ both at 9%. Other barriers identified included: ‘too much information on admission’; ‘dementia’; ‘spiritual beliefs of staff’; ‘unwilling resident’; ‘poor skills’; and ‘too little time’.(19)

Palliative care

“*The goal of palliative care is to improve the quality of life of patients with an active, progressive disease that has little or no prospect of a cure*”.(20)

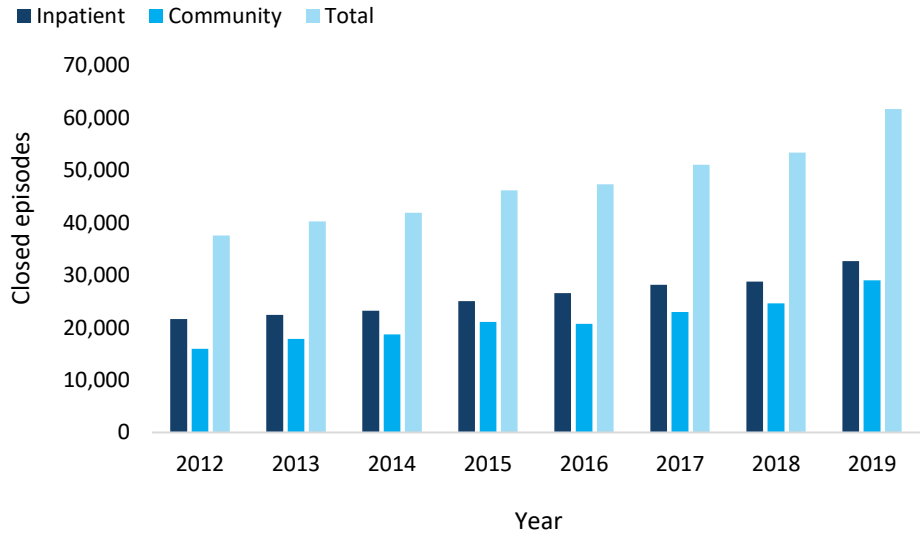
There are four palliative care phases used nationally: stable, unstable, deteriorating and terminal. A palliative care phase describes a stage of the patient's illness within an episode of care and provides a clinical indication of the level of care required.(20) Patients may transition back and forth between phases during an episode of care, with there likely to be more than one phase per episode of care.

Palliative care can be provided in inpatient settings and community settings by a range of care providers. Capacity of GPs to co-ordinate care for these patients, in particular those with advanced cancer, is reduced due to factors including lack of confidence in providing care due to the complexity of these patients, insufficient resources and training, problems with communication with specialists and treating teams, and barriers in successfully transitioning patients from acute hospital to home/community settings.(21)

In 2019, 47,214 patients nationally received palliative care services across 64,297 episodes of care; almost half of which (48.7%) were in community settings. There were 153,108 phases of care with just over half (51.5%) being provided in the community.

The number of closed episodes of palliative care have increased between 2012 and 2019, with a 7.5% annual average change between 2015 to 2019.

Figure 23: Number of closed episodes by palliative care setting, Australia, 2012 to 2019



Source: AIHW, 2021

Approximately one in five (21.2%) episodes in inpatient palliative care closed at 1-2 days, conversely 19.2% of community care palliative care episodes closed at >90 days. The majority of phases in palliative care for both inpatient and community settings were for deteriorating care phase (34.9% and 42.6% respectively). Inpatient palliative care had a relatively even split between stable, unstable and terminal phases, however community palliative care had much higher proportion of care in stable (37%) followed by lower rates of unstable (12.7%) and terminal (7.7%). Overall, community palliative care had an average episode length almost 4 times that of inpatient palliative care (36.6 days compared to 9.4 days), with a median episode length of 21 days compared to 5 days.

Table 13: Palliative care phase count by setting, Australia, 2019

	Inpatient		Community	
Palliative care phase	Number	%	Number	%
Stable	18,889	25.5	29,203	37.0
Unstable	13,810	18.6	9,990	12.7
Deteriorating	25,910	34.9	33,636	42.6
Terminal	15,573	21.0	6,097	7.7
Total	74,182	100.0	78,926	100.0

Source: AIHW, 2021

Three-quarters (75.9%) of individuals in palliative care were aged 65 years and over, this is true for both inpatient palliative care (75.6%) and community palliative care (76.5%). Individuals from least disadvantaged IRSAD quintiles had the highest proportion of palliative care episodes (27.6%), this was reflected across both inpatient palliative care (25.6%) and community palliative care (29.8%).

Almost three-quarters of palliative care episodes in 2019 were for individuals with a cancer diagnosis. Of these, neoplasm of the lung, colorectal and other gastro-intestinal cancer were the three most common cancer diagnoses for palliative care patients.

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national palliative care outcomes and benchmarking program. The 2019 PCOC benchmark results show that overall community setting for palliative care does not reach benchmark levels for 11 of the 12 measures, and inpatient setting for palliative care does not reach benchmark levels for 4 of the 12 measures.

Nationally there was 271 employed palliative medicine specialists in 2018, giving a rate of 1.0 FTE per 100,000 population. Of these specialists, 190 worked in a hospital setting. Palliative medicine specialists worked an average of 38.3 hours per week, 29.7 of which were in a clinical capacity. New South Wales had 91 palliative medicine specialists, with a rate of 1.1 FTE per 100,000 population.

In 2018, there was 3,528 employed palliative care nurses nationally, giving a rate of 12.2 FTE per 100,000 population; 83.6% were registered nurses. Palliative care nurses worked an average of 32.6 hours per week, with 30.3 hours per week being in a clinical role. More than half of the palliative care nurses nationally worked in a hospital setting. New South Wales employed almost a third of the palliative care nurses nationally (n=1,047; 29.7%).

Palliative Care Australia maintains the National Palliative Care Services Directory on their website; services join the list voluntarily. Review of the directory shows that there are approximately 30 services that are based within our region.(22)

Aged care workforce

The Department of Health conducted an Aged Care Workforce Census in 2020 to provide an overview of the aged care sector workforce. The Census covered residential aged care facilities, home care package program providers and Commonwealth home support programme providers nationally. Responses were received across ACPRs from:

- 1,329 Residential Aged Care (RAC) facilities (49% of all RAC facilities)
- 616 Home Care Packages Program (HCPP) providers (47%)
- 505 Commonwealth Home Support Programme (CHSP) providers (38%).

There are five job groups that make up the aged care workforce:

- Personal care workers, which include personal care worker and personal care worker formal traineeship job roles
- Nurses, which include enrolled nurse, nurse practitioner, and registered nurse job roles
- Allied health, which includes Aboriginal and/or Torres Strait Islander health worker/practitioner, dietitian, diversional therapist, exercise physiologist, occupational therapist, pharmacist, physiotherapist, podiatrist, psychologist, social worker, speech therapist, allied health assistants, and other (not specified) allied health
- Administration, which includes administration, management, and quality and education coordinator job roles
- Other, which is made up of ancillary care (such as cleaning, kitchen, gardening, and maintenance) and pastoral/spiritual care worker job roles.

Personal care workers made up 78.7% of the direct care workforce in residential aged care in NSW, compared to 71% nationally. NSW has a much lower proportion of the workforce made up of enrolled nurses compared to nationally (1.8% compared to 7.8%). A similar trend is also seen in allied health assistants which made up 0.7% of the direct care workforce in NSW compared to 1.4% nationally. All other job groups were comparable between NSW and nationally.(23)

Gender

Both nationally and within NSW, females were employed as direct care workforce within residential aged care facilities at a rate 6 times that of males. This trend was reflected across all job groups, with the exception of allied health professionals, where females were employed at a rate 3.5 times the rate of males.(23)

Table 14: Job role by gender, NSW and Australia, 2020

Gender	NSW		Australia	
	Number of staff	Proportion of staff (%)	Number of staff	Proportion of staff (%)
	Total direct staff			
Female	57,502	86.1	177,070	86.1
Male	9,271	13.9	28,604	13.9
Other	-	-	-	-
	Personal care worker			
Female	45,552	86.6	125,594	86.1
Male	7,023	13.4	20,347	13.9
Other	-	-	-	-
	Registered nurse			
Female	8,884	84.9	28,069	86.1
Male	1,580	15.1	4,549	13.9
Other	-	-	-	-
	Enrolled nurse			
Female	1,088	90.1	14,327	89.8
Male	120	9.9	1,622	10.2
Other	-	-	-	-
	Nurse practitioner			
Female	38	79.2	170	82.9
Male	10	20.8%	35	17.1
Other	-	-	-	-
	Allied health professional			
Female	1,561	76.4	6,369	78.4
Male	466	22.8	1,715	21.1
Other	15	0.7	40	0.5
	Allied health assistant			
Female	379	84.2	2,541	88.2
Male	71	15.8	335	11.6
Other	-	-	4	0.1

Source: GEN, 2021

Age

Age distribution by job type in residential aged care direct care staff shows that across NSW, there is a slightly older workforce in the job types of nurse practitioner and enrolled nurses compared to nationally; all other job types show relatively comparable age distribution.(23)

Table 15: Job role by age groups, NSW and Australia, 2020

Age Group	NSW		Australia	
	Number of staff	Proportion of staff (%)	Number of staff	Proportion of staff (%)
	Personal care worker			
< 20 years	976	1.9	2,392	1.6
20-29 years	13,591	25.8	35,581	24.4
30-39 years	12,722	24.2	38,252	26.2
40-49 years	9,730	18.5	28,729	19.7
50-59 years	10,118	19.2	26,697	18.3
60+ years	5,466	10.4	14,106	9.7
	Registered nurse			
< 20 years	12	0.1	36	0.1
20-29 years	1,988	19.0	6,440	19.7
30-39 years	4,061	38.8	13,215	40.5
40-49 years	1,722	16.5	5,596	17.2
50-59 years	1,370	13.1	4,003	12.3
60+ years	1,309	12.5	3,326	10.2
	Enrolled nurse			
< 20 years	2	0.2	62	0.4
20-29 years	209	17.4	2,987	18.8
30-39 years	196	16.3	3,698	23.3
40-49 years	200	16.7	3,059	19.3
50-59 years	315	26.3	3,695	23.3
60+ years	277	23.1	2,382	15.0
	Nurse practitioner			
< 20 years	-	0.0	-	0.0
20-29 years	6	12.5	16	7.8
30-39 years	6	12.5	62	30.2
40-49 years	19	39.6	49	23.9
50-59 years	4	8.3	53	25.9
60+ years	13	27.1	25	12.2
	Allied health professional			
< 20 years	4	0.2	22	0.3
20-29 years	314	15.4	1,484	18.4
30-39 years	728	35.8	2,651	32.8
40-49 years	430	21.1	1,853	22.9
50-59 years	386	19.0	1,358	16.8
60+ years	174	8.5	716	8.9
	Allied health assistant			
< 20 years	4	0.9	33	1.2
20-29 years	50	11.1	374	13.0
30-39 years	76	16.9	473	16.5
40-49 years	81	18.0	580	20.2
50-59 years	154	34.1	840	29.3
60+ years	86	19.1	568	19.8

Source: GEN, 2021

Qualifications

Aged care workforce respondents were asked whether one or more of their staff, by job role, had specialised skills (from 5 different skill sets). Diversity awareness was consistently low in the proportion of staff specialised skills, often followed by palliative care.

Allied health professionals generally had the lowest proportion of staff with specialised skills in each area.(23)

Table 16: Proportion of facilities who responded to Census and had skills by job role, Australia, 2020

Job Role	Skill				
	Dementia care (%)	Diversity awareness (%)	Falls risk (%)	Infection prevention & control (%)	Palliative care (%)
Personal care worker	75	57	66	73	58
Registered nurse	82	61	76	86	77
Enrolled nurse	75	52	67	76	63
Nurse practitioner	64	34	78	81	51
Allied health professional	49	42	54	53	29

Source: GEN, 2021

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phn
CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

Regional priority populations

2022-2024 Needs Assessment

15 November 2021

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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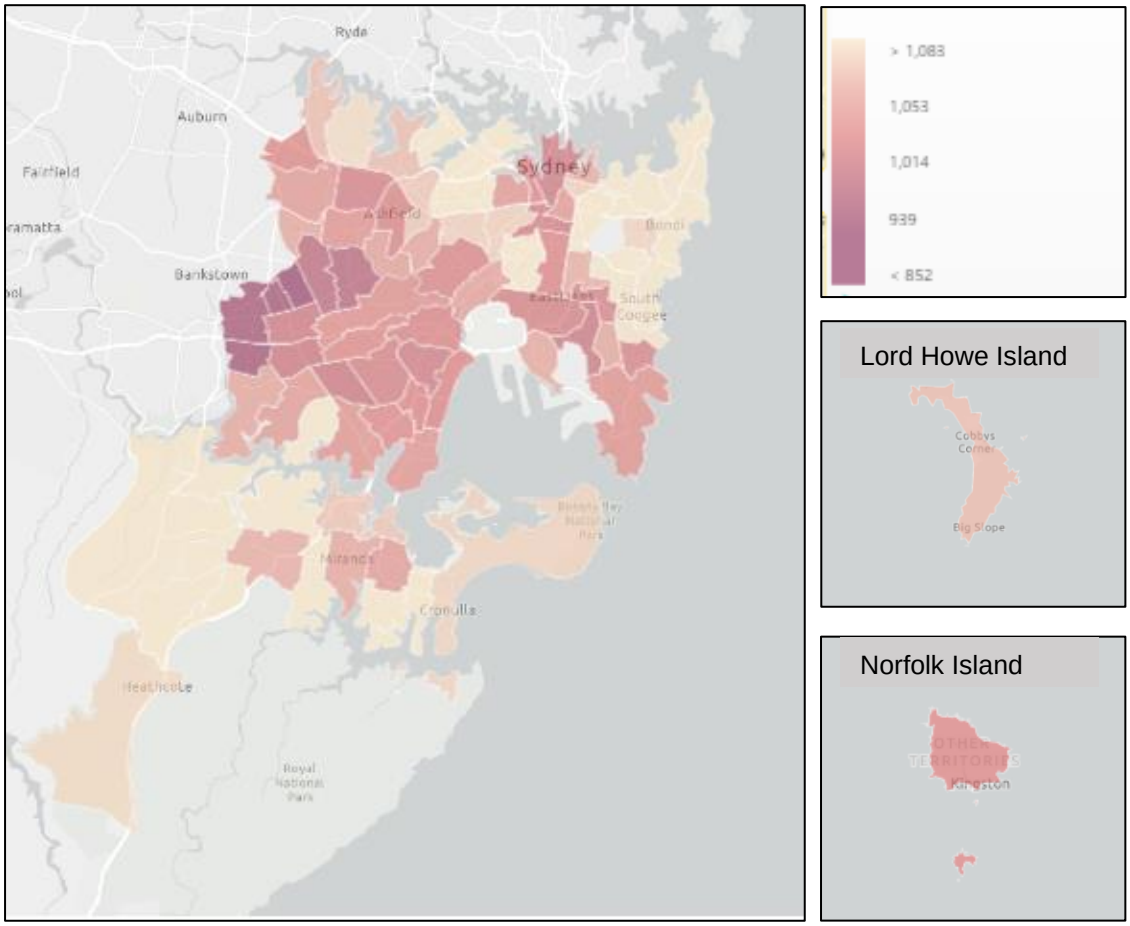
List of tables

List of figures

Socio-economically disadvantaged populations

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.(1)

Figure 1: Index of Relative Socio-Economic Disadvantage (IRSD) in the CESPHN region by SA2, 2016



Source: ABS 2018 SEIFA

There are 17 SA2s with an Index of Relative Socioeconomic Disadvantage (IRSD) value below 1,000 indicating socioeconomic disadvantage. Almost half of the most disadvantaged SA2s are in Canterbury. Other pockets of disadvantage are in Sydney Inner City, Eastern Suburbs-South, Hurstville, Botany, Strathfield-Burwood-Ashfield, and Kogarah-Rockdale.

Table 1: Most disadvantaged SA2s in the CESPHN region with an IRSD value below 1,000, 2016

SA2	IRSD
SA3 Botany	
Pagewood - Hillsdale - Daceyville	971
Mascot - Eastlakes	995
SA3 Canterbury	
Lakemba	852
Wiley Park	875
Punchbowl	881
Canterbury (South) - Campsie	930
Belmore - Belfield	939
Narwee - Beverly Hills	974
Roselands	978
SA3 Hurstville	
Riverwood	875
Hurstville	973
SA3 Kogarah - Rockdale	
Rockdale - Banksia	986
Bexley	994
SA3 Strathfield - Burwood - Ashfield	
Burwood - Croydon	991
SA3 Sydney Inner City	
Sydney - Haymarket - The Rocks	977
Redfern - Chippendale	990
SA3 Eastern Suburbs - South	
Maroubra - South	998

Source: ABS 2018 SEIFA

Health status

Generally, socio-economically disadvantaged populations are at greater risk of poor health and have higher rates of chronic health conditions, disability and death, in comparison to populations with high socioeconomic advantage.(2)

The 2017-18 National Health Survey (3) found that adults living in the lowest socioeconomic areas fared worse across a range of health risk factors and chronic health conditions compared to adults from the highest socioeconomic areas. They were:

- 3.3 times as likely to smoke daily
- 1.6 times as likely to be obese
- 1.3 times as likely to be insufficiently active
- 1.2 times as likely to have uncontrolled high blood pressure

- 2 times as likely to have chronic obstructive pulmonary disease (among people aged 45 and over)
- 2.2 times as likely to have diabetes
- 1.3 times as likely to have heart, stroke, and vascular disease
- 2.3 times as likely to die from potentially avoidable
- 3 years less life expectancy.

Service gaps

In 2019-20, the Patient Experience Survey (4) reported that compared to people from the highest socioeconomic areas, people from areas of most socio-economic disadvantage were:

- More likely to delay or not seek care because of cost:
  - GP: 3.9% compared to 3.0%
  - After hours GP: 2.8% compared to 1.5%
  - Dental professional: 26.8% compared with 12.5%
  - Prescribed medication: 9.3% compared to 4.7%
- Less likely to report having private health insurance (33.2% compared to 76.5%)
- More likely to visit the emergency department 17.6% compared with 12.5%.

Potentially preventable hospitalisations are also more common among people from areas of most socio-economic disadvantage compared to people from the highest socioeconomic areas (3,643 per 100,000 persons compared to 2,132 per 100,000 persons).(5)

The following are opportunities to address health inequities experienced by people from socio-economically disadvantaged areas:

- Improve health literacy and provide self-management support for individual health care
- Provide prevention and health promotion programs in the community
- Take action on the social determinants of health through inter-sectoral groups
- Work toward a fairer system by removing financial and other barriers to accessing services.(6)

Culturally and linguistically diverse communities

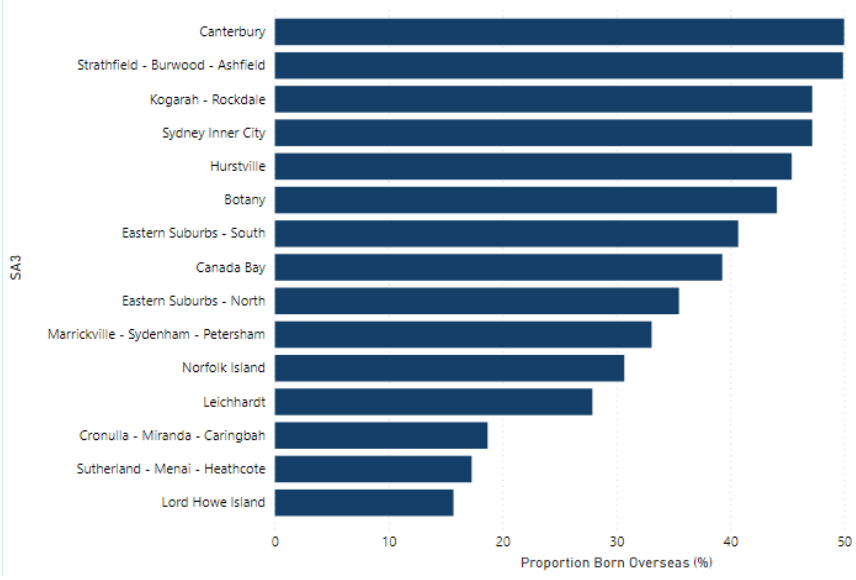
Population

There is significant cultural diversity across the CESPHN region, including diversity in language spoken and country of birth. Forty per cent of residents were born overseas, 38% speak a language other than English at home and 7% do not speak English well or at all.(7)

The areas with the highest proportions of people born overseas are Canterbury (50%), Strathfield-Burwood-Ashfield (50%), Kogarah-Rockdale (47.2%), Sydney Inner City (47.2%) and Hurstville (45.4%), compared to the NSW average of 31%.(8)

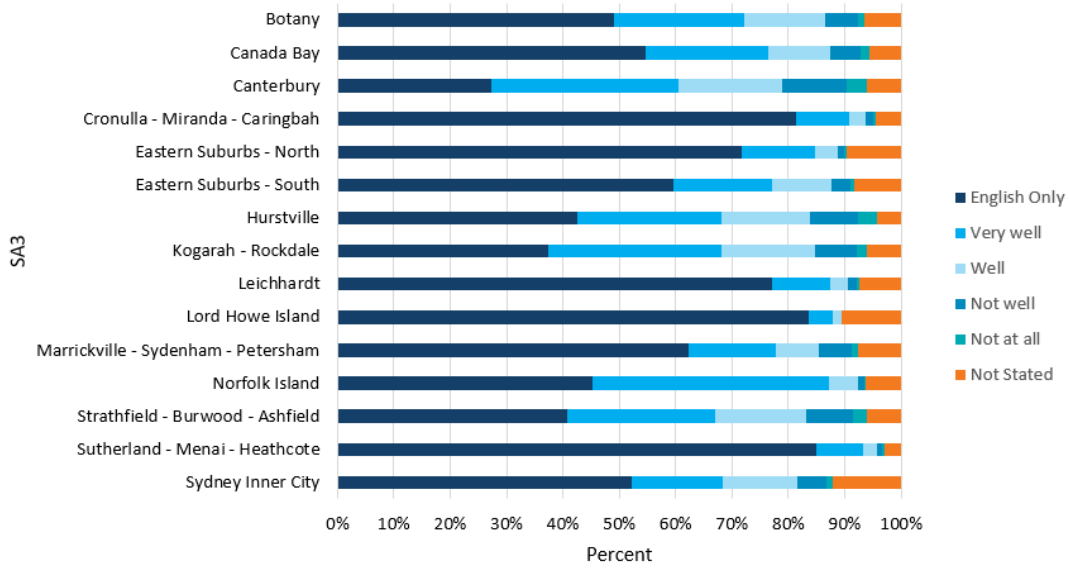
The areas with the highest proportions of people who do not speak English well or not at all are Canterbury (15%), Hurstville (12%), Strathfield-Burwood-Ashfield (10.7%) and Kogarah-Rockdale (9.3%), compared to the NSW average of 4.5%.(7)

Figure 2: Proportion of people born overseas by SA3, 2016



Source: ABS, 2018

Figure 3: English proficiency by SA3, CESPHN region, 2016



Source: ABS, 2016

Thirty eight percent of the CESPHN population speak a language other than English at home. The top five spoken languages, other than English, in the CESPHN region are Mandarin (7% of residents), Cantonese (4% of residents), Greek (4% of residents), Arabic (3% of residents) and Italian (2% of residents). Areas with a high concentration of speakers of these languages are (7):

- **Mandarin**: 20% of Mandarin speakers live in Sydney Inner City, 19% live in Hurstville and 17% live in Strathfield-Burwood-Ashfield.
- **Cantonese**: 25% of Cantonese speakers live in Hurstville, 16% live in Strathfield-Burwood-Ashfield and 12% live in Kogarah-Rockdale.

- **Greek**: 20% of Greek speakers live in Canterbury, 21% live in Kogarah-Rockdale and 11% live in Hurstville.
- **Arabic**: 41% of Arabic speakers live in Canterbury, 20% live in Kogarah-Rockdale and 11% live in Hurstville.
- **Italian**: 22% of Italian speakers live in Canada Bay, 20% live in Strathfield-Burwood-Ashfield and 10% live in Canterbury.

Other commonly spoken languages spoken across the CESPHN region include Spanish, Vietnamese, Korean, Indonesian, Bengali, Thai, Macedonian, Hindi, French, Russian, Tagalog, Urdu, German, Japanese and Croatian.(1)

Refugees and asylum seekers

The CESPHN region also has a significant population of refugees and asylum seekers. In 2020-21, 75 people arrived and settled in the region on a humanitarian visa, an 81.9% reduction from the 414 people in 2016-17. Over 40% of humanitarian arrivals in 2020-21 resided in Canterbury.(9, 10) Humanitarian visas encompass both Protection visa types (applied onshore) and Refugee visa types (applied offshore).(11)

As at June 2021, a total of 508 people who came seeking asylum by boat and were granted a Bridging Visa E resided in the CESPHN region. Approximately 72% resided in Canterbury SA3, 16% in Strathfield-Burwood-Ashfield SA3 and 12% in Kogarah-Rockdale SA3.(12) Asylum seekers and refugees can be on Protection or Refugee visa types, a Bridging Visa E (temporary visa), or awaiting a Bridging Visa E while their Protection visa application is being processed. Each visa type confers different entitlements and eligibilities for various services, which has implications for access to health services and the health status of this population group.

International students

In December 2020, there were 329,953 international students enrolled in NSW with over 70% enrolled in institutions in one of the four SA4s in the CESPHN region. The top five countries international students enrolled from are China, Nepal, India, Brazil and Thailand. Only 111,915 of enrolments commenced their studies, with the top five (5) countries for commencing students being China, Nepal, Brazil, Colombia and India.(13)

Table 2: Enrolments and commencements of international students, CESPHN region, 2020

Nationality	Enrolments	Commencements
China	79,047	32,337
Nepal	28,877	10,604
India	18,565	5,920
Brazil	13,408	7,159
Thailand	11,206	5,577
Indonesia	10,017	4,569
Colombia	9,718	6,031
Korea, Republic of (South)	8,854	4,325
Vietnam	6,954	3,161
Philippines	5,911	2,737

Source: Department of Education, Skills and Employment, 2021

Health status

Overseas-born people generally have good health. This is particularly true for new migrants, whereby people in good health are more likely to meet the eligibility criteria and have the physical and financial means to migrate to another country. But the 'healthy migrant effect' can diminish over time, particularly among immigrants from non-English speaking backgrounds where language may act as a barrier to accessing health services and impact employment prospects that can have broader socioeconomic impacts.(14)

For immigrants from some countries – especially refugees – events prior to migration (such as exposure to violence) and after migration (such as a lack of support networks, discrimination and uncertainty about visa status) can make this community more susceptible to adverse health outcomes.

The area with the greatest concentration of people born overseas in the CESPHN region is Canterbury, with half of its residents born overseas. The population of Canterbury has the highest rates of psychological distress and people reporting fair or poor health. It is also the only area in the CESPHN region to see an increase in potentially avoidable deaths. Canterbury has the highest rates of risk factors such as smoking and low exercise, the lowest rate of bowel cancer screening, and the highest rate of children with one or more developmental vulnerability domains.

Service gaps

People from CALD backgrounds may find it difficult to access health care due to:

- Limited English language skills (and by extension low health literacy)
- Cultural barriers including a lack of provider cultural competence
- Issues with eligibility associated with visa status
- Lack of knowledge about services available and how to navigate those services.

The following strategies are needed to ensure people from CALD backgrounds have equitable access to health care services that are culturally responsive:

- Build health literacy among consumers and their carers so they can be actively involved in decisions about their health

- Ensure translation and interpreting services are available
- Provide cultural competency training for service providers
- Ensure culturally appropriate services.

Translating and Interpreting Services (TIS) National provides free interpreting services to medical practitioners and pharmacies, but not allied health professionals. To address this gap, CESPHN funds the Access to Interpreting Service for Allied Health Professionals Program. Private allied health professionals that register in the program are provided access to interpreting services from TIS National at no cost.

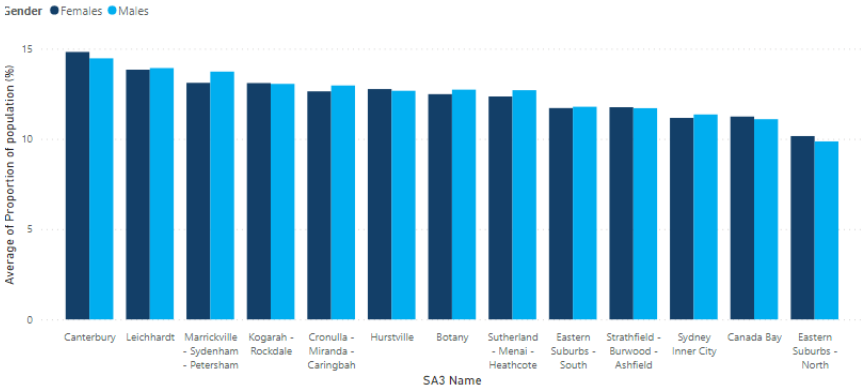
People living with a disability

Population

Prevalence

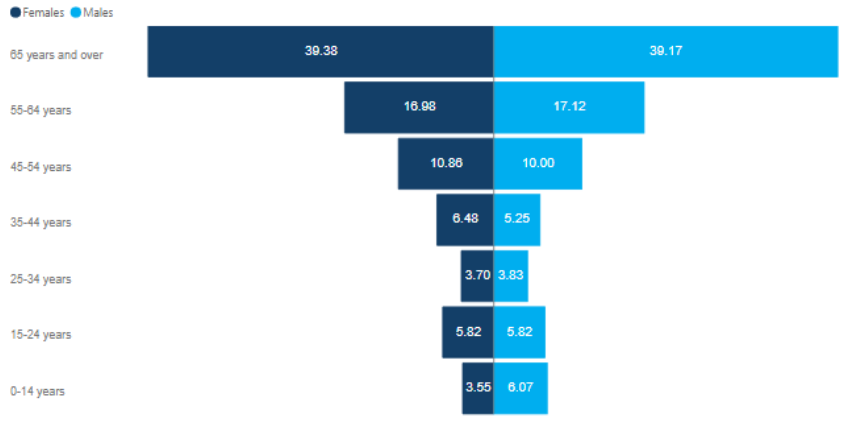
Within the CESPHN region, approximately 180,000 people live with a disability (11%). Canterbury SA3 has the highest proportion of both males and females with any disability.(15) Approximately 2 in 5 persons aged 65 years and over living within the CESPHN region have some level of disability.(15)

Figure 4: Proportion of population with disability by SA3, 2018



Source: ABS, 2018

Figure 5: Proportion of the population with disability by age and gender, 2018



Source: ABS, 2018

Disability free life expectancy

Since 2003, males and females 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).(15)

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).

Figure 6: Expected years of life without disability by gender, trend

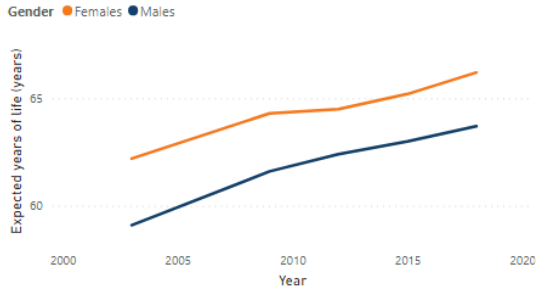


Figure 7: Expected years of life with disability by gender, trend

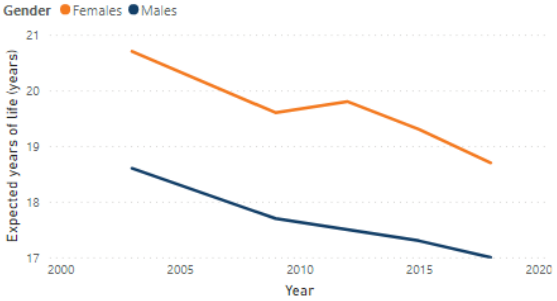


Figure 8: Expected years of life without severe or profound disability by gender, trend

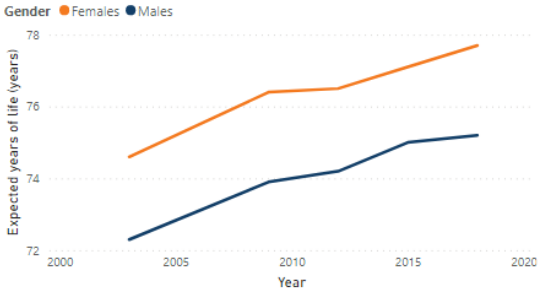
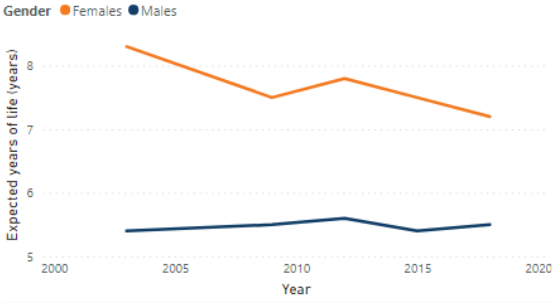


Figure 9: Expected years of life with severe or profound disability by gender, trend

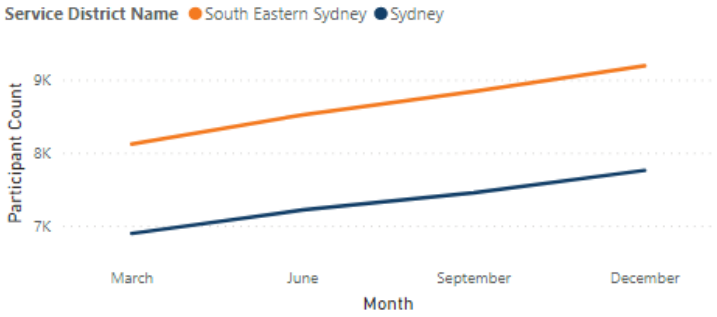


Source: ABS, 2018

NDIS participant numbers

In 2020, NDIS participant numbers across service districts within the CESPHN region increased from 15,010 in March 2020 to 16,950 in December 2020.(16)

Figure 10: NDIS participant count by service district, 2020



Source: NDIS, 2020a

Over a period of six months, 1 April to 30 September 2020, the 7-to-14-year age band made up the highest proportion of NDIS participants across the CESPHN region. Within the South Eastern Sydney service district there was a higher proportion of those aged 65+ compared to the national benchmark, and within the Sydney service district there were higher rates of 45 years+ compared to the national benchmark.(17)

Table 3: NDIS participants by age band, service district and benchmark, 2020

Age band	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES Relative to benchmark	Sydney Relative to benchmark
0 to 6	15.6	15.2	16.0	1.0	1.0
7 to 14	21.8	19.6	25.2	0.9	0.8
15 to 18	6.8	5.7	7.5	0.9	0.8
19 to 24	8.9	7.7	8.4	1.1	0.9
25 to 34	9.5	8.2	9.0	1.1	0.9
35 to 44	8.8	9.4	8.4	1.1	1.1
45 to 54	11.4	13.5	10.5	1.1	1.3
55 to 64	13.1	16.3	12.1	1.1	1.4
65+	4.0	4.4	3.1	1.3	1.4

Source: NDIS, 2020b

In the six months, 1 April 2020 to 30 September 2020, three of the top six primary disability groups in both South Eastern Sydney and Sydney service districts had rates higher than the national benchmark figures, of particular note is the rate of psychosocial disability within Sydney service district which is 1.67 times the national rate.(17) Participants with stroke as their primary disability in Sydney service district participated at a rate 1.5 times the national benchmark.

More than 1 in 4 of the NDIS participants (29.9%) in the CESPHN region have autism, almost 1 in 5 (19%) have an intellectual disability and 1 in 7 (14%) have a psychosocial disability.(16)

Table 4: NDIS participants by primary disability, service district and national benchmark, December 2020

Primary disability	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark	Sydney relative to benchmark
Autism	29.9	26.2	31.6	1.0	0.8
Intellectual disability	17.2	16.6	18.3	0.9	0.9
Psychosocial disability	11.3	16.4	9.8	1.2	1.7
Developmental delay	4.6	4.4	7.4	0.6	0.6
Hearing impairment	6.1	5.7	4.9	1.2	1.2
Other neurological	5.4	5.2	4.4	1.2	1.2
Other physical	4.0	4.0	4.3	0.9	0.9
Cerebral palsy	4.4	3.8	3.9	1.1	1.0
Acquired brain injury	3.0	3.0	3.2	0.9	0.9
Down syndrome	3.3	2.7	2.7	1.2	1.0
Visual impairment	2.6	2.7	2.1	1.2	1.3
Global developmental delay	1.9	2.6	2.0	1.0	1.3
Multiple sclerosis	2.7	2.1	1.9	1.5	1.1
Stroke	1.5	2.2	1.4	1.1	1.5
Spinal cord injury	1.6	1.5	1.2	1.4	1.3
Other sensory/speech	0.3	0.5	0.7	0.5	0.7
Other	0.3	0.4	0.3	1.0	1.3

Source: NDIS, 2020b

NDIS detailed market data shows that in the six months 1 April to 30 September 2020, both South Eastern Sydney and Sydney service districts had rates of individuals with low level of function higher than the national benchmark (1.84 and 3.07 times National rates respectively).(17)

Demographic data shows that within our service districts we have higher proportions of CALD participants compared to the national benchmark, however a lower proportion of participants who identify as Aboriginal and/or Torres Strait Islander (here in referred to as Aboriginal people). The rate at which people did not state Aboriginal status is 1.3 to 1.35 the national rate.(17)

Table 5: NDIS participants by level of function, service districts and National benchmark, December 2020

Level of function	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark	Sydney relative to benchmark
1 (High)	7.7	7.5	8.5	0.9	0.9
2 (High)	0.4	0.2	0.2	2.3	0.9
3 (High)	5.0	4.3	5.5	0.9	0.8
4 (High)	8.4	7.3	6.4	1.3	1.2
5 (High)	6.7	6.1	7.2	0.9	0.9
6 (Medium)	17.3	16.3	20.0	0.9	0.8
7 (Medium)	6.9	5.3	6.0	1.2	0.9
8 (Medium)	5.2	6.3	7.0	0.7	0.9
9 (Medium)	0.9	0.7	0.5	1.8	1.4
10 (Medium)	9.9	13.0	11.3	0.9	1.2
11 (Low)	3.8	3.3	3.9	1.0	0.8
12 (Low)	17.9	21.1	15.2	1.2	1.4
13 (Low)	7.7	6.7	6.4	1.2	1.1
14 (Low)	2.2	1.9	2.0	1.1	1.0
15 (Low)	0.1	0.1	0.0	1.8	3.1

Source: NDIS, 2020b

Table 6: Demographic details relative to benchmark by service district, December 2020

Service district	Aboriginal	Non-Aboriginal	Aboriginal status not stated	CALD	Non-CALD
South Eastern Sydney (%)	3.5	71.9	24.6	13.8	86.2
Sydney (%)	3.5	71.0	25.5	20.5	79.5
Benchmark (national avg) (%)	6.6	74.5	18.9	9.3	89.2
SES Relative to benchmark	0.5	1.0	1.3	1.5	1.0
Sydney Relative to benchmark	0.5	1.0	1.4	2.2	0.9

Source: NDIS, 2020b

NDIS data by SA3s shows that as at 31 December 2020 Canterbury SA3 had the highest number of participants from within our region (n=2,015), followed by Sydney Inner City SA3 (n=1,693) and Strathfield-Burwood-Ashfield SA3 (n=1,648).(16)

Table 7: NDIS participant count by SA3, December 2020

SA3	Sum of Participant Count
Botany	704
Canada Bay	823
Canterbury	2,015
Cronulla - Miranda - Caringbah	1,285
Eastern Suburbs - North	850
Eastern Suburbs - South	1,566
Hurstville	1,574
Kogarah - Rockdale	1,617
Leichhardt	582
Marrickville - Sydenham - Petersham	682
Strathfield - Burwood - Ashfield	1,648
Sutherland - Menai - Heathcote	1,590
Sydney Inner City	1,693
Grand Total	16,629

Source: NDIS, 2020a

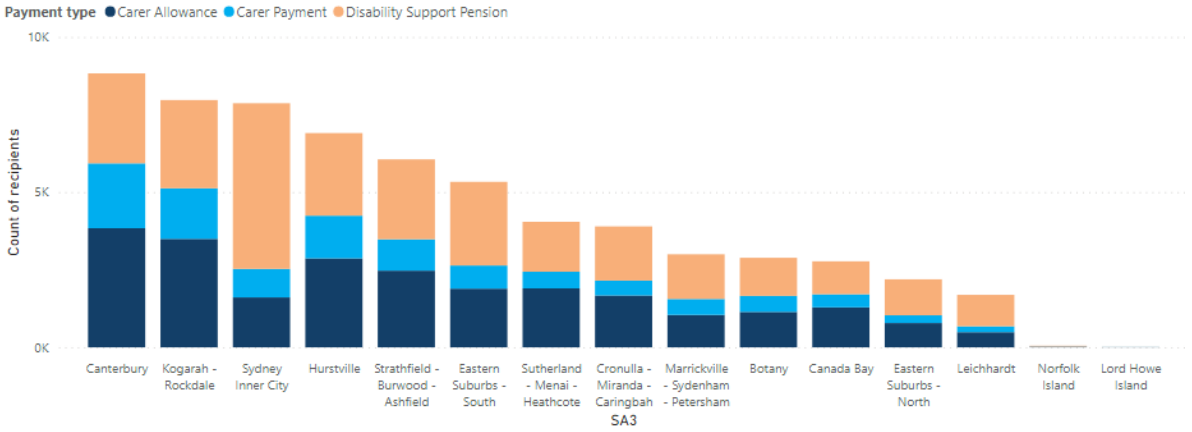
Support pensions and allowances

As at March 2021, there were approximately 28,300 individuals within the CESPHN region receiving a disability support pension, 24,500 individuals receiving a carer allowance and 10,687 individuals receiving a carer payment.(18)

Across the CESPHN region, Sydney Inner City SA3 had the highest number of recipients of disability support pensions (n=5,339), followed by Canterbury SA3 (n=2,900) and Kogarah-Rockdale SA3 (n=2,844).

Canterbury SA3 had the highest number of recipients of carer payments and carer allowance (n=2,091 and n=3,839 respectively), followed by Kogarah-Rockdale SA3 (n=1,630 and 3,496 respectively).

Figure 11: Count of recipients by payment types, by SA3, March 2021



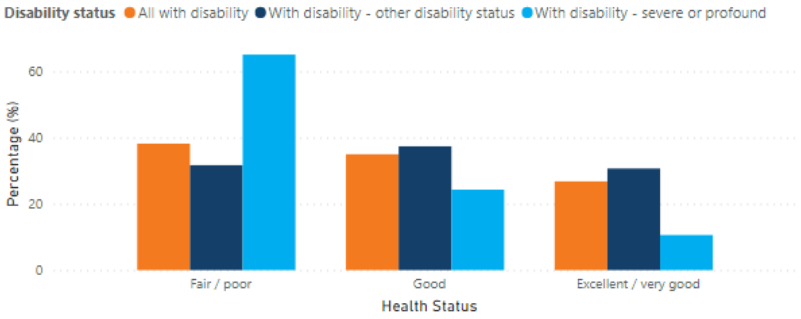
Source: DSS, May 2021

Health status and risk factors

Self-reported health status

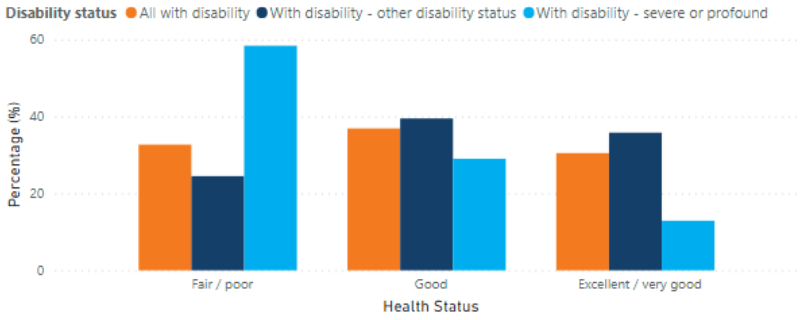
National level data shows that those with severe or profound disability report poorer health status than all people with disability and those with other disability status. This is true for both 18-64 year old age group and 65 years+ age group.(19)

Figure 12: Health status by disability status, 18-64 years, 2018



Source: AIHW, 2020

Figure 13: Health status by disability status, 65 years+, 2018



Source: AIHW,2020

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.(19)

Table 8: Psychological distress by age and disability severity group, 2018

Psychological distress level	18-64 years			65 years +		
	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	33.2	37.7	15.9	57.0	64.5	32.7
Moderate distress level	24.5	25.9	18.8	24.5	22.7	30.3
High distress level	21.2	19.8	27.2	12.5	9.1	23.2
Very high distress level	20.9	16.6	38.5	6.1	3.6	13.5

Source: AIHW, 2020

Modifiable health risk factors

Individuals with a disability have higher rates of modifiable risk factors across all age groups and genders compared to those without disability, with the exception of exceeding alcohol consumption guidelines.(19)

Access to services

Assistance with activities

Nationally, an estimated 2.5 million people living with a disability need assistance with at least one activity.(15) Approximately 542,000 people aged 0-64 years require assistance with health care, 473,000 people received assistance, and 100,000 people did not have their health care assistance needs fully met. Approximately 700,000 people aged 65 years and over require assistance with health care, 617,000 people received assistance, and 98,000 people did not have their health care assistance needs fully met.(15)

Table 9: Estimated assistance needs for individuals with profound core activity limitation, nationally, by age groups, 2018

	Aged 0–64 years			Aged 65+ years		
	Needed (%)	Received (%)	Not fully met (%)	Needed (%)	Received (%)	Not fully met (%)
Cognitive or emotional tasks	69.9	66.5	33.5	33.5	29.7	5.6
Communication	45.1	42.3	19.6	16.8	14.7	1.1
Health care	63.4	58.6	11.9	83.4	75.7	10.3
Household chores	39.1	37.9	10.7	73.5	70.9	13.7
Meal preparation	31.3	29.7	6.7	42.6	40.2	3.9
Mobility	83.9	79.1	20.5	89.4	82.9	14.8
Property maintenance	35.6	31.8	9.0	65.2	58.1	14.7
Reading or writing tasks	24.3	23.0	4.7	33.4	30.3	2.9
Self-care	69.2	64.3	15.3	61.5	53.5	8.2
Transport	42.3	40.4	9.4	80.0	76.3	8.7

Source: ABS, 2018

In NSW, an estimated 780,000 people living with a disability need assistance with at least one activity. Approximately 400,000 people require assistance with health care with an estimated 345,000 people receiving assistance with health care.(15)

Table 10: Estimated assistance needs for those with profound core activity limitation in NSW, by age groups, 2018

	Aged 0–64 years		Aged 65+ years	
	Needed (%)	Received (%)	Needed (%)	Received (%)
Cognitive or emotional tasks	66.1	61.3	34.4	33.5
Communication	40.8	39.7	21.5	17.5
Health care	63.4	57.8	82.3	72.9
Household chores	43.5	41.9	67.3	62.4
Meal preparation	36.9	32.2	37.6	38.3
Mobility	87.3	80.3	88.5	80.4
Property maintenance	38.4	33	62	51.2
Reading or writing tasks	26.1	26.8	28.5	23.5
Self-care	72.9	70.1	60.3	52.4
Transport	44.9	44	75	72.8

Source: ABS, 2018

Access to health services

Nationally, of people with disability living in households:

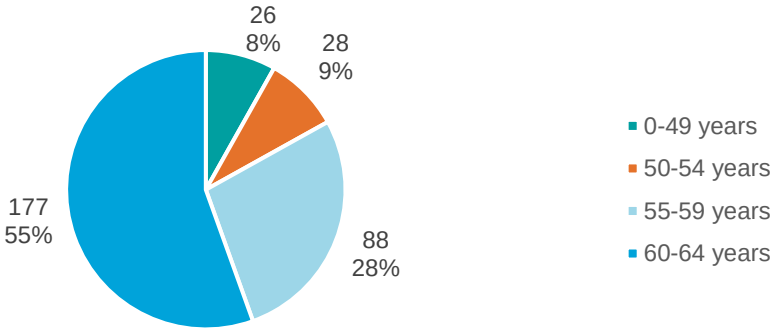
- 6% aged 64 years and under with a severe or profound disability delayed seeing or did not see a GP due to cost

- 26.8% aged 15-64 years with a severe or profound disability waited longer than they felt acceptable to see a GP
- 5% aged 64 years and under with a severe or profound disability delayed seeing or did not see a medical specialist due to cost
- 38.3% aged 15-64 years with a severe or profound disability waited longer than they felt acceptable to see a medical specialist
- 21.5% of those with a profound or severe disability delayed seeing, or did not see, a dental professional due to 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
- 12.8% aged 5 to 64 years with a severe or profound disability had difficulty accessing medical facilities (including GP, dentist, hospital).(19)

People aged under 65 in aged care

At 30 June 2020, 329 individuals aged under 65 years were in residential aged care in the CESPHN region; 319 were permanent residents.(20) 15 of the 329 residents (4.6%) identified as Aboriginal, 14 were aged 50 years and older (11 in permanent care and 3 in respite), an additional resident in permanent care identified as Aboriginal and was aged 0-49 years.(20)

Figure 14: Residents in aged care under 65 years, by age group, June 2020



Source: AIHW, 2020

MBS utilisation

A recent report from the ABS has shown that 95.6% of NDIS participants 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%).(21)

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.(21)

Providers

Across the six months of 1 April to 30 September 2020, the average number of participants per provider under NDIS was:

- Relatively equal to the national benchmark for South Eastern Sydney service district with the exception of 0-4-year age group
- Below the national benchmark for Sydney service district for all age groups.(17)

The average number pf participants per provider under NDIS in South Eastern Sydney and Sydney service districts was highest for those with a primary disability of hearing impairment.(17)

Three of the five high function groups in the South Eastern Sydney service district have an average number of participants at rates higher than the national benchmark.(17)

Table 11: Average number of participants per provider by age group, service district and benchmark, December 2020

Age band	South Eastern Sydney	Sydney	Benchmark	SES relative to benchmark	Sydney relative to benchmark
0 to 6	9.6	6.8	7.1	1.4	1.0
7 to 14	7.0	4.6	7.1	1.0	0.7
15 to 18	2.6	1.6	3.2	0.8	0.5
19 to 24	2.8	2.0	2.8	1.0	0.7
25 to 34	2.3	1.7	2.6	0.9	0.7
35 to 44	2.1	1.6	2.3	0.9	0.7
45 to 54	2.1	1.9	2.5	0.9	0.8
55 to 64	2.5	2.2	2.7	0.9	0.8
65+	1.2	1.1	1.3	1.0	0.8

Source: NDIS, 2020b

Table 12: Average number of participants per provider by service district and benchmark, December 2020

Primary disability	South Eastern Sydney	Sydney	Benchmark	SES relative to benchmark	Sydney relative to benchmark
Acquired brain injury	1.1	0.9	1.4	0.8	0.7
Autism	6.4	4.7	7.4	0.9	0.6
Cerebral palsy	1.5	1.4	1.5	1.0	0.9
Developmental delay	7.0	4.2	5.7	1.2	0.7
Down syndrome	1.5	1.1	1.6	1.0	0.7
Global developmental delay	4.0	3.1	2.8	1.5	1.1
Hearing impairment	7.9	4.7	4.4	1.8	1.0
Intellectual disability	3.4	2.2	3.8	0.9	0.6
Multiple sclerosis	1.4	1.2	1.4	1.0	0.9
Psychosocial disability	2.9	2.7	3.1	0.9	0.9
Spinal cord injury	1.1	1.0	1.0	1.1	1.0
Stroke	1.1	1.0	1.0	1.1	0.9
Visual impairment	2.9	2.0	1.9	1.6	1.0
Other neurological	1.8	1.3	1.6	1.1	0.8
Other physical	1.7	1.2	1.8	0.9	0.7
Other sensory/speech	2.4	2.7	2.5	1.0	1.1
Other	0.6	0.7	1.0	0.6	0.7

Source: NDIS, 2020b

Table 13: Average number of participants per provider by service district and benchmark, December 2020

Level of function	South Eastern Sydney	Sydney	Benchmark	SES relative to benchmark	Sydney relative to benchmark
1 (High)	8.1	6.6	6.0	1.4	1.1
2 (High)	2.7	2.0	1.9	1.5	1.1
3 (High)	3.0	2.9	3.1	1.0	0.9
4 (High)	5.5	3.4	3.6	1.5	1.0
5 (High)	3.1	2.2	3.3	0.9	0.7
6 (Medium)	5.6	4.1	5.5	1.0	0.7
7 (Medium)	2.5	1.8	2.7	0.9	0.7
8 (Medium)	1.0	1.6	2.5	0.7	0.7
9 (Medium)	0.8	1.0	0.9	0.7	1.2
10 (Medium)	2.1	1.9	2.7	0.9	0.7
11 (Low)	1.5	1.0	1.9	0.8	0.5
12 (Low)	2.6	2.2	2.8	1.0	0.8
13 (Low)	2.4	1.6	2.3	1.0	0.7
14 (Low)	0.8	0.8	0.9	0.9	0.9
15 (Low)	0.4	0.5	0.5	0.8	1.1

Source: NDIS, 2020b

Utilisation plan budget

In the six months of 1 April to 30 September 2020, South Eastern Sydney and Sydney service district participants utilised their approved plans at rates above national utilisation rates. Both the 19-24 year and 55-64 year age groups in Sydney service district were slightly lower than the national utilisation rates and the 65+ age group was 5% lower in Sydney than nationally.(17)

Individuals whose primary disability was stroke had lower utilisation rates of their approved plans in both South Eastern Sydney and Sydney service districts compared to national utilisation rates. In Sydney service district, those with “other neurological” as their primary disability also had lower utilisation of plans than nationally.(17)

Table 14: Utilisation plan budget by service district, December 2020

Service district	Active participants with approved plans	Average plan budget ($)	Utilisation (%)
South Eastern Sydney	8,631	73,000	74
Sydney	7,244	71,000	70
New South Wales	130,118	72,000	72
Australia	412,534	71,000	67

Source: NDIS, 2020b

Table 15: Utilisation plan budget by service district, age bands, December 2020

Age Band	South Eastern Sydney (%)	Sydney (%)	New South Wales (%)	Australia (%)
0 to 6	75	75	67	61
7 to 14	78	80	73	68
15 to 18	75	73	68	64
19 to 24	72	66	70	67
25 to 34	74	73	74	69
35 to 44	76	73	74	70
45 to 54	75	72	75	71
55 to 64	72	65	70	66
65 +	65	56	63	61
All Ages	74	70	72	67

Source: NDIS, 2020b

Table 16: Utilisation of plan budget by service district, primary disability group, December 2020

Disability Group	South Eastern Sydney (%)	Sydney (%)	New South Wales (%)	Australia (%)
ABI	72	68	71	68
Autism	79	76	74	69
Cerebral palsy	72	78	75	72
Developmental delay	69	71	60	53
Global developmental delay	75	76	69	60
Hearing impairment	53	59	52	45
Intellectual disability	78	77	77	72
Multiple sclerosis	76	66	67	63
Other	63	66	66	62
Other neurological	64	57	63	62
Other physical	65	61	64	59
Other sensory/speech	77	67	65	59
Psychosocial disability	72	64	67	62
Spinal cord injury	75	73	73	71
Stroke	54	56	61	60
Visual impairment	63	67	64	61

Source: NDIS, 2020b

Workforce

NDIS Provider growth

In the six months, 1 April 2020 to 30 September 2020, there was provider growth in both service districts within the CESPHN region in line with the national benchmark for the 19–24-year participants age band. South Eastern Sydney service district also had growth in line with the national benchmark for 45–54-year participant age band, and Sydney service district had growth in line with national benchmark for 0-to-6-year participant age band. All other age bands, in both service districts, had provider growth lower than the national benchmark; the lowest being South Eastern Sydney service

district in both 0 to 6 year and 15 to 18 year participant age bands, where the rate relative to benchmark was 0.49.(17)

In the six months, 1 April 2020 to 30 September 2020, there was zero provider growth in South Eastern Sydney service district where the primary disability was hearing impairment and zero growth in Sydney service district where the primary disability was 'other sensory/speech'.(17)

Provider growth in South Eastern Sydney service district was almost 5 times the national benchmark rate where the primary disability was 'other sensory/speech'. The only primary disability group within Sydney to have provider growth higher than the national benchmark was acquired brain injury.(17)

There was zero to low provider growth in both service districts at both high level of function and low level of function ends of the spectrum.(17)

Table 17: Provider growth by primary disability, service district and benchmark, December 2020

Primary disability	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark (%)	Syd relative to benchmark (%)
Acquired brain injury	6.3	17.3	16	0.4	1.1
Autism	10.9	10.7	17	0.7	0.65
Cerebral palsy	11.5	5.5	13	0.9	0.4
Developmental delay	40.0	28.6	35	1.1	0.8
Down syndrome	4.5	9.8	10	0.4	0.9
Global developmental delay	28.6	14.3	28	1.0	0.5
Hearing impairment	0.0	18.2	19	0.0	1.0
Intellectual disability	10.6	9.7	15	0.7	0.6
Multiple sclerosis	19.5	3.4	16	1.2	0.2
Psychosocial disability	22.	16.0	22	1.0	0.7
Spinal cord injury	5.6	12.0	18	0.3	0.7
Stroke	3.4	11.1	19	0.2	0.6
Visual impairment	5.3	8.7	13	0.4	0.7
Other neurological	17.1	16.5	19	0.9	0.9
Other physical	18.2	13.6	22	0.8	0.6
Other sensory/speech	33.3	0.0	7	4.5	0.0
Other	33.3	14.3	18	1.8	0.8

Source: NDIS, 2020b

Table 18: Provider growth by level of function, service district and benchmark, December 2020

Level of function	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark (%)	Syd relative to benchmark (%)
1 (High)	25	7.7	28	0.9	0.3
2 (High)	0	-	12	0.0	-
3 (High)	0	14.3	11	0.0	1.3
4 (High)	22	0.0	18	1.2	0.0
5 (High)	2	8.8	16	0.1	0.6
6 (Medium)	13	10.6	18	0.7	0.6
7 (Medium)	10	10.8	14	0.7	0.8
8 (Medium)	12	14.8	15	0.8	1.0
9 (Medium)	25	20.0	13	1.9	1.5
10 (Medium)	14	15.0	17	0.8	0.9
11 (Low)	9	6.7	15	0.6	0.4
12 (Low)	13	12.6	16	0.8	0.8
13 (Low)	13	13.2	17	0.8	0.8
14 (Low)	9	9.6	12	0.8	0.8
15 (Low)	0	0.0	21	0.0	0.0

Source: NDIS, 2020b

NDIS Provider shrinkage

In the six months of 1 April to 30 September 2020, provider shrinkage was highest in both service districts for the 19 to 24 year age band; shrinkage was also above the national benchmark rates for both districts.(17)

Provider shrinkage was also highest in both service districts in the primary disability group global developmental delay; with both districts having rates 2.01 times the national benchmark. Stroke was the second highest provider shrinkage group with both districts having 1.45 times the national benchmark rate.(17)

Table 19: Provider shrinkage by age band, service district and benchmark, December 2020

Age band	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark	Syd relative to benchmark
0 to 6	7.5	8.6	8.1	0.9	1.1
7 to 14	17.3	9.8	15.6	1.1	0.6
15 to 18	21.0	16.7	16.5	1.3	1.0
19 to 24	29.1	23.9	19.9	1.5	1.2
25 to 34	15.0	13.0	18.8	0.8	0.7
35 to 44	16.4	15.5	16.5	1.0	0.9
45 to 54	21.0	16.1	16.8	1.3	1.0
55 to 64	19.9	15.3	17.8	1.1	0.9
65+	17.1	22.1	21.2	0.8	1.0

Source: NDIS, 2020b

Table 20: Provider shrinkage by primary disability, service district and benchmark, December 2020

Primary disability	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark	Syd relative to benchmark
Acquired brain injury	23.8	13.3	17.9	1.3	0.7
Autism	17.1	17.0	15.7	1.1	1.1
Cerebral palsy	21.8	21.8	20.2	1.1	1.1
Developmental delay	0.0	0.0	4.6	0.0	0.0
Down syndrome	27.3	15.7	20.8	1.3	0.8
Global developmental delay	14.3	14.3	7.1	2.0	2.0
Hearing impairment	11.1	9.1	8.5	1.3	1.1
Intellectual disability	19.9	17.6	18.0	1.1	1.0
Multiple sclerosis	12.2	17.2	17.0	0.7	1.0
Psychosocial disability	9.0	16.8	13.2	0.7	1.3
Spinal cord injury	22.2	16.0	17.9	1.2	0.9
Stroke	24.1	24.1	16.6	1.5	1.5
Visual impairment	15.8	17.4	18.9	0.8	0.9
Other neurological	18.3	19.8	17.4	1.0	1.1
Other physical	9.1	6.8	18.2	0.5	0.4
Other sensory/speech	0.0	0.0	11.9	0.0	0.0
Other	0.0	0.0	18.4	0.0	0.0

Source: NDIS, 2020b

Table 21: Provider shrinkage by level of function, service district and benchmark, December 2020

Level of function	South Eastern Sydney (%)	Sydney (%)	Benchmark (%)	SES relative to benchmark (%)	Syd relative to benchmark (%)
1 (High)	12.5	0.0	4.8	2.6	0.0
2 (High)	0.0	0.0	8.7	0.0	0.0
3 (High)	16.7	14.3	12.9	1.3	1.1
4 (High)	0.0	13.3	9.7	0.0	1.4
5 (High)	10.9	14.7	12.6	0.9	1.2
6 (Medium)	15.3	10.6	12.1	1.3	0.9
7 (Medium)	19.0	18.9	14.0	1.4	1.4
8 (Medium)	22.4	14.8	15.5	1.5	1.0
9 (Medium)	12.5	0.0	15.8	0.8	0.0
10 (Medium)	14.8	17.0	16.9	0.9	1.0
11 (Low)	25.4	25.0	15.4	1.7	1.6
12 (Low)	17.2	18.4	20.0	0.9	0.9
13 (Low)	19.6	20.9	16.9	1.2	1.2
14 (Low)	28.7	19.2	20.7	1.4	0.9
15 (Low)	0.0	25.0	18.8	0.0	1.3

Source: NDIS, 2020b

Forecast workforce needs

The Department of Social Services (DSS) have forecast the workforce needs by postcode under the NDIS by 2023. The forecast estimates:

- Home-based support workers
- Community-based support workers
- Occupational therapists, speech pathologists and physiotherapists, and
- Others, which includes health and non-health related workforce.

Within the CESPHN region, postcodes 2035 and 2036 are both in the top five postcodes for forecast estimates for home-based and community-based support workers, Occupational Therapists, Speech Pathologists and Physiotherapists.(22)

The following visuals use the below colour scale to identify the forecast level by postcode.

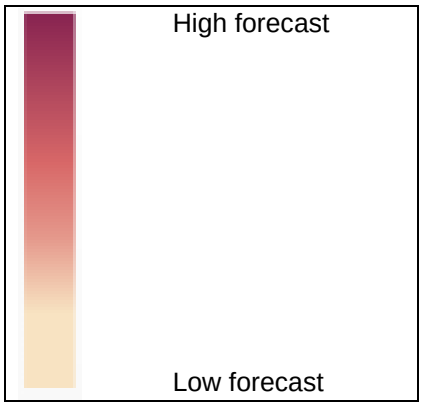
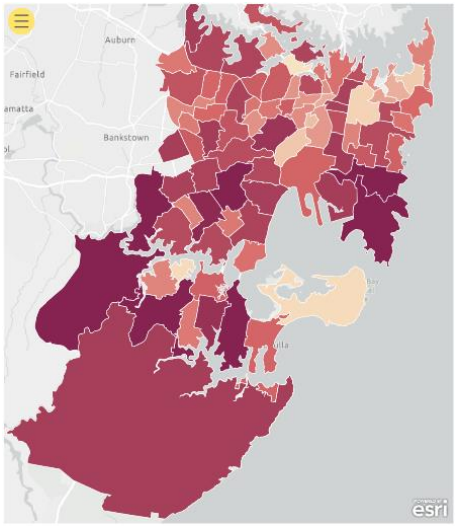


Figure 15: Forecast home-based support workers by postcode

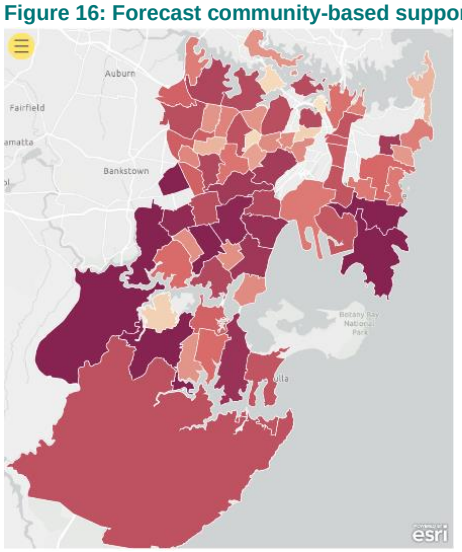


Top 5 postcodes:

- 2036
- 2035
- 2232
- 2234

Source: DSS, 2020

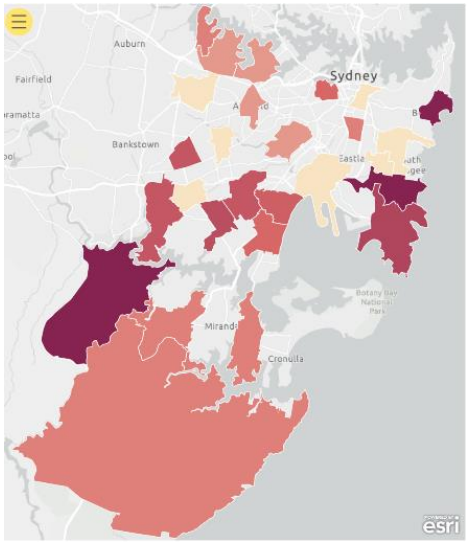
Figure 16: Forecast community-based support workers by postcode



Top 5 postcodes:
- 2036
- 2035
- 2195
- 2220
- 2210

Source: DSS, 2020

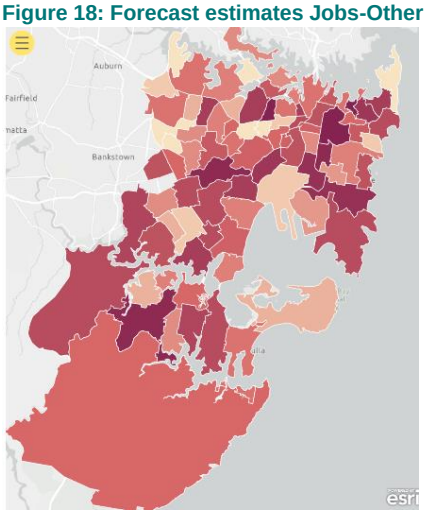
Figure 17: Forecast OTs, SPs and Physios by postcode



Top 5 postcodes:
- 2026
- 2234
- 2035
- 2036
- 2220

Source: DSS, 2020

Figure 18: Forecast estimates Jobs-Other by postcode



Top 5 postcodes:
- 2028
- 2038
- 2021
- 2033
- 2206

Source: DSS, 2020

People experiencing domestic family violence

Population

The 2016 ABS Personal Safety Survey found 1 in 6 Australian women and 1 in 16 men have been subjected to physical and/or sexual violence by a current or previous cohabiting partner. Domestic violence often happens repeatedly – more than half (54%) of women and 65% of men experienced more than one incident.(23) Groups most at risk include:

- Aboriginal women
- Young women
- Pregnant women
- Women from CALD backgrounds
- Women with disabilities
- Women experiencing financial hardships
- Women and men who experienced abuse or witnessed domestic violence as children.

Few people who experience domestic violence report the incident to police – only 17% of women and 4% of men who experienced violence by their current partner contacted the police.

Between July 2020 and June 2021, there were 5,676 domestic violence related assault incidents recorded in the CESPHN region. Sydney LGA ranked highest in the CESPHN region with 1,098 recorded incidents per 100,000 population and ranked 57 out of 120 LGAs in NSW.(24)

Table 22: Number of recorded domestic violence related assault incidents by Local Government Area: number, rate and rank, July 2020 to June 2021

LGA	No. of incidents	Rate per 100,000 population	CESPHN Rank	NSW Rank
Sydney	1,098	445.7	1	57
Canterbury-Bankstown	1,415	374.4	2	71
Bayside	650	364.4	3	73
Sutherland Shire	670	290.5	4	91
Georges River	444	278.4	5	93
Randwick	389	24.9	6	95
Strathfield	116	247.2	7	96
Waverley	175	235.5	8	99
Inner West	431	214.6	9	101
Burwood	87	214.2	10	102
Canada Bay	125	130.1	11	114
Woollahra	76	130.1	12	115

Source: NSW Bureau of Crime Statistics and Research 2021

Service gaps

GPs and allied health professionals have an important role to play in addressing DFV in our community 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. It is estimated that full time GPs see up to five women per week who have experienced some form of intimate partner abuse.(25) Only one in 10 women experiencing DFV are asked about it. Victim survivors are two times more likely to disclose their experience if asked.

Barriers preventing health professionals from identifying and providing support to patients experiencing domestic and family violence include a reluctance to interfere, victim blaming attitudes, fear of offending patients, not knowing what to do, inadequate training, lack of time, lack of referral options, victim accompanied by child or partner and language and cultural barriers.

The 2021 DFV Health Professional Survey reported the following key findings:

- 58% feel confident to appropriately respond and provide support
- >40% do not know of local support services available
- 72% have seen at least one patient who has experienced coercive control in last 3-months
- 74% have seen at least one patient who has experienced physical or sexual abuse in last 3-months
- 37% respondents' practices have no policies or procedures related to DFV
- 39% were not sure if practices have policies or procedures related to DFV.

CESPHN is one of six PHNs funded by the Australian Government Department of Health to address DFV. CESPHN's DFV Assist service provides training to GPs, allied health professionals and practice staff to enhance their capacity to identify and appropriately respond to DFV presentations from

patients or colleagues. Training is offered in-practice as well as through continuing professional development (CPD) events.

DFV Assist will also provide a referral support service exclusively for health professionals to better support their patients and colleagues experiencing DFV by:

- Facilitating appropriate local referral pathways.
- Providing secondary consultations (guidance and advice for supporting specific patients).
- Supporting in-practice quality improvement such as development of relevant policies and procedures.

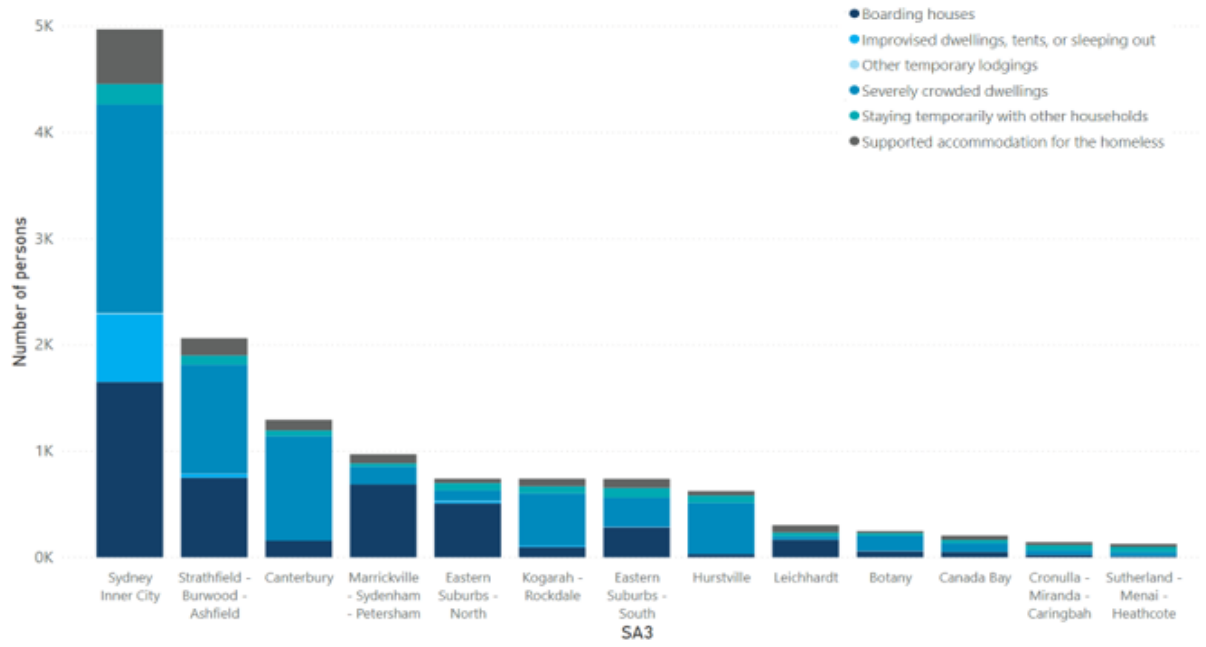
People experiencing homelessness or at risk of homelessness

Population

On Census night in 2016, 13,180 people were experiencing homelessness in the CESPHN region, equating to 35% of the state's homeless population. The highest numbers of people experiencing homelessness were located in Sydney Inner City (4,979 people), followed by Strathfield-Burwood-Ashfield (2,070 people) and Canterbury (1,295 people).(26)

There were 4,476 people living in boarding houses within the CESPHN region, accounting for 65.3% of all NSW boarding house residents and 25.6% of boarding house residents across Australia.(26)

Figure 19: Number of people experiencing homelessness in the CESPHN region by homeless operational group and SA3, 2016



Source: ABS 2018 Homelessness

In 2019-20, 8,106 people in the CESPHN region received specialist homelessness services that can include short-term advice and information, meals, shower/laundry facilities, financial advice and counselling or legal services.(27) Sydney Inner City had the highest number of clients receiving specialist homelessness services (2,795 clients), followed by Canterbury (795 clients) and Strathfield-Burwood-Ashfield (769 clients).

Men are a highly represented population experiencing homelessness as are Aboriginal people. Other population groups at particular risk of homelessness include those who have experienced family and domestic violence, young people, children on care and protection orders, people leaving health or social care arrangements, and people aged 55 or older.(28)

Homelessness is caused by a range of economic, social and personal circumstances such as poverty and financial disadvantage, the undersupply of affordable housing, domestic and family violence and mental health and substance use issues.(29) Factors that reduce rates of homelessness include employment, community connectedness, and an effective service system with early intervention.

On 30 June 2020, there were 32,654 social housing residential dwellings across the CESPHN region. This accounted for 21.5% of the NSW social housing residential dwellings.(30) Fifteen percent (15.2%) of general applicants for social housing in NSW were for allocation zones within the CESPHN region and one-third (33.3%) of priority applicants in NSW were for allocation zones within the CESPHN region. Of the general applicants, there is an expected minimum 5 year wait for a social housing property for allocation zones within the CESPHN region.(31)

A high proportion of social housing in the CESPHN region is high density, apartment towers. This poses particular risk for spread of COVID-19 to residents of these dwellings.

Table 23: Applicants on NSW Housing register, CESPHN region, 2020

Allocation zone	General Applicants	Priority Applicants
Inner City	792	335
Eastern Suburbs	1,065	189
Leichhardt/Marrickville	1,020	365
Canterbury	684	108
Inner West	1,203	257
Sutherland	587	158
St George	1,422	334
Riverwood	255	21
NSW	46,087	5,308

Source: Communities and Justice, 2020

Health status

Data from the 2015 Homelessness Inner City Registry Week showed people experiencing homelessness in the Sydney LGA had been homeless for an average of 5.3 years and had complex health and social needs.(32) Of the survey participants:

- 72% reported problematic alcohol and other drug use
- 53% reported a serious mental illness

- 49% reported a history of trauma (including emotional, physical, psychological, sexual or other trauma)
- 35% reported having a disability
- 29% reported having a brain injury.

Service gaps

People experiencing homelessness or at risk of homelessness have more complex needs and face more barriers to accessing services compared to the general population. Identified gaps in the service system include:

- Integration of the service system
- Access to primary care
- Access to post-crisis support and support for people experiencing secondary and tertiary homelessness
- Geographical reach of assertive outreach services
- Innovative models of care that deliver flexible, integrated care
- Workforce that routinely delivers respectful person-centred care.(29)

The Intersectoral Homelessness Health Strategy 2020-2025 (29) is a collaboration between CESPHN, St Vincent's Health Network, Sydney Local Health District, South-Eastern Sydney Local Health District, Department of Communities and Justice, and City of Sydney to improve health outcomes and access to health care among people experiencing homelessness in the central and eastern Sydney region. The Strategy includes five priority action areas:

- Improving access to the right care at the right time
- Strengthening prevention and public health
- Increasing access to primary care
- Building workforce capability
- Establishing collaborative governance and shared planning.

Actions under the Strategy include the development of a coordinated response to disease prevention among people experiencing or at risk of homelessness. A pilot assessment tool will also be developed for early identification of people at risk.

Partnerships between housing services, health services and other organisations will be strengthened as well as broader support for assertive outreach services including street-based outreach.

Primary care will be enhanced through the provision of continuing professional development for primary health professionals. General practices and allied health working with people experiencing homelessness will receive practice support and GP Registrars will be supported to work in homelessness health clinics during their training. There will be a high focus on building leadership and workforce capability with targeted training to address gaps in workforce development.

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer communities

Population

Data from the 2016 Census indicates that the CESPHN region has a high concentration of same sex couples living together in the region (n=8,320), representing 18% of same sex couples living together in Australia. Sydney Inner City SA3 had the highest number of same sex couples for both male and female, representing 47% of same sex couples in the CESPHN region.(33) There is no formal estimate on the number of people who identify as transgender in the region.

Health status

People who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) experience a significant amount of stigma and discrimination which can have an impact on their health outcomes and health service encounters, particularly in relation to mental health. It is important to note that there is considerable diversity within the LGBTIQ community with specific health needs and health service needs.

The 2021 Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ People found that compared to the general population, LGBTIQ people experience higher levels of psychological distress than the general population:

- 83.3% of LGBTIQ young people aged 16 to 17 years reported high or very high levels of psychological distress (compared with 27.3% in the general population)
- 57.2% of LGBTIQ people aged 18 years and over reported high or very high levels of psychological distress.(34)

The 2019 National Drug Strategy Household Survey found that in comparison to heterosexual people, gay, lesbian or bisexual people were:

- 1.5 times as likely smoke daily
- 1.5 times as likely to exceed the lifetime risk guideline to reduce the harm from drinking alcohol
- 9.0 times as likely to have used inhalants in the previous 12-months
- 3.9 times as likely to have used meth/amphetamines in the previous 12-months
- 2.6 times as likely to have used ecstasy in the previous 12-months.(35)

Respondents of the Sydney Women and Sexual Health (SWASH) Lesbian, Bisexual and Queer Women's Health Survey 2020 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).(36) Results from the same survey also highlighted the need for increased cancer screening efforts for this cohort. Of the survey respondents:

- 37% were overdue for a cervical screen
- 31% of 50–69-year-olds were overdue for a mammogram, and
- 41% of 50–74-year-olds were overdue for a bowel screen.(36)

The Gay Community Periodic Survey: Sydney 2021 reported that there were reduced rates of HIV testing (76.8%, 66.2%) and use of pre-exposure prophylaxis (PrEP) (4.8%, 3.0%) among non-HIV-

positive participants between 2020 and 2021, likely due to COVID-19.(37) Similarly, testing rates for sexually transmitted infections (STIs) declined between 2020 and2021 for both non-HIV-positive (77.9%, 66.4%) and HIV-positive participants (85.5%, 78.3%), again likely due to COVID-19.(37)

The 2018 Australian Trans and Gender Diverse Sexual Health Survey 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.(38) It was noted that experiences of gender insensitivity within sexual health care were associated with frequency of testing, meaning that participants with experiences of gender insensitivity were less likely to have been tested recently and reported testing less often.(38)

Service gaps

LGBTIQ people can experience barriers to health care services as a result of discrimination and a lack of understanding of the specific health needs, which may prevent this cohort from receiving appropriate care and achieving good health outcomes.

Gender affirming health care

Clients of ACON continue to report misgendering and lack of basic awareness in primary care services around gender affirming care. Building the capacity of mainstream/general practice services to deliver gender affirming health care and increasing access to specialist providers is crucial to improving the health and wellbeing of trans and gender diverse (TGD) people.(38)

In 2019, there was a sudden loss of access to specialist care for hormone therapy from a Sydney-based endocrinologist. GPs in the CESPHN region have noted an increase in the number of TGD patients seeking hormone therapy in the primary health care setting and have expressed willingness to prescribe and monitor hormone therapy for TGD patients but have raised the need for training and guidelines.

CESPHN has continued to offer education opportunities to upskill GPs to offer gender affirming health care. Furthermore, in 2019 CESPHN and HealthPathways launched a clinical pathway ‘Transgender and Gender Diversity’ to support GPs to plan and manage the health needs of TGD patients.

Access to primary care services

CESPHN has consulted ACON on their recent experiences of delivering services to the gender and sexuality diverse communities during the COVID-19 pandemic. It was noted that a lack of access to LGBTIQ inclusive GPs or no pre-existing relationships with a GP is a critical gap in people accessing health services and support. Telehealth has proven to be clinically effective, with high levels of client engagement and retention. For some clients, their engagement in telehealth counselling has been the first time they have sustained a clinical engagement, as it has enabled them to feel safer and more secure. For other clients seeking AOD counselling, they are hesitant or reject telehealth options, indicating their preference for in-person services despite there being an unknown (and possibly lengthy) delay due to lockdown.

People in contact with the criminal justice system

Population

NSW has the largest prisoner population with 13,066 adults and 202 juveniles in custody in the June quarter 2021.(39) Prisoners in NSW are predominately male (93% adults and 94% juveniles) and there is an over representation of Aboriginal persons (27% of adults and 36% of juveniles in custody). The majority (51%) of the prisoner population is aged 25 to 39 years and 15.4% are non-English speaking.(40)

In recent years, there has been a steady decline in the number of Aboriginal young people aged 10-17 years in custody in NSW from 145 young Aboriginal people in December 2015 to 121 in December 2019. Over the same period the number of non-Aboriginal young people in custody has remained stable.(41)

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. In 2020, 19,866 individuals were released from NSW adult correctional centres, and more than 50% of this cohort will return to prison within two years.(39, 42) The CESPHN region becomes the place of residence for approximately 19% of all people exiting custodial settings in NSW.(43)

Health status

Inmates have a complex and diverse health profile. They have higher levels of mental health disorders, alcohol and other drug use, chronic conditions, communicable diseases and disability. The most recent NSW inmate health survey found the following health concerns and issues commonly reported by prisoners:

- 23% of men and 29% of women described their health as either fair or poor
- 27% reported having three or more health conditions
- 20% had been diagnosed with hepatitis C
- 86% were smokers
- 13% of inmates had been diagnosed with an alcohol use disorder
- Cannabis was the most common drug ever used (82%), followed by methamphetamine (67%), amphetamines (57%), and cocaine (50%)
- 60% of prisoners have been diagnosed with a mental illness; of these, 55% were diagnosed between the ages of 18-24, and almost half reported having no previous contact with a mental health clinician
- Almost half of prisoners had received some form of psychiatric care prior to their current period of incarceration
- A significantly higher proportion of women in prison suffered from schizophrenia (29%) compared to 1% of the general population, and approximately 23% of the prison population were on psychotropic medications

- 18% had made at least one suicide attempt at some stage throughout their lifetime.(44)

Service gaps

Upon release many ex-prisoners face barriers accessing basic services. A vast number of prisoners are released into society without identification or Medicare cards, and with little support or planning, especially those who are released without parole. More than half (54%) of prison discharges expected to be homeless on release from prison, with 44% planning to sleep in short term or emergency accommodation, 2% planning to sleep rough, and 8% did not know where they would sleep.(45) Older prisoners face barriers in receiving aged care on exiting, as RACFs are often cautious to provide housing and care for these clients upon release. Other vulnerable groups include people who have a cognitive impairment, people who have a mental illness, Aboriginal people, and women with dependent children.

There are few organisations that provide support specific to the needs of ex-prisoners. Post-release transitional services based on a flexible, through-care outreach model of long-term, wrap-around support, a housing first approach and strong interagency partnerships need to be developed to ensure basic needs are met, and appropriate referral pathways into primary health care, LHD services, and other support services are made.

Remote populations

Lord Howe Island

Lord Howe Island is 700km north-east of Sydney. It has a small population of residents (403 people in 2020) and fluctuations in the population due to the tourism industry. There is a slightly higher proportion of female residents (53%) than males (47%).(7) The median age of residents is 44 years.

Lord Howe Island has one medical facility service, Gower Wilson Memorial Hospital, providing primary, secondary and tertiary care for residents and visitors. The service has three inpatient beds currently used for acute medical and/or surgical admissions. Complex cases are transferred to the mainland.

SESLHD Clinical Service Plan encompasses Lord Howe Island. This includes their responsibilities for the Gower Wilson Memorial Hospital, from which the general practice services operate. CESPHN continues to support SESLHD in the delivery of health services, particularly in relation to general practice accreditation to ensure access to MBS incentives, medical software and using MBS items for management of vulnerable groups.

Norfolk Island

Population

Norfolk Island is located 1,600km north-east of Sydney. In 2020, the estimated population for Norfolk was 1,748. There is a slightly higher proportion of female residents (53.2%) than males (46.8%). The median age of people in Norfolk Island is 49 years. People aged 65 years and over comprise more

than 24% of the population, and children (aged 0 - 14 years) 16.9%. There were 491 families making up the population, with an average of 1.8 children per family.(46)

It is estimated that 0.5% of the Norfolk Island population identifies as Aboriginal. Of this population, 75% are female and 25% male.(46)

The Norfolk Island community has a distinct cultural heritage with its composition still reflecting elements of its settlement history, including ancestry from co-located Pacific nations such as Pitcairn. Norfolk Island became an external Australian territory in July 2016 and Medicare became accessible to residents at this time.

Health status

The majority of Norfolk Islander residents consider themselves to be healthy and fewer report a sedentary lifestyle compared with the general Australian population. However, 63% of the Norfolk Island population were overweight or obese, which is higher than the NSW population, but similar to the outer reginal and remote areas of NSW (65%).(46)

The Norfolk Island community reported higher levels of high or very high psychological distress (13%) compared to the NSW population (8.5%), but comparable levels to those in the outer regional and remote areas in NSW. The rationale for this higher level is not clearly known but may relate to the poor economic conditions and geographic isolation factors.(46)

Rates of diagnosed hypertension amongst the Norfolk Island population are up to 17% of the total population and are indicative of a range of risk factors in addition to genetic predisposition. It has also been noted that there is a degree of undiagnosed hypertension, as well as diabetes.(46)

The prevalence of visual impairment and blindness among Norfolk Island population is low, particularly among those with Pitcairn Island ancestry.

Service gaps

Most services are provided by the Norfolk Island Health and Residential Aged Care Service (NIHRACS) which includes general practice, emergency care, acute admitted care, and residential aged care as well as public health, allied health and community health services such as cancer screening, health promotion, physiotherapy, counselling services and dentistry. There are also a number of support services available on Norfolk Island including pathology, diagnostic imaging, pharmacy and ambulance services.

However, many of the health facilities on Norfolk Island are dated and do not comply with the Australasian Health Facilities Guidelines. Based on the 2020 Norfolk Island Health Plan, Norfolk Island will require updated facilities that can deliver a range of preventative health services (e.g. chronic disease management and mental health support) and residential aged care facilities.

The NIHRACS general practice service employs 3.6 full time equivalent GPs. However, there is no external after-hours coverage or telephone from a deputising service or telephone advice line. Two of the three GPs provide a 24 hour on-call roster with a 1 in 3 on-call availability.(46)

In addition to NIHRACS, the Norfolk Island community has a small number of resident private health practitioners including:

- One community pharmacy outlet that dispenses prescriptions for the NIHRACS residential aged care residents and the community.
- One psychologist (it is not known how many patients they see each year).
- One optometrist (visiting service with no fixed schedule).

SESLHD also facilitates a number of specialists and allied health professionals visiting the island on a regular or as needed basis to support community access to services. Specialist telehealth sessions have also been implemented. It should be noted that 16.1% of the Norfolk Island households do not have sufficient access to the internet or have it readily available within their place of residence. This has implications for healthcare communication tools such as My Health Record, certain health literacy strategies and telehealth style responses to delivery of healthcare for remote regions.

Since 2015, CESPHN has implemented a range of health promotion programs on Norfolk Island. These have focused on four key life stages (children, young people and families, adults, older people and whole community). Various health promotion activities are reported to have taken place with positive community engagement and participation. These have included men's health checks, health education presentations, the '*health and wellbeing expo*' and a range of chronic disease focused programs including the '*healthy cooking program*' and '*get started exercise program'*.(47)

There are several challenges in recruiting and retaining healthcare professionals to Norfolk Island, which inevitably impacts the health services themselves in terms of what services are available. Such challenges include professional and social isolation, poorer local amenities and infrastructure, limited availability for training and development and difficulty in delivering services in remote locations.

Patients that cannot be safely managed with the skill and experience level of the hospital/staff are referred and transferred to a mainland hospital. Children requiring admission are automatically transferred or evacuated. Both medical evacuations and transfers required increased from 20-40 in 2013-14 to 60-70 in 2017-18.(46)

The rates of interstate referrals are higher in comparison to medical evacuations, as these tend to be for non-time critical treatments and consultations. The highest number of referrals are for ophthalmology (16%), gastroenterology (10%) and oncology (9%).

Feedback from the CESPHN 2021 Stakeholder Survey noted that patients were still being referred to the mainland for specialist services and treatment during the COVID-19 pandemic, despite a lack of air services. While Norfolk Island remained "*covid free*", long awaited specialist services were unable to travel to the remote Island due to the COVID-19 outbreak on the mainland.

There are limited maternal and child health services provided on Norfolk Island. While initial antenatal and postnatal care is provided via a shared care model with a GP and/or midwife, mothers typically have to travel to the mainland four weeks prior to giving birth. Planned birthing services ceased in 2012 on Norfolk Island due to a lack of available GP obstetricians and aestheticians. However, this is reported to be a common trend across most regional and remote areas of Australia.(46)

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Mental health and suicide prevention

2022-2024 Needs Assessment

15 November 2021

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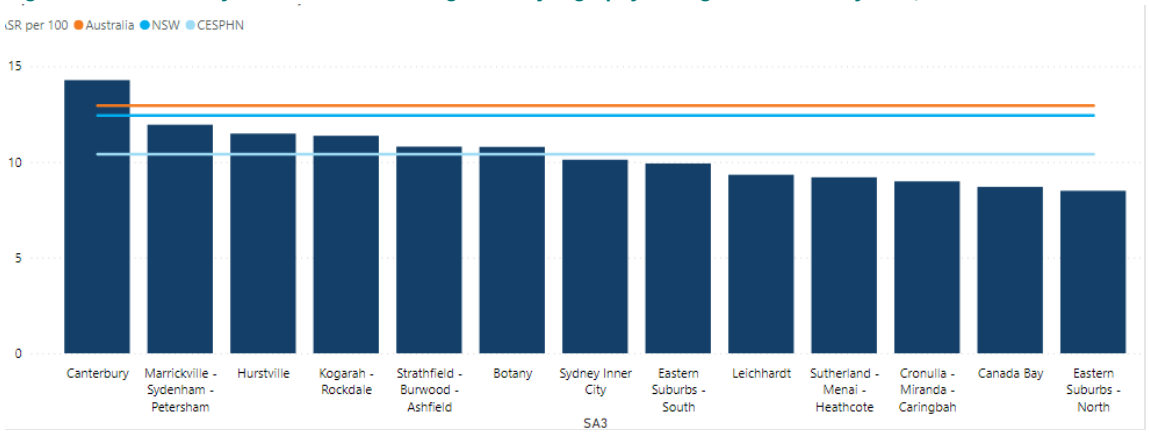
Prevalence of mental health issues and suicide

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 2017-18, the rate of people experiencing high or very high psychological distress in the CESPHN region was 10.4 age-standardised rate (ASR) per 100 people, which is below the NSW rate (12.4 ASR per 100) and the national rate (12.9 ASR per 100).(1) Within the CESPHN region, Canterbury SA3 had the highest age-standardised rate of psychological distress (14.3 per 100 population), followed by Marrickville-Sydenham-Petersham SA3 (12.0 per 100), Hurstville SA3 (11.5 per 100). Canterbury SA3 is the only SA3 in our region that had estimated rates of psychological distress higher than the NSW and Australian rates.

Figure 1: Persons 18 years and over with high or very high psychological distress by SA3, 2017-18



Source: PHIDU, 2021

The ABS Household Impacts of COVID-19 Survey collects monthly information on the impact of COVID-19 across a range of key areas including psychological distress. During the COVID-19 pandemic, women have consistently reported higher levels of concern due to COVID-19 than men, and people aged 18–64 years have reported higher levels of concern due to COVID-19 than people aged 65 years and over. In June 2021, 19.4% of respondents living in NSW experienced high or very high levels of psychological distress in the last four weeks, similar to March 2021 (18.0%) and November 2020 (19.3%).(2)

Mental health in adults

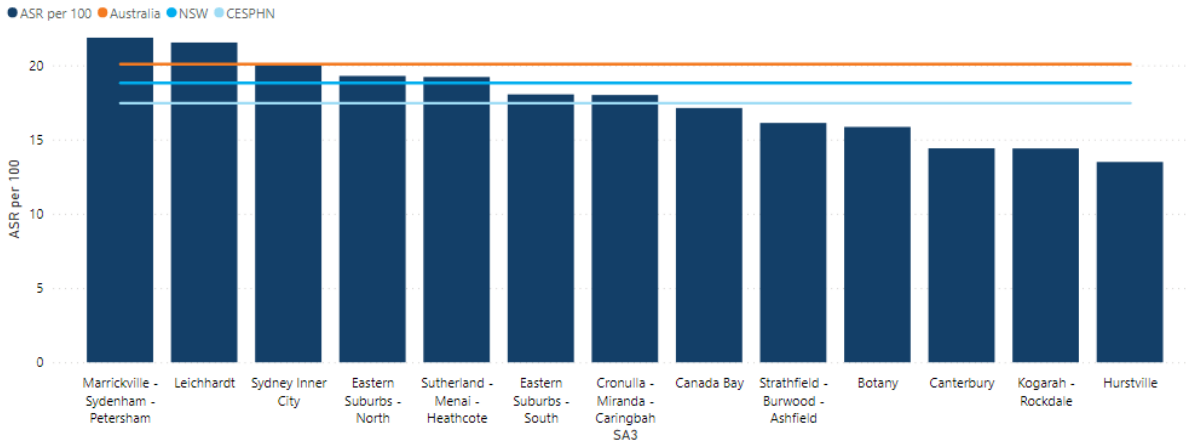
In 2017-18, the estimated prevalence of mental health and behavioural problems in the CESPHN region was 17.5 per 100 (ASR), which is lower than the NSW (18.8 per 100) and national (20.1 per 100) rates.(1)

The SA3s with the highest estimated prevalence of mental health and behavioural problems were Marrickville-Sydenham-Petersham SA3 (21.9 per 100) followed by Leichhardt SA3 (21.5 per 100),

and Sydney Inner City SA3 (20.1 per 100). Females had higher prevalence rates of mental and behavioural problems in comparison to males across all SA3s in the CESPHN region.(1)

This indicator is based on a person self-reporting that they were told by a doctor or nurse that they had mental health and behavioural problems that were current and long term. It therefore does not capture persons who have not sought help for their mental health.

Figure 2: Persons 18 years and over with mental and behavioural problems by SA3, 2017-18



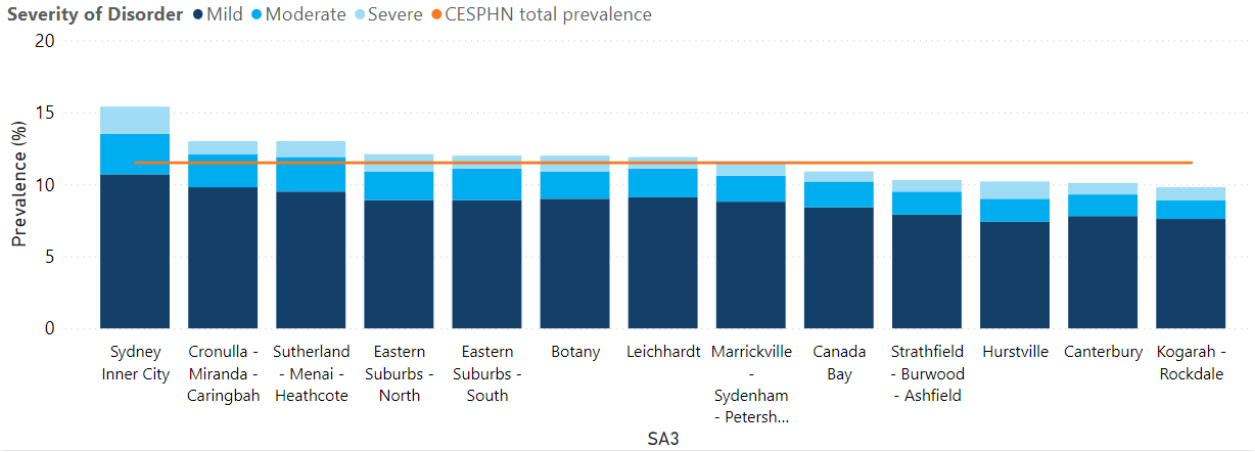
Source: PHIDU, 2021

Mental health in children and young people

The synthetic prevalence estimate of mental health issues among 4-17 year-olds in the CESPHN region is 11.8%, which is lower than the national rate (14.1%) across all severity levels.(3) However, there are SA3 areas where the prevalence estimates are higher:

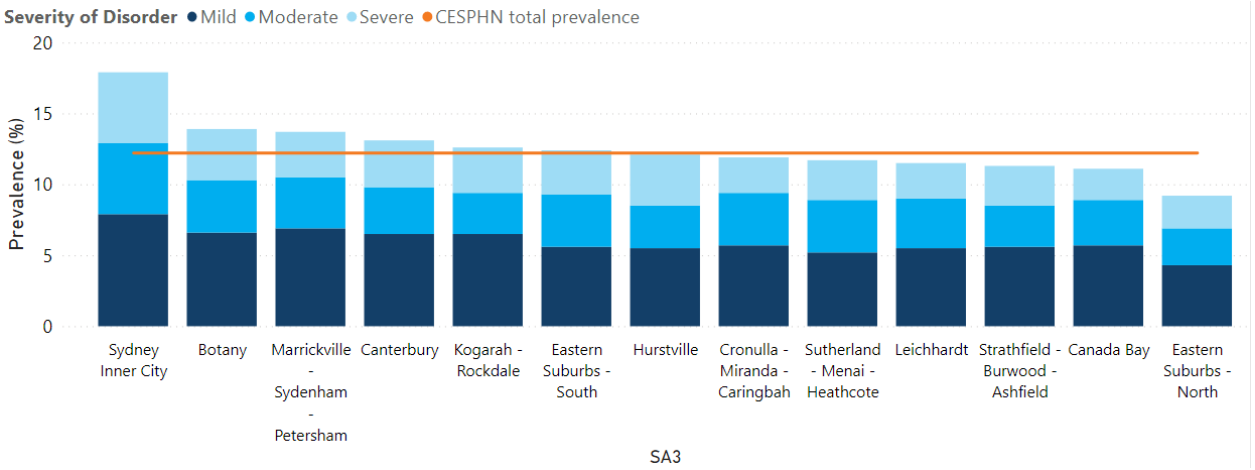
- For children aged 4-11 years old:
  - Sydney Inner City (15.4%), Cronulla-Miranda-Caringbah (13.0%) and Sutherland-Menai-Heathcote (12.9%) had higher prevalence estimates than the CESPHN rate (11.5%)
- For young people 12-17 years old:
  - Sydney Inner City (18.0%), Botany (14.0%), and Marrickville-Sydenham-Petersham (13.7%) had higher prevalence estimates than the CESPHN rate (12.2%)
- Children and young people aged 4-17 years old with moderate mental health issues:
  - Sydney Inner City (3.7%), Cronulla-Miranda-Caringbah (2.9%) and Sutherland-Menai-Heathcote (2.9%) had higher prevalence estimates than the CESPHN rate (2.5%)
- Children and young people aged 4-17 years old with severe mental health issues:
  - Sydney Inner City (3.1%), Hurstville (2.3%) and Botany (2.1%) had higher prevalence estimates than the CESPHN rate (1.8%).

Figure 3: Prevalence of mental health illness in children aged 4-11 years, by severity of disorder and SA3, June 2013 to April 2014



Source: Young Minds Matter, 2018

Figure 4: Prevalence of mental health illness in young people aged 12-17 years, by severity of disorder and SA3, June 2013 to April 2014

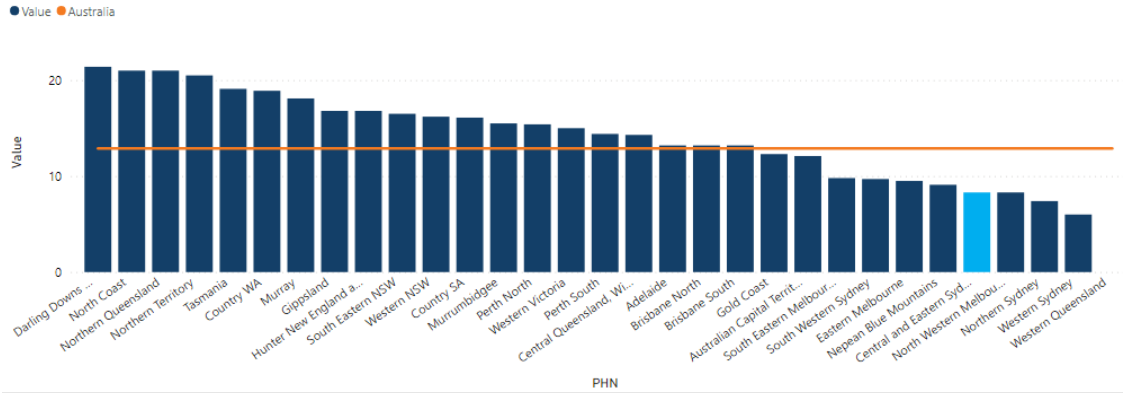


Source: Young Minds Matter, 2018

Suicide

In 2019, there were 148 deaths by suicide within the CESPHN region, this is a decrease of 9.2% from the previous year. Suicide rates in the CESPHN region continue to fluctuate, in 2019 the ASR of suicide was 8.3 per 100,000 people, the fourth lowest of all reported PHNs.(4)

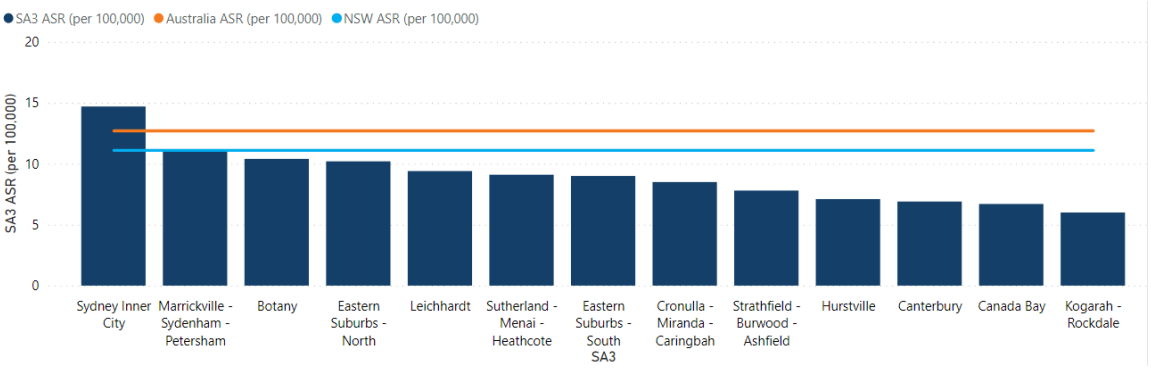
Figure 5: Suicide rate per 100,000 population, by PHN, 2019



Source: AIHW, 2021

Suicide data for 2015-2019 shows that Sydney Inner City SA3 had the highest rate of suicide within the CESPHN region (14.7 per 100,000 population) with rates higher than both NSW (11.1 per 100,000 population) and Australia (12.7 per 100,000 population), followed by Marrickville-Sydenham-Petersham SA3 (11.1 per 100,000 population) and Botany SA3 (10.4 per 100,000 population).(4)

Figure 6: Suicide rate by SA3, 2015-2019



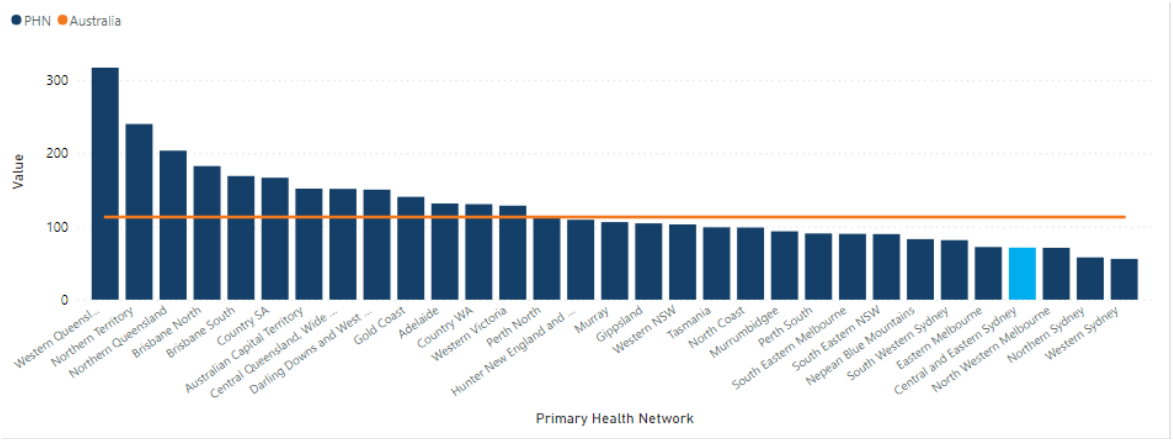
Source: AIHW, 2021

The NSW Suicide Monitoring System reported 901 suspected or confirmed deaths by suicide in NSW in 2020. This compares to the 943 suspected or confirmed deaths by suicide recorded in 2019.(5) From 1 January to 31 July 2021, there have been 522 suspected or confirmed deaths by suicide. This compares to 509 suspected or confirmed deaths by suicide recorded over the same period in 2020.(5)

Self-harm hospitalisation

In 2019-20, there were 1,175 self-harm hospitalisations in the CESPHN region giving a rate of 71.1 per 100,000 population. Sixty percent of hospitalisations were for females.

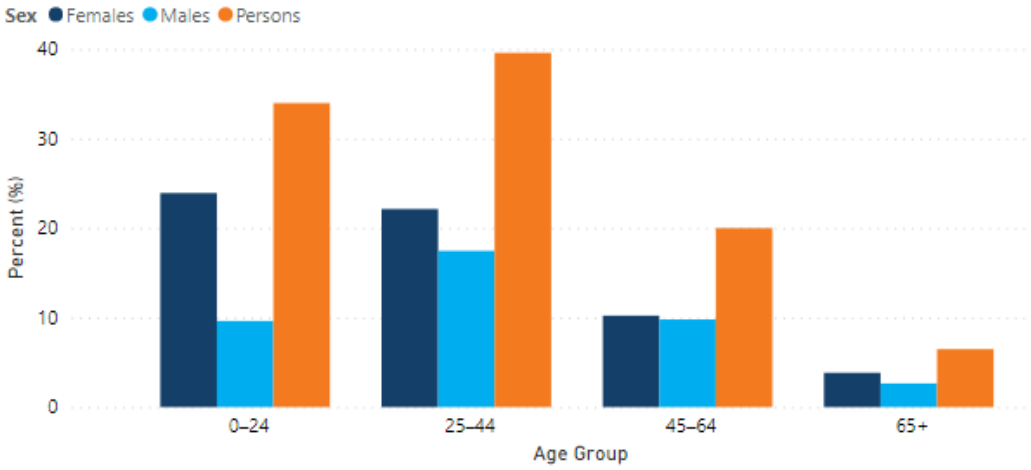
Figure 7: Self harm rate by PHN, 2019-20



Source: AIHW, 2021

Individuals in the 25-44 year age group had the highest proportion of self-harm hospitalisations in the CESPHN region (39.6%), followed by 0-24 year-olds (34%).(4)

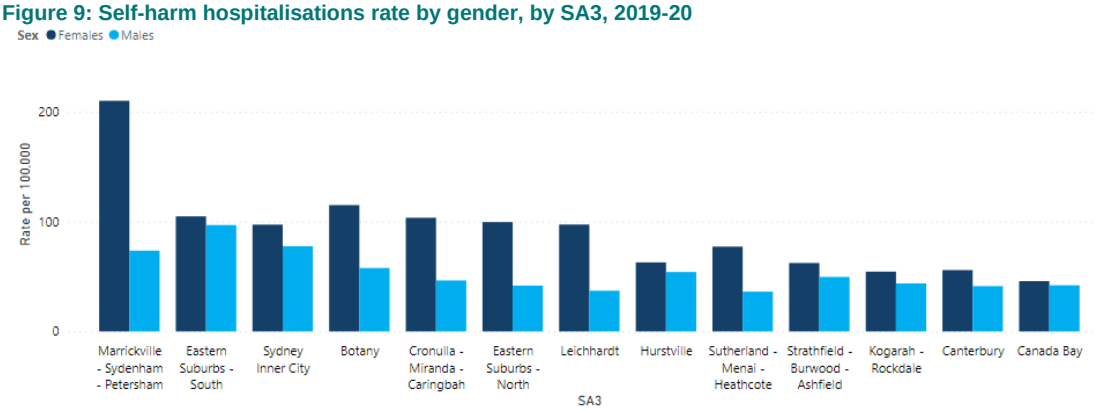
Figure 8: Self-harm hospitalisations by age group and gender, CESPHN, 2019-20



Source: AIHW, 2021

Females in the Marrickville-Sydenham-Petersham SA3 had the highest self-harm hospitalisation rates (210.1 per 100,000 population) within the CESPHN region, followed by Botany SA3 (115.1 per 100,000 population). Across all SA3s, females had higher rates of self-harm hospitalisations than males.(4)

Figure 9: Self-harm hospitalisations rate by gender, by SA3, 2019-20



Source: AIHW, 2021

Vulnerable groups

A number of vulnerable groups in the CESPHN region are recognised as having higher rates of mental ill health and associated risk factors than their peers. Groups at elevated risk and/or facing unique challenges are identified as:

- Children and young people
- Refugees settling
- Parents experiencing perinatal mental health issues
- Older people including residents of aged care facilities
- Aboriginal and Torres Strait Islander peoples (herein referred to as Aboriginal people)
- People from culturally and linguistically diverse (CALD) backgrounds, including newly arrived in the region
- People who are homeless or at risk of homelessness
- Lesbian, gay, bisexual, trans, queer and intersex (LGBTQI) people
- People with an intellectual disability
- People living with complex mental health and co-existing complex physical health needs
- People living in regions that are highly disadvantaged
- People with co-existing drug and alcohol issues
- Family and carers of people experiencing mental ill health
- Neurologically diverse people
- Veterans.

Many people will fit into multiple vulnerable groups.

Mental health service utilisation

The data presented in this section largely relates to 2019-20 or earlier which does not give a complete picture of the impact of the COVID-19 pandemic and subsequent restrictions. At the local level we have limited data, although some noticeable changes have been:

- Increased wait times for people accessing mental health care
- A 20% increase in referrals to the commissioned Psychological Support Services (PSS) program for people wanting to access psychological therapies
- Increase in demand for headspace centre services, and an increase in frequency and duration of interventions required.

National and state level data across a range of mental health related services have shown heightened service usage since 20 March 2020 when COVID-19 pandemic restrictions were introduced:

- Beyond Blue, Kids Helpline and Lifeline all reported increases in demand in March 2020 and have recorded fluctuations in activity during the course of the COVID-19 pandemic
  - In the 4 weeks to 19 September 2021:
    - Lifeline answered 30,705 calls from New South Wales. This represented increases of 22.8% and 69.7% from the same periods in 2020 and 2019, respectively.
    - Kids helpline received 32,572 answerable contact attempts, up 4.6% and 16.7% from the same periods in 2020 and 2019 respectively
- The ReachOut and Head to Health websites both saw a spike in activity early in the pandemic, peaking in March 2020
  - ReachOut website views increased from an average of 9,526 users per day in the week beginning 9 March 2020 to an average of 13,380 users per day in the week beginning 30 March 2020
  - Head to Health website views increased from an average of 1,675 users per day in the week beginning 9 March 2020 to an average of 9,309 users per day in the week beginning 23 March 2020
- The 4-week period with the highest mental health-related MBS service use during the pandemic in NSW was the 4 weeks to 12 September 2021 with 4,557 services per 100,000 population.(6)

The 2021 Greater Sydney Stay at Home Orders impacted the access and availability of services across the region. Service disruptions included:

- Suspension of programs which needed to be delivered face-to-face
- Increased wait times
- Reduced workforce due to redeployment to other areas.

There was also a shift in the way services were delivered. In the four weeks to 19 September 2021, just over half (53.3%) of services in NSW were delivered via telehealth compared to less than 25% being delivered by telehealth at the same time in 2020.

The Australian Government has responded with a range of measures including wider availability of telehealth services, additional Medicare-subsidised psychological therapy sessions, and additional service capacity funding.

Service navigation

Service navigation plays a critical role in the stepped care approach to mental health to ensure people experiencing mental health issues receive the right care, at the right place, at the right time. Community and stakeholder consultations have raised that service navigation is a continuing issue for people experiencing mental ill health and their carers. It was noted that Community Pharmacy, if appropriately trained, could play a role in directing people to the appropriate level of care.

Challenges with service navigation include access issues due to service eligibility, vulnerabilities during transitions between services, and lack of awareness of the most appropriate service available. These points are further explored in the service gaps section of this chapter.

CESPHN funded programs

CESPHN has implemented a stepped care approach to commissioning mental health services by ensuring services are available for all levels of mental health needs, from low intensity to severe and complex needs.

Low intensity services

Access to low intensity services earlier in the mental health trajectory can improve longer term mental health and wellbeing and reduce the need for higher intensity interventions. These services are designed to be accessed quickly, without need for formal referral and involve few short sessions. CESPHN commissions the following low intensity services:

- NewAccess Coaching
- Mindfulness Program
- headspace Centres
- Reconnect Wellbeing Program Older Persons
- Residential Aged Care Facilities – Mental Health Education Programs.

Moderate intensity services

Access to moderate intensity services aims to address mild to moderate symptoms and distress where individuals meet criteria for a diagnosis. Individuals, whose symptoms will have typically been present for 6 months or more, may also be experiencing complexity around risk, functioning or co-existing conditions but not at very severe levels. These services are structured, reasonably frequent and intensive interventions. CESPHN commissions the following moderate intensity services:

- Psychological Support Services
- Cognitive Behavioural Therapy (CBT) Group for people with Autism Spectrum Disorder
- Emotional Wellbeing for Older Persons.

High intensity services

These services include periods of intense intervention that may involve multi-disciplinary support. CESPHN commissions the following high intensity services:

- Connect and Thrive – National Psychosocial Support (NPS) Program
- Continuity of Support (CoS) Program
- Dialectical Behaviour Therapy (DBT) Group Therapy
- GP Mental Health Shared Care Program
- Service Navigation for Psychosocial Services
- Keeping the Body in Mind – Primary
- Primary Integrated Care Supports (PICS) Program
- Youth Enhanced Services.

Suicide prevention services

These services support people who have attempted suicide or experienced a suicidal crisis. CESPHN commissions the following suicide prevention services:

- The Way Back Support Service (in collaboration with the NSW Ministry of Health)
- Connector service (Aboriginal/ Torres Strait Islander specific)

- Psychological Support Services (PSS) Suicide Prevention Service (SPS).

The NSW Ministry of Health also funds Suicide Prevention Outreach Teams (SPOT) and Safe Havens in the following locations:

- SESLHD: SPOT is based in Sutherland with the Community Mental Health Team and the Safe Haven is located nearby the St George Hospital.
- SLHD: SPOT is based out of Canterbury Hospital and supporting Concord, Croydon, Canterbury and Bankstown areas and the Safe Haven will be located near RPA emergency department.
- SVHN: combined SPOT and Safe Haven will be located at the site of the Former Green Square Hotel, on the corner of Victoria and Liverpool St Darlinghurst
- SCHN: combined SPOT and Safe Haven is located at the Sydney Children's Hospital in Randwick.

NSW Health has commissioned the Standby Response Service to expand across the whole of NSW. This service provides post suicide support to anyone bereaved or impacted by suicide in the form of:

- Counselling
- Links to other support services
- Group Support
- Information and Resources
- Training and upskilling to groups and professionals.

Services are delivered to groups and/ or individuals by professionals trained in Suicide ASIST who have a tertiary background in psychology, social work, and counselling. Post Suicide Support is a consortium led by StandBy with Jesuit Social Services Support After Suicide, Roses in the Ocean and University of New England.

Table 1. Suicide prevention services across the care continuum, CESPHN region

Primary care Low intensity	Primary care moderate intensity	Primary care high intensity	Specialist acute	Hospital alternatives	Post discharge
Suicide Call Back Service Better Access or Psychological Support Services (PSS)	PSS or Better Access Lifeline Being supported Suicide Call Back Service Alternatives to Suicide peer support group (if near Marrickville)	PSS-Suicide Prevention Service (SPS) Alternatives to Suicide peer support group (if near Marrickville) SPARC Other non-SP specific MH services e.g., Connect and Thrive	Mental Health Line Community Mental Health Teams SESLHD, SLHD, SVH and SCHN hospital emergency departments and Mental Health Units	Safe Havens SPOT	Community Mental Health Teams PSS-SPS SPOT The Way Back

	Suicide Prevention and Recovery College (SPARC)				

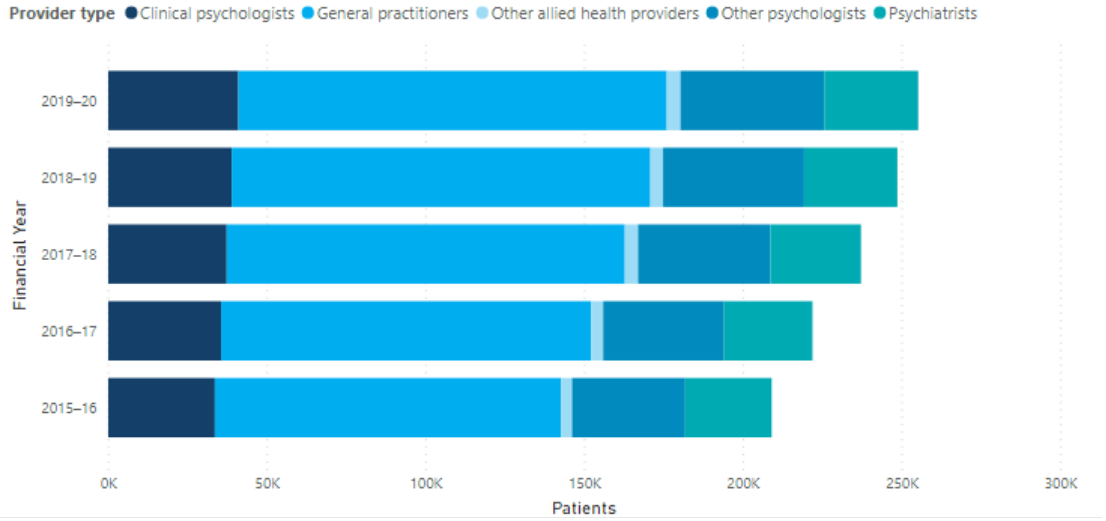
Source: Adapted from Central and Eastern Sydney Mental Health and Suicide Prevention Regional Planning

Medicare-subsidised mental health services

The 2021 RACGP's General Practice Health of the Nation report stated that 70% of GPs reported psychological conditions as one of the most common reasons for patient presentations in 2021, an increase from 61% in 2017.(7)

In 2019-20, there were 255,264 people (15.4% of the population) who accessed Medicare-subsidised mental health services in the CESPHN region. This is an increase of 46,173 people (22.1%) from 2015-16.(8)

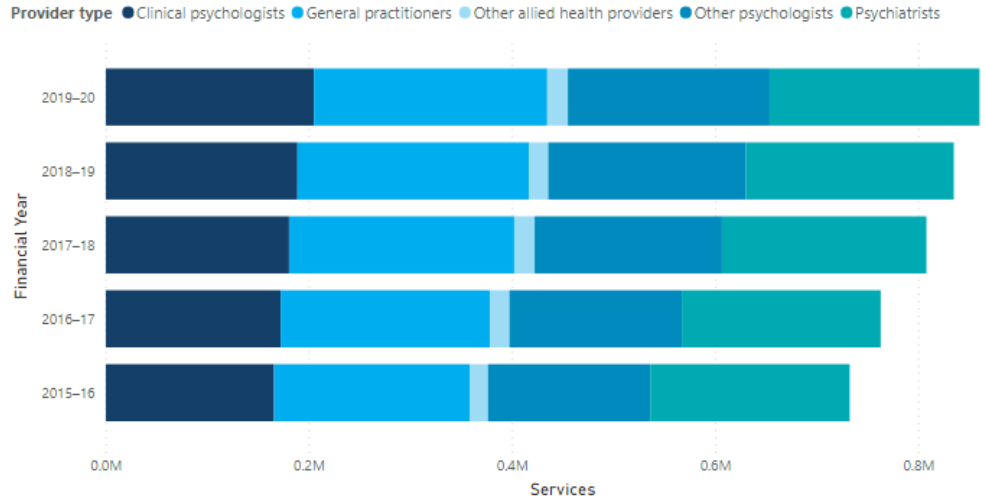
Figure 10: Number of people accessing Medicare-subsidised mental health services by service type, CESPHN region, 2015-16 to 2019-20



Source: AIHW, 2021

In the same period, there was a 17% increase in the number of services in the CESPHN region for all mental health providers (n=127,862). There was an increase in the number of services for each mental health provider type, with the increases ranging from 5.3% increase for psychiatrists to 24.3% increase for "*other psychologists*".(8)

Figure 11: Number of Medicare-subsidised mental health services by service type, CESPHN region, 2015-16 to 2019-20

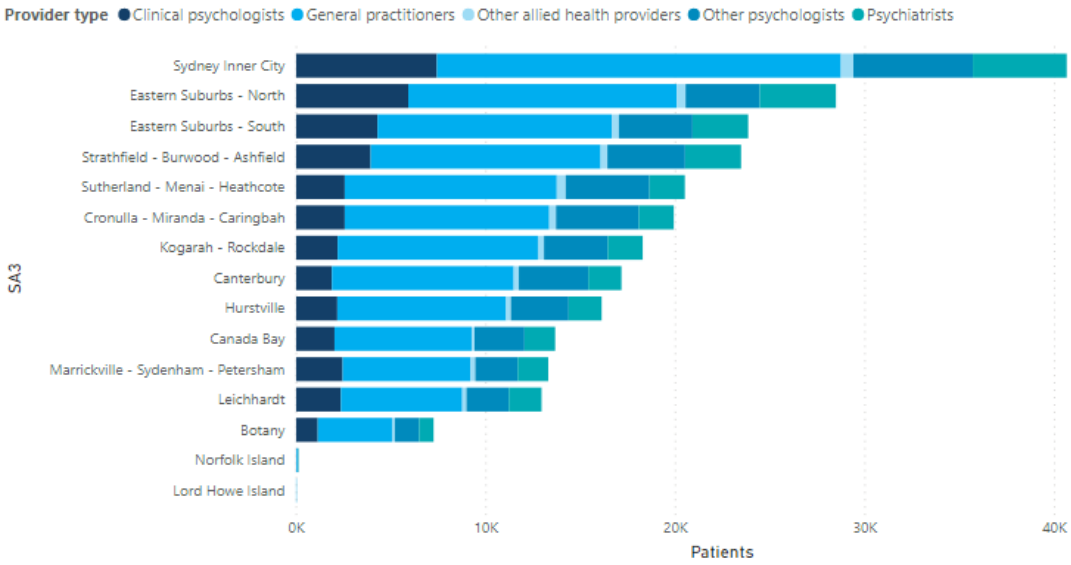


Source: AIHW, 2021

There are considerable variations in the number of Medicare-subsidised mental health services between SA3s. Sydney Inner City SA3 had the highest number of patients (40,673), followed by Eastern Suburbs-North SA3 (28,496) and Eastern Suburbs-South SA3 (23,868) across all service types. Lord Howe Island, Norfolk Island and Botany SA3 had the lowest number of services (44,148 and 7,269 respectively).(8)

Approximately 50% of patients across all SA3s saw a general practitioner for Medicare-subsidised mental health services, the exception was Norfolk Island, where 85% of patients saw a GP.(8)

Figure 12: Number of people accessing Medicare-subsidised mental health services by service type, by SA3, 2019-20

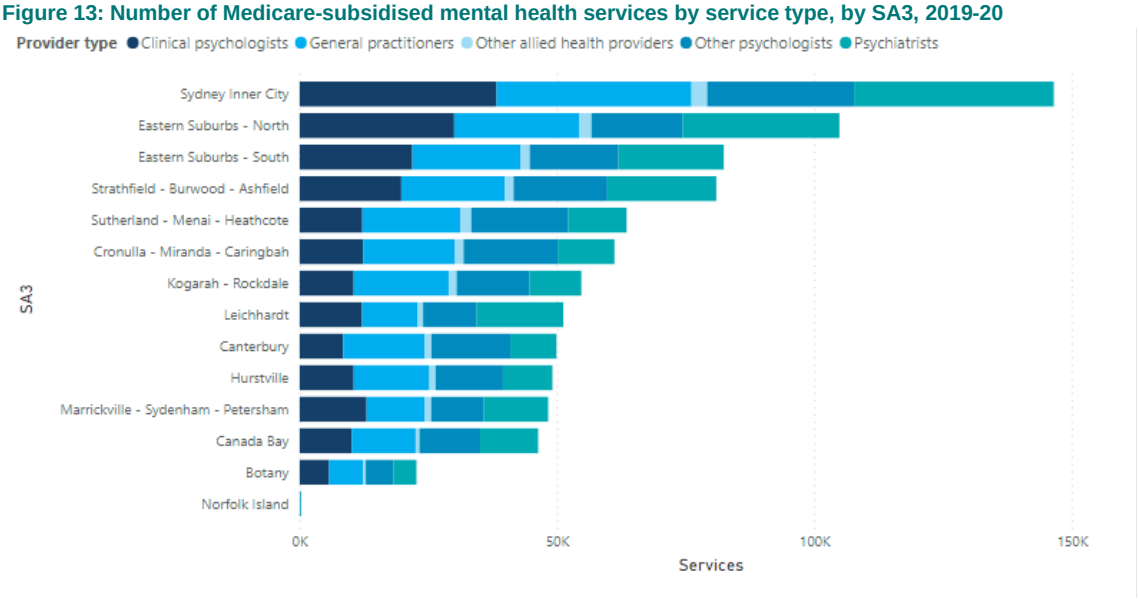


Source: AIHW, 2021

Across the CESPHN region, 23% of services were provided by general practitioners, within the region there is variation in the proportion of services provided by general practitioners ranging from 20.9% in

Leichhardt SA3 to 33.7% in Kogarah-Rockdale SA3. Leichhardt SA3 had the highest proportion of services provided by a psychiatrist (32.8%).(8)

Figure 13: Number of Medicare-subsidised mental health services by service type, by SA3, 2019-20



Source: AIHW, 2021

Mental health related prescriptions

In 2019-20, across the CESPHN region, there were 212,069 people who had a mental health related prescription under the PBS, giving a rate of 12.8 per 100 population. Almost six in ten patients (58.4%) were female and 41.6% were male. In this same year, almost 1.8 million mental health related prescriptions were filled, at a rate of 1,085.4 per 1,000 population.(8) In this same year, almost 1.8 million mental health related prescriptions were filled, at a rate of 1,085.4 per 1,000 population.

Across the five years to 2019-20, rates of patients per 100 population have remained stable. Rates of MH related prescriptions were relatively stable between 2015-16 to 2018-19, however there was a 5% increase in rates between 2018-19 and 2019-20.(8)

Table 2: Patients and prescriptions, CESPHN region, 2015-16 to 2019-20

Measure	2015–16	2016–17	2017–18	2018–19	2019–20
Number of patients	196,742.0	199,503.0	202,630.0	206,656.0	212,069.0
Patients per 100 population	12.8	12.7	12.6	12.7	12.8
Number of prescriptions	1,590,240.0	1,624,091.0	1,648,414.0	1,686,266.0	1,794,987.0
Prescriptions per 1,000 population	1,033.9	1,035.3	1,027.0	1,033.6	1,085.4

Source: AIHW, 2021

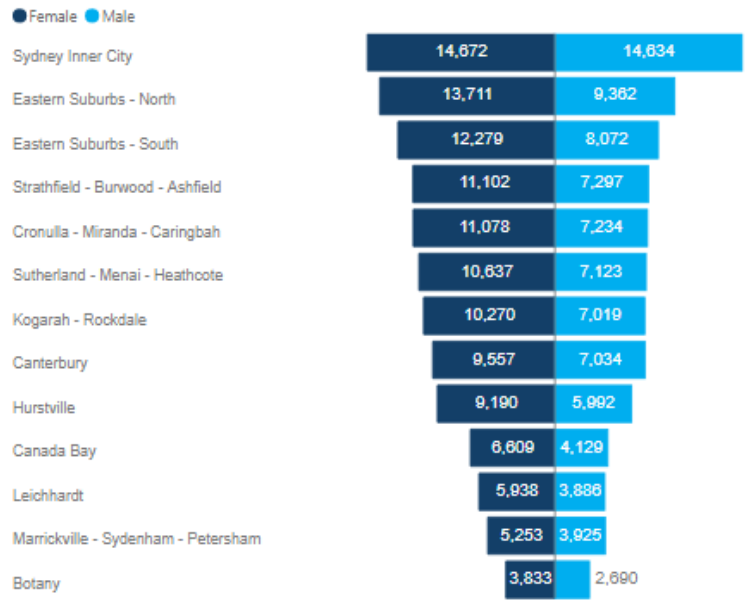
Within the CESPHN region in 2019-20, patients aged 45-54 years of age accounted for 17.1% of the patient profile, and 18% of prescriptions; this population group accounted for 11.9% of the CESPHN population. Those aged 55-64 years made up a further 15.4% of patients and 16% of prescriptions; this population group accounted for 10.3% of the CESPHN population.(8, 9)

Table 3: Patients and prescriptions by age group, CESPHN region, 2019-20

Age Group	Patients (%)	Prescriptions (%)
0–4 years	0.0	0.0
5–11 years	1.8	1.5
12–17 years	3.0	2.9
18–24 years	5.3	4.7
25–34 years	12.3	10.6
35–44 years	14.9	14.5
45–54 years	17.1	18.0
55–64 years	15.4	16.0
65–74 years	13.7	14.1
75–84 years	10.3	10.9
85 years and over	6.1	6.8
Total	100.0	100.0

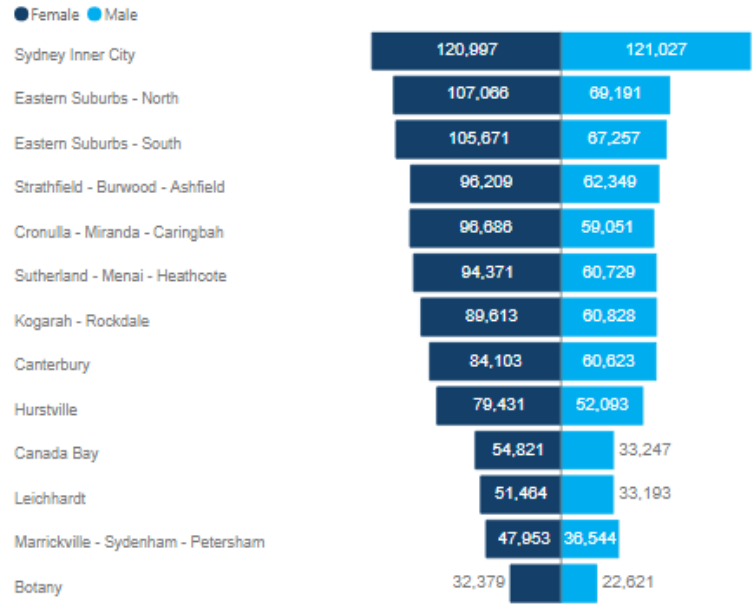
Source: AIHW, 2021

Figure 14: Patients sex by SA3, CESPHN region, 2019-20



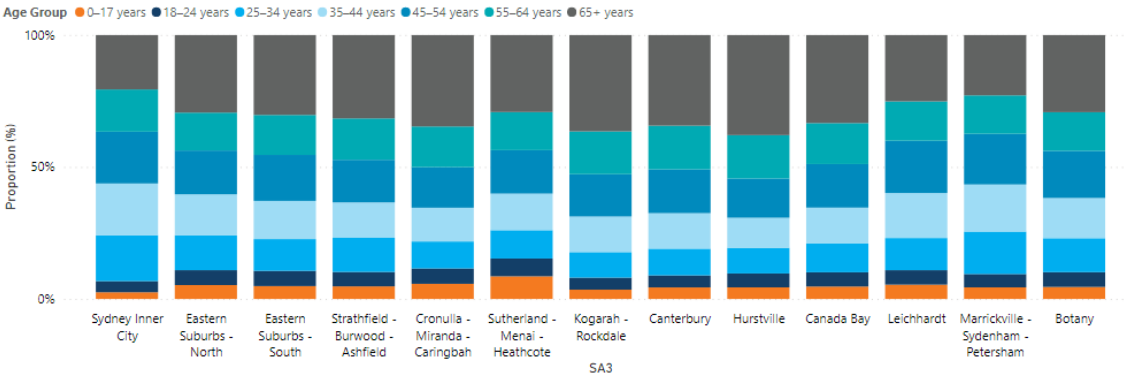
Source: AIHW, 2021

Figure 15: Prescriptions by sex by SA3, CESPHN region, 2019-20



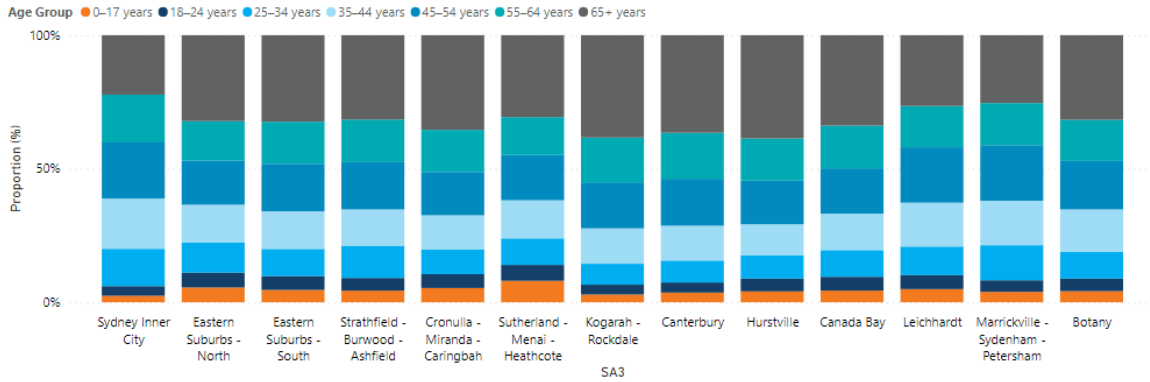
Source: AIHW, 2021

Figure 16: Patients by age group by SA3, CESPHN region, 2019-20



Source: AIHW, 2021

Figure 17: Prescriptions by age group by SA3, CESPHN region, 2019-20



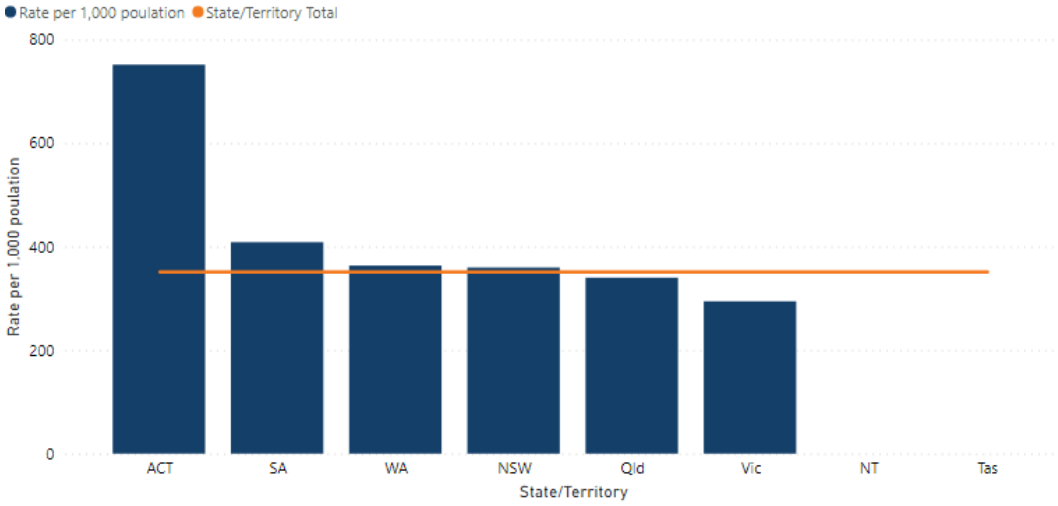
Source: AIHW, 2021

Community mental health care

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

In 2018-19 there were 2,166,545 service contacts provided in major cities in NSW by community mental health care. This equates to a rate of 359.7 service contacts per 1,000 population, slightly higher than state and territory totals of 351 per 1,000 population.(8) This equates to a rate of 359.7 service contacts per 1,000 population, slightly higher than State and Territory totals of 351 per 1,000 population.(8)

Figure 18: Community mental health service contacts, by state, 2018-19



Source: AIHW, 2021

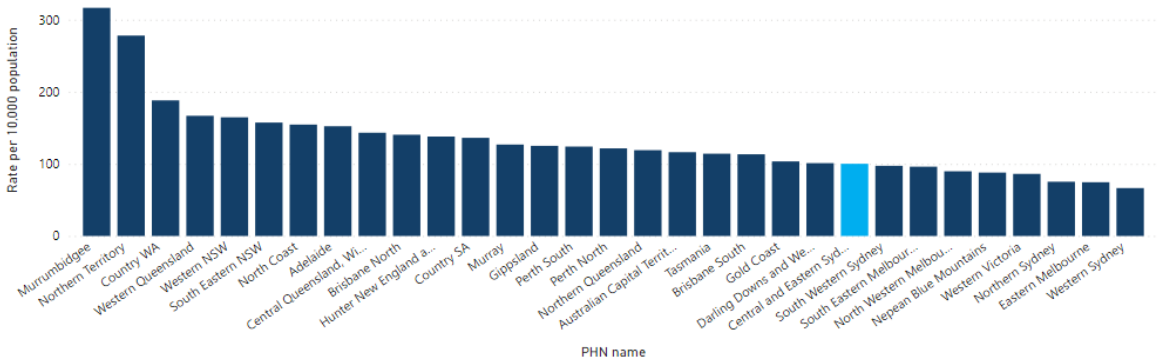
Hospitalisations for mental health conditions

Hospital emergency services

Between 2015-16 to 2019-20, there was a 3% average annual increase in the number of mental health related emergency department presentations, and a 1.7% average annual increase in the number of total emergency department presentations in the CESPHN region.

In 2019-20, there was 100.2 mental health related emergency department presentations per 10,000 population in the CESPHN region.

Figure 19: Mental health related emergency department presentations, PHN, 2019-20

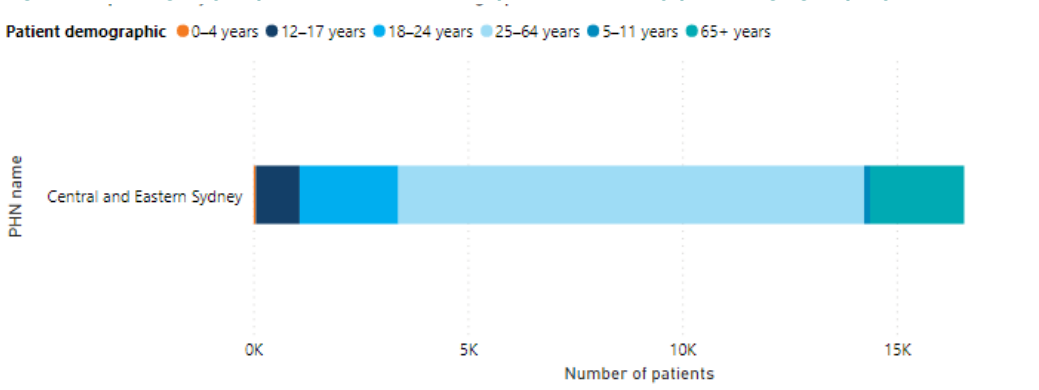


Source: AIHW, 2021

There were 16,573 mental health related emergency department presentations across the CESPHN region in 2019-20. Of these, 65.5% were individuals aged 25-64 years of age, followed by 18–24-year-olds (13.9%) and individuals aged 65 years+ (13.2%).

Almost nine percent (8.7%) of mental health related emergency department presentations in the CESPHN region were individuals who identified as Aboriginal.

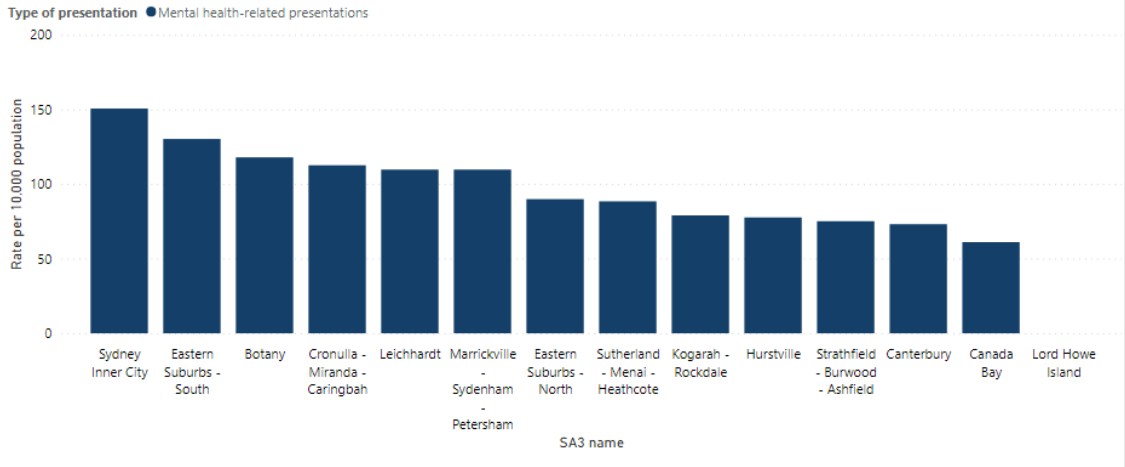
Figure 20: Emergency department mental health presentations, by patient age group, by PHN, 2019-20



Source: AIHW, 2021

Across the CESPHN region, Sydney Inner City SA3 had the highest proportion of mental health related emergency department presentations per 10,000 population (6.2%), followed by Leichhardt SA3 (4.7%) and Eastern Suburbs-South SA3 (4.5%).(8)

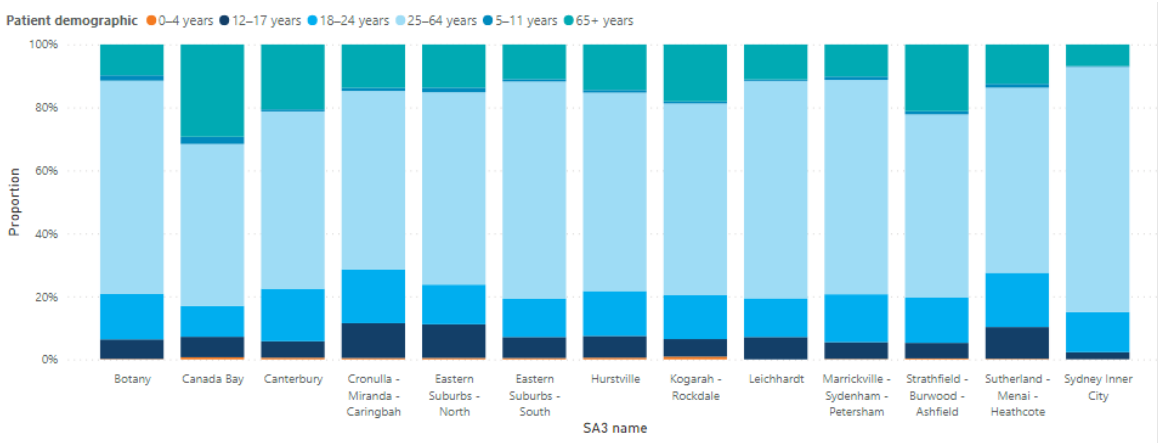
Figure 21: Emergency department presentations by SA3, 2019-20



Source: AIHW, 2021

Approximately 80% of presentations in the Sydney Inner City SA3 were individuals aged 25-64 years-old (77.8%). In Canada Bay SA3, almost one-third of presentations (29.3%) were individuals aged 65 years and over.(8)

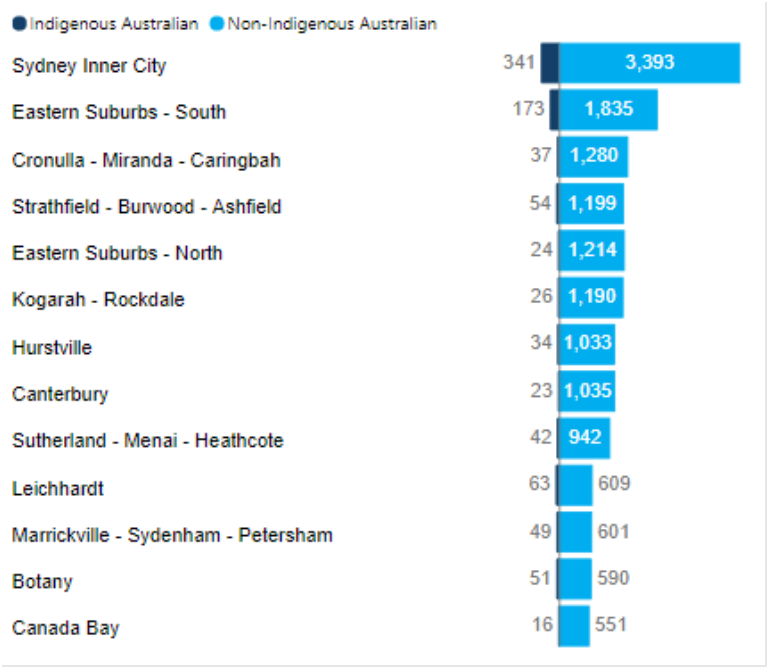
Figure 22: Emergency department mental health presentations, by patient age group, by SA3, 2019-20



Source: AIHW, 2021

Across the CESPHN region, 9.3% of mental health related emergency department presentations in the Leichhardt SA3 were individuals who identified as Aboriginal. Sydney Inner City had the second highest proportion with 8.9%, and Eastern Suburbs-South SA3 with 8.5%. Eastern Suburbs-North SA3 had the lowest proportion with 1.9%.(8)

Figure 23: Emergency department mental health presentations, by patient Indigenous status, by SA3, 2019-20



Source: AIHW, 2021

Overnight admitted mental health-related care

In 2018-19, there were 103.3 overnight admitted mental health-related separations per 10,000 population in the CESPHN region, slightly lower than the national average (107.1 per 10,000 population). There was a total of 1,561.4 patient days per 10,000 population, slightly higher than the national average (1,408.1 per 10,000 population). The majority (75%) of these patient days were for psychiatric care.

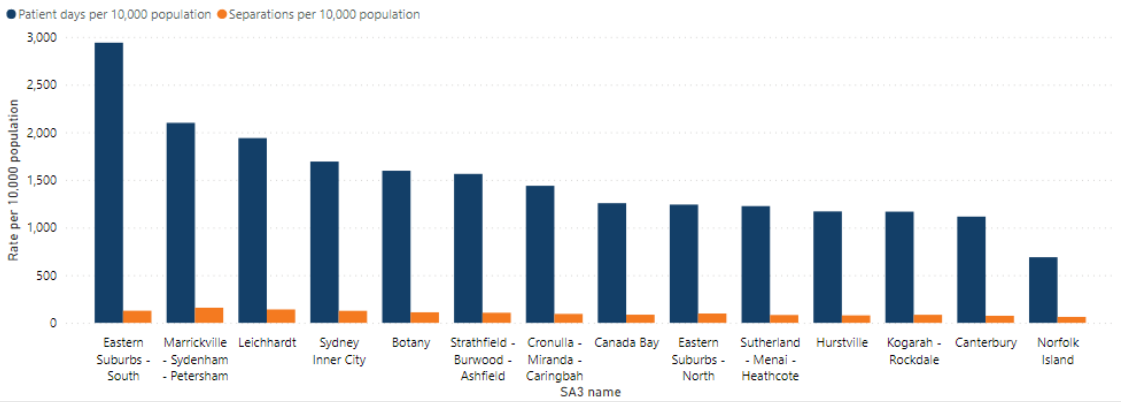
Table 4: Overnight admitted mental health related rates in the CESPHN region, 2018-19

PHN	Patient days per 10,000 population	Procedures per 10,000 population	Psychiatric care days per 10,000 population	Separations per 10,000 population
Central and Eastern Sydney	1,561.4	270.5	1,176.8	103.3

Source: AIHW, 2021

The highest number of overnight admitted mental health-related separations were recorded in Leichardt SA3 (129.3 per 10,000 population), Sydney Inner City SA3 (120.0 per 10,000 population) and Eastern Suburbs South SA3 (116.8 per 10,000 population).

Figure 24: Overnight admitted mental health related rates by SA3, 2018-19



Source: AIHW, 2021

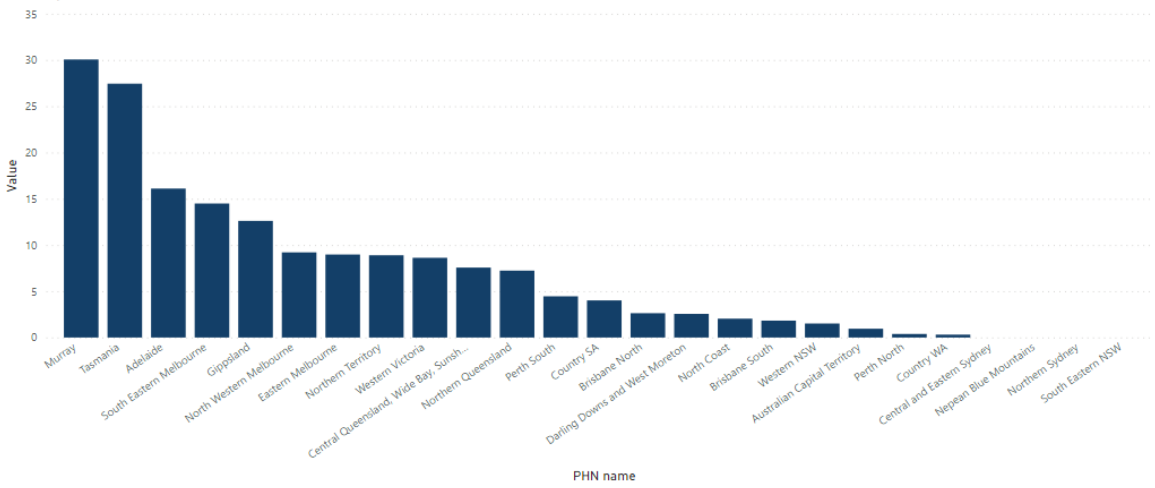
Same day admitted mental health-related care

There is no local level data for same day admitted mental health-related care. In 2018-19, there were 7.2 same day admitted mental health separations per 10,000 population in NSW.

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. There was no data for our region on residential mental health care services in 2018-19.

Figure 25: Residential mental health care, by PHN, 2018-19



Source: AIHW, 2021

Psychosocial disability (NDIS)

The CESPHN region is covered by two NDIS service districts, South Eastern Sydney and Sydney. As of 31 December 2020, 11.3% of participants from South Eastern Sydney and 16.4% of participants from Sydney had a primary disability of psychosocial disability. Both service districts have rates higher than the benchmark rate of 9.8% of participants.(10)

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 (2.88), Sydney (2.69) and benchmark (3.07).(10)

Nationally, where psychosocial disability was the primary disability, there was a 66.2% plan utilisation. Within the CESPHN region, this varied between service districts (71.7% in South Eastern Sydney and 64.5% in Sydney).

There were lower proportions of participants who reported that they chose who supported them within the service districts in CESPHN region; South Eastern Sydney had 45.6% of participants with primary disability of psychosocial disability who chose who supported them compared to 44% in Sydney and 53% 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 74.1%, Sydney 78.2%) compared to national benchmark (72.2%).(10)

Specialist homelessness services

In 2019-20, there were 25,375 clients with a mental health issue receiving specialist homelessness services in NSW. The top reasons clients with a mental health issue sought support were housing crises/inadequacy, family/domestic violence, and financial difficulties.

Psychiatry workforce

In 2020, there were 364 psychiatrists working in a clinician role in the CESPHN region (344.6 FTE) giving a rate of 21.9 per 100,000 population (20.7 FTE per 100,000 population), higher than the state and national rates for number of practitioners (12.8 and 13.7) and FTE (12.2 and 13.0) per 100,000 population respectively.(11)

Table 5: Psychiatrists by location, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	364.0	1,042	3,519.0
Number of Practitioners (rate per 100,000 population)	21.9	12.8	13.7
FTE Total	344.6	992.4	3,329.4
FTE Total (rate per 100,000 population)	20.7	12.2	13.0
FTE Clinical	293.6	860.5	2,914.5
FTE Clinical (rate per 100,000 population)	17.6	10.5	11.3

Source: HWA, 2021

Demographics

Fifty-six per cent (56.0%) of psychiatrists working across the CESPHN region in 2020 were male.(11)

In 2020, seven out of ten (70.1%) of FTE psychiatrists across the CESPHN region were aged 45 years and older, this is slightly lower than both the state and national rates of 73.9% and 72.2% respectively.(11)

Table 6: Proportion of psychiatric workforce by age groups and location, 2020

Age group	CESPHN (%)	NSW (%)	Australia (%)
20-34	2.0	2.6	3.4
35-44	27.9	23.5	24.6
45-54	28.6	34.5	33.2
55-64	22.4	22.5	23.8
65-74	14.3	13.1	12.5
75-99	4.8	3.8	2.7
Total	100.0	100.0	100.0

Source: HWA, 2021

Years intend to work

In 2020, 39% of psychiatrists in the CESPHN region intended to only work up to another 10 years. 100% of psychiatrists in Hurstville SA3 indicate that they intend to only work up to five more years. Almost 60% of psychiatrists in Leichhardt SA3 indicate that they do not intend to work more than ten years.(11)

Table 7: Psychiatrist years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Canada Bay	18.9	18.9	13.5	16.2	21.6	10.8	0.0
Canterbury	0.0	0.0	0.0	0.0	100.0	0.0	0.0
Cronulla-Miranda-Caringbah	0.0	40.0	30.0	30.0	0.0	0.0	0.0
Eastern Suburbs – North	27.5	22.5	12.5	17.5	20.0	0.0	0.0
Eastern Suburbs – South	15.7	5.9	9.8	21.6	39.2	7.8	0.0
Hurstville	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Kogarah-Rockdale	11.1	11.1	18.5	22.2	37.0	0.0	0.0
Leichhardt	41.2	17.6	23.5	17.6	0.0	0.0	0.0
Marrickville-Sydenham-Petersham	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	22.9	25.7	0.0	17.1	34.3	0.0	0.0
Sutherland-Menai-Heathcote	25.8	16.1	7.3	15.3	28.2	4.8	2.4
Sydney Inner City	22.6	16.4	10.9	17.0	27.9	4.5	0.8
CESPHN	18.9	18.9	13.5	16.2	21.6	10.8	0.0

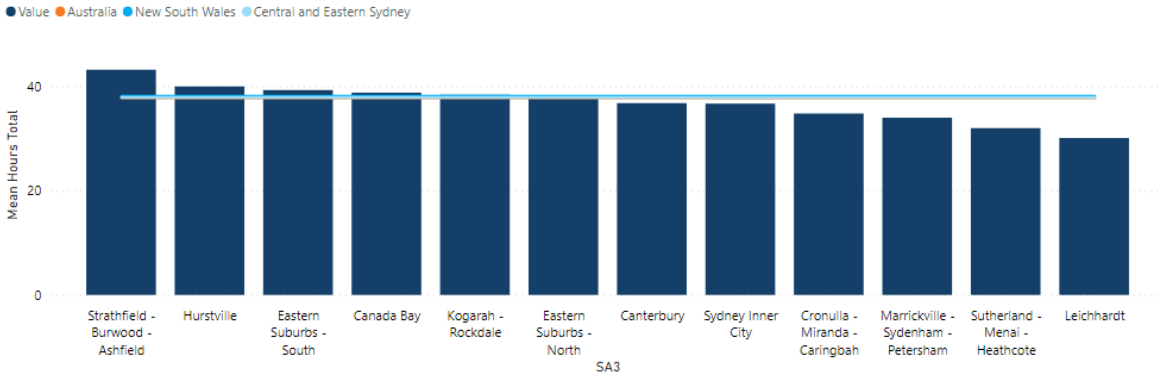
Source: HWA, 2021

Hours worked per week

Total hours

In 2020, on average psychiatrists in Australia worked 37.8 total hours per week, slightly lower than NSW where psychiatrists worked on average 38.1 total hours per week. In the CESPHN region, psychiatrists worked on average 37.9 total hours per week.(11) Average weekly working hours ranged from 43.2 hours per week in Strathfield-Burwood-Ashfield SA3 to 30.1 hours per week in Leichhardt SA3.(11)

Figure 26: Psychiatrist mean hours total by SA3, 2020

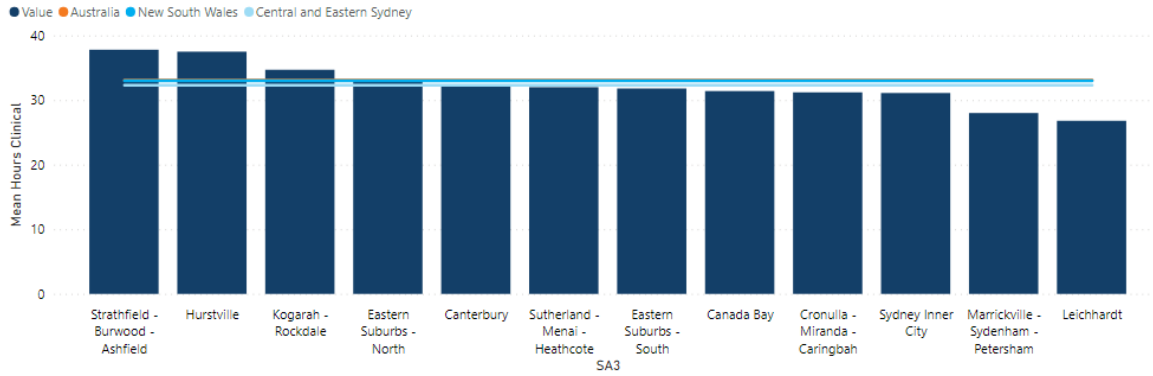


Source: HWA, 2021

Clinical hours

In 2020, on average psychiatrists in Australia worked 33.1 clinical hours per week, slightly higher than NSW where psychiatrists worked on average 33.0 clinical hours per week. Psychiatrists in the CESPHN region worked, on average, 32.3 clinical hours per week.(11) Average weekly clinical hours ranged from 37.8 hours in Strathfield-Burwood-Ashfield SA3 to 26.8 hours in Leichhardt SA3.(11)

Figure 27: Psychiatrist mean hours clinical by SA3, 2020



Source: HWA, 2021

Psychologist workforce

In 2020 there were 2,705 psychologists working in a clinical role in the CESPHN region (2,284.4 FTE) giving a rate of 162.4 per 100,000 population (137.2 FTE per 100,000 population), higher than the state and national rates for number of practitioners (114.0 and 110.0) and FTE (96.3 and 93.4) per 100,000 population respectively.(11)

Table 8. Psychologists by region, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	2,705	9,315.0	28,264
Number of Practitioners (rate per 100,000 population)	162.4	114.0	110.0
FTE Total	2,284.4	7,863.7	23,992.8
FTE Total (rate per 100,000 population)	137.2	96.3	93.4
FTE Clinical	1,851.4	6,435.9	19.536.4
FTE Clinical (rate per 100,000 population)	111.2	78.8	76.0

Source: HWA, 2021

Demographics

Eight in ten (81.1%) of psychologists working in the CESPHN region in 2020 were female.(11)

In 2020, approximately one-fifth (21.2%) of FTE psychologists across the CESPHN region were aged 20-34 years old, this is in line with both the state and national rates of 21.3% and 21.9% respectively; there is a higher proportion of psychologists aged 35-44 years in our region than state and national rates.(11)

Table 9: Proportion of psychologist workforce by age groups and location, 2020

Age group	CESPHN (%)	NSW (%)	Australia (%)
20-34	21.2	21.3	21.9
35-44	28.8	26.9	27.1
45-54	24.5	23.7	24.5
55-64	15.5	17.5	17.0
65-74	8.7	9.3	8.4
75-99	1.2	1.3	1.3
Total	100.0	100.0	100.0

Source: HWA, 2021

Years intended to work

Approximately one-third (32.2%) of psychologists working in the CESPHN region intend to work up to another 10 years. Of note, all psychologists currently working on Norfolk Island intend to work up to 5 years only. Approximately four out of every ten psychologists in Botany SA3 intend to work up to 10 years only.(11)

Table 10: Psychologist years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	17.4	21.7	17.4	26.1	0.0	17.4	0.0
Canada Bay	17.4	18.3	11.0	19.3	24.8	5.5	3.7
Canterbury	13.7	12.3	6.8	28.8	20.5	13.7	4.1
Cronulla-Miranda-Caringbah	9.2	20.9	11.1	27.5	20.3	8.5	2.6
Eastern Suburbs – North	14.5	17.3	10.5	25.0	21.6	9.0	2.2
Eastern Suburbs – South	15.7	13.9	12.5	18.2	23.9	12.5	3.2
Hurstville	14.6	14.6	9.7	21.4	26.2	10.7	2.9
Kogarah-Rockdale	14.4	20.3	12.7	19.5	24.6	5.9	2.5
Leichhardt	18.4	16.3	17.0	22.7	13.5	12.1	0.0
Marrickville-Sydenham-Petersham	17.3	20.0	13.3	14.7	21.3	9.3	4.0
Norfolk Island	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	21.8	16.8	13.4	20.7	19.6	7.8	0.0
Sutherland-Menai-Heathcote	18.4	19.3	12.3	17.5	17.5	12.3	2.6
Sydney Inner City	14.4	16.1	9.5	21.1	25.1	11.3	2.5
CESPHN	15.5	16.8	11.2	21.5	22.5	10.4	2.2

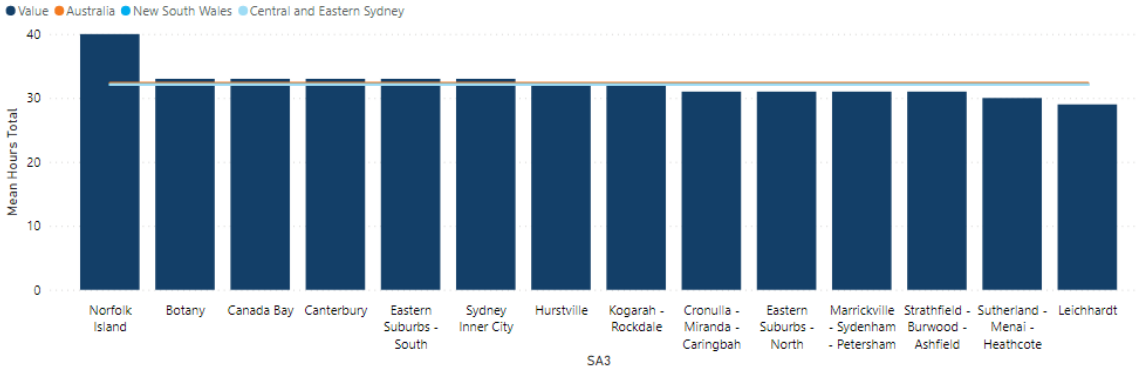
Source: HWA, 2021

Hours worked per week

Total hours

In 2020, on average psychologists in Australia worked 32.3 total hours per week, slightly higher than NSW where psychologists worked on average 32.1 total hours per week. Across the CESPHN region, psychologists worked 32.1 total hours per week.(11) Average weekly working hours ranged from 40 hours per week on Norfolk Island to 29 hours per week in Leichhardt SA3.

Figure 28: Psychologist mean hours total by SA3, 2020

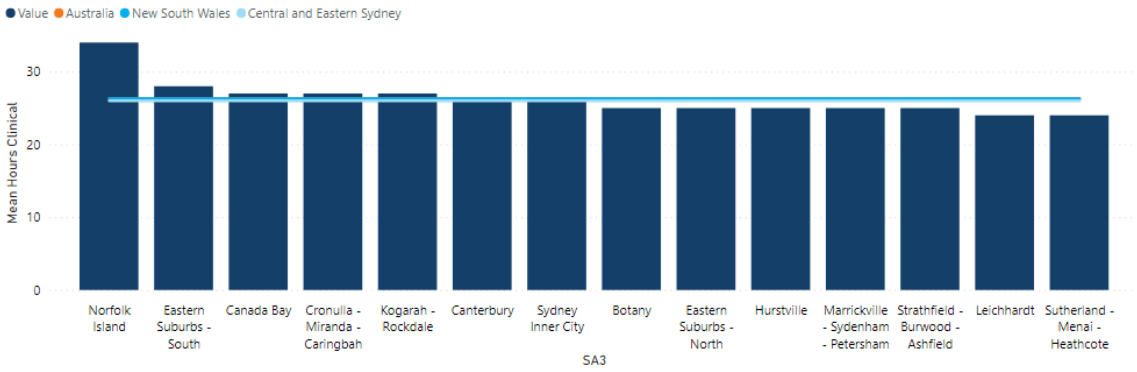


Source: HWA, 2021

Clinical hours

In 2020, on average psychologists across both Australia and NSW worked 26.3 clinical hours per week. Psychologists in the CESPHN region worked, on average, 26.0 clinical hours per week.(11) Average weekly clinical hours ranged from 34.0 hours on Norfolk Island to 24.0 hours in Sutherland-Menai-Heathcote SA3.

Figure 29: Psychologists mean hours clinical by SA3, 2020



Source: HWA, 2021

Mental health nurse workforce

In 2020 there were 1,428 mental health nurses working in a clinician role in the CESPHN region (1,400.1 FTE) giving a rate of 85.7 per 100,000 population (84.1 FTE per 100,000 population), higher than the state rates for number of practitioners (82.1) and FTE (79.0) per 100,000 population respectively.(11)

Table 11: Mental health nurses by region, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	1,428	6,709.0	23,347.0
Number of Practitioners (rate per 100,000 population)	85.7	82.1	90.9
FTE Total	1,400.1	6,451.2	22,008.7
FTE Total (rate per 100,000 population)	84.1	79.0	85.7
FTE Clinical	1,367.8	6,282.1	21,468.3
FTE Clinical (rate per 100,000 population)	82.1	76.9	83.6

Source: HWA, 2021

Demographics

Two-thirds (66.6%) of mental health nurses working in the CESPHN region in 2020 were female.(11)

In 2020, over one-third (39.0%) of FTE mental health nurses across the CESPHN region were aged 20-34 years old, this is higher than both the state and national rates of 27.8% and 25.9% respectively.(11)

Table 12: Proportion of mental health nurse workforce by age groups and location, 2020

Age group	CESPHN (%)	NSW (%)	Australia (%)
20-34	39.0	27.8	25.9
35-44	24.2	22.7	22.4
45-54	17.3	22.0	23.4
55-64	14.8	21.4	22.8
65-74	4.4	6.0	5.3
75-99	0.3	0.2	0.2
Total	100.0	100.0	100.0

Source: HWA, 2021

Years intended to work

In 2020, 42.0% of mental health nurses in the CESPHN region intended to only work up to another 10 years. Of note, 100% of mental health nurses working in the Sutherland-Menai-Heathcote SA3 indicate that they do not intend to work more than 10 years. More than half of mental health nurses in Strathfield-Burwood-Ashfield (57.8%) and Eastern Suburbs North (56.5%) SA3's do not intend to work more than 10 years and 50% in Hurstville SA3 intend to work up to 5 years.(11)

Table 13: Mental health nurse years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Canada Bay	21.2	21.2	10.6	14.7	21.2	6.9	4.1
Canterbury	15.0	30.0	25.0	15.0	15.0	0.0	0.0
Cronulla-Miranda-Caringbah	16.9	16.9	9.1	26.0	13.0	14.3	3.9
Eastern Suburbs – North	13.0	43.5	0.0	17.4	13.0	0.0	13.0
Eastern Suburbs – South	21.5	19.2	10.1	20.6	17.8	8.2	2.6
Hurstville	50.0	0.0	50.0	0.0	0.0	0.0	0.0
Kogarah-Rockdale	17.4	22.6	12.2	10.4	23.5	10.4	3.5
Leichhardt	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Marrickville-Sydenham-Petersham	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	35.3	22.5	9.8	15.7	7.8	3.9	4.9
Sutherland-Menai-Heathcote	0.0	100.0	0.0	0.0	0.0	0.0	0.0
Sydney Inner City	21.5	18.2	9.1	18.9	17.8	11.4	3.0
CESPHN	21.7	20.3	10.7	17.9	17.5	8.6	3.4

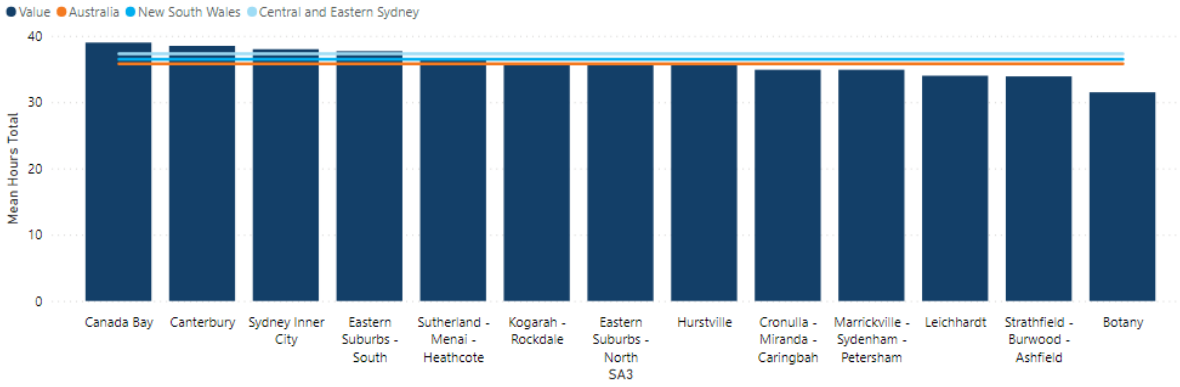
Source: HWA, 2021

Hours worked per week

Total hours

In 2020, on average mental health nurses in Australia worked 35.8 total hours per week, slightly lower than NSW where mental health nurses worked on average 36.5 total hours per week. Across the CESPHN region, practice nurses worked 37.3 total hours per week.(11) Average weekly working hours ranged from 39 hours per week in Canada Bay SA3 to 31.5 hours per week in Botany SA3.(11)

Figure 30: Mental health nurses mean hours total by SA3, 2020

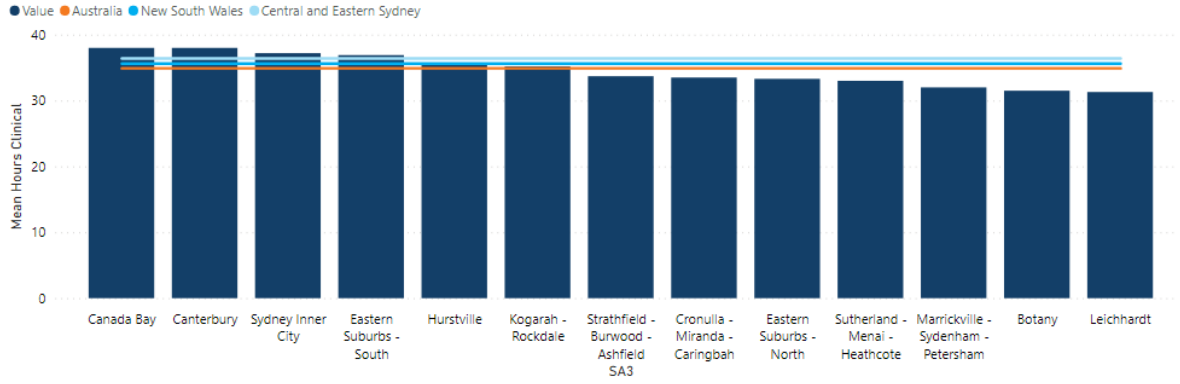


Source: HWA, 2021

Clinical hours

In 2020, on average mental health nurses in Australia worked 34.9 clinical hours per week, slightly lower than NSW where mental health nurses worked on average 35.6 clinical hours per week. Mental health nurses in the CESPHN region worked, on average, 36.4 clinical hours per week.(11) Average weekly clinical hours ranged from 38 hours in Canada Bay SA3 to 31.3 hours in Leichhardt SA3.(11)

Figure 31: Mental health nurses mean hours clinical by SA3, 2020



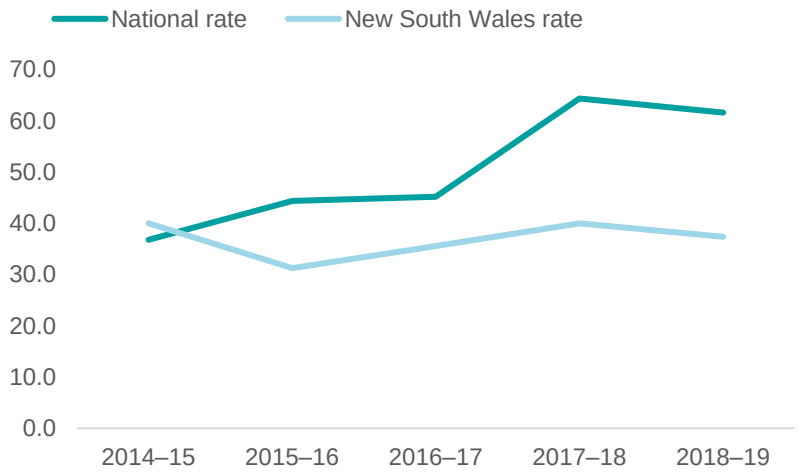
Source: HWA, 2021

It has been reported that a large proportion of the mental health nurse workforce was redeployed throughout various stages of the COVID-19 pandemic. It is still unknown what ongoing affects this will have and when this workforce will return to business as usual.

Peer workforce

In 2018-19 there were 37.3 (FTE) consumer peer workers per 10,000 mental health care providers in NSW who worked within the public health system. This is lower than the national rate of 61.6 (FTE) consumer peer workers per 10,000 mental health care providers. The rate of consumer peer workers in NSW has remained relatively stable over the last five years, however the rate has increased nationally. It is important to note that there is a limitation to this data as The National Mental Health Establishments Database does not capture peer workers outside the public mental health system. Figures (numbers) reported are an underestimate of (lower than) total peer workers in NSW.(12)

Figure 32: Rate of consumer peer workers (FTE) per 10,000 Mental Health Care Providers



Source: AIHW, 2021

Community managed workforce

In 2021, the community managed organisation (CMO) mental health workforce in NSW was:

- Estimated to be 5,838 paid workers, including direct care, managers and administrators, and 2,429 volunteers. In terms of the paid workforce, this translates to 3,911.3 FTE or 28% of the total mental health workforce in NSW
- Female dominated (72% of workers are female) and young (64% of workers are aged under 45 years)
- Primarily made up of mental health support workers (49%), followed by consumer peer workers (14%), support coordinators (8%), allied health (6%) and psychiatrist/ other medical practitioner (4%).(12)

Just over half (52%) of the CMO workforce was employed on a permanent basis, with the remainder of the workforce being employed on a temporary basis. The majority (54%) of the workforce was employed on a part time basis. Most CMOs surveyed in 2021 believe a further increase in workforce numbers, with higher skill levels, will be demanded in the future.(12)

Service gaps

Service gaps identified through consultation and program feedback include:

Workforce:

- Recruitment issues due to current workforce shortages in the mental health sector and changes to MBS Better Access sessions in 2020.
- Lack of identified and bi-lingual positions to engage with Aboriginal peoples and CALD individuals.
- Lack of access to psychologists, particularly for people in RACFs as there is a lack of financial incentive for psychologists to provide visits to RACFs.
- Lack of clinicians trained in geriatric psychology /psychiatry.
- Low access to bulk billing psychiatric care in the region and few psychiatrists working in outpatient services for GPs to refer their patients to.
- Low access to affordable child and adolescent psychiatrists across the region
- Hesitancy of service providers to use translation services such as TIS.
- Support and training needed for GPs to confidently identify people who would benefit from the MBS items for eating disorders.
- Support and training needed for GPs to confidently provide care to people with complex mental health needs.
- Challenges for GPs to seek and receive timely advice on medication management from a psychiatrist.

Coordination and integration:

- Referrer confusion about appropriate referral pathways to services and general service navigation.
- Service planning and continuity of care is challenging with time limited funding.
- Poor cross collaboration between services within the sector.
- Excessive information and regular changes to service availability and service modalities leading to confusion, particularly for the CALD communities.
- Lack of communication processes for patient discharge information between LHD services and PHN commissioned services, to ensure the individual is linked to the most appropriate service and is well supported during the transition of care.
- Need for improved pathways for transition of care for severe mental health consumers being discharged from hospital to community programs.
- Lack of information sharing on availability of mental health services.

Digital technologies

- Lack of infrastructure to offer digital options for RACF residents.
- Improved technological solutions are needed for referral forms such as smart forms.
- Poor uptake of telehealth due to technology fatigue, difficulties accessing/ using technology, lack of privacy when using the technology, with individuals deferring care until COVID-19 safe face to face services become available.

- There has been a drop in health professionals offering telehealth support in the recent COVID-19 outbreak (from June 2021) and people are finding supports (GP, psychologist, psychiatrist) difficult to engage with or unavailable to them.
- Insufficient use of secure messaging or MyHealth Record across different professions.

Low intensity services:

- Wait times for headspace centres.
- Increased complexity of mental health needs of clients presenting at low intensity services, causing increased pressure on services.

Moderate intensity services:

- Increasing demand causing longer wait times to access PSS services.
- Challenges with identifying mental health needs in older people from CALD backgrounds, and their willingness to engage with services, particularly if services are not culturally appropriate.
- Affordable access to psychometric assessment and neuropsychological assessment.
- Affordable access to dieticians as part of the Eating Disorder treatment plans
- Lack of sufficient services specifically for the treatment of personality disorders and eating disorders in primary care.
- Increased complexity of mental health needs of clients presenting at moderate intensity services, causing increased pressure on services.
- Reduced access to evidence-based treatment, in particular group therapy, due to COVID-19 restrictions as telehealth options are not suitable for some therapeutic approaches or for some cohorts.
- Lack of mental health services in Canterbury LGA particularly for youth.
- Lack of funding and services to diagnose and treat people with neurodiversity.

High intensity services:

- Some Aboriginal people and CALD individuals have difficulty accessing psychosocial services. Canterbury was also identified as an area with inequitable access to psychosocial services.
- Service providers have observed increased psychosocial needs in Sydney Inner City and Inner West particularly for people from Chinese speaking backgrounds for which there is a lack of culturally appropriate services.
- There are higher levels of referrals than can be supported by the Youth Enhanced Services and lower availability of appropriate LHD child and youth services. Long wait times for Aboriginal youth access to mental health services at LHD's have also been reported. This is increasing pressure on headspace services.
- There is a lack of mental health services that address physical health needs at the same time as mental health needs. Increasing demand for metabolic clinic and physical health care for those with a mental health diagnosis. There is a backlog of health screening and assessment plans for health screening due to appointments during lockdown being postponed meaning there will be a need for surge staff to meet demands after lockdown.
- A need for a model of shared care which includes upskilling of GPs to manage individuals prescribed clozapine. Higher engagement with GPs is required to decrease pressure on LHD run clinics and provide consumers with a choice in the setting in which they are more comfortable to receive care.

- Lack of longer-term referral options are available for people with severe mental illness with complex needs who require care coordination to assist their recovery but are not eligible for the NDIS. Increased referral out options are needed including outreach programs and step-down options from psychosocial programs.
- Lack of services specifically for the treatment of personality disorders in primary care, and few options at the community and sub-acute level.
- Lack of clinicians in the region trained in providing DBT and a lack of confidence to deliver this intervention. The lack of clinicians, and high demand for DBT services has caused long waitlists for the limited services currently available. Group DBT including those targeted at young people specifically is needed. LHD DBT services have paused during the COVID-19 pandemic due to staff being deployed elsewhere, or the need to deliver this service face to face rather than by telehealth.
- Both Connect & Thrive and Primary Integrated Care Supports (PICS) programs have a large waiting list with long wait times (approximately 8 weeks); particularly in the areas of Newtown, Marrickville and Burwood.
- Community consultations indicated the following unmet psychosocial needs: housing, lack of community engagement, isolation and loneliness, education, daily living skills, and employment.
- Limited opportunities for families, friends, and carers to be involved in support.
- Challenges reaching out to and engaging with complex severe mental illness (SMI) clients who are homeless or rough sleepers where it is difficult to access and gain trust.
- Upskilling opportunities for commissioned services staff in providing support like housing, welfare, advocacy, Centrelink, education– the cohort of people referred into psychosocial services experiencing SMI often present with highly complex additional support needs including crisis support.
- Upskilling and training for commissioned services staff on housing, welfare, Centrelink processes and procedures would be highly beneficial not only to the workforce but in ensuring people referred into mental health programs receive the wraparound support they need

Suicide prevention services:

- A need for services addressing people (including family/ carers/ friends) who are impacted by attempted suicide who require support.
- A need for better integration and coordination between services, sharing of data/ clinical documentation between service providers as people often present at different hospitals in our region, and more awareness of services available to reduce hospital emergency admissions from intentional self-harm.
- Lack of primary care professionals identifying individuals at risk of attempting suicide.
- Appropriate aged care supports and potential gate keeper training of GPs, Primary Care nurses and community pharmacists for older people who have attempted suicide or experience suicidal ideation (whether in residential care or living independently in community).
- Supporting police to respond to a mental health crisis.
- Bilingual or culturally appropriate services.
- Youth suicide prevention:
- Lack of youth friendly service providers and services
- Need for peer support networks and more resilience and health promotion strategies.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Alcohol and other drugs

2022-2024 Needs Assessment

15 November 2021

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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List of figures

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 disorder
- 465 will have a benzodiazepine misuse disorder
- 2,300 will have a cannabis misuse disorder
- 793 will have a non-medical opiate (including heroin) misuse disorder.

The table below translates these rates to the current and future populations (aged 10 years and over) of the CESPHN region.(1) 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, 2020 and 2036

Drug disorder type	Standard rate (per 100,000 people)	2020 prevalence *	2036 prevalence **
Alcohol	8,838	132,505	158,954
Methamphetamine	646	9,685	11,619
Benzodiazepine	465	6,972	8,363
Cannabis	2,300	34,483	41,366
Non-medical opiate	793	11,889	14,262
Total	13,042	195,535	234,564

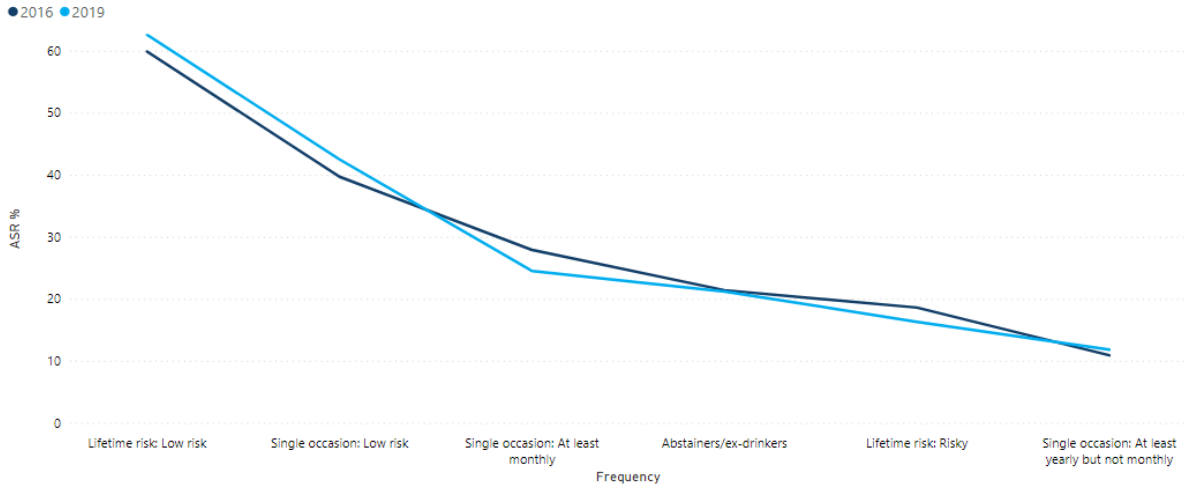
Sources: CESPHN 2020, *ABS 2021, **HealthStats 2021

2019 National drug strategy household survey

In 2019, 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).(2)

Recent 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 1: 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 2020 NSW IDRS sample comprised 155 people aged 18 years or older who injected illicit drugs at least once monthly in the preceding six months and resided in Sydney.(3)

Over half of the NSW sample (57%) reported that heroin was their drug of choice, with 55% of participants reporting heroin was also the drug they injected most often in the past month, similar to findings in previous years.(4) The use of methamphetamine has gradually been increasing while cocaine use has generally decreased since the beginning of monitoring.

Recent non-prescribed buprenorphine naloxone, oxycodone and codeine use significantly decreased in 2020. Non-prescribed benzodiazepine use also declined significantly from 2019 (41%) to 2020 (27%). Almost one-third (31%) reported having an injection-related health issue in the past month, a significant decrease from 2019 (46%), 47% self-reported a mental health problem in the six months prior to interview and 56% were in drug treatment at the time of interview.(4)

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 2020 NSW EDRS sample comprised 100 people who regularly use ecstasy and other illicit stimulants in Sydney.(3)

Over one third (35%) of the NSW sample reported cannabis as their drug of choice. Ecstasy was the next most common drug of choice (18%), followed by alcohol (15%) and cocaine (12%).(3)

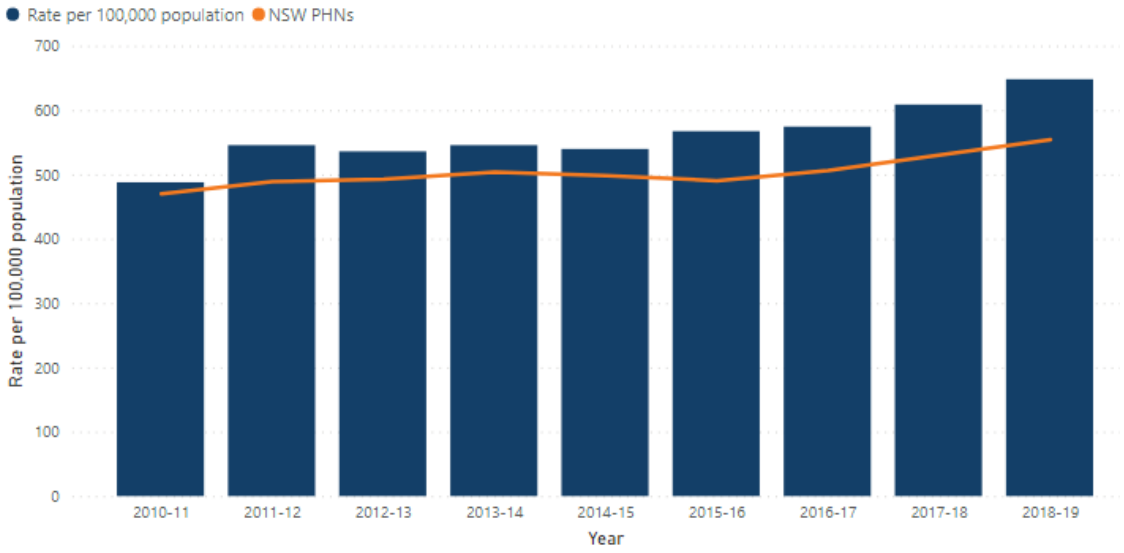
Weekly or more frequent use of ecstasy had been declining since the commencement of monitoring but increased from 12% in 2019 to 21% in 2020. There has been a significant decline in the use of the crystal form from 68% in 2019 compared to 47% in 2020.(3)

Recent use of any methamphetamine has also been declining since the commencement of monitoring from 87% in 2003 to 17% in 2020. Recent use of cocaine has been increasing with the largest proportion reporting any recent use recorded in 2020 (84%).(3) Most consumers reported infrequent use of cocaine (7% weekly or more).

Hospitalisations

In 2018-19, there were 11,086 alcohol-related hospital admissions (including rehabilitation admissions) in the CESPHN region. Almost two-thirds (60.7%) of hospital admissions were males. CESPHN has a higher rate of hospitalisations (648.1 per 100,000 population) than the NSW rate (554.1 per 100,000 population).(5)

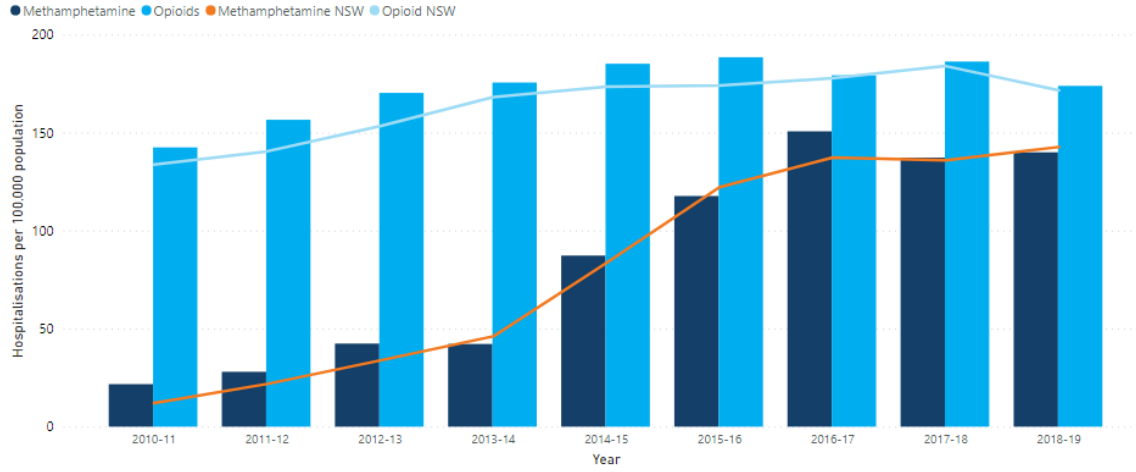
Figure 2: Alcohol related hospitalisations, CESPHN region, 2010-11 to 2018-19



Source: HealthStats NSW, 2020

Hospitalisation rates for opioids continue to be higher (173.9 per 100,000 population) than hospitalisation rates for methamphetamine (140.0 per 100,000 population) in the CESPHN region. However, the rates of methamphetamine hospitalisations increased significantly between 2013-14 and 2016-17 whereas opioid hospitalisations remained relatively stable over this period. The same trends are seen for NSW.(5)

Figure 3: Hospitalisation rates for methamphetamines and opioids, CESPHN region, 2010-11 to 2018-19



Source: HealthStats NSW, 2020

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 Local Health Network. There are also non-government organisations (NGOs) who have both widely applicable models of care and specifically targeted models of care. 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 (as provided by NADA and HealthPathways)

Organisation	Service
2 Connect	St George Youth Services
Alcoholics Anonymous (AA), Narcotics Anonymous (NA)	Self-help, peer led support groups.
ACON	ACON Substance Support Service
Aboriginal Medical Service	Drug and Alcohol Treatment Program
Exodus Youth Worx	Youth Support Services
Haymarket Foundation	Haymarket Foundation Bourke Street Project
	Haymarket Foundation Centre HIV/AOD Program
	Haymarket Foundation Waitlist Support Program
Odyssey House McGrath Foundation	Odyssey House Community Services
Salvation Army	Alf Dawkins Detox

	William Booth House
	Pathways Maroubra
Salvation Army OASIS Youth Sydney	SA Oasis Youth Drug and Alcohol Program/Choices
St Vincent de Paul Society	Continuing Coordinated Care Program
SMART Recovery Australia	SMART Recovery Groups
Ted Noffs Foundation	Program for Adolescent Life Management (PALM)
The Station Ltd	The Station
Waverley Drug and Alcohol Centre	Waverley Drug and Alcohol Centre
Waverley Action for Youth Services WAYS	Waverley Action for Youth Services WAYS
Womens Alcohol and Drug Advisory Centre	Jarrah House Detoxification
Wayback Committee	Jarrah House Rehabilitation
Alcohol and Drug Foundation NSW	Kathleen York House Aftercare
	Kathleen York House Residential
	Kathleen York House Transition
Catholic Care Holyoake	Holyoake Family AOD Program
Co.As.It.	Co.As.It.
Construction Industry Drug and Alcohol Foundation	Foundation House
Community Restorative Centre	Alcohol & Other Drugs Transition Project
Drug and Alcohol Multicultural Education Centre (DAMEC)	Drug and Alcohol Counselling for CALD communities (Culturally and Linguistically Diverse background)
Glebe House	Glebe House
Grace Manor	Grace Manor
Guthrie House	Guthrie House
Leichhardt Women's Community Health Centre	Leichhardt Women's Community Health Centre
Mission Australia	MA Centre - Drug and Alcohol Program
Sydney Women's Counselling Centre	Sydney Women's Counselling Centre
Weave Youth and Community Services Inc	WEAVE
WHOS	WHOS Sydney Gunyah
	WHOS Sydney MTAR Men
	WHOS Sydney New Beginnings
	WHOS Sydney OSTAR2
	WHOS Sydney Peppercorn
	WHOS Sydney RTOD
	WHOS Sydney Women's MTAR

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).(6)

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

Drug type	Assumption of Misuse Treated rate			Assumption of overall prevalence Treated Rate (%)	Estimated quantum needed 2020
	Mild (%)	Mod (%)	Severe (%)		
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.(1)

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.(7)

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 2019-20, there were 70 government funded AOD treatment services in the CESPHN region that provided 7,772 closed treatment episodes. This equates to 533.33 episodes or 327.37 clients per 100,000 population.

Client demographics

In 2019-20, there were 4,770 clients of publicly funded AOD treatment services in the CESPHN region. Of these clients:

- 97.7% attended for their own drug use
- 65.8% were male and 34.0% female
- 27.2% were aged 30-39 years, 25.0% aged 40-49 years, 21.0% aged 20-29 years, 13.9% aged 50-59 years, 7.2% aged 10-19 years and 5.7% aged 60+ years
- 11.5% were Aboriginal and Torres Strait Islander people (here in referred to as Aboriginal people).(8)

Principal drug of concern

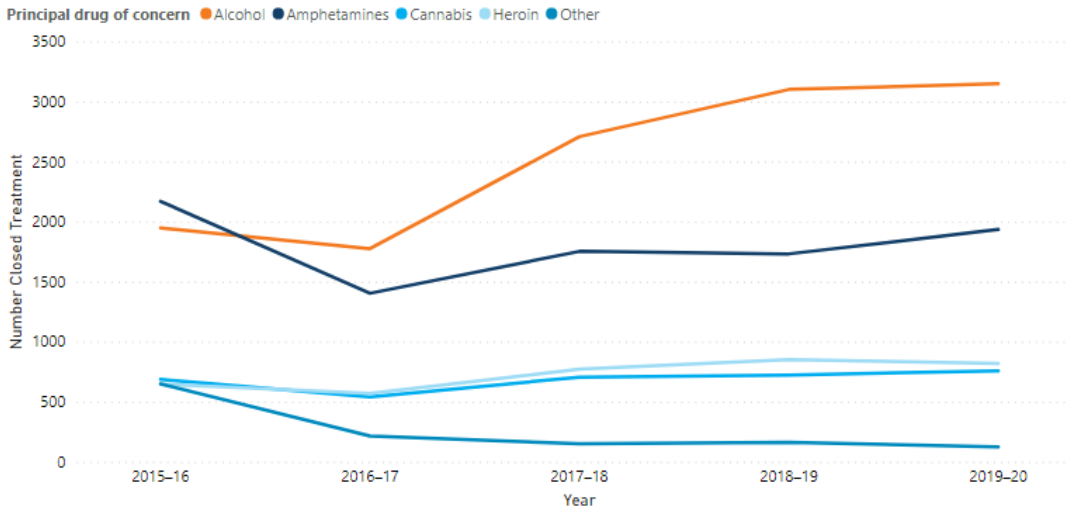
In 2019-20, the four most common principal drugs of concern for which clients sought treatment were alcohol (38.7% of all clients), amphetamine (25.5%), cannabis (11.3%), and heroin (10.7%). These were also the top four principal drugs of concern nationally – alcohol (32.7%), amphetamines (27.5%), cannabis (20.9%) and heroin (4.8%).(8)

Between 2015-16 and 2019-20, the number of closed treatment episodes with alcohol as the principal drug of concern increased by 62% (from 1,949 to 3,149 episodes). Across this same time period, alcohol was the most common principal drug of concern except in 2015-16 where it was amphetamines.

While only accounting for a small number of episodes, the following principal drugs of concern have seen an increase in closed treatment episodes between 2015-16 and 2019-20:

- Benzodiazepines from 114 to 250 episodes
- Cocaine from 89 to 244 episodes
- Other sedatives and hypnotics from 10 to 86 episodes.

Figure 4: Number of closed treatment episodes by principal drug of concern, CESPHN region, 2015-16 to 2019-20



Source: AIHW, 2021

Stakeholders have confirmed that methamphetamines and alcohol are the two most commonly occurring sources of substance related problems 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 clients accessing LHD AOD services are requiring support for pharmaceutical misuse – opioids, benzodiazepines, gabapentin, quetiapine, and some GHB (gamma hydroxybutyrate). While it has been more difficult for clients to obtain benzodiazepines by prescription, stakeholders report there has been an increase in illicit distribution.

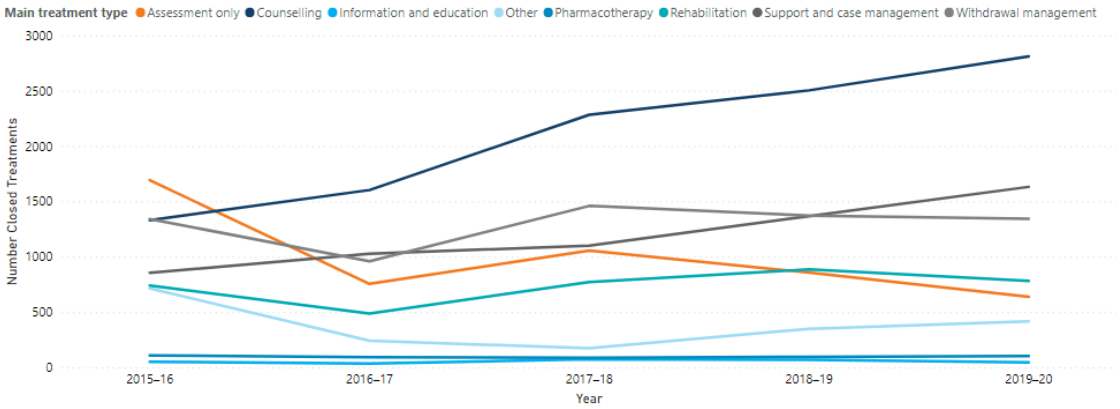
The most relevant changes in drugs of choice since 2016 has been the increase in benzodiazepine use and decrease in oxycontin use. Aboriginal participants commented on an increased use among adolescents particularly of 'Yarndi' (cannabis) and benzodiazepines. It was also noted that co-morbidities associated with drug use are becoming more concentrated in treatment populations.

Treatment type

In 2019-20, counselling was the most common main treatment type provided to clients (41.2% of all clients), followed by support and case management (21.5%), withdrawal management (13.5%) and rehabilitation (7.9%). Compared to national figures, the CESPHN region had a much higher percentage of clients whose main treatment type was support and case management (21.5% compared to 12.6%), withdrawal management (13.5% compared to 6.5%) and rehabilitation (7.9% compared to 4.9%).(8)

Counselling has been the most common main treatment type since 2016-17. The number of closed treatment episodes for support and case management has steadily increased and is now the second most common main treatment type. Since 2017-18 we have seen a decline in the number of closed treatment episodes for withdrawal management and assessment only. The small decline in rehabilitation services observed between 2018-19 and 2019-20 may be due to reduced face-to-face services during the COVID-19 pandemic.

Figure 5: Number of closed treatment episodes by main treatment type, CESPHN, 2015-16 to 2019-20



Source: AIHW, 2021

Source of referral

In 2019-20, just over half (51%) of all closed treatment episodes had a source of referral as self/ family. The next most common source of referral was a health service (33% of closed treatment episodes).(8)

Treatment setting

In 2019-20, the majority (68%) of closed treatment episodes were provided in non-residential treatment facilities, followed by residential facilities (30%). There were very low numbers of treatment episodes provided in outreach settings (106 episodes) and in the client's home (37 episodes).(8)

Primary care

There are no specific drug and alcohol 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.

We expect that the majority of GPs would be seeing patients who have alcohol and other drug problems 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.

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 early 2020 that there were 96 pharmacies dosing in the CESPHN region and a further 16 private/ public clinics. Botany and Canada Bay SA3 had the lowest number of dosing points.

Table 6: OTP dosing points by SA3, CESPHN region, 2020

SA3	Dosing point sites
Botany	1
Canada Bay	3
Canterbury	9
Cronulla-Miranda-Caringbah	7
Eastern Suburbs – North	7
Eastern Suburbs - South	13
Hurstville	8
Kogarah-Rockdale	13
Leichhardt	10
Marrickville-Sydenham-Petersham	4
Strathfield-Burwood-Ashfield	8
Sutherland-Menai-Heathcote	5
Sydney Inner City	24
Total	112

Source: NSW Ministry of Health, 2020

NSW Health also advised in early 2020 that there were 306 OTP prescribers in the CESPHN region. This equates to 14% of all GPs in the region and indicates a low percentage of GPs in the region who are confident, capable, and willing to engage in prescribing of pharmacotherapy options for opioid dependency.

For a prescriber to provide OTP to a patient they can prescribe unaccredited with limited capacity or complete the opioid treatment accreditation (OTAC) course followed by a half day clinical placement to become accredited with the NSW Ministry of Health Opioid Pharmacotherapy Subcommittee. In NSW, just under half (47%) of prescribers who complete the OTAC course became accredited. From January 2018 to August 2021, 94 prescribers completed the OTAC course in the CESPHN area and would be eligible to apply for accreditation to prescribe opioid treatment.

There is a need to safely transition clients from the public OTP clinics to private 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 depot buprenorphine can be administered outside of public clinics
- Incentivising the uptake of clients on OTP for GPs who have recently completed the OTAC course
- Adequate renumeration (i.e. MBS) for what is often complex and time-consuming work
- Ongoing support, mentoring and CPD/training
- Stigma and discrimination training.

This feedback has been obtained through recent work undertaken into opioid treatment in SESLHD, revising the model of care post-COVID19 and discussions with LHD Drug and Alcohol representatives, NGOs, addiction specialists, GPs and shared care nurses.

Priority populations

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.

In 2018-19, an estimated 27% of the Aboriginal population in NSW had used substance(s) in the previous 12 months. Modelled estimates at the PHN level suggests that 33.5% of the Aboriginal population in the CESPHN region had used substance(s) in the previous 12 months.(9)

Table 7: Substance use in NSW, 2018-19

Substance use	Males (%)	Females (%)	Total NSW (%)
Used substance(s) in last 12 months	33.2	21.6	26.7
Has not used substance(s) in last 12 months	65.9	76.6	72.5

Source: ABS, NATSIHS 2019

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.

Culturally and linguistically diverse (CALD) communities

It is difficult to identify rates of alcohol and other drug use in CALD communities as national surveys tend to be administered in English and there are limitations in the way data is collected. While the 2019 NDSHS suggests that overall AOD rates amongst CALD respondents are lower than non CALD communities, people from CALD populations are underrepresented in AOD treatment and when in treatment are less likely to be connected to appropriate support services.(10)

The Drug and Alcohol Multicultural Education Centre (DAMEC) has identified a need for clinical standards and a culturally appropriate assessment framework to provide cultural perspectives on substance use and treatment, guide the development of specific program models and design, support the identification of the specific needs of CALD communities and improve access, treatment and client outcomes. DAMEC has also noted that alcohol and methamphetamine continue to be the primary drugs of concern for clients accessing their service.

Research has highlighted that people who inject image and performance enhancing drugs (IPADs) 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 CALD groups.(11)

Young people

According to the 2019 NDSHS the age at which people first tried alcohol has risen over time from 14.7 years in 2001 to 16.2 years in 2019. There has also been an increase in the proportion of young people who abstain from alcohol. However, young people aged 18-24 years are the most likely of all

age groups to exceed the single occasion risk guidelines at least monthly (41%). This age group also has the highest estimates of illicit drug use in the last 12 months (31%). Cannabis, cocaine and ecstasy are the illicit drugs most commonly used by people aged 18–24 years.

The 2017 Australian Secondary School Students Survey of Alcohol and Drug Use (ASSAD) found fewer students are drinking alcohol since 2011 (down from 74% to 66%), with 15% drinking in the last week. Use of illicit drugs remains low in this group with 2% having used opiates, 2% cocaine and 3% ecstasy.(12)

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.

Young people have reported feeling more anxious and isolated during the COVID-19 pandemic. Aside from the risks associated with the virus itself, stressors include the loss of employment, closure of recreational sites and restrictions on socialising and travel, education and opportunities to engage with their community. These stressors can have negative impacts on financial security and overall mental health and emotional wellbeing. There is a need to provide holistic care for young people that supports not only drug and alcohol needs but also mental health needs.

LGTBIQ communities

The 2019 National Drug Strategy Household Survey found that in comparison to heterosexual people, gay, lesbian or bisexual people were:

- 1.5 times as likely to smoke daily
- 1.5 times as likely to exceed the lifetime risk guideline to reduce the harm from drinking alcohol
- 9.0 times as likely to have used inhalants in the previous 12-months
- 3.9 times as likely to have used meth/amphetamines in the previous 12-months
- 2.6 times as likely to have used ecstasy in the previous 12-months.(2)

Respondents of the Sydney Women and Sexual Health (SWASH) Lesbian, Bisexual and Queer Women's Health Survey 2020 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).(13) 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 2018.

CESPHN has consulted with ACON on their recent experiences of delivering services to the gender and sexuality diverse communities during the COVID-19 pandemic. The following observations were noted:

- The impact of the COVID-19 pandemic has led to loss of social connections, triggering AOD relapses. Risk of harm appear to have increased due to reduced use/tolerances post lockdowns. Drugs of particular concern include methamphetamine and GHB/L. There has also been an increase in alcohol and tobacco use. Alcohol, methamphetamine and cannabis continue to be the substance of concern for people accessing treatment.

- Treatment settings continue to be difficult to access due to high demand – for this reason it's important that there is a focus on health promotion around other supports for harmful/ dependent patterns of use that is accessible for GP, counsellor/psychologist, peer support, groups like Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery.
- The 2021 lockdown (compared to the 2020 lockdown) has seen less engagement with services, with an increase in cancellations and no shows indicative of loss of motivation, sense of helplessness and hopelessness.
- In general, Telehealth has proven to be clinically effective, with high levels of client engagement and retention. For some clients, their engagement in Telehealth counselling has been the first time they have sustained a clinical engagement, as it has enabled them to feel safer and more secure. For other clients seeking AOD counselling, they are hesitant or reject Telehealth options, indicating their preference for in-person services despite there being an unknown (and possibly lengthy) delay due to lockdown.
- Lack of access to LGBTIQ inclusive GPs or no pre-existing relationship with a GP is a critical gap in people accessing support.
- There is a need for more GPs to offer home based supported withdrawal and detox for alcohol and cannabis and for GPs to offer non-judgmental psychoeducation around impacts of methamphetamine use on physical and mental health particularly to people living with HIV.
- There is a gap in LGBTIQ therapeutic groups for DBT skills development augmenting AOD treatment and short-term relapse prevention groups online and in-person.
- There is currently a wait for access as demand continues to grow for the CESPHN funded ACON service.

People experiencing homelessness

People experiencing homelessness have higher prevalence rates of drug and alcohol dependence disorders than the general population. Data from the 2015 Homelessness Inner City Registry Week showed 72% of people experiencing homelessness in the Sydney LGA reported substance use issues and 64% reported having both substance use and mental health issues .(14)

From consultations with service providers in the region, it has been noted that there have been impacts to people experiencing homelessness during the COVID-19 pandemic. Some service sites that provide a range of drop-in services and supports for people have temporarily closed, with many clients and organisations unaware of the often-changing opening hours, availability, and access.

Additionally, people experiencing homelessness may not have access to mobile phones, data or technology to connect with services that have moved to providing AOD 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.

Many homelessness services offering temporary accommodation have also reduced the number of clients residing on premises due to COVID-19 social distancing regulations. It is unclear how long the rapid housing response can be sustained, and it is noted that alongside housing, individuals often require a variety of additional supports which may not always be available and require coordination.

People in contact with the criminal justice system

In 2020, 19,866 individuals were released from NSW adult correctional centres, and more than 50% of this cohort will return to prison within two years.(15) 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 majority of people in prison have AOD use that is associated with their incarceration.(16) 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.

Consultation with service providers reveals:

- Clients are commonly using MDMA, cannabis and benzodiazepines, although there are reports that benzodiazepines are harder to acquire and therefore more expensive. There has also been a shift from heroin to crystal methamphetamines among this group.
- 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.

Service gaps

Service availability and navigation

Service accessibility and the matching of services to localised need were commonly referenced, with the Sutherland Shire raised as an area with poor access. Alongside this was a general reference to the lack of outreach services targeting difficult to reach cohorts.

The majority of participants in the consultation process expressed support for increased access to support services that addressed the multitude of problems generally associated with a significant substance misuse problem. 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.

Improvements in care co-ordination and team-based service provision were also raised as models of care that should be pursued. Access to psychology, nutrition, medical and social work were all necessary to provide holistic care. A role for pharmacists as potential treatment co-ordinators was also raised. Services to support people with gambling and gaming addiction was noted by stakeholders as an emerging need.

There was interest amongst participants in assistance with better pathway navigation through the service system as extensive amounts of staff time were being utilised in trying to match clients to service eligibility criteria. It was felt by some that service connection initiatives and the building of inter-service relationships may assist in addressing this.

During the pandemic as pharmacists, GPs and allied health professionals are focussed on the COVID-19 response and related mental health supports, this has led to delays in accessing these services. Similarly private counselling has waiting lists which creates additional strain for GPs relying on use of mental health care plans to support patients. It was also reported that IDAT (Involuntary Drug and Alcohol Treatment) program currently has significant waiting times and is not admitting clients living in LGAs of concern.

A steadily rising need for opioid treatment was noted by many stakeholders, with increasing demand placed on public health OTP clinics. This is worsened by large numbers of people exiting custody who have been placed on depot buprenorphine 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.

With the move of many services towards telehealth, it is recognised that this is not a one size fits all solution and some community groups face barriers to using telehealth and risk falling through the cracks. A recent paper by Turning Point points out that clients of AOD treatment services often do not have computer access, have poor digital literacy, cannot afford internet access and have no private space to meet. While telephone is an alternative it lacks the ability to assess clients as effectively.

Services should consider alternatives to overcome barriers for these clients to ensure equitable access to essential treatment.(17)

To address some of the above needs, CESPHN has commissioned The Salvation Army to open a new Pathways program in Miranda, which commenced in July 2021, to provide care coordination, counselling, drug and alcohol support, and therapeutic group programs. CESPHN has also co-commissioned with other NSW PHNs a new GP-led home-based alcohol withdrawal project to support eligible patients, via regular video consultations with a GP and AOD Nurses, to withdraw from alcohol as well as provide aftercare support and follow up.

Methamphetamine use and interventions

Surveys have found that the prevalence of methamphetamine use, including crystal methamphetamine, has remained the same but the harm has increased significantly.(18) Submissions to the NSW Inquiry into the Drug 'Ice' from research centres and medical bodies speculates that this may be due to a decrease in new users and an increase in harm arising from purer forms of crystal methamphetamines and different methods of use.

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.(19) 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.

Residential rehabilitation beds

The general lack of availability of residential rehabilitation beds across the state was a strong theme from the consultation. In addition, the need for culturally appropriate rehabilitation for Aboriginal people was raised. 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.

Residential rehabilitation bed availability has been reduced due to COVID-19, with the need to reduce bed numbers to comply with social distancing regulations. Also, the number of people accessing residential rehabilitation centres has reduced; many services are supporting clients to obtain COVID-19 tests and vaccinations prior to entry and have slowed down their intake rate in order to facilitate the increased activities required.

Co-morbidities associated with drug use

Dealing with mental health co-morbidities in the context of AOD use was a central theme in almost every consultation. More than 1 in 3 with a substance use disorder have at least one mental health disorder and the rates are even higher among people in substance use treatment.(20) 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 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.

Services for Aboriginal people

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. 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 highlighted the relationship between suicide and drug misuse 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.

Services for priority populations

The lack of specific services for women and the lack of utilisation of services from people from a CALD background were noted by consultation participants.

Numerous participants noted the low proportion of CALD clients within AOD services, compared to the CALD population living within the CESPHN region. Poor access to interpreter services was raised as a barrier to participation for these clients and some participants questioned whether specialist transcultural counselling services could be used to bridge this gap.

The link between drug and alcohol use and violence was a common theme in the consultation. This was in relation to both domestic violence and other forms of violence. The impact of polydrug use on decision-making in this regard was referenced. Early intervention and population wide culture change programs were both discussed as important service gaps to respond to the significant harms associated with violence in the community.

Stakeholders referred to the dearth of available services for those recently released from the prison system, and the impact this has on relapse. Case management of this cohort was described as short term, inadequate and ineffective. The interface between unavailability of accommodation and subsequent AOD relapse was noted. Potential partnerships with boarding house providers was seen as a possible service response to this gap.

Physical co-morbidities were also noted. Addressing hepatitis C in AOD populations and within the correctional system was considered a high priority. The impact of extensive stimulant use on general physical welfare, including dental hygiene, was also raised. Lack of access to pain management services and the potential impact on opioid misuse was raised by clinicians participating in the consultation.

It was considered beneficial to engage the community regarding AOD issues. Workshops and forums where CESPHN could lead discussion, and potentially address stigma, were considered a valuable opportunity.

Workforce development

Support was also expressed for workforce development initiatives that improve the capacity of the existing AOD workforce to address the complexity of substance misuse. This could include awareness and screening for blood borne viruses, dealing with the issues associated with post prison release, having basic skills in mental health assessment and interventions and addressing the specific cultural needs of communities within the CESPHN region including Aboriginal people and those who identify as LGBTIQ. Improvements by mainstream services in providing services with cultural competence and inclusiveness were desired by many participants.

There was substantial commentary on the benefits of better information dissemination and education for general practice on responding to drug disorders. The greater availability of specialist advice for GPs was also referenced, and access to training regarding trauma informed care.

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Access, coordination and integration

2022-2024 Needs Assessment

15 November 2021

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Access to primary care

General practitioners (GPs) are the first point of contact for most people seeking health care, with 83.1% of the population in the CESPHN region seeing a GP in the last 12 months.(1) Over half (53.9%) of our stakeholder survey respondents said they get most of their health care from a regular GP or family doctor, a quarter of respondents said specialist doctor and 22.4% said pharmacist.

In 2020-21, there were 10,007,960 GP attendances in the CESPHN region. This equates to an age standardised rate of 589 services per 100 people (or 5.9 services per person), slightly lower than the national average of 627.8 per 100 people.(2)

There were more specialist attendances in the CESPHN region (123.6 per 100 people) compared to the national average (93.8 per 100 people), reflecting the large number of specialists located within the region. However, stakeholder feedback indicates that patients still experience barriers in accessing outpatient clinics and/or specialist services, particularly those from lower socioeconomic backgrounds.

Rates for other Medicare-subsidised services (allied health and diagnostic imaging) in the CESPHN region were similar to national rates.

Table 1: Medicare-subsidised services per 100 people (age standardised), CESPHN region, 2020-21

Medicare-subsidised service	CESPHN	Metropolitan	Australia
Allied health attendances (total)	98.5	101.4	97.7
Diagnostic imaging (total)	98.9	101.9	100.6
GP attendances (total)	589.0	649.7	627.8
Specialist attendances (total)	123.6	100.6	93.8

Source: AIHW, 2021

In 2020-21, Sydney Inner City SA3 had the highest number of GP attendances (n=1,156,438), Canterbury SA3 had the highest rate per 100 people within the CESPHN region (734.4 per 100 people).(2)

Table 2: GP attendances by SA3, CESPHN region, 2020-21

SA3	No. services	Services per 100 people
Botany	340,279	601.7
Canada Bay	596,664	636.3
Canterbury	1,080,436	734.4
Cronulla-Miranda-Caringbah	829,667	695.1
Eastern Suburbs – North	795,643	570.4
Eastern Suburbs – South	850,015	542.8
Hurstville	887,985	638.9
Kogarah-Rockdale	979,367	626.7
Leichhardt	349,516	566.0
Lord Howe Island*	n.p.	n.p.
Marrickville-Sydenham-Petersham	346,901	576.5
Norfolk Island	n.p.	n.p.
Strathfield-Burwood-Ashfield	1,015,206	593.3
Sutherland-Menai-Heathcote	815,169	724.1
Sydney Inner City	1,156,438	451.6
CESPHN	10,007,960	600.9

Source: AIHW, 2021

* No data published for Lord Howe or Norfolk Islands

Bulk billing

In 2016-17, 88.6% of GP attendances were bulk billed in the CESPHN region, compared to 85.7% nationally. Canterbury SA3 had the highest bulk billing rate (97.9%) in the CESPHN region.

Out-of-pocket costs

In 2020-21, the total out of pocket cost for GP attendances was $44,156,740 ($4.41 per GP attendance) in the CESPHN region. Eastern Suburbs-North SA3 had the highest out of pocket cost at $10,631,530 ($13.36 per GP attendance).(2)

Table 3: GP attendances total out of pocket by SA3, CESPHN region, 2020-21

SA3	Out of pocket	Average out of pocket per service
Botany	$1,042,348.00	$3.06
Canada Bay	$1,839,786.00	$3.08
Canterbury	$793,460.00	$0.73
Cronulla-Miranda-Caringbah	$3,450,501.00	$4.16
Eastern Suburbs – North	$10,631,530.00	$13.36
Eastern Suburbs – South	$4,686,980.00	$5.51
Hurstville	$1,924,849.00	$2.17
Kogarah-Rockdale	$1,674,342.00	$1.71
Leichhardt	$3,298,935.00	$9.44
Lord Howe Island*	n.p.	n.p.
Marrickville-Sydenham-Petersham	$1,688,886.00	$4.87
Norfolk Island	n.p.	n.p.
Strathfield-Burwood-Ashfield	$2,351,225.00	$2.32
Sutherland-Menai-Heathcote	$2,864,207.00	$3.51
Sydney Inner City	$7,909,736.00	$6.84
CESPHN total	$44,156,740.00	$4.41

Source: AIHW, 2021

* No data published for Lord Howe or Norfolk Islands

Patient experience

In 2019-20, patients from the CESPHN region overall reported positive health care experiences and access opportunities compared to national responses. Ninety per cent, or more, of respondents from the CESPHN region indicated that they felt their GP always or often listened, showed respect, and spent enough time, mirroring national responses.

Regarding cost measures, overall CESPHN residents reported lower proportions of people experiencing cost as a barrier to care compared to nationally. This pertained to GP access, prescriptions, and dental care.

The proportion of individuals in the CESPHN region who reported waiting longer than acceptable to see a GP was in-line with national rates. However, there was a higher proportion of people in the CESPHN region who reported having to wait longer than acceptable to see a medical specialist (71.2% compared to 68.6%).(1)

Table 4: Patient experience measures, CESPHN region and Australia, 2019-20

Patient experience measure	CESPHN (%)	Australia (%)
Adults who felt their GP always or often listened carefully	92.4	92.3
Adults who felt their GP always or often showed respect for what they had to say	95.1	94.6
Adults who felt their GP always or often spent enough time	90.0	90.9
Needed to see a GP but did not	12.0	13.9
Adults who did not see a GP due to cost	1.7	3.8
Adults who delayed or avoided filling a prescription due to cost	5.4	6.6
Adults who did not see or delayed seeing a dentist, hygienist or dental specialist due to cost	13.2	19.1
Adults who felt they waited longer than acceptable to get an appointment with a GP	18.6	19.0
Adults referred to a medical specialist who waited longer than they felt acceptable to get an appointment	71.2	68.6

Source: AIHW, 2021

The main barriers to accessing health services in the CESPHN region, as identified in our stakeholder survey, were:

- Impacts of COVID-19 (68.4%)
- Finding the right service (57.9%)
- Feeling comfortable/safe to access services (56.6%)
- Having time to attend the service (55.2%)
- Waiting times (53.9%)
- Specific services not available (52.6%).

Dental care

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, Commonwealth Seniors Health Card.

As at March 2021, there were 1,342 children and 24,275 adults waiting for public dental assessments and treatment in Local Health Districts (LHDs) within the CESPHN region.(3) The COVID-19 pandemic put restrictions on dental services during lockdown which has seen the waitlist increase since mid-2020 when restrictions were eased. Note that these figures reflect the LHD where the service was provided, not patients' LHD of residence and does not include patients who are waiting for specialist dental services.

Table 5: Number of patients waiting for public dental treatment or assessment by LHD in CESPHN region, March 2021

Local Health District	Child assessment	Child treatment	Adult assessment	Adult treatment
South Eastern Sydney	1,115	0	1,700	6,599
Sydney	222	5	1,532	14,444
Total	1,337	5	3,232	21,043

Source: NSW Health, 2021

After hours

Almost half (47.4%) of respondents of our stakeholder survey said the hospital emergency department is the service they would most likely use during the after-hours period, followed by telephone advice line (42.1%) and regular GP or family doctor (35.5%).

Practice incentive payments

As at May 2018, 58% of general practices in the CESPHN area were receiving a Practice Incentive Payment (PIP) for After Hours services. Of the practices receiving the After Hours PIP, 67% were accessing Level 1.(4)

For the purposes of the After Hours PIP, the complete after hours period is outside of 8am to 6pm weeknights, outside of 8am to 12pm Saturdays and all-day Sunday and public holidays. The complete after hours period is further broken into:

- Sociable after-hours period:
  - 6pm to 11pm weeknights

- Unsociable after-hours period:
  - weeknights between 11pm and 8am,
  - outside 8am and 12pm Saturdays, and
  - all day Sunday and public holidays.

Table 6: After-hours PIP practices in CESPHN region, May 2018

After Hours PIP level	No. practices	After Hours PIP practices (%)
1 - Formal arrangements in place to ensure practice patients have access to care in the complete after hours period.	241	67
2 - Cooperative arrangement with other general practices that provides after hours care to practice patients in the sociable after hours period, and formal arrangements to cover the unsociable after-hours period.	34	9
3 - Provide after-hours care to practice patients directly through the practice in the sociable after hours period and formal arrangements to cover the unsociable after-hours period.	26	7
4 - Cooperative arrangement with other general practices that provides after hours care to practice patients for the complete after hours period.	12	3
5 - Provide after hours care to practice patients in the complete after-hours period.	46	13
Total	359	100

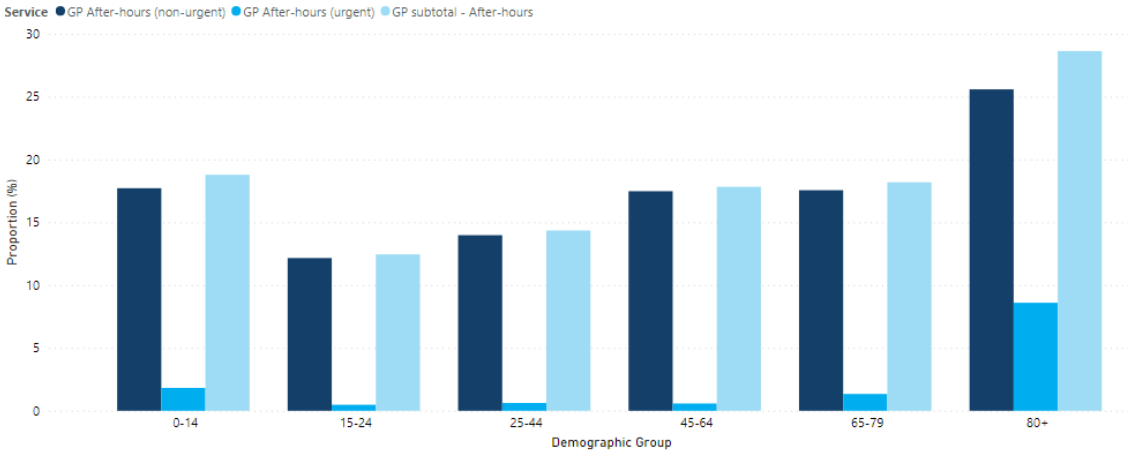
Source: Department of Health PHN Practice Incentives Program Data 2018

Medicare-subsidised services

In 2020-21, 274,576 people (16% of the population) in the CESPHN region received an after hours GP service. There has been a 14.4% decrease in the number of patients receiving an after hours GP service since 2013-14.(2) People were more likely to receive a non-urgent after hours GP service (15.9%) than an urgent after hours GP service (1.2%). A higher proportion of females received an after hours GP service than males (17.3% compared to 15.7%). People aged 80 years and over were

most likely to receive an after hours GP service (28.6%), followed by people 14 years and younger (18.8%).(2)

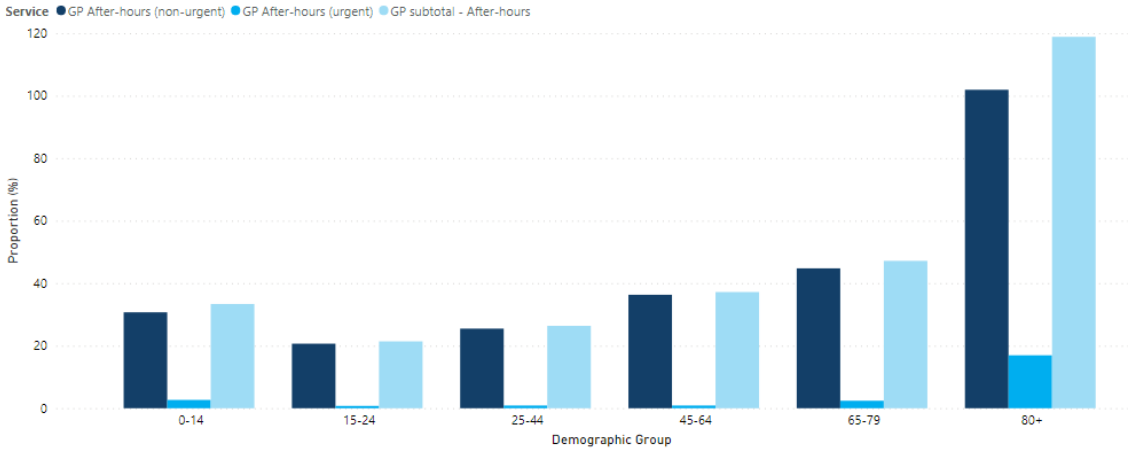
Figure 1: Proportion of the population who received an after hours GP service, by age group, CESPHN region, 2020-21



Source: AIHW, 2021

In 2020-21, there were 581,718 after hours GP services provided in the CESPHN region, equivalent to 34.9 services per 100 people. People aged 80+ years received the highest number of services per 100 people (118.9), followed by those aged 65-79 years (47.2 services per 100 people).(2)

Figure 2: After hours GP services per 100 people by demographic group, CESPHN region, 2020-21



Source: AIHW, 2021

Helpline

HealthDirect Australia provides a nurse triaged helpline and after hours GP helpline for the after hours period. In 2020, 57,691 calls were made to the HealthDirect nurse triage helpline during this period from CESPHN residents.(5) Approximately one third of all calls to the helpline occurred in the T1 period (32.1%), followed by T4 (30.1%), T2 (20.4%) and T3 (17.4%).

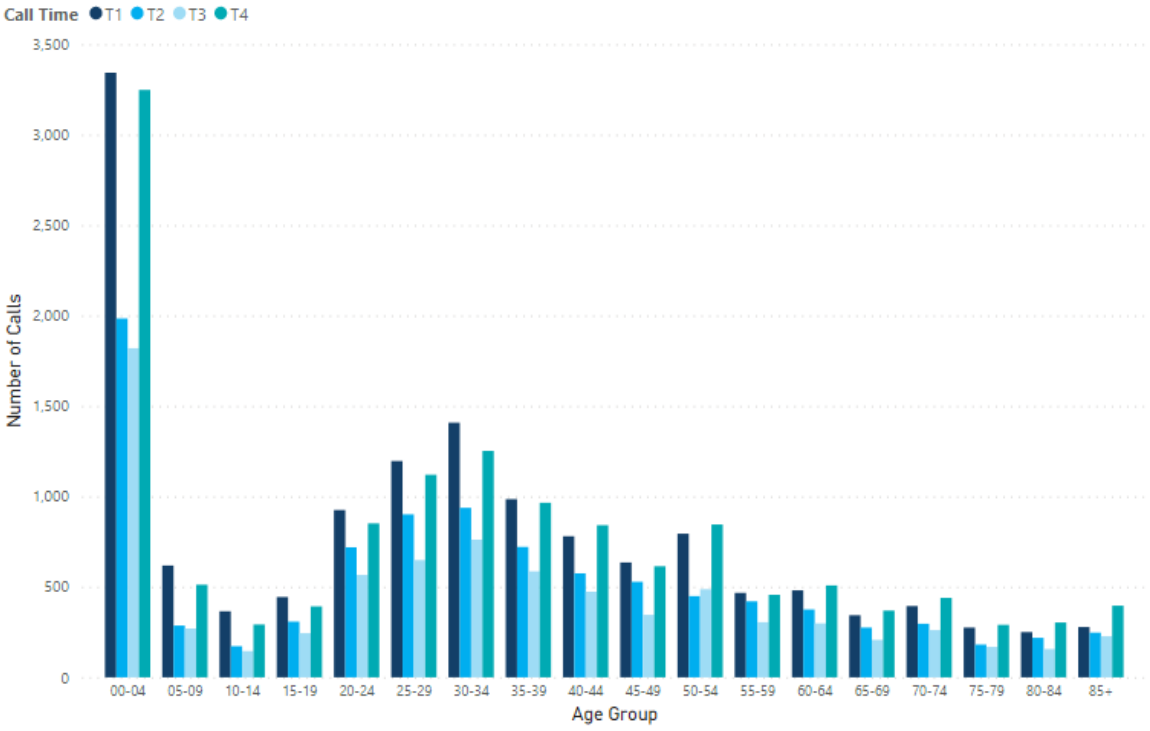
Table 7: After hours calls to HealthDirect helpline, CESPHN region, 2020

PIP timeframe	Number of calls	% of calls
T1 (6pm to 11pm weeknights)	18,537	32.1
T2 (11pm to 8am weekdays)	11,765	20.4
T3 (outside 8am to 12pm Saturday)	10,043	17.4
T4 (Sunday and public holidays)	17,346	30.1
Total	57,691	100.0

Source: HealthDirect Australia HealthMap, 2021

Calls to the helpline were largely for patients aged 0-4 years (23.0%) – this pattern was consistent across all time periods.(5)

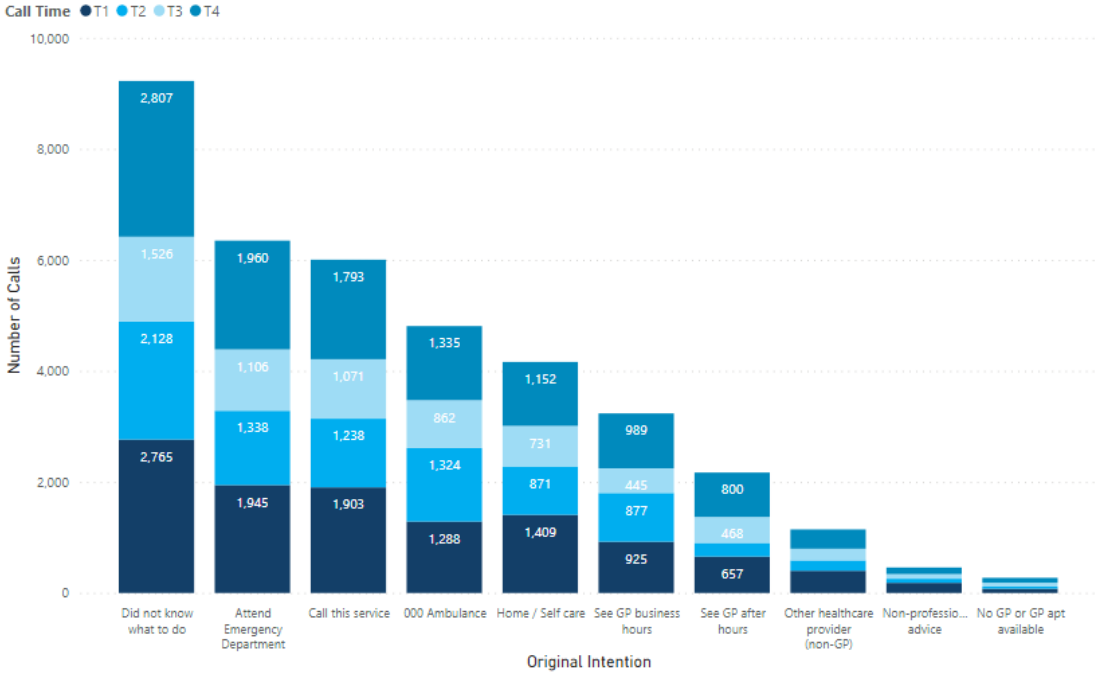
Figure 3: Number of calls to HealthDirect helpline by patient age, CESPHN region, 2020



Source: HealthDirect Australia HealthMap, 2021

The original intention of callers identifies the level of care the caller was considering prior to calling the helpline. Original intention was recorded for 37,835 calls. Almost one-quarter (24.4%) of callers did not know what to do, 16.8% would have attended their local ED and 15.9% would have called the helpline service.(5)

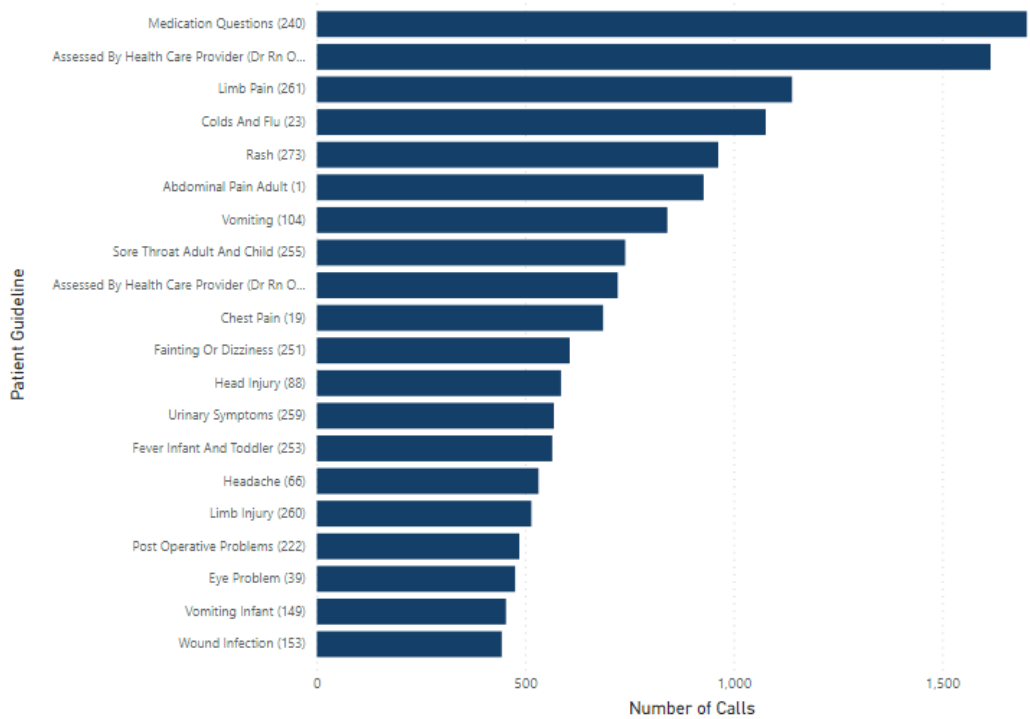
Figure 4: Number of calls to HealthDirect helpline by original intention, CESPHN region, 2020



Source: HealthDirect Australia HealthMap, 2021

In 2020, the reason for calling the helpline (the patient guideline) was recorded for 22,839 calls. The graph below shows the two major reasons for calling the helpline were for medication questions (7.5%) and assessment by a health care provider (7.1%).(5)

Figure 5: Number of calls to HealthDirect helpline by patient guideline, CESPHN region, 2020

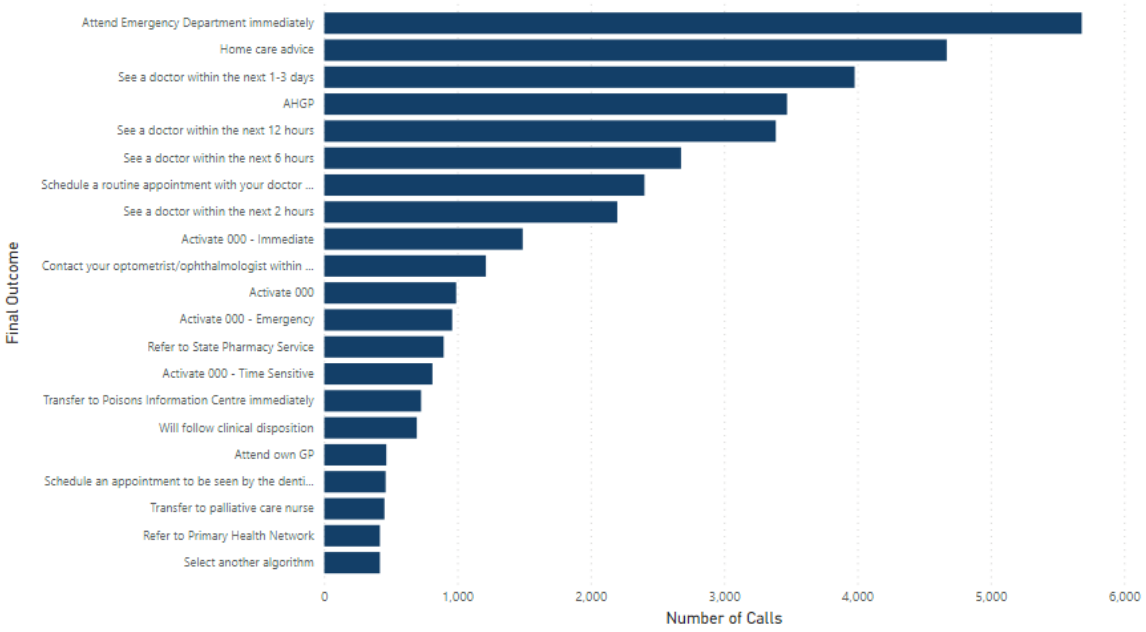


Source: HealthDirect Australia HealthMap, 2021

The final outcome considers the context of the patient including willingness of services and availability of services. Of the 39,618 final outcomes recorded for calls:

- 5,682 (14.3%) were advised to attend ED immediately
- 4,670 (11.8%) were given home care advice
- 3,979 (10.0%) were advised to see a doctor within the next 1-3 days
- 3,472 (8.8%) were advised to see an after hours GP
- 3,388 (8.6%) were advised to see a doctor within the next 12 hours.

Figure 6: Number of calls to HealthDirect helpline by final outcome, CESPHN region, 2020



Source: HealthDirect Australia HealthMap, 2021

Lower urgency Emergency Department (ED) presentations

Lower urgency ED presentations are presentations to a public hospital ED with a triage category of 4 (semi-urgent) or 5 (non-urgent), where the patient did not arrive by ambulance, or police or correctional vehicle and was not admitted to the hospital, not referred to another hospital, or did not die.

In 2018-19, there were 149,818 lower urgency ED presentations in the CESPHN region, equivalent to 91.8 per 1,000 people which is lower than the national rate of 117.4 per 1,000 people.(6) Fifty per cent (75,011 or 46.0 per 1,000 people) of these presentations were in the after hours period.

After hours lower urgency presentations have fallen by 11% (from 51.7 to 46.0 per 1,000 people) since 2015-16. There has also been a decrease in all lower urgency ED presentations over the same time period.(6)

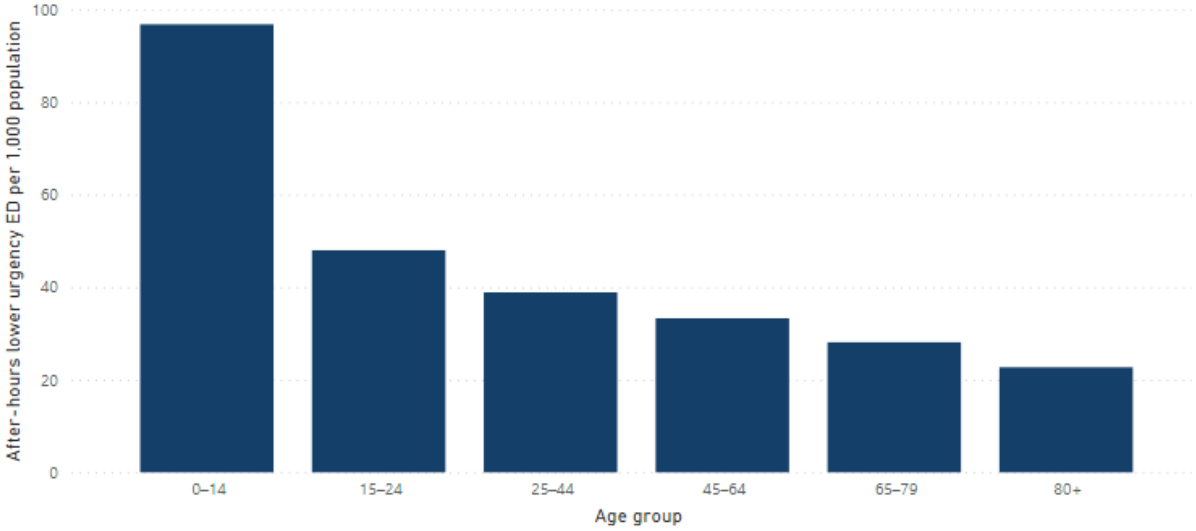
Table 8: Lower urgency ED presentations, CESPHN region, 2015-16 to 2018-19

Year	No. lower urgency ED presentations	Lower urgency ED per 1,000 population	No. after hours lower urgency ED presentations	After-hours lower urgency ED presentations per 1,000 population
2015-16	155,978	101.4	79,535	51.7
2016-17	150,639	96.0	76,258	48.6
2017-18	150,734	94.0	75,370	47.0
2018-19	149,818	91.8	75,011	46.0

Source: AIHW, 2020

In 2018-19, males had a higher rate of lower urgency care presentations in the after hours period (49.4 per 1,000 people) than females (42.5 per 1,000 people). The 0-14 year age group had the highest rate of after hours lower urgency ED presentations per 1,000 population across the CESPHN region at 96.8 per 1,000 people.(6)

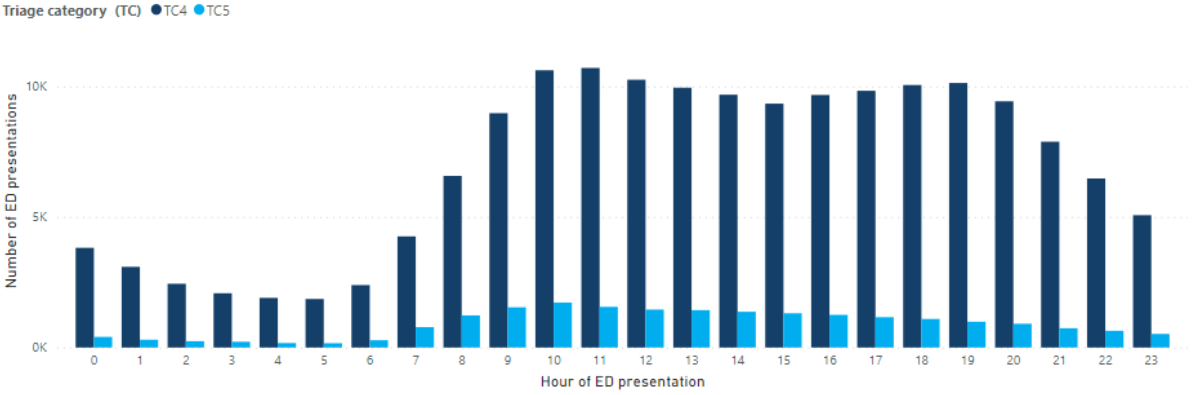
Figure 7: After hours lower urgency ED presentations by age group, CESPHN region, 2018-19



Source: AIHW, 2020

For all triage category 4 and 5 presentations, the peak time of presentation was 10am. In the after hours period the peak time was 7pm.(6)

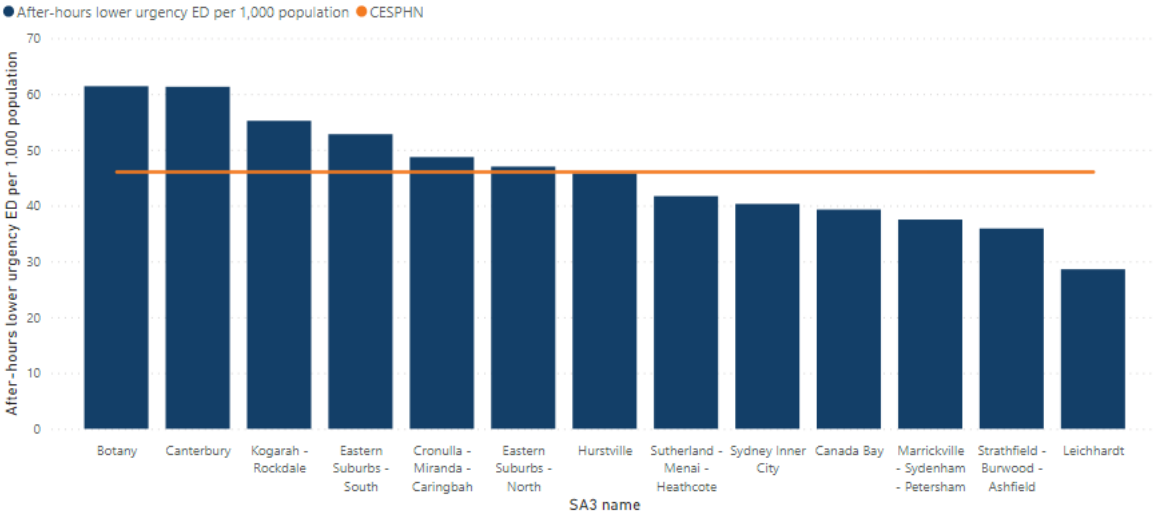
Figure 8: Number of triage category 4 and 5 ED presentations by time, CESPHN region. 2018-19



Source: AIHW, 2020

In 2018-19, Botany, Canterbury, Kogarah-Rockdale, Eastern Suburbs-South, Cronulla-Miranda-Caringbah, and Eastern Suburbs-North all had rates per 1,000 population of after hours ED presentations higher than the CESPHN rate.(6) The areas with the four highest rates per 1,000 population are generally more socioeconomically disadvantaged and culturally diverse with poorer English proficiency.

Figure 9: After-hours lower urgency ED presentations, SA3, 2018-19



Source: AIHW, 2020

Service navigation and coordination

Community and stakeholder consultations have identified the following key issues impacting the ability to navigate and coordinate health services in the CESPHN region:

- Service coverage
- Low health literacy
- Provider issues with identifying and navigating services most appropriate to an individual's disease profile and individual characteristics
- Inability to communicate patient information systematically and reliably between health care providers (see the digital health and data section below for more information).

Service coverage

The CESPHN region has a high population density with a significant number of services available.

These services are funded by all levels of government as well as privately.

Joint planning and collaborative commissioning among the different funding bodies can assist to identify and reduce service gaps and duplication and improve care coordination. The co-design of these services with consumers and peer workers ensures that the patient's experience and needs are considered during the planning phase.

We participate in a number of 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 and COVID-19.
We are currently collaborators on two regional plans:

- The Regional Mental Health and Suicide Prevention Plan 2019-2022 aims to improve the health and wellbeing of people with (or at risk of) mental health issues or at risk of suicide. This joint plan commits CESPHN, Sydney Local Health District, South Eastern Local Health District, St Vincent's Health Network and the Sydney Children's Hospital to work together to fulfil 88 actions.
- The Intersectoral Homelessness Health Strategy 2020-2025 is a collaboration between CESPHN, St Vincent's Health Network, Sydney Local Health District, South-Eastern Sydney Local Health District, Department of Communities and Justice, and City of Sydney to improve health outcomes and access to health care among people experiencing homelessness in the central and eastern Sydney region. The Strategy includes five priority action areas:
  - Improving access to the right care at the right time
  - Strengthening prevention and public health
  - Increasing access to primary care
  - Building workforce capability
  - Establishing collaborative governance and shared planning.

Collaborative commissioning partners local health districts and primary health networks to assess local needs, pool resources and develop interventions to improve shared patient and community outcomes. We are currently working with the local health districts, speciality health networks and NSW Ministry of Health to pilot a collaborative commissioning project in the CESPHN region. We are also working with these partners on integrating their virtual care models with the primary care sector.

Health literacy

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 the 2006 Health Literacy Survey, only 41% of adult Australians had a level of literacy that would allow them to meet their complex health needs.(7) The survey also indicated that health literacy was lower in those who speak English as a second language (21%).

Identifying and navigating services

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. One strategy CESPHN employs to integrate primary health care services with services provided by SLHD, SESLHD, SVHN and SCHN is the development and implementation of HealthPathways, which provides recommended diagnosis and management options for specific conditions, and options for referral pathways across health systems.

Outpatient clinics

In July 2021, CESPHN surveyed clinicians to identify gaps in outpatient clinics across the region. Key findings from 113 responses were:

- Information on outpatient services:
  - Most respondents look to HealthPathways (50%) and hospital service directories (47%) for information on outpatient services, followed by LHD/LHN websites (29%).
  - Respondents emphasised a need for improved availability of information on clinics, for instance through a centralised database or more comprehensive hospital websites.
  - Close to 80% of respondents said that there is no clear contact point for enquiries about outpatient services and referrals. Only 6% believe there is a clear contact point and 12% were unsure.
- Referral process:
  - Respondents noted poor communication, lack of appointment availability, and difficult referral processes were reported as key reasons as to why a service was hard to refer to.
  - Over half of the respondents use e-referrals for outpatient clinics whenever possible (36%) or occasionally (18%). A quarter of respondents never use e-referrals, and a fifth of respondents are not familiar with e-referrals.
  - Over two thirds (67%) of respondents do not believe that the referral process is consistent across various hospital departments. Differences in intake criteria, communication quality, referral processes, and waiting times are the major differences noticed across various hospital departments.
- Discharge process:
  - Over half of the respondents (55%) said that in less than 50% of cases do they receive a letter or discharge summary within 10 days of a patients discharge from the outpatient service. Almost a quarter of respondents (24%) receive it in more than 60% of cases, and close to a fifth (19%) receive it between 80-100% of cases.
  - Most respondents (71%) receive letter/discharge summaries via HealthLink or other electronic platforms. Fax (29%) was the second most common method of receiving letter/discharge summaries, followed by mail (18%) and from patients (16%).
  - Only 17% of respondents said that letters are either always or mostly uploaded to My Health Record. Nearly half of respondents (48%) said that letters are uploaded occasionally and over a quarter (27%) said that letters are never uploaded.
- Cost as a barrier:
  - Over three quarters of respondents notice public outpatient clinics co-located with private specialist clinics that do not bulk bill either frequently (31%) or sometimes (46%).
  - Over three quarters of respondents agreed that cost is either always (18%) or commonly (58%) a barrier to referring patients to private medical specialists. A further 22% of respondents said that cost is sometimes a barrier, and only 2% said that cost was not a barrier at all.
  - Of the private specialist services that respondents noted cost being a particular barrier, the following were the most common responses: dermatology (26%) and psychiatry (23%).

Digital health and data

The COVID-19 pandemic has 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 digital health needs of

clinicians and services were related to the level of digital health use maturity, as well as the interoperability between digital health systems across service providers.

Table 9: Digital health initiatives in the CESPHN region, as at August 2021

Digital health initiatives	No. of general practices	% of computerised practices	% of general practices
Computerised practices (clinical software)	547	100.0	90.1
Registered to access MyHR	462	84.5	76.1
Use secure messaging solution	535	97.8	88.1
Use Smart Forms and eReferrals	326	59.6	53.7

Source: CESPHN CRM database, 2021

My Health Record

Meaningful use of 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. MyHR statistics generally demonstrate increases in views and uploads by various health care services in the CESPHN region, largely propelled by the following:

- Software vendors continuing to integrate MyHR functionality.
- Increases in the number of hospitals and pathology services uploading discharge summaries and pathology reports.
- Increases in the number of pharmacies uploading prescription records and pharmacist shared medicine lists.
- Views in general practice of hospital discharges have increased by 118% and pathology records by 113% between 2019-20 and 2020-21.

Table 10: MyHR document views in general practice by document type

Information viewed	No. of views FY2020	No. of views FY2021
Hospital discharges	9,264	20,282
Pathology records	5,935	12,670

Source: ADHA Collaborate data, 2020-21

Despite the high rate of general practice MyHR registration in the CESPHN region, only 33 general practices uploaded at least one summary per week between April and June 2021, indicating that more work is required to integrate MyHR into daily practice activity.

As at August 2021, 410 out of 440 pharmacies were MyHR registered. Uploads by pharmacies of prescription records have increased by 23% and pharmacist shared medicine lists by 210% between 2019-20 and 2020-21.

Table 11: MyHR document uploads in pharmacies by document type

Information uploaded	No. of uploads FY2020	No. of uploads FY2021
Prescription records	1,130,702	1,390,518
Pharmacist shared medicine lists	7,513	12,670

Source: ADHA Collaborate data, 2020-21

From an allied health perspective, technology integration with MyHR is a major issue of national significance. The vast majority of platforms used for allied health are not able to integrate with MyHR,

and the National Provider Portal only facilitates viewing and downloading, not uploading. This has resulted in only 91 allied health practices that 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 recent introduction of online solutions such as 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, in particular between general practices using differing platforms.

As at July 2021, 98% of computerised general practices in the CESPHN region are registered to use secure messaging software, with HealthLink representing the most popular solution.

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.

As at July 2021, 326 general practices and 12 medical specialist practices were configured to send Smart Forms and eReferrals. Between July 2020 to June 2021, 31,395 eReferrals were sent in the CESPHN region and 7,737 specialist letters were uploaded to MyHR.

Electronic prescribing

In 2020, the Department of Health partnered with the Australian Digital Health Agency to develop and deploy electronic prescribing, which provides an option for prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme prescription in place of a paper prescription and is delivered via a prescription exchange service. Originally slated for release in late 2021, the deployment of electronic prescribing was accelerated as a result of the COVID-19 pandemic.
As at June 2021, 92% of pharmacies were able to dispense electronic prescriptions and 46% of computerised general practices were able to issue electronic prescriptions.

Table 12: Electronic prescribing capable practices in the CESPHN region, July 2021

Type	No. of practices
General practice	249
Pharmacy	405

CESPHN CRM database, 2021

Telehealth capability

Uptake of telehealth increased significantly in 2020 as a result of the introduction of temporary MBS telehealth items and a CESPHN initiative to roll out the Healthdirect Video Call (VCC) service. While VCC registration and usage can be measured, complexities in measuring the uptake of telehealth in

the CESPHN region include the existence of multiple standalone platforms (e.g. Zoom and Skype), and the fact that the Department of Human Services does not provide figures on telehealth MBS items at the local level.

As at July 2021, the number of Healthdirect Video Call accounts in the CESPHN region was 120. Over 2,000 hours of consultations took place on the platform.

Table 13: Healthdirect Video Call accounts in the CESPHN region, July 2021

Type	No. of practices
General practice	106
Allied health practice	9
RACF	3
Medical specialist practice	2

Source: Healthdirect Video Call, 2021

Data for quality improvement

The introduction of the new Quality Improvement Practice Incentive Program (PIP QI) in 2019 has significantly increased the total number of practices that submit data to CESPHN. So far 352 practices have registered for the PIP QI. General practices enrolled in the PIP QI Incentive commit to implementing continuous quality improvement activities relating to the management of their patient's health and submitting nationally consistent, de-identified data against 10 quality improvement measures (QIMs).

The AIHW's first annual report on 10 QIMs support a regional and national understanding of chronic disease management. The CESPHN region was below the national average for most of the 10 QIMs– the only exceptions related to QIM 2 (smoking status) and QIM 3 (height, weight and BMI). Similar to the national average (22.6%), the CESPHN region had a high number of records where Aboriginal status was not stated (22.9%). Increased uptake of Topbar and Walrus, which provide point-of-care prompts when a record is missing data, could help improve levels of completeness.

Table 14: Proportion of regular clients with data recorded in their GP record by QIM and PHN, July 2021

Measure	CESPHN	Australia	Range	Rank
QIM 1: % of regular clients with diabetes with an HbA1c result recorded in their GP record within the previous 12 months, all ages				
HbA1C recorded - Type 1 diabetes	54.9	59.0	49.0 - 69.4	25/31
HbA1C recorded - Type 2 diabetes	69.7	73.4	66.5 - 82.1	27/31
HbA1C recorded - Undefined diabetes	64.9	66.3	58.1 - 76.4	20/31
QIM 2: % of regular clients with a smoking status record and result in their GP record, 15 years age and over				
Smoking status recorded	55.4	66.1	55.4 - 73.7	31/31
Current smoker	11.7	14.7	7.4 - 23.5	28/31
Ex-smoker	17.4	22.4	13.9 - 31.8	29/31
Never smoked	70.9	62.9	50.8 - 74.9	3/31
QIM 3: % of regular clients with height and weight recorded in their GP record and a derived BMI result, 15 years age and over				
Height & Weight Recorded	19.7	23.6	17.2 - 46.9	26/31
BMI Underweight	2.5	2.0	1.4 - 2.7	3/31
BMI Healthy	36.0	25.8	19.1 – 37	2/31
BMI Overweight	34.4	32.5	29.1 – 35	3/31
BMI Obese	27.1	39.8	25.2 – 49	30/31
QIM 4: % of regular clients aged 65 years and over with an influenza immunisation status recorded in their GP record within the previous 15 months, 65 years age and over				
Immunisation Status Recorded	61.3	64.2	47.3 – 73.5	22/31
QIM 5: % of regular clients with diabetes with an influenza immunisation status recorded in their GP record within the previous 15 months, all ages				
Immunisation Status Recorded	56.3	58.2	42 – 68.7	20/31
QIM 6: % of regular clients with COPD with an influenza immunisation status recorded in their GP record within the previous 15 months, 15 years age and over				
Immunisation Status Recorded	64.4	66.8	52.8 – 75.5	19/31
QIM 7: % of regular clients with an alcohol consumption status recorded in their GP record, 15 years age and over				
Alcohol Status Recorded	55.9	56.2	44.3 – 75.7	18/31
QIM 8: % of regular clients with a record of the necessary risk factors in their GP record for CVD risk assessment, 45-74 years age				
CVD Risk Factors Recorded	39.4	48.5	36 – 67.5	27/31
QIM 9: % of regular female clients with an up-to-date cervical screening test record in their GP record within the previous 5 years, 25-74 years age				
Screening Test Recorded	36.0	37.4	21.8 – 46	23/31
QIM 10: % of regular clients with diabetes with blood pressure recorded in their GP record within the previous 6 months, all ages				
BP Recorded	54.8	58.7	51.4 – 66.4	28/31

Source: AIHW PIP measures national report 2020-21

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phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Primary care workforce

2022-2024 Needs Assessment

15 November 2021

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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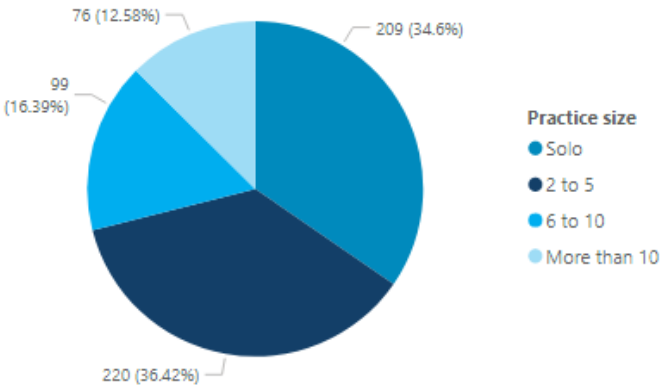
General Practice

As at September 2021, there were 607 general practices operating within the CESPHN region. This includes one Aboriginal Medical Service in Redfern.(1)

Figure 1: General practice size in CESPHN region, September 2021



Source: CESPHN CRM, 2021

Two-thirds (66.6%) of general practices within the CESPHN region were accredited or registered for accreditation in September 2021.(1)

Table 1: Accreditation status of general practices by SA3, CESPHN region, September 2021

SA3	Accredited	Registered for Accreditation	Not accredited	Total
Botany	9	0	9	18
Canada Bay	20	1	7	28
Canterbury	41	2	14	57
Cronulla - Miranda - Caringbah	23	0	6	29
Eastern Suburbs - North	27	2	23	52
Eastern Suburbs - South	24	1	14	39
Hurstville	33	1	13	47
Kogarah - Rockdale	35	0	30	65
Leichhardt	18	1	6	25
Marrickville - Sydenham - Petersham	11	0	12	23
Strathfield - Burwood - Ashfield	42	3	28	73
Sutherland - Menai - Heathcote	31	2	7	40
Sydney Inner City	72	4	33	109
Lord Howe and Norfolk Islands	1	0	1	2
Total	387	17	203	607

Source: CESPHN CRM, 2021

General practitioners

In 2020 there were 2,177 general practitioners (GPs) working in the CESPHN region (1,920.8 FTE) giving a rate of 130.2 per 100,000 population (114.9 FTE per 100,000 population), higher than the state and national rates.(2)

Table 2: GPs by region, 2020

Measure	CESPHN	NSW	Australia
Number of practitioners	2,177.0	9,773.0	31,620.0
Number of practitioners (rate per 100,000 population)	130.2	119.7	123.0
FTE total	1,920.8	9,101.3	28,978.3
FTE total (rate per 100,000 population)	114.9	111.4	112.8
FTE clinical	1,784.3	8,534.0	27,214.7
FTE clinical (rate per 100,000 population)	106.7	104.5	105.9

Source: HWA, 2021

Across the CESPHN region in 2020, Sydney Inner City SA3, Leichhardt SA3 and Eastern Suburbs-North SA3 all had rates of general practitioners per 100,000 population higher than state and national rates for number of practitioners, FTE total and FTE clinical; conversely Marrickville-Sydenham-Petersham SA3 and Botany SA3 consistently had the lowest rates across our region; significantly lower than state and national.(2)

Table 3: GPs by SA3, CESPHN region, 2020

SA3	No. of practitioners (rate per 100,000)	FTE total (rate per 100,000 population)	FTE clinical (rate per 100,000 population)
Botany	74.3	74.4	64.2
Canada Bay	144.0	112.5	107.5
Canterbury	104.7	104.5	95.8
Cronulla-Miranda-Caringbah	107.2	99.5	91.9
Eastern Suburbs – North	169.9	139.2	129.4
Eastern Suburbs – South	122.0	104.7	97.1
Hurstville	97.1	89.7	82.5
Kogarah-Rockdale	92.1	85.5	80.8
Leichhardt	184.6	155.8	141.3
Marrickville-Sydenham-Petersham	73.1	77.4	74.1
Strathfield-Burwood-Ashfield	113.4	101.5	95.3
Sutherland-Menai-Heathcote	123.5	113.3	106.9
Sydney Inner City	201.5	172.3	157.0
CESPHN region	130.2	114.9	106.7
NSW	119.7	111.4	104.5
Australia	123.0	112.8	105.9

Source: HWA, 2021

**Lord Howe and Norfolk Island figures have been excluded due to data suppression rules*

There has been a 16.2% increase in the number of GPs in the CESPHN region since 2013. Sydney Inner City SA3 has had the biggest increase in the number of GPs (35.4% increase), followed by Kogarah-Rockdale SA3 (27.4% increase). Marrickville-Sydenham-Petersham SA3 has had the

biggest decrease in number of GPs (24.6% decrease), followed by Cronulla-Miranda-Caringbah SA3 (3.0% decrease).(2)

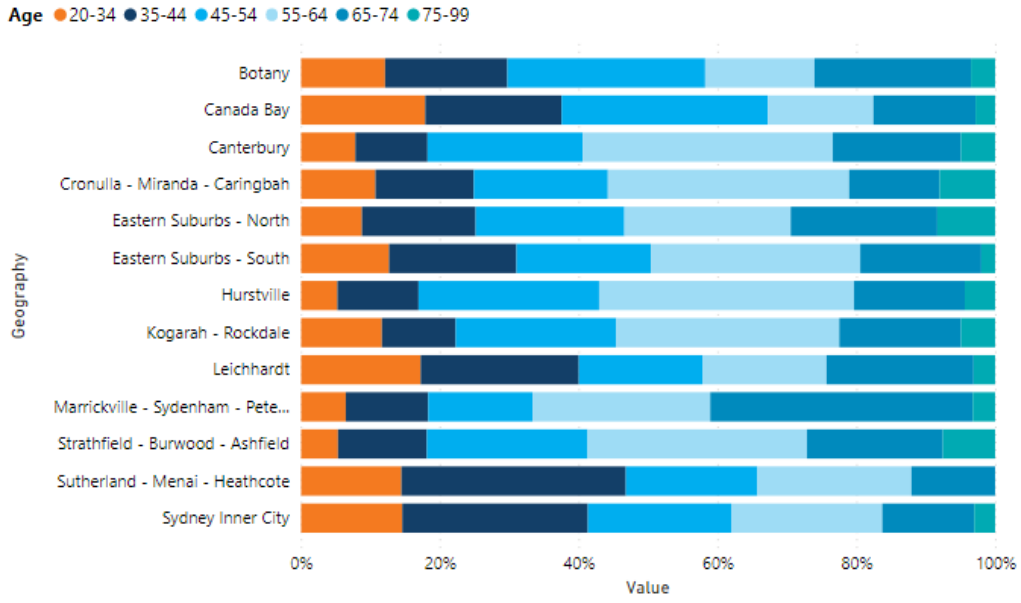
A recent stakeholder survey highlighted the need for a local GP located in Kurnell (part of Cronulla-Miranda-Caringbah SA3) due to there being no current local GPs and access to GPs in Cronulla is limited due to transport issues, waitlists or closed books.(3)

Demographics

Fifty-five per cent (54.7%) of GPs working across the CESPHN region in 2020 were male. Marrickville-Sydenham-Petersham SA3 had the highest proportion of male GPs with 74.3% of the FTE workforce, followed by Botany SA3 (72.2%) and Kogarah-Rockdale SA3 (66.9%).(2)

In 2020, approximately 50% of FTE GPs across the CESPHN region were aged 55 years or older (47.8%), this is higher than both the state and national rates of 43% and 40% respectively; a further 40% were aged 35-54 years old. Marrickville-Sydenham-Petersham SA3 (64.2%), Canterbury SA3 (59.7%) and Strathfield-Burwood-Ashfield SA3 (58.7%) had the highest rates of GPs aged 55 years and over across the CESPHN region.(2)

Figure 2: Proportion of GP workforce by age group, SA3, 2020



Source: HWA, 2021

Years intend to work

Almost half of GPs (44.7%) in the CESPHN region in 2020 intended to only work up to another 10 years.(2) Norfolk Island (100%), Marrickville-Sydenham-Petersham SA3 (61.4%) and Botany SA3 (53.3%) had the highest rates of GPs who intended to only work up to another 10 years.(2)

Table 4: GP years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	20.0	33.3	15.6	15.6	0.0	8.9	6.7
Canada Bay	21.7	17.8	12.4	14.0	21.7	10.1	2.3
Canterbury	20.7	24.0	18.0	14.7	18.0	4.7	0.0
Cronulla-Miranda-Caringbah	30.5	15.6	12.5	13.3	18.8	7.0	2.3
Eastern Suburbs – North	29.7	18.3	14.0	15.7	16.2	4.8	1.3
Eastern Suburbs – South	25.1	21.9	12.6	16.9	14.2	9.3	0.0
Hurstville	22.6	27.8	11.3	20.3	12.8	3.0	2.3
Kogarah-Rockdale	22.5	29.7	13.0	13.0	15.2	6.5	0.0
Leichhardt	21.4	15.2	10.7	16.1	24.1	9.8	2.7
Lord Howe Island	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Marrickville-Sydenham-Petersham	29.5	31.8	6.8	6.8	18.2	6.8	0.0
Norfolk Island	50.0	50.0	0.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	26.6	25.5	14.4	12.8	17.0	3.7	0.0
Sutherland-Menai-Heathcote	25.9	14.1	11.9	14.8	26.7	4.4	2.2
Sydney Inner City	21.5	16.3	10.1	18.7	22.1	9.1	2.2
CESPHN region	24.2	20.5	12.4	15.8	18.6	6.8	1.6

Source: HWA, 2021

Hours worked per week

Total hours

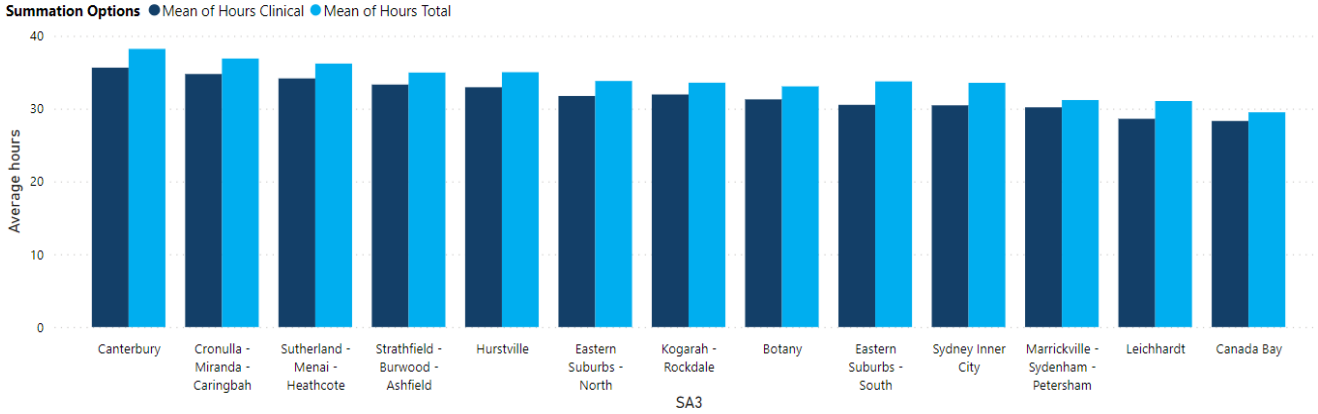
Total hours are the total hours worked per week in the profession, including paid and unpaid work.(4) In 2020, on average GPs in Australia worked 34.9 total hours per week, slightly lower than NSW (35.9 total hours per week). In the CESPHN region, GPs worked 34.7 total hours per week. Average weekly working hours ranged from 38.2 hours per week in Canterbury SA3 to 29.5 hours per week in Canada Bay SA3.(2)

Clinical hours

Clinical hours are the total clinical hours worked per week in the profession, including paid and unpaid work. The average weekly clinical hours is the average of the clinical hours reported by all employed professionals, not only those who define their principal area of work as clinician.(4)

In 2020, on average GPs in Australia worked 32.9 clinical hours per week, slightly lower than NSW where GPs worked on average 33.8 clinical hours per week. GPs in the CESPHN region worked, on average, 32.3 clinical hours per week.(2) Average weekly clinical hours ranged from 35.6 hours in Canterbury SA3 to 28.3 hours per week in Canada Bay SA3.(2)

Figure 3: General practitioner mean hours worked per week by SA3, 2020

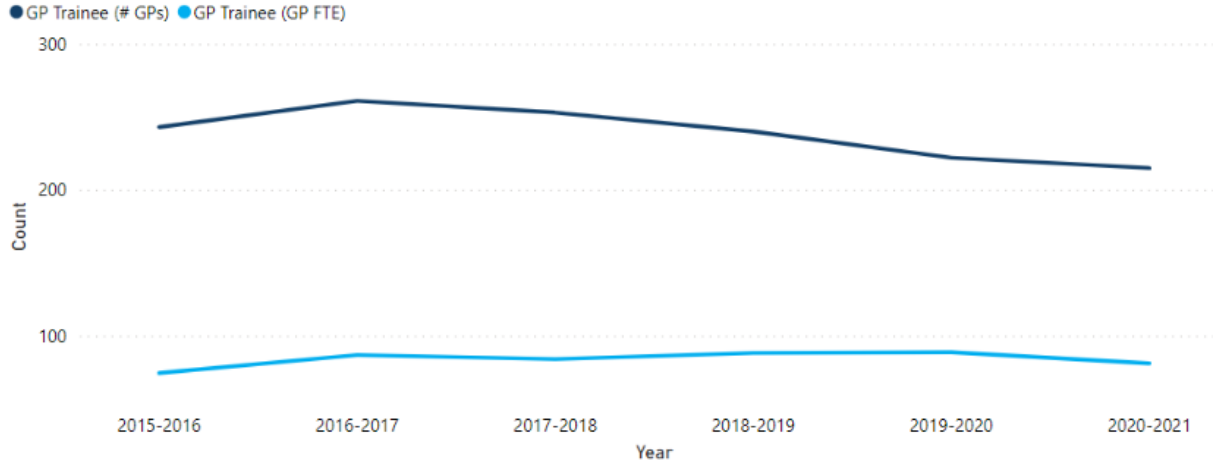


Source: HWA, 2021

Trainees

In the 2020-21 financial year, there were 215 GP trainees working across the CESPHN region, totalling an FTE of 81.2. The highest number of GP trainees across the CESPHN region were in Sydney Inner City SA3 (n=50), with an FTE of 12.4. Sutherland-Menai-Heathcote SA3 had the second highest number of GP trainees in the CESPHN region (n=35, with an FTE of 12.4).(5) Whilst we have seen a small decline in the number of GP trainees in the CESPHN region over the past 6 years, the FTE rate has slightly risen.

Figure 4: Number and FTE of GP trainees, CESPHN region, 2020-21



Source: Department of Health, 2021

**GP trainees includes participants on the Australian General Practice Training Program, the Remote Vocational Training Scheme or the Australian College of Rural and Remote Medicine's Independent Training Program.*

Data also shows that at September 2020, approximately 1 in 4 practices across the CESPHN region was accredited to deliver training to GP Registrars; with only approximately 1 in 5 practices across the CESPHN region actively training.(6)

Practice nurses

In 2020, there were 594 practice nurses working in the CESPHN region (476.3 FTE) giving a rate of 35.5 per 100,000 population (28.5 FTE per 100,000 population), lower than the state and national rates for number of practice nurses (48.3 and 57.2 per 100,000 population) and FTE (36.8 and 43.6 per 100,000 population respectively).(2) Low rates of practice 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 the underutilisation of skills.

According to the 2020 Australian Primary Health Care Nurses Association (APNA) annual workforce survey, approximately 45% of nurses in the CESPHN region say they are not practising to the full extent of their capabilities often or most of the time. This is slightly higher than the national average of 40%. Interestingly 49% of nurses were never using telehealth items.(7)

There has been a 32% increase in the number of practice nurses in the CESPHN region since 2013. Canterbury SA3 has had the biggest increase in the number of practitioners (213% increase), followed by Hurstville SA3 (59% increase). Marrickville-Sydenham-Petersham SA3 had a decrease in the number of practice nurses (33% reduction).(2)

Table 5: Practice nurses by region, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	594.0	3,949.0	14,697.0
Number of Practitioners (rate per 100,000 population)	35.5	48.3	57.2
FTE Total	476.3	3,007.6	11,195.7
FTE Total (rate per 100,000 population)	28.5	36.8	43.6
FTE Clinical	449.4	2,868.0	10,693.8
FTE Clinical (rate per 100,000 population)	26.9	35.1	41.6

Source: HWA, 2021

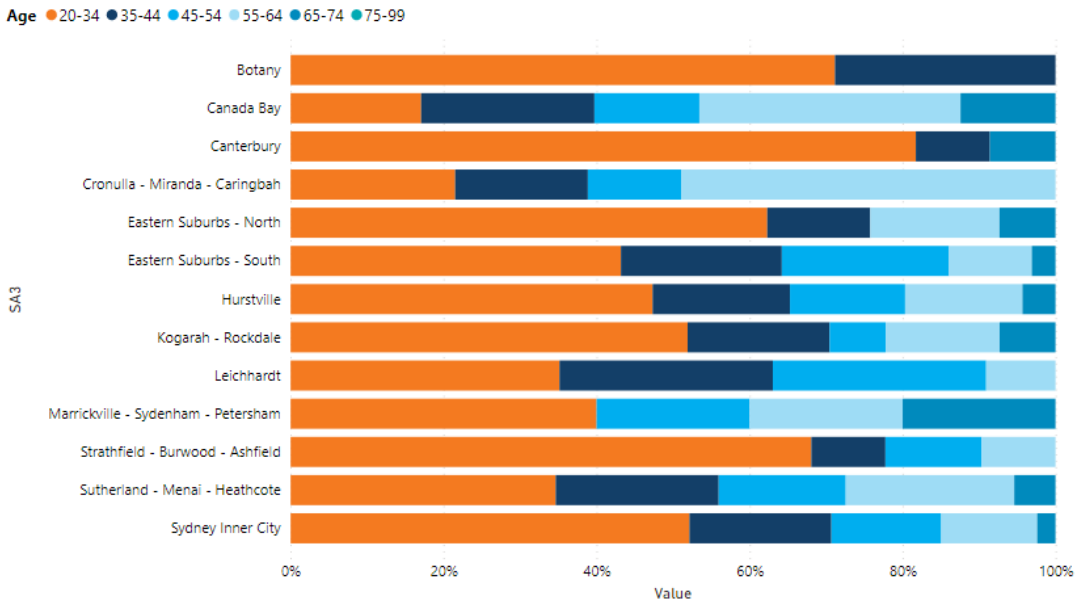
Demographics

The majority (91.7%) of FTE practice nurses working in the CESPHN region in 2020 were female, slightly lower than the national proportion of 95.2%.(2)

In 2020, approximately one in five (20.4%) FTE practice nurses across the CESPHN region were aged 55 years or older. Two-thirds (66.5%) were aged under 45 years of age, this is higher than both the state and national rates of 50% and 48.5% respectively.(2)

There was a higher proportion of FTE practice nurses aged 20-34 years in the CESPHN region (49.1%) compared to NSW (31.0%) and Australia (30.2%) highlighting a younger workforce in our region. Approximately four in five (82.6%) of FTE practice nurses in Canterbury SA3 were aged 20-34 years in 2020.(2)

Figure 5: Proportion of FTE practice nurse workforce by age group, SA3, 2020



Source: HWA, 2021

Years intend to work

In 2020, 44.9% of practice nurses in the CESPHN region intended to only work up to another 10 years.(2)

Table 6: Practice nurses years intended to work by SA3, 2020

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	0.0	0.0	30.0	0.0	0.0
Canada Bay	34.3	20.0	11.4	17.1	8.6	0.0	8.6
Canterbury	24.3	18.9	0.0	18.9	18.9	18.9	0.0
Cronulla-Miranda-Caringbah	41.7	25.0	11.1	11.1	11.1	0.0	0.0
Eastern Suburbs – North	22.0	19.5	0.0	17.1	17.1	17.1	7.3
Eastern Suburbs – South	14.6	24.4	14.6	24.4	22.0	0.0	0.0
Hurstville	26.1	15.2	6.5	17.4	15.2	13.0	6.5
Kogarah-Rockdale	29.8	17.0	10.6	19.1	14.9	8.5	0.0
Leichhardt	0.0	0.0	0.0	62.5	18.8	18.8	0.0
Marrickville-Sydenham-Petersham	0.0	0.0	50.0	0.0	0.0	50.0	0.0
Strathfield-Burwood-Ashfield	25.0	34.4	0.0	12.5	28.1	0.0	0.0
Sutherland-Menai-Heathcote	23.1	25.6	0.0	17.9	15.4	10.3	7.7
Sydney Inner City	20.4	22.5	7.7	19.7	16.2	9.9	3.5
CESPHN region	24.4	20.5	7.4	18.8	16.4	9.2	3.3

Source: HWA, 2021

**Lord Howe and Norfolk Island figures have been excluded due to data suppression rules*

Hours worked per week

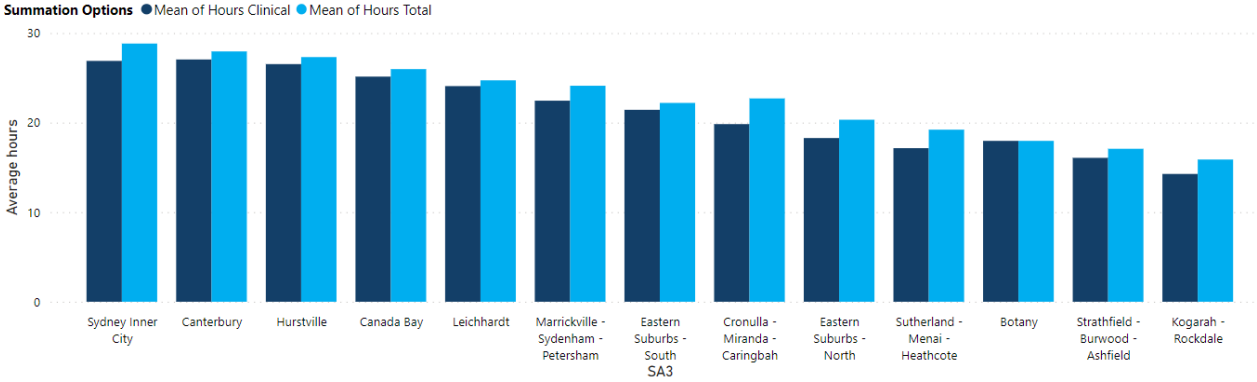
Total hours

In 2020, on average practice nurses in Australia worked 27.2 total hours per week, slightly higher than NSW where practice nurses worked on average 25.9 total hours per week. Across the CESPHN region, practice nurses worked 28.0 total hours per week.(2) Average weekly working hours ranged from 28.8 hours per week in Sydney Inner City SA3 to 15.9 hours per week in Kogarah-Rockdale SA3.

Clinical hours

In 2020, on average practice nurses in Australia worked 25.5 clinical hours per week, similar to NSW where practice nurses worked on average 24.6 clinical hours per week. Practice nurses in the CESPHN region worked, on average, 26.2 clinical hours per week.(2) Average weekly clinical hours ranged from 26.9 hours in Sydney Inner City SA3 to 14.3 hours in Kogarah-Rockdale SA3.

Figure 6: Practice nurses mean hours worked per week by SA3, 2020



Source: HWA, 2021

Allied health professionals

In 2020, there were 12,832 Australian Health Practitioner Regulation Agency (AHPRA) registered allied health professionals (AHPs) working in the CESPHN region (11,610 FTE) giving a rate of 770.5 per 100,000 population (697.1 FTE per 100,000 population).(2) Psychologists had the highest rate of AHPs per 100,000 population (161.8), followed by physiotherapists (129.4) and pharmacists (105.0).

Since 2013, there has been a 16.9% increase in the number of AHPs in the CESPHN region. Physiotherapist numbers have increased the most (31.7% increase in the number of practitioners), followed by podiatrists (28.4%). Over this same period, there was a 19% reduction in the number of osteopaths within the CESPHN region.(2)

In 2020, psychologists in the CESPHN region had the highest FTE total rate per 100,000 population (136.6), followed by physiotherapists (122.1 per 100,000 population); this differs to NSW and Australia, where physiotherapists had the highest FTE rates followed by psychologists.(2)

Physiotherapists in the CESPHN region had the highest FTE clinical rate per 100,000 population (112.8), followed by psychologists (110.7 per 100,000 population), the same pattern was seen in FTE clinical per 100,000 population in NSW, however differs to Australia, where physiotherapists had the highest FTE clinical rates followed by pharmacists.(2)

Primary care workforce

Table 7: Number, FTE total and FTE clinical AHPs, CESPHN region, 2020

AHP	CESPHN		NSW	Australia	CESPHN		NSW	Australia	CESPHN		NSW	Australia
	No.	Rate per 100,000	Rate per 100,000	Rate per 100,000	FTE	Rate per 100,000	Rate per 100,000	Rate per 100,000	FTE Clinical	Rate per 100,000	Rate per 100,000	Rate per 100,000
Aboriginal health practitioners	-	-	1.3	2.4	-	-	1.3	2.6	-	-	1.2	2.1
Chinese medicine practitioners	578	34.6	19.3	15.6	447	26.7	14.3	11.4	398	23.8	12.7	9.6
Chiropractors	423	25.3	20.8	20.0	386	23.1	18.5	16.6	344	20.6	16.5	14.6
Dental practitioners	1,682	100.6	77.9	83.9	1,528	91.4	71.4	75.7	1,383	82.7	65.0	67.8
Medical radiation practitioners	972	58.1	59.0	59.9	883	52.8	52.4	55.2	860	51.4	51.1	51.5
Occupational therapists	1,045	62.5	67.8	84.5	943	56.4	60.2	75.0	880	52.6	56.6	64.6
Optometrists	462	27.6	21.1	21.2	394	23.5	18.5	18.6	373	22.3	17.7	17.1
Osteopaths	116	6.9	6.4	9.9	104	6.2	5.5	8.3	87	5.2	5.0	7.4
Paramedicine practitioners	636	38.0	54.0	66.9	722	43.2	62.6	78.0	712	42.6	61.6	72.0
Pharmacists	1,756	105.0	85.0	104.3	1,590	95.1	78.1	95.9	1,481	88.6	73.2	81.9
Physiotherapists	2,163	129.4	104.2	118.8	2,042	122.1	96.5	108.7	1,886	112.8	89.5	93.3
Podiatrists	294	17.6	16.9	19.8	290	17.4	16.2	18.4	263	15.7	14.7	16.2
Psychologists	2,705	161.8	114.0	123.0	2,284	136.6	96.3	104.9	1,851	110.7	78.8	78.4

Source: HWA, 2021

In addition to AHPRA registered AHPs, there are:

- 788 social workers
- 722 exercise physiologists
- 705 speech pathologists
- 452 dietitians
- 24 orthotic prosthetists in the CESPHN region.[1]

Demographics

Almost two in three (59.5%) of AHPRA registered FTE AHPs working across the CESPHN catchment in 2020 were female. This reflects national proportions, where 61.2% of AHPRA registered FTE AHPs were female.(2)

Table 8: Proportion of AHP workforce by gender and location, 2020

AHP	CESPHN		Australia	
	Females	Males	Females	Males
Aboriginal health practitioners	-	-	77.5	22.5
Chinese medicine practitioners	53.3	46.7	52.6	47.4
Chiropractors	27.5	72.5	34.6	65.4
Dental practitioners	41.2	58.8	48.0	52.0
Medical radiation practitioners	66.4	33.6	64.1	35.9
Occupational therapists	89.4	10.6	88.6	11.4
Optometrists	56.6	43.4	52.2	47.8
Osteopaths	40.9	59.1	48.0	52.0
Paramedicine practitioners	41.0	59.0	41.3	58.6
Pharmacists	58.3	41.7	58.4	41.6
Physiotherapists	53.1	46.9	58.7	41.3
Podiatrists	46.7	53.3	53.4	46.6
Psychologists	78.7	21.3	78.0	22.0
Total	59.5	40.5	61.2	38.8

Source: HWA, 2021

In 2020, 64.1% FTE AHPs across the CESPHN region were aged 20-44 years old; this is slightly lower than both the state and national rates of 65 and 66.2% respectively.(2)

[1] The number of non-AHPRA registered AHPs has been sourced from Peak Bodies (Australian Association of Social Workers, Exercise and Sports Science Australia, Speech Pathology Australia, Dietitians Australia and Australian Orthotic Prosthetic Association).

Table 9: Proportion of AHP workforce by age groups, CESPHN, 2020

AHP	20-34 years (%)	35-44 Years (%)	45-54 Years (%)	55-64 Years (%)	65-74 Years (%)	75-99 Years (%)
Chinese medicine practitioners	8.3	17.7	26.9	32.2	12.2	2.7
Chiropractors	38.3	26.0	21.4	11.2	2.4	0.8
Dental practitioners	26.7	27.0	19.3	20.3	5.9	0.7
Medical radiation practitioners	52.0	23.0	11.6	10.0	3.4	0.0
Occupational therapists	58.8	23.2	11.7	5.9	0.4	0.0
Optometrists	39.2	19.6	18.6	17.8	4.7	0.0
Osteopaths	15.6	20.1	29.0	21.5	10.9	2.9
Paramedicine practitioners	48.2	22.8	22.1	6.2	0.7	0.0
Pharmacists	45.9	26.2	14.0	10.1	3.1	0.8
Physiotherapists	56.9	19.2	14.0	7.8	1.9	0.2
Podiatrists	47.4	18.4	21.7	7.7	3.8	1.0
Psychologists	21.2	28.8	24.5	15.5	8.7	1.2
Total	40.0	24.1	18.1	12.7	4.5	0.6

Source: HWA, 2021

Years intend to work

In 2020, 36% of AHPs in the CESPHN region intended to only work up to another 10 years; this ranges from 45.7% of Chinese medicine practitioners to 25.9% of occupational therapists.(2)

Table 10: AHP years intended to work by profession, CESPHN region, 2020

AHP	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Chinese medicine practitioners	17.9	27.7	11.2	19.0	15.9	4.9	3.3
Chiropractors	9.2	17.3	10.6	23.8	24.5	10.4	4.2
Dental practitioners	15.1	21.2	14.0	17.6	22.1	8.0	2.0
Medical radiation practitioners	16.2	17.8	6.8	19.0	24.9	11.4	3.8
Occupational therapists	11.7	14.2	9.0	20.6	24.5	15.1	5.0
Optometrists	14.8	21.5	14.1	15.9	20.0	11.0	2.7
Osteopaths	15.9	21.2	19.5	20.4	15.0	5.3	2.7
Paramedicine practitioners	13.0	28.2	11.5	23.8	16.1	5.9	1.5
Pharmacists	19.9	22.2	7.4	18.8	21.0	7.4	3.4
Physiotherapists	18.4	20.6	10.3	18.6	19.6	9.7	2.9
Podiatrists	16.2	21.8	10.6	17.3	18.3	12.3	3.5
Psychologists	15.5	16.8	11.2	21.5	22.5	10.4	2.2
Total	16.0	20.0	10.6	19.6	21.3	9.6	2.9

Source: HWA, 2021

Hours worked per week

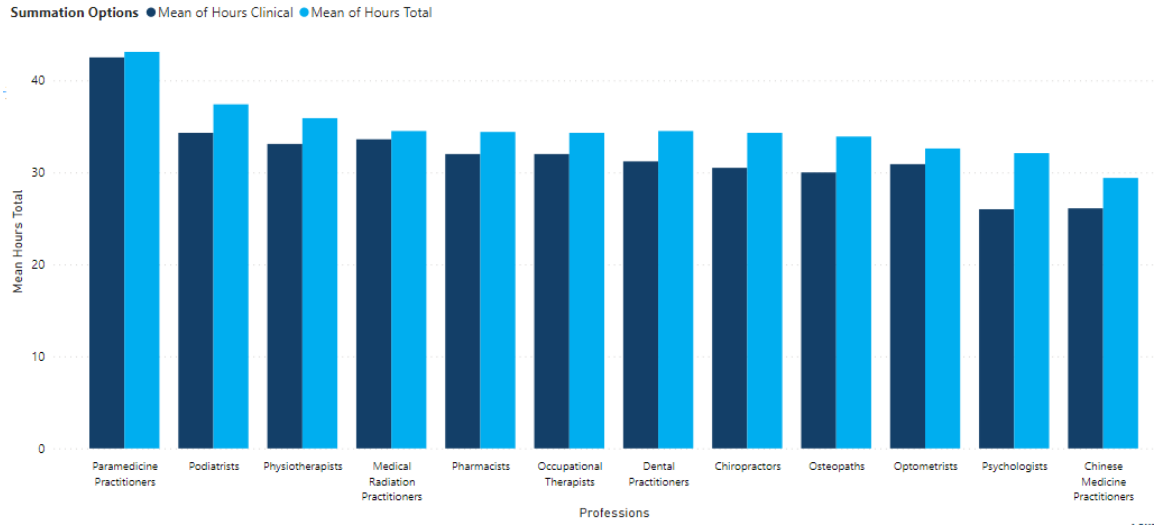
Total hours

In 2020, on average AHPs in Australia worked 34.1 total hours per week, slightly lower than NSW where AHPs worked on average 34.4 total hours per week. Within the CESPHN region, AHPs worked, on average, 34.7 total hours per week.(2) Average weekly working hours ranged from 43.1 hours per week for paramedicine practitioners to 29.4 hours per week for Chinese medicine practitioners.

Clinical hours

In 2020, on average AHPs in Australia worked 29.9 clinical hours per week, slightly lower than NSW where AHPs worked on average 31.7 clinical hours per week. AHPs in the CESPHN region worked, on average, 31.9 clinical hours per week.(2) Average weekly clinical hours ranged from 42.5 hours for Paramedicine practitioners to 26 hours for psychologists.

Figure 7: Allied health professionals mean hours total by profession, CESPHN region, 2020



Source: HWA, 2021

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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Pandemic and disaster response

2022-2024 Needs Assessment

15 November 2021

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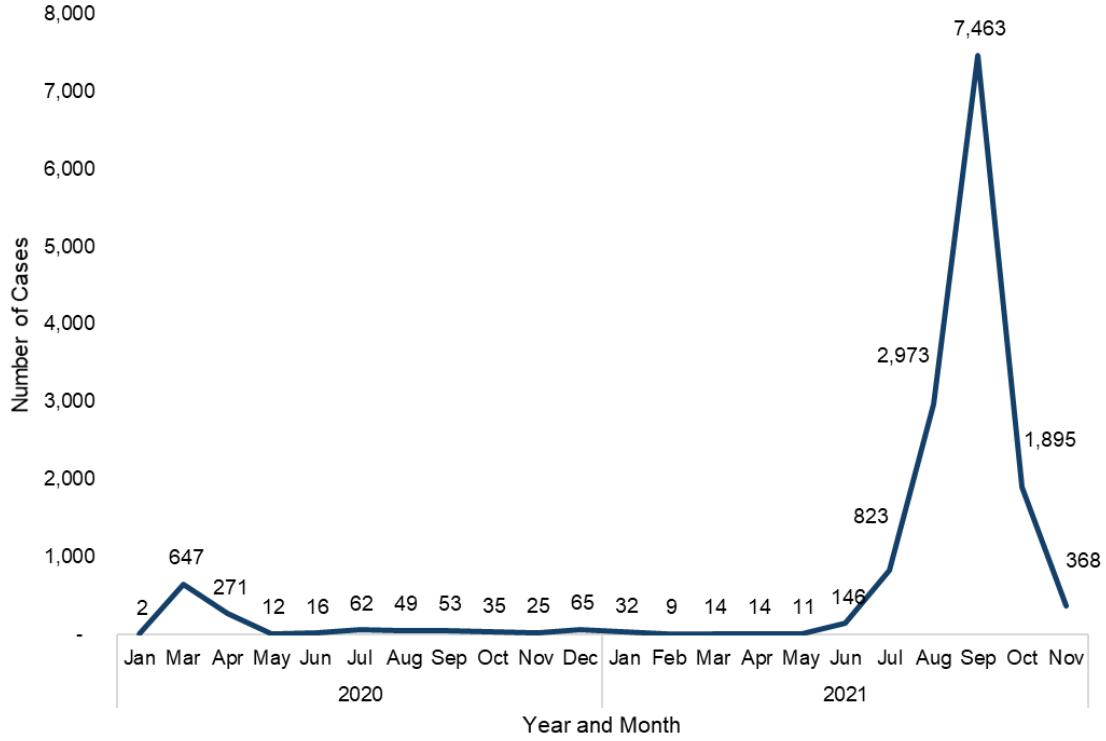
COVID-19 cases

NSW observed its first three cases of COVID-19 on 25 January 2020. As at November 2021, there have been 14,985 cases in the CESPHN region.(1) Cases have been concentrated in the following Local Government Areas (LGAs) during the 2021 outbreak: Canterbury-Bankstown, Sydney, Randwick, Bayside, Georges River, Inner West, Sutherland, Strathfield, and Canada Bay.

Figure 1: COVID-19 cases in the CESPHN region by month, 2020-21



Source: NSW COVID-19 cases data
* Cases include those acquired locally, interstate and overseas, and do not necessarily reflect the patient's place of residence.

COVID-19 vaccinations

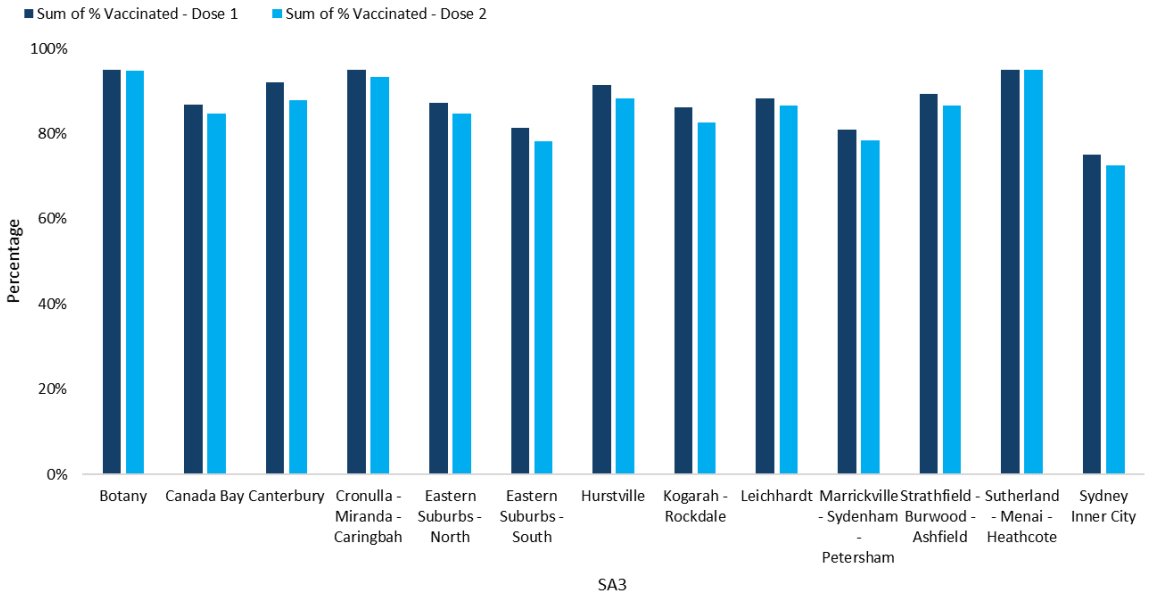
By 30 June 2021, there were 361 general practices in the CESPHN region participating in the vaccine rollout in addition to the five general practice respiratory clinics and the Aboriginal Medical Service in Redfern. Pharmacies commenced administering the vaccine at the end of September.

The majority of the population in the CESPHN region have had their first dose – over 88% of the population aged 15 and over have received one vaccine dose and over 85% are fully vaccinated.(2) While vaccination rates were initially much lower in areas including Botany, Canterbury, Hurstville and Kogarah-Rockdale, these rates have increased markedly.

Hard to reach groups include those unable to leave their home, socially disadvantaged, people who speak English poorly. CESPHN in partnership with the Local Hospital Districts has developed the Vax

at Home program for those people who are housebound and not able to leave their house (and their carers) to receive a COVID-19 vaccination.

Figure 2: Percentage of eligible vaccinated population in the CESPHN region by SA3, November 2021



Source: Australian Government COVID-19 vaccination data
Note: Botany SA3 dose 1 is >95%, Cronulla-Miranda-Caringbah SA3 dose 1 is >95% and Sutherland-Menai-Heathcote SA3 doses 1 and 2 are >95%

COVID-19 impacts

COVID-19 continues to have profound impacts on the CESPHN region – these include service disruptions and broader population health and household impacts. It is important to use the experience of this pandemic to help us better prepare for the next one and to consider the sustained improvements needed in our health system.

The sections below summarise the findings from CESPHN's report *COVID-19 Challenges and Opportunities for Primary Care.*(3)

Service disruptions

COVID-19 has created a significant disruption to health services and changed demand in the primary health sector. Providers have had to adapt quickly and adopt new technology to enable remote working and consultations. Many providers had to reduce the delivery of services due to physical distancing requirements and may now be experiencing reduced revenue, a reduced workforce and limited capacity. COVID-19 also has had significant implications for workforce physical and mental wellbeing.

Digital models of care

Many providers in the CESPHN region have moved to digital models of care during the pandemic. Lower numbers of community and allied health providers were using telehealth when surveyed by CESPHN in July 2020 – 42% of respondents reported that they were delivering over half of their services via phone, and 11% reported they were delivering over half of their services via video. The remainder were delivering less than half or none of their services via telehealth. This compares to 83% of GP respondents who reported they were billing MBS item numbers to telehealth.

Most providers reported easier adoption of telephone consultations. Those who reported barriers to telehealth highlighted difficulties in accessing technology, particularly for older people and people from culturally and linguistically diverse backgrounds. Others reported that telehealth is more taxing and labour-intensive for clinicians, and that it can be more difficult to diagnose patients (given the lack of visual and other non-verbal cues) or to engage patients, including for chronic disease management. Another barrier noted was the additional administration required to refer patients to pathology, radiology or other services, which have not been digitised and require more steps for both the patient and the provider when done through telehealth.

The shift to telehealth also has implications for consumers who may be unable to access services virtually or prefer in-person consultations. Several vulnerable population groups face barriers in accessing telehealth services, particularly among homeless and elderly populations. Lack of privacy, overcrowding, ability to use technology and poor access to devices and high-speed internet could mean that patients may not benefit equally from the service provision.

Provider viability

In July 2020, CESPHN surveyed primary health care providers about the impact of COVID-19. Across all survey respondents, 56% reported that they had experienced a decline or a significant decline in income as a result of COVID-19. Those with a significant decline reported that this had resulted in their practice or service operating at a financial loss. This differed slightly between respondents, with:

- 50% of GPs reporting a decline in income, and 22% a significant decline in income
- 18% of community organisations reporting a decline in income, and 27% a significant decline in income
- 50% of allied health reporting a decline in income, and 33% a significant decline in income.

As well as reduced income, practices have faced additional costs to ensure their practices are COVID safe. These include costs of additional personal protective equipment (PPE), intensive cleaning, additional time off for staff unable to attend work due to illness or following COVID-19 testing. Many community organisations and allied health practices are not eligible to receive masks from the national stockpile and have faced challenges both sourcing PPE and meeting this additional cost.

The increase in remote healthcare models comes with set-up costs and new technology investments for providers and practices, as well as the need to invest in new training, capability and protocols.

Moving forward, providers in the region are also likely to face a backlog of patients due to stalled service delivery and increasing waitlists. Some practices and providers, particularly smaller or solo providers, may decide that now is the time to leave the industry as a result of the disruption to their businesses of COVID-19. This will have longer-term capacity impacts for the primary care system.

Provider wellbeing

The experience of responding to COVID-19 has been shown to have generated higher levels of anxiety among healthcare workers, with the potential to lead to higher rates of burnout. Other potential adverse effects on healthcare workers include heightened risk of exposure and infection.

COVID-19 has had a varying impact on healthcare professionals' workload – 38% of healthcare professionals surveyed by CESPHN said they had seen their workload increase, while 53% said it had decreased. Specifically, 75% of pharmacists and healthcare managers reported increases, as did 45% of nurses. Most surgeons (91%) and 72% of allied health practitioners reported decreases in their workload. A key challenge is to rebalance resources as certain specialties decrease whilst others increase their workload during the pandemic.

Population health impacts

Beyond COVID-19 itself, the pandemic has had and will continue to have broader population health impacts. These include:

- Mental health impacts as a result of increased anxiety, stress and isolation
- Increased drug and alcohol consumption
- Increased domestic and family violence
- Reduced access to care and increased isolation for people with disability and older people
- Increased implications of chronic diseases as a result of people not being able to access preventative treatments during the pandemic
- Increased demand for services required to support rehabilitation of COVID-19 patients, the impacts of which are not currently fully understood
- Increased emphasis on the need to provide care for the most vulnerable who are at particular risk of pandemics.

See the Mental Health and Suicide Prevention and Alcohol and Other Drugs reports for further analysis on the impact of COVID-19.

Household impacts

The impact of job losses has been significant in the central and eastern Sydney area, with the inner-city Sydney area shedding 43,000 jobs in April 2020. The city and inner south areas experienced 17,300 job losses in the same period, while the eastern suburbs experienced 1,900 job losses. The Centre of Full Employment and Equity's Employment Vulnerability Index (EVI) has identified several Sydney communities as being most at-risk of COVID-19 related job losses, including the Punchbowl and Sydney CBD areas. Sydney's second city-wide COVID-19 lockdown has hit jobs harder than the first lockdown. New data show payroll jobs in Greater Sydney have fallen nearly 9% since lockdowns began on 26 June 2021.

COVID-19 challenges and opportunities

COVID-19 has rewritten the agenda for primary health care, presenting the sector with both challenges and opportunities. It is enabling the acceleration of key initiatives such as telehealth and e-prescribing and providing an opportunity for the transformation of the health system. Primary care has been at the forefront of the pandemic response: monitoring and testing, protecting vulnerable communities, disseminating information, promoting continuity of care, adopting new telehealth initiatives, and instituting COVID safe practice.

Challenges and opportunities for CESPHN include how to:

- Engage and communicate with community members and primary care providers
- Communicate relevant and up-to-date information with a large and diverse group of primary care providers, with different service delivery models, different needs and pressures, and different professional standards
- Adequately support practices and allied health professionals given the large number of providers
- Support our providers to adapt and change their modes of service delivery
- Maintain the capacity of existing primary care services, facilitating surge capacity to respond to emerging COVID-19 challenges, while maintaining the wellness and wellbeing of the primary care workforce
- Build capability in a rapidly changing environment through remote delivery methods
- Flex our operating model in an increasingly complex environment with shifting priorities and changing responses required during different stages of the pandemic, whilst also continuing to address our other health and wellbeing priorities
- Identify at-risk populations, and ensure the more vulnerable groups in our region are supported
- Influence policy and regulatory discussions and advocate on behalf of primary care
- Improve the coordination and communication between primary and secondary care to deliver an integrated approach.

COVID-19 provides an opportunity to re-think and work towards greater integration across the system. Immediate priorities to work through include improving system integration to better enable referrals between settings of care and improving the flow of shared patient information (such as test results and discharge summaries). Supporting residential aged care facilities to respond to outbreaks of COVID-19 is another key area of work.

The local health districts and networks within the region are all implementing virtual hospital models – initially to care for patients with COVID-19. Clarifying the role of general practice and allied health in these models is important as is the need for some consistency in approach across the region.

Integration should also involve collaboration with the wider community sector and community members. This becomes particularly important in considering the significance of addressing the social determinants of health and broader population health impacts in relation to COVID-19. Community organisations and community members will be critical partners in responding to this challenge.

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