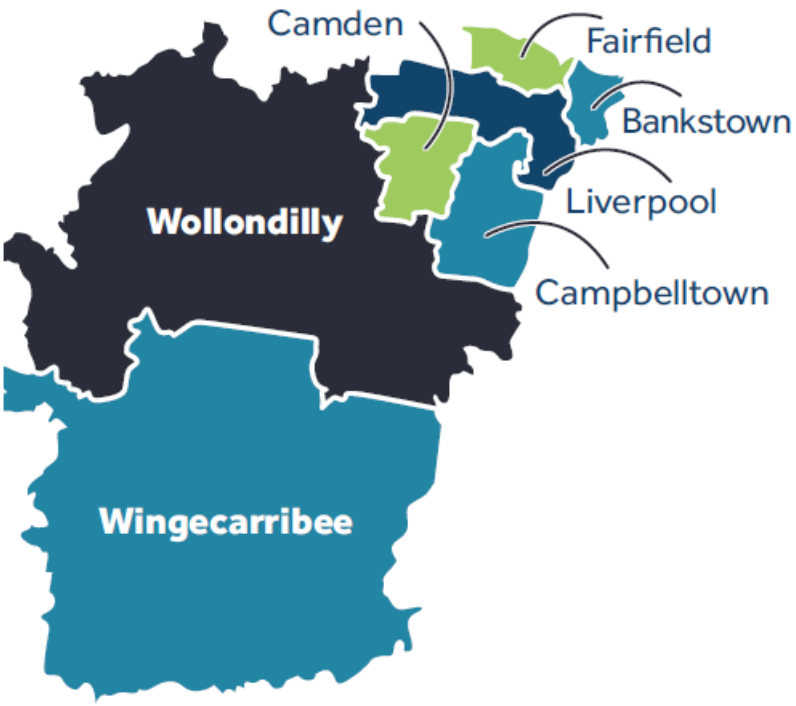
SWSPHN 2025-2028 Needs Assessment 2025 Update



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Public

SWSPHN NEEDS ASSESSMENT 2025 – 2028

Needs Assessment Sections

Section 1: Narrative

SWSPHN NEEDS ASSESSMENT 2025 – 2028

1.1: Needs Assessment process and issues

South Western Sydney PHN's Needs Assessment 2025 Update incorporates updated data sets released in 2025, findings from recent consultations and literature reviews. The report identifies areas that have been substantially updated by the use of red asterisks following titles. Areas with updated data, data visualisations and minor text changes only are marked with a blue asterisk.

The needs assessment is an ongoing process, involving:

- Literature reviews
- Data collection and analysis
- Stakeholder and community surveys
- Consultations and focus groups

SWSPHN has several organisational processes to support the Needs Assessment development including an internal governance oversight structure. This year, improvements have been made to:

- The flow of the report through changes to its structure.
- The future-proofing and standardisation of data visualisations through the development and utilisation of an R coding database
- Evolving arrangements for the sharing of data with our Local Health District

Evaluation of the year's process is conducted after submission to identify opportunities for improvement.

Data collection and analysis

We analysed demographic and epidemiological data from national, state and local level data sources. Where possible, data at smallest geographic level (e.g., LGA, SA3, Postcode) has been analysed. including (but not limited to):

- Australian Bureau of Statistics (ABS)
- Australian Institute of Health and Welfare (AIHW)
- Medicare and Pharmaceutical Benefits Scheme statistics
- NSW HealthStats
- Public Health Information Development Unit (PHIDU) from Torrens University
- PHN commissioned services
- Primary Mental Health Care Minimum Data Set (PMHC-MDS)
- Drug and Alcohol MDS
- Clinical and workforce data from General Practices, including, ChilliDB, POLAR, and the LUMOS project (a collaboration with the NSW Ministry of Health) which links data from 152 SWS general practices with NSW Health data to follow patient journeys and identify underlying trends and gaps
- Qualitative data collected from surveys and consultations with stakeholders.

Consultations with stakeholders

SWSPHN is committed to engaging with local communities and health professionals throughout the needs assessment process. Some of our ongoing stakeholder engagement activities include:

- Joint South Western Sydney Local Health District (SWSLHD) / South Western Sydney Primary Health Network (SWSPHN) Population Health and Planning Committee which meets quarterly to advise and review health planning activities
- SWSPHN Community Advisory Committee
- SWSPHN Clinical Advisory Committee

SWSPHN's bi-annual Local Health Forums that facilitate face-to-face stakeholder feedback continued successfully in 2024 and 2025. Focus areas in the FY 2024/25 included end of life and advance care planning and alcohol and other drugs. Work has commenced on the first Local Health Forum for FY 2025-26, antenatal care.

Health need specific consultations and co-design activities

We use face-to-face consultations, phone interviews, focus groups, steering committees, consultation with various advisory committees, surveys in a minimum of four community languages, for the collection of qualitative information from consumers, health professionals, and service providers. Consultations in FY 2024-25 included:

- Wollondilly Health Alliance Needs Assessment ongoing into FY 2025/26
- Advance Care Planning
- Alcohol and other drugs
- First Nations engagement
- Allied Health
- Suicide Prevention
- Antenatal Care ongoing into FY 2025/26

Qualitative data from these consultations has been analysed thematically and incorporated into the needs assessment document.

Key issues arising

Issue	Summary Description	Page Number
Primary Care Workforce	Reduced business viability, difficulties in recruiting and retaining GPs and Practice Nurses, GP retirements and practice closures are a key issue in SWS. The reduced affordability, availability and accessibility of healthcare reported by community members across the region is the natural flow on from workforce issues coupled with population growth and shortages in other health sectors such as specialist services.	16
First Nation's people's health	Despite the strength, resilience and cultural knowledge of First Nations communities in SWS, current health systems	23, 89, 130

	and services still result in inequitable access and poorer health outcomes for the community.	
CALD and Refugee Communities	In 2021, 42.4% of residents in SWS were born overseas compared with 34.6% for NSW. Just under 38% of the NSW intake of refugees are settled in SWS. This rich cultural and linguistic diversity is a major strength of SWS, bringing extensive community networks, lived experience, and multilingual capability However, our CALD population experiences poorer outcomes and significant health access and equity issues... Lack of culturally safe services, lack of use of interpreters, and issues with refugee health assessments and on-going care inhibit access for CALD and refugee communities. Access is also impacted by health literacy, English proficiency, cultural norms and perceptions of the health system.	29, 96, 131
Older people's health	The proportion of the SWS population over 65 years is growing. Health issues associated with ageing especially falls, frailty, dementia and associated behavioural symptoms, elder abuse and complex multimorbidity, increase health service usage and reduce independence placing increasing demand on health, aged care and carer services.	33, 98, 134
E-cigarette and tobacco smoking	SWS has tobacco smoking and lung cancer rates that are higher than the NSW rate especially in males from some CALD groups. E-cigarette smoking has grown rapidly and is now slightly higher in SWS than NSW in general. E-cigarette smoking in young people aged 16-24 is a pressing issue.	42
Overweight and obesity	Higher than state rates of both overweight and obesity in both adults and children from age five years. Hospitalisations related to overweight and obesity are higher in SWS than in NSW generally. Overweight and obesity are associated with a range of chronic diseases that also have high rates in SWS including type-2-diabetes, gestational diabetes, and CVD.	52
Potentially preventable hospitalisations (PPH)	There are high PPH rates in SWS for vaccine preventable conditions and chronic diseases. People in the age groups of 0-14 years, 65 years and over, and 75 plus had the most PPH in 2021-22.	55

Family and domestic violence	SWS has significantly high rates of family and domestic violence, and the trend is increasing across most of the region. SWS is home to many people from the groups at highest risk including CALD and First Nations women, people from disadvantaged areas and people with disability.	86
High psychological distress	SWS residents experience higher levels of psychological distress, with 18.5% of adults self-reporting high, or very high psychological distress compared to NSW average (16.9%). The data indicates high levels of psychological distress among disadvantaged groups such as young people, Culturally and Linguistically Diverse (CALD) and First Nations communities. Furthermore, these groups tend to experience greater barriers to accessing mental health care.	106

Synthesis and triangulation

The needs assessment has synthesised the main themes, identified consistently throughout the analysis process, and triangulated these with available evidence to identify key opportunities, priorities and options. Issues and needs from literature review, data analysis and consultations were summarised into themes. A prioritisation process was applied to identify the emerging priorities for SWSPHN. The process included the following evidence-based criteria:

- Scale of the issue – number of people affected, prevalence/incidence of the issue, trends over time
- Benchmarking of the issue – benchmarking against national/state, neighbouring regions, comparisons of smaller geographic areas within SWS, comparison between population groups
- Impact of the issue – consequences of the issue, consequences of inaction
- Inequity of the issue
- Practicality of addressing the issue

The prioritisation was undertaken with SWSPHN Population Health Steering Committee and Subject Matter Experts at SWSPHN to ensure it was balanced and views of different stakeholders were considered.

1.2: Additional Data Needs and Gaps

SWS is a region divided into seven local government areas (LGAs) that are particularly characterised by their diversity. For a regional primary health organisation such as SWSPHN to understand the patterns of disease prevalence and plan interventions and efficient, effective services that are in the right place at the right time, health issues need to be examinable for each LGA. SWSPHN has previously reported on data fragmentation and gaps and the difficulty these cause in assessing current needs without current data. We can now add lack of granularity in data on disease prevalence and health services. The issue of lack of data at smaller geographic levels (LGA, SA3, Postcode) reported in 2024 remains following the NSW Ministry of Health decision to discontinue LGA Level reporting on data gained from the NSW Population Health Survey

due to potential privacy concerns. This has reduced the PHNs ability to analyse health issues including smoking, obesity, diabetes, kidney disease and COPD.

Data gaps in the following population groups have also been identified:

- First Nations people where data is outdated and fragmented
- People from culturally and linguistically diverse background (CALD)
- People experiencing homelessness and those at risk of homelessness
- People experiencing domestic and family violence
- LGBTQIA+ communities
- Primary care palliative care due to the lack of MBS item numbers for palliative care in general practice
- Dementia prevalence

1.3: Additional comments or feedback

At SWSPHN, the needs assessment process has given means and opportunity to expand our knowledge of the region in which we operate and seek to influence in terms of health outcomes. SWSPHN partnered with South Western Sydney Local Health District in developing a joint needs assessment for the region in 2019 and a new Joint Needs Assessment is currently in progress with a 2026 release date. This relationship is fostering improved efficiency in data sharing processes and understanding health needs across the community. Early work to establish processes for collaborative community consultation is furthering these sought after efficiencies.

SWSPHN is a maturing organisation that has approached the development of the 2025 needs assessment update with the learnings from previous years embedded into our process. However, with populations, their health, services and systems being in a continual state of flux we continue to learn and refine our processes. This year's process has reinforced the influence of social determinants of health in our region. In SWS the greatest need is felt by population subgroups who have poorer health outcomes across a range of conditions. This underpins the importance of our cross-sector alliances with local governments and continuing efforts to build and maintain collaboration with relevant organisations such as the Local Health District, non-government organisations, community organisations, universities and neighbouring Primary Health Networks to better understand and address the health needs of our region. Our plans for the future include greater inclusion of health disparities across socioeconomic groups and investigation of the social determinants of health in SWS.

SWSPHN is working to produce needs assessments with utility to a greater number of people from curious individuals to small organisations looking to respond to commissioning opportunities to local charitable organisations with funds to target areas of need.

To achieve this SWSPHN is working towards:

- providing succinct summaries of key regional priorities to our population
- moving away from the use of deficit discourse where appropriate and including like-for-like comparisons across sub-populations instead of always comparing sub-populations to the 'norm'.
- focusing on improving readability to improve utility for stakeholders within the region in assisting with their own service planning
- making greater use of infographics in public facing documentation

Section 2: Outcomes of the Health and Service Needs Analysis

Note: The SWSPHN Needs Assessment has combined Sections 2 and 3 of the Department of Health and Aged Care Needs Assessment template into a single section for ease of reading

Section 2.1: Demographics, Growth and Access to Health Services

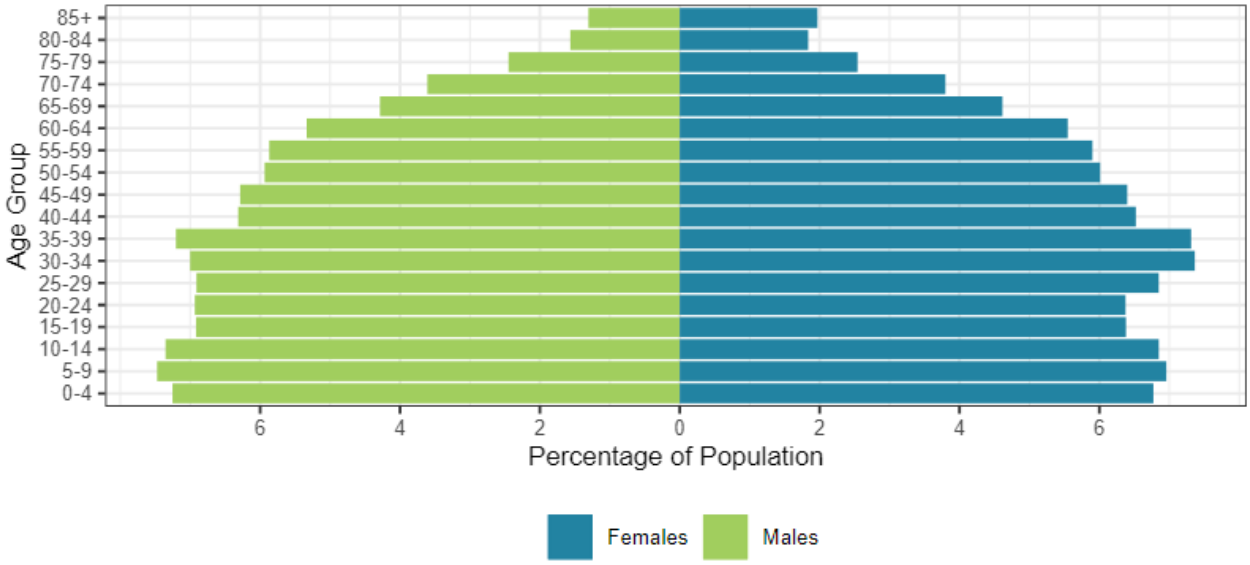
2.1.1 General Population

Current population and expected growth

The population of SWS is spread across the seven Local Government Areas (LGAs) of Camden, Campbelltown, the Bankstown portion of Canterbury-Bankstown, Fairfield, Liverpool, Wingecarribee and Wollondilly. Between the 2016 and 2021 census the population climbed to just over a million people, 1,057 080 (ABS 2022) driven mostly by greenfield developments and urban intensification. Figure 1 shows the region's age and gender mix.

Key Issue for our region	South Western Sydney continues to experience significant population growth, particularly in greenfield areas, putting continued pressure on healthcare access across the region

Figure 1: SWSPHN population by age and gender, 2021 (ABS 2022)



Prior to 2021 the NSW Department of Planning and Environment (DPE) projected SWS population growth of 11.3% between 2021 and 2026. However, due to the COVID pandemic and associated restrictions on immigration, DPE issued a revised projection of 4.6% to 2026 and projected the population will reach 1,402,684 by 2041. The SWS population is forecast to grow by 31% between 2021 and 2041 which is lower than originally forecast but remains higher than NSW growth of 21% over the same period.

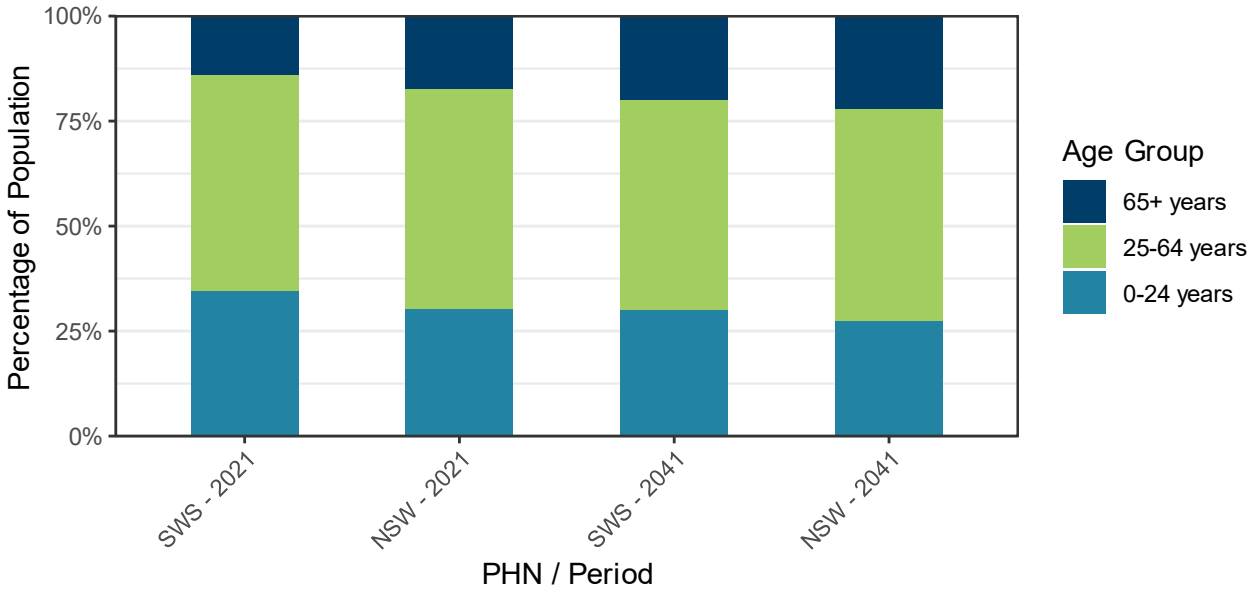
While growth for SWS is forecast to be 31% it belies the considerable variation across the region's individual LGAs which will range between 17% in Canterbury- Bankstown LGA to 83% in Camden LGA. Table 1 shows the expected percentage growth for each LGA, SWS and NSW over twenty years between 2021 and 2041.

Table 1: Projected population growth in SWS and NSW, 2021-2041(DPE 2022)

LGA	2021 Census Population	2041 DPE Population Projection	% population growth 2021 to 2041
Camden	107,908	197,735	83
Campbelltown	174,662	229,301	31
Canterbury-Bankstown	381,067	446,102	17
Fairfield	210,804	247,803	18
Liverpool	232,303	312,653	35
Wingecarribee	52,320	70,969	36
Wollondilly	54,039	90,356	67
South Western Sydney	1,213,103	1,594,920	31
New South Wales	8,166,757	9,872,934	21

The population in SWS is ageing as it is in NSW. Figure 2 shows how the percentage of the population aged over 65 is forecast to grow between 2021 and 2041 while that of children and youth (0 – 24) is forecast to decline. People's health needs increase as they age which will lead to increased demand on the region's health services.

Figure 2: Current and forecast population composition by children and youth, working age and older adults, SWS and NSW, 2021 and 2041 (ABS 2022, DPE 2022)**.**



Socio-economic status

Socio Economic Indexes for Areas (SEIFA) is a collection of four indexes which summarise Census data on income, education, employment, occupation, housing and family structure and facilitate comparison of areas. Each index has a base score of 1,000 for Australia, scores above 1,000 indicate relative advantage and those below 1,000 indicate relatively disadvantage. Scores are arranged into deciles where 1 represents the lowest 10% of scores and 10 the highest 10%.

This report focuses on three of the four indexes (ABS 2023a).

- The Index of Relative Socio-economic Disadvantage (IRSD) is a general indicator of the economic and social conditions of an area within SWS.
- The Index of Economic Resources (IER) summarises information on income and housing, people living in an area with decile ten are more likely to have a high income and own their own home compared to decile one who are more likely to have a low income and pay low rent.
- The Index of Education and Occupation reflects education level attained, employment status and occupation by skill level. An area with a high IEO is likely to have more people with higher education qualifications and in highly skilled occupations compared to an area with a low IEO that has more people without qualifications working in low skilled occupations.

Key issue for our region	South Western Sydney has significant pockets of socio-economic disadvantage

Table 2 and Figure 3 illustrate the diversity of socio-economic conditions across the SWSPHN region but that it is dominated by mid to low scores and deciles e.g. SEIFA 2021 by SA1 shows around 64% of the population in SWS resides in areas with (IRSD) decile below 5; 29% of the population reside in the most disadvantaged areas, decile 1. Within SWS LGAs, Fairfield LGA and Canterbury-Bankstown are the most disadvantaged LGAs with an IRSD of 1, followed by Liverpool (2) and Campbelltown (3).

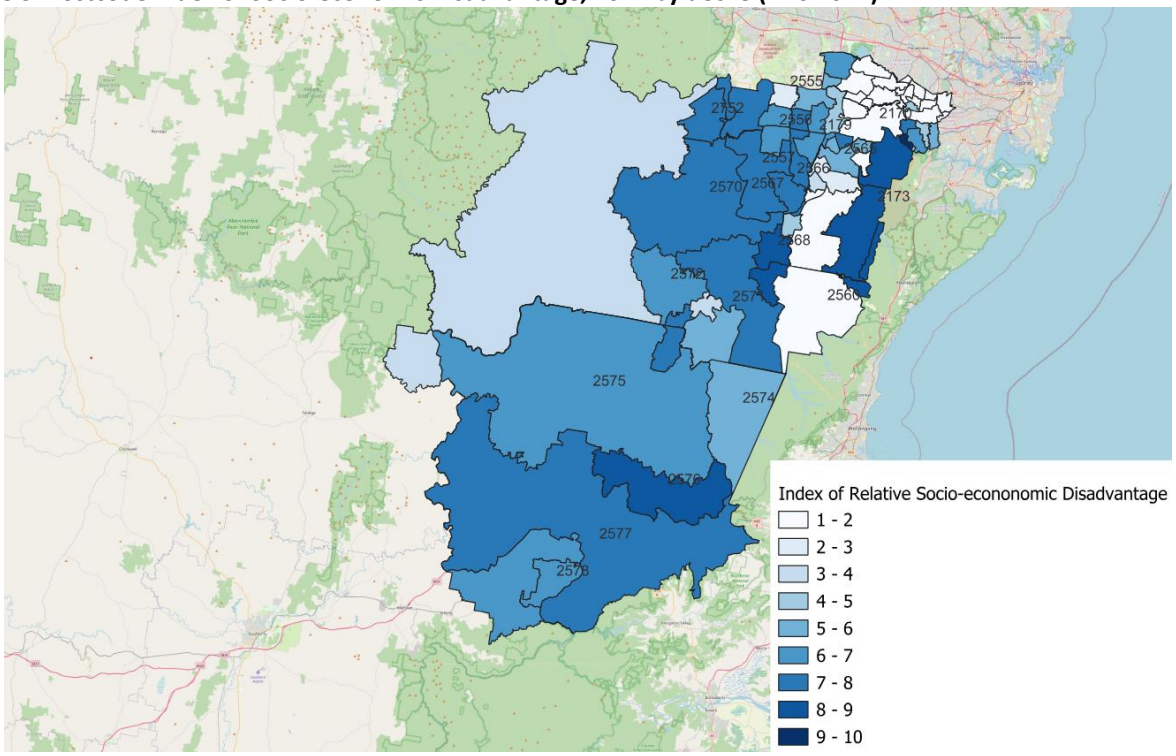
Table 2: Local Government Area (LGA) index of Relative Socio-economic Disadvantage (IRSD), 2021(ABS,2023)

2021 Local Government Area (LGA) Name	IRSD		Index of Economic Resources		Index of Education and Occupation	
	Score	Decile	Score	Decile	Score	Decile
Camden	1045	9	1098	10	1002	8
Campbelltown (NSW)	947	3	981	5	949	6
Canterbury-Bankstown	917	1	949	2	996	8
Fairfield	814	1	937	1	919	3
Liverpool	931	2	999	7	976	7
Wingecarribee	1045	9	1055	9	1020	8
Wollondilly	1041	9	1093	10	960	6

Across postcodes, there are pockets of disadvantage, mostly in the metropolitan areas as shown in Figure 3 below. Five SWS suburbs were ranked among the most disadvantaged in NSW: Miller (5), Airds (6), Cartwright (8), Claymore (10) , and Sadleir (14) Villawood (ABS 2023b). There is strong evidence from Australia and other developed countries that low socioeconomic status has a direct correlation with poor health, higher incidence of risky health behaviours and reduction in access to health care services(Turrell 2000, Blakely T 2004).

Assisting Communities through Direct Connection reports were completed in 2022 for Cabramatta, Greenacre and the Wollondilly LGA (ACDC 2022a) (ACDC 2022b). Each region identified financial stress and housing issues as the largest areas of both community and personal concern. The COVD-19 pandemic was also seen as a community challenge in all areas and physical health issues were an individual challenge for respondents living in Greenacre (ACDC 2022c).

Figure 3: Postcode Index of Socio-economic Disadvantage, 2021 by decile (ABS 2022).

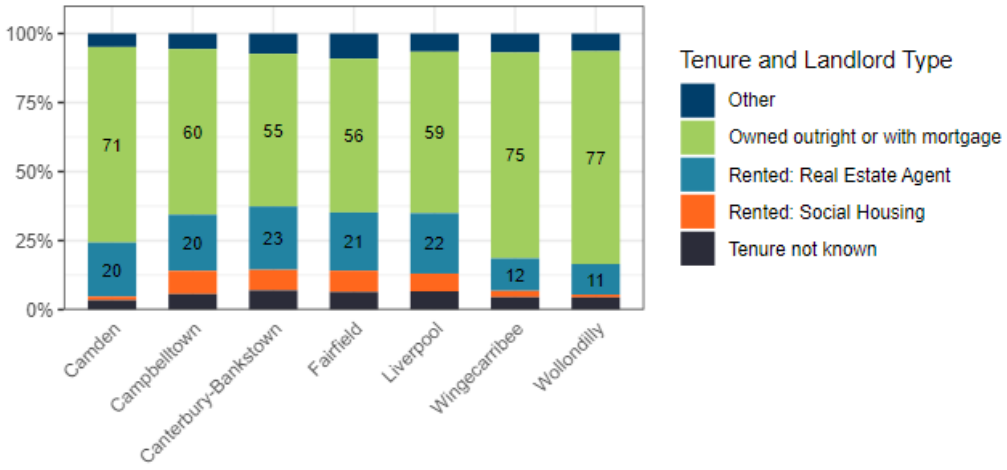


Access to housing

The majority of dwellings in each of region's LGAs are owned either outright or with a mortgage with the proportion varying in line with the index of relative disadvantage (IRD), range 55% in Canterbury-Bankstown to 77% in Wollondilly. Rental through a real estate agent in the most common form of tenure amongst those who do not own their own home as shown in Figure 4, ranging from 11% in Wollondilly to 23% in Canterbury-Bankstown. Low rental housing provided by the State Government and community housing providers varies with IRD ranging from 8% in Fairfield and Campbelltown to 1% Camden and Wollondilly.

At the 2021 census households where mortgage payments were more than 30% of household income ranged from 6% in Wingecarribee to 10% Wollondilly (ABS 2023c) . The proportion of households where rent payments were more than 30% of household income ranged from 4% in Wollondilly to 16% in Fairfield LGA (ABS 2023d).

Figure 4: SWS home ownership and tenure by LGA, 2021 (ABS 2022)



Recent housing challenges in Australia have led to a new National Housing Accord with targets set for new housing completions between 2024 and 2029. In NSW targets have been set for 43 LGAs that are expected to experience the highest growth. Regional NSW has been allocated a total of 55,000 new homes with the majority built in existing regional growth areas. Wingecarribee LGA within the SWSPHN region has been included in this total. The remaining six LGAs have been allocated individual new build completion targets(DPE 2024). In descending order these are Liverpool 16,700, Canterbury-Bankstown 14,500, Campbelltown 10,500, Camden 10,200, Fairfield 5,900 and Wollondilly 5,500 totalling 63,300.

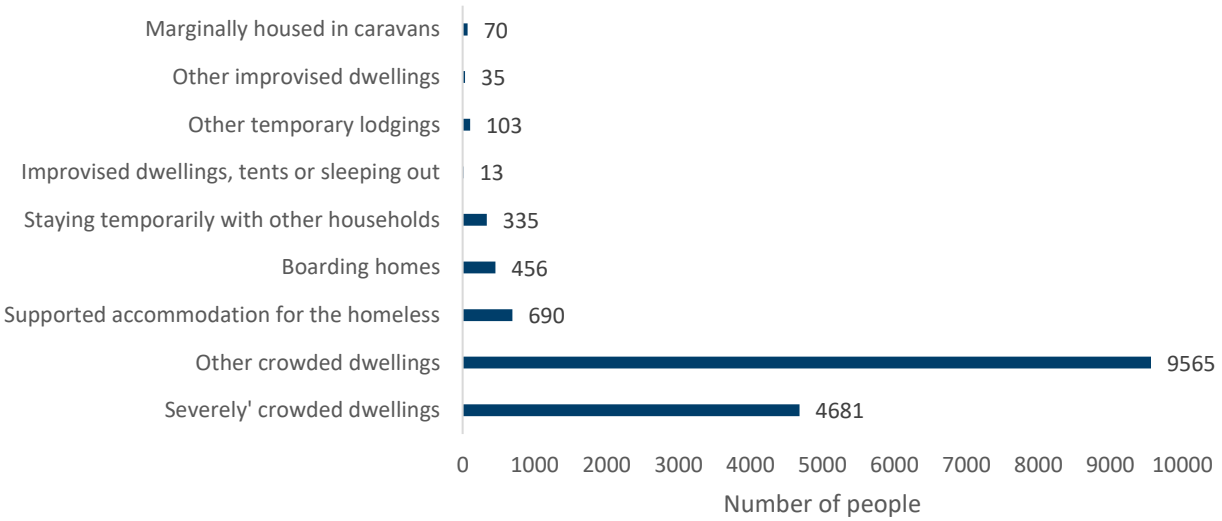
Homelessness

In 2021, an estimated 122,494 people were experiencing homelessness at the time of the ABS Census, a 5.2% or 6,067 person increase compared to 2016 (ABS 2023). In 2021, the rate of homelessness in NSW decreased to 43.40 people per 10, 000, a 7.2% or 50.4 person per 10, 000, decrease (Homelessness NSW 2021)NSW has the third highest rate of homelessness compared to other jurisdictions. In NSW, the highest estimate of form of homelessness classification is living in 'severely' overcrowded dwellings (18.1 people per 10, 000 or 14, 623 people). This is followed by living in boarding houses (6.20 people per 10, 000 or 8, 820 people). The rate of homelessness was highest in people aged 19 to 24 years (83.80 per 10, 000 people) followed by those aged 25-34 years (70.60 per 10, 000 people). In NSW, Aboriginal and Torres Strait Islander people represented 7% of the homeless population.

Key issue for our region	**South Western Sydney has a high proportion of over-crowded residences and unstable housing**

In SWS, an estimated 6,419 people were experiencing homelessness in 2021. The dominant form of homelessness in SWS was people residing in 'severely' crowded dwellings (4,710 people). Only 11 people were recorded to be living in improvised dwellings, tents, or sleeping out. It is important to note that the number of people experiencing this form of homelessness is significantly under represented by the ABS as people may not have had the means to complete the Census (ABS 2022). In SWS, Canterbury-Bankstown has the highest prevalence of homelessness (2,695 people or 42%) compared to other regions.

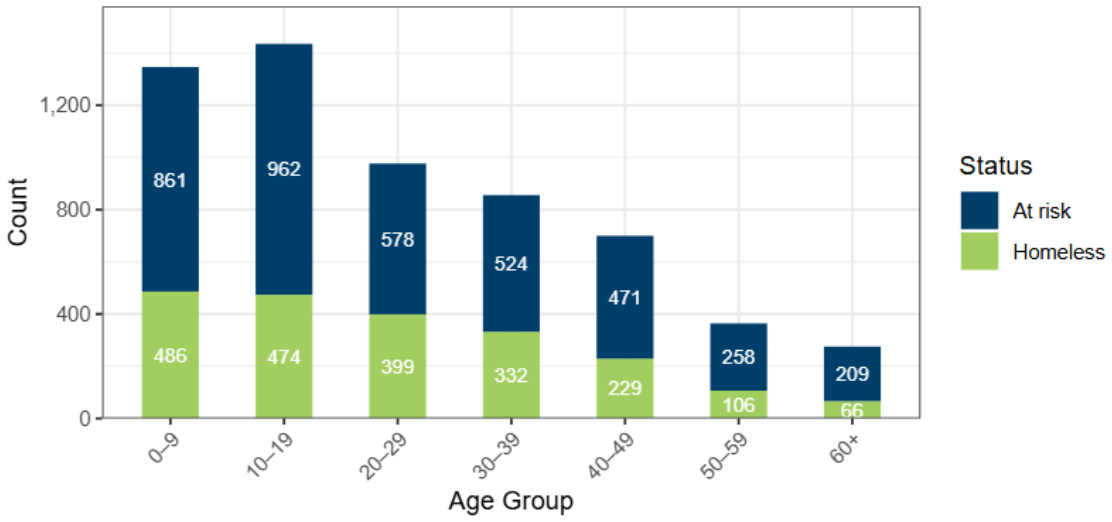
Figure 5: Homelessness by operational group, SWS, ABS 2021 Data



In 2022-23, there were 6,311 clients accessing Specialist Homelessness Service (SHS) agencies in SWS (PHN) which represents 2.3% of all clients in Australia (AIHW 2024b).
Of the clients supported by SHS agencies in 2022-23:

- 58.7% reported being at-risk of homelessness at first report (68.6% females; 31.4% males)
- 30.2% reported being homeless at first report (60.6% females; 39.4% males)
- 58.5% were female and 41.5% were male
- 16.7% were under 10 years

Figure 6: Specialist Homelessness Services clients, by age, SWS, 2023 – 24 (AIHW 2024b)



People who are homeless experience numerous other barriers to service access due to issues such as:

- disengagement with the health sector, particularly following a poor experience with a service
- lack of GPs willing or able to support the homeless community (e.g., completing medical forms to access housing)
- financial barriers (e.g., accessing psychiatry for a diagnosis which is needed for housing and support service applications)

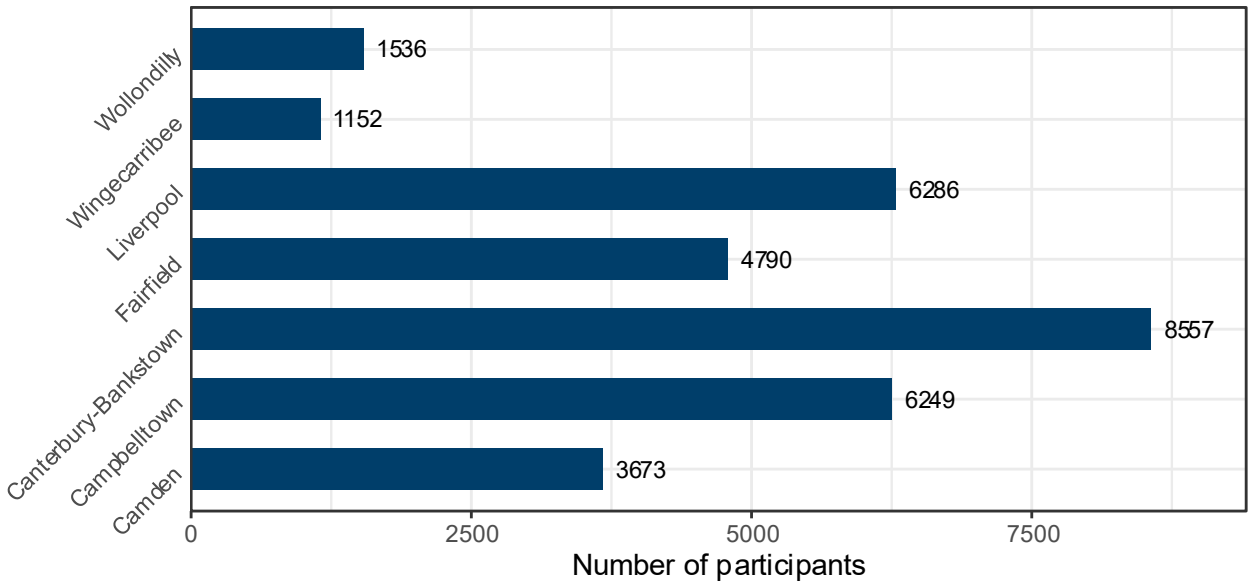
People living with a disability

People living with a disability often have higher levels of illness than the general population such as multiple chronic and complex care issues. People with an intellectual disability are more likely than the rest of the population to be under-diagnosed or under-treated. They also face significant financial and physical barriers to accessing health services as well as discrimination (AIHW 2010).

In 2022, 21.4% (5,483,200) people in NSW had a disability, a statistically significant increase compared to 2018 (17.7%). Approximately 7.9% of the NSW population had a profound or severe disability which was also a statistically significant increase compared to 2018 (5.7%). An estimated 1,054,500 people in NSW had profound core activity limitation and 982,100 had severe core activity limitation (ABS 2024).

Key issue for our region	**South Western Sydney has a higher percentage of people living with a disability, resulting in increased demand for health services**

Figure 7: Number of SWS National Disability Insurance Scheme participants by LGA, December 2024 (NDIA 2024)



As of December 2024, Canterbury-Bankstown LGA had the largest number of NDIS participants (8,557) followed by Liverpool (6,286) and Campbelltown (6,249) . In SWS, there are 32,243 active NDIS participants, this is projected to increase to 40,200 by June 30, 2030 (24.7% increase) (NDIA 2024).

Access to primary care services

General Practitioners are the cornerstone of primary care and the gatekeepers to other health and social services. Therefore, access to GP services is crucial to the function of a region's health system as whole.

In consultations with SWSPHN during 2024, consumers told us that the three biggest limitations to their ability to see a GP were wait times, affordability and poor accessibility to preferred practice. Accessibility is influenced by the size of the population needing to see the available GPs, affordability is influenced by bulk billing practices and physical accessibility is influenced by such things as travel time and public transport (AIHW 2024e). GP availability and bulk billing practices are workforce issues of increasing importance that may result in people delaying or not seeking treatment, increased avoidable hospital presentations, and poorer health and wellbeing outcomes.

The SWSPHN region had 1225 GPs which equates to 115.9 GPs per 100, 000 people based upon the 2021 census population of 1,057,080. The three main workforce issues affecting SWS are:

Key issue for our region	**SWS has the lowest number of GPs per capita of any part of the greater Sydney Metropolitan Area with higher rates of older GPs and solo GP practices**

Ageing GP Workforce

The GP workforce in SWS is ageing with a median age of 53 years. Fairfield LGA in particular has a GP median age of 59 and has also experienced a decline in GP FTE in the past five years. A large proportion of practices in the Fairfield and Bankstown LGAs are solo (62% and 55% respectively). Many practices are non-accredited with limited capacity to support the increased patient demand expected from not only projected population growth, but also as the elderly GPs retire over coming years.

General practice wellbeing under pressure

General practices across the SWS region are finding it increasingly difficult to stay financially viable due to lack of appropriate indexing of the patient rebate. SWS has traditionally had high bulk-billing rates, many practices and consumers are reporting a transition to mixed billing to remain open. Between 2023 and 25 September 2025, 52 practices have closed or amalgamated and another 4 are at risk of closure

Primary care workforce shortage

Some areas of SWS are experiencing workforce shortages due to difficulty in recruiting and retaining GPs and Practice Nurses. A NSW Legislative Council 2020 report highlighted anecdotal evidence from medical professionals that it was difficult to get health care workers to live and work in SWS, as opposed to other areas of Sydney. Many medical professionals working in SWS live in other parts of Sydney and face long commutes to work.

The report also identified poorer and more stressful working conditions compared to other health districts, including lack of resources, limited career paths, and heavy workloads. SWS has, and will continue to experience, significant population growth in the coming years. Not only will this require an increase in GPs but also nurses, allied health professionals and specialists to support multidisciplinary team care. The diverse nature of the region's population creates a need to ensure the workforce is culturally appropriate and suitably skilled to provide quality care. This and other difficulties can be ameliorated by recruiting overseas medical professionals but hiring Overseas Trained Doctors (OTD) is difficult because section 19AB

of the Health Insurance Act 1973 places restrictions on where OTDs may work, and SWS is currently excluded.

SWSPHN analysis of service usage (demand) and GP FTE (supply) has found that this region has one of the largest negative gaps in NSW which is not adequately illustrated by looking at the GP FTE to population ratio alone.

Table 3: Number of General Practices and GPs by LGA, SWS, September 2025 (SWSPHN, 2024)

LGA	Number of General Practices	Percentage of Total	Practices per 100,000 Population	Unique Number of GPs	2025 Estimated Population	GPs per 100,000 Population
Bankstown	81	21%	37	222	227,198	98
Camden	30	8%	24	182	141,733	128
Campbelltown	56	14%	31	265	189,986	140
Fairfield	107	27%	51	231	209,827	110
Liverpool	71	18%	30	257	257,175	100
Wingecarribee	23	6%	43	117	55,371	211
Wollondilly	23	6%	42	149	60,382	247

The areas of greatest need for additional GPs within South Western Sydney include Fairfield and Bankstown (ageing workforce without new GP replacement)

- Campbelltown and Camden (current workforce unable to meet expected population growth)
- Liverpool (nine practice closures since September 2022 due to GP shortages)

Many GPs request workforce support from the PHN, with requests ranging from assistance to advertise and help navigating NSW Ministry of Health and Department of Health and Aged Care workforce support programs such as Area of Need and District of Workforce Shortage programs.
Issues raised through community and GP consultation in 2024 included:

- Community concern regarding attracting health care professionals to SWS, particularly the southern sectors of Wingecarribee and Macarthur
- Need for funding for early intervention and general preventative/educational projects
- Providing workforce support, such as resources and professional development on chronic disease care to GPs and nurses
- Poor access to psychiatrists
- Cultural competency should be included in the education and training of the entire health workforce
- Multicultural Health Workers are underutilised by clinicians

Key Issue for our region	**Many previously bulk-billing GP practices are now moving to mixed billing or gap payment reducing affordable access to primary care**

Our 2024 community consultation regarding primary care access indicated concerns with long waiting times (82% of respondents) and lack of bulk-billing practices (62%). South Western Sydney has always had a high bulk-billing rate (83%), but this has been dropped to 69% to date (23/9/2024) with more practices moving to mixed billing or gap payment (25% of practices).

Feedback from the community has indicated that many residents are now delaying visiting their GP unless absolutely necessary due to the financial cost, resulting in a decrease in preventative health care. It also coincides with an increase in Category 4 and 5 presentations to Emergency Departments, particularly in Camden and Campbelltown LGAs.

Primary care professional development

Following the COVID-19 pandemic, GPs have indicated a shift in preference regarding CPD training with 88% of CPD survey respondents indicating they preferred either virtual or a mixture of virtual and face to face training events (SWSPHN 2022). The top five clinical areas for CPD events were:

- Mental health
- Aged care
- Diabetes
- Women's health
- Preventative health

Recruitment and retention of nurses at General Practices

There are 476 practice nurses employed in the SWSPHN region (as at 25/9/2025). The Australian Primary Health Care Nurses Association (APNA) surveyed SWS practice nurses as part of its annual national Workforce Study, 2023. Although it received poor uptake (31 SWS practice nurses) its main findings were that 20% of primary health care nurses and midwives are underutilised and 80% regularly or often work to their full scope of practice (APNA 2023). The issues reported by participants were inadequate workforce preparation during training, low workforce utilisation, an ageing workforce, employments models and pay. The results reinforced those of previous studies by McInnes and Halcomb et al and the University of Wollongong in collaboration with SWSPHN (McInnes, Halcomb et al. 2019).

Access to community health services

SWS has more than 60 sites including early childhood and other centres from which community health services are delivered. Eleven of these are major community health centres. Community health facilities have inadequate space to respond to the high demand for services (lack of treatment and meeting rooms, office areas and parking spaces); and to respond to specific needs e.g., needle and syringe program facilities.

Other specialist clinical services which provide care in community settings will experience increased demands as their target populations and their health needs grow, including oral health, drug health, mental health, aged care and rehabilitation, respiratory and cardiovascular. There is also increased demand on services in areas with more vulnerable populations and complexity of their health problems (e.g. people from low socioeconomic backgrounds, Aboriginal people and people from non-English speaking background including refugees(SWSLHD 2013a).

Issues raised through the 2024 consultations include:

- Lack of community-based services from chronic and palliative care in Wingecarribee
- Lack of home visiting nurses for patients with a long-term chronic condition, including severe mental illness
- Service closure has a high impact on the community
- Mental health respite services are minimal.

Access to private health services

In 2019-20 in SWS:

- 45.9% of adults reported having private health insurance in the preceding 12 months, an increase of 5.9% from 2017-18 and much lower than national average (56.5%)
- 2.7% of adults did not see or delayed seeing a GP due to cost in the previous 12 months; this rate is similar to the national rate (3.8%)
- 7.2% of adults delayed or avoided filling a prescription due to cost (national rate of 6.6%)
- 25.7% of adults did not see or delayed seeing a dentist, hygienist or dental specialist due to cost, higher than the national rate (19.1%) (AIHW 2020j).

AIHW reports on indicators from the National Health Performance Framework (NHPF) (AIHW 2024f). Reporting on elective surgery waiting times in SWS public hospitals shows:

- Bowel cancer surgery patients: The median waiting time for large bowel resection in 2022–23 was 20 days
- Breast cancer surgery patients: the median waiting time for breast lump excision and biopsy in 2022 – 23 was 21 days

Elective surgery waiting time - % of patients seen within clinical urgency:

- Urgent – 100% in each of the five years between 2018-19 and 2022-23
- Semi-urgent – decreased from 99% in 2018 - 19 to 64% in 2022-23
- Non-urgent – decreased from 98% in 2018 - 19 to 63% in 2022–23

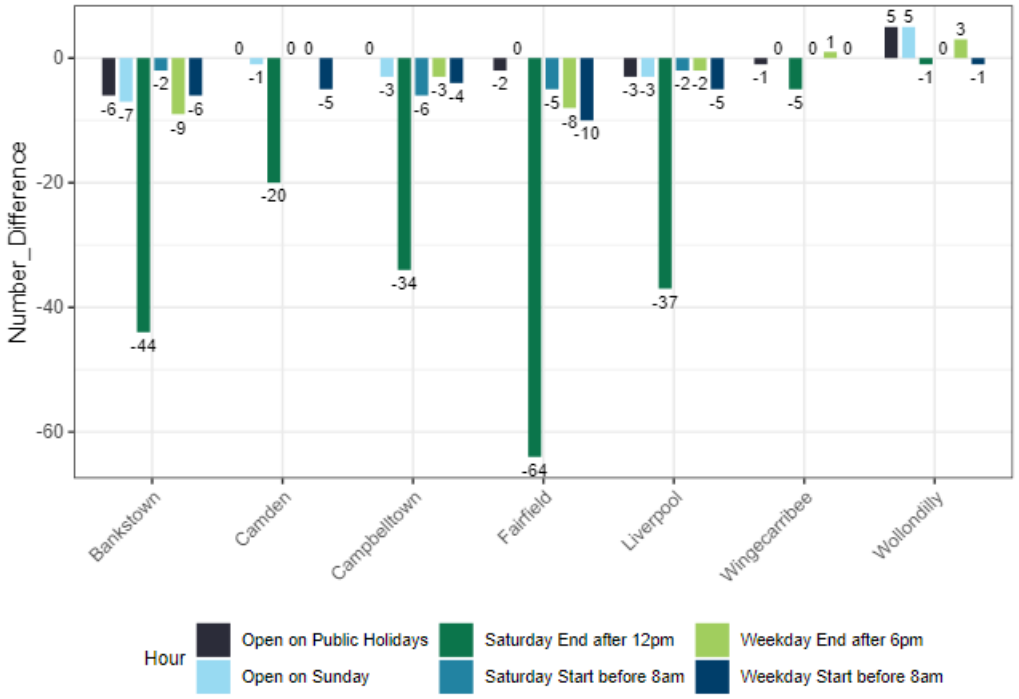
Key issue for our region	**South Western Sydney has half the private hospital beds and day-procedure centres than other areas of Sydney**

Access to after-hours services

General practices opening after hours in South Western Sydney

128 general practices in SWS operate after hours (before 8am or after 6pm) during weekdays. There is significant variability in opening hours across the region, with the majority of the after-hours practices located in the Campbelltown, Fairfield, Bankstown and Liverpool LGAs. Most of the practices close by 8pm. There's no general practice operating after 8pm in Wingecarribee or Wollondilly LGA(SWSPHN 2020). Over the five year period between 2019 and 2024 as workforce issues such as practice viability have increased there has been considerable reductions in general practices opening after-hours, especially on Saturdays after 12pm as illustrated by Figure 8.

Figure 8: Change in SWS General Practices opening after hours between 2019 and 2024 by LGA (SWSPHN 2024a)



Utilisation of after-hours services in SWS, GP After-hours attendance increased from 54.9 services per 100 people in 2021-22 to 60.65 services per 100 people in 2022-23, much higher than the national average of 30.77 services per 100 people (2022-23). Females have higher attendances compared with males. Attendances by people aged 80 years and over increased markedly from 126 services per 100 people in 2021-22 to 151 in 2022-23, they were also the highest attendances among all age groups. Across SA3 areas, Bankstown has the highest attendances, followed by Campbelltown and Fairfield (AIHW 2024g).

Key issue for our region	Significantly higher utilisation of after-hours services in South Western Sydney

Emergency Department presentations for lower urgency care

Lower urgency care are ED presentations at a formal public hospital ED, where the patient:

- did not arrive by an emergency services vehicle
- was assessed as needing semi-urgent or non-urgent care, and
- was discharged without referral to another hospital.

Some lower urgency presentations to hospital ED may be avoidable through provision of other appropriate health services in the community.

In the five year period between 2018-19 and 2022-23, the use of ED for this type of care after-hours fell both nationally and in SWS. In SWS, after-hours ED presentations for lower urgency care, decreased from 53,695 (age standardised rate 53 per 1,000) in 2018-19 to 47,758 (age standardised rate 44.6 per 1,000) in 2022-23, lower than the national rate of 52.4 per 1,000. In 2022-23 among all age groups, people aged less than 15 years have the highest attendance, while people aged 80 years and older have the lowest

attendance. Across SA3 areas, with 8,898 Fairfield had the highest number of after-hours presentations, followed by Bankstown (7,962) and Campbelltown (7,853) (AIHW 2025b).

Community surveys show overall awareness of after-hours services is high (82%) in SWS. However, people are more likely to go to hospital ED (35.4%) than use after hours service (23.6%) or go to another GP that is open (17.3%). Issues raised through community consultations include:

- Confidence in differentiating between urgent and non-urgent conditions is low
- Lack of ancillary services compared to hospital or services during sociable hours (e.g., no access to pathology, radiology, specialists and pharmacy)
- Obscure or inaccessible locations (e.g., due to actual distance from home or limited access via public transport routes)
- Out of pocket costs for after-hours primary healthcare services
- Limited workforce associated with unappealing hours
- Waiting time is perceived as too long and comparable to hospital waiting times.

Service needs identified through consultations include:

- Effective and equitable access to medical care in after-hours period to all residents of SWS
- Minimise out-of-pocket expenses for after-hours medical care (no co-payments)
- Blended delivery of service – after-hours facility, home visit, telephone and telehealth consultation
- Interactions in after-hours period communicated effectively and in a timely manner to a patient's regular GP
- Coverage for residential aged care homes across SWS
- Encourage and support more GP practices to operate their own after-hours service provisions.

Urgent Care Sites

By 30 June 2025 SWS had five urgent care sites, located in Bankstown, Campbelltown, Gregory Hills and Liverpool and Fairfield. A sixth site is planned for the Bringelly-Green Valley SA3 area. The sites offer an alternative to emergency department presentation between 8am and 10pm. The sites are equipped with medical and ancillary services such as radiology and pathology. During the 2024 – 2025 financial year, the sites provided services to 30,460 unique patients. The age group with highest presentations has been 0 – 14 years. People who identified as Australian represented 54% of patients, people identifying as First Nations people made up 4.4% of patients. People presenting to urgent care sites are asked where they would have gone if the urgent care site was not available. Answers to this question varied by site location and time presenting. People presenting to the Gregory Hills site were more likely to report they would have gone to an emergency department regardless of time of day (49%). In contrast, at Campbelltown and Liverpool sites people reported they were more likely to have seen a GP, 84% and 81% respectively. In Campbelltown this was consistent throughout the day, in Liverpool the proportion moved towards half and half in the after-hours period (SWSPHN 2025b).

Data sharing between primary and secondary care services

Data sharing between mainstream health services and GPs in the area through electronic referrals and hospital discharge reports is poor. GPs have limited to no access to hospital pathology therefore unnecessarily duplicate effort. NSW Health transition to HealtheNet may address some of these issues.

Issues raised through the consultation:

- The My Health record system is seen as an important tool by the community
- Perceived cultural clash between the government promoting My Health record and community concerns about privacy and confidentiality

Barriers to accessing healthcare for rural areas

SWS consumers, NGOs, and LHD staff continue to raise, and report concerns in relation to limited transport options which would enable access to a range of services across the region to meet their needs. Community transport options are available but are insufficient to cope with demand. Safe, timely and affordable transport in the after-hours period is a community concern.

Recent consultations have highlighted access to acute GP care in the after-hours period as a significant barrier. Limited access to GPs is a contributing factor for older people self-presenting to ED for low-acuity issues. Poor access to home visits, same day appointments, and the lack of GPs in Wingecarribee have been raised as concerns.

The built environment, such as poor infrastructure, impacts access to healthcare in rural areas. Older people are at highest risk of falls within community due to poor mobility and balance issues.

There is disproportionate access to healthcare services in Wingecarribee compared to other regions in SWS. Consultations have indicated the availability of services, both public and private, do not meet the demand of older person's health needs and goals. Need for increased access to falls prevention clinics, specialist geriatricians, and pain clinics were emphasised.

2.1.2 First Nation's Community

SWS includes the traditional boundaries of the Dharawal, Gundungurra and Darug nations. Migration and historic settlement patterns have resulted in the diverse First Nations community of SWS, made up of people from across the state and country. Although sharing many similarities, First Nations people also have significant individual and cultural differences.

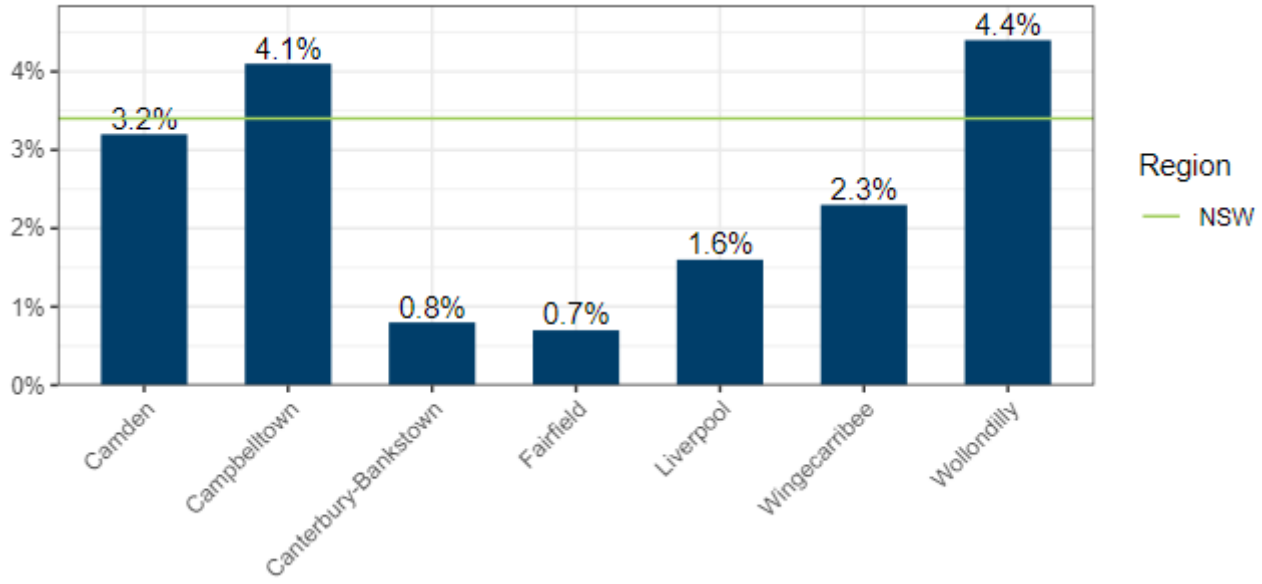
Current population and expected growth

In 2021, 26,336 people in SWS identified as First Nations, which was an increase of 5,155 people from the 2016 Census. Aboriginal and Torres Strait Islander people represent 2.5% of the total SWS population compared with 4.2% for NSW (PHIDU 2024).

There are considerable variations between LGAs in the proportion of the population identifying as First Nations. In SWS 62% of the First Nations population live in the Macarthur area, and a further 18% in Liverpool LGA.

Key issue for our region	South Western Sydney has a large urban First Nation's community

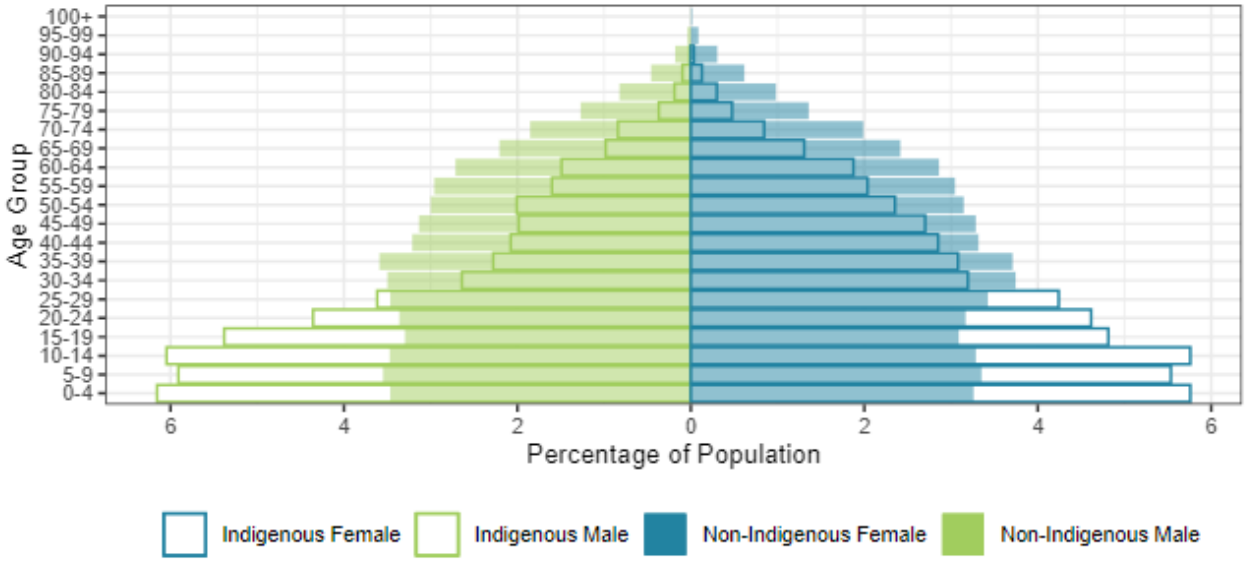
Figure 9: First Nations population as a proportion of LGA total, SWS, 2021 (ABS 2022)



The SWS First Nations community is younger than the non-First Nations population, with the First Nations population median age in 2021 being 23 years compared with 38 years of age for non-First Nations population.

More than half of the First Nations population in SWS is less than 25 years of age, compared to around 35% for the total population. The proportion of older First Nations people aged 55 years or over (11.5%) is almost three times lower than the general older population aged 65 years and over. (PHIDU 2024)

Figure 10: First Nations and non-First Nations population in SWS by age group and gender, 2021 (ABS 2022)



The SWSPHN region and three of its neighbouring PHN regions are home to a significant urban population of First Nations people. SWSPHN 26,336, Central and Eastern Sydney PHN (CESPHN) 19,423, Nepean Blue Mountains PHN (NBMPHN) 21,966, and Western Sydney PHN (WSPHN) 20,593 totalling 83,318 people (PHIDU 2024a).

Socio-economic status

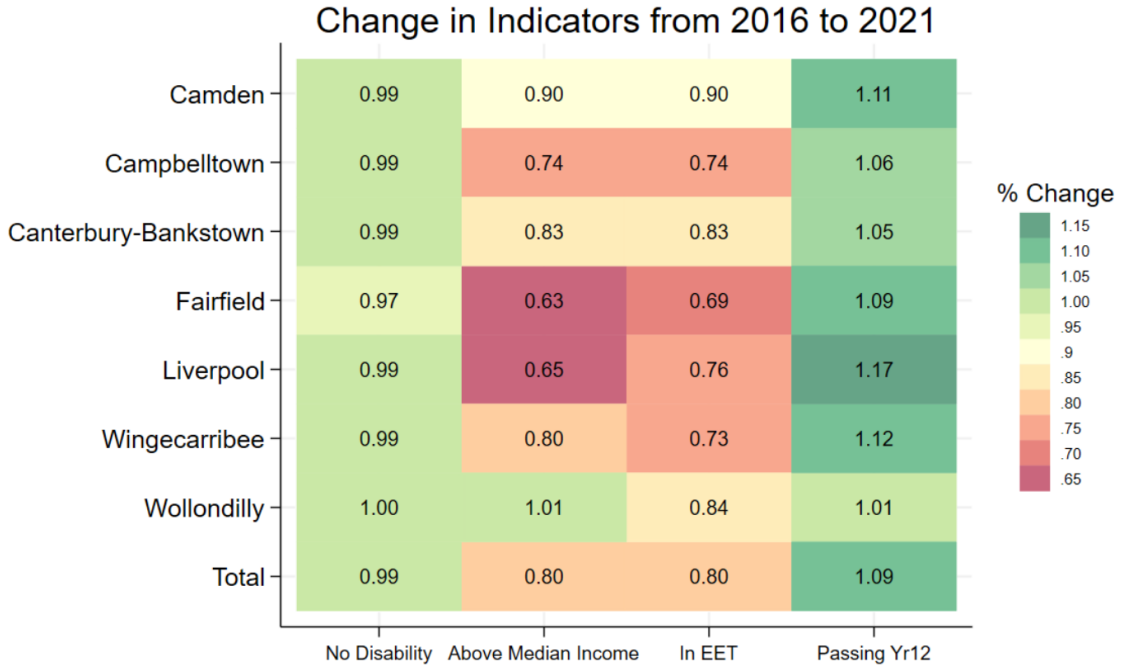
SWS includes pockets of significant socioeconomic disadvantage, in communities such as Claymore, Airds, Miller and Cartwright. These suburbs have traditionally had high levels of social housing stock and have been home to a high proportion of First Nations people. First Nations people are also disproportionately represented in the criminal justice system, with rates of incarceration at least 14 times higher than the general population.

Key issue for our region	**First Nation's communities experience higher levels of socio-economic disadvantage**

Compared with the 2016 Census, Census 2021 shows that more First Nations people completed year 12 across SWS while some areas worsened for First Nations people including: people engaged in education and training and above average median income.

This heatmap shows the percentage change of variables within the First Nations populations in SWS LGAs between 2016 and 2021. A value of 1.00 is indicative of no change, while anything lower indicates a decrease and anything higher indicates an increase. The "Above Median Income" variable refers to personal income. The "In EET" variable refers to the number of individuals who are engaged in education, employment or training programs.

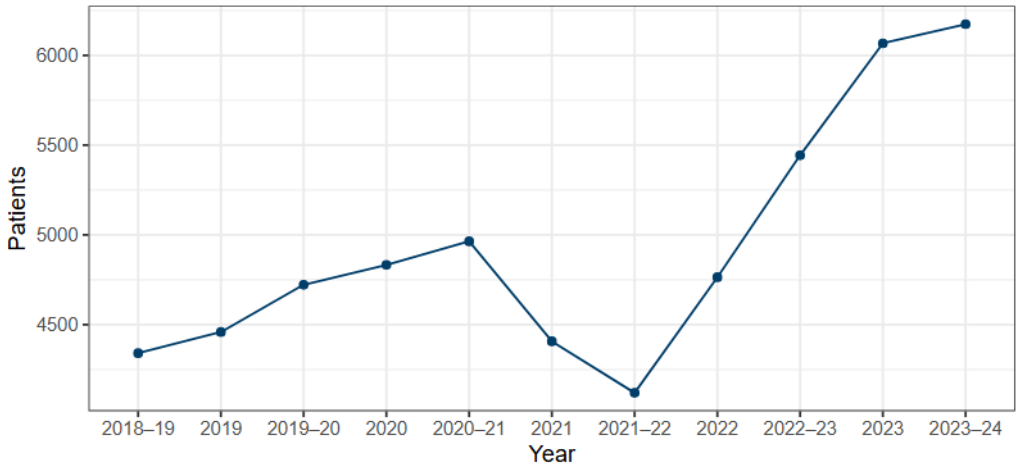
Table 4: Heatmap of demographic characteristics of First Nations populations in SWS, change between 2016 and 2021.



Utilisation of First Nations Health Assessments

Numbers of First Nations health assessments (MBS item 715) performed by GPs in SWS increased steadily until the COVID-19 pandemic when lockdown arrangements limited access to preventative care. Health checks have shown a strong recovery reaching a high of 6,174 in 2023–2024 illustrated in Figure:11 (AIHW 2024h).

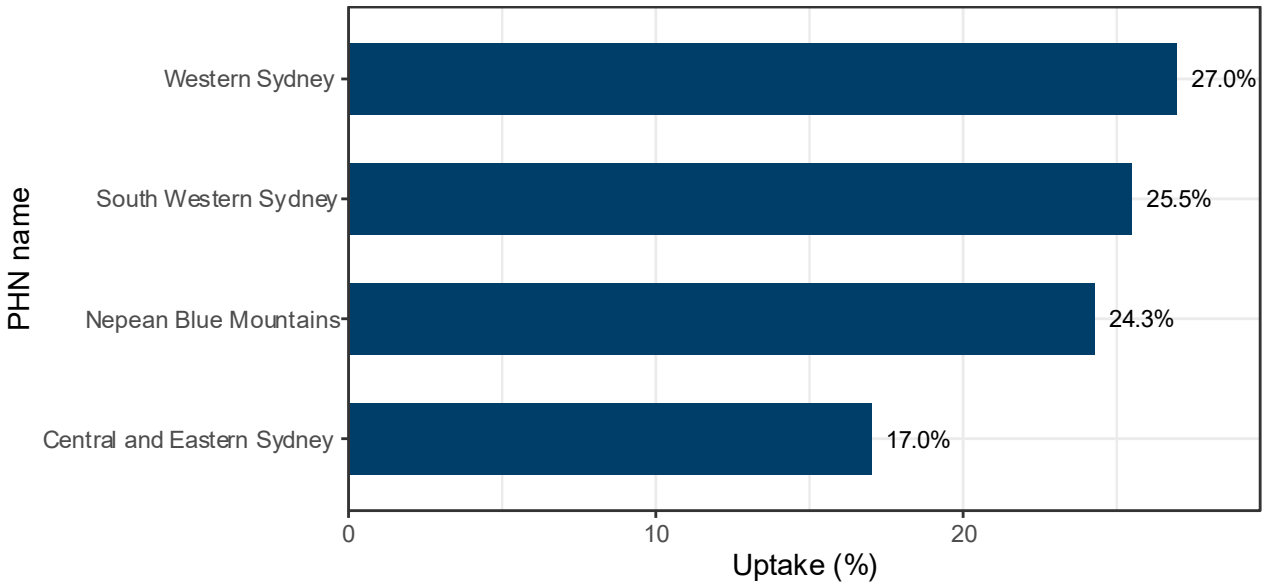
Figure 11: MBS data, use of First Nations health check and follow-up items, SWS, all ages, 2016-17 to 2021-22 (AIHW 2024h)



This is encouraging but it only represented 25.5% of the SWS first Nations population (AIHW 2024h) and was similar to the three neighbouring PHNs with similar urban First Nations populations as shown in Figure 12 below. Kim Usher and colleagues (Usher Kim 2023) reported barriers to uptake of health checks including the perception that some questions in the health check were sensitive or invasive. This perception

has evolved due to historical colonial interventions and has been expressed anecdotally in SWS. This is an important barrier that needs addressing along with the time burden on First Nations people and health professionals to complete the health check. A lack of embedded systems in healthcare also creates a barrier to uptake.

Figure 12: First Nations health check uptake in SWS and three adjoining PHNs 2024 (AIHW 2024h)



In 2022-23, 1,362 people received follow-up chronic disease prevention services from an allied health professional, First Nations Health professional or practice nurse. This was an increase of 41% over the 2021-22 number and represented 25% of the SWS people who had completed a 715 health-check. In comparison to nearby PHN regions, this proportion was the lowest, CESPHN 31.7%, NBMPHN 25.9%, WSPHN 36%.

People with chronic disease may have a GP chronic disease management plan and a team care arrangement prepared to assist them to best manage their health. At the national level, 30.8% of people who had a 715 health check received chronic disease management services. People aged 55 and over were the dominant age group receiving chronic disease management services (AIHW 2024h).

Health Equity and Access issues

First Nations people may experience barriers to accessing health care including but not limited to:

- Cultural barriers, including a lack of culturally safe and competent health services
- A lack of trust in the health service as a result of transgenerational trauma
- Social determinants of health, including income, employment status, education and housing
- Inability to meet the financial obligations for treatment, including transportation to and from appointments.

These barriers may also limit First Nations people from participating in preventative health programs, and may cause a First Nations person to delay seeking medical attention for their condition until well after the onset of the ailment(SWSLHD/SWSPHN 2018).

Specific First Nations health services

Specific non-government First Nations health services have been successfully established to support health and wellbeing in the First Nations community by means of providing culturally safe and holistic health care for First Nations people in SWS.

Tharawal Aboriginal Corporation, based in Airds, is a not-for-profit Aboriginal Community Controlled Health Organisation (ACCHO) that provides a wide range of culturally safe health and wellbeing services to First Nations people in South Western Sydney with confirmation of Aboriginality. These services include a general practice, visiting specialists and allied health professionals delivering primary care, preventative care, chronic disease management, social and emotional support and health promotion activities.

Gandangara Local First Aboriginal Council (GLALC), based in Liverpool, covers the LGAs of Liverpool, Fairfield and Bankstown. GLALC operates Gandangara Health Services providing culturally safe general practice, visiting specialists and allied health professionals, preventative care, chronic disease management and social and emotional wellbeing support. GLALC also operates Marumali, a health promotion and brokerage service that provides health promotion activities, health system navigation and brokerage to reduce financial pressures arising from health issues.

The intersection and collaboration between First Nations organisations and SWSLHD is essential in addressing health inequity for First Nations communities. The SWSLHD, assisted by funding from SWSPHN delivers the Aboriginal Chronic Care Program (ACCP) at the Budyari and Wellama Aboriginal Community Health Centres in Miller and Bankstown. The program works with First Nations people to effectively manage chronic conditions including cardiovascular, renal and respiratory conditions, diabetes, mental illness, and cancer. A team consisting of Aboriginal health workers, care coordinators and allied health professionals e.g. dietitian, exercise physiologist, social worker work together with the patient as well as their families to support them in improving their health and wellbeing.

Culturally appropriate after-hours services

Past consultation revealed community concern relating to the availability of First Nations staff within the ED to support the community. This is particularly a concern within mental health. Aboriginal Liaison Officers (ALOs) are not available after hours in SWSLHD. The SWSLHD Aboriginal Health Plan to 2027 commits to expanding its ALO positions to achieve full time coverage at Campbelltown and Liverpool hospitals and supporting an after-hours virtual model for other hospitals within the region by 2027 (SWSLHD 2023a).

Data reported by SWSPHN commissioned after-hours services between July 2020 and April 2024 indicates uptake has been lower than what may be expected based upon proportional representation of First Nations people in the population.

PHN commissioned urgent care site hours extend into the after-hours period. Medicare sites are open from 8am to 10pm and the NSW Health site opens from 8am to 8pm. At Medicare sites between July 2024 to June 2025, First Nations people have made up 4.8% of people using the region's Medicare Urgent Care Clinics which is greater than expected on the basis of proportional representation. In Campbelltown where First Nations people represent 4.1% of the population uptake (8.4% of attendees) has been particularly strong. During the same period, at the NSW Health Urgent Care Service in the Camden LGA, First Nations people have represented 2.7% of attendees which is slightly below their proportional representation in the LGA of 3.2% (SWSPHN 2025b).

Consultations

Issues raised through consultations:

- 5As initiative should include intergenerational drug abuse among First Nations communities
- Need for workforce interventions to attract and support First Nations people to be trained in specialised areas such as psychology and counselling, nursing and midwifery, and other supports
- Services need more First Nations liaison positions, and staff of First Nations background
- Cultural barriers when accessing cancer screening, cancer services and prohibitive cost of cancer treatment
- Lack of awareness among some GPs of cultural safety, Closing the Gap initiative and other First Nations specific programs
- Lack of awareness of cultural issues associated with mental illness and available support services
- Group model approach interventions are preferred in the First Nations community where people support each other to participate
- Involvement of First Nations health workers is key to support programs to engage First Nations community.

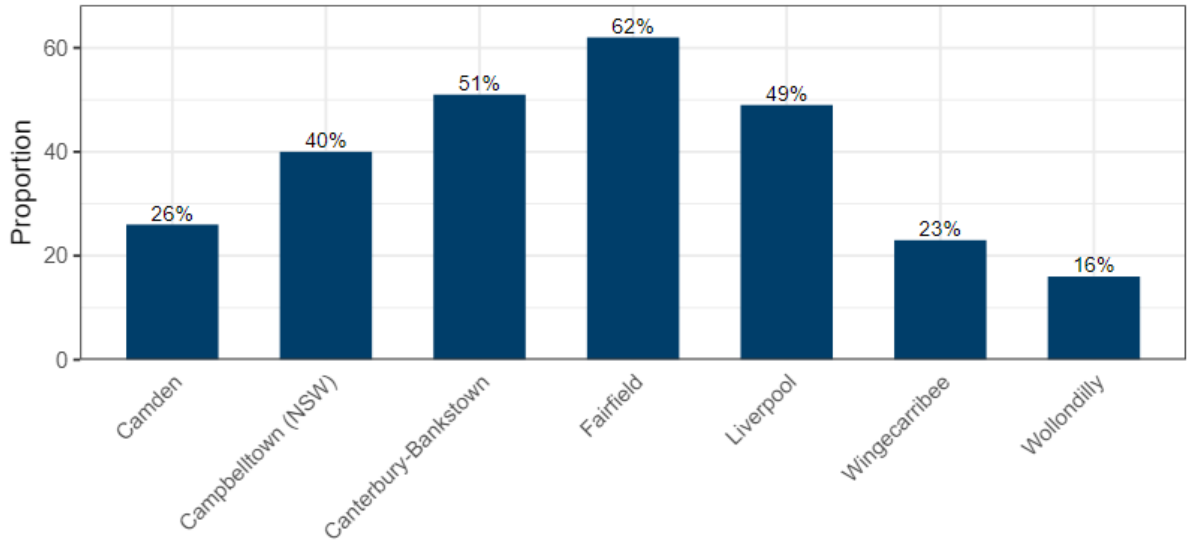
2.1.3 Culturally and Linguistically Diverse Communities

Current population and expected growth

In 2021, 42.4% of residents in SWS were born overseas compared with 34.6% for NSW. The proportion of residents born overseas varies across the region's seven LGAs as shown in Figure 13 (ABS 2022). The top five countries of birth in order are Vietnam (61,000 people), Iraq (44,000 people), Lebanon (22,000 people), India (20,000) and China excluding administrative regions and Taiwan (18,000).

Key issue for our region	South Western Sydney has one of the largest populations of CALD communities within Australia, resulting in complex health access and equity challenges

Figure 13: Proportion of SWS residents born overseas by LGA, 2021 (ABS 2022)



The five most frequently spoken languanges other than English spoken home in 2021 were Arabic (108,000 people), Vietnamese (81,000 people), Assyrian Neo-Aramaic (23,000 people), Cantonese (19,000 people) and Mandarin (19,000 people). SWS includes more than double the state average of population who identify they speak English 'not well or not at all'(11% vs 4.5% respectively . English language proficiency varies across SWS with a higher proportion of Fairfield (23%), Bankstown (≈13%) and Liverpool (≈9%) LGA residents reporting they "speak English not well or not at all" (ABS 2022).

Table 5: English lanuage proficiency, SWS and NSW, 2021 (ABS 2022)

Measure	SWS	NSW
Speaks a language other than English at home	51.3%	32.4%
Speaks English 'not well or not at all'	11.0%	4.5%

Refugee and asylum seeker communities

People from refugee backgrounds often have complex health problems related to their prior access to health care and /or their individual experiences of persecution or trauma. Health needs commonly

identified in refugees and asylum seekers after arrival in Australia include (Milosevic, Cheng and Smith 2012):

- Psychological issues and other physical consequences of torture or trauma
- Nutritional deficiencies
- Infectious diseases and under-immunisation
- Poor dental health, optical health and management of chronic diseases
- Delayed growth and development in children

Key issue for our region	More than a third of the NSW refugee intake is settled in South Western Sydney

Most humanitarian entrants who arrive in NSW tend to settle in South Western Sydney and Western Sydney. About 5898 humanitarian entrants settled in NSW under the Humanitarian Resettlement Program between 1 July 2022 and 30 June 2023, representing 30% of refugees settled nationally.

Of the refugees who settled in NSW, 37.8% settled in South Western Sydney, predominantly in Fairfield and Liverpool LGAs.

Table 6: Place of settlement for humanitarian entrants and refugees in SWS by LGA, 1/7/2022 to 30/6/2023 (Data,2024)

LGA	Number of humanitarian entrants	% of SWS humanitarian entrants
Fairfield (C)	1286	57.6%
Liverpool (C)	656	29.4%
Bankstown (C)	146	6.5%
Campbelltown (C)	109	4.9%
Camden (A)	24	1.1%
Wollondilly (A)	5	0.2%
Wingecarribee (A)	5	0.2%
Total SWS	2231	37.8% of NSW Intake
NSW Intake	5898	30% of National Intake

On 31, March 2024 the top five countries of origin for refugees settling in NSW are Sri Lanka, Iran, Bangladesh, stateless, Iraq Syria (Refugee Council of Australia 2024). The large number of refugees re-settling into the region and their health needs, is expected to have a significant impact on provision of health and social welfare services in the area.

Health access and equity

Key issue for our region	Significant health access and equity issues for CALD communities

Recent migrants to Australia often have better health than their Australian born counterparts especially in the prevalence of lifestyle-related health risk factors (SWSLHD 2021). However, over time and with acculturation this "healthy migrant" effect diminishes. Population groups of CALD background are less likely to understand issues related to their health or access the health services they need. They are more likely to be at risk of mismanaging their medication and experience social isolation (CIRCA 2017). This may reflect long-term challenges in accessing health information and services.

Health literacy

Health literacy can be defined as how people find, understand, evaluate, use and communicate health information and health services so they can act to maintain or improve health outcomes and quality life (SWSLHD/SWSPHN 2024). Health literacy is a major barrier to health care for people from a CALD background and refugees. About 59% of Australians have low health literacy and 75% of those with low health literacy are born overseas (SWSLHD 2021). There are many reasons for low health literacy in CALD populations, such as low English language proficiency, cultural differences, and a lack of familiarity with the Australian health system. (Murray and Skull 2005, Henderson and Kendall 2011). Cultural beliefs and practices may have significant impacts on the physical and psychological wellbeing and capacity to seek and access health information and services (SWSLHD 2021). Previous studies have reported individuals with limited English language proficiency have more difficulty in gaining access to health care compared to English proficient individuals (Shi 2009). The 2019 after-hours GP survey showed that compared with people whose main language is English, people from a CALD background are less likely to have a regular GP, are less aware of after-hours GP services and more likely to go to ED when they need after-hours medical care (SWSPHN 2019a).

The Australian health system may vary from the systems previously experienced by immigrants and refugees. Without adequate education or information on the health system it may be used inappropriately. In SWS, issues raised by refugees at a 2019 Fairfield focus group included: lack of language specific and culturally safe services and differences in cultural perceptions in the health systems (e.g., "hospital is the place to go when you are sick, doctors outside of hospitals are no good") (SWSPHN 2019a). A retrospective study of Liverpool Hospital ED presentations during 2018 found that of 73,007 presentations 53.7% were CALD patients who had a higher median age (53.7 years) than non-CALD patients (40.4 years). Significantly more CALD patients were in the lowest SEIFA quintile than non-CALD patients (45.4% vs 37.1% P<0.0001). There was a higher proportion of CALD patients who were admitted to the hospital 48.2% CALD and 44.6% non-CALD (P <0.0001) (Moore 2023).

In 2017 SWSPHN developed an online health literacy resource called Health Resource Directory (HRD), which provides factsheets on a range of health conditions and psychosocial presentations. The website and printable factsheets are available in English, Arabic, simplified Chinese, and Vietnamese. Audio versions, including in-language versions, are also available. HRD includes information on local services, distinguishing itself from national and state-based translated health literacy resources to assist residents in SWS who do not speak English to have the same access to content as English-speaking people. Early use of HRD by people of CALD background is encouraging with 646 Chinese, 103 Vietnamese and 13 Arabic users during the 2024 calendar year to 31 August.

Culturally appropriate health services

In 2024 SWSPHN undertook a CALD and Refugee needs assessment and co-design process. Community consultations revealed difficulty with knowing where to get help, access to in language resources and interpreters, cost of services, cultural norms, social isolation and transport as significant barriers to accessing primary care. Low uptake of interpreter services among GPs and lack of bilingual service providers further exacerbated these issues.

The main priority areas SWSPHN identified were to improve access and quality of care, build health literacy, improve system responsiveness and to understand the need.

Table 7: SWS CALD and Refugee community consultations results 2024

Barriers to access	Priority needs	Social determinants of ill health
Difficulty with service navigation (25%)	Improve awareness of services and systems (18%)	Stress (26%)
Language barriers (20%)	Address language barriers (18%)	Lack of opportunities for physical activity (26%)
Cost of services (20%)	Provide culturally tailored care (18%)	Gambling (11%)
Cultural norms and social beliefs (10%)	Utilise bilingual workers (18%)	Social Isolation (11%)
Social isolation (10%)	Address cost barriers (16%)	Domestic Violence (7%)
Transport (10%)	Build social connection (14%)	Trauma (7%)

Ongoing care for refugees

Upon arrival in New South Wales, refugees undergo a comprehensive health assessment to ensure their well-being and integration into the community. This process is completed by Refugee Health Nurses, this includes reviewing medical history, conducting physical examinations, screening for infectious diseases, immunisation check, a mental health review and dental and vision assessments are performed with appropriate referrals (DoH 2011). Refugees are assigned a primary care provider for ongoing care, referred to specialists for specific conditions, and provided with health education on navigating the Australian healthcare system. Coordination with settlement services and access to interpreting services further support refugees in their transition, ensuring they receive comprehensive and culturally sensitive care. RACGP has outlined some of the key issues with Refugee health assessments:

- Provider time constraints
- Provider unfamiliarity with refugee health issues
- Inadequate use of interpreters by providers
- Mistrust and/or anxiety from refugees
- Financial constraints for refugees

2.1.4 Older People

Current population and expected growth

Key issue for our region	The number of older people living in South Western Sydney is expected to increase by 85% between 2021 and 2041.

Older adults are Aboriginal people 50 years and over and non-Aboriginal people aged 65 years and over. It is estimated that in 2021, in South Western Sydney, about 175,890 people were older adults, an increase of 26, 558 since 2016 (PHIDU 2024). The highest numbers of older adults in SWS live in Canterbury-Bankstown and Fairfield LGAs, followed by Liverpool. It is expected the number of people aged 65 years and older will reach up to 325,073 by 2041, an increase of 85% over 20 years. Growth in the next 20 years is expected to be particularly significant among those over 85 years of age (an increase of 195%) with an additional 34,045 people. The most significant increase in the older population in the next 20 years will be in: Camden (165%), Liverpool (113%), and Wollondilly (111%) LGAs), followed by Campbelltown (97%) LGA (DPE 2022).

Table 8: Older population distribution in SWS and by LGA, 2021 (ABS 2022)

LGA	Older Population	% of LGA Population	% of SWS Older Population
Camden	11,852	9.9%	6.7%
Campbelltown (NSW)	23,468	13.3%	13.3%
Canterbury-Bankstown	55,656	15%	31.6%
Fairfield	34,967	16.8%	19.9%
Liverpool	26,984	11.6%	15.3%
Wingecarribee	14,725	27.9%	8.4%
Wollondilly	8,238	15.3%	4.7%
Total	175,890	14.5%	100%

At 27.9% the Wingecarribee LGA has the highest estimated proportion of its population over 65 years of age. Physical access to healthcare and other services is a concern for some rural communities primarily in outlying towns and properties within Wollondilly and Wingecarribee. As people age, their use of health services increases and the “rurality” of these residents will become increasingly important, particularly as by 2041, the number of older people in Wingecarribee will increase by 71% to be 36.7% of the population (Informed Decisions 2025).

Key issue for our region	Older people living in the rural areas of South Western Sydney have additional challenges in accessing healthcare services

Usual Residence

Most older people live within the community in a range of housing options, most commonly private dwellings. In 2021, an estimated 165,867 people aged >65 years lived in private homes as per the ABS 2021 census. The highest number of older people living in the community was in Canterbury-Bankstown (52,207 people) followed by Fairfield (32,909) and Liverpool (25,460) (ABS 2022).

There are two manufactured home parks (ABS 2019) and 15 caravan parks that offer a more affordable choice and a lifestyle that includes a sense of community and access to communal facilities. Retirement villages are a growing choice for older adults in SWS. A retirement village has purpose-built housing for independent living on a single site with communal facilities and services. In response to population ageing, there has been an increase in "ageing-in-place" offerings with independent living units, serviced apartments or hostel places, and residential aged care available in one location. There are 24 retirement villages in South Western Sydney ranging in size from ten units to campus-style offering 335 dwellings (DCM Group 2024).

Residential Aged Care Homes (RACHs)

Residential aged care is provided in aged care homes on a permanent or respite basis. Residents receive accommodation, support (cleaning, laundry, and meals) and personal care services. Those with greater needs may also receive nursing care, continence aids, basic medical and pharmaceutical supplies, and therapy services.

Key issue for our region	**The projected demand for residential aged care services in SWS is expected to exceed capacity, resulting in older people being unable to access the level of care required**

There were 69 aged care homes in SWS on 30 June 2024 providing 8,075 places including 116 transition care places. The occupancy rate for residential care in SWS was 86.5% (AIHW 2024i). Although there was an increase of 347 places in the 12 months to June 2024, places are not keeping pace with population ageing. This is evidenced by the fall in place availability from 82.7 places per 1000 people aged 70 and over in 2017 to 70 places in 2024. The demand for permanent residential aged care is expected to increase significantly in the region with the growth in the number people aged 85 and over.

The proportion of people living in residential care who had a dementia diagnosis on 30 June 2022 was 57.1%.

There has been change in the SWS aged care environment since the royal commission into aged care. As of 30 June 2024, not-for-profit providers had increased their dominance in the market providing 59.5% of residential aged care places, 39% were provided by private providers , and 1.4% were government operated transition care places (AIHW 2024i).

Table 9: Places in aged care by organisation type, SWS (PHN region), June 2024. (AIHW 2024i)

Organisation Type	Places	Percentage
Government	116	1.4%
Not for profit	4806	59.5%
Private	3153	39%

Aged Care Supports

Transition Care and Short-term Restorative Care

Transition care assists older people in regaining physical and psychosocial functioning following an episode of inpatient hospital stay to help maximise independence and avoid premature entry to residential aged care. Short-term restorative care is similar to transition care but is provided to people who have had a setback or decline in function without having been in hospital. Respite or short-term care facilities also provide a break for informal carers. At 30 June, 2024, 418 people in SWS were using respite residential care (AIHW 2024j). The region has two short term restorative care providers with 36 places operated by NGOs (AIHW 2023). In SWS, there are two facilities with 116 beds for transition care both of which are operated by the NSW government.

SWS has a higher proportion of potential aged care recipients over 55 years of age who need assistance with core activity (17.6%) and significantly higher proportion of recipients born overseas (58.2%) and who preferred a language other than English (44.7%) compared with NSW (20.7%) and Australia (16.5%) (AIHW 2023).

Table 10: Census overview of people who might become aged care recipients SWS (PHN region), NSW, and Australia, 2021. (AIHW 2024i)

Region	Aboriginal and Torres Strait Islander (50+)	Core activity need for assistance (55+)	Lives alone (65+)	Born overseas (65+)	Preferred other language than English (65+)
SWS	1.1%	17.6%	17.5%	58.2%	44.7%
NSW	1.68%	13.3%	22.1%	35.9%	20.7%
Australia	1.7%	13.0%	22.7%	34.6%	16.5%

Commonwealth Home Support Program (CHSP)

An entry-level aged care program that helps older people to live independently in their homes. Support can include help with daily tasks, home modifications, transport, social support and nursing care. Home support also provides respite services to give carers a break. As of 30 June 2024, 85 home support outlets across the PHN region had delivered home care to 167 per 1000 people over the age of 65 (AIHW 2024i).

Home Care Packages Program (HCPP)

HCPP is a program that supports older Australians with complex needs to remain living at home through a coordinated package of care and services to meet the individual needs of consumers (Commission 2018). There are four levels of care ranging from low-level care needs (home care package level 1) to high care needs (home care package level 4). Services provided under these packages are tailored to the individual and might include personal care, support services and/or clinical care (Commission 2018).

In SWS, there are 72 home care service providers who can provide services at each of the four levels (DHDA 2025a). These services delivered home care packages to 39 people per 1,000 people aged 65 and over as of 30 June 2024 (AIHW 2024i).

As of 31 March 2025, there were 10,533 people in the HCPP across the SWS Aged Care Planning Region, of which 493 people were new entries in the March 2024 quarter (DHDA 2025a). These figures do not include people in the Wingecarribee LGA which is included in the Southern Highlands ACPR which extends from Wingecarribee to the Victorian border. There were 2,688 people waiting on a HCP at their approved level on 31 March 2025, who had yet to be offered a lower-level HCP while they wait for their approved level package (DHDA 2025a)

Key issue for our region	**Insufficient community-based aged care supports available**

Access to primary care services in the community

GP attendances – Level 1 GP attendances are standard GP appointments of between six and 20 minutes that address one or more health issues. MBS data indicates that 90.3% of the SWS population attended a GP for a level one service in 2023 – 24, at a rate of 760 per 100 people (7.6 visits per person). People aged 65 years and over attend a GP appointment more than other age groups with a rate of 1337 per 100 people (65 – 79 years) and 1926 per 100 people once 80 years and older (AIHW 2024g).

There were GP Chronic disease management plans prepared for 76,115 (39%) of people aged 65 and over in 2023 – 34, in SWS. This was the highest proportion of any age group. The 75+ Health Assessment (MBS item 715) was completed for 20,612 people 65 and over which was 51% of all items 715 claimed by GPs in 2023-24 in SWS (AIHW 2024g).

Home medication management reviews (HMMR)

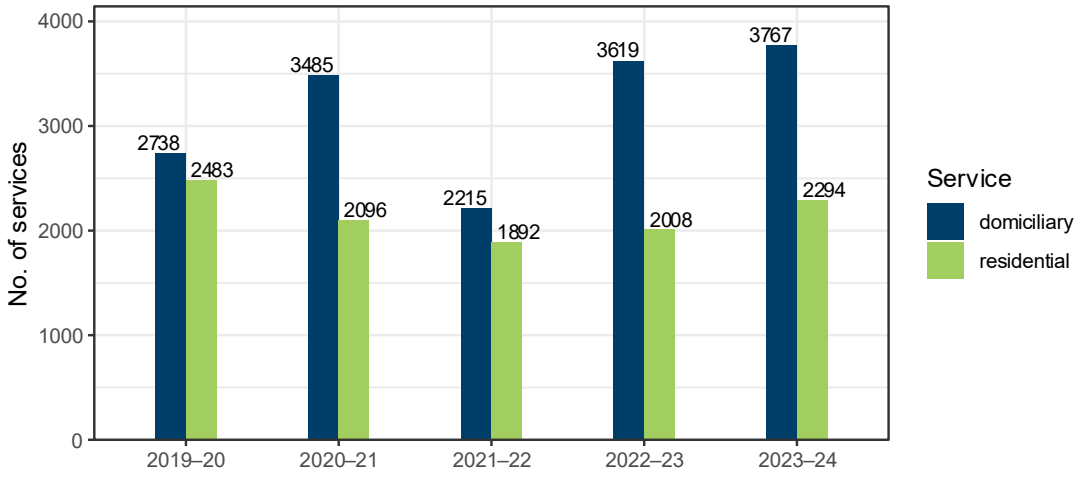
Key issue for our region	**Continual decline in the use of Residential and Home Medication Management reviews in South Western Sydney**

As people age, they become more sensitive to the effects of medicines. Older people also tend to take more medications because they are more likely to have one or more chronic health conditions. Polypharmacy, the use of five of more medicines daily including prescription, over-the-counter and complimentary medicines is common in people over 75 years of age. Polypharmacy increases the risk of harm and mismanagement occurring (ACSQHC 2021). An analysis of PBS and Repatriation PBS data covering 2018-19 showed high rates of polypharmacy occurring in two SWS SA3s, Wollondilly and Bringelly-Green Valley where the rates of prescribing five or more medicines to people aged 75 years and older were 52,407 and 50,991 per 100,000 people respectively.

Home medication management reviews are a structured, multidisciplinary effective strategy for maximising the benefit and minimising potential harm to older people from medications. In SWS in 2018-19 the number of people aged 75 years and over who had at least one MBS subsidised HMMR was 4,755 per 100,000 age standardised (2,761 people), lower than the NSW rate of 5,233 per 100,000 age standardised (ACSQHC 2021).

The following figure depicts the decline in utilisation of HMMR (MBS item 900) while COVID-19 lockdowns were in place and strong recovery since. People aged 65-79 years of age were the most common recipients of a home medication management review, accounting for 1,664 (44.17%) services provided in 2023-24 (AIHW 2024g).

Figure 14: Number of Medication Reviews, Home and Aged Care (MBS items 900 & 903), SWS, 2019- 20 to 2023-24. (AIHW 2024g)



Access to primary care services in RACHs

Medicare subsidised medication management reviews (MBS item 903) for residents of aged care homes (RACHs) showed slower recovery post COVID-19 which may reflect ongoing outbreaks and systemic issues with medication management in RACHs. There were 2294 medication management reviews in SWS RACHs in 2023-24 a 16.4% increase over 2022 – 23. Just over 76% of reviews were for residents aged 80 years and over (AIHW 2024g).

There are 266 GPs who have self-reported attending the 69 RACHs in SWS, 19.4% of total GPs and registrars. Figure 14 based upon MBS data shows a pattern of increasing RACH patient numbers and attendances over time. RACH residents in SWS received an average 21.5 GP attendances in the 2023-24 years. This was around two attendances more than the 19 average attendances for all people aged 80 years and older (AIHW 2024g). The high number of attendances reflects residents' complex health status.

Table 11: GP attendances per person in residential aged care homes 2017-18 to 2023-24. (AIHW 2024g)

Year	Number of GP RACH patients (SWS)	Number of attendances (SWS)	GP attendances per RACH patient (SWS)	GP attendances per RACH patient (National)
2017–18	8,283	161,757	19.5	17.2
2018–19	8,291	169,998	20.5	17.9
2019–20	8,364	180,225	21.5	18.2
2020–21	8,311	180,706	21.7	17.8
2021–22	8,341	160,963	19.3	16.9
2022–23	8,620	178,116	20.7	17.5
2023–24	8,870	191,140	21.5	18.4

Hospitalisations

In NSW in 2022–2023 hospitalisations increased with age. People 85 and over having the highest rates of hospitalisation across all categories of cause except maternal, neonatal and congenital.

In NSW in 2021–2022 people over the age of 65 years had the highest rate of potentially preventable hospitalisations for all reported conditions except eclampsia, convulsions/epilepsy, dental conditions and pelvic inflammatory disease (CEE 2024s)..

For older people in SWS 2021-2022 total PPH were slightly higher in SWS, 1773.4 per 100,000 people than in NSW 1718.8 per 100,000. Vaccine-preventable PPH in SWS 236.9 per 100,000 population was higher than NSW 133.6. Likewise, chronic conditions PPH were higher in SWS than NSW 701.4 per 100,000 vs 678.2 per 100,000. SWS had a lower rate of PPH for acute conditions than NSW 859.9 per 100,000 vs 921.3 (CEE 2025b)

Section 2.2: Heath Needs and Gap Analysis

2.2.1 Preventative Health in South Western Sydney

Antenatal Care

Antenatal care has been found to have a positive effect on the health outcomes for both mother and baby. Australian guidelines recommend that the first antenatal checkup after pregnancy has been confirmed should be within the first 10 weeks. Regular checkups should follow through to birth. Ten visits are recommended for first time uncomplicated pregnancies and seven are recommended for consequent pregnancies.

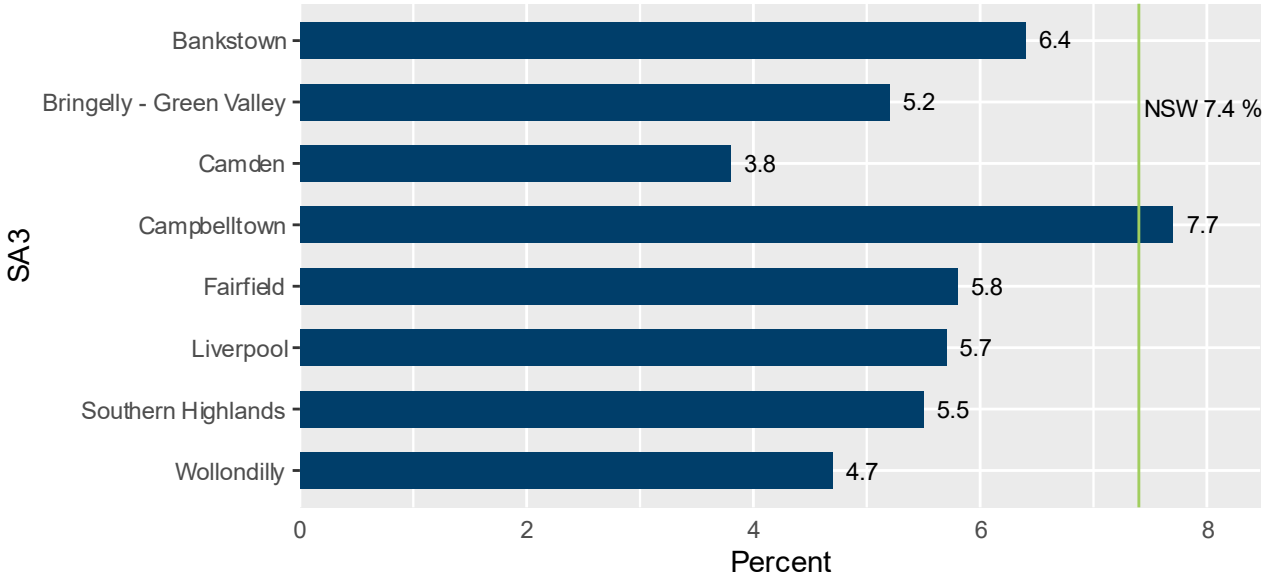
AIHW data indicates that at 57.7% the SWSPHN region had the lowest proportion of first antenatal visits within the first 14 weeks in NSW (79.9%) and Australia (79.2%) in 2023 (AIHW 2023d, AIHW 2025b). However, we report this with caution as there is variation in the way hospitals record this information. SWSLHD do not publish data on this indicator on HealthStats due to concerns with "small numbers, confidentiality or concerns about the quality of data" (Health 2024)

Data to measure the number of antenatal visits is recorded for women who have five or more antenatal care visits. In this measure of antenatal care, SWSPHN region equalled the NSW 2023 proportion of 93.7% and was similar to neighbouring PHN regions Nepean Blue Mountains (94%) and Western Sydney (94.9%) (AIHW 2023d).

Smoking during pregnancy

Smoking during pregnancy is a preventable risk factor for a wide range of complications impacting both mother and baby. In 2023, the proportion of mothers who reported any smoking during pregnancy was 6.2% for SWS compared to 7.4% for NSW (CEE 2016a).

Figure 15: Maternal smoking during first 20 weeks of pregnancy (all women by %) by SA3, SWS, 2023 (CEE 2020a, AIHW 2023d)



Alcohol during pregnancy

Drinking alcohol during pregnancy is another preventable risk for poorer outcomes for the baby including low birthweight, being small for gestational age, pre-term birth and foetal alcohol spectrum disorder (AIHW

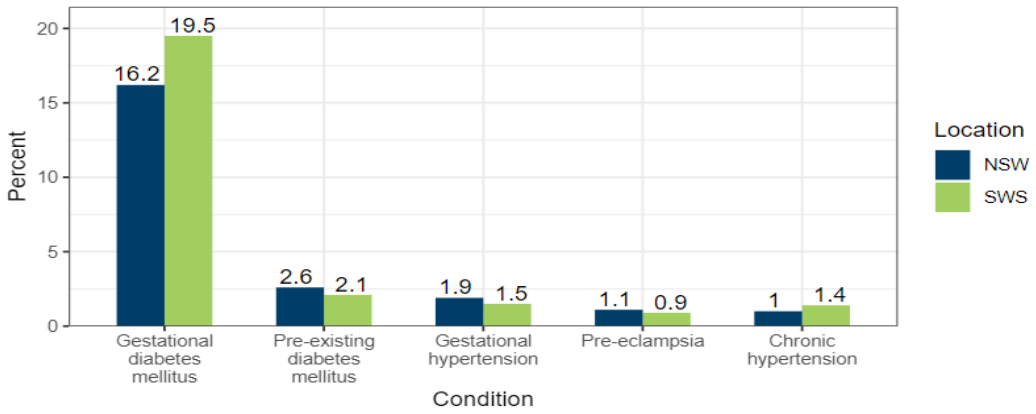
2025b). There is no data available for alcohol during pregnancy for NSW. In other states and territories consumption in 2023 ranged from 0.5% in Tasmania to 5.6% in Queensland.

Maternal medical conditions

Uncontrolled Gestational Diabetes Mellitus (GDM) may result in adverse pregnancy outcomes such as pregnancy loss, premature delivery and stillbirth. Complications to the baby might include excessive birth weight, preterm birth, respiratory distress syndrome, hypoglycaemia, jaundice, increased future risk for developing obesity and type 2 diabetes (Simmons 2015). In 2023, the proportion of SWS mothers who had GDM in pregnancy decreased to 19.3% from 19.5% in 2022. SWS still has a substantially higher rate of GDM in pregnancy compared to the NSW average of 16% (CEE 2024q).

In 2023, the proportion of SWS mothers with gestational hypertension was 2.2% which is a slight increase compared to 2022 (2.1%). Despite this slight increase, the proportion of SWS mothers with gestational hypertension is lower than the NSW average at 2.6%. SWS is doing more first trimester screening and studies into women with risk factors for gestational hypertension. Low dose aspirin use, before 16 weeks gestation, has been promoted for women with identified risk factors.

Figure 16: Maternal medical conditions by % SWS and NSW, 2022 (CEE 2020a, CEE 2024q)



Smoking

Tobacco smoking

Tobacco smoking is the single most preventable cause of death and disease worldwide. Tobacco smoking harms current smokers and ex-smokers, as well as non-smokers via exposure to second-hand smoke. It is linked as a cause with 41 diseases including: 19 types of cancer, 7 cardiovascular diseases, chronic obstructive pulmonary disease and asthma.

The rate of burden from overall tobacco has progressively fallen between 2003 and 2024, however it is still the second highest ranked risk factor behind overweight including obesity. Tobacco use was responsible for 7.6% of the Australian total burden of disease in 2024. At 11.6% it remained the highest ranked risk factor for deaths (AIHW 2024p).

Data from the Australian Institute of Health and Welfare (AIHW) (AIHW 2021d) shows that in 2022-23 people aged 14 years and over:

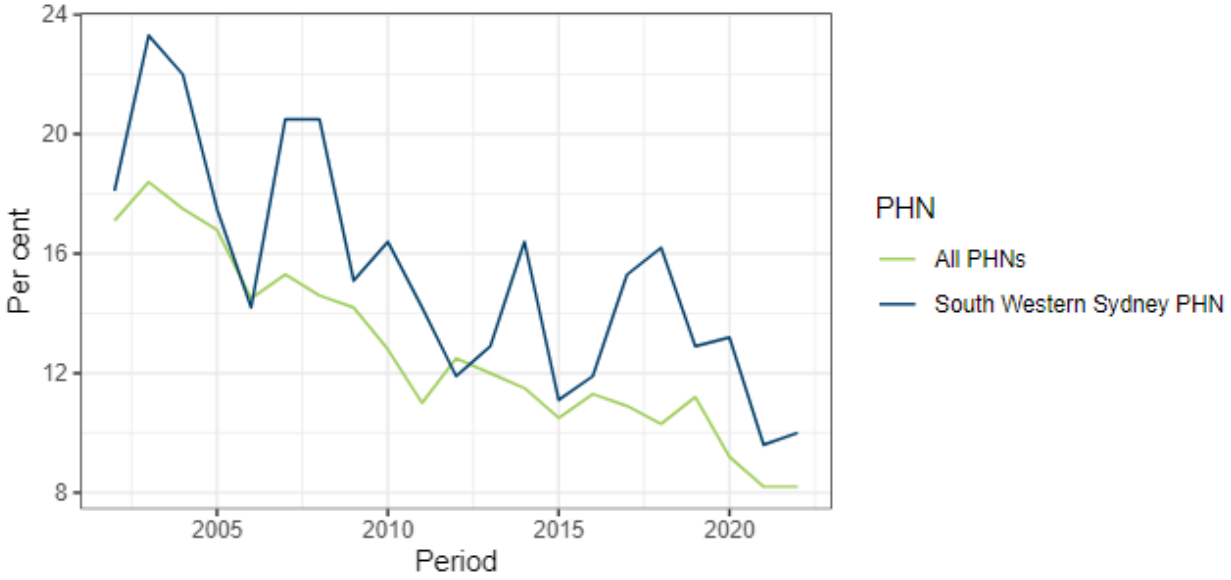
- living in the most disadvantaged areas were more likely to smoke, 13.4%, than those living in the least disadvantaged areas, 4.1%. The evidence consistently indicates that individuals from lower socioeconomic backgrounds are more likely to smoke and face greater barriers to quitting, with significant disparities in smoking prevalence, cessation success, and access to tobacco products

(Casetta 2017, Bendotti 2024, Morris 2024) However, the proportion of people living in quintile 1 areas had a statistically significant reduction in daily smoking between 2019 (18.1%) and 2022-23 (13.4%).

- From a CALD background were more likely to have never smoked, 82%, than people who mostly spoke English at home, 63%. However, cultural factors significantly influence smoking behaviours in Australia, particularly among certain CALD communities. Lower levels of acculturation and the interplay of cultural norms, social expectations, and familial influences creates a complex landscape that shapes smoking initiation, maintenance, and cessation (CC 2013, Reiss 2015)
- living with a disability were more likely to be current daily smokers, 14.1% compared to 8.6% without a disability. Smoking prevalence among people with disabilities is exacerbated by lack of tailored cessation support and the presence of systemic barriers hindering effective quitting strategies. Smoking and its related health issues also creates a cycle of disadvantage, meaning individuals with disabilities are less likely to access effective cessation resources (Disney 2023, Vourliotis 2024)
- who were unemployed were more likely to be current daily smokers than adults working either full time or part time, 24.3%, 11% and 8.3% respectively
- with a bachelor's degree were less likely to be current daily smokers
- living as a family with dependent children were less likely to be current daily smokers than those living in group households or living alone, 8.6%, 17.6% and 13.8% respectively. Smoking prevalence in single-parent households is higher than coupled households with dependent children. This higher prevalence impacts both the health of single parents and exposes their children to second-hand smoke, increasing risk of adverse health outcomes. Factors contributing to this trend include low socioeconomic status, younger age, and higher stress levels associated with single parenting (Hanley-Jones 2022)

Key issue for our region	***The prevalence of tobacco smoking in South Western Sydney is above the state average***

Figure 17: Estimated proportion of SWS adults who are daily smokers by PHN 2002-2022 (CEE 2024a)



In 2021, the estimated smoking rate in adults was 9.6% in SWS, higher than the NSW average of 8.2%. More men than women smoked daily across all age groups in SWS (CEE 2024a). Figure 17 above compares the steady decline in daily smoking in NSW adults with the rollercoaster nature and higher rates of daily smoking in SWS adults. Higher smoking rates are likely due to the region's large population of individuals born overseas, with studies showing higher smoking prevalence and nicotine dependence among specific immigrant groups, including Arabic-speaking males (Girgis 2009) and men born in Europe, North Africa, and the Middle East (Weber 2011). Significant socioeconomic disadvantage in pockets of SWSPHN also likely contribute to increased smoking and e-cigarette use, which is further exacerbated by a high density of tobacco and e-cigarette retailers (Casetta 2017, Bendotti 2024).

Smoking attributable hospitalisations

Smoking-attributable hospitalisation rates were lower in SWS compared to NSW (531.7 and 563.3 per 100,000 population respectively). Between 2020-21 and 2021-22, smoking-related hospitalizations in New South Wales (NSW) slightly decreased overall, from 571.7 to 563.3 per 100,000 people. However, in the SWSPHN these hospitalizations increased during the same period, from 505.3 to 531.7 per 100,000. This increase could be due to higher rates of respiratory diseases, including COVID-19, and higher smoking rates in the region. People living in socioeconomically disadvantaged areas are also more likely to experience smoking-related hospitalizations, with rates of 660.5 per 100,000 compared to 476.9 per 100,000 in less disadvantaged areas.

Table 12: Smoking attributable hospitalisations, number and age standardised rate per 100,000 population, SWS, 2021-22 (CEE 2024h)

Area	Male	Female	Total	Rate per 100,000
SWSPHN	3662	2482	6144	531.7
NSW	32292	23827	56118	563.3

Smoking attributable deaths

Smoking-related deaths in SWS have continued to decline, even among the most disadvantaged groups. Between 2019 and 2021, these deaths decreased from 66.8 to 58.1 per 100,000, remaining below the

overall NSW rate of 59.3 per 100,000. Lower lung cancer rates, which account for about one-third of smoking-related deaths, and slightly lower COPD mortality rates may explain this trend.

Table 13: Smoking attributable deaths by socioeconomic status, NSW, 2021 (CEE 2024b)

Socioeconomic status	Number	Rate per 100,000 population
1st Quintile least disadvantaged	853.2	40.1
2nd Quintile	997.5	48.5
3rd Quintile	1271.3	59.7
4th Quintile	1767.1	72.4
5th Quintile most disadvantage	1723.7	80.1
NSW	6614.4	59.3

E-cigarette use

E-cigarettes include electronic cigarettes and vapes. E-cigarettes heat liquid to make a mist that is breathed in by users. The liquid used may have nicotine in it, even when not written on labels. They also contain known toxic chemicals. There is evidence that regular use of e-cigarettes is harmful to health (AIHW 2024). Known short-term health risks include damage to the nose, throat and lungs, nicotine poisoning and dependence and harm to developing adolescent brains (DoHAC 2023) As e-cigarettes are newer than tobacco cigarettes, long term health effects are not yet known. Research has started but there is not enough data or evidence yet. Research (DoH 2021a) already shows:

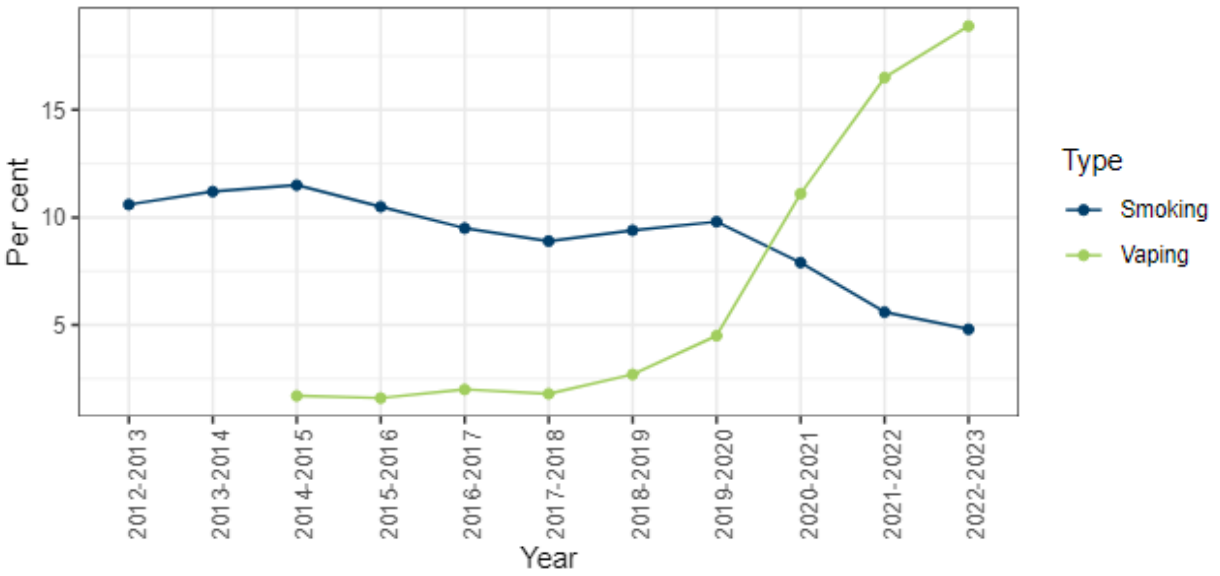
- A strong link between the use of e-cigarettes by non-smoking youth and chances of future smoking
- That many e-cigarette users appear to be still using tobacco products at the same time (dual users). Dual users may be breathing in even more toxins compared to people who only use tobacco products

Key issue for our region	Increasing rates of e-cigarette use

E-cigarettes are widely promoted on social media, with many posts violating platform policies due to inadequate regulation allowing pro-vaping content to flourish, likely contributing to increased e-cigarette use among young people (Jancey 2023, Jancey 2024). Many young people perceive 'non-nicotine' and flavoured variants as being less harmful, increasing their susceptibility to vaping which is a risk factor for subsequent smoking uptake (Scully 2023, Yazidjoglou 2024)

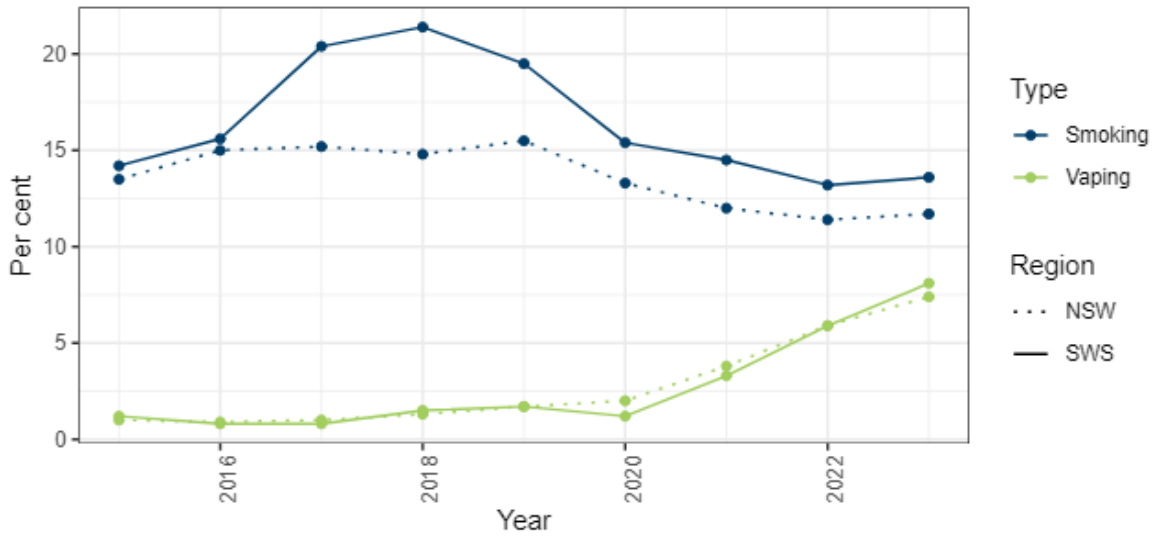
The *AIHW National Drug Strategy Household Survey (NDSHS) 2022-2023* report showed that between 2019 and 2022-23 there was a large increase in people reporting that they had used e-cigarettes at least once, 11.3% to 19.8%. Both federal and state governments have been prompted to make stronger policies and laws to control the growth in e-cigarette use. Starting in early 2024 it is harder to import, advertise and sell e-cigarettes in Australia.

Figure 18: Proportion of 16 - 24 age group who are currently smoking, and currently vaping, 2012 to 2023 NSW



In NSW, E-cigarette usage has seen a drastic increase, particularly among younger age groups. In 2022-23 45% of people aged 16 to 24 years had used e-cigarettes at least once, higher than any other age group, and were the highest current users, 19% compared to 4.5% in 2019–2020 as shown in Figure 18. This trend is driven by the widespread availability of e-cigarettes (Jongenelis 2023), often attributed to the illegal import of so-called 'non-nicotine' vapes and targeted marketing strategies aimed at young people, especially through online platforms (Hardie 2023, Jancey 2023). The rising social acceptability of vaping among younger demographics (Yazidjoglou 2024) is further compounded by low health literacy regarding smoking and e-cigarette products, with vaping being perceived as a 'healthier' alternative to traditional smoking (Thoonen 2023).

Figure 19: Proportion of people all ages currently smoking and currently vaping by SWS and NSW, 2014 to 2023 (CEE 2024c)



Daily e-cigarette use by SWS adults aged over 16 has increased rapidly since 2020 from 2.1% to 8.5% as shown in Figure 19. Users who have ever used an E-cigarette increased from 18.1 to 21.3 per 100,000 between 2020-21 to 2022-23, with current users rising from 2.7 to 8.1 per 100,000 in the same period. This rise is likely due to increased social acceptability, targeted marketing towards younger smokers, and the ability to vape in places where smoking is prohibited.

Key priority areas

- Addressing high smoking rates, especially in disadvantaged communities and certain CALD communities
- Curbing vaping among young people aged 16-24, with an emphasis on preventing progression to smoking, particularly considering new legislation banning the sale of non-nicotine vapes, which will reduce e-cigarette availability.
- Reducing hospitalizations attributable to smoking through early intervention, including smoking cessation support at primary and community care levels

Cancer Screening

Some cancers can be detected before symptoms appear. Early detection by cancer screening can find cancer while it is still in its early stages where treatment can be more successful and likely to be survived.

Key issue for our region	**South Western Sydney has lower cancer screening rates for breast, bowel and cervical cancer than the NSW average**

Incidence and Mortality of breast, cervical and bowel cancers in SWS

Table 14: Incidence and mortality of cancers with screening programs in SWS, 2021 (CINSW 2024a)

Cancer type	Incidence	Rank from 29	Mortality	Rank from 29	Most affected population group
Breast	647	2	108	4	Non English speaking country of birth
Cervical	39	25	13	27	Non English speaking country of birth
Colon	354	4	112	3	Non English speaking country of birth

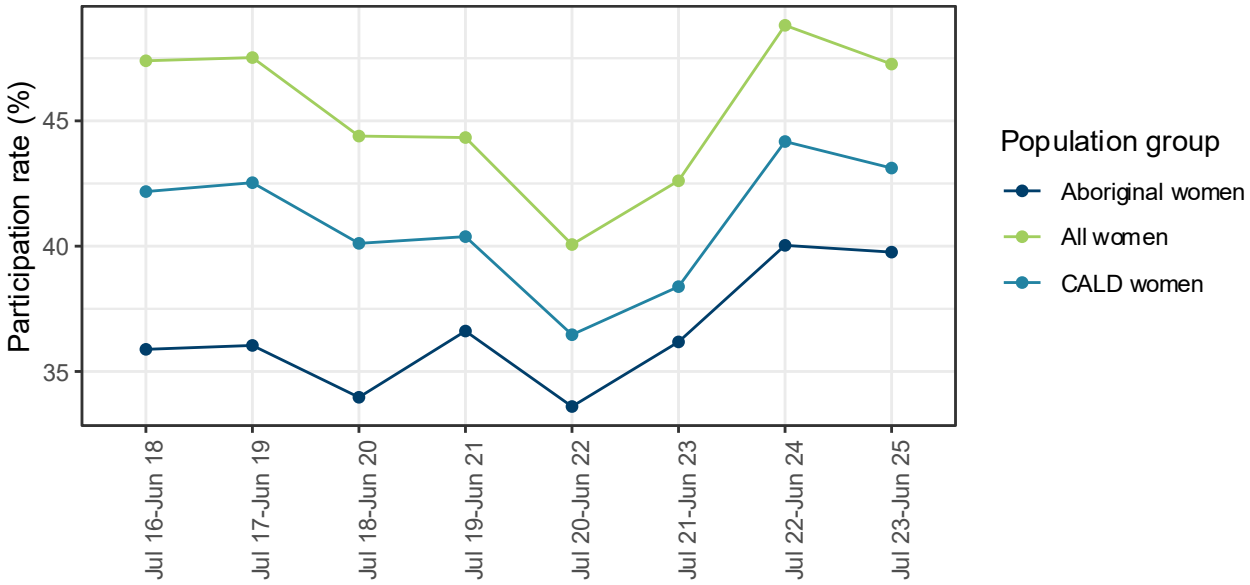
Breast Cancer Screening

In the biennial period 2023-25, the breast cancer screening participation rate for women aged 50-74 years was lower in SWS (47.3%) compared with NSW (50.9%) (CINSW 2024b). Compared to other NSW PHN regions, SWS had the third lowest participation rate. Compared to Western Sydney PHN region that has similar demographics to SWS

The participation rate for SWS Aboriginal women increased from 36.2% in the 2021-2023 biennial period to 39.8% in 2023-2025. Previous consumer consultation had indicated a need culturally appropriate and respectful approaches are required to screening in Aboriginal communities. Tharawal Aboriginal Medical Services have been working with BreastScreen NSW to deliver these approaches. This may be reflected in the positive increase in screening rates. During the same period screening for women from a CALD background also increased from 38.3% to 43.1%.

Screening rates were lower for women living with most disadvantage (46.2%) than women living with least disadvantage (53.2%). Screening rates for were highest in Wingecarribee (55.1%) and lowest in Canterbury-Bankstown (42.9%) (CINSW 2024b). In SWS, breast cancer has the second highest incidence and the sixth highest mortality by tumour site (CINSW 2025).

Figure 20: Breast screening participation rate by population group, SWS, July 2016 – Jun 2025 (CINSW 2024)



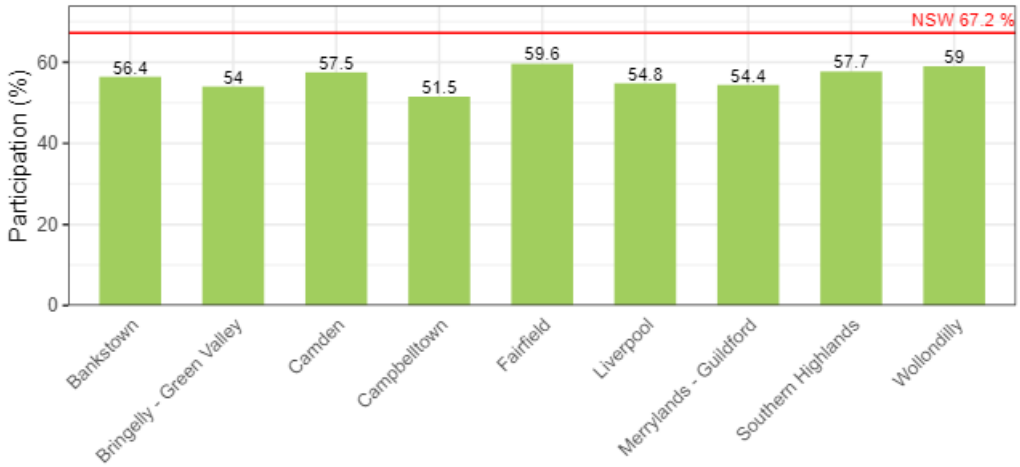
Issues raised through earlier consumer consultations regarding breast cancer screening have not changed and include:

- The need for GPs to encourage patients to participate in cancer screening
- A need for promotion of preventative screening among refugee communities
- More availability of screening locations at more appropriate times of the day

Cervical Cancer Screening

The proportion of females who have HPV vaccination coverage at 15 years of age in SWS is 83.3%, slightly lower than NSW (85.9%). The impact of vaccination will take several decades to be seen, therefore the combination of vaccination and cervical screening every five years remains key to the elimination of cervical cancer by 2035 as forecasted (CINSW 2024a).

Figure 21: Cervical Cancer Screen Participation% by SA3, SWS, 2020-21 (AIHW 2023e)



Cervical screening participation in SWS during 2018-21 for women aged 25-74 years in was 55.8%, lower than for NSW (60.6%) and Australia (62.4%) (CINSW 2024a). Across SA3 areas in SWS, participation has

increased since 2018- 19 when all were below 50% participation. In 2018-21 participation increased to over 50% in all SA3s as shown in figure 21. Participation was lowest in Campbelltown (51.5%) and highest in Fairfield (59.6%). Women aged 70-74 years have the lowest participation among all age groups.

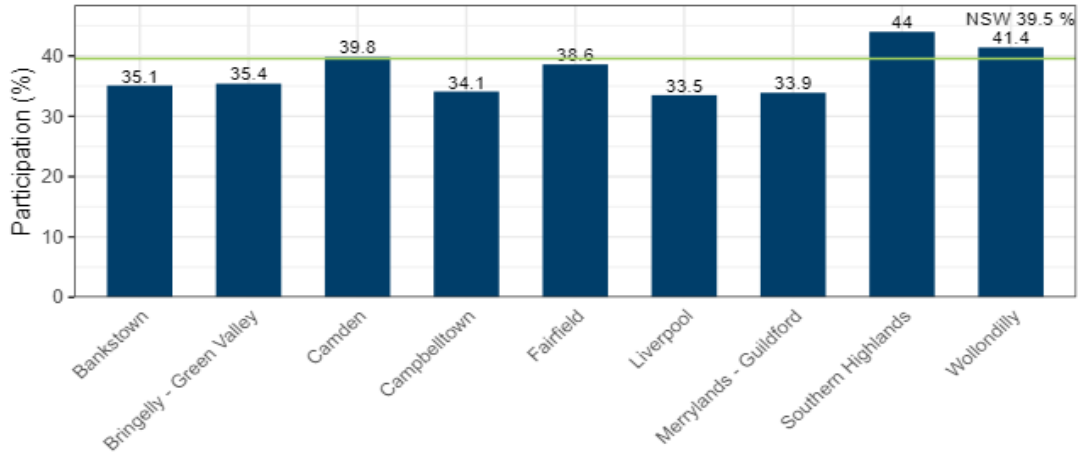
A consistent theme across the SWS region in cervical cancer screening was the preference for female GPs to conduct the PAP smear, placing female GPs in greater demand. HPV cervical screens completed by self-collection were introduced in NSW in 2022. Evidence shows that self-collected samples are as accurate in detecting HPV as health professional collected samples and may encourage overdue screeners. SWS has the lowest proportion of cervical screens completed by self-collection in 2023-24, 15.6% vs 25.9% in NSW.

Healthcare professionals have a central role to play in promoting cervical screening options to their patients and maintaining up to date data on cervical screening in the previous five years in their GP clinical records. At 22.4% in July 2023, SWS GPs had the lowest proportion of up to date records compared to 45.5% in the highest PHN area, Hunter New England and Central Coast and 37.5% in Australia.

Bowel Cancer Screening

The annual bowel cancer participation rate for people aged 50-74 years in SWS peaked at 38.7% in 2019-20 but declined to 33.8% in 2022-23, one of the lowest rates in NSW. The rate for SWS was lower compared to NSW, 37.5% which had also declined since 2018 when it was 40.2% (CINSW 2024a). Across SA3 areas in SWS, in 2020-21 screening participation was lowest in Liverpool (33.5%) and Merrylands-Guilford (33.9%) and highest in the Southern Highlands and Wollondilly as shown in Figure 22.

Figure 22: Bowel cancer screening participation rate by SA3, SWS, 2020-21 (CINSW 2021, AIHW 2023e)



Bowel cancer screening participation rates across the target age group, 50-74 years, increase with age, however bowel cancer is increasing in people under 50 leading to the participation age being lowered to 45 years from 1 July 2024. There is a need to increase participation in the younger portion of the target group. Encouragement and guidance in normalising screening behaviour from GPs has been shown to increase participation (CINSW 2024a)

A positive faecal occult blood test (FOBT) during screening is mostly followed by a colonoscopy after an initial specialist consultation. The new Direct Access Colonoscopy (DAC) initiative expedites access to a colonoscopy and reduces cost barriers such as consultation fees, travel and parking and loss of income by replacing the specialist consultation with a nurse-led telephone triage assessment. DAC clinics in SWS are available at Liverpool and Campbelltown hospitals.

Immunisation

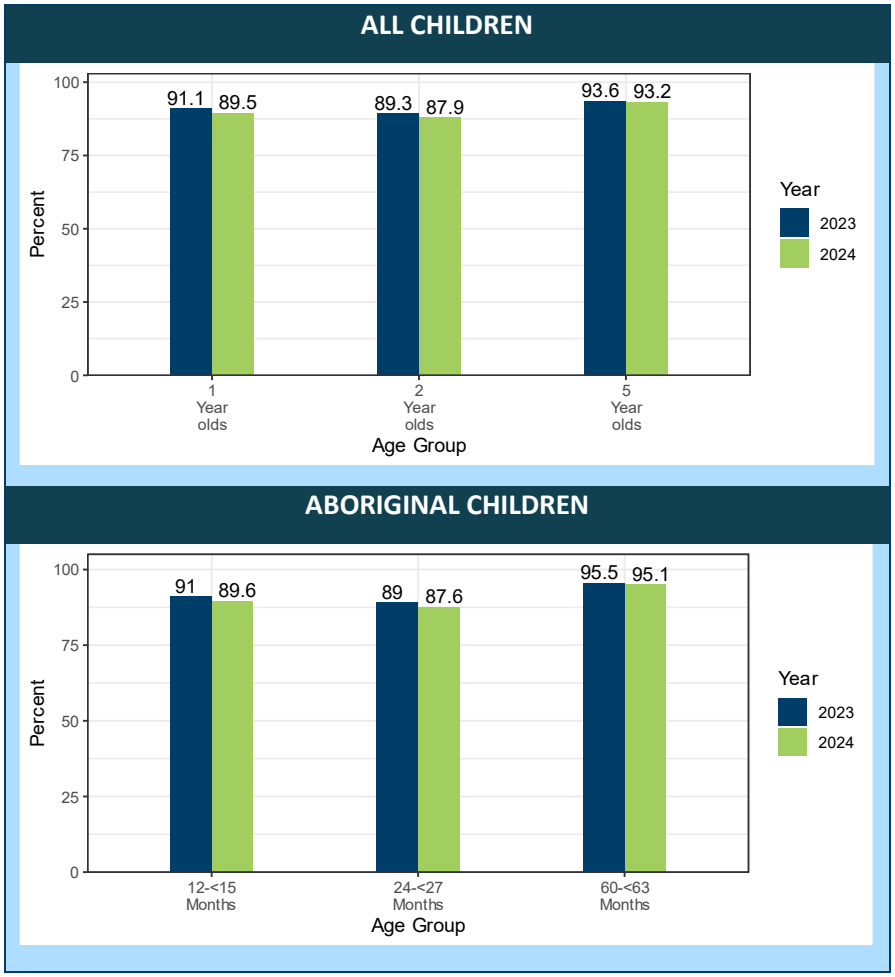
Immunisation is one of the most effective ways a population can protect the community and future generations from infectious diseases. In other words, if you vaccinate, you help wipe out diseases that could spread now and into the future

Low immunisation coverage for children aged two years in SWS

Key issue for our region	South Western Sydney has lower immunisation coverage rates across a number of age ranges and disease types

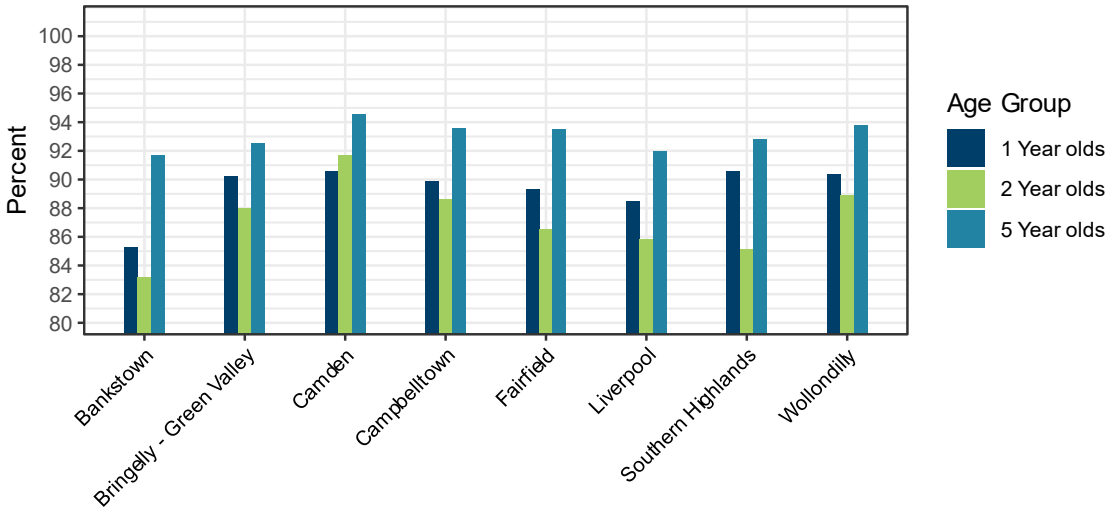
In SWS, childhood immunisation coverage for all children aged one, two and five years was stable between 2023 and 2024. Vaccination is lower for two year olds than those aged one and five years. In 2024 immunisation coverage was lower in SWS at each age point than in NSW: 1 year olds 89.5% vs 92.4%, 2 year olds 87.9% vs 90.5%, 93.2% vs 93.7% respectively. First Nations five year olds had higher levels of vaccination in SWS in 2024. First Nations children in SWS had lower vaccination coverage than First Nations children in NSW at each age point: 1 year olds 89.6% vs 91.5%, 2 year olds 87.6% vs 89.6% 5 year olds 95.1% vs 95.7% respectively (DoHAC 2024a).

Figure 23: Childhood Immunisation Coverage(%), SWS 2023-2024 (DoH 2021c, DoHAC 2024a)



In the period between July 2024 and June 2025 , across SA3 areas in SWS, Bankstown had the lowest coverage for children aged one year (85.3%), two years (83.2%), and five years (91.7%) (DoHAC 2024a).

Figure 24: Childhood immunisation coverage by SA3, SWS, July 2024 – June 2025 (DoHAC 2024a)



In 2017, SWSPHN participated in a national research project to follow up immunisation overdue children with their last immunisation providers(Lauren Dalton 2018). According to the last immunisation providers, the most common reason for children being overdue for immunisation in SWS is family have moved out of the area (35%). Often families have not updated their address with Medicare, they are still shown as living in the SWS area despite having moved elsewhere.

Adult infectious disease immunisation

In 2020-21, there was a dramatic fall in incidence and hospitalisations for influenza and pneumonia due to the restrictions in place to reduce COVID-19 transmission. There were 265 hospitalisations due to influenza and 20,225 hospitalisations due to pneumonia in NSW (2.9 and 203.3 per 100,000 population respectively), of which 64% (12,872) were people aged 65 years and older. Influenza immunisation uptake in adults over 65 years of age has significantly improved in NSW and SWS. Influenza immunisation in NSW was steady for five years until 2020 when there was a significant increase from 75.1% in 2019 to 83.1% in 2020. The *NSW Population Health Survey* indicates that in 2020-21, 79.7% of older adults in SWS were immunised against influenza compared with 83.7% in NSW (CEE 2020d).

Vaccination coverage for pneumococcal disease is low but slowly growing in Australia from a low 23.9% in 2021 to 33.8% in 2022. First Nations adults had higher coverage starting at 25.1% in 2021 and growing to 37.7% in 2022 (AIHW 2025c). Consultation with GPs identified that a main reason for low uptake of pneumococcal immunisation included low awareness of pneumococcal immunisation among immunisation providers and patients, including at-risk groups.

Most adults require vaccination only once for pneumococcal disease therefore GPs are reluctant to give patients the immunisation if their vaccination status is unknown. The fact that adult immunisation was not reported to the Australian Immunisation Register (AIR) prior its expansion in 2017 leaves a gap in knowledge for GPs.

Overweight and obesity

Adults

People who are overweight or obese have a buildup of excess fat in their body (World Health Organisation 2024). A person's weight and height are used to work out their Body Mass Index (kg/m2) score. A BMI score

of 25 or more is overweight and 30 or more is obese. The excess fat often is due to a higher energy intake (diet) than use (activity). There are many causes, such as social, daily living and physical causes, that influence a person's weight.

Prevalence

In 2022, around 36.9% of SWS adults were in the healthy weight range for how tall they are. This is lower than NSW (42.2%). SWS was higher in the overweight range than NSW (35.3% to 33.8%) and obese range (27.6% to 24.2%).

Key issue for our region	Only 37% of SWS residents, 16 years and over, fall into a healthy weight range.

Figure 25 shows the change in the number of people who are overweight and obese over time. Rates of people being overweight increased during the COVID-19 pandemic, before dropping but not below the pre-pandemic level. The rate of obesity has risen each year since 2019 with the gap between SWS and NSW growing wider.

Figure 25: Estimated prevalence of overweight and obesity for SWS population 2002 – 2022 (CEE, 2024)

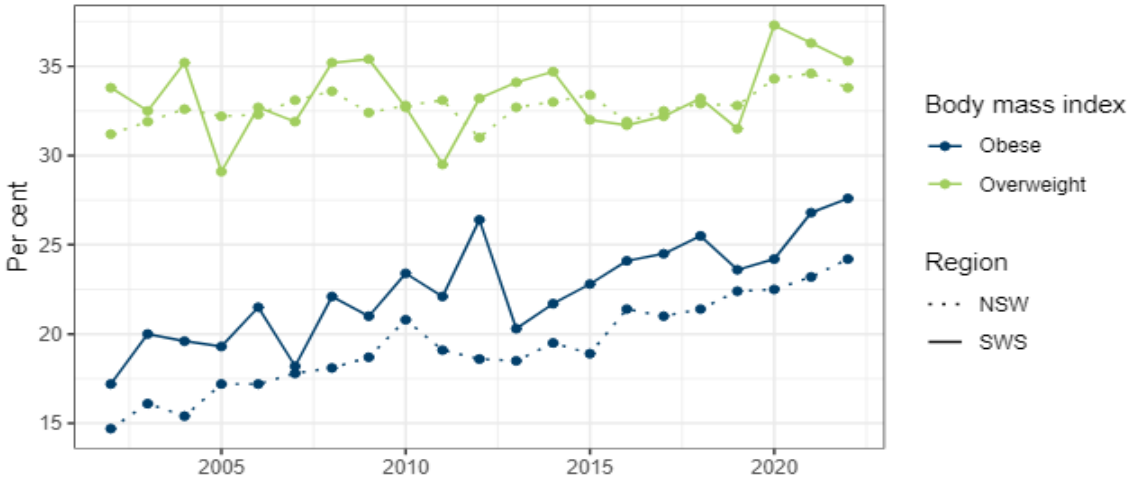
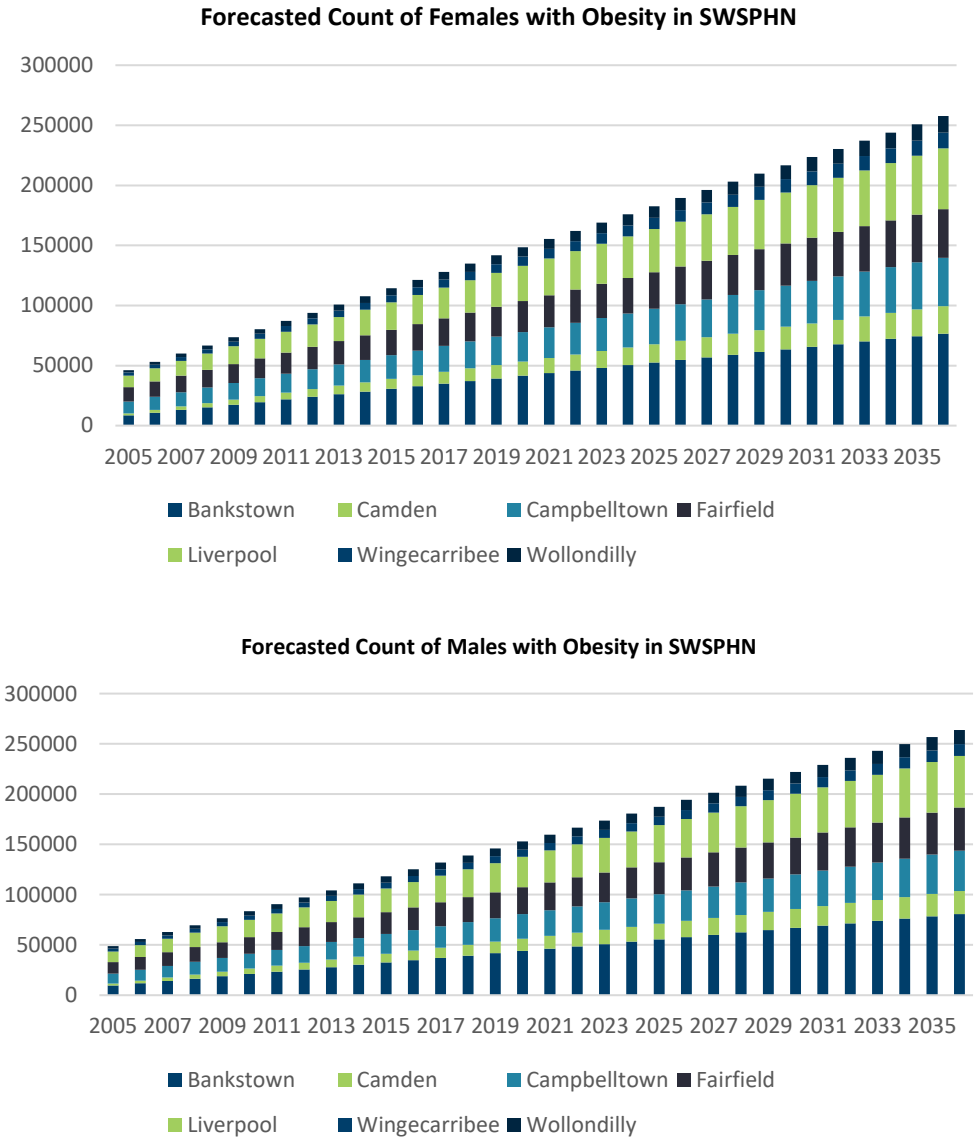


Figure 26: Projected number of obese persons for SWS by LGA and gender, 2016 to 2036 (ABS 2022)



Associated disease

Being overweight or obese affects our physical and mental health. It is the second leading risk factor for illness and early death in Australia. It is linked with many preventable chronic diseases, heart disease, dementia, some musculoskeletal conditions and cancers (AIHW 2023).

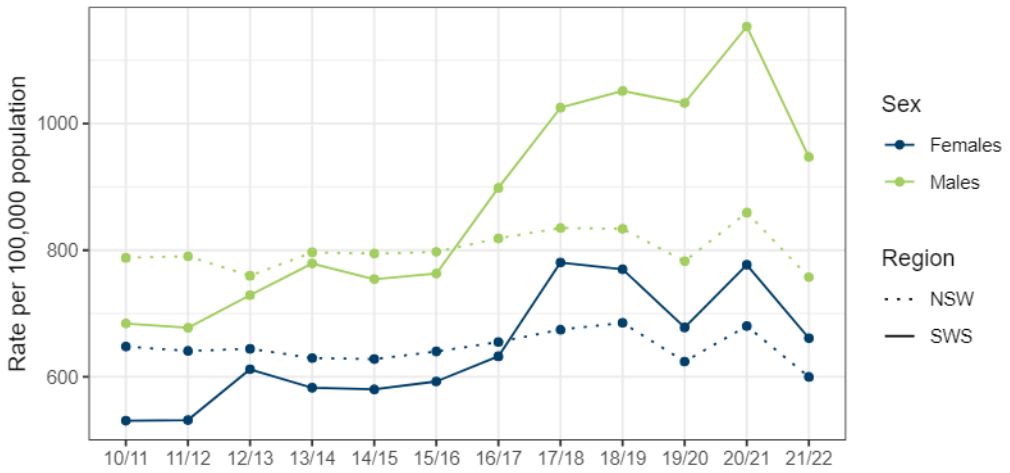
Overweight including obesity was the highest ranked risk factor playing a part in 8.3% of the total disease burden in Australia in 2024 (AIHW 2024p) including:

- 55% of the type 2 diabetes disease burden
- 51% of hypertensive heart disease burden
- 43% of the chronic kidney disease burden, and
- 29% of the osteoarthritis burden.

Attributable deaths and hospitalisations

Being overweight or obese is linked to higher rates of hospitalisations and deaths (CEE 2024). SWS has higher rates of overweight and obesity attributable hospitalisations than NSW. The rate is much greater for males than females as shown in figure 27.

Figure 27: Rates of overweight and obesity attributable hospitalisations, by sex and SWS vs NSW



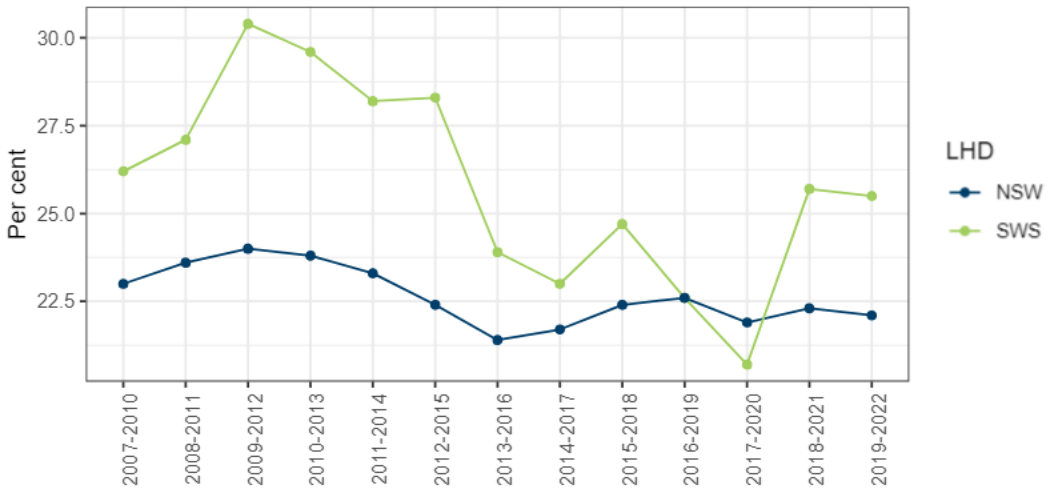
In NSW, the rate of deaths linked to being overweight or obese dropped between 2011 and 2020. It decreased from 45.3 per 100,000 people to 38.7 per 100,000. The rate in SWS also dropped (47.3 per 100,000 to 41.5) but not as much as NSW has (CEE 2024).

Children and adolescents

Prevalence

The state average for people aged five -16 years who are overweight or obese is approximately 24%. This remained stable between 2011 and 2022. In SWS, the rate went as high as 30.4% in 2012 before dropping below the state average in 2019. During the COVID-19 pandemic, the rate increased quickly and as of 2022, it is 25.5%, 3% higher than the state. The number of boys who are overweight or obese (27.4%) is consistently higher than girls (23.5%) in SWS (CEE 2024).

Figure 28: Proportion of five – 16 year olds in SWS living with overweight and obesity, 2022



Associated disease

Living above a healthy weight impacts children's physical and mental health, and social wellbeing. Obesity in childhood increases the risk of breathing problems and there is growing evidence of links to asthma. The risk of fractures, hypertension, early markers for cardiovascular disease and insulin resistance is also increased (Health 2020). Overweight children are more likely to become obese adults and develop chronic diseases earlier. This is in turn linked with a higher chance of early death and disability (World Health Organisation 2024).

Priorities

Issues raised through consultations on overweight and obesity issues include:

- Most common barriers to maintaining a healthy weight reported were costs of gym memberships and healthy food options, modern lifestyles including long working hours and increasing sedentary behaviour
- Navigation of services that address obesity is difficult. Lack of information about available services locally
- Need for patient resources in other languages (including pictures)
- Increase development of partnerships/relationships with GPs
- Need for community education and health promotion activities targeting shopping centres, schools and other community venues
- Gaps in availability of programs targeting youth
- Need to reach disadvantaged people with disability, people with mental illness and Aboriginal people
- Services need to have an outreach approach and deliver to existing groups e.g., women's groups, social housing estates, schools and in community neighbourhood centres as transport is an issue to access such initiatives. Provision for language assistance and programs available in minority languages as well as more common languages
- All programs e.g. Go4Fun should have a holistic and culturally specific approach
- Lack of routine monitoring and recording height and weight measures in children and adolescents.

Potentially Preventable Hospitalisations (PPH)

Potentially Preventable Hospitalisations are those conditions for which hospitalisation is considered potentially avoidable through preventive care and early disease management, usually delivered in an ambulatory setting, such as primary health care. For SWS in 2021-22, there were 19,674 PPHs for total potentially preventable conditions (1,738 per 100,000 persons) (CEE 2024s).

In 2021-22, potentially preventable hospitalisations for the conditions listed in Table 15 below were equal to or higher in SWS compared to NSW:

Table 15: PPH by condition per 100,000 people (age standardised), SWSPHN and NSW 2021–22

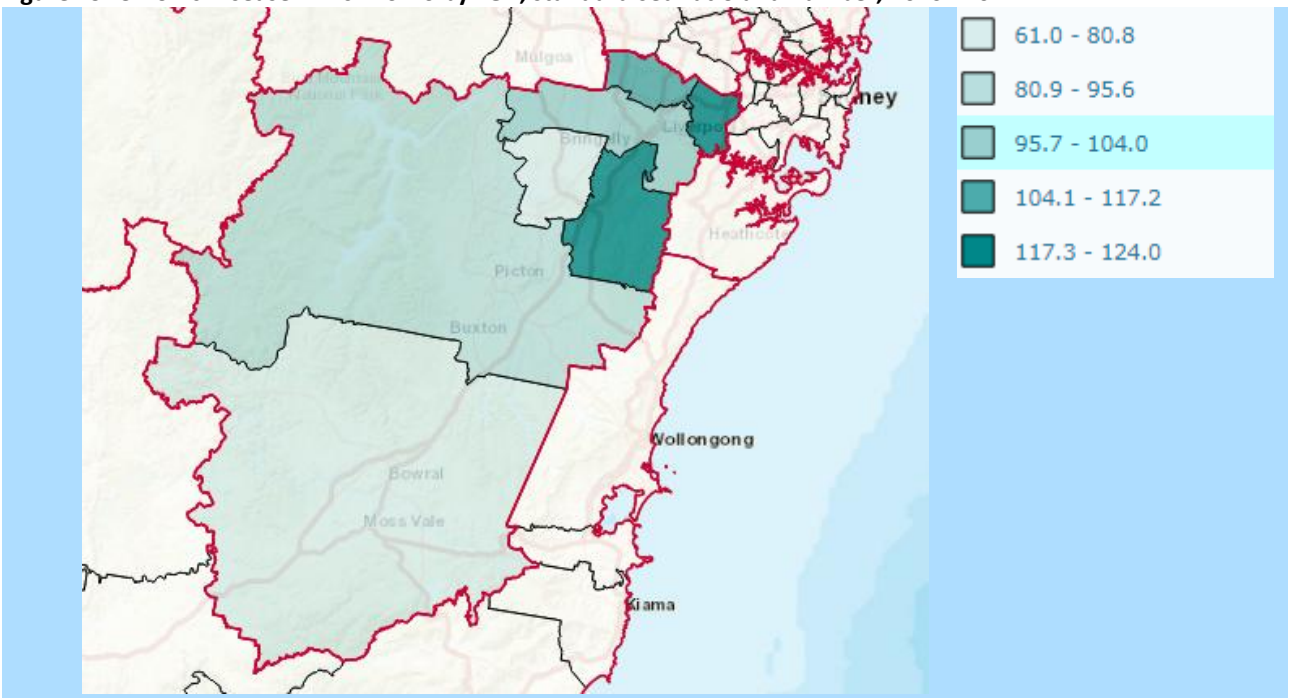
Condition	SWSPHN	NSW
Pneumonia and influenza (vaccine-preventable)	112	69
Other vaccine-preventable conditions	123	65
Asthma	87	73
Congestive cardiac failure	131	126
Diabetes complications	118	118
Hypertension	26	26
Pneumonia (not vaccine-preventable)	3	2
Urinary tract infections, including pyelonephritis	201	196
Perforated/bleeding ulcer	21	17
Ear, nose and throat infections	111	102
Convulsions and epilepsy	109	106
Total	1738	1719

We examined 2020-21 PPH data by age group and LGA utilising the standardised ratio which compares LGA data with an assigned national rate of 100 with values greater than 100 represent proportionally higher rates than the national and vice versa. We found SWS PPH were higher than the national rate in all LGAs for 0 – 14 year olds, five out of seven LGAs for people aged 65 years and over and six of seven for people aged 75 years and older. Campbelltown LGA had PPH higher than the national rate in all age groups (PHIDU 2024).

Key issue for our region	**South Western Sydney had higher than state average rates of PPHs for a range of health conditions**

Figure 29 shows the Torrens University Social Health Atlas map of chronic disease PPH by LGAs within the SWSPHN region expressed as a standardised ratio and by number. The standardised ratio compares the LGA with the national rate, values greater than 100 represent proportionally higher rates than the national and values less than 100 represent rates lower than the national. Campbelltown and Bankstown are local hotspots for chronic disease PPH where primary health quality improvement strategies and consumer education appropriately targeting health literacy levels could be prioritised followed by Fairfield and Liverpool.

Figure 29: Chronic Disease PPHs in SWS by LGA, standardised ratio and number, 2020 - 2021



Name of Local Government Area of residence	Standardised ratio	Number
NSW: Camden	78	675
NSW: Campbelltown (NSW)	124	1,664
NSW: Canterbury-Bankstown - part b	120	2,013
NSW: Fairfield	106	1,689
NSW: Liverpool	101	1,743
NSW: Wingecarribee	61	290
NSW: Wollondilly	92	383

Oral Health

Oral health plays a vital role in overall health and wellbeing. Poor oral health can reduce quality of life and accounted for 4.5%of the total non-fatal disease burden in Australia in 2022 (AIHW 2023)

Key issue for our region	South Western Sydney has poorer rates of oral health than the state average.

The dental care system in Australia is mainly fee-for-service private dental practices. In 2022-23 50 million dental services were subsidised by private health insurers for people who had purchased cover. The Australian Government's Child Dental Benefits Schedule (CDBS) provides access to basic dental services for eligible children 0-17 years old. It subsidised 5.2 million services in 2022-23.

The National Oral Health plan identifies four priority groups that have poorer oral health than the general population and experience barriers to accessing oral health care. The groups identified are:

- People from socially disadvantaged or on low incomes
- First Nations Australians
- People living in regional and remote areas

- People with additional and or/ specialised health care needs (AIWH, 2018)

Oral health in children

Making a recent dental visit, e.g. in the last 12 months, is a measure of access to the dental care system (AIHW 2025d). Data from the National Dental Telephone Interview Survey 2021, indicated 72% of 5-17 year olds had made a dental visit in the previous 12 months. Groups with lower access included 19% whose most recent dental visit was between one and two years ago, 5% between two and five years ago and 4% had not made a dental visit at all or it was more than five years ago. Females were more likely to attend than males (76% and 68% respectively. Children from families with private health insurance (77%) were more like to have had a dental visit in last 12 months.

Dental caries are the most prevalent oral disease in Australian children making up 99% of non-fatal burden (AIHW 2023). However, there has been a decrease in percentage of children receiving fillings from 29% in 1994 down to 18% in 2021. Children receiving clean and scale services has increased from 54% in 1994 to 68% in 2021 and is now the most common preventative service received (AIHW 2025d).

Oral health in adults

The National Study of Adult Oral Health 2017–2018 revealed that most Australian adults have experienced dental decay, with only about 1 in 9 adults (11%) having no history of it (AIHW, 2024)

On average, Australians aged 15 and over had 11 teeth that were decayed, missing, or filled during this period. The number of teeth affected by dental caries increased with age: 15–34-year-olds averaged 4 affected teeth, 35–54-year-olds averaged 10, 55–74-year-olds averaged 19, and those aged 75 and over had an average of 24 affected teeth (AIHW 2023).

In 2018–19, around 3 in 10 adults (28%) aged 15 years and over avoided or delayed visiting a dental practitioner. Nearly 1 in 6 (18%) avoided or delayed visiting a dental practitioner due to cost. The proportion of adults avoiding or delaying visiting a dental practitioner has decreased over time from 33% in 2014–15, with those avoiding or delaying due to cost also decreasing from 20%.

Public dental services

NSW Health provides “safety net” dental services for eligible NSW residents. Public dental clinics are usually located in public hospitals and community health centres, schools and mobile services and provide comprehensive dental care for patients. Children can receive CDBS services at these clinics. Reporting on public dental patients waiting times changed from 28 October 2024. Assessment and treatment wait lists have been combined and are reported as percent of patients waiting less than the maximum waiting time. Maximum waiting times are determined by assigned triage code based upon urgency of need (excluding patients who are waiting for specialist dental services). Adult maximum waiting times range from one day to 545 days, children’s waiting times range from 1 day to 365 days (Health 2024a). In SWS as of 28 July 2025 100% of patients had been waiting for less than their assigned maximum waiting time (Health 2025).

Dental hospitalisations

The two main reasons for hospitalisations in 2020-21 to 2022-23 were developmental disorders of the teeth making up 46% of oral health hospitalisations and dental caries making up 33% of oral health hospitalisations (CEE 2024y).

In SWS, there were 3578 hospitalisations (337per 100,000 population) recorded for dental conditions in 2020/21-2022/23.

In 2022–2023, South Western Sydney had lower rates of hospitalisation for the removal and restoration of teeth for dental caries in children across all age groupings and total 0-14 years compared with NSW (0-14 years, 478.5 vs 530.2 respectively).

Table 16: Hospitalisation for removal and restoration of teeth for dental caries in SWS and NSW, rate per 100,000 population, 2022 - 2023 (CEE 2024y)

PHN	0-4 years	5-14 years	0-14 years (total)	15+ years (total)	All ages
SWS	349.4	539.7	478.5	29.5	121.7
NSW	370.6	605.8	530.2	50.7	149.2

Blood borne virus prevention

There are three blood born viruses of public health concern, Hepatitis B, Hepatitis C and HIV. Harm minimisation has been a key policy of Australian state and federal governments since 1985. Harm reduction aims to minimise behaviours that increase the risk of spreading blood borne viruses primarily through the distribution of sterile injecting equipment to intravenous drug users and provision of information, advice and referral services. The National Drug Strategy 2017–2026 focuses on reducing harm using three approaches (DoH 2017a):

- reduce risky behaviours – such as sharing of drug use equipment and unprotected sex
- effective public policy such as needle and syringe programs
- safer settings for example facilities for safe disposal of needles and syringes

A continued harm reduction approach combined with other complementary prevention strategies is the key to prevention efforts(MoH 2019). This includes:

- Better detection of newly acquired hepatitis C notifications.
- Prompt appropriate education, care, referral, testing and contact tracing by diagnosing clinicians.
- Culturally appropriate harm reduction strategies for Aboriginal and Torres Strait Islander people in both community and prison settings

HIV

Prevalence

Between 2019 and 2023, 142 people were diagnosed with HIV infection in SWS. This number accounted for 13.3% of NSW newly diagnosed HIV infections during the same period. There was very little variation in the numbers of newly diagnosed HIV infection notifications received each year from 2019-2023 in SWS (MoH 2024).

The majority of NSW notifications for newly diagnosed HIV infections was among males in the 20-29 years and 30-39 years age groups accounting for 31.6% and 36.2% of notifications (MoH 2024).

Only 28.1% (n=65) of new diagnoses in 2023 showed evidence indicating their infection happened during the previous 12 months (early-stage HIV infection). This proportion has been slowly declining since 2018.

Among newly diagnosed HIV infection notifications in 2023 there were 11 notifications identified among Aboriginal and/or Torres Strait Islander people the highest number since 2018.

In 2023, NSW residents notified with newly diagnosed HIV infection reported HIV risk exposures including men who have sex with men (MSM) for 64.5% (n=149), heterosexual sex for 20.3% (n=47), and injecting drug use (IDU) for 1.7% (n=4).

Pre-exposure prophylaxis for HIV (PrEP)

PrEP (pre-exposure prophylaxis) is an HIV prevention method in which people who do not have HIV take a pill every day to reduce their risk of becoming infected with HIV. On 1 April 2018, HIV pre-exposure prophylaxis was PBS listed as a streamlined authority item. People with a Medicare card who meet high or medium HIV infection risk criteria can purchase PrEP from community pharmacies with a GP prescription(MoH 2018). PrEP dispensing has increased annually since 2018 among all age groups being dispensed to 18, 328 people in 2023 (MoH 2024).

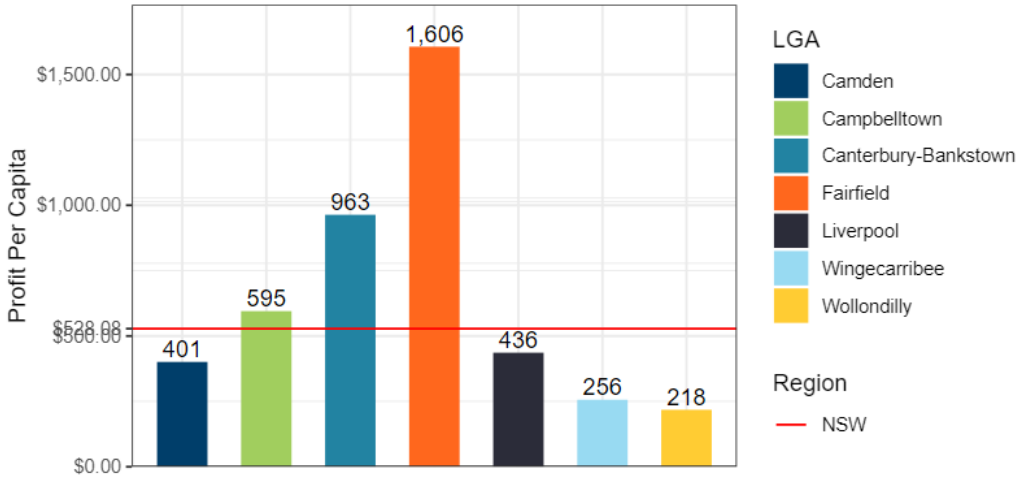
Gambling Harm

In 2022, the Australian Gambling Research Centre conducted an online general community panel survey to explore gambling participation and related harm among Australian adults (AGRC,2023), 3 in 4 Australians (73%) aged 18 and over reported spending money on one or more gambling products in the past 12 months (AIHW)

It is estimated 1% of the adult population are classified as problem gamblers, 7.2% of people who gamble are at moderate risk of problem gambling(Roy Morgan 2018). As a result of gambling, people with gambling problems can experience harm which have negative impacts on their quality of life. The risk of harm is higher with gaming machines, young males aged 18-24 who are single and unemployed gambling problems (Armstrong and Carroll 2017), speaking a language other than English, being of a non-Caucasian ethnicity and immigrant status (Okuda, Liu et al. 2016).

The Fairfield community is at greater risk of gambling harm compared with the rest of SWS and NSW. Fairfield LGA has the lowest median weekly income per household in SWS, but it has the highest number of gaming machines per capita and highest net profit per capita from gaming machines. In 2019, Fairfield had 9.4 gaming machines per 1,000 population, three times that of the NSW average of 3.1 per 1,000 population. The net profit from gaming machines in Fairfield was $1,606.00 per capita, three times that of NSW average of $528 per capita (Liquor&Gaming 2024).

Figure 30: Gaming machine net profit per capita, SWS, December 2023 (Liquor&Gaming 2024)



Research has found only a small proportion (<10%) of the individuals with gambling problems seek formal help (Cunningham 2005, Slutske, Blaszczynski and Martin 2009). Screening for gambling harm is not part of routine practice in primary health care and may indicate a lack of professional awareness and education. In a recent Victorian study of more than 300 clinicians working in mental health services, only 10.6 per cent of clinicians were aware of screening and assessment tools for gambling harm (Abbott, Stone et al. 2016). This was confirmed during SWSPHN's community consultation in 2019 as well as the additional barrier of lack of support and treatment services for gambling harm.

To assist primary care clinicians, a Gambling Harm Screening Tool that helps health professionals spot patients at risk of gambling harm or those already negatively affected. Developed by the Fairfield Health Alliance, a collaboration between SWSPHN, SWSLHD, and Fairfield City Council, this tool provides a structured way to assess patients' needs and guide them toward appropriate support or referral services. SWSPHN also provides access to referral pathways and information on its website.

The National Gambling Trends study conducted in 2022 (AIHW 2023f) described a range of emerging trends in gambling and observed that there has been:

- an increase exposure into gambling marketing through various media outlets including advertising, promotions, incentives and sponsorships
- an increase in online gambling and concerns about ease of access, new onshore and offshore gambling operators within limited monitoring
- increased spending on poker machines post COVID
- convergence of video gaming and gambling through products appealing to young people
- normalisation of gambling for youth and risk of harm.

2.2.2 Chronic Disease in South Western Sydney

Many chronic diseases share common preventable risk factors. Modifying these risk factors (such as reducing tobacco use, improving physical activity and diet, etc.) can reduce the risk of developing a chronic condition, leading to large health gains in the population through the reduction in disease burden and mortality. Behavioural risk factors often occur together and may cluster particularly in disadvantaged communities and groups. These behaviours contribute to the development of biomedical risk factors, including overweight and obesity, high blood pressure, and high cholesterol levels which in turn lead to chronic disease.

Key issue for our region	**South Western Sydney has higher rates of chronic disease risk factors, particularly for diabetes, CVD, respiratory disease, cancer and mental health**

SWSPHN undertook community consultations on chronic disease in 2023. Five key strategies with a range of activities to address regional variations evolved from the consultations.

1. Improve access to health care through improved affordability, technology and reduced waiting times
2. Address workforce challenges through greater education, culturally appropriate services and increased workforce
3. Improve care planning/coordination through data linkage, improved discharge and shared care models
4. Provide education to raise awareness through health promotion that is culturally appropriate
5. Implement service navigation tools through service navigator models, and a central information hub for consumers and health professionals

Diabetes

Diabetes and its associated complications contribute significantly, both directly and indirectly, to the cost of health care, mortality, morbidity and poor quality of life of sufferers and carers. The number of people with type 2 diabetes (T2DM) is growing as a result of rising overweight and obesity rates, lifestyle and dietary changes, and an ageing population. Type 2 diabetes accounts for about 85-90% of all diabetes cases and primarily affects people older than 40 years. Around 20% of people with T2DM use insulin. Several modifiable risk factors play a role in the onset of type 2 diabetes, including obesity, physical inactivity and poor nutrition, as does genetic predisposition and ageing. (SWSLHD/SWSPHN 2018).

In NSW, diabetes is prevalent among people aged 75 years and over, males, Aboriginal people, people with lower socioeconomic status and people from a non-English speaking background. Diabetes has been reported by local GPs to be the most common health issue in the community, and the second most common concern reported by the local community (CEE 2020d).

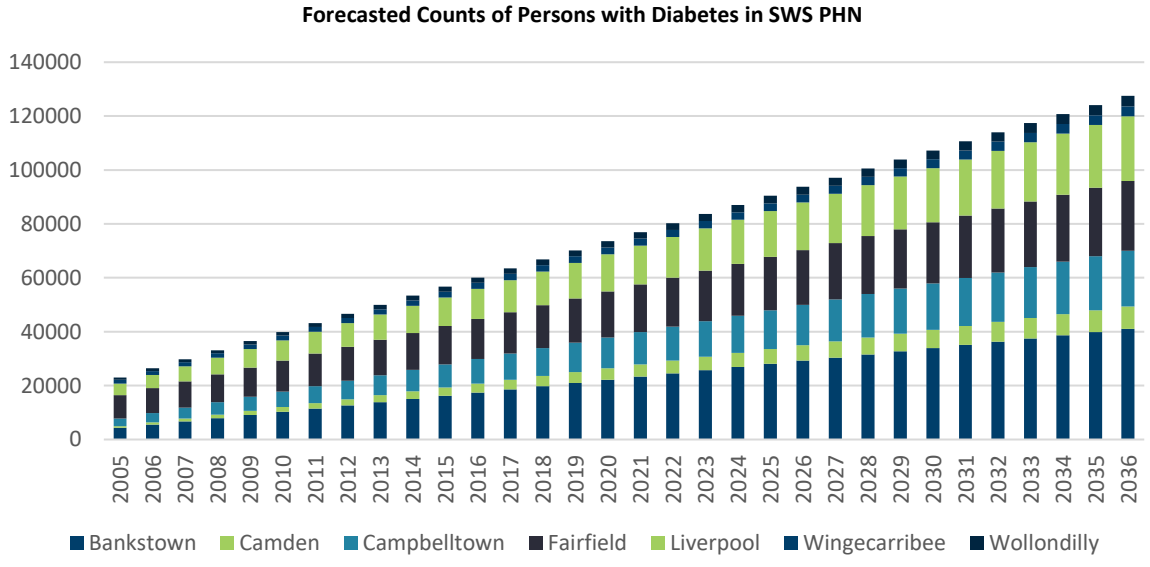
Key issue for our region	The rate of diabetes diagnoses within South Western Sydney has doubled in the past 20 years, resulting in a higher rate than the NSW average

Prevalence data for diabetes is mostly collected via self-reporting methods, and less often through more accurate biomedical measures. A large proportion of the Australian population who have diabetes remains undiagnosed. It is estimated one in four people with diabetes is unaware of having the condition. This finding limits the value of self-reported data for estimating population prevalence.

In self-reported census data from 2021, 61,086 people in SWS had diabetes not including gestational diabetes, a standardised rate of 6.4 per 100 people, higher than the self-reported NSW rate (4.8 people per 100). Across the region's LGAs Campbelltown had the highest rate (7.7 per 100 people and Wingecarribee had the lowest (3.6 per 100 people) (PHIDU 2024). This is just 55% of the number of diabetes diagnoses extracted from General Practice data in September 2025 using the POLAR extraction tool. This data indicates 109,477 unique patients in the SWSPHN region had a diabetes diagnosis (SWSPHN 2025c). Type-2-Diabetes was dominant making up 85% cent of the patients, 5% had Type-1 and 35% did not have a sub-type recorded. Prevalence varied across the region's LGAs with Liverpool having the highest prevalence, 21,819 patients and Wollondilly having the lowest prevalence at 2,956.

Figure 31 illustrates the expected increase to 127,481 people with diabetes by 2036 based upon the more conservative self-reported data.

Figure 31: Estimated Number of persons with diabetes in SWS by LGA, 2005 to 2036 (CEE 2020d, ABS 2022, Diabetes-Australia 2022)



Diabetes Australia estimates that the National Diabetes Service Scheme (NDSS) covers 80%–90% of people with diagnosed diabetes. Therefore, registrations with the NDSS can provide a reasonable estimate of the number of people living with diabetes. Based upon NDSS registrations it is known that in March 2024 almost 1.5 million Australians are living with Diabetes mostly with type-2-diabetes, 85.7% (Diabetes-Australia 2024).

In SWS registration data is higher than self-reported but is still likely to underestimate the true number as it

only includes people who have been diagnosed and who have registered with the scheme. In 2021, there were 72,190 people registered (6.6% of SWS population), higher than the NSW average of 5.1%. Of these, 88.2% have type 2 diabetes, 7.3% have type 1 diabetes, and 3.7% have gestational diabetes (Diabetes-Australia 2022). Across LGAs in SWS, Fairfield has the highest proportion of NDSS registrants (8.1%), and postcodes 2164 and 2176 within the Fairfield LGA have even higher proportions, 9% and 8.3% respectively. Campbelltown LGA has the second highest proportion (7.5%) and contains the postcodes 2564 and 2565 where the registered population proportion is 9% and 8% respectively. While Liverpool LGA has the third highest proportion of registrants (6.9%), it has the region's two highest registrant proportions by postcode, 2179 at 14.3% is more than double that of SWS, NSW and Australia, postcode 2555 at 11% is also very high (Diabetes-Australia 2023).

Each of the three LGAs mentioned above contain postcodes where NDSS registrations are very high ranging from 1.4 to 2.6 times the population proportion for NSW and Australia as shown in Table 9. Liverpool LGA contains the postcodes 2179 and 2555. Postcodes 2164 and 2176 are located within the Fairfield LGA and 2564 and 2565 are in Campbelltown LGA.

Table 17: NDSS registrations by LGA, SWS, 2023 (Diabetes-Australia 2023)

LGA	Registrants	Population	% of population
Camden	5970	106717	5.6
Campbelltown	14280	190165	7.5
Canterbury-Bankstown	28010	419005	6.7
Fairfield (C)	19530	240771	8.1
Liverpool	17100	247298	6.9
Wingecarribee	2650	57978	4.6
Wollondilly	3020	58742	5.1
SWSPHN	77570	1128139	6.9
NSW	480070	8639398	5.6
National	1502620	27058462	5.6

Table 18: Very High proportion of NDSS registrations Postcodes, SWS, 2023 (Diabetes-Australia 2023)

Area	Registrant % Population
2179	14.3
2555	11
2164	9
2564	8.6
2176	8.3
2565	8
South Western Sydney	6.9
NSW	5.6
National	5.6

Diabetes has increased in SWS which may be due to growth in population groups at higher risk of T2DM, as well as growth in lower SES areas. Socio-economic status is linked to diabetes, with lower SES areas/populations consistently shown to have a higher proportion of individuals with diabetes (AIHW 2024k) (Zhu 2023) and an increased risk of individuals developing T2DM (Agardh 2011) (Hwang 2014). This is likely due to dietary impacts, fewer physical activity opportunities, typically lower educational achievement and limited health resources.

Some CALD groups are also at an increased risk of T2DM such as individuals born in Polynesia and Melanesia (Cordato 2022), as are First Nations people (AIHW 2024k). There is also evidence to suggest the information being provided to patients from CALD backgrounds is being written in a higher reading level than recommended (Lin 2020) and are not tailored as effectively as they could be, leading to reduced uptake of advice (Lin 2020, Lau 2023) and impacting on the health literacy levels regarding diabetes in SWS.

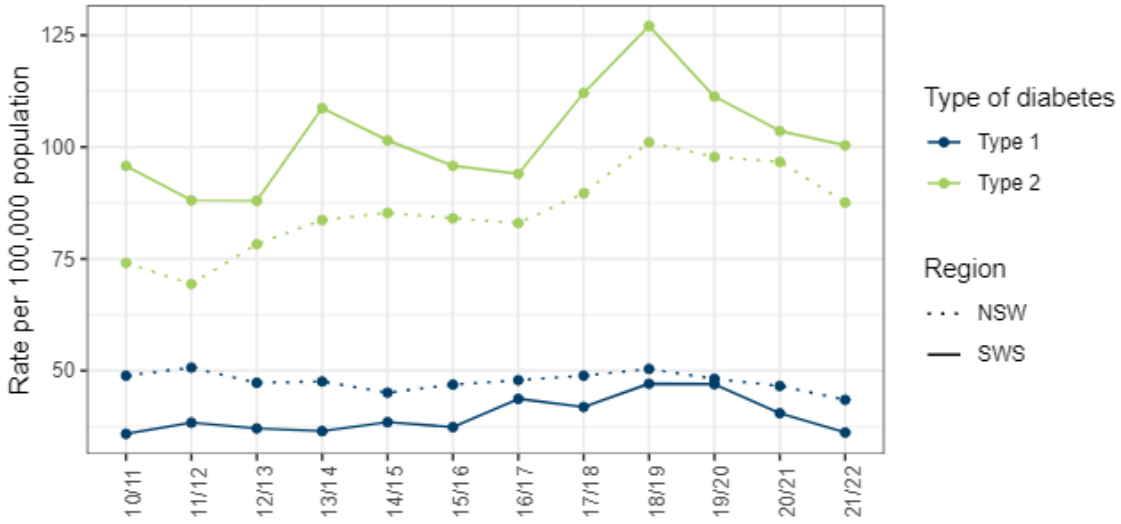
There is also evidence COVID-19 is associated with new onset diabetes (Zhang 2022), which may contribute to the increase seen in SWS since 2019.

SWS has a higher rate of gestational diabetes (GDM) compared to state-wide rates in NSW, NDSS registrants with GDM in SWS is 3.7% compared to the national rate of 2.9%. The high prevalence is driven by the increasing proportion of the population that is overweight and obese from a young age (SWSLHD/SWSPHN 2018). CALD populations also tend to have higher rates of GDM (AIHW 2024k), which may be a contributing factor to overall rates in the PHN. CALD women have been recorded as feeling they face additional challenges from healthcare providers when accessing services for help with GDM (Haigh 2023).

Diabetes Related Hospitalisations

There were 1.3 million hospitalisations associated with diabetes in 2020-21 accounting for 11% of all hospitalisations in Australia. Most, 72%, of diabetes hospitalisations were of people aged 60 years and over (AIHW 2024k) Figure 32 illustrates the sharp rise in type-2-diabetes hospitalisations in NSW and SWS after 2016-17 peaking in 2018-19. The rate then decreased through the pandemic years but had not reduced back to the 2016-17 level by 2021-22. Hospitalisation rates with type-2-diabetes as principal diagnosis have been higher in SWS compared with NSW throughout the 2010-11 to 2021-22 period. Type-1-diabetes hospitalisations have been relatively stable between 2020-11 and 2021-22 in NSW and SWS with SWS rates consistently lower than NSW.

Figure 32: Hospitalisation rate, type 1 & type 2 diabetes as principal diagnosis SWS and NSW, 2010-11 to 2021-22 (CEE 2024r)



Diabetes hospitalisations rates were higher for males across all the region's LGAs. Males in Campbelltown had the highest hospitalisation rate while females in Wingecarribee had the lowest as shown in Table 20 below. For type 1 diabetes hospitalisations in 2021-22, people aged 0-24 have the highest rate (54.3 per 100,000 population). Type 2 diabetes hospitalisations increase with age. In 2021-22 people aged 75 years and over had the highest rate (534.8 per 100,000 population), which is 6.1 times the rate for the general population (CEE 2024r).

Table 19: Type 1 and type 2 diabetes hospitalisations (rate per 100,000 population), SWS and NSW by age, 2021-22

		0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75+ years	All ages
Type 1	NSW	54.3	49.9	40	33.2	36	25.2	31.1	43.5
	SWSPHN	6.7	6.2	4.7	3.5	2.9	1.5	1.7	36.2
Type 2	NSW	1.8	14.4	27.8	89.5	172.4	314.2	534.8	87.6
	SWSPHN	0.5	2.1	5.5	12.2	25.1	41.4	57.5	100.4

Table 20: Type 1 & Type 2 Diabetes as a principal diagnosis: Hospitalisations by LGA, SWS, 2020-21 (PHIDU 2024)

LGA	Male number	Male ASR per 100,000	Female number	Female ASR per 100,000
Camden	84	129	61	93
Campbelltown	185	190	143	150
Canterbury-Bankstown -	176	150	110	97
Fairfield	161	152	102	99
Liverpool	191	151	119	96
Wingecarribee	38	141	18	70
Wollondilly	37	127	27	98

In 2020-21 both diabetes-related hospitalisations and diabetes related potentially preventable hospitalisations were higher in SWS than the rest of NSW. SWS has a proportionately large concentration of higher-risk groups for diabetes (CALD, lower SES), who may also have lower primary healthcare/specialist healthcare utilisation rates, which can lead to higher hospitalisation rates for diabetes due to sub-optimally managed diabetes.

If the quality of care for diabetes is good (e.g. due to primary care QI practices), patients might be reviewed more frequently as part of their management plan, which could prevent complications that lead to potentially preventable hospitalisations.

Potentially preventable hospitalisations for diabetes complications

Diabetes complications are among the most common chronic conditions for which hospitalisation is considered to be potentially preventable by timely and appropriate provision of primary or community-based care(AIHW 2018b).

In SWS in 2020-21, the age-standardised rate of potentially preventable hospitalisation (PPH) for diabetes complications was 171 per 100,000 people, higher than the NSW rate of 162 per 100,000. Within SWS, Campbelltown has the highest rate (242 per 100,000 people) of PPH (PHIDU 2024).

Table 21: Potentially preventable hospitalisations for diabetes complications, SWS and NSW, by LGA, 2020-21 (PHIDU 2024)

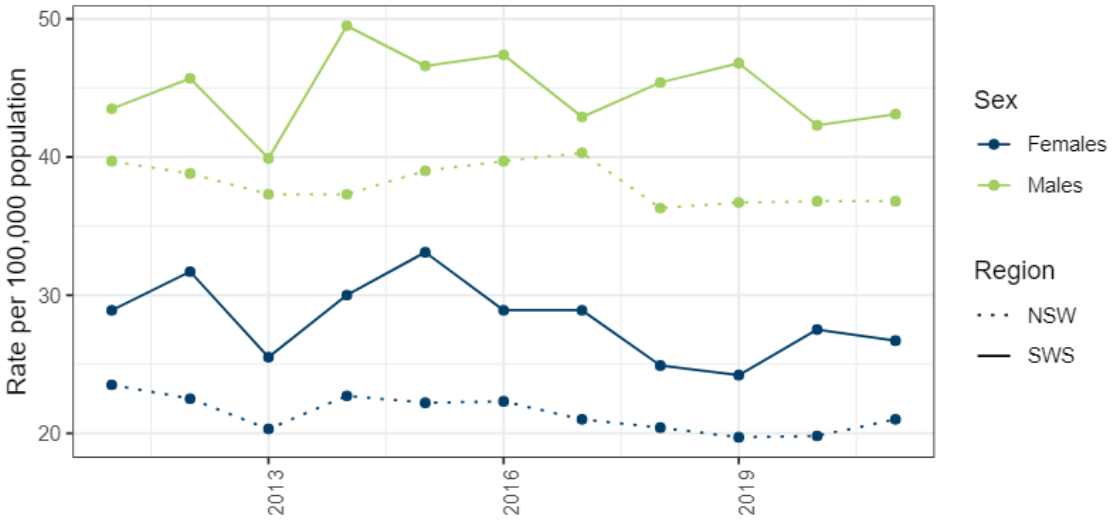
LGA	Number	ASR per 100,000
Camden	145	163
Campbelltown (NSW)	328	242
Canterbury-Bankstown - part b	286	173
Fairfield	263	168
Liverpool	310	177
Wingecarribee	56	131
Wollondilly	64	156
SWS	1,461	171
NSW	11,927	162

Diabetes related deaths

Diabetes-related deaths are those where diabetes is either the underlying cause of death or it is an associated cause of death, where the underlying cause is one of the commonly recognised complications of diabetes. These complications include heart disease (including heart attacks and angina), stroke or diseases caused by stroke, heart failure, sudden death (cardiac arrest), peripheral vascular disease, kidney disease, hyperglycaemia (high blood sugar) or hypoglycaemia (low blood sugar). Total deaths associated with diabetes include those with underlying causes not related to diabetes but where diabetes was an associated cause of death (CEE 2024r).

In 2021, the diabetes death rate in SWS was 34.3 per 100,000 population, higher than NSW rate of 28.4 per 100,000 population (AIHW 2020b, CEE 2024r). Age-adjusted death rates for diabetes in SWS have been consistently higher than NSW rates between 2011 and 2021when they were 1.2 times higher than the NSW average. During the same period, males 43.1 per 100,000 in 2021, have had higher rates than females 26.7 per 100,000 in 2021.

Figure 33: Diabetes related deaths (underlying + selected associated), NSW & SWS 2011 – 2021 (CEE 2024r)



Variations between population groups

Males are 1.7 times as likely to die from diabetes complications than females. Aboriginal and Torres Strait Islander people are 2.5 times as likely to die from diabetes compared to non-Aboriginal people (68.5 and 27.1 per 100,000 population respectively). People who are socioeconomically disadvantaged are more likely to die from diabetes than those who are less disadvantaged. In 2021, people in the bottom 20% of most disadvantaged quintiles (IRSD) were 2.3 times as likely to die from diabetes complications compared to the top 20% least disadvantaged (40.2 and 17.2 per 100,000 population respectively) (CEE 2024r).

Priority areas of focus for diabetes in South Western Sydney

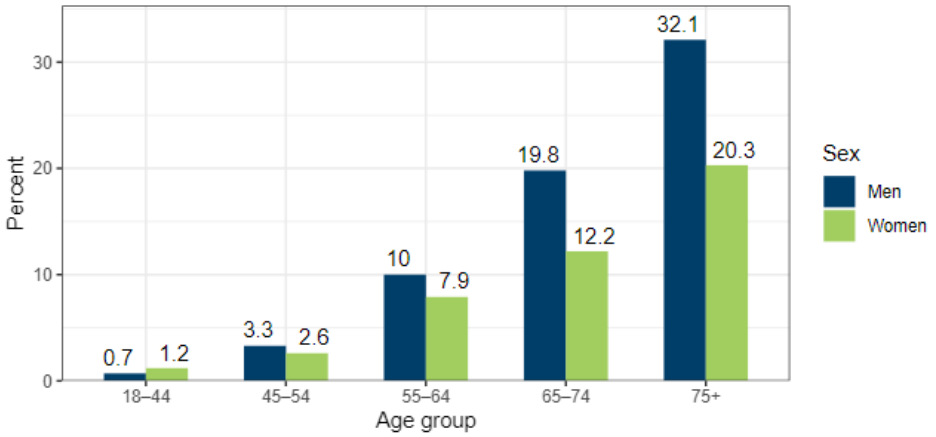
- Addressing higher rate of diabetes and diabetes-related hospitalisations through continued QI implementation
- Tailored/language appropriate resources
- Community-based initiatives to improve diabetes risk factors (dietary habits, physical activity, screening).

Cardiovascular disease

Cardiovascular (or circulatory) disease (CVD) comprises all diseases of the heart and blood vessels. Commonly, this group of conditions is referred to under the broader term of 'heart disease' or 'cardiovascular disease' (AIHW 2018c).

In Australia, CVD was the underlying cause of 45,000 deaths (24% of all deaths) in 2022. 6.7% of adults (1.3 million) had one or more conditions related to heart, stroke, or vascular disease in 2022. The prevalence of CVD increases strongly for those aged 45 and over and triples for individuals aged 65 and over. Aboriginal and Torres Strait Islander Australians had CVD hospitalisation and death rates at twice the rate of non-Aboriginal and Torres Strait Islander Australians(AIHW 2018e).

Figure 34: Prevalence of CVD, among SWS persons aged 18 and over, by age and sex, 2017-18 (AIHW 2018e)



In the ABS 2021 Census 35, 682 people in SWS reported having heart disease including heart attack and angina an age standardised rate of 3.9 per 100 people, similar to the national and state rates of 3.9 and 3.8 per 100 people respectively. The heart disease rate reported across the region's LGA's ranged from 3.3 per 100 people in Wingecarribee to 4.6 per 100 people in Campbelltown (PHIDU 2024).

Key issue for our region	**While the prevalence of cardiovascular disease in South Western Sydney is lower than the state average, it is predicted to increase by 38% by 2031**

CVD related hospitalisations

In SWS, The CVD hospitalisation rate decreased in the five year period between 2018-19 and 2022-23 for both males and females (CEE 2024t). During this time CVD hospitalisations in SWS declined from 1619.2 to 1403.0 per 100,000 population. Both were lower than the NSW rate (of 1679.7 and 1522.7 per 100,000 population respectively) during the reference period. The hospitalisation rate for females was lower than males.

In NSW and SWS, coronary artery disease has the highest hospitalisations rate among all circulatory diseases (427.4 and 401.4 per 100,000 population). In 2022-23, it accounted for 29.0% of hospitalisations among all cardiovascular diseases in SWS (CEE 2024t).

Table 22: Circulatory disease hospitalisations by disease type, persons, SWS 2022-23 (CEE 2024t)

Disease type	Number	Rate per 100,000 population
Atrial fibrillation and flutter	1,562	133
Haemorrhoids	1,409	131
Heart failure	2,058	170
Paroxysmal tachycardia	535	48
Stroke	1,549	129
Transient ischaemic attacks	450	37
Varicose veins of lower extremities	472	43
Remaining cardiovascular diseases	4,657	402
Cardiovascular disease (total)	16,546	1403

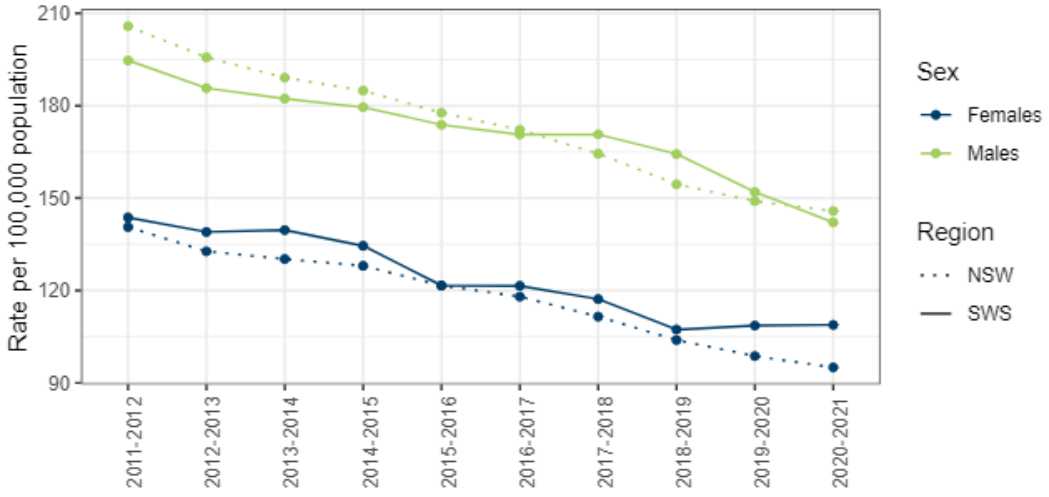
CVD related deaths

Overall, the death rates from all forms of circulatory disease have steadily decreased since 2001 due to:

- Decreased incidence, associated with reductions in some risk factors, including smoking, saturated fats in the diet, and levels of blood pressure
- Increased survival, as a result of improvements in medical and surgical treatment and follow-up care(CEE 2020d).

In 2020-21, there were 1,454 deaths attributed to circulatory diseases in SWS. The death rates in SWS were lower for females (108.8 per 100,000) compared with males (142.1 per 100,000 (CEE 2024t).

Figure 35: Circulatory disease deaths, SWS, NSW 2011-12 to 2020-21 (CEE 2024t)



Variation between population groups

In NSW, males are 1.5 times as likely to die from circulatory diseases as females (145.5 and 95.7 per 100,000 population respectively). Aboriginal and Torres Strait Islander people are 1.6 times more likely to die from cardiovascular disease as non-Aboriginal people (196.2 and 126.4 per 100,000 population respectively). People who are socioeconomically disadvantaged are more likely to die from circulatory diseases than those who are less disadvantaged. In 2020-21, people in the most disadvantaged (IRSD)

quintile are 1.5 times more likely to die from diabetes compared to those in the least disadvantaged quintile (145.3 and 94.8 per 100,000 population respectively (CEE 2024t).

Kidney disease

Kidney disease is a subset of symptoms including problems or complaints about the kidneys, renal pain and renal colic (kidney stones). Many people do not know they have kidney disease and up to 90% of kidney function can be lost before symptoms appear. Chronic kidney disease (CKD) occurs when there is evidence of kidney damage or reduced kidney function lasting for at least three months.

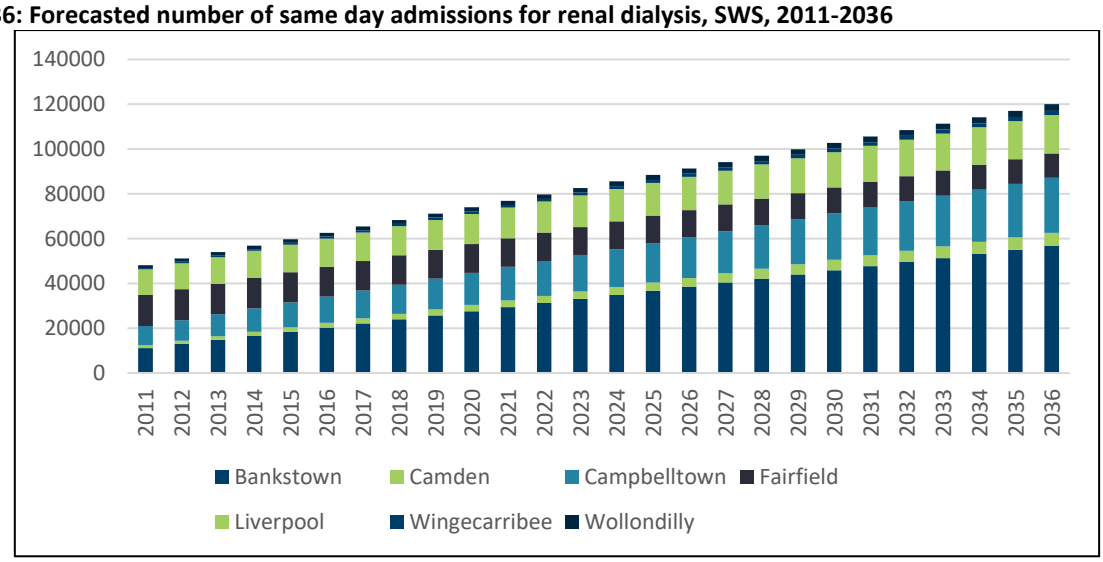
CKD is largely preventable as many of its risk factors are modifiable, such as high blood pressure, insufficient physical activity, overweight and obesity, and smoking. Diabetes and high blood pressure are two of the most common causes of CKD (SWSLHD/SWSPHN 2018).

Key issue for our region	**16% of people in the state who have kidney disease reside in South Western Sydney**

In the 2021 census, 9,324 people in SWS self-reported having kidney disease a standardised ratio of 109 compared to 100 nationally. All LGAs with the exception of Wingecarribee (75), had a higher standardised ratio with the highest (134) in Campbelltown (PHIDU 2024)

The number of same day admissions for renal dialysis amongst SWS residents is projected to increase by 92% between 2016 and 2036 rising from 62,554 to 119, 966 (PHIDU 2024)

Figure 36: Forecasted number of same day admissions for renal dialysis, SWS, 2011-2036



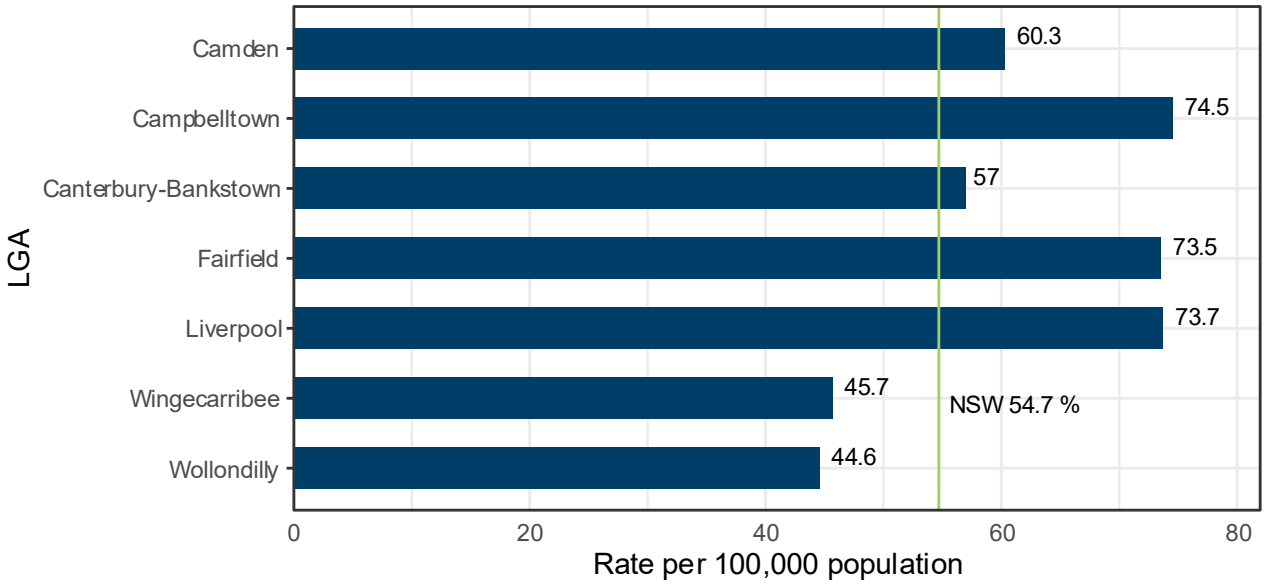
CKD hospitalisations

In SWS, CKD hospitalisations (including dialysis) in 2018-19 was 8.105.5 per 100,000 population, higher than NSW 5,878.4 per 100,000 population. It is the highest among all PHNs in NSW. Within SWS, four of the seven LGAs have a significantly higher standardised ratio of same day dialysis hospitalisations compared to nationally (100), Campbelltown (206), Canterbury-Bankstown part b (176), Fairfield (164) and Liverpool (180) (PHIDU 2024).

CKD deaths

Between 2020 and 2022, average deaths per year in SWS were 759, representing a higher death rate than the state (64.7 and 54.7 per 100,000 population, respectively). Across LGAs, Campbelltown had the highest death rate 74.5 per 100,000 population. SWS LGAs except for Wingecarribee and Wollondilly had a death rate higher than the NSW rate as shown in Figure 37 below (CEE 2020c).

Figure 37: Chronic Kidney Disease deaths by LGA (Rate per 100,000 population), SWS and NSW 2020 - 2022 (CEE 2020c)



Variations between population groups

In 2021-22 in NSW, males were 1.8 times more likely to be hospitalised with CKD compared to females (7680.4 and 4270.1 per 100,000 population respectively) and 1.6 times more likely to die from CKD. Aboriginal and Torres Strait Islander people are 3.5 times as likely to be hospitalised with CKD compared to non-Aboriginal people (19313.6 and 5513.9 per 100,000 population respectively) and are 2.2 x as likely to die from CKD. CKD prevalence increases with socioeconomic disadvantage. In 2019-20, people in the most disadvantaged (IRSD) quintile are twice as likely to die from chronic kidney disease compared to the least disadvantaged quintile (37.0 and 66.6 per 100,000 population respectively) (CEE 2020c, PHIDU 2024).

Respiratory disease

Respiratory disease covers a range of respiratory-related conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD).

Key issue for our region	**The rate of hospitalisations for respiratory diseases such as asthma and COPD are higher in South Western Sydney than the state average**

Asthma

Asthma is among the most common chronic conditions for which hospitalisation is considered to be potentially preventable(AIHW 2018a). According to the *NSW Child Population Health Survey 2018-2019*, in SWS, 11.3% of children were reported to have current asthma. Further, 21.3% of children were reported to have ever had asthma. Torrens University modelling estimates that in 2017-18, 95, 074 (9.7%) of people in

SWS had asthma with a standardised ratio of 86 compared to the nation's 100 (PHIDU 2024).

In SWS, asthma hospitalisation rates for people aged between five and 34 years have decreased between 2018-19 and 2021-22 from 176.9 per 100,000 people to 120.9 per 100,000 people. In 2021-22, the hospitalisation rate for SWS residents of all ages was slightly higher than the NSW rate (98.4 and 86.7 per 100,000 population, respectively) (CEE 2018, CEE 2024v) . In 2020-21, the age-standardised rate of potentially preventable hospitalisation (PPH) for asthma was 103.5 per 100,000 people, higher than the NSW rate of 86.0 per 100,000 population. Across SWS, Liverpool LGA has the highest PPH (147.0 per 100,000), followed by Campbelltown (133.3 per 100,000) and Canterbury-Bankstown part b (124.3 per 100,000) (PHIDU 2024).

COPD

According to the 2017-18 national health survey, people with self-reported COPD were more likely to be current smokers, physically inactive, and/or obese, compared to those without COPD (AIHW 2024n). In SWS in 2017-18, the estimated prevalence of COPD was 2.2%, with 19,820 people affected. This was the same as the state rate. Prevalence ranged from 2.0% in Canterbury-Bankstown part b, Fairfield and Wingecarribee to 2.4% in Campbelltown and Wollondilly (PHIDU 2024).

COPD hospitalisations

Hospitalisation rates for all ages for COPD have been falling in both NSW and SWS since 2018-19 and in 2021-22 were lower in SWS compared with the rest of the state (114.9 and 133.4 per 100,000 population, respectively). Rates for older people aged 65 years and older have been decreasing since 2019-20 and were slightly lower in SWS compared with the rest of NSW by 2021-22 (730.3 and 779.3 per 100,000 population, respectively) (CEE 2024w)..

COPD is amongst the most common chronic conditions for potentially preventable hospitalisations. In 2022–23 SWS had a rate of 147 PPH per 100,000 population which was lower than the national rate of 192 (AIHW 2025c). When compared with our bordering PHN regions, SWS is placed in the mid-range results for COPD PPH as shown in Table 23 below. An average hospital length of stay in SWS was slightly higher to the national length of stay (5.9 and 5.1 respectively) (AIHW 2025c).

Table 23: Potentially preventable hospitalisations for COPD. SWS region compared to bordering PHN regions, 2022 – 2023 (AIHW 2025c).

PHN Region	PPH per 100,000 people (age standardised)	PPH per 100,000 people (crude)	Number of PPH	Number of same-day PPH	Percentage of PPH that are same-day (%)	Total PPH bed days	Average length of stay (days)
South Western Sydney	147	162	1,745	87	5	10,245	5.9
Central and Eastern Sydney	113	136	2,110	430	20.4	12,330	5.8
Western Sydney	150	141	1,523	105	6.9	10,622	7.0
Nepean Blue Mountains	178	218	845	18	2.1	5,237	6.2
South Eastern NSW	193	309	2,003	143	7.1	11,130	5.6
National	192	247	6,4354	7298	11.3	330,453	5.1

COPD related deaths

Chronic obstructive pulmonary disease, which includes chronic bronchitis and emphysema is strongly associated with a history of cigarette smoking. COPD mortality has declined during the past 20 years and in 2022 only appeared in the five leading causes of death for people aged 65 years and over. This reflects declining smoking rates. During the period from 2015 to 2019, First Nations Australians were 2.8 times more likely to die from COPD than non-First Nations Australians (NIAA 2024). People in NSW who have lower socioeconomic backgrounds and people who live in regional areas have higher COPD mortality rates (AIHW 2024m, CEE 2024w)

COPD was responsible for 2,275 deaths in NSW in 2020-21 (2,050 or 90% of those aged 65 years and over). In 2020-21 the number of deaths in SWS (212.50) accounted for about 8.9% of NSW COPD attributed deaths. The COPD death rate in SWS was similar to the state rate (18.8 and 20.4 per 100,000 population, respectively).

Liver Diseases

Metabolic Dysfunction-Associated Fatty Liver Disease (MAFLD)

MAFLD (fatty liver disease) is a condition in which too much fat builds up in the liver. The condition is associated with increasing waist size and body mass index and insulin resistance. Early fatty liver disease can be managed and even reversed with diet and lifestyle changes. Without intervention, it can lead to metabolic dysfunction-associated steatohepatitis (MASH) which involves too much fat within, and inflammation of, the liver. This is an increasingly frequent cause of liver cirrhosis (scarring), liver failure and cancer of the liver (hepatocellular carcinoma) (GSA. 2024, ALF 2025).

There is a dearth of epidemiological and prevalence data on MAFLD in Australia, but it is estimated that one in three adults has the condition. Researching in regional Victoria, Vaz et al found that the prevalence of MAFLD increased over 15 years in conjunction with a rise in obesity and reduction in healthy lifestyles (Vaz 2023). People at risk of developing MAFLD are:

- Overweight or obese
- Living with prediabetes or type-2-diabetes (T2D)
- Living with high blood pressure or high cholesterol

Data from SWS general practices (October 2025) indicates that 46,950 people in SWS have a diagnosis of MAFLD representing 4.1% of the population (SWSPHN 2025c). This is well below the 30% estimated population prevalence rate (GSA. 2024).

MAFLD is likely an emerging health issue in SWS due to the region's high rates of overweight and obesity, see page 52, and T2D, see page 63. However, there has been barriers to its initial diagnosis in general practice including lack of Australian clinical guidelines and pathways, lack of awareness of and access to methods to assess the severity of liver disease. The Gastroenterological Society of Australia released a consensus statement and recommendations to support general practice in case-finding and management of MAFLD in 2024 (GSA. 2024). SWSPHN provides a HealthPathway for MAFLD to support GPs Home - Community HealthPathways South Western Sydney.

Hepatitis B

With treatment, people with hepatitis B normally clear all the virus from their body. About 15% of adults who get hepatitis B are not able to clear all the virus. These people have what is called chronic hepatitis B

(CHB). They can still spread the virus to others, even if they don't know they have it or feel sick. Some people with CHB — around 15% to 40% — will go on to have liver failure or liver cancer (Health 2025a).

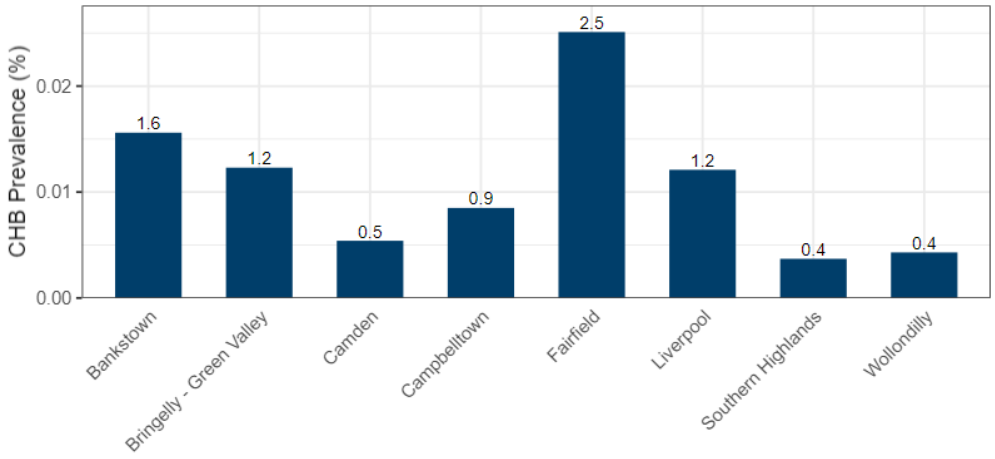
Hepatitis B prevalence

In 2023, 77,844 people in NSW were living with Chronic Hepatitis B (CHB). In SWS, 14,474 people had CHB in 2023 which represented 1.36% of the population. Only the Northern Territory PHN had a higher percentage of people with CHB (MacLachlan J.H 2025).

More than 90% of new cases of CHB in Australia are attributable to migration and cannot be prevented through local vaccination initiatives (ASHM 2018). People born in North-East Asia and South-East Asia have the highest prevalence of 6.2% and 4.8% respectively (ASHM 2020a). Over 80% of people living with CHB in SWS were born overseas (MacLachlan J.H 2025). Fairfield and Bankstown were found to have the highest prevalences of 2.5% and 1.5% respectively (ASHM 2025), reflecting the large proportion of residents born in countries with a high prevalence of hepatitis B including Vietnam, China, Cambodia, the Philippines, and Fiji.

Key issue for our region	South Western Sydney has the second highest rate of hepatitis B in Australia

Figure 40: Prevalence of Chronic Hepatitis B; SA3 areas 2022 (ASHM 2025)

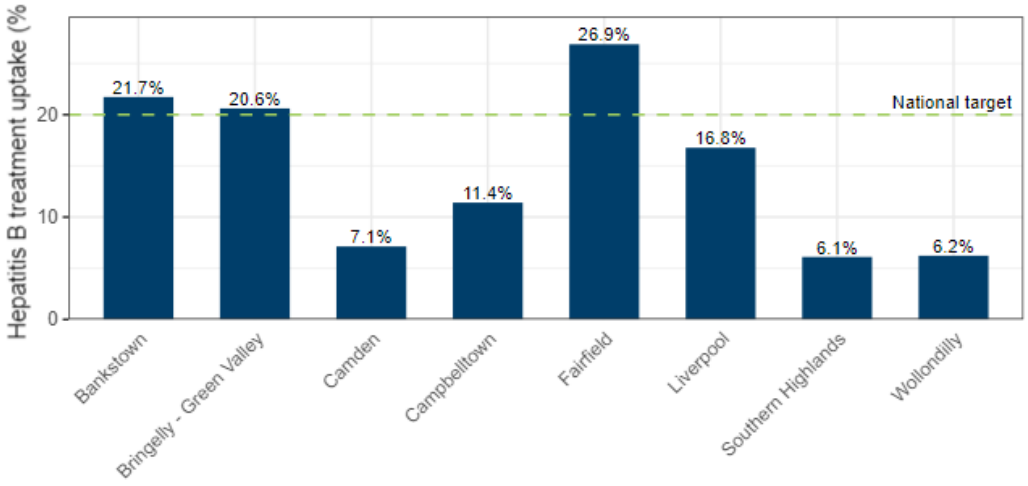


Hepatitis B treatment

People living with CHB need regular check-ups, testing and treatment to avoid poor health. This can happen through general practice. Based on Medicare billing, 21.9% of people with CHB in Australia got at least one treatment prescription from a GP. In SWS, this number was much lower at 11.1% but in line with the trend of less GP prescribing in major cities (MacLachlan J.H 2025).

In NSW, only 29.3% of people living with CHB were getting care and just 15% were receiving treatment in 2023 (MacLachlan J.H 2025). However, SWS had the best results in Australia for care and treatment. In this region, 37.0% of people with CHB were getting care and 20.2% were taking antiviral treatment (ASHM 2018). This made SWS the only PHN/LHD region to meet the 20% treatment target set by the National Hepatitis B Strategy (2018–2022) (DOH 2018).

Figure 41: 2023 Chronic Hepatitis B treatment uptake (percentage) by SA3 and national target (ASHM 2025)



Hepatitis C

Hepatitis C (Hep C) is a notifiable disease. This means that each new case must be reported to health authorities. These reports (called notifications) are used to measure its spread (Health 2025).

Most new cases of hepatitis C in Australia are among people with a history of injecting drug use or history of incarceration (Naruka 2024). Sharing of used needles and syringes is a common cause of these new infections (Health 2025). Mostly people don't have symptoms at the time they get the virus or in the early stages of liver disease. This means a person with hepatitis C may not know that they have the virus. During this time, they can pass the virus on to other people. Regular testing for hepatitis C among people at medium to high risk of getting the virus allows early diagnosis. They can then receive direct acting anti-viral medicines which can cure hepatitis C with 98% efficacy (ASHM 2025).

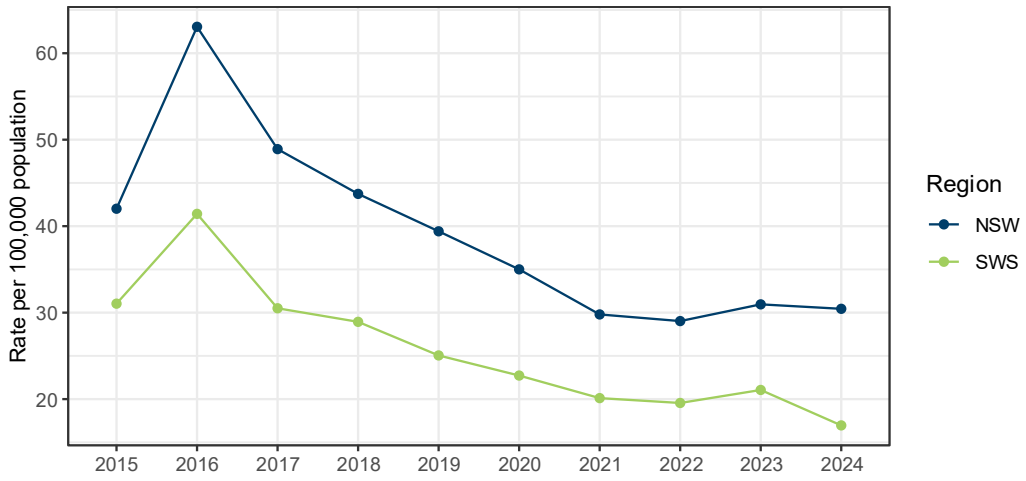
From March 2016 to June 2024, treatment uptake in SWS was 12.1% lower than the national average (ASHM 2025). The average monthly number of people receiving treatment in SWS has dropped sharply. It went from 119 people in March 2016 to just 19 people in June 2024. This drop is similar to trends seen across the country. In 2024, a total of 186 people in SWS started hepatitis C treatment. Of these, 51% of treatments were prescribed by GPs (Health 2025).

Hepatitis C prevalence

Hep C antiviral medicines were added to the Pharmaceutical Benefits Scheme (PBS) in 2016. Since then, hepatitis C notifications have steadily dropped in both NSW and SWS. In NSW, there were 2,518 hep C notifications in 2024, 203 of these were for SWS residents (NCIMS 2025). The majority of notifications were among people aged 25-44 years.

In 2023, the age-standardised hepatitis C notification rate for Aboriginal and Torres Strait Islander people was 165.5 per 100,000 population. This was a 21% decrease from the 2019 rate of 211.2 per 100,000. The current rate is more than six times as high as that for non-Aboriginal people (25.7 per 100,000) (Naruka 2024). Figure 42 below illustrates SWS has consistently lower notification rates than NSW and exceeded the State downward trend in 2023-24.

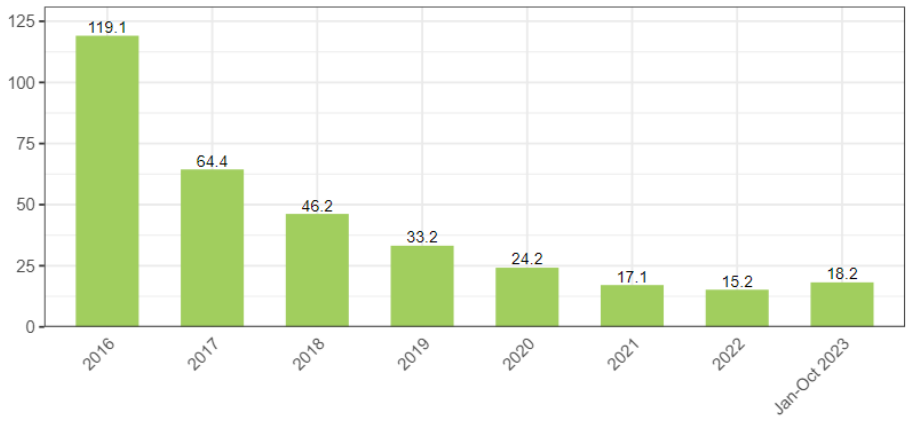
Figure 42: Chronic (unspecified) hepatitis C notification rates for SWS and NSW (standardised rate per 100,000 population) by year, 2015-2024 (NCIMS 2024a)



Hepatitis C Treatment

From March 2016 to June 2024, treatment uptake in SWS was 12.1% lower than the national average (ASHM 2025). The average monthly number of people receiving treatment in SWS has dropped sharply. It went from 119 people in March 2016 to just 19 people in June 2024 (ASHM 2025). This drop is similar to trends seen across the country. In 2024, a total of 186 people in SWS started hepatitis C treatment. Of these, 51% of treatments were prescribed by GPs (Health 2025).

Figure 43: Chronic Hepatitis C Treatment Uptake SWS, 2016 – Oct 2023 (ASHM 2025)



Consultation took place in 2021 with the 'SWSPHN/SWSLHD Improving Hep C Testing & treatment in PHC Implementation Group' which included representation from SWS GPs, specialists, and the LHD Public Health. At that time a range of gaps were identified in our region. Since then, SWSPHN has introduced several initiatives that targeted the identified gaps to enhance hepatitis C (HCV) testing and treatment. Through the joint SWSLHD–SWSPHN Hepatitis Clinical Support and Quality Improvement Project, GPs and practice nurses receive support from a hepatitis Clinical Nurse Consultant (CNC) to boost HCV screening and treatment. The Clinical Quality Improvement (CQI) program targets recall, screening, and treatment of at-risk and those with positive HCV diagnosis.

To further build GP capacity, SWSPHN developed an information brochure and a comprehensive Hep C Toolkit. Additionally, five keystone practices received funding to focus on testing and treating at-risk populations. As a result, hepatitis C testing rates in the region have tripled over the past year.

Chronic pain

In 2020, 16.1% of those aged 15 and older were reported to be living with chronic pain in Australia(Deloitte 2019). This is projected to increase by 0.9% by 2050. NSW has the highest number of reported chronic pain cases among all Australian states, representing close to one third (32%) of all cases of chronic pain in the country.

Several factors increase the likelihood of developing chronic pain, including being female, increasing age, genetic predisposition and environmental influences, such as socioeconomic disadvantage. Behaviour risk factors including physical inactivity, smoking, and being overweight or obese have been linked to chronic pain. Several long-term health conditions are associated with chronic pain, including musculoskeletal conditions, cardiovascular diseases, diabetes, asthma, stroke, and bowel disease (AIHW 2020e)

Chronic pain hospitalisations

In 2017–18, 105,000 hospitalisations in Australia involved chronic pain. Hospitalisation rates were higher for women and increased with age. The average bed days for patients with chronic pain was five days longer than patients without chronic pain. The rate of hospitalisation is higher for people in lower socioeconomic areas (AIHW 2020e).

Treatment

The cost of pain in Australia report by Painaustralia 2019 (Deloitte 2019) shows the treatment of pain management is medication dominant and varies by for people living in rural and remote areas. For example, one in five GP consultations are related to pain management including medication prescription, referral for diagnostic imaging and referral to a specialist. Nationwide, medications were used to manage chronic pain in approximately 68.4% of GP consultations. These medications included prescription opioids, other analgesics and migraine medications.

People living in rural and regional areas are more likely to be prescribed medication, and less likely to receive a referral to a specialist (Deloitte 2019).

In 2016, among those aged 45 and over, more than half (57%) of people with chronic pain were dispensed analgesics, compared with one in five (21%) people without chronic pain. These medications included prescription opioids, other analgesics and migraine medications.

People with chronic pain were almost 3 times as likely to be dispensed opioids, other analgesics or migraine medications as those without chronic pain (AIHW 2020e). There is increasing evidence of harm and negative side effects, and a lack of evidence of the effectiveness of long-term opioid use for managing chronic pain (Currow, Phillips and Clark 2016, AIHW 2018c). Opioid misuse is of national and international concern. All opioids carry a risk of dependence, accidental overdose, hospitalisation and death (AIHW 2018c).

Painaustralia online survey, 2022 (Painaustralia 2022) respondents identified the following action areas:
Pain Australia online survey, 2022 (Painaustralia 2022) respondents identified the following action areas:

- Improve access to treatment – 59.6% of respondents reported difficulties in accessing treatment and 43.1% reported a lack of alternative treatments provided by their health professional. Chronic pain management should include access to allied health treatment, non-opioid medication, lifestyle advice, pain management clinics/programs and referral to specialists.
- Improve health professional support: Only 48.6% of respondents felt adequately support by their health professional in managing chronic pain. General practitioners should receive training to educate patients, provide holistic care and guide patients through the appropriate care pathways.
- Education and awareness: National strategy needs to be provided at all levels to reduce stigma and increase awareness of pain, including seeking funding for a consumer engagement strategy that informs consumers to make decisions about their pain treatment, together with resources to support consumers such as a national database where consumer stories can be shared, covering the spectrum of lived experience (Painaustralia 2022).

Cancer

Cancer is a term describing a group of diseases involving cells that grow abnormally and multiply uncontrollably, invading health tissue. There are more than 200 types of cancer (ACRF 2024).

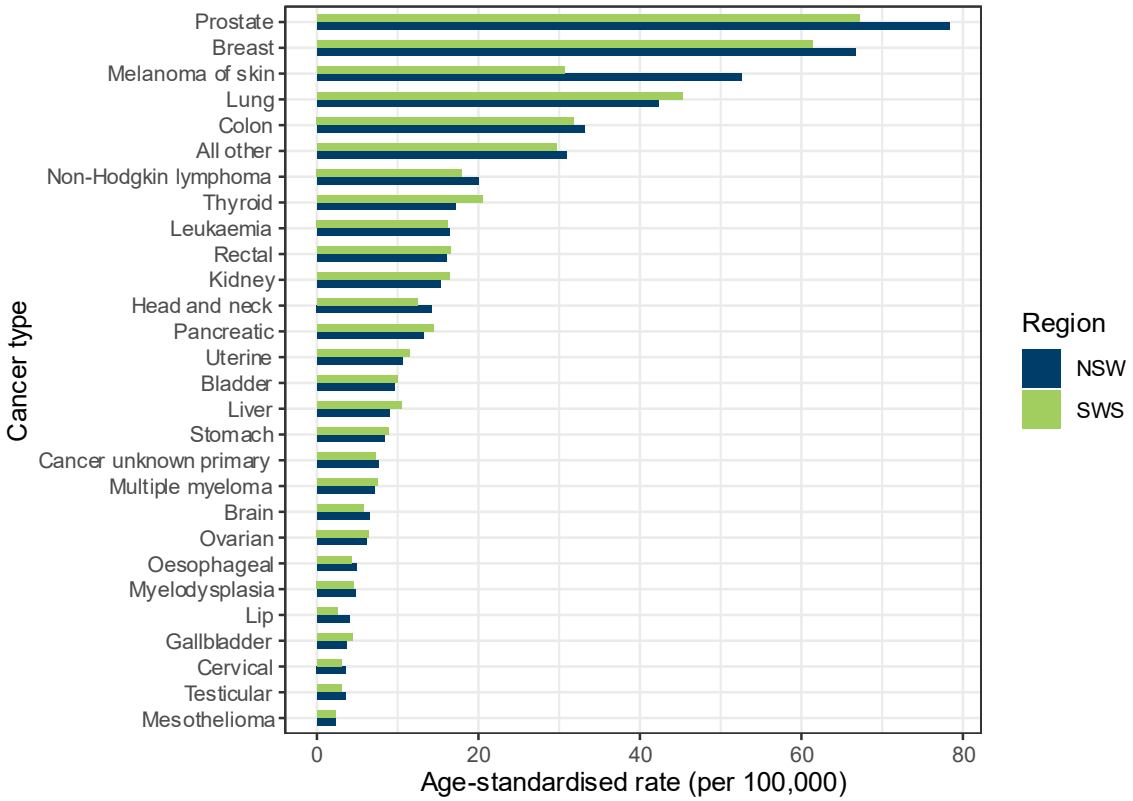
To provide worldwide consistency in describing solid cancers (not blood, brain or childhood cancers) and thereby assist in diagnosis, treatment and prognosis a staging approach is taken. Staging describes the size and severity of the cancer. The stage of the cancer is determined at the initial diagnosis and does not change even if the cancer continues to grow and spread:

- Stage zero –non-invasive cancer - non-invasive, non-life threatening cancer.
- Stage one – localised cancer - cancer cells begin to invade the neighbouring tissue.
- Stages two and three – regional spread **-** the cancer has spread to the region around the original tumour but has not yet spread to other parts of the body
- Stage four – distant spread - cancer cells have spread to other organs or parts of the body. Cancer that forms because of spreading from the primary site is referred to as metastatic or secondary cancer (ACRF 2024).

Cancer Incidence

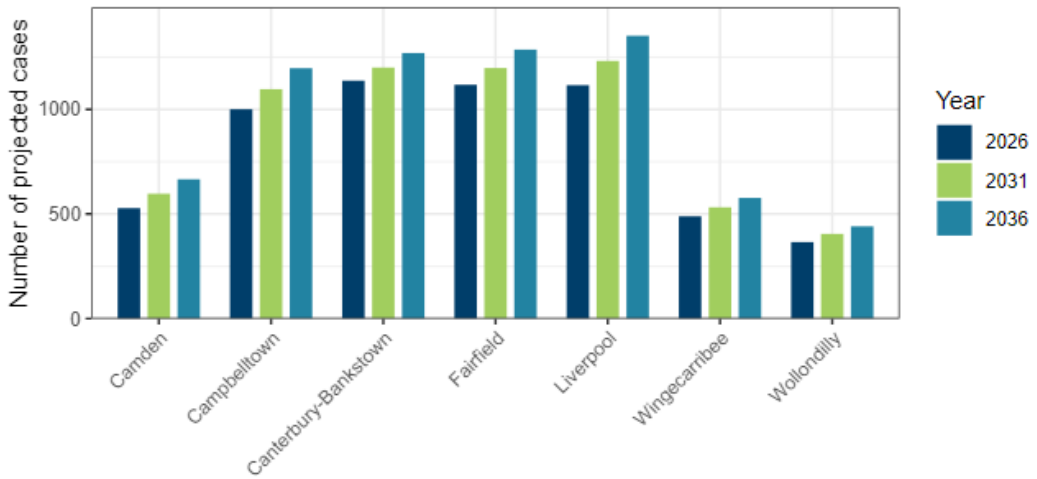
The Cancer Institute of NSW (CINSW) uses standardised incident ratio (SIR) to easily see if an area has lesser or greater cancer incidence than NSW taken as a whole. A value of one is assigned to NSW incidence, values less than one are indictive of lower incidence and vice versa. Between 2019 and 2023, SWS had an SIR of 0.93. The SIR was significantly lower for the following cancers: melanoma, prostate, breast, head and neck, lip and non-Hodgkins's lymphoma. Liver, gallbladder, thyroid and lung cancers stand out as having significantly higher SIRs in SWS. Figure 38 illustrates cancer incidence, the five most frequently diagnosed cancers in SWS are in order prostate, breast, lung, colon and melanoma of the skin (CINSW 2024b).

Figure 38: Cancer incidence by cancer type, age standardised, SWS and NSW, 2019-2023 (CINSW 2021)



In 2023, the total cancer incidence in SWS was 5,824 an increase of 13% since 2019 (5,142) (CINSW 2024b). It is expected that by 2036, SWS will have around 6,698 new cases of cancer diagnosed per year (excluding non-melanoma skin cancers) (CINSW 2024b). Figure 39 below shows the projected growth in cancer incidence by LGA between 2026 and 2036. The projection is based on an understanding of the population growth, current incidence, population profile and risk factors in the local population., The greatest projected increase is in Camden (26%), Liverpool and Wollondilly (both 21%) and the lowest in Canterbury-Bankstown and Fairfield (12% and 15% respectively) (CINSW 2024b).

Figure 39 : Projected number of new cases of cancer in SWS for years 2026, 2031 and 2036, by LGA (CINSW 2024b)



Cancer mortality

CINSW uses standardised mortality ratio (SMR) to easily see if an area has lesser or greater cancer mortality than NSW taken as a whole. A value of one is assigned to NSW mortality, values less than one are indictive of lower mortality and vice versa. Between 2019 and 2023, there were 8,065 cancer deaths in SWS. Cancer mortality in SWS was similar to NSW (SMR 1.02 vs 1.0 respectively) (CINSW 2024b) (CINSW 2021). SWS had significantly higher standardised mortality ratios (SMR) for gallbladder, stomach and lung cancer. During the same period the SMR for prostate cancer was significantly lower in SWS.

The mortality rate for males was 1.2 times higher than females (544.1 and 438.0 per 100,000 population respectively) in SWS. Lung cancer caused the highest mortality, 1,676 deaths, followed by pancreatic cancer 645. Colon and breast cancer followed and each accounted for a similar number of deaths (565, and 543 respectively) (CINSW 2024b).

Barriers to access cancer services

Issues raised through community consultations include:

- Increasing demand for cancer services due to population growth posed a challenge for SWSLHD cancer services
- The community views GPs as a key provider to prevent cancer and guide patients through their cancer journey
- Service gaps were raised including transport, access to palliative care services, the cost of specialist services and the lack of services for carers
- Poor coordination/collaboration between primary care services and cancer therapy centres
- Lack of community-based palliative care dietitians
- Lack of community-based services for chronic and palliative care in Wingecarribee
- Need more resources for palliative care in all hospitals

Cancer treatment service needs

With the increasing number of people diagnosed and surviving cancer, there is a concerted push for GPs to be more involved in shared-care follow-up, such as the CISCO Breast Cancer Shared Care Follow-Up Model. This is a clinical area in which GPs have not typically been involved in and capacity building both in terms of processes and education is required. CINSW has produced a Primary Care Cancer Control Quality Improvement Toolkit to guide general practices to improve cancer screening rates and prevention activities

Increase use of immunotherapy treatment methods, which often require the patient to be on immunotherapeutics for the rest of their life, will continue to add complexity for GPs to manage their patient's care due to ongoing side effects, drug interactions, etc. Further support for GPs is needed as immunotherapy becomes a more routine cancer treatment.

Regional disparities

There are clear disparities in the impact of cancer felt by the SWS population. People living in SWS with a non-English speaking country of birth accounted for 44% of total cancer cases between 2017 and 2021, double the proportion for this population group in NSW as a whole of 22% (CINSW 2024a). Specific cancers have a significant impact on multicultural communities that have distinctive factors that may influence this including:

- high smoking rates among some CALD communities. Men born in China (20.3%), Vietnam (32.0%) and Lebanon (39.3%) have higher smoking rates compared to total NSW (14.7%) which may raise lung cancer numbers
- primary liver cancer numbers are high in SWS and may be linked to high rates of hepatitis B and/or C among CALD communities, which is one cause of this cancer

People living in areas of higher disadvantage in SWS have higher incidence and poorer outcomes than those living in the areas of least disadvantage. In NSW between 2017 and 2021 cancer incidence was similar across SES quintiles, the incidence rate varied from 510 cases per 100,000 people in the most disadvantaged quintile to 490.8 cases per 100,000 people in the least disadvantaged quintile. In SWS though, the region's most disadvantaged residents represented 35% of all cancer cases in SWS compared to 22% in NSW as a whole.

Conversely, people in the most disadvantaged quintile died at 1.5 times the rate of people in the least disadvantaged quintile (178.3 per 100,000 and 122.1 per 100,000 people respectively. People living with the highest disadvantage also died at 1.2 times the NSW rate of 147.0 per 100,000 people (CINSW 2024b). This pattern is repeated in SWS and compounded for people born in non-English speaking countries and living in areas of the highest disadvantage (SWSLHD 2023)

Low participation in the national screening programs for bowel, breast and cervical cancer can lead to delayed diagnosis, occurring at a more severe cancer stage which results in poorer outcomes. Across all cancers, people diagnosed at stage four have less than a 50% chance of surviving five years after diagnosis, but this may be considerably lower when individual cancers are examined. In SWS this is of particular concern for First Nations women and women from non-English speaking backgrounds who have low screening participation rates. The three LGAs with the highest representation of people from non-English speaking backgrounds among cancer cases also have the highest incidence of diagnosis at stages three and four (SWSLHD 2023)

Key focus areas:

- Sustained effort to reduce high daily smoking rates
- Culturally responsive quit smoking programs and information for CALD communities especially males
- Sustained effort to increase participation in cancer screening, especially bowel cancer screening
- Promotion of the lung cancer screening program to eligible patients following commencement in July 2025
- Implementation of the CINSW Primary Care Cancer Control Quality Improvement Toolkit in general practices
- Promotion and uptake of Hepatitis C treatment through coordination by SWSLHD CNC to reduce high rates of liver cancer

Integration of services for chronic disease management

Projected population growth, an increasing proportion of people aged 65 years and older and climbing rates of chronic diseases will place greater demand on primary care provision in the region. Lack of coordination and collaboration between services are viewed as a significant barrier to efficient health care. Consumers, service providers and GPs frequently raised the issue of a lack of collaboration and communication between services. Themes commonly arising across multiple consultations is the lack of clinical information being available across primary and secondary services, changes made to a patient's medications while in hospital not being communicated to their regular GP, and patients having to tell their story again and again as there is no shared patient record across health agencies. A number of these issues could be addressed through information sharing.

An increasing number of integrated care initiatives within SWS are focusing on integrated and coordinated health care between primary care and acute care at both the system level and individual chronic diseases of concern in the region:

Health Alliances

Intersectoral collaborations with the acute health service and local government bodies allow the PHN to broaden its sphere of influence into health public policy and improve the coordination and effectiveness of health services in the region and support healthier neighbourhoods through place-based strategies.

HealthPathways and Health Resource Directory

In 2015, SWSLHD and SWSPHN implemented HealthPathways South Western Sydney, an online health information portal aimed at general practitioners to assist them with referrals to local specialists and services and improve care coordination between primary and secondary care services. This program has grown to include 748 localised pathways.

In 2017, a patient portal for HealthPathways was developed called Health Resource Directory. This provides health literacy content adapted from HealthPathways in four languages in web, print and audio formats. Health Resource Directory has a strong focus on fostering a working relationship between the health consumer and their care team.

My Care Partners

In 2021, SWSPHN and SWSLHD implemented My Care Partners, a 'medical neighbourhood' model of care designed to address potentially preventable hospitalisations of at-risk patients in South Western Sydney. The goal of My Care Partners is to:

- improve coordination between the patient's medical home, primary and community services and acute care
- improve outcomes for patients with complex and chronic conditions who are at risk of potentially preventable hospitalisations
- improve patient and provider experience by encouraging continuity of care and team-based care to reduce the risk of omission or duplication of services

Type 2 diabetes case conferencing clinics and Telehealth case conferencing for GPs

SWSPHN and SWSLHD provide integrated support to the region's GPs in the management of their patients with type 2 diabetes. GPs and their patients living with complex type 2 diabetes access a diabetes specialist and diabetes educator to receive guidance and support to achieve good glycaemic control within their

general practice. GPs needing clinical guidance and support from diabetes specialists are able to access this through telehealth case conferences. These integrated services have proven to be sought after in the region.

SWSLHD has three established multidisciplinary Diabetes Centres at Bankstown-Lidcombe, Campbelltown and Liverpool Hospitals. Fairfield has a nurse-led service. The Campbelltown service provides outreach services to Camden and Bowral Hospital. Wollondilly and Wingecarribee LGAs rely largely on private providers of diabetes services, or travel to other regions.

Breast Cancer Survivorship Shared Care

In 2022, SWSPHN and SWSLHD commenced a project supporting survivors of early breast cancer to participate in a transition process where their survivorship care is transitioned from Cancer Services to their regular GP. This project includes escalation processes for GPs as well as care coordination support to all stakeholders to ensure a seamless move into shared care.

Hepatitis C

To improve uptake of hepatitis C treatment within the general practice setting SWSPHN in partnership with South Western Sydney LHD (SWSLHD), provided a Viral Hepatitis CNC to deliver extra support and care coordination of clients with hepatitis C. The support will be delivered by SWSLHD alone from October 2025.

2.2.3 Communicable Diseases in South Western Sydney

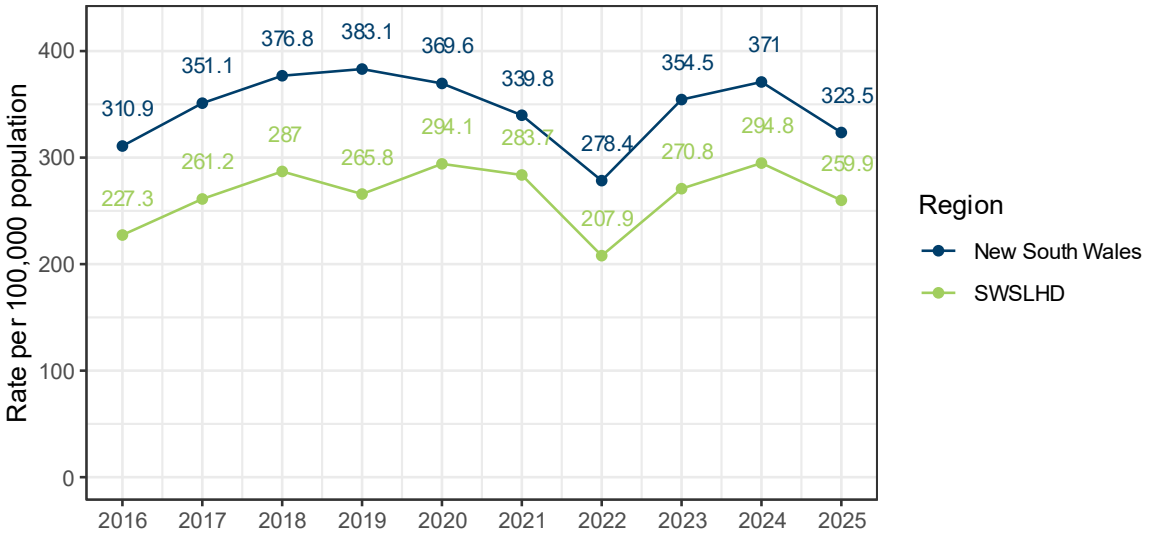
Sexually transmitted infections

Key issue for our region	Increasing rates of sexually transmitted infections, including medication resistant syphilis

Chlamydia

There was a decline in the rate of chlamydia notifications per 100,000 population during the COVID-19 pandemic, which then rebounded and went beyond pre-pandemic levels reaching 294.8 per 100,000 population by 2024 (MoH 2024). Between 2022 and 2025 notification rates for SWSLHD have been lower but mirrored NSW notification rates.

Figure 44: Chlamydia notifications (rate per 100,000 population) for SWS and NSW, by financial year 2016 - 2025 (NCIMS 2024a)

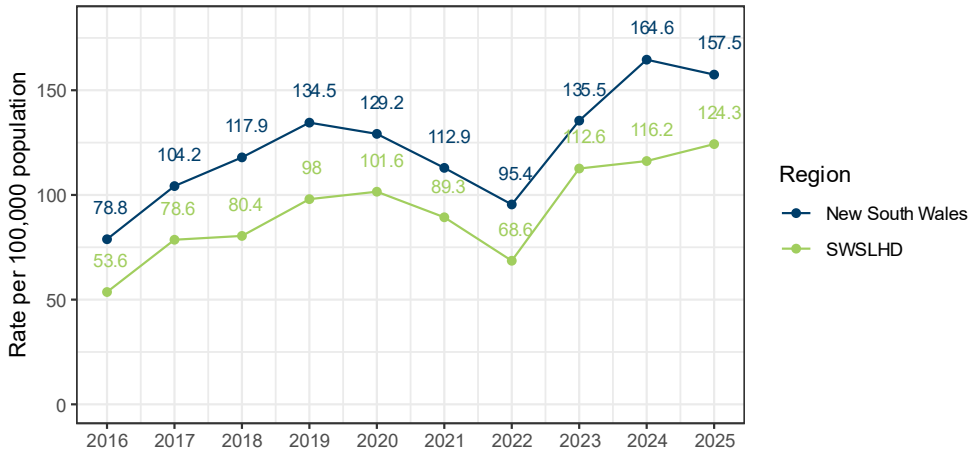


More males than females were notified with chlamydia infections during the 2024 calendar year 12,163 females and 13,936 males (NCIMS 2024a). Women with untreated chlamydia infections are more likely to develop pelvic inflammatory disease (PID) and in the most severe form have an increased likelihood of ectopic pregnancy and infertility. Chlamydia notifications increased significantly between the ages of 10 and 19 years and were highest in the 20 to 24-year age group, after which, notifications declined with increasing age.

Gonorrhoea

There was a steady increase in the rate of gonorrhoea notifications in SWSLHD per 100,000 population from 2016 to 2020 as shown in Figure 45 below. Notifications fell during the COVID-19 lockdowns and restrictions. Rates increased sharply in 2023 to new peak of 112.6 per 100,000 and have continued a steady rise since reaching 124.3 per 100,000 in 2025. Notification rates for SWSLHD have been consistently lower than the NSW state notification rates, ranging from 16% to 30% lower over the 2022-25 period (MoH 2024). Between 2022 and 2025, gonorrhoea notification rates increased with age from 10-14 years until 25-29 years, after which notifications declined with increasing age.

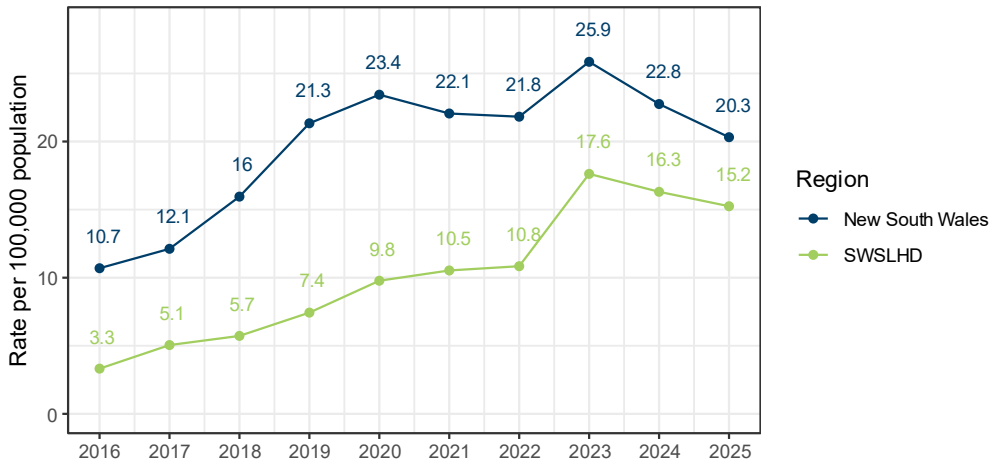
Figure 45: Gonorrhoea notification rates for SWSLHD and NSW (standardised rate per 100,000 population) by financial year, 2016-2025 (NCIMS 2024a)



Syphilis

Rates of notifications of syphilis - infectious for less than 2 years - in SWSLHD increased by 63% between 2022 and 2023 reaching a new peak of 17.6 per 100,000 population. NSW notifications in the same period increased by 19% as shown in Figure 46 below. Notifications in both NSW and SWSLHD have declined since then however the decline has not been as marked in SWS (22% vs 14% respectively). During the five year period July 2020 to June 2025, most notifications were among men. The difference was striking for infections of less than two years duration where males had 9.5 times the number of notifications (8,360) than females (885). Syphilis infections start to increase in age group 15-19 years reaching their highest point in the 30-34 age group before declining with age (NCIMS 2024a).

Figure 46: Syphilis - infectious less than 2 years - notification rates for SWSLHD and NSW (crude rate per 100,000 population) by financial year 2016-2025 (NCIMS 2024a)



2.2.4: Violence, Abuse and Neglect in South Western Sydney

Family Domestic and Sexual Violence

Family and domestic violence is a term used for violence that occurs within family relationships including extended family members, carers, foster carers and co-residents (AIHW 2024l). Intimate partner violence (IPV) is a specific term used to describe forms of domestic and family violence that The World Health Organization (WHO) has defined as, 'behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship' (2012). In Australia, IPV is the most commonly experienced form of family violence (Devries et al., 2013; Our Watch, 2018; World Health Organization [WHO], 2012).

The majority of people in Australia who experience FDSV are women, in 2021–22, one in four women and one in 14 men had experienced IPV since the age of 15 years (AIHW 2024l). Commentary on interpersonal violence-related hospitalisations in NSW reveals that for females in 2020–2021, in 42% the perpetrator was their spouse or domestic partner, 14% were an unspecified person and 11% by another family member (CEE 2025e). Children are vulnerable to family, domestic and sexual violence – it affects children's physical and mental wellbeing; development and schooling and is the leading cause of children's homelessness in Australia (AIHW 2024l).

There are many factors that can combine within an individual's context that increase their risk and experience of violence. These include power imbalance in relationships of trust, alcohol consumption, education levels, employment levels and income levels.

According to the Australian Institute of Family Studies (Kaspiew 2016) populations at higher risk of FSDV include women and children from:

- Aboriginal and Torres Strait Islander communities - First Nations women are more likely to experience domestic violence (Audit Office of NSW 2011).
- Culturally and Linguistically Diverse communities - CALD and refugee women are particularly vulnerable to family violence. Women with unsecure visa status are in particular at an increased risk, often lacking the financial resources to plan for the future and ensure their own safety (Vasil 2024) . In addition to physical and sexual violence, women from refugee backgrounds are particularly vulnerable to financial abuse, and immigration-related violence including in migration pathways and traumatic pre-arrival experiences, as well as settlement issues such as acculturation stress and social isolation. CALD women are at increased risk of reproductive coercion (domestic abuse), an aspect of which is the restricted access to healthcare services (Suha 2022). Women from CALD backgrounds face additional barriers to help-seeking such as a lack of CALD specific information, language and communication barriers, fear and distrust of authorities, cultural norms and beliefs that discourage intervention (AIHW 2024l)
- Those living with disability – people with disability are more likely to experience FDSV than people without disability. Abuse of people with disability occurs in a wider range of settings and perpetrators. They have additional factors that increase their risk including dependence on others, understanding the abuse, and communication challenges, and barriers to getting help.

The term elder abuse refers to violence, abuse and neglect of people aged 65 years and over and First Nations people aged 50 years and older. Elder abuse is the single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust such as family members, friends, neighbours and professionals such as paid carers (AIHW 2024l).

Information on elder abuse in Australia is limited, but there is evidence of elder abuse occurring from both family members (Kaspiew 2016) and within aged-care homes (Yon 2019).The National Elder Abuse Prevalence Study of 2020 estimated that one in six older people (15%) living in the community had experienced elder abuse in the past year. These forms of abuse are more common based on certain factors such as frailty, limited mobility/functional dependence and history of substance misuse by both perpetrator and victim. The older person's children were the most frequent perpetrators, 18%. Among family members, financial abuse (60%), and neglect (55%) were the dominant forms. It is expected that elder abuse will rise with forecasted population ageing (AIHW 2024l).

Evidence suggests adults and children who experience family, domestic and sexual violence (FDSV) often experience significant mental health conditions as a result, including anxiety, depression, post-traumatic stress disorder (PTSD) and complex PTSD requiring longer term trauma-informed mental health support. The effects of FDSV are varied and can last for many years with recovery requiring assistance to address legal, financial and security concerns

Key issue for our region	**South Western Sydney has the highest incidence of domestic and family violence in the Sydney metropolitan area**

In comparison with the previous year, the number of domestic violence-related assaults reported to police in South Western Sydney fell by 248. Between July 2024 and June 2025, there were 5,859 domestic violence-related assaults and 1,299 sexual assaults reported (BOCSAR 2024). Last year we reported rapid growth in domestic violence-related assault rates in four out of seven LGAs. Table 24 shows the trend has stabilised across the region and Fairfield LGA has seen a 10% decrease in reports. Domestic violence-related assault was most likely to occur in Campbelltown, with a rate of 602.3 per 100,000 people.

Table 24: Reported domestic violence, SWS by LGA and NSW, 2024 - 2025 (BOCSAR 2024)

NSW Local Government Area	Two year trend (%)	Five year trend (annual average % change)	Ten year trend (annual average % change)	Ratio to NSW	Rank	Number	Rate per 100,000 population
Camden	Stable	8.9	8.4	0.7	85	455	337.5
Campbelltown	Stable	3.0	2.5	1.3	46	1113	602.3
Canterbury-Bankstown	Stable	4.2	2.0	1	67	1688	444.4
Fairfield	-10.1	Stable	Stable	0.9	76	826	393.8
Liverpool	Stable	7.9	5.4	1.3	47	1482	598.4
Wingecarribee	Stable	Stable	Stable	0.4	106	97	182.6
Wollondilly	Stable	Stable	Stable	0.8	83	198	343.7
NSW**	**Stable**	**3.7**	**3.0**	**1**	**n.c.**	**38169**	**457.5**
	Significant increase						
	Lower than NSW						

Access to Violence Abuse and Neglect (VAN) services

There are 19 public health and NGO violence, abuse and neglect service providers across South Western Sydney. Consultation with the community indicates access and demand issues for people requiring services. This includes limited access to emergency housing and refuges for people escaping DFV.

SWS is one of the fastest growing regions in the state. All LGAs across SWS will experience population growth by 2041 due to growth in greenfield areas and increased density. The population growth and high prevalence of FDSV cases within the region, demonstrates a strong need for more FDSV services in SWS.

SWSPHN supporting recovery from family, domestic and sexual violence

Consultations in SWS revealed a need for longer term services to assist recovery. With funding from the Australian Government *National Plan to End Violence Against Women and Children,* SWSPHN has commissioned the Supporting Recovery service. The service provides free, culturally sensitive, and holistic recovery support for victim-survivors of family, domestic and sexual violence for up to two years. The service has two streams one providing non-clinical support and case management, the other providing clinical mental health services. The service has assisted 1,236 clients since it commenced, of these:

- 26% identify as living with a disability
- 43% identify as from a CALD background
- 14% identify as First Nations Australians
- 4% identify as LGBTQIA+

Priority focus areas for FDSV in South West Sydney

- Increase availability and awareness of culturally appropriate services for CALD populations, as lack of knowledge is a major barrier
- Outreach to at risk populations e.g. women with unsecure visa status and other CALD women
- Increased awareness of elder abuse and available services for helping those experiencing elder abuse

2.2.5 Health Needs and Service Gaps for our First Nations Communities

For Aboriginal and Torres Strait Islander (First Nations) people, good health is more than the absence of disease. It is a well-rounded view that includes physical, social, and emotional wellbeing for individuals and community. It recognises connection to the land, sea, cultural, and spiritual wellbeing are vital for good health. Australia's colonial history and political factors have and continue to negatively affect the health and wellbeing of First Nations Australians.

Life expectancy at birth is slowly improving for First Nations people in NSW. In the five years from 2015-17 to 2020-22 life expectancy at birth for males increased from 70.9 years to 73.8 and for females from 75.9 years to 77.9 years ((RIFIC) 2024). In 2020-22 non-First Nations people still had longer life expectancy at birth with 81.3 years for males and 85.3 years for non-First Nations females (ABS 2023g).

Analysis by AIHW into the health gap between First Nations and non-First Nations Australians indicated 28% of First Nations adults were assessed to be in good health, based on the composite health measure, compared with 54% of non-First Nations adults (AIHW 2020f).

Key issue for our region	**Significant health inequity for First Nations peoples**

Social determinants (34%) and health risk factors (19%) accounted for more than half (53%) of this health gap between First Nations and non-First Nations working-age adults.
Five social determinants were identified to account for 34% of the health gap:

- Household income (14%)
- Employment and hours worked (12%)
- Level of schooling completed (8.7%)
- Highest non-school qualification
- Housing adequacy.

AIHW identified six health risk factors which account for 19% of the health gap:

- Smoking (10%)
- Binge drinking
- High blood pressure
- Overweight and obesity status
- Inadequate fruit and vegetable consumption
- Insufficient physical exercise.

The 47% of the health gap that remained unexplained after accounting for the selected social determinants and health risk factors can be related to other variables not able to be included in the analysis, which include differences in access to health services.

Antenatal Care

Antenatal care has been found to have a positive effect on the health outcomes for both mother and baby as it increases the likelihood of receiving effective interventions where needed. In SWS there are three specific antenatal services that are culturally safe for First Nation's women. Tharawal AMS provides a Midwife Group practice located in Airds. SWSLHD provides an Aboriginal Liaison Midwife at Liverpool hospital delivering antenatal care. They provide a similar service at Campbelltown hospital which covers both the antenatal and postnatal period. In 2020, 90.4% of SWS First Nations mothers received five or more antenatal care visits (AIHW 2023g).

Key issue for our region	Poorer antenatal outcomes for First Nations mothers

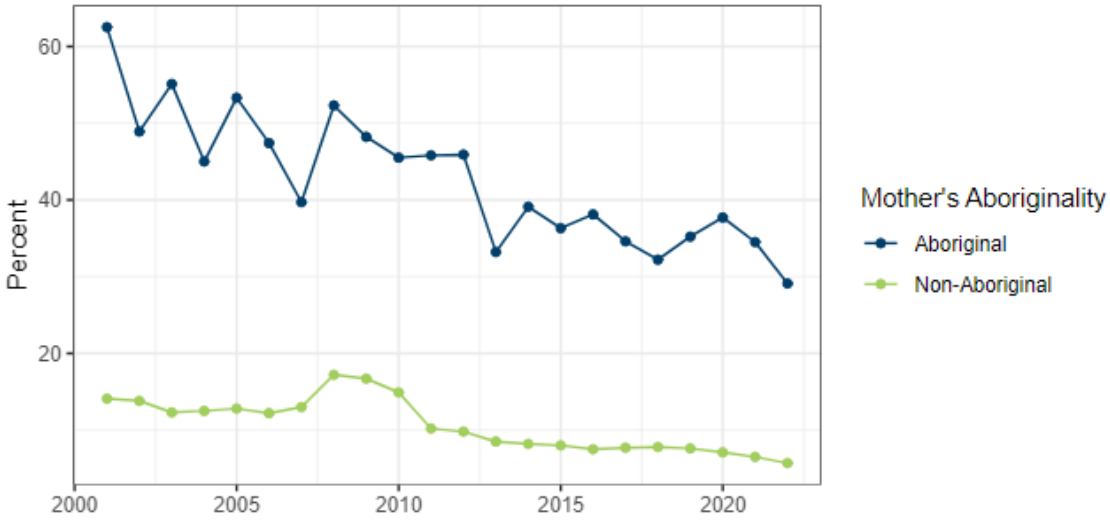
First Nations mothers compared to non-First Nations mothers in SWS are:

- less likely to receive their first antenatal care visit during the first trimester i.e. before 14 weeks gestational age, 67.8% in 2020 (AIHW 2023g)
- more likely to smoke during pregnancy than non-First Nations women(CEE 2016a).
- more likely to have preterm babies compared with non-First Nations women
- have a higher infant mortality rate in NSW overall, however this disparity decreased from 1.5 times in 2017 to 1.2 times in 2021 (CEE 2024x)

Smoking during pregnancy

Smoking during pregnancy is associated with a wide range of complications impacting both mother and baby. First Nations women tend to have higher rates of smoking during pregnancy. In 2020, 41.7% of SWS Aboriginal and Torres Strait Islander women reported smoking during pregnancy, the lowest percent since 2017, but was slightly higher than the NSW average of 37.7% (CEE 2016a).

Figure 47: Smoking in pregnancy, all women and Aboriginal women from 2001 - 2022, SWS (CEE 2024x)



Preventative health risk factors and First Nation's Peoples

Key issue for our region	Higher rates of preventative health risk factors for First Nations Peoples

Alcohol use

In NSW in 2024, more Frist Nations people abstained from alcohol (27.4%) than non-First Nations people. Comparatively there was only small variation in the percentage of people who drank alcohol within recommended guidelines 68.3% in First Nations people and 69.1% in non-First Nations. Similarly, the variation between people who drank alcohol in excess of the guidelines was small, 31.7% in First Nations people and 30.9 in non-First Nations (CEE 2024x). In NSW in 2021-22 the rate, of alcohol attributable hospitalisations for First Nations people was twice that of non-Frist Nations people.

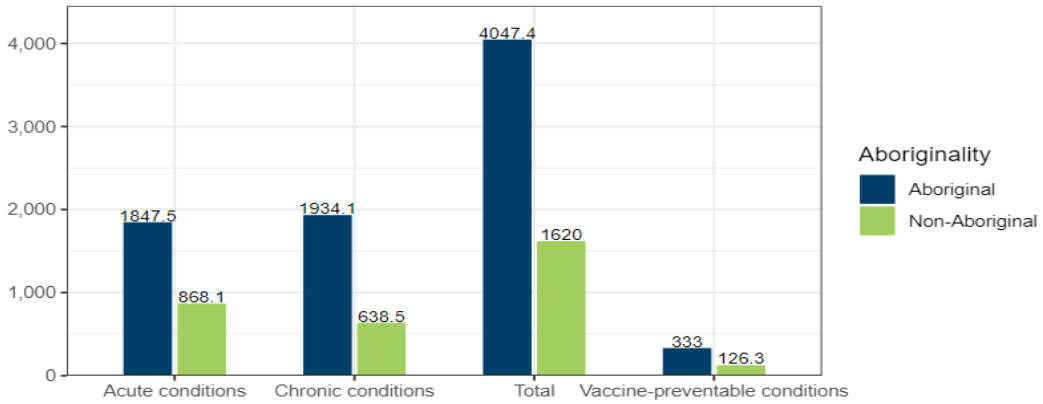
Tobacco use

A positive trend for First Nations people between 2002-03 and 2022-23, was the decline in the rate of daily or occasional smoking in adults from 40.2% to 29.4%. Tobacco use remains a high risk factor for First Nations people's health as the smoking rate still 2.7 times the rate of non-Aboriginal people (10.9%) (CEE 2024a).

Potentially Preventable Hospitalisations

The rate of Potentially Preventable Hospitalisations (PPH) among First Nations people in 2021-22 was 2.5 times as high as non-First Nations people (4047.4 and 1620 per 100,000 population respectively). The largest disparity among all PPH conditions were chronic conditions – the rate for First Nations people is three times as high as non-First Nations people (1934.1 and 638.5 per 100,000 population respectively).

Figure 48: Potentially preventable hospitalisations by First Nations people and condition, NSW, 2021-22 (CEE 2024s)



Chronic disease and First Nations Peoples

Diabetes

In 2023 diabetes was the fourth leading cause of death for First Nations males and the leading cause of death for First Nations women (ABS 2025). The National Aboriginal and Torres Strait Islander Health Measures Survey was conducted from August 2022 to April 2024. The survey measured biomarkers of chronic disease and nutrition in urine and blood samples provided voluntarily by participants aged five years and over from across Australia.

The study found that:

- 15.5% of people aged 18 and over had diabetes
- Prevalence was higher in males 16.7% than females 14.3% but this difference was not statistically significant
- Diabetes increased with age from 5.5% in people 18 – 34 years old to 34.6% in people aged 55 years and above
- First nations people living in non-remote areas were less likely to have diabetes (14.3% vs 21.7%)

Key issue for our region	High rates of diabetes for First Nations Peoples

Diabetes hospitalisations among First Nations people in NSW peaked during the COVID-19 pandemic at 559 per 100,000 people in 2020-21 then decreased to 477.1 in 2021-22 the lowest rate since 2016–2017. During the same period the rate remained the same among non-First Nations people in NSW. First Nations people were 3.7 times as likely to be hospitalised for diabetes compared with non-First Nations people in 2021-22 (CEE 2024r).

In SWS, about 2.7% of the NDSS registrants are Aboriginal, lower than the NSW rate of 3.2%. Across SWS, the registration rate in Canterbury-Bankstown is higher than the state average (3.3%) compared to the NSW rate (AIHW 2021f).

Table 25: Number and percentage of First Nations NDSS registrants in SWS by LGA, 2022 (Diabetes-Australia 2023)

LGAs	Aboriginal NDSS Registrants (n)	(%) Registrants
Canterbury-Bankstown	150	3.9
Camden	80	2.7
Campbelltown	330	3.7
Fairfield	70	3.2
Liverpool	170	3.6
Wingecarribee	40	2.7
Wollondilly	60	2.6

Respiratory disease

Disease burden

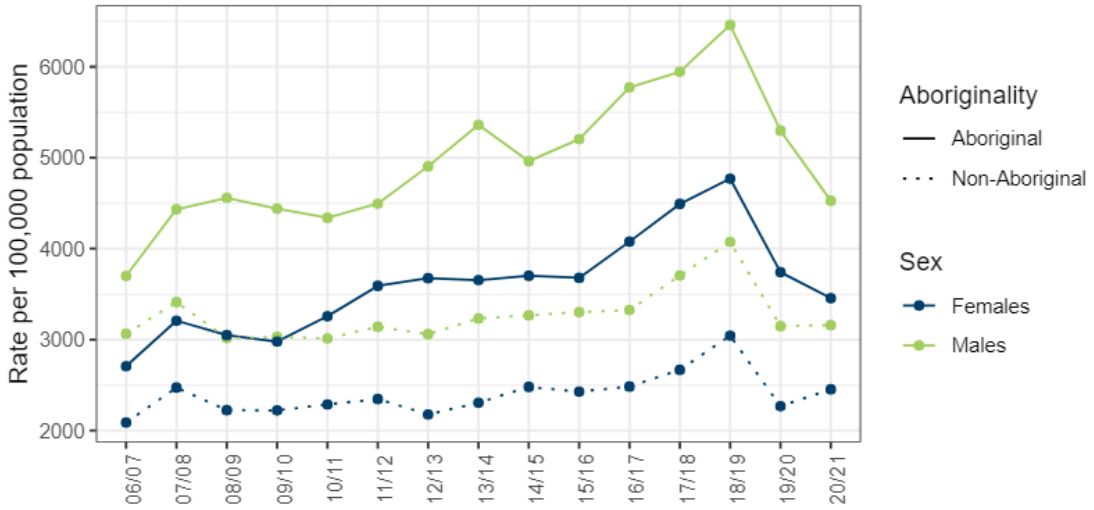
In NSW, Aboriginal people have higher asthma prevalence compared to non-Aboriginal people. In 2017, asthma prevalence for Aboriginal people was 1.5 times of the prevalence for non-Aboriginal people(SWSLHD 2016c).

Key issue for our region	Higher rates of respiratory disease for First Nations Peoples

Respiratory-related hospitalisations

Chronic obstructive pulmonary disease (COPD) hospitalisations among Aboriginal people aged 65 years and over increased from 2006-07 to 2018-19, peaking at 6268.9 per 100,000 people before falling by 41% to 3701.2 per 100,000 in 2021-22. Rates for non-Aboriginal people remained relatively stable during the same period in NSW. In 2021-22, the COPD hospitalisation rate for Aboriginal people was six times the rate for non-Aboriginal people (CEE 2024w).

Figure 49: Acute respiratory infection hospitalisations: All acute respiratory infection, by First Nations, persons aged 0-4 years, NSW 2006-07 to 2020-21 (CEE 2024x)



In NSW, acute respiratory infection hospitalisations of Aboriginal and Torres Strait Islander children aged four years and under steadily increased between 2006-07, from 3217.7 per 100,000 population to 6541 per 100,000 in 2018-19, before decreasing to 4008.1 in 2020-21. The rate for Aboriginal children remained 1.4 times the rate of non-Aboriginal children in 2020-21. Figure 49 above shows the disparity experienced by male Aboriginal children in comparison to female Aboriginal children and non-Aboriginal children (CEE 2024x) .

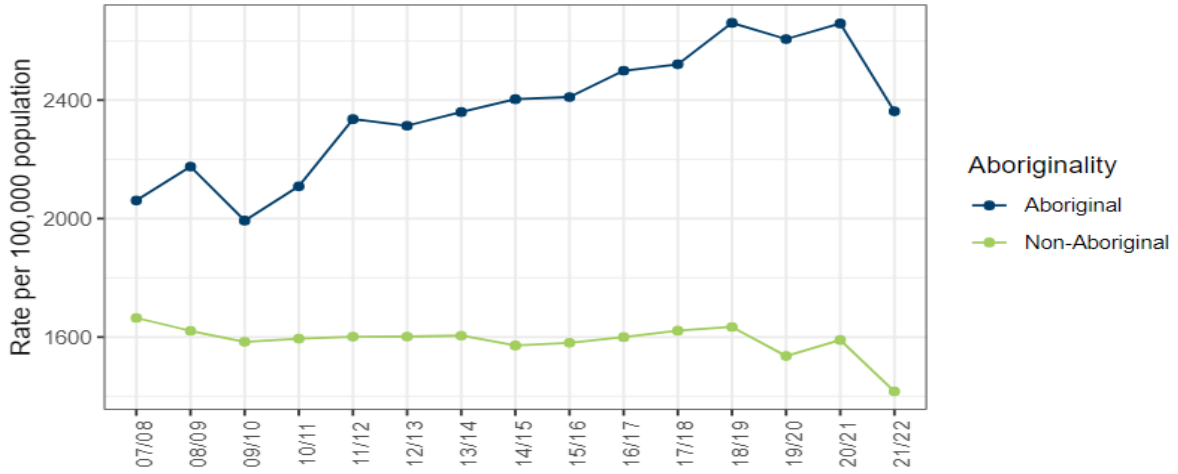
Circulatory disease

Key issue for our region	**Higher rates of circulatory disease for First Nations Peoples**

In NSW, Aboriginal people have a higher rate of cardiovascular disease related hospitalisations and deaths. Between 2007-8 and 2020-21, circulatory disease-related hospitalisations for Aboriginal people have increased (2071.4 and 2689.1 per 100,000 population respectively). In 2022-23 the rate had decreased to 2439.

- In 2022-23 Aboriginal people were 1.7 times as likely to have cardiovascular disease-related hospitalisations as non-Aboriginal people (2439.2 and 1477.9 per 100,000 population respectively
- Aboriginal people are 1.6 times as likely to die from cardiovascular disease as non-Aboriginal people (196.2 and 126.4 per 100,000 population respectively).

Figure 50: Circulatory disease hospitalisations First Nations, NSW 2007-08 to 2022-23 (CEE 2024x)



Circulatory disease related deaths

Between 2001 and 2016, circulatory disease deaths have steadily declined for both Aboriginal people and non-Aboriginal people, however, the rate for Aboriginal people is consistently higher than non-Aboriginal people(CEE 2020d).

Coronary heart disease

Aboriginal people in 2021-22 were 1.8 times as likely to have coronary heart disease related hospitalisations compared to non-Aboriginal people (749.7 and 406.9 per 100,000 population respectively).

Dementia

There are no national-level estimates of the incidence and prevalence of dementia among First Nations people. A number of studies have indicated Aboriginal and Torres Strait Islander people across urban, regional, and remote Australia have higher rates of dementia, and earlier age of onset, than comparable populations of non-Aboriginal and Torres Strait Islander people (AIHW 2024d).

While the reasons for this are not known the following risk factors for dementia are present at higher levels among First Nations Australians: head injury, stroke, diabetes, high blood pressure, renal disease, cardiovascular disease, obesity, hearing loss, childhood stress and trauma, and lower socioeconomic status.

Key issue for our region	Higher rates of dementia for First Nations Peoples

In NSW, there has been a steady increase of dementia hospitalisations among Aboriginal women since 2009. During the period 2020-21 to 2022-23, there were 391 First Nations people living in NSW hospitalised due to dementia (AIHW 2024d)

During 2020–2022 there were approximately 460 First Nations people who died due to dementia (300 women and 160 men) i.e. dementia was recorded as the underlying cause of death. A further 1,034 died with dementia i.e. dementia was recorded as the underlying and/or an associated cause of death. Dementia was the fifth leading cause of death in First Nations men and women 65 years and over. Deaths due to dementia are expected to increase due to ageing of the First Nations population (AIHW 2024d).

In *Dementia in Australia* 2024, AIHW reported First Nations people with dementia may experience higher barriers to receiving a timely diagnosis than both non-Aboriginal people and Aboriginal people who don't have dementia due in part to fear of leaving Country for treatment or residential care, lack of culturally appropriate services, and complex and competing issues.

2.2.6: Health Needs and Service Gaps for our Culturally and Linguistically Diverse Communities

Migrants to Australia typically start with better health, but health declines over time, especially for those with lower English proficiency. People who speak a language other than English tend to have lower levels of health literacy. In consultations they reported:

- Less agreement in feeling understood and supported by healthcare professionals
- Insufficient information to manage their health
- Lower levels of actively managing their health
- Less social support for health compared to English speakers.
- Difficulties in navigating the health system
- Difficulty understanding health information well enough to make health choices.

Key issue for our region	**Greater health declines in migrant communities**

Low English proficiency and inadequate health literacy contribute to inferior quality of care received and increase the misuse of primary and acute health care services (overuse or underuse). It is known that CALD communities are more likely to utilise ED services rather than community or GP health services. As a result, CALD populations have been recorded as having a higher median resource utilisation (Moore 2023).

Low English proficiency and inadequate health literacy also hinder patients' comprehension and utilisation of health information, ultimately leading to poor health outcomes compared to English speakers (SWSPHN 2023b). CALD populations in Sydney have also been recorded as having lower levels of active engagement with healthcare providers, leading to increased costs associated with chronic diseases for this group (Tannous 2021).

Social Determinants of health

CALD and Refugee populations are more likely to experience factors that collectively contribute to a complex landscape of negative influences on health outcomes compared to the average population. The data outlines social determinants of health for CALD communities at three levels: macro (low education, unstable housing), meso (limited access to culturally appropriate health services), and micro (genetic predisposition, immigration-related challenges) (SWSPHN 2023b)

Chronic Disease Prevalence in CALD communities

In SWS total rates of chronic illness are higher in people born in Australia (19%) compared with people born overseas (14%), but this is not the case for all chronic conditions (AIHW 2023a). Some CALD populations in SWS had a higher prevalence of Type II Diabetes compared to the Australian-born population particularly people born in regions such as Polynesia, South Asia and the Middle East.

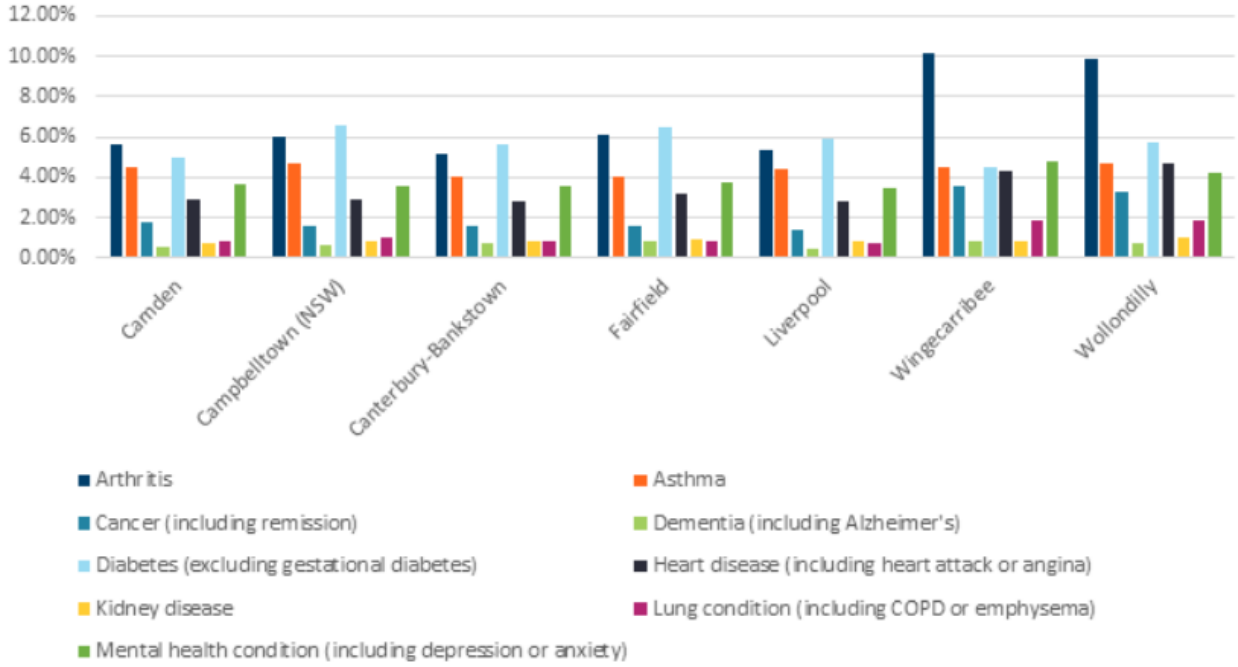
Key issue for our region	Greater health declines in migrant communities

Analysis of 2021 Census data indicates that the prevalence of mental health conditions and arthritis increases with the length of time a person born overseas lives in Australia. Lower levels of English proficiency are linked with poorer long-term health outcomes and risk of chronic conditions is exacerbated by continued low-level English proficiency Migrants in Australia for more than 10 years with low English proficiency have a 33% prevalence of long-term health conditions. In SWS, the risk of long-term health conditions rises by an average of 5% after more than ten years since arrival. (ABS 2022).

There are regional differences in the prevalence of chronic conditions in CALD communities in SWS illustrated in Figure 51:

- CALD communities in Wingecarribee and Wollondilly exhibit higher rates of chronic conditions, including arthritis, asthma, cancer, dementia, heart disease, lung conditions, stroke, and mental health issues
- CALD populations in Campbelltown and Fairfield show an elevated prevalence of type 2 diabetes

Figure 51: Chronic disease prevalence in SWS CALD populations by LGA (ABS 2022)



Key focus areas for SWS CALD communities

- Ensuring culturally- and linguistically appropriate information is available is key, as lower English proficiency is linked to poorer chronic disease outcomes
- Increasing CALD engagement with preventative health actions to attempt to reduce the likelihood of chronic conditions in older age, particularly culturally tailored programs leveraging key community contacts to ensure traction of messaging.

2.2.7 Health Needs and Service Gaps for our Older People

Older persons refers to people who are aged 65 years and over. Due to the health and life expectancy disparities of First Nations people, older persons are those aged 50 years and over. PHNs have become more active in the support of older persons since the release of reports from the Royal Commission into Aged Care Quality and Safety (Pagone 2021) and a stocktake and analysis of activities at the interface between the aged care, health and disability systems (AIHW 2019a). SWS has completed or is engaged in work to:

- create aged care health pathways for health professionals to better navigate the aged care system.
- support healthy ageing and ongoing management of long-term conditions, in SWS
- enable virtual access to primary care in RACHs
- support after-hours planning and processes in RACHs
- support vulnerable people to navigate and access aged care services
- reduce falls through commissioning of a falls prevention program

Dementia

Dementia is a term used to describe a range of similar conditions that progressively erode brain function and lead to reduced life expectancy. Changes that occur over time due to the condition include impaired memory, speech, thought, behaviour, mobility and personality (AIHW 2024d). Dementia can occur across the lifespan; however, incidence and prevalence increase with age with diagnoses increasing dramatically after age 70 years.

Dementia is the second leading cause of death of Australians contributing to 6.6% of all deaths in males and 12% of all deaths in females in 2022. In 2018, dementia was estimated to cost Australia more than $15 billion. The total cost of dementia is projected to increase to $36.8 billion by 2056 (The National Centre for Social and Economic Modelling 2016).

The number of people living with dementia is estimated in Australia as there is no single authoritative data source for deriving prevalence. In SWS, the estimated number of people living with dementia in 2022 was 13,457, made up of 8,384 women and 5,072 men.

Key issue for our region	**Based on population projections, there will be dementia prevalence increases between 72% and 83% across SWS 2054.**

Dementia Prevalence 2024–2054 (Dementia 2023) reports estimates of growth in the number of people living with dementia in the LGAs of the SWSPHN region and NSW as shown below in Table 27. The table also shows SWS will have two LGAs in the 10 highest prevalences. This will increase demand on health, aged care, and carer services in the region.

Table 26: Dementia projections and rankings by LGA and NSW 2024 – 2054. (Dementia 2023)

LGA	Estimated number of people living with dementia 2024	Estimated number of people living with dementia 2054	Percentage change	LGA rank out of 129 2024	LGA rank out of 129 2054
Camden	1082	1875	73%	43	44
Campbelltown	2018	3463	72%	26	26
Canterbury-Bankstown	5703	10,419	83%	2	2
Fairfield	3307	5910	79%	8	8
Liverpool	2468	4328	75%	23	23
Wingecarribee	1398	2494	78%	32	32
Wollondilly	765	1339	75%	53	53
NSW	138, 200	252, 800	83%		

Many people with dementia rely on health and aged care services and often require a high level of care and support. According to the Australian Institute of Health and Welfare 57% of all people in permanent government-subsidised residential aged care in SWS had a diagnosis of dementia (AIHW 2024j). Compared to aged care residents without dementia, they need a high level of care in relation to activities of daily living and behaviour.

People with dementia living in the community also depend on informal care provided by family and friends. Around 42% of primary carers of people with dementia were the spouse/partner and 44% were the child. SWS is experiencing a rapid growth in the ageing population. As a leading cause of death and burden of disease, the demand dementia places on health and aged care services are expected to increase considerably.

Dementia and CALD communities

Finding appropriate aged care services for individuals with dementia from a CALD background is a critical issue as these individuals often end up relying solely on family as carers (Gilbert 2022). There have also been issues with health literacy levels relating to dementia within CALD communities, although some of these gaps have been identified and partially addressed (Patel 2022)

Dementia-related hospitalisations

In NSW, men over 65 years have higher hospitalisations for dementia recorded as a principal diagnosis and/or comorbidity than women (1743.3 and 1285.7 per 100,000 population, respectively). Between 2013-14 and 2022-23 the hospitalisation rate increased for Aboriginal and Torres Strait Islander people from an adjusted rate of 2356 per 100,000 people to 2,598 per 100,000 people (CEE 2024o).

In 2022-23, there were 23,076 dementia-related hospitalisations of people aged 65 and over in NSW, 2,641 of the hospitalisations (or 7%) were in SWS. Dementia related hospitalisations (a principal diagnosis or as a comorbidity) in SWS have decreased between 2018-19 and 2022-23 from 1912.1 to 1694.2 but remain

slightly higher compared with the NSW rate of 1490.1 per 100,000 people. Within SWS, Canterbury-Bankstown and Liverpool LGAs have the highest rates.

Palliative care planning for people with dementia

Many people living with dementia struggle to access palliative care that appropriately responds to their needs and respects their wishes, due to issues around capacity for decision making, difficulties in communication and lack of community understanding of the disease (PCA 2018). Advance care planning and engagement with palliative care for people with dementia should commence early. The demand for palliative care is expected to increase by 67.5% in the region with the number of people requiring this type of care increasing from 2,275 in 2016 to 3,811 by 2031.

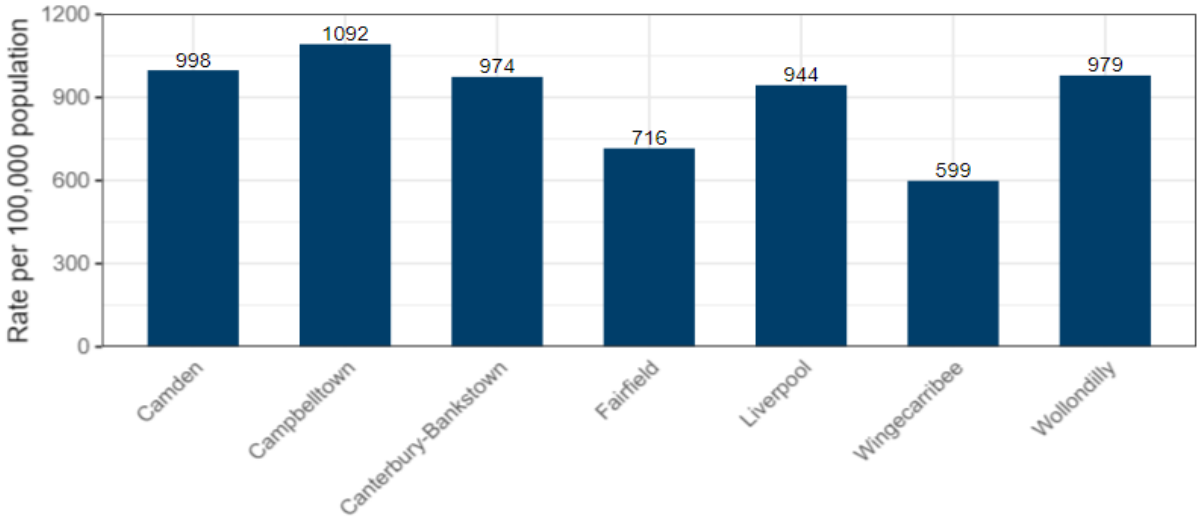
Issues raised by community care providers and residential aged care homes (RACH) include:

- a lack of community and health professional awareness that dementia is a life-limiting illness and palliative care should be considered
- RACH staff who have the most contact with residents do not have the skills to recognise deterioration towards end-of-life
- structural barriers for the provision of palliative care in RACHs.
- limited advance care planning resources available that match the literacy/reading ability/language of the SWS population although SWSPHN has partially addressed this with the release of an easy-read fact sheet on dementia, a dementia and palliative care directory and dementia community education.
- health professionals, community services staff and RACH staff are not comfortable or skilled at having conversations about death and dying.

Falls and falls related injuries

More than one in three people aged 65 or over fall at least once a year and many fall more often. Falls are the most identified cause of injury-related hospitalisations in NSW, at a cost of around $752 million. Equally as important is the human cost to the older person and their family following a fall. A spiralling sequence of events can include extended hospitalisation and rehabilitation, increased care needs including potential admission to aged care services, and far too commonly, death (CEC 2023).

Figure 52: Fall-related hospitalisations by LGA 2021-2022(HealthStats2024)



Fall-related injury hospitalisations

In SWS in 2021-22, a total of 1,905 males and 3,712 females aged 65 years and older were hospitalised (overnight and day only) for injury related to falls. The falls-related injury hospitalisation rate for people aged 65 years and older in SWS was higher than for the state (4414.4 and 4082.6 per 100,000 population respectively) (CEE 2024z). Within SWS, Campbelltown has the highest fall-related injury hospitalisations. Fall related hospitalisations in SWS grew by 63.7% in the ten year period between 2012-13 and 2021-22 with growth expected to continue due to population ageing.

Oral health

Poor oral health is a significant problem for older Australians, leading to issues such as tooth decay, gum disease, and tooth loss (Chalmers 2001). Despite improvements in dental care, gum health has worsened, particularly for those in lower-income groups and institutionalised settings (Chalmers 2001, Nakamura 2021). Poor oral health is linked to serious conditions like diabetes, heart disease, dementia and respiratory problems, increasing the risk of death (Badewy 2021).

Social isolation

Social isolation is linked to poor health outcomes, increased hospital visits, and reduced well-being (Courtin 2017). It limits access to mental health care, pain management, and other services, contributing to avoidable hospitalisations. Loneliness affects mental health, while social isolation worsens overall health.

Palliative Care

Palliative care aims to prevent and relieve suffering and improve the quality of life of children, adults, and their families with life-limiting illness. Palliative care can be delivered by a wide range of health and community providers, is not limited to any specific condition, can be delivered at any stage of illness, and can accompany curative treatments (AIHW 2018f).

According to the latest findings from the AIHW Palliative Care Services in Australia 2022-23:

- 65% of patients who died as admitted patients received palliative care
- The average patient age at admission was 75 years
- 60% of palliative care-related admissions were for people aged 75 and over and 8.3% were for people aged under 55 years
- people living in areas classified as having the lowest socioeconomic status had almost twice the rate of public hospital palliative care-related hospitalisations (44 per 100,000) than those living in the areas of highest socioeconomic status (24 per 100,000)
- 2.0% of residential aged care residents were assessed as requiring palliative care
- 1 in 1,000 GP encounters were palliative care-related

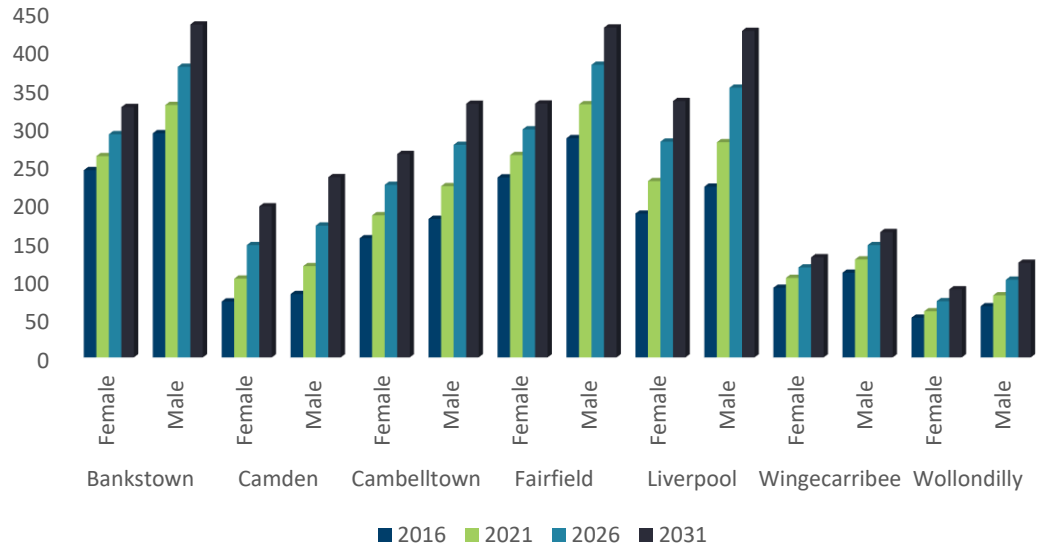
The ageing population and rising rates of cancer and other chronic conditions have led to a rise in the demand for palliative care services. Nationally, hospitalisations for palliative care rose by 37% between 2015-16 and 2022-23 from 73,600 to 101,000 hospitalisations (AIHW 2018f). Palliative care-related hospitalisations were most frequently recorded for cancers of secondary/unspecified site, lung, colorectal and pancreas.

Key issue for our region	**Increasing demand for palliative care services**

In 2021-22, 2.0% of people living in residential aged care in Australia had an Aged Care Funding Instrument (ACFI) appraisal indicating the need for palliative care. Based on ACFI appraisals, the need for palliative care increased with age — from less than 10% for those aged under 70 to just over 50% for people aged 85 years and over. The most common diagnoses requiring palliative care were cancer and diseases of the circulatory system (21% each) followed by the musculoskeletal system (11%).

In NSW Primary Health Networks, the rate of palliative care-related hospitalisations ranged from 27.1 per 10,000 in Western Sydney PHN to 58.6 per 10,000 in Murrumbidgee PHN. SWS PHN had the second lowest rate of 34.6 per 10,000 (3,735 admissions). The demand for palliative care is expected to increase by 67.5% in the region with the number of persons requiring this type of care increasing from 2,275 in 2016 to 3,811 by 2031 with dementia and cancer being the primary drivers for this increase. An increase in service demand is expected throughout all LGAs, likely due to population dynamics leading to an increased number and proportion of elderly residents.

Figure 53: Number of SWS residents requiring palliative care by LGAs and gender, 2016 to 2031(SWSLHD/SWSPHN 2018)



Increasing service demand and complexity for older people

Many older adults have multiple chronic conditions, many of which require ongoing management. Managing these conditions often requires complex medical regimens which can be difficult and increase the risk of functional limitations within older people (Chamberlain 2022). This in turn can increase the burden placed on healthcare services.

Frailty in older adults makes them more vulnerable to health deterioration, even from minor illnesses or injuries. Frailty slows the healing process; potentially elongating hospital stays. Frail and pre-frail populations are expected to grow rapidly (Taylor 2019) which will likely place additional strain on existing healthcare services.

When combined with frailty, multi-morbidity can have varying negative effects on health outcomes (Woo. J 2014). The combinations of these can also lead to an increase in bed-blocking, which has been shown to increase with the complexity of diagnosis (Pellico-López 2019).

Issues raised through consultations regarding service demand include:

- population growth and ageing and an introduction of new models of care will also increase demand on GPs and other primary and secondary health care providers
- there is a shortage of private geriatricians, which impacts not only on the care afforded to the community, but also on the network of providers available to support general practitioners caring for elderly patients
- the need for better support for mental health issues in residents of aged care homes in the Liverpool area, as current support by mental health specialists close to the retirement age is deemed inadequate
- the need for more community-based services and aged care homes, services for frail and complex care
- increased number of chronic diseases as a consequence of an ageing population in the Camden area

Key focus areas:

- support and carer availability for people living with dementia
- support for carers of people living with dementia
- palliative care services
- falls prevention strategies in aged care
- oral health
- social isolation

Section 2.3: Alcohol and Other Drugs Needs and Gap Analysis

2.3.1 Alcohol and Other Drugs in the General Population

Alcohol

The impact of alcohol and other drug use, including pharmaceuticals, on individuals, families and communities is significant including quality of life, physical and mental health, family and community function and crime rates. Excessive alcohol consumption is one of the main preventable public health problems in Australia, with alcohol being second only to tobacco as a preventable cause of drug-related death and hospitalisation (CEE 2018a).

In Australia in 2023, mental health and substance use caused 15% of the total disease burden (98.3% non-fatal and 1.7% fatal). The proportion of fatal burden in all persons was highest for alcohol use disorders (13%), other mental health and substance use disorders (4.4%) and drug use disorders (2.4%) (AIHW 2023c).

In NSW in 2023, 27.1% of people did not meet the NHMRC guidelines (they drank more than 10 standard drinks a week, or more than 4 standard drinks on any one day), 25.4% of people consumed more than 4 standard drinks on a single occasion in the last four weeks and 9.9% consumed more than 10 standard drinks in the past week.

Risky drinking among men (more than 10 standard drinks a week, or more than 4 standard drinks in one day) is 1.9 times higher compared to women (35.6% and 19% respectively). People aged 35-44 years had the highest rate among all age groups while people aged 75+ had the lowest rate (34.2% and 13.4% respectively). The rate for Aboriginal adults is 1.1 times higher compared with non-Aboriginal people (31% and 27% respectively). People who were born in English-speaking countries and Australia had much higher rates compared to those who were born in non-English speaking countries (33.7%, 31.4% and 11.1% respectively). People in inner regional areas have higher rates compared to people in outer regional and remote areas and those in major cities (31.9%, 30.7% and 25.6% respectively).

In SWS in 2023, 16.8% of people consumed alcohol at levels that did not meet the NHMRC guidelines which is 0.6 times less than the NSW rate.

Alcohol drinking in secondary school students

In the final NSW School Students health Behaviours Survey of 2017, 46.7% of SWS secondary school students aged 12-17 years self-reported they had consumed alcohol in the past compared to 61.4% school students in NSW. The Australian Secondary Students Alcohol and Drug survey reported similar patterns of alcohol use in 2022-23. The study found 65% of surveyed students had consumed alcohol at some time, even if only a sip (Scully M 2023). SWSPHN conducted consultation with our community on alcohol and other drugs in 2025. Survey results showed that 64.3% of participants tried alcohol between the ages of 12 and 17 years (SWSPHN 2025). Harm from alcohol-related accident or injury is experienced disproportionately by younger people; more than half of all serious alcohol-related road injuries occur among 15–24-year-olds (CEE 2020d).

Alcohol attributable hospitalisations

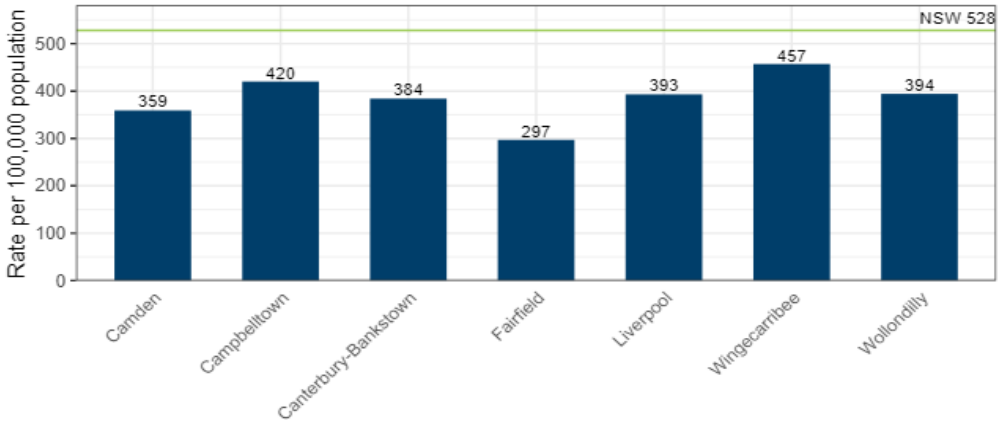
In 2021-22, there were 3,940.6 alcohol-related hospitilisations in SWSPHN region. Rates for both males (463 per 100,000 population) and females (270.8 per 100,000 population) were lower than the state rates (605.4 and 401.4 respectively). There are variations in the spatially adjusted rate across SWS LGAs, from

457 in Wingecarribee to 279 in Fairfield (CEE 2024i).

Between 2019-20 and 2021-22, the alcohol attributable hospitalisation rate in SWS has increased from 336.7 to 363.5 per 100,000 population.

Alcohol attributable hospitalisations among Aboriginal males are two times higher than the rate for all population in NSW.

Figure 61: Alcohol attributable hospitalisations by LGA, SWS, 2020-21 – 2021-22 (CEE 2020b)



Alcohol related death

Rates for death attributed to alcohol have declined since 2001-02 in SWS for both males and females and was similar to the state rate(CEE 2020d). In SWS in 2020-21 the rate of alcohol attributable deaths was 17.7 per 100,000 population (or 201.3 deaths), slightly lower than the NSW rate (18.7per 100,000 population). Across SWS, Wingecarribee had the highest alcohol attributable deaths rate (19.7 per 100,000 population or 17.4 deaths) while Canterbury-Bankstown had the highest number of deaths (75.9 deaths (CEE 2024j).

Illicit drug use

In 2024, 2.9% of the total disease burden in Australia was due to illicit drug use (AIHW 2024p). Illicit drug use includes burden from opioids, amphetamines, cocaine and cannabis and other illicit drug use, as well as their unsafe injecting practices. Illicit drug use was responsible for all burden associated with drug use (excluding alcohol). It was associated with 73% of burden from poisoning, 67% from acute hepatitis C, 31% from liver cancer and chronic liver disease, and 24% from Hepatitis B. Disease burden due to illicit drug use was highest in people aged between 25 and 44, peaking in ages 25–34 years. Males experienced more than twice the total burden compared to females up to the age of 44 years.

More than 21,000 people participated in the 2022-23 National Drug Strategy Household Survey (AIHW 2024o). In the survey illicit drugs are defined as any drug which is illegal to possess or use, and any legal drug used in an illegal way. Examples include prescription drugs used recreationally to bring about or enhance a drug experience, weight loss or performance enhancement and glue/petrol sniffing, Ten percent of participants living in the SWSPHN region reported recent illicit drug use, a reduction from 12.2% in the 2019 survey.

According to the *AIHW Alcohol and Other Drugs Treatment Services Report (2021):*

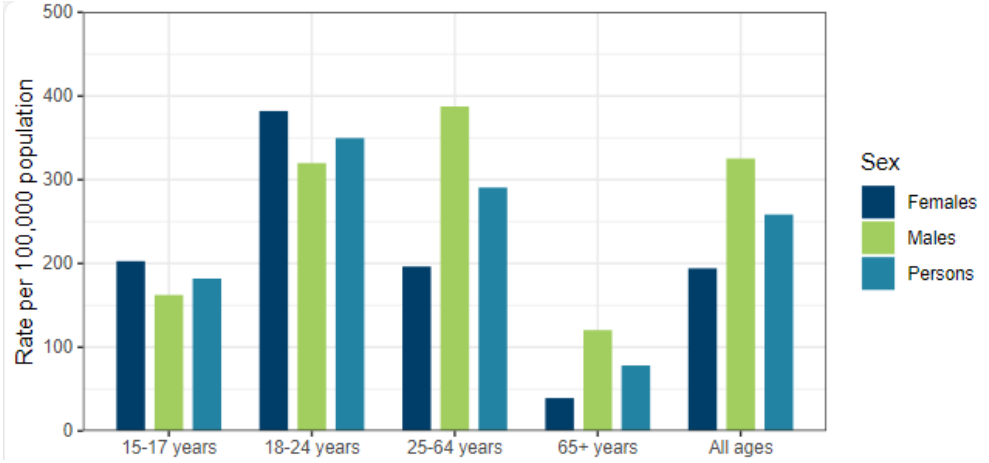
- When seeking treatment for their own drug use, clients most reported their principal drug of concern as alcohol (34% of treatment episodes), amphetamines (28%), cannabis (18%) and heroin (5.1%).

- Where amphetamine was reported as the principal drug of concern, over three quarters (78%) of closed treatment episodes were for methamphetamine only.

Hospitalisations

Between 2021-22, mental and behavioural disorders due to use of alcohol hospitalisations rate was 1,150 per 1,000,000 per population (AIHW 2024c).

Figure 62: Alcohol problems: presentations in 84 emergency departments, Comparison by age, 15 years and over, NSW, 2022-23 (CEE 2020b)



The age-standardised rate for alcohol and other drug related hospitalisations (excludes emergency department presentations where there was no hospitalisation) in 2022-23 was 794.8 per 100,000 people in both public and private hospitals in SWS, lower than 1192.8 per 100,000 people in NSW. Within SWS, The Campbelltown LGA had the highest rate (951.5 per 100,000 people) followed by Wingecarribee LGA (906.8 per 100,000 people) (CEE 2024p).

The highest alcohol related ED presentations by ED triage category were Triage 3 - potentially life threatening. The alcohol attributable deaths rate increases with age. People aged 85 years and older are 15 times as likely to have alcohol attributable deaths compared to the rate for all population. Alcohol attributable deaths rate increases as socioeconomic status decreases. Liver cancer had the highest percentage among all alcohol attributable deaths by conditions.

Methamphetamine

The Magistrates' Early Referral into Treatment (MERIT) program 2021 annual report indicates stimulants such as methamphetamine was the principal drug of concern for 56% of Sydney based participants. This was followed by cannabis 29% and opiates mainly heroin (10%) (DCJ 2024).

In 2022-23, there were 763 hospitalisations (or 98.4 per 100,000 population) in SWS, a declining rate since 2019-20 (117.3 per 100,000) and lower than the NSW rate of 140.4 per 100,000 population(CEE 2024k).

In NSW, people aged 35-44 and 25-34 years had the highest Methamphetamine-related related hospitalisations among all age groups (243.1 and 240.1 per 100,000 respectively) (CEE 2024k).

In 2022-23, people aged 35-44 years had the highest rate of methamphetamine-related emergency department presentations among all age groups within NSW. People aged 25-34 and 35-44 years also had the highest methamphetamine-related related hospitalisations and emergency department presentations among all age groups (4.7 and 5.1 per 1,000 unplanned presentations).

Opioid use

In NSW, there were 7,724 (or 121.1 per 100,000 population) opioid-related hospitalisations in 2022-23, a slight increase over 2021-22 (119.4 per 100, 000). People aged 45-54 had the highest hospitilisations rate among all age groups. Between 2022-23, Aboriginal people were 7.2 times more likely to be hospitalised compared to non-Aboriginal people (726.4 and 101.1 per 100, 000 respectively). People living in major cities had higher hospitilisations rate (120.2 per 100,000 population) compared to those living in inner regional (112.8 per 100,000 population) and outer regional and remote areas (98.7 per 100,000 population). Opioid-related hospitalisations increase as socio-economic status decreases. The hospitalisation rate among people in the most disadvantaged 20% was 1.7 times as high as those in the least disadvantaged 20% (CEE 2024l).

The rate of opioid-related hospitilisations in SWSPHN was lower than that of NSW in 2022-23 (110.9 and 121.1 per 100, 000 population). The hospitalisations rate for men were 1.7 times higher than women (138.7 and 83.4 per 100,000 population respectively). SWS had the fourth highest rate of opioid-related hospitalisation among all PHNs in NSW, accounting for 11.7% of all opioid-related hospitalisations (CEE 2024l).

In NSW, there were 286 (or 3.5 per 100, 000 population) opioid drug deaths in 2022 (CEE 2024m). This is a steady decline since 2017 (7.0 per 100, 000 population). Males are more likely to die from opioids compared to females (5.0 and 2.1 per 100, 000 respectively).

AOD Services

On 1 July 2023, a community pharmacy program for opioid dependence treatment (ODT) medicines including on-site pharmacist administration of injectable buprenorphine, was introduced nationally. Although otherwise very positive, this has led to closure of a Fairfield ODT clinic and major changes to another in Liverpool affecting 800 patients. This has created a need for more GP prescribers in SWS. SWSPHN has been working to attract more GP prescribers, but many GPs do not feel comfortable becoming ODT prescribers. This coupled with retirement and deaths of elderly prescribing GPs has created the most significant shortfall in AOD treatment in SWS

PHN Commissioned Services

SWSPHN commissions six AOD services that work directly with clients, two wholistic emotional and social wellbeing services for First Nations people that include AOD and two services that build the capacity of GPs to work with their patients with AOD issues.

Analysis of SWSPHN commissioned AOD treatment services clients in SWS in FY2023-24 (SWSPHN 2024) found that:

- 69.9% were male, compared to 29.7% female, and 0.4% not stated.
- 85.5% were non-Aboriginal, 12.8% were Aboriginal and/or Torres Strait Islander people.
- 77.2% were born in Australia. For clients born overseas, the top three countries were: New Zealand (2.8%) Vietnam (2.3%), and Lebanon (1.8%).
- The highest percentage of clients came from the Campbelltown LGA (26.4%) followed Liverpool LGA (18.5%), and Bankstown (17.7%), and 15% came from outside the SWS region.
- The most common principal drugs were Alcohol (31%), Methamphetamine (24.3%), Cannabinoids (16.7%), and heroin (8.2%).

Detoxification services

SWSLHD has 15 beds for inpatient detox unit in Fairfield (Fairfield Inpatient Withdrawal Unit). 684 admissions for withdrawal management were reported in 2023-24. Alcohol was identified as primary drug of concern for 63% of inpatient episodes, followed by heroin and other opioids 13%, methamphetamine 11% and cannabis 6% of inpatient episodes (SWSLHD 2024).

Services to support people with complex needs

Providers reported a limitation of current withdrawal management services to address methamphetamine withdrawal. Withdrawal treatment services have limited and set time periods for managing withdrawal. Methamphetamine withdrawal requires an extended period of withdrawal management and psycho-social support. Lack of ability to access services quickly when relapsing and challenges in linking up discharge from detox and acceptance into rehabilitation programs were reported. Services mostly tailored to crisis support, with limited availability of services to provide ongoing counselling to clients to remain abstinent.

Social issues such as Centrelink payments, court appearances, and employment impact drug and alcohol clients' ability to maintain their health. Consultation with health professionals and NGO service providers revealed they encounter challenges to addressing the social issues that impact clients' lives due a lack of integration and coordination of care between drug and alcohol and other services and agencies. Community consultations suggested services should offer holistic programs that target physical, mental and social support.

Stigma around drug and alcohol issues exist in the community and create obstacles in accessing treatment services. Targeted interventions delivered by GPs have been demonstrated to be effective but implementation is challenging within the constraints of general practice (Brickley 2019).

AOD services for pregnant women

SWSLHD Drug Health Service Substance Use in Pregnancy and Parenting Service is a multi-disciplinary inpatient and outpatient service that provides care for women who use drugs and alcohol and their babies, during pregnancy and for up to two years following birth.

Providers reported challenges accessing treatment services for parents of young children. These related to limited family approaches to care, as well as fear that children would be taken away if the parent's drug problem is recorded.

SWSPHN Consultations

Alcohol and Other Drugs was the topic for consultation during SWSPHN's April 2025 Local Health Forum series held in the Southern Highlands, Campbelltown and Bankstown. There were 65 attendees (Bowral 14, Campbelltown 38, Bankstown 13) including community members, health professionals, service providers and academics. Overall community member attendance was lower than previous forum series (SWSPHN 2025).

There were 930 responses to forum questions submitted.

- 36.9% of responses noted a lack of public awareness and promotion of available services, particularly those open after-hours
- Timely care and adequate resourcing were identified as a priority in 25.7% of responses

- 24.1% of respondents reported services are overwhelmed and under-resourced, with staff burnout, high turnover, and limited availability leading to inadequate follow-up and support
- 17.5% highlighted negative patient experiences, including short-term support, lack of follow-up, and unclear communication.

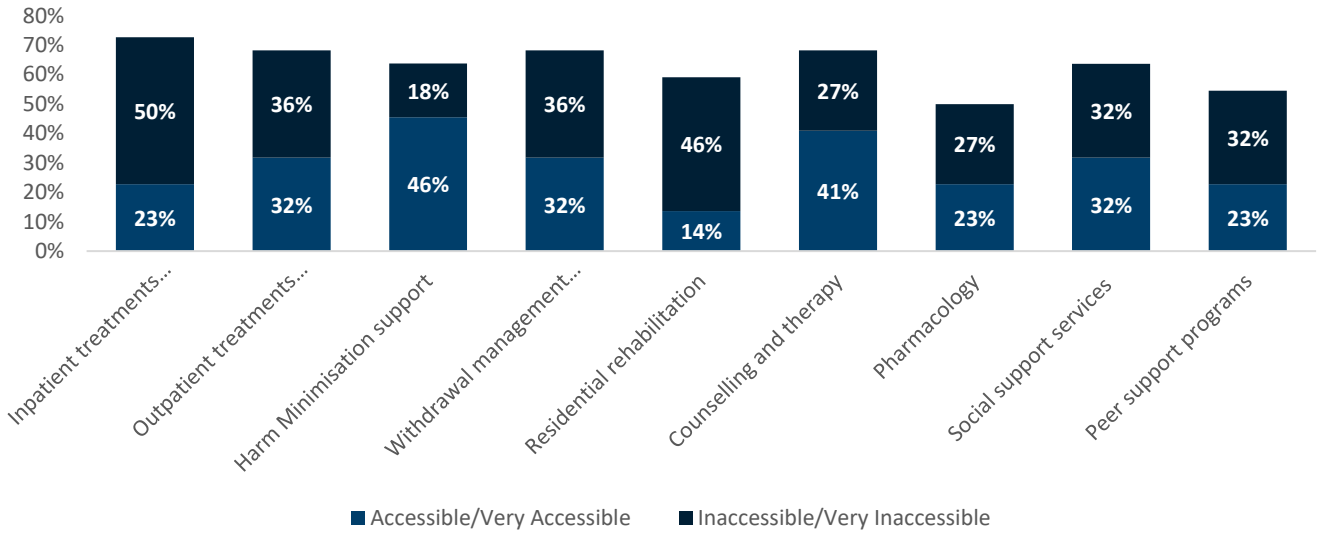
When asked to consider support for priority populations, 35% of participants identified a need for:

- Strongly advocating for the inclusion of real stories, peer support, and workers with lived experience.
- Services to address trauma, reduce stigma, and avoid "one-size-fits-all" models
- Meaningful training across working with diverse communities
- Support for integrated, holistic care

In addition to the forums, an online survey available in English, Arabic, Simplified Chinese, and Vietnamese, and modified to suit two target groups (health professionals and community members). The surveys were conducted between 31 March and 30 April 2025. A total of 36 respondents completed the survey (22 health professionals and services providers; 14 community members).

Regarding AOD services, only 22.7% of survey respondents felt confident in understanding the range of AOD services available to patients. When service providers were asked about service accessibility, they responded the most inaccessible services were inpatient treatments, MAT (Medication-Assisted Treatment)/dual diagnosis, residential rehabilitation, and outpatient treatments (refer Figure A). Approximately one third of respondents (36.4%) believe existing services were inaccessible by way of lack of cultural sensitivity. The top reported access barriers were long waiting times (68%), stigma (64%) and service proximity (59%) (SWSPHN 2025).

Figure 63: Accessibility of SWS AOD treatment and management



by the people who engaged with SWSPHN during this consultation period (SWSPHN 2025).

Top priorities

1. **System change –** There is a strong call for system-wide change through increased, long-term funding and better resourcing of the AOD workforce. This includes support for community-based services, improved access to treatment, and capacity building to meet rising demand.
2. **Improved coordination and collaboration -** Participants emphasised the importance of stronger collaboration across services—through interagency partnerships, local health forums, communities of practice (COPs), and ongoing consultation. Building and maintaining local relationships is seen as key to improving outcomes.
3. **AOD awareness and perceptions -** There is a clear need to address stigma around alcohol and other drug use. Respondents highlighted the importance of education, public awareness campaigns, and more compassionate, person-centred approaches to shift community attitudes and promote help-seeking.

Section 2.4: Impacts of Disaster

2.4.1 Bushfires

Bushfires are increasing in frequency, with longer fire seasons and fire severity, due to climate change. Record low rainfall, prolonged drought, hot temperatures and heatwaves created the conditions for the Black Summer 2019/2020 bushfires that significantly impacted NSW and areas of SWS.

The 2019-20 bushfires in Australia burned more than 17 million hectares of land, destroyed more than 3,000 homes and killed at least 33 people. In NSW, the bushfires had burnt 5.4 million hectares (6.7% of the state). In SWS, areas of Wollondilly and Wingecarribee were severely affected by the Green Wattle Creek fire. Additionally, indirect effects were seen in neighbouring LGAs such as Camden.

Significant impacts of this fire included:

- 270,700 hectares of land burnt
- 19 homes destroyed
- 18 homes damaged
- 8 facilities destroyed and 3 damaged
- 66 outbuildings destroyed and a further 45 damaged
- 270 rural landowners impacted (Leadbeater Group Pty Ltd 2020)

It was estimated 80% of Australians were directly or indirectly affected by the bushfires. The scale and duration of the fires were unprecedented, and a state of emergency was declared three times.

Figure 64: 2019-20 Bushfires by severity, SWS (DPC 2020, AIHW 2020i)

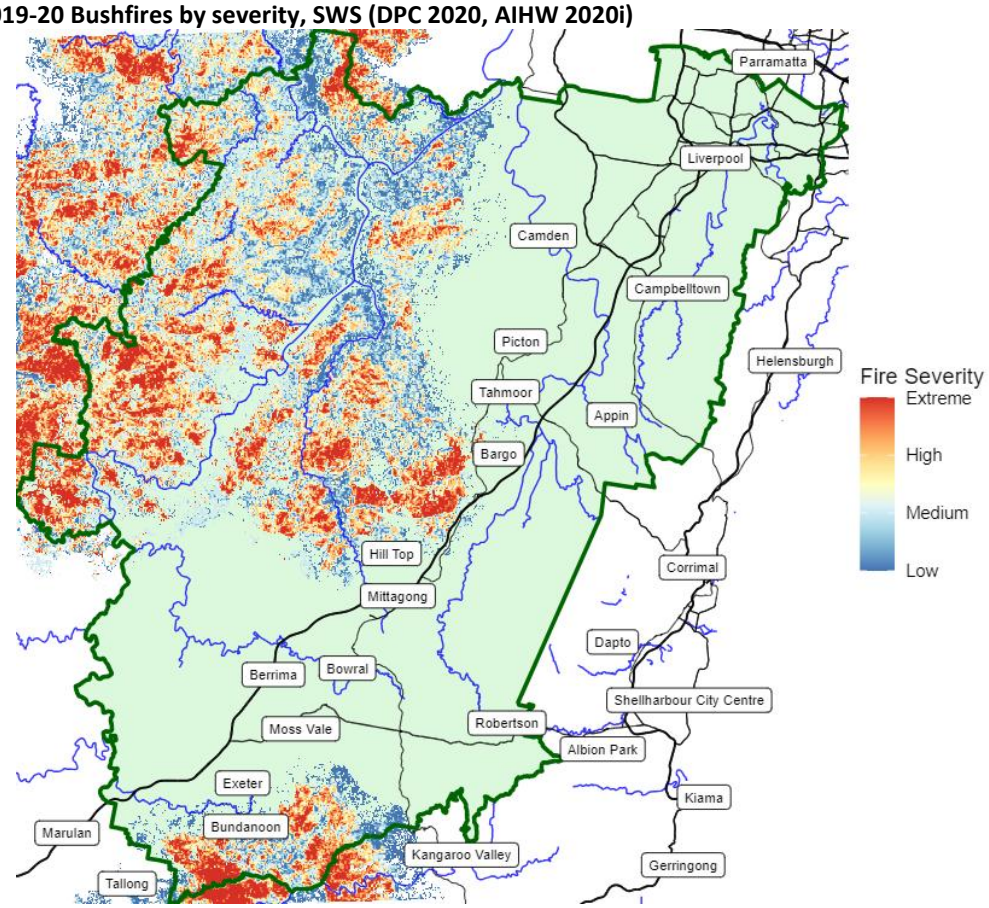


Table 30: Key facts about 2019-20 bushfires in NSW (DPC 2020, DPE 2020)

5.4 million hectares of land burned in NSW	37% of all NSW National Park estate was burned	26 lives lost in NSW
42% of all NSW state forest was burned	4% of all NSW freehold land burnt	2476 homes destroyed in NSW
25% of suitable koala habitat in eastern NSW was destroyed	52% of heathlands in NSW burnt	$899m infrastructure losses in NSW
81% of the Greater Blue Mountains World Heritage Area burned	54% of Gondwana Rainforests of Australia World Heritage Area in NSW burned	601,858ha pastureland damaged in NSW
39% reduction in ecological condition in the fire ground since 2013	39% reduction in ecological carrying capacity in the fire ground since 2013	$43m telecommunication site losses in NSW

Key Issue for our region	Health-related risks associated with bushfires

Respiratory effects

Devastation of the natural environment and the resulting bushfire smoke compromises air quality. Like other forms of air pollution, bushfire smoke includes gases and particulate matter (DoH 2020). Particulate matter is a complex mixture of solid and liquid particles and is classified according to size:

- PM_{10} – particles smaller than 10 microns in diameter. These contribute to visible smoke haze, can irritate the eyes, throat and lungs but are too large to enter the bloodstream.
- $PM_{2.5}$ – particles smaller than 2.5 microns in diameter. These are too small to see and when breathed in, will penetrate deep into a person's lungs.

Smoke from bushfires, such as the bushfires in 2019-2020, can reach levels up to 10 times the standard hazardous air quality levels leading to a rise in emergency department presentations and hospital admissions particularly for asthma and COPD. Older people, people with cardiorespiratory diseases or chronic illnesses, children, and people who work outdoors are particularly vulnerable (Morgan, Sheppeard et al. 2010). In the aftermath of the fires a study estimated the health burden attributable to bushfire smoke in NSW during the 2019-20 bushfires as shown in Table 31 below.

Table 31: Estimated number of excess deaths, hospitalisations for cardiovascular and respiratory problems, and emergency department presentations with asthma in NSW between 1 October 2019 and 10 February 2020 that could be attributed to bushfire smoke exposure (Borchers Arriagada, Palmer et al. 2020)

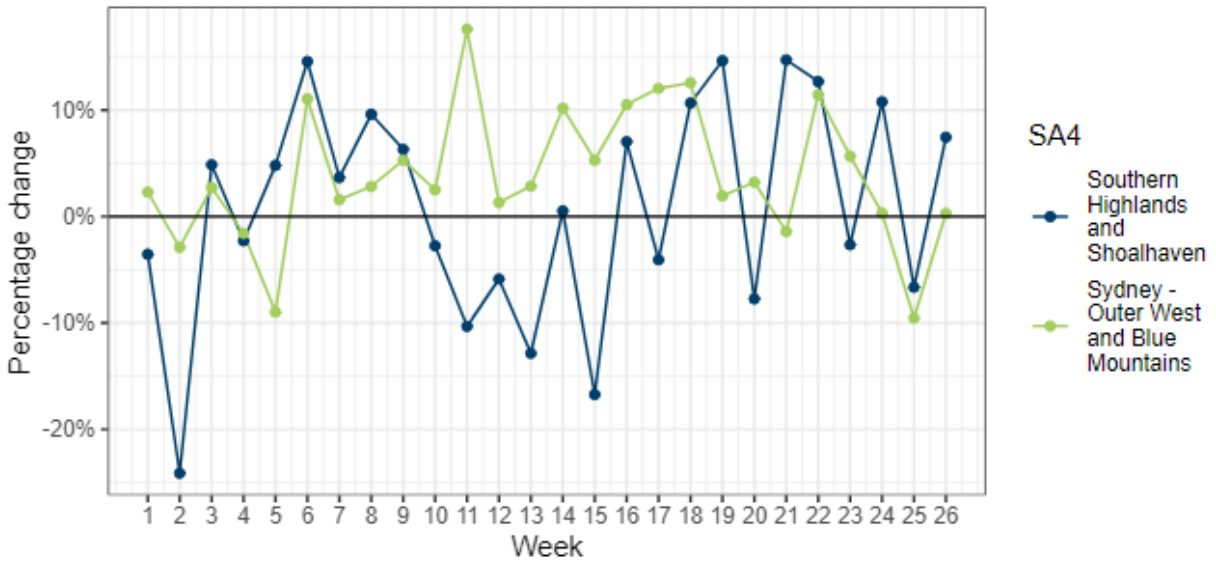
	Estimated number of cases (95% confidence levels)	
Outcome	NSW	Australia
Excess deaths	219 (81-357)	417 (153-980)
Hospital admissions, cardiovascular	577 (108-1050)	1124 (211-2047)
Hospital admissions, respiratory	1050 (0-2204)	2027 (0 – 4252)
ED attendance, asthma	702 (379-1026)	1305 (705-1908)

Emergency department presentations for respiratory health

NSW ED data shows a clear rise in presentations for respiratory problems during the bushfire season. Figure 69 below shows the change (%) in ED presentations in SWS (including areas outside SWS) during each week

of the 2019-20 bushfire season from 1 September 2019 to 29 February 2020 (week 1 to week 26). Compared with the same time in 2018-19, there is a clear increase from week 15 (8 December) to week 22 (26 January). It peaked at 60.0 per 100,000 population (or a total number of 4,946 presentations) during the 2019 Christmas week (week 17), representing an 8% increase compared with the same week in the previous year. The volume remained high for the week beginning 29 December (4,814 presentations, or 57.7 per 100,000 population—a 13% increase compared with the same week in the previous year). This rate increase ranged from 12% in the week beginning 1 December 2019 (from 44.8 to 50.3 presentations per 100,000 population) compared with the same week in 2018, to a 22% increase in the week beginning 15 December (AIHW 2020i).

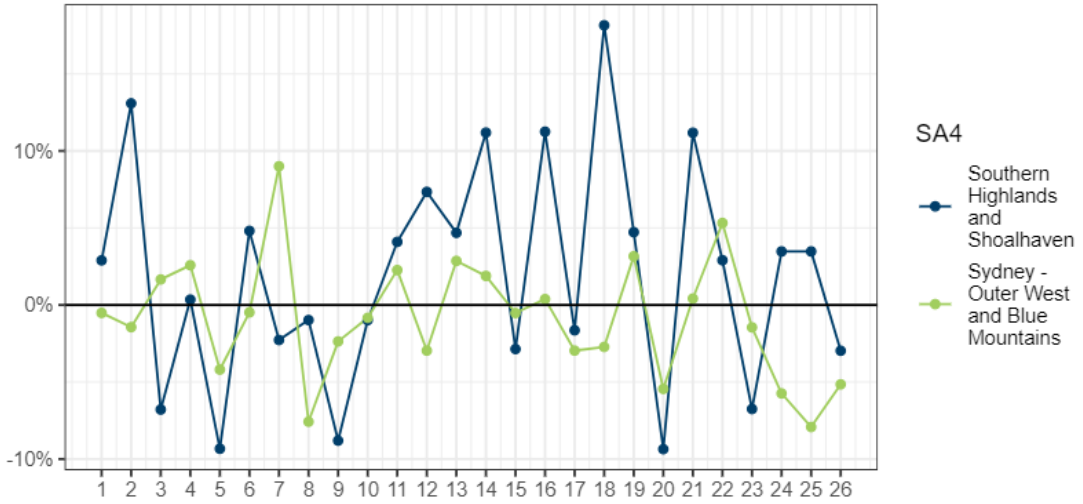
Figure 65: Percentage of change in age-standardised rate (per 100,000) of emergency department presentations for diseases of the respiratory system by week, 2019-20 bushfire season (AIHW 2020i)



Mental health effects

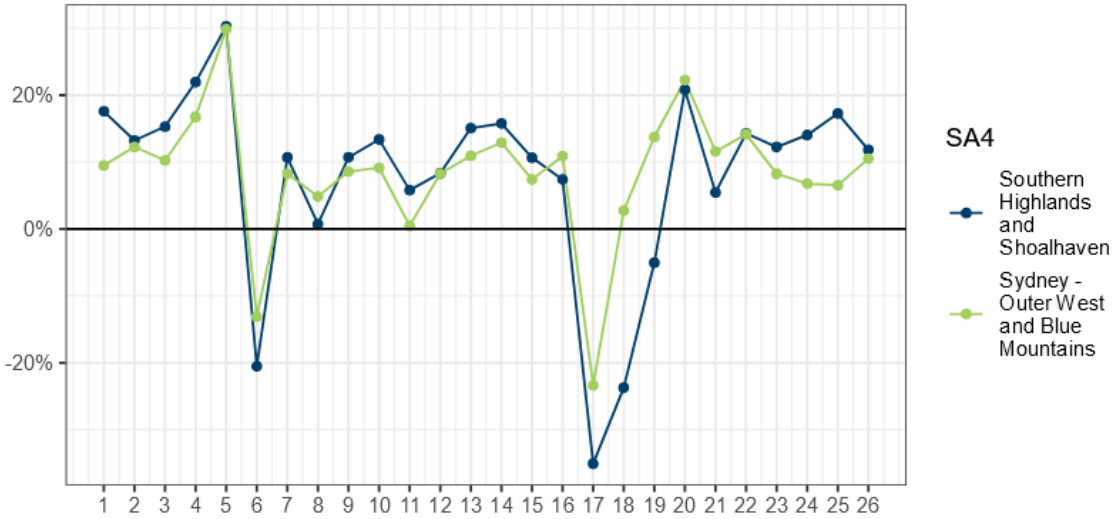
Bushfires can cause loss of life, property destruction and community disturbance, which have a significant impact on the mental health and wellbeing of affected communities and individuals. Overall rates of presentations to NSW emergency departments for mental and behavioural problems were not notably higher in the 2019–20 bushfire season compared with the same weeks in 2018–19. However, as can be seen in figure 70 below presentations in the areas of the SWSPHN region most affected by fires were up to 15% and more higher during the 2019-20 bushfire season from 1 September 2019 to 29 February 2020, compared with the same time in 2018-19.

Figure 66: Percentage of change in age-standardised rate (per 100,000) of emergency department presentations, mental and behavioural disorders by week, 2019-20 bushfire season (AIHW 2020i)



Mental health impacts of the fires were also seen in primary care during the 2019-20 bushfire season. months after bushfire events, it will be important to monitor mental health impacts in SWS communities. Figure 67 below, reflects changes in all MBS mental health item usage in the SA4 areas of SWS most affected by fires across the 26 week season. It reveals claims were low at times of peak fire activity and increased between these times when immediate danger decreased.

Figure 67: Percentage change in use of all MBS mental health items, by week and SA4, 2019–20 bushfire season compared to previous 5-year average (0%) (AIHW 2020i)

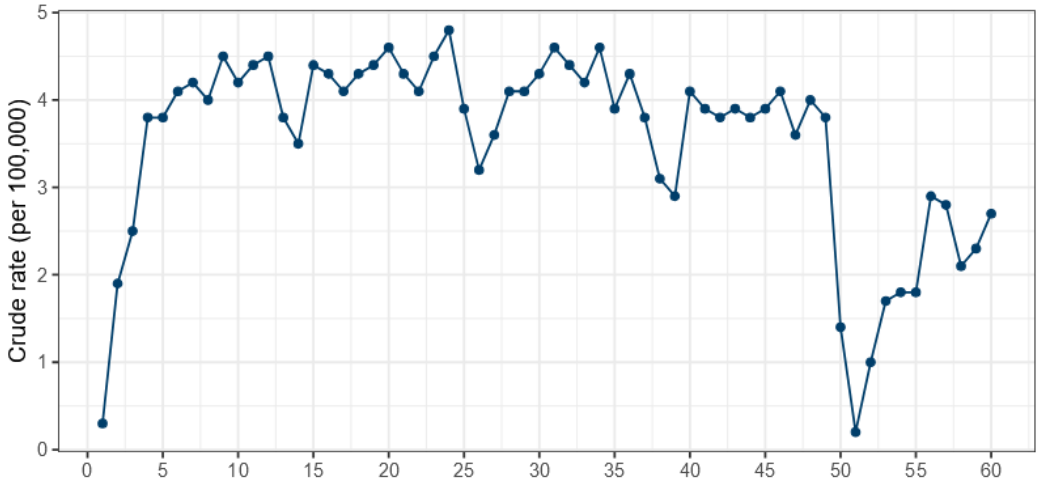


The impact on mental health can last months or years after the bushfire. Many people experience stress-related problems, including post-traumatic stress disorder (PTSD) and depression (Norris, Friedman et al. 2002). Two studies reported that 1 year after the bushfire, 42% of the affected people were distressed. Twenty months after the bushfire, 23% of the affected people were distressed (McFarlane 1988, McFarlane, Clayer and Bookless 1997).

Intersecting traumas, pre-existing vulnerabilities and increased stressors associated with the COVID-19 pandemic led to an increase in mental ill-health and delayed recovery from the effects of the bushfires (Cowlishaw 2023).

Figure 68 below shows indicates that use of MBS items specific to bushfires remained active to March 2021, 12 months after the end of the 2019-20 bushfire season. Additionally, SWSPHN received funding to commission immediate counselling and other mental health services to support the needs of people experiencing distress or trauma because of the bushfires, including emergency response personnel. SWSPHN received 262 referrals to these services which ceased on 30 May 2023.

Figure 68: Use of mental health bushfire specific MBS items NSW, and week,12 January 2020 – 6 March 2021 (AIHW 2020i)



Recovery from bushfires is a long process and mental health impacts can emerge any time and the outcomes may be driven by financial strain and community recovery, rather than direct experience of the fires. Therefore, the SWS population will require monitoring.

Cardiovascular and carcinogenic effects

There is very good evidence that short-term exposure to $PM_{2.5}$ in general worsens existing cardiovascular disease and increases cardio-vascular mortality, while long-term exposure accelerates the progression of disease and also increases mortality (Pope III and Dockery 2006).

Evidence of harm from bushfire smoke is less clear. However, based on the detailed assessments to the WHO and US EPA, it is likely that $PM_{2.5}$ from bushfires exacerbates cardiovascular disease. There is evidence from Australia and the US that bushfires are associated with an increased risk of out of hospital cardiac arrests (DoH 2020).

Occupational exposure to smoke as a firefighter is classified as a possible (Class 2B) carcinogen by the International Agency for Research on Cancer (IARC). Firefighters are regularly exposed to bushfire smoke (seasonally and over their working career).

There is no evidence of a cancer risk in the general community from exposure to bushfire smoke.

Effects on maternal health and pregnancy outcomes

There is emerging evidence that exposure to $PM_{2.5}$ during pregnancy may be related to low birth weight and preterm birth (Breton, Park and Wu 2011) but data from bushfire studies is limited.

One study has shown an association between birth weight and $PM_{2.5}$ from bushfires. It found average birthweight was reduced by 9 grams in babies whose mothers were exposed during the second trimester of pregnancy (Vardoulakis, Jalaludin et al. 2020). Another recent study of bushfire $PM_{2.5}$ found average birth weight was reduced by 6 grams in babies whose mothers were exposed during the first trimester of pregnancy (Ritz and Yu 1999). A study on exposure to poor air quality during the bushfires of 2019 – 2020 and the COVID-19 pandemic lockdowns during pregnancy and a range of birth outcomes in the South Western Sydney Local Health District and South Eastern Sydney Local Health District. Between 1 November 2017 and 31 December 2020 there were 60 054 births. There was an increase in low birthweight babies born to women who were exposed to poor quality air during semesters one and two of pregnancy (aOR 1.18, 95%CI 1.03 – 1.37) only (Brew and Haasdyk 2022).

While there is potentially a small increase in the risk of certain health effects after a period of exposure, this is likely to be extremely low in the long term for most individuals. However, as there is limited information about the long-term implications of prolonged exposure, research is ongoing to better characterise longer-term health effects, particularly across groups at higher risk, such as those with chronic conditions, very young children, pregnant women and their babies.

2.4.2 Heat-related impacts

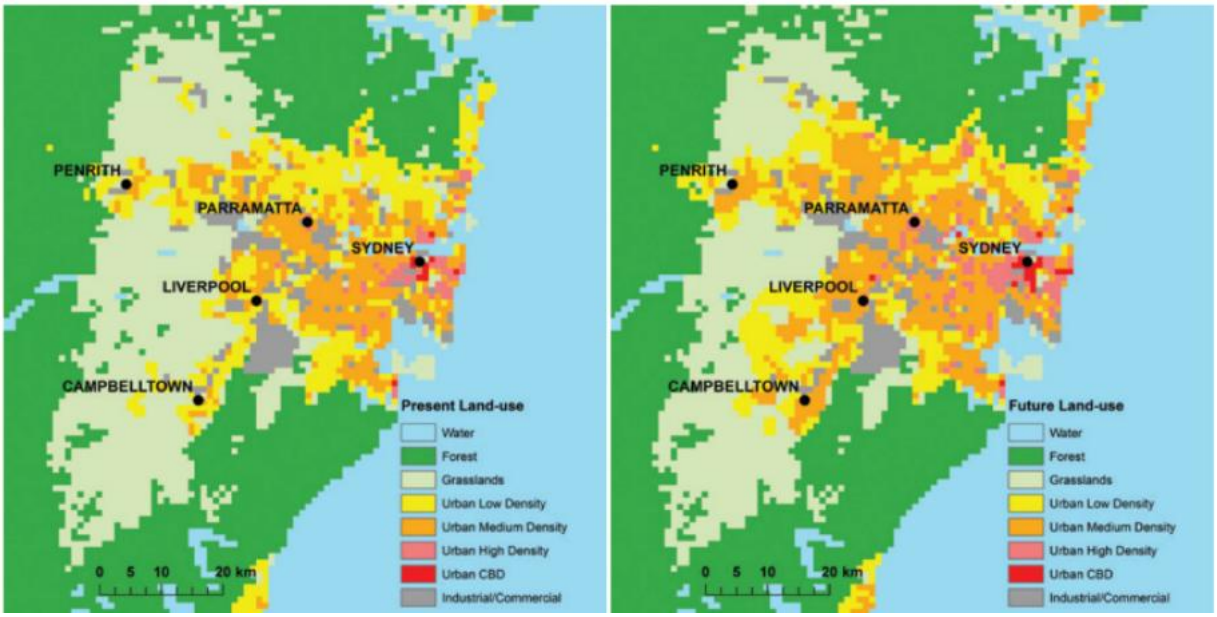
Australia is undergoing a consistent pattern of long-term climate change as evidenced by observations, reconstruction of past climate and modelling. Climate change is being exacerbated by human activities such as changes in land use (BOM 2024). Extreme weather events, such as heatwaves, very hot days over 35C and extremely hot days over 40C are becoming more frequent and intense. Heatwaves are defined by the Bureau of Meteorology (BOM 2024a) as when the maximum and minimum temperatures are unusually hot over three days. This is compared to the local climate and past weather. BOM classifies heatwaves into three intensities related to how much shock they cause to people's bodies.

- **Low-intensity heatwaves** are frequent during summer. Most people can cope during these heatwaves
- **Severe heatwaves** are less frequent. They are likely to be more challenging for vulnerable people. This can include older people, particularly those living with medical conditions
- **Extreme heatwaves** are rare. They are a problem for people who don't take precautions to keep cool – even for healthy people

Cities such as Sydney interact with and influence the surrounding atmosphere and climate creating their own microclimate (OEH 2015). Urban areas have less vegetation and water bodies and more building materials and surfaces such as bricks, concrete, roads and carparks that trap heat from the sun and radiate it into the atmosphere nearby. As a result, urban areas tend to heat more during the day and cool less at night than surrounding non-urban areas, a characteristic referred to as the urban heat island (UHI). Other human activities drive the UHI such as transport, industry and heat produced by appliances, air conditioning for example.

Population growth in Sydney changes land usage from green pastures to low density urban areas and increases density in older established suburbs raising the UHI effect and number of hot days. This form of growth is particularly evident in the south-west and north-west of Sydney as illustrated in the figure below (OEH 2015, AdaptNSW 2024).

Figure 69: Change in Sydney urban land use between 2015 and 2036 (OEH 2015)



Health effects

Heat-related conditions can range from rashes and cramps to serious conditions such as heatstroke. Excessive heat also exacerbates a range of health conditions such as heart disease, diabetes, kidney disease and mental and behavioural conditions (AMA 2015). Heat indirectly contributes to injury from operating vehicles and power tools, and assault by increasing irritability and fatigue and decreased performance (AIHW 2023b). Given the level of greenfield sites within south-western Sydney, this is predicted to be a significant population health concern in the future for our region.

Key issue for our region	Increase in heat-related hospitalisations and mortality

Some population groups are more vulnerable to the effects of heat including people who work outdoors, older people due to age related changes in their bodies, people with chronic diseases, infants and young children, and people from disadvantaged areas living in poorer quality housing and fewer options for cooling (WHO 2008).

Extreme weather events increase hospitalisations and death in Australia (Varghese 2020). There were 247 deaths attributed to extreme weather in 2018-19 to 2020-21 (AIHW 2023b). Heat is the most frequent cause of extreme weather-related injury hospitalisations and deaths in Australia. Between 2019-20 and 2021-22 there were 2,150 people hospitalised for heat injuries nationally. People aged 65 and over represented the highest proportion of hospitalisations (36.88%) followed by those aged 25-44 years. Males were more likely to be hospitalised than females across all age groups (AIHW 2023b).

In NSW during the same period there were 531 extreme weather-related hospitalisations of which 348 (65.5%) were for heat.

2.4.3 Floods

Flooding, the overflow of water onto land that is normally dry, costs the NSW economy about $250 million each year (AdaptNSW 2024). Flooding can occur when too much water runs into creeks and rivers from heavy or prolonged rain or short intense storms. The Georges, Nepean and Wingecarribee rivers and their tributaries flow through the SWSPHN region bringing flooding of variable severity to each of the region's seven local government areas during extreme weather events. Most recently, flooding occurred in 2022 in all LGAs except for Fairfield and Wingecarribee, as shown in Figure 73 and Table 34 below.

Figure 70: Areas affected in SWS by floods 2021-22 (Padgham 2017)

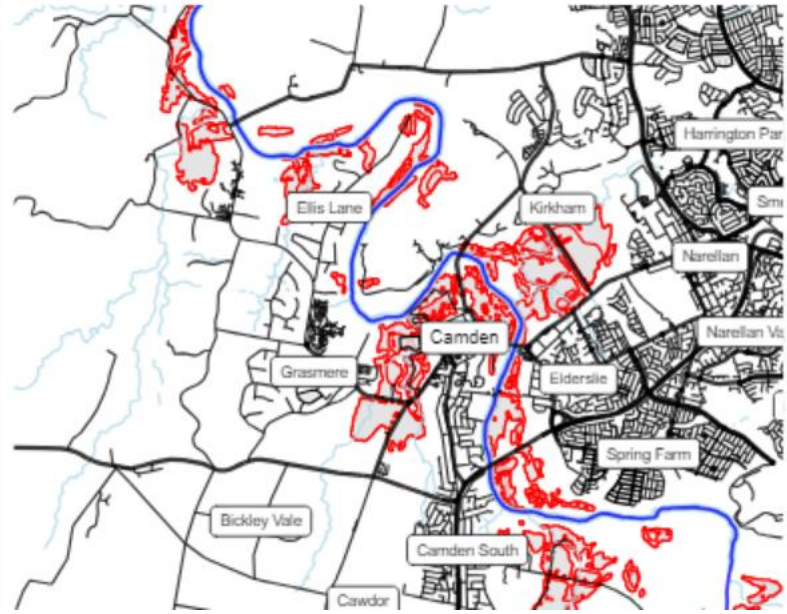


Table 32: SES flood classifications attained by SWSPHN region LGAs during the 2022 flooding event (Laboratory 2023)

Local Government Area	Flood Classification	Times Classified
Camden	Moderate	1
Campbelltown	Major	1
Canterbury-Bankstown	<Minor Moderate	1 1
Fairfield		
Liverpool	Moderate	1
Wingecarribee		
Wollondilly	Major	1

Climate change is expected to make storms and flooding more severe (AdaptNSW 2024). The floods of 2022 were the third most severe in the history of New South Wales. This climate-related event had an immense impact on people and communities in the South Western Sydney region, particularly those in the

Camden, Campbelltown and Wollondilly Local Government Areas. Across Sydney, an estimated 85,000 individuals were either forcibly displaced or requested to evacuate their residences by relevant authorities (Wikipedia 2022). Significant impacts of this flood included:

- 150 evacuation orders and warnings
- over 140 rescues
- 19,000 homes lost power.
- tens of thousands of people were displaced

Health effects

Floods bring extensive losses of property, livestock, wildlife and infrastructure leaving behind serious economic burden. There are immediate and longer-term impacts on physical health, mental health and wellbeing from flooding. Immediate impacts include injuries, drownings, infections from contaminated water and food, bites from snakes and spiders, high levels of stress and anxiety, and in the aftermath, increased vector-borne disease.

Key issue for our region	Increase in mental health presentations following flood events

Floods lead to displacement and restricted access to food, support networks, health care, and social services, thereby having a considerable effect on the psychological health and wellbeing of affected individuals and communities. A global systematic review of 83 studies has revealed that direct and indirect exposure to floods can lead to an increased risk of post-traumatic stress disorder (PTSD), psychological distress, depression, and anxiety in flood-affected areas, as compared to unaffected regions (Institute 2021). The risk of experiencing flood related mental health issues include the level of exposure to the flood event, the degree of warning received, pre-existing physical and mental difficulties and the level of social support available. Psychological stress may be compounded by repeated exposure to disasters such as people exposed to the bushfires of 2019 – 2020, COVID-19 2020 – 2021, and flooding in 2022. SWS general practice data shows that from a baseline of 1764 in 2021, PTSD diagnoses increased in 2022 and 2023, 2102 and 2338 respectively, before declining to 2266 in 2024. This may have been associated with climate events (SWSPHN 2025c).

Priority Populations

Some of the region's population groups are more vulnerable to long-term mental health impacts from extreme weather events and disasters. These events may worsen disadvantage and social marginalisation for people living in poverty or low socioeconomic areas, First Nations communities, people from CALD and refugee backgrounds, people with disabilities and their carers, and older people (Chandonnet 2021, Li 2023, Beggs, Trueck et al. 2024). Contributing factors include, but are not limited to:

- poorer quality housing that is less likely to withstand extreme events
- existing economic disadvantage that limits resources available for recovery
- fewer social networks
- existing health conditions

- poor English language proficiency and lack of knowledge about extreme weather events and the local landscape amongst CALD and refugee people
- pre and during migration trauma
- lack of in-language information, emergency planning tools and culturally appropriate emergency services and support within the community

The SWSPHN region is prone to hazardous weather events and natural disasters. Between December 2020 and January 2021, SWSPHN undertook a rapid needs assessment into supporting our community during bushfires. Since then, there is an increasing realisation that primary health care and the PHN have a role to play in disaster preparedness and response. With the region's ongoing risk of bushfires, flooding and heatwaves, the findings of the needs assessment, being applicable to other climate related events and disasters, have formed the basis of an expanded body of work with the following objectives that have been actioned by SWSPHN:

- improve awareness of and access to non-clinical and clinical bushfire related services
- increase availability of information related to wellbeing and disaster planning and recovery in English and dominant community languages
- encourage coordination and communication between services
- improve sense of connection to the community and participation through community-led engagement initiatives
- build capacity of service providers so community members receive trauma informed care and support
- improve sense of preparedness for service providers to respond to the mental health needs of communities affected by climate events and disasters.

2.4.4: COVID-19

The COVID-19 pandemic in NSW was part of the ongoing worldwide pandemic caused by SARS-CoV-2 virus. The epidemiology of COVID-19 in NSW continued to evolve from the first three cases reported in NSW on 25 January 2020 in people who acquired their infection in China.

- On 25 February 2020, the Australian Government activated the Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements.
- On 11 March 2020, WHO declared a worldwide pandemic.
- On 20 October 2023, the Australian Government determined that the COVID-19 pandemic was no longer a Communicable Disease Incident of National Significance (CDINS).

Key issue for our region	**Persistently high numbers of COVID infections**

COVID-19 is now managed in the same way as other common viral diseases, with a focus on:

- Prevention through vaccination,
- reducing transmission through good hygiene; and
- managing serious illness, hospitalisations and death (DHDA 2025b).

This history of the impact of COVID-19 on SWS is provided to aid understanding of health patterns between 2020 and 2025. It can be used to assist health planning and will remain in the needs assessment at least until the 2028–2031 report is prepared.

The first locally acquired COVID-19 case in NSW was reported on 2 March 2020 and by mid-March case numbers had increased rapidly among overseas returned travellers and their contacts and within localised community outbreaks. In NSW, the number of reported daily cases peaked on 27 March 2020 at 213 cases. Public health action and the introduction of a range of stringent Federal and NSW control measures led to a decline in cases. Community transmission was interrupted by the end of May 2020. Further 2020 outbreaks occurred in November and December; however, both were interrupted by January 2021.

The outbreak of the highly infectious delta strain across NSW began in mid-June 2021 in Sydney's east and spread from there to SWS. Clusters developed across the state prompting NSW government to reimpose a strict lockdown in Greater Sydney, the Blue Mountains, the Central Coast and Wollongong. Cases and hospitalisations continued to rise till October 2021 reaching a peak NSW daily record of 1,599 cases on 10 September 2021. On 30 October 2021, there had been 75,112 confirmed cases and 574 deaths in NSW since 13 January 2020(MoH 2021a). In SWS, there had been 22,750 cases as of 1 November 2021(MoH 2021a).

Figure 71: Cumulative Covid 19 cases in SWS as of 30 October 2023 (MoH 2023a)

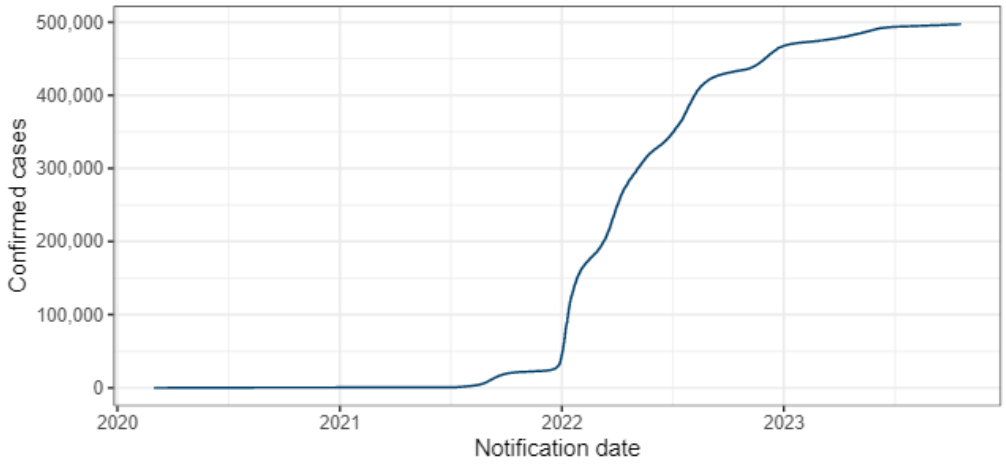
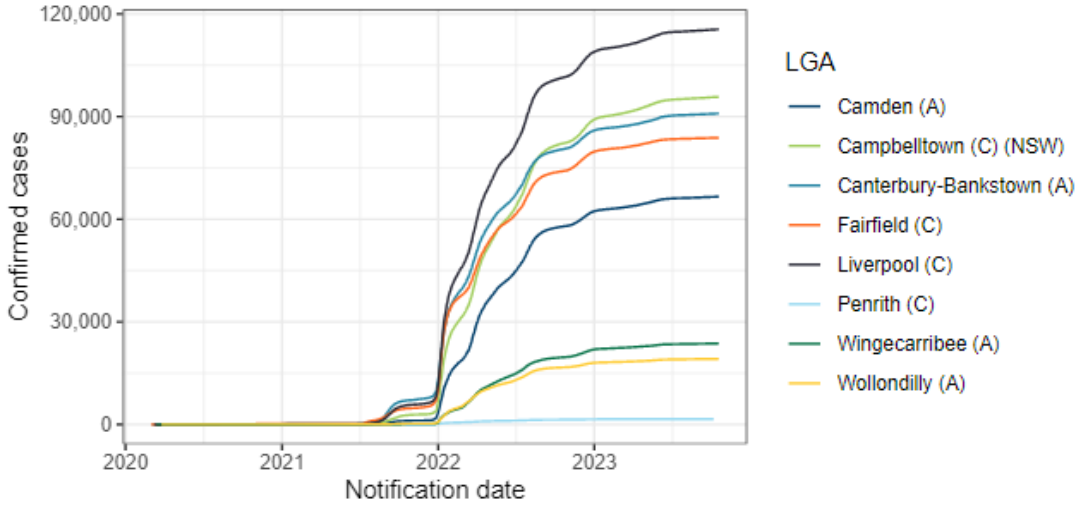


Figure 72: Confirmed Covid 19 cases by LGA, SWS as of 30 October 2023 (MoH 2023b)



Canterbury-Bankstown, Liverpool and Fairfield LGAs were most affected with 364.4, 277.5, and 238 confirmed cases per 10,000 population respectively. Overall, SWS had a rate of 235.4 cases per 10,000 population. Most affected post-codes were 2200, 2190, 2570, 2560, 2165, and 2170.

Hospitalisations and deaths

In SWS, 22,300 cases were reported in the delta wave, and approximately 10% (2269 admissions) required hospitalisation. 16% (1.6% of all cases) of hospital admissions (363 people) required intensive care and 84% of patients recovered in the community. There were 187 COVID deaths from 22 June to 25 November 2021.

The Omicron variant

The Omicron COVID-19 variant, first reported in South Africa on 24 November 2021, caused an outbreak across Australia and NSW, forcing businesses to shut down due to virus-related staff shortages amid few COVID 19 restrictions. It caused a rapid surge in cases and hospitalisations and led to critical staff shortages across some of the largest hospitals in Sydney as more than 4,000 were furloughed due to contracting COVID-19 or due to isolation needs following exposure. The Australian Technical Advisory Group on

Immunisation (ATAGI) updated their advice and reduced the time between primary courses and booster vaccine doses to three months.

Mental health service use

According to NSW Mental Health Commission COVID-19 community wellbeing survey in July 2021 (MHCNSW 2021):

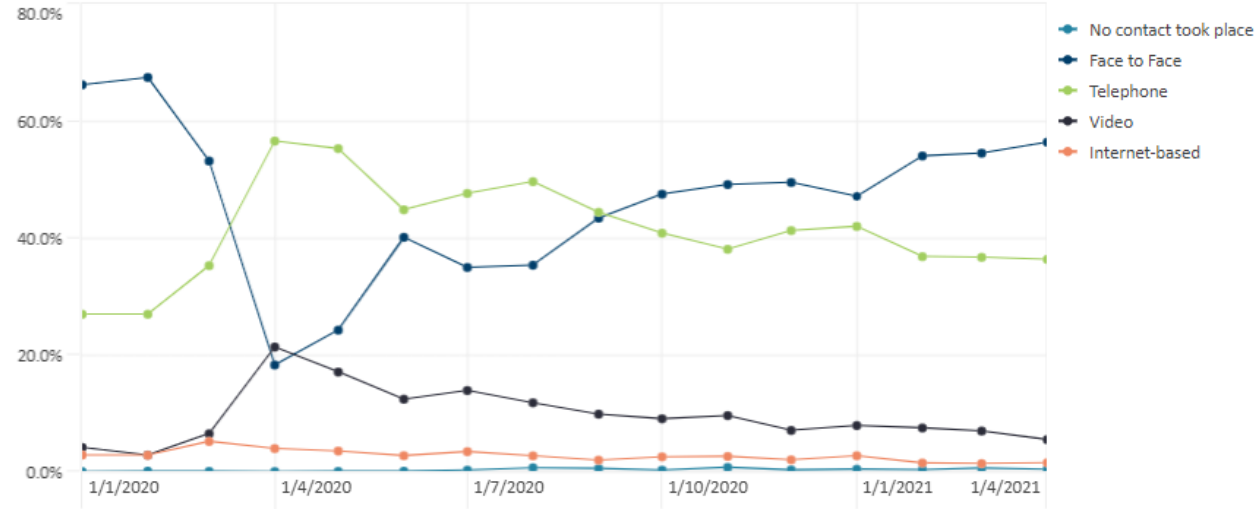
- Age was significantly associated with how COVID-19 impacted people's lives. Younger adults (18–29-year-olds) felt more negative impacts on their relationships, health, work/study, and finances, compared to older people.
- About one in two people accessed some type of formal or informal support during 2020 and it was recognised that a range of services will continue to be needed to support NSW's recovery from the impacts of the pandemic.
- Services through GPs, online advice about typical mental health issues, and guidance for supporting young people were the top preferences to ensure that mental health is supported post-COVID.
- Majority of services were delivered via telehealth
- The volume of mental health-related PBS prescriptions dispensed spiked in March 2020 when the first restrictions were introduced
- In the four weeks to 24 January 2021, Beyond Blue received over 22,000 contacts (an increase of 27.2% and 29.6% from the four weeks to 26 January 2020 and 27 January 2019 respectively).

An analysis of COVID-19 mental health-related data by AIHW summarised the key impacts of COVID-19 in Australia (AIHW 2021j): There have been temporary increases in mental health service use around lockdowns evidenced by large increases in contacts with support organisations such as Beyond Blue and Kids Helpline. It also notes an increase in self-harm presentations of children at EDs during the pandemic as well as longer term metal health effects related to COVID-19.

Increased use of telehealth and video mental health services during COVID-19 pandemic

For SWSPHN commissioned mental health services, consultations via telephone have increased from 26.9% (of all consultations) in January 2020 to 56.5% in April 2020 at its peak, then gradually declined and maintained at around 36.8%. Consultations via video increased from 4.1% to 21.3% during the same period and remained at around 7%. Face-to-face consultations have seen a sharp decrease from 66.2% of all consultations in January 2020 to 18.2% in April 2020, then gradually climbed back to 56.3% in April 2021.

Figure 73: SWSPHN Commissioned Mental Health services by modality, Jan 2020 - Apr 2021 (SWSPHN 2021)

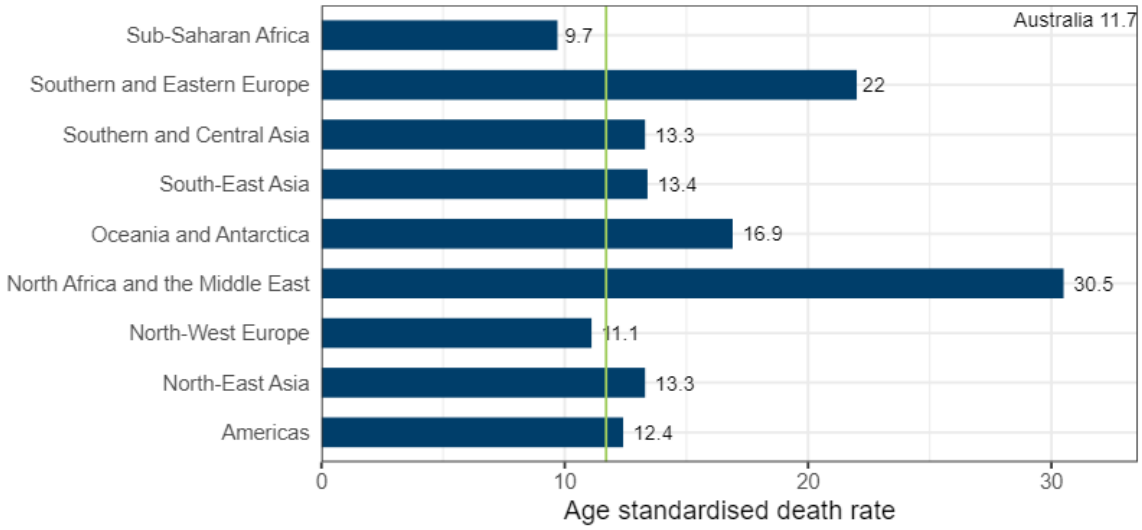


Impacts on CALD and Refugee health

Culturally and Linguistically Diverse (CALD) and refugee communities were significantly impacted by the pandemic, both socially and physically. These groups faced an elevated risk of morbidity and mortality from COVID-19. Those born overseas who died from COVID-19 had an age-standardised death rate 1.4 times higher than people born in Australia (16.0 deaths per 100,000 people compared to 11.7 deaths).

In 2020, the age-standardised death rate for those born overseas was 2.1 times higher, rising to 3.9 times higher in 2021, before decreasing to 1.3 times higher in 2022.

Figure 74: Age standardised COVID-19 death rates by Country of Birth to 30-9-2023 Australia (ABS 2023e)



CALD and refugee groups experienced disproportionate social impacts due to factors such as lower socio-economic status, employment in jobs that could not be performed remotely, crowded living conditions, and limited access to medical care or paid leave. In Fairfield, for instance, people are seven times more likely to work in blue-collar occupations than those in metropolitan Sydney. Fairfield, along with Campbelltown, Canterbury-Bankstown, Blacktown, Liverpool, and Cumberland, were among the eight local government areas (LGAs) where stricter lockdowns and policing were enforced, exacerbating historical mistrust between these communities and government systems.

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Extended lockdowns, isolation, managing home schooling/working from home, job losses, financial pressures, burnout, future uncertainties, not being able to visit loved ones who are sick in hospital, not being with loved ones during their final days, not being able to attend funerals and being restricted from seeing family and friends has had major negative mental health effects across population groups in SWS.

A survey of SWS CALD and refugee communities (Voola 2021) revealed the following:

- Top three mental health concerns impacted by COVID-19:
    - Increased feelings of loneliness/isolation
    - Increased anxiety and/or psychological distress
    - Increased prevalence of stress and burnout
- The most vulnerable population groups in SWS due to the impact of COVID-19:
    - Health professionals and front-line workers
    - Young people (12-25) & older adults (25+)
    - Financially disadvantaged/unemployed
    - Culturally and Linguistically Diverse (CALD) and Refugee groups
- Top three most needed initiatives to improve mental health of residents in SWS:
    - Initiatives that promote mental health and decrease stigma among community
    - Psychological therapies
    - Psychosocial services and suicide prevention approaches

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