Population Health Needs Assessment for the Communities of South Western Sydney and the Southern Highlands

November 2014

NSW GOVERNMENT Health
South Western Sydney Local Health District

medicare local
SOUTH WESTERN SYDNEY
Connecting health to meet local needs

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Foreword

It has been just over 12 months since the release of the Population Health Needs Assessment for the Communities of South Western Sydney – Initial Report, and significant progress has been made.

Recognizing the striking diversity of South Western Sydney, we've strengthened our engagement with population groups whose particular needs may not have been fully explored during our first round of consultation. To this end, we actively sought to engage the people and service providers among the Aboriginal community, culturally and linguistically diverse communities, young people, aged people and people living with severe and persistent mental illnesses.

Throughout this process, I have been encouraged by the honest and constructive reflections that our communities have shared with us about the state of health in South Western Sydney. I have found people from all walks of life to be very generous with their time and experience, and it is because of this that our needs assessment work is possible. It is feedback like this that strengthens our resolve to actively address the needs of our diverse area.

You may notice some significant changes from this version to the last. As a result of community feedback we have added to our initial 10 priority areas, Aboriginal Health, Aged Care and Culturally and Linguistically Diverse communities.

We've also utilised this time to further refine our strategies for addressing the now 13 priority areas. This involved an extensive literature review and consultation with field experts and the community. In each case, the aim is to ensure that we drive quality interventions supported by evidence to optimise possible benefit to the community.

I would like to extend my sincere gratitude to the executive and staff of the South Western Sydney Local Health District (SWSLHD) for all of their support. In particular, the contributions of the SWSLHD's Planning Unit, who partnered with us to jointly develop our needs assessment. Without their support and expertise, this product would not have been possible.

During this process, the Australian Government has undertaken significant review of the health sector. One subsequent outcome is the decision to lapse funding to Medicare Locals and redirect this to contracts for larger Primary Health Networks. Despite these announcements, we still felt it important to deliver a high quality needs assessment with a long-term perspective. This will allow all our stakeholders, including the Primary Health Network that will service South Western Sydney, to use and effectively apply this resource and meet the needs of the local community.

We therefore trust that this work is our legacy in making a tangible contribution to the health landscape of South Western Sydney and extend a heartfelt thank you to all involved.

"It is good to have an end to journey toward; but it is the journey that matters, in the end." - Ernest Hemingway

Regards,

Dr Matthew Gray
Chair, South Western Sydney Medicare Local

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Executive Summary

South Western Sydney covers the south western suburbs of metropolitan Sydney and extends south to the Southern Highlands, an area of 6,243 square kilometres. It includes the seven Local Government Areas (LGAs) of Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly.

South Western Sydney Medicare Local was established in 2012 by the Australian Government as the key body for integrated, quality primary health care services in South Western Sydney. It is a requirement for Medicare Locals to assess the needs of their region in order to develop locally focussed solutions. The Needs Assessment process commenced in late 2012 with data collection, consultation and literature review, to develop an interim report. The outcomes were fed back to the community in 2013 and work to develop a more complete picture of the health of South Western Sydney was undertaken. The result is this Population Health Needs Assessment report, which aims to provide a better understanding of the health status of local communities.

This Needs Assessment provides an overview of the demographic and health characteristics of the communities which reside in South Western Sydney; the health services available, how they are used, how they work together to meet patient needs and the workforce that provides health care.

An estimated 875,763 people live in South Western Sydney, predominantly in the more densely populated areas of Bankstown, Fairfield, Liverpool and Campbelltown. It has a relatively young profile, with 21% of residents under 15 years of age and a further 15% in the 15-24 year age range.

The region has experienced considerable growth which extends across all LGAs. High fertility rates and new urban development are the major sources of growth. Substantial growth is projected over the next 10 -20 years, driven by the urban development in the South West Growth Centre (in Camden and Liverpool), new developments in Wollondilly and urban infill in established areas. At the same time, the aged population which is currently relatively small will grow by 45%.

South Western Sydney is characterised by its diversity. There is a large Aboriginal community of 13,070 people and 36% of residents were born overseas. In Fairfield LGA 74% of residents speak a language other than English at home while in Bankstown, Liverpool and Campbelltown LGAs 60%, 55% and 30% of residents speak a language other than English at home, respectively. There are pockets of considerable disadvantage with Fairfield, Liverpool, Bankstown and Campbelltown amongst the most disadvantaged LGAs in metropolitan Sydney. Approximately 9% of residents live in metropolitan fringe LGAs of Wingecarribee and Wollondilly, many in smaller towns and rural properties. The disadvantage of geographical isolation is accentuated by relatively poor public transport and high dependence on private transport. It is also an issue for people in new housing estates and in locations of greater socioeconomic disadvantage, such as public housing estates.

National and state surveys indicate that on a range of measures the health of residents in South Western Sydney is poorer than for NSW as a whole. 79% of South Western Sydney residents consider their health to be very good, good or excellent (compared with 82% of NSW residents); 12.9% report high or very high levels of psychological distress (compared to 10.3% for NSW); 44% report adequate levels of physical activity; 51% report eating the recommended daily fruit intake; 19% are current smokers; 20% drink at risky levels; and 21% report they are obese. The trends indicate that demand for health care in the future will grow.

Health data on mortality and morbidity also indicates patterns of concern:

- Cardiovascular disease is the most common cause of death and the reason for a large proportion of hospitalisations. Rates were particularly high in Campbelltown.
- The death rate and hospitalisations due to diabetes were higher than the state average, and were particularly high in Fairfield.
- 14.8% of people in NSW treated for chronic kidney disease (CKD) reside in South Western Sydney. Rates of CKD are higher than NSW for all LGAs except Camden and Wollondilly.
- In the years 2004-2006, there were 16,609 cases of cancer with mortality rates higher than the NSW rate. Participation in early detection programs such as breast and cervical cancer screening is well below the NSW target.
- There were 16,123 hospitalisations related to respiratory disease in 2012-13. The rate of hospitalisations for Aboriginal people was well above the local rate.
- Injury and poisoning is the leading cause of death for people under 45 years. Common causes of injury related death are suicide (25%), motor vehicle accidents (17%) and falls (12%).
- Schizophrenia and major affective disorders are the major reasons for a mental health admission to hospital.
- The region has the 2nd highest number of notifications for Hepatitis B in NSW, with notifications particularly high in Fairfield and Bankstown. SWS also has the 4th highest number of notifications for Hepatitis C.
- 46% of residents report a long term health condition i.e. the 5th highest level of any metropolitan region.
- Both infant mortality and child mortality rates are higher in Campbelltown LGA than other LGAs in South Western Sydney, and are higher than the NSW state averages. Only 56% of women attend their first antenatal visit before 14 weeks and 15.3% report smoking during pregnancy.
- Children in Bankstown, Campbelltown, Fairfield and Liverpool have higher levels of developmental vulnerability in two or more domains than the NSW average.
- Rates of potentially avoidable deaths in Bankstown and Campbelltown and preventable hospitalisations in Campbelltown, Wingecarribee and Bankstown are above the NSW average.

The region has a number of communities which experience poorer health. For example, on a range of indicators the health of Aboriginal people in South Western Sydney is poorer than that of other local residents. Other people at heightened risk include those with mental health conditions, intellectual or physical disabilities; carers; people from non-English speaking backgrounds; people in contact with the criminal justice system; people living in public housing estates or in rural areas; people with drug and alcohol problems; people who are homeless; and children who are in care or in families with child protection issues.

Primary and specialist health services prevent and treat health problems. Issues identified through the needs assessment process include:

- General practitioner (GP) headcount to population ratios range from 1 GP for 568 residents in Wingecarribee to 1 GP per 2,200 residents in Wollondilly. Practice nurses who increase access to health care and follow-up are predominantly used by practices in Wingecarribee and Campbelltown LGAs.
- The relatively high levels of bulk billing by GPs in the region improves access however cost is a significant barrier for access to medical specialists, dental services, allied health services and when filling a prescription.
- Although after hours GP services operate across the region, more than half of the after-hours presentations were through Emergency Departments (ED).
- Waiting times are a barrier particularly to medical specialists and allied health and for some dental services. This reflects an underdeveloped private sector in parts of the region and gaps in

public outpatient services. Waiting times for planned surgery meet the NSW target for all surgery types except non-urgent surgery and waiting times for ED are below the NSW target.

- Information about specialist services, referral processes, waiting times and service criteria is poorly developed and deficits in verbal communication and information sharing hamper transfer of care and service provision.
- Many primary healthcare providers are reluctant to adopt meaningful use of the ehealth record system within their practices. This affects the availability of the system to the population of South Western Sydney.
- Knowledge and use of the Medicare Australia Practice Incentive Program (PIP) by GPs is varied. Use of brief intervention tools, health checks and health plans such as the Diabetes Cycle of Care requires attention. Targeted programs such as Connecting Care and sustained home nurse visiting programs are well utilised and well regarded.
- There are considerable gaps and inequities in some specialist health and community services including mental health, rehabilitation, health promotion and immunisation. The increased demand for health related transport in particular is not considered sustainable.
- The demographic and health profile of local communities means that a broader range of responses is required including outreach and targeted service provision and a stronger focus on prevention
- The General Practice workforce is ageing, particularly in Fairfield where there are a large number of solo practices. With significant projected growth and ageing of local communities, planning for growing the primary care workforce is critical.

The Needs Assessment identifies thirteen priority areas for immediate attention: Mental health; Overweight and Obesity; Tobacco; Chronic Disease - Diabetes and Cardiovascular Disease; Cancer; Pregnancy and the Early Years; Strengthening prevention; Advocacy; Information: Workforce; Aboriginal Health; Aged care and Culturally and Linguistically Diverse Communities. Strategies have been identified to address these priorities, including a strong focus on information sharing about the findings from this Needs Assessment.

To support the information provided in this Report, a supplementary data report entitled *Health Indicators for the Communities of South Western Sydney and the Southern Highlands* has been produced. The supplementary report brings together publically available information about the health and other characteristics of local communities in South Western Sydney and the Southern Highlands. It is anticipated that this will be a useful resource for health professionals, local agencies and the broader community. Where possible, data is reported at an LGA level. Please note that in some circumstances, the most recently available statistics are only at whole region level. The most recent statistics are contained within this report, for LGA level statistics for the previous reporting period, please refer to the supplementary report.

1. Background

As part of the Australian Government's National Health Reform agenda, sixty one Medicare Locals were established across Australia to work with local primary health care providers, such as general practitioners (GPs), Local Health Districts and communities to ensure that patients receive "*the right care in the right place at the right time*" and to help reorient the health system away from acute hospital based care. Medicare Locals were established with the following national strategic objectives:

1. Improving the patient journey through developing integrated and coordinated services
2. Provide support to clinicians and service providers to improve patient care
3. Identification of the health needs of local areas and development of locally focussed and responsive services
4. Facilitation of the implementation and successful performance of primary health care initiatives and programs
5. Be efficient and accountable with strong governance and effective management

South Western Sydney Medicare Local

Vision: To be the principal organisation which delivers an effective & innovative integrated primary health care system for the residents of our region.

Mission: To enhance and connect primary health care so residents and patients achieve better health outcomes.
Service Standard Aim: To deliver and support primary care services so all residents in our region can access the right care, at the right time, by the right people, at the right location.

South Western Sydney Medicare Local Ltd. (SWSML) was established in July 2012. It is the prime body for integrated, quality primary health care services delivered in South Western Sydney, covering the Local Government Areas of Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly.

As part of the funding agreement with the Australian Government, Medicare Locals are required to identify the health needs of populations within the local area and develop locally-focused and responsive services. The agreement requires Medicare Locals to undertake health needs assessments and planning. The needs assessment identifies key health priorities and activities for addressing the health needs of the local community, these activities are incorporated into the organisation's annual plan.

A national review of Medicare Locals was conducted by Professor John Horvarth AO in December 2013, and some measures of this review were subsequently adopted in the Federal Budget in May 2014.

Key points include:

- Closure of 61 Medicare Locals and establishment of fewer Primary Health Networks (PHNs) by June 2015
- Contestable processes for establishment of PHNs, which may include private not-for-profit organisations. The tendering process began in late 2014, with successful PHNs to establish in the last three months of the 2014-15 financial year.
- Closure of the Australian Medicare Local Alliance, a national Medicare Local support agency, effective from 30 June 2014.

In spite of these announcements, SWSML has developed a robust needs assessment which could be adopted by the Primary Health Network.

The Process

In late 2012, South Western Sydney Medicare Local (SWSML) commenced detailed planning for an Interim Population Health Needs Assessment of the communities of South Western Sydney. The aim of the Needs Assessment was to profile the health of local residents, to map local health services and identify service strengths and weaknesses. It also sought to identify priorities for action and the strategies to be undertaken by SWSML in partnership with other agencies. In mid 2013 SWSML submitted an interim needs assessment to the then Department of Health and Ageing. This Interim Needs Assessment was developed in partnership with South Western Sydney Local Health District (SWSLHD). Key steps in this process are detailed below:

- Establishment of a steering committee of key stakeholders including representatives from the SWSML Board and staff, Non-Government Organisations (NGOs), universities, general practitioners, community members and the Local Health District, including experts in epidemiology and population health;
- In depth review of local, state and national policy;
- Extensive data collection and collation;
- Extensive consumer and provider consultation with around 900 people via surveys of local NGOs and Government Organisations, SWSLHD streams and services, residential aged care facilities, allied health practitioners, practice nurses, GPs and community members attending local general practices. In addition 8 community focus groups were held, an NGO consultation meeting, a GP focus group and meetings with SWSLHD clinical service directors;
- Triangulation of these sources to identify 60 broad concerns within three categories- health issues, target populations and systemic issues;
- Prioritisation of these concerns using a modified Hanlon Method for Prioritising Health Problems. The criterion considered were relative size of the problem compared to NSW; absolute number of people affected; policy or other imperatives surrounding the issue; amenability to primary health care; the severity or impact of the health problem on quality of life; the number of stakeholders who identified this as a key problem; and the number of agencies which could partner to address the problem.

The needs assessment found that although there were differences in the health status of residents across the region, on a wide number of health indicators, local residents experienced poorer health and had elevated rates of behaviours, such as smoking, which are linked to poorer health status than other people in NSW. These problems are exacerbated for people experiencing disadvantage. The assessment also found that there were differences in the quality and quantity of primary and other health care services with opportunities to improve health through a stronger focus on prevention, more consistent use of evidence based practice and stronger referral, communication and a partnership approach between GPs, public health care services, other agencies and the community.

The following initial priorities were determined:

1. Mental Health
2. Overweight and Obesity
3. Tobacco Control
4. Chronic Disease- Diabetes and Cardiovascular Disease
5. Cancer
6. Pregnancy and the Early Years
7. Strengthening Prevention
8. Advocacy

9. Information
10. Workforce

Working parties of people with experience and knowledge in each of the priority areas were then convened to determine promising strategies to address each priority. Working parties comprised of GPs, SWSML staff, community members and carers, NGOs, SWSLHD clinicians and health promotion staff and/or university representatives. A total of 66 potential strategies were identified.

The Steering Committee collectively considered these potential strategies and agreed to 30 priority strategies using criteria such as evidence, cost effectiveness and equity. These recommendations were then endorsed by the SWSML Board.

The Interim Needs Assessment Report was released for comment in mid 2013 and formed the basis of detailed consultations with a range of stakeholders including local non-government organisations, the community, Local Health District clinicians, and general practitioners. Targeted meetings were also held with representatives of hard to reach priority populations i.e. younger people; older people and the frail aged; people living with a disability; people living with mental illness; people from culturally and linguistically diverse communities; Aboriginal people; and refugees and humanitarian arrivals. Over 400 people were engaged in this process.

The 10 priority areas were reviewed by the Steering Committee and the SWSML Board in light of consultation and data. The result was confirmation of the initial 10, with the addition of 3 priority areas.

Confirmed Priorities:

1. Mental Health
2. Overweight and Obesity
3. Tobacco Control
4. Chronic Disease – Diabetes and Cardiovascular Disease
5. Cancer
6. Pregnancy and the early years
7. Strengthening Prevention
8. Advocacy
9. Information
10. Workforce
11. Aboriginal Health
12. Aged care
13. Culturally and Linguistically Diverse Populations

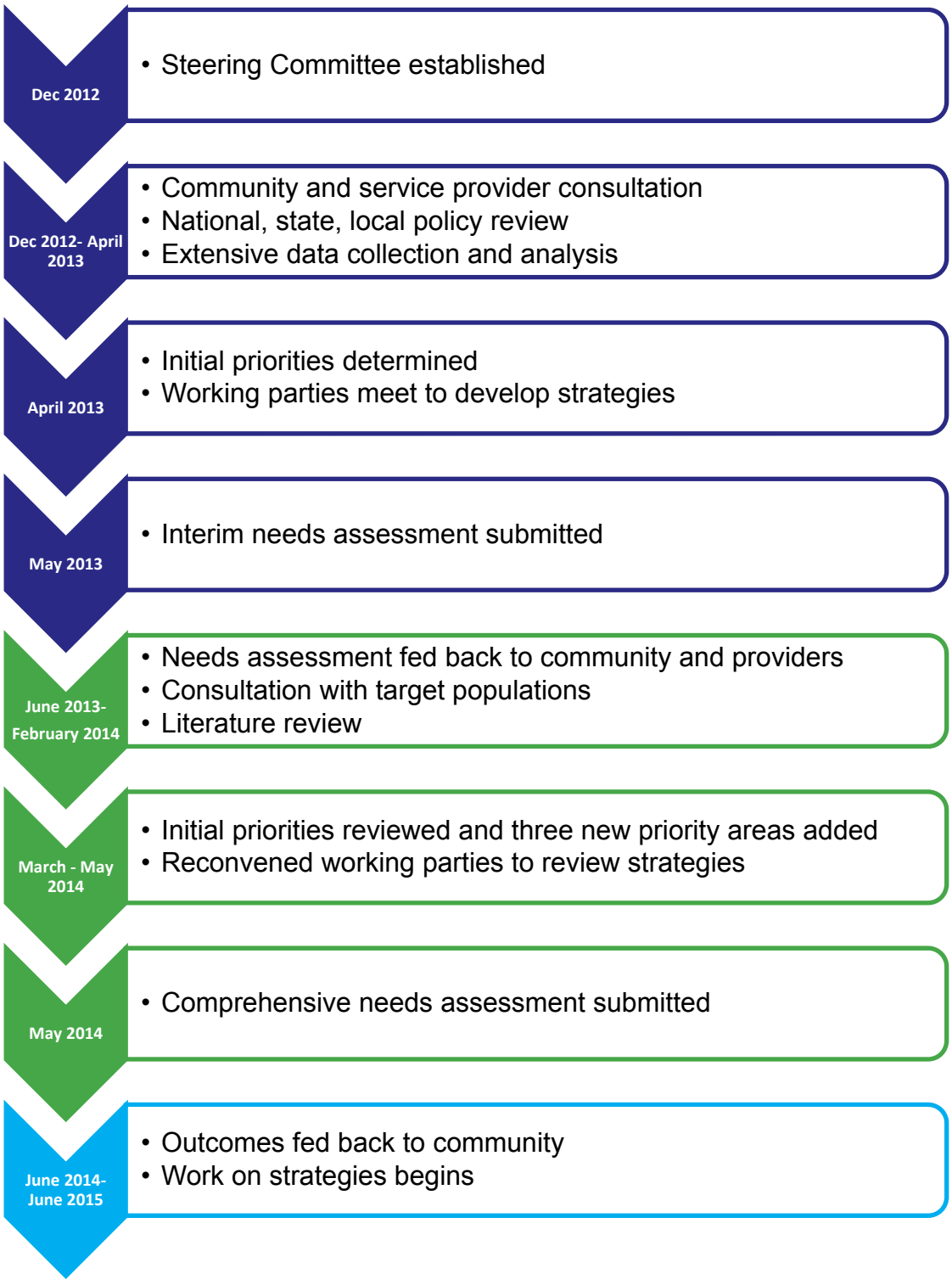
These priorities are not listed in order of importance. Throughout the process, the linkages between these priority areas was acknowledged, and to that end, a matrix was developed to represent the intersect between these areas (Figure 1). The matrix illustrates that systemic issues can improve outcomes in health conditions, and priority populations are afflicted by these health conditions.

Figure 1: Health Priority Matrix for South Western Sydney

A detailed literature review was undertaken which identified over 200 articles (including systematic reviews) about best practice for each priority. High quality systematic reviews for primary healthcare were often not available.

Working parties were reconvened for the 13 priority areas to reconsider the initial strategies in light of the extensive literature review and feedback from the community and hard to reach population groups. Discussion was informed by factors such as equity, reach, evidence, impact and local knowledge. Each strategy was allocated a score for these factors between 1 and 5, and fed back to the working parties for approval. This score allowed strategies to be compared across priority areas. In addition, working parties provided an indication of the most important strategies for advancement. The result was 49 strategies across 13 priority areas. These strategies were reviewed by the Steering Committee. The committee considered the ranking of the 49 strategies, as well as the consensus and recommendations of the working parties. The steering committee shortlisted 17 activities to be advanced in 2014-15. A visual representation of this timeline has been provided in Figure 2.

Figure 2: Process Diagram Timeline of Events 2012 to 2015

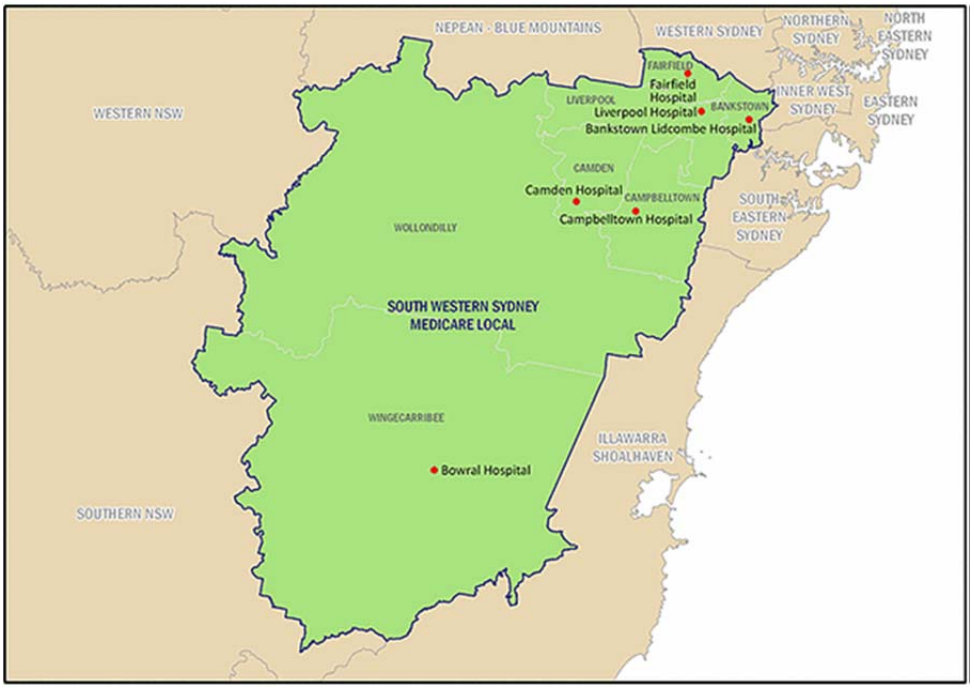


2. The Region

South Western Sydney Medicare Local covers the south western suburbs of metropolitan Sydney and extends south to the Southern Highlands i.e. an area of 6,243 square kilometres. It includes the seven local government areas of Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly.

The established LGAs of Bankstown, Fairfield, Liverpool and Campbelltown combine low and medium density housing with pockets of commercial and industrial areas, and rural areas to the north and west. Camden LGA is still predominantly rural although new housing developments are changing this profile and Wollondilly and Wingecarribee LGAs combine rural towns and villages, agricultural lands and bush.

Figure 3: Geographical Coverage of South Western Sydney



Large national and state parks and rivers predominantly form natural boundaries for the region: the Blue Mountains and Kanangra-Boyd National Parks to the north and north west; the Wollondilly River to the west; Wingello State Forest and Morton National Park to the south; Budderoo National Park in the south east; Lake Cataract, Woronora Special Area, Heathcote Road and Sutherland, Hurstville and Canterbury LGAs to the east; and Auburn LGA and Elizabeth Drive in the north east. South Western Sydney provides 97% of Sydney's water supply with the Georges, Wollondilly and Wingecarribee Rivers forming part of the catchment for Warragamba Dam, Sydney's main water supply. The Avon, Cataract Nepean and Cordeaux Dams are also located in the region.

The climate is temperate in the urban areas however the Southern Highlands experience very cold conditions during winter. Average temperatures range from 25 to 30 degrees in summer and 4 to 18 degrees in winter.

South Western Sydney is home to some of Sydney's major strategic centres. Liverpool is the regional city centre servicing Sydney's south west and parts of regional NSW and is a major employment

centre, transport hub and shopping region. Campbelltown and Bankstown are major shopping, business and civic centres for local communities and the *Draft Metropolitan Strategy for Sydney to 2031* identifies that Fairfield, Prairiewood and Leppington are earmarked to become major centres of Sydney in coming years.

In rural areas, Bowral, supported by Mittagong and Moss Vale, function as the major centre for the Southern Highlands. Wollondilly LGA comprises smaller towns including the centres of Picton and Tahmoor and in the Camden LGA; urban development is overtaking the towns of Camden and Narellan.

Major Sydney roads include the M5 motorway which links central Sydney to South West Sydney and the M7 Motorway which provides an orbital link from Prestons to the M2 freeway in the north. Both motorways connect with the F3 Freeway and the Hume Highway, the major arterial road linking Sydney with the major cities in the ACT and Victoria. Other major transport infrastructure includes Bankstown airport and the Southern Rail Link. Increasingly companies are relocating to the region to take advantage of lower land costs, freight access to the M7 and the proposed Moorebank Intermodal being the freight rail link to Port Botany which will provide a pick up and drop off point for an estimated 3,300 trucks per day.

The NSW Government has started work to set aside a future corridor for a South West Rail Link extension to Sydney's proposed second airport at Badgerys Creek. The South West Rail Link involves a new 11.4 kilometre rail line from Glenfield Station and bus/rail interchange, new stations at Edmondson Park and Leppington and a train stabling facility at Rossmore.

Other key industries in the east are construction, manufacturing, property and business, transport and storage while agriculture and mining are found predominately in the Southern Highlands and Macarthur. Tourism is important for the Southern Highlands in particular and generates in excess of 1 million visitors annually.

Major educational facilities are the University of Western Sydney and the South Western Sydney Institute of Technical and Further Education (TAFE), which is one of Australia's largest TAFE Institutes. The Cumberland Campus, University of Sydney is located just outside the borders of the region in Lidcombe.

3. South Western Sydney Communities

Chapters 2, 3 and 4 provide an overview of the communities of South Western Sydney, including the demographic characteristics of the residents and their health.

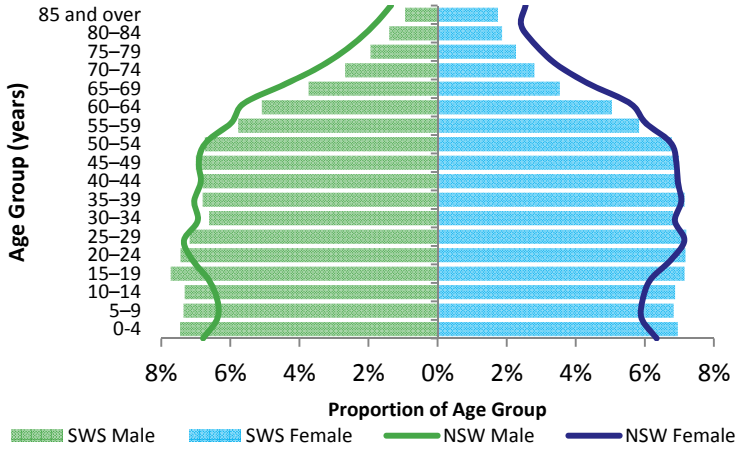
The Estimated Resident Population (2011) for South Western Sydney is 875,763 people i.e. 12% of the population of NSW.[1] The distribution of residents is not evenly spread with the majority of residents (83%) living in Fairfield, Bankstown, Liverpool and Campbelltown LGAs. The uneven spread is reflected in the population density which ranges from 2,518 people per square kilometre (km^2) in Bankstown (well above Sydney's density of 380 people per km^2) to 17.2 people per km^2 in Wollondilly LGA.[2]

In 2013, 13,420 babies were born to local residents, a higher fertility rate than NSW. The highest fertility rates were in Bankstown and Liverpool LGAs (2.21 and 2.14 respectively) and the lowest in Fairfield (1.90) i.e. the only LGA with a fertility rate below that of NSW (1.95).[3]

Table 1: Geographical Size and Population Density of Local Government Areas
Source Australian Classification of Australian Governments

LGA	Size km^2	Pop'n Density (no/$km^{2)}$
Bankstown	77	2,518
Camden	201	301
Campbelltown	312	489
Fairfield	102	1,954
Liverpool	305	626
Wingecarribee	2,689	17.5
Wollondilly	2,561	17.2

Figure 4: Population Structure South Western Sydney compared to NSW 2011
Source ABS Census 2011



As indicated in the figure above, South Western Sydney[4] has a young population profile compared to NSW. There are 187, 274 children aged 0-14 years (21% compared with 19% for NSW) with the largest proportions in the Camden, Liverpool and Wollondilly LGAs. In addition, there are 129,130 young people aged 15 – 24 years (15% compared to 13% for NSW). Campbelltown and Fairfield have the largest proportion of young people (15.9% and 15.4% respectively) and Wingecarribee LGA the lowest (11%).

Working age adults aged 25 – 70 years comprise 56% of the population. Residents of the rural and southern LGAs of Wollondilly, Wingecarribee, Camden and Campbelltown are predominately technicians and trade workers, clerical and administration workers and professionals. In comparison,

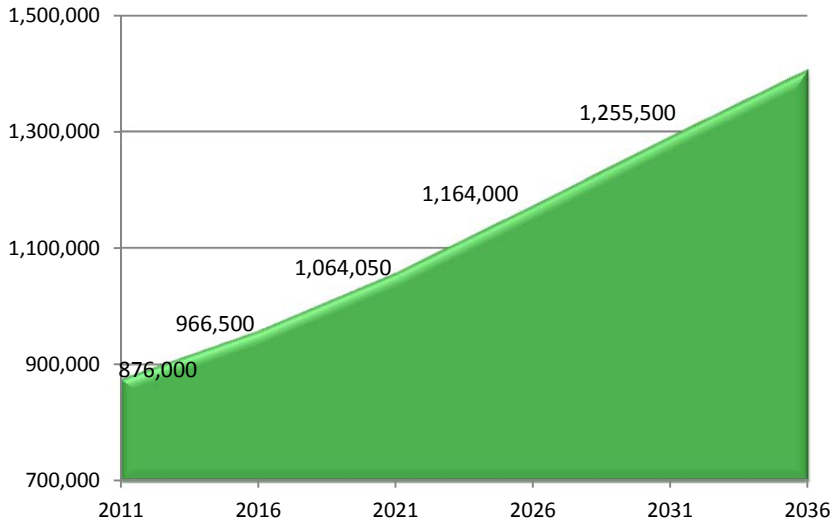
residents of the developed urban areas of Bankstown, Fairfield and Liverpool work mainly in accommodation and food services, retail, construction, clerical and administration. They are more likely to have semi or unskilled jobs such as labourers.

The aged population is smaller than NSW with 68,564 residents aged over 70 years. This includes 11,798 people aged over 85 years (1.4% of the population, compared to 2% for NSW). Residents in Wingecarribee and Bankstown LGAs are older with 2.6% and 2.1% of residents respectively being over 85 years of age.

Population Growth

In the decade to 2011, South Western Sydney experienced substantial growth. Liverpool and Bankstown LGAs were in the five highest growing LGAs in NSW and Camden was the second fastest growing LGA in NSW.[2]

Figure 5: Population Growth in South Western Sydney 2011 to 2036
Source: NSW Health Population Projection Series 1.2009.
Department of Planning and the State-wide Services Development Branch, NSW Health, March 2009



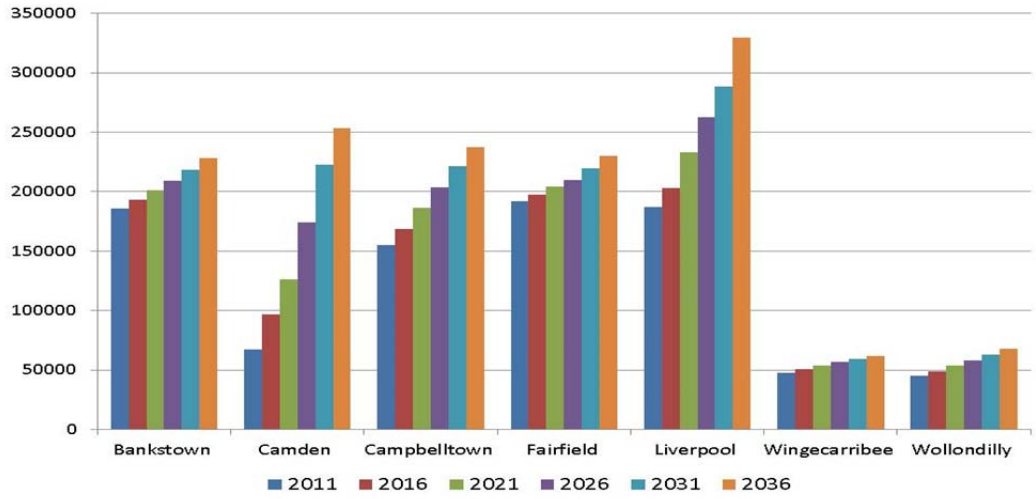
Population growth and changes in the region's age profile is expected to accelerate over the decade 2011- 2021. Growth will be particularly evident in Camden (84.35%), Liverpool (26%) and Campbelltown (23.58%) LGAs. By 2016, a population of 966,500 people is projected with 1,064,050 people by 2021.

Projected population growth will be uneven with the most significant growth occurring in Camden LGA in absolute and relative terms, i.e. 84.3% growth of the population. Least growth is projected for Wingecarribee and Fairfield LGAs. Across the region, there will be substantial increases in the size of communities driven largely by the urban development of the South West Growth Centre, new developments in Wollondilly and urban infill in established areas.

Over the next decade, the number of children (0-14 years) will grow by 22% to 230,097 (in 2021). Those aged 70-84 years will grow by 54% with an additional 19,500 people, with the largest growth in people aged over 85 years (an increase of 60%, or an additional 7,150 people).[5]

Figure 6: Projected Population Growth by LGA 2011 – 2036

NSW Department of Planning and Environment, New South Wales State and Local Government Area Population Projections: 2014 Final



Household Structure

Consistent with a relatively young age structure, the majority of families (52%) are couples with children, higher than the NSW average (45.5%) for all LGAs except Wingecarribee (38.9%), which has an older population. Wingecarribee (26%) has the highest proportion of lone person households, slightly above the NSW average (24%), reflecting the LGA's older age profile.

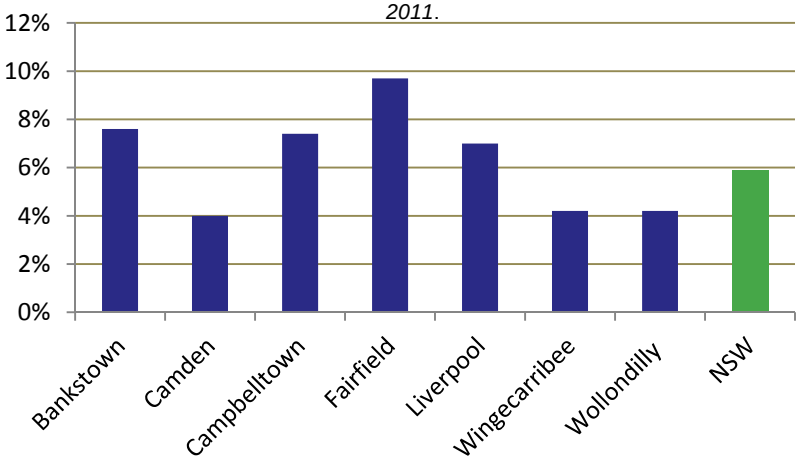
The proportion of single parent families of 19% is higher than the NSW average (16%), with the highest in Bankstown (19%), Campbelltown (22%) and Fairfield (23%).

Socioeconomic Status

The people of South Western Sydney are socioeconomically diverse. Residents of Camden and Wollondilly are generally of a higher socioeconomic status than the rest of the region, with Wingecarribee also similar to the State average for most indicators. On a range of indicators, socioeconomic status varies across the region with greater disadvantage in the more established LGAs of Bankstown, Liverpool, Fairfield and Campbelltown and a profile similar to or above the NSW average in Camden, Wingecarribee and Wollondilly.[4] Specifically,

Figure 7: Proportion of people unemployed (over 15 years)

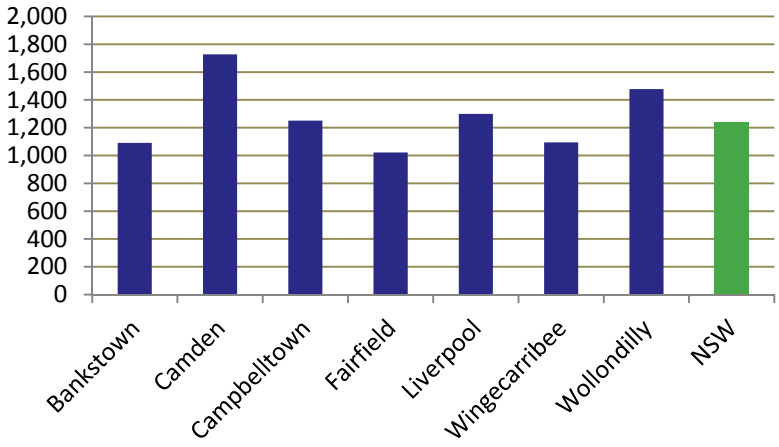
Australian Bureau of Statistics, Census of Population and Housing 2011.



- There is a higher level of unemployment in Fairfield, Liverpool, Bankstown and Campbelltown than the NSW average (Figure 7).
- Median household incomes in Fairfield, Bankstown and Wingecarribee are below NSW household income of $1,237 per week. Median individual incomes are higher than the NSW average in Wollondilly and Camden LGAs (Figure 8).

- There is a higher proportion (41%) of residents aged 15 years and over that have been educated to year 10 or equivalent, compared to NSW (37%). This is true for all LGAs except Liverpool.
- As indicated above, Wingecarribee has the highest proportion of lone person households in the region and the proportion of single parent families is highest in Bankstown, Campbelltown and Fairfield.
- Internet access (benefiting education and health literacy) is variable. Across NSW approximately 4 in 5 people are connected to the internet at home, however in Fairfield and Bankstown LGAs 25.3% and 23.2% of residents respectively have no internet connection.
- There is a higher use of private cars than the NSW average in every LGA. Public transport use is lower than the NSW average in all LGAs except Bankstown and Campbelltown, with use particularly low in Wingecarribee and Wollondilly at 1.8% and 2.1%.

Figure 8: Median weekly household income
Australian Bureau of Statistics, Census of Population and Housing 2011



The *Australian Bureau of Statistics Socio-economic Indexes for Disadvantage* (SEIFA) (2011) [6] indicates that South Western Sydney has some of the poorest communities in NSW. Regions which score below 1,000 on the Index of Relative Socioeconomic Disadvantaged (IRSD) are considered disadvantaged, compared with regions which score above 1,000.

Fairfield (886), Bankstown (946), Campbelltown (939) and Liverpool (968) are in the ten most disadvantaged LGAs in metropolitan Sydney, with IRSD scores well below the Australian average of 1,000. At a suburb level this disadvantage becomes most apparent, with twenty-nine local suburbs in NSW's ten percent most disadvantaged suburbs. They are all located in Campbelltown, Fairfield, Liverpool and Bankstown LGAs. The table following lists these disadvantaged suburbs. Of note is that 14 of the 20 most disadvantaged suburbs in metropolitan Sydney are in South Western Sydney.

Table 2: Suburbs in South Western Sydney with the highest level of disadvantage (Source: ABS SEIFA 2011)

Suburb	Rank in SWSLHD	SEIFA Score	Rank in NSW	Local Government Area
Claymore	1	576	5	Campbelltown
Airds	2	622	7	Campbelltown
Miller	3	734	14	Liverpool
Cartwright	4	763	24	Liverpool
Villawood	5	763	25	Bankstown / Fairfield
Ashcroft	6	763	26	Liverpool
Sadleir	7	775	31	Liverpool
Cabramatta	8	777	32	Fairfield
Warwick Farm	9	793	41	Liverpool
Yennora	10	801	48	Fairfield / Holroyd
Heckenberg	11	802	49	Liverpool
Busby	12	812	60	Liverpool
Canley Vale	13	820	69	Fairfield
Fairfield	14	823	72	Fairfield
Carramar	15	830	82	Fairfield
Cabramatta West	16	838	90	Fairfield
Fairfield East	17	842	101	Fairfield
Canley Heights	18	844	107	Fairfield
Bonnyrigg	19	850	121	Fairfield
Fairfield Heights	20	854	130	Fairfield
Lurnea	21	862	149	Liverpool
Macquarie Fields	22	867	166	Campbelltown
Liverpool	23	869	169	Liverpool
Mount Pritchard	24	887	246	Liverpool
Smithfield	25	888	251	Fairfield
Old Guildford	26	888	253	Fairfield / Bankstown
Bankstown	27	891	273	Bankstown
Chester Hill	28	894	291	Bankstown

Other Characteristics and Determinants of Health

Social capital provides a measure of the community's health, well-being and productivity. The presence of social capital is identified through social networks and communities, with those fully engaged in social networks less likely to participate in risky behaviours. As indicated in Figure 9 following, local residents perceive their community to be less safe than the average community in NSW. In 2013 only 67% of SWS residents reported that they felt most people can be trusted and 65% felt safe walking down their street after dark, compared to 77%, and 75% respectively for NSW. Poorer social cohesion was reported in the community than the NSW average, with less than half of respondents (39%) feeling they could ask someone in the neighbourhood to care for their child and 53% saying they had visited someone in the neighbourhood in the last week (compared to 53% and 60% respectively for NSW).[7] Please note, many of the data indicators presented in this section are reported for the entire region only. This is because the most up to date information available does not currently provide an LGA level breakdown. LGA level data for these indicators is available in the supplementary Data Report, but pertain to the previous reporting period.

Figure 9: Social capital, South Western Sydney residents 2011-12
Source: NSW Population Health Surveys

The NSW Bureau of Crime Statistics and Research indicates higher rates per 100,000 of incidents of domestic assault for the period between January 2012 and December 2013, in Campbelltown (592.6), Liverpool (475.5) and Bankstown (387.2) LGAs compared with NSW (380.9). Incidents of assault were higher in Campbelltown LGA (1227.0 per 100,000) and slightly higher in Liverpool LGA (910.6 per 100,000) than NSW (903.7 per 100,000). South Western Sydney has also been the scene for outbreaks of community disturbance including in the Housing NSW areas of Airds and Macquarie Fields; anti-Islamic sentiment demonstrations in Camden; and drive-by shootings in the north of the region. These occurrences which are reported in metropolitan media reinforce residents perceptions about local safety.[8]

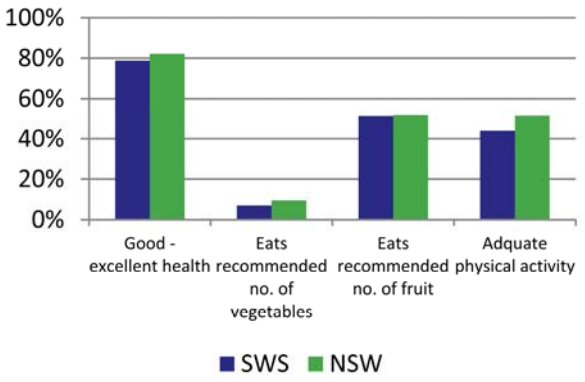
In 2012, about 8.3% of local residents aged over 16 years reported that they had experienced food insecurity in the previous 12 months compared to 7.2% for NSW. Food insecurity exists when people lack sustainable physical or economic access to enough safe, nutritious, and socially acceptable food for a healthy and productive life. The pattern of food insecurity in the region was different to that of the state. At a state level, food insecurity is fairly evenly spread across age groups, however for South Western Sydney there were greater reports of food insecurity for people in the 25-39 year age bracket (29%), compared to NSW (19.4%). People aged over 80 years experienced the lowest levels of food insecurity at both the region and state level. Also of note is that locally there are differences between the genders, with men experiencing less food insecurity than women overall, but with the highest level in the region recorded for men aged 30-39 years.[9] Rates of food insecurity are much higher in Aboriginal people, 20.6% compared with 6.9% for non-Aboriginal people within NSW. The Fairfield (LGA) Nutrition Project (2008) by NSW Refugee Health Service found that some refugee communities settled in the Fairfield Local Government Area were eight times more likely to be food insecure than the greater Australian population, and two and a half times more likely to experience food insecurity than residents of a similar Sydney suburb. This represents an overall prevalence of 42% for food insecurity and 11% for hunger among refugees settled in the Fairfield Local Government Area.[79]

4. The Health of Local Communities

The Population Health Survey collects data on health and life style nationally. The findings in the survey report include self-reported health status on physical activity, smoking prevalence, alcohol consumption, fruit and vegetable intake and other risk and protective behavioural factors. Self-reported health status has been shown to be a reliable predictor of ill- health, future healthcare use and premature mortality, independent of other medical, behavioural or psychosocial risk factors. Survey respondents were asked to state their perception of their current health status by indicating whether, in general, they would say their health was excellent, very good, fair or poor. The NSW Population Health Survey (2010-2012), indicates that 78.8% of local residents reported very good, good or excellent health. This was lower than the NSW average of 82.1%. (Note: Supplementary Data Report contains data by LGA available for the period 2008-2010).[10]

Overall, local residents have been identified as having elevated rates of behaviours linked to poorer health status such as smoking, excess consumption of alcohol, physical inactivity and unhealthy diet. Concurrently, residents report lower rates of health protective factors such as an adequate physical activity, non-smoking and well balanced diet, when compared with the total NSW population. This profile is reflected in the following graphs:

Figures 10 and 11: Behaviours contributing to health outcomes, South Western Sydney residents 2013
Source: NSW Population Health Surveys



Obesity is a major risk factor for cardiovascular disease, type 2 diabetes, some musculoskeletal conditions and some cancers. In addition, being overweight can impede the ability to control or manage chronic conditions**.** Across the region in 2013, 20.9% of residents were defined as obese based on their reported height and weight, and 33.6% were defined as overweight, both slightly above the NSW rate of 32.6%. Residents of all LGAs except Fairfield and Camden were of particular concern. Less than half of local residents were defined as achieving an adequate level of physical activity (44%). 51.3% achieved the recommended daily fruit intake and only 7% of residents achieved the recommended daily vegetable intake.

Of all risk factors, tobacco smoking is responsible for the greatest burden of disease in the Australian population. Tobacco smoking is a major risk factor for conditions such as coronary heart disease, stroke, peripheral vascular disease, numerous cancers and other diseases and conditions. In South Western Sydney, 19.2% of residents aged over 16 years reported they were **current smokers,** with rates particularly high in Campbelltown (25.3%) and Liverpool (22.3%) compared with the state average of 17%. Tobacco usage is also higher in the Aboriginal community. Smoking is also more

common among some cultural groups, with anecdotal evidence of higher rates of passive smoking where cultural conventions make it is less socially acceptable to ask smokers to smoke outside the house. The rate of smoking by pregnant women is significantly higher than the state average and is particularly problematic for local Aboriginal women. Aboriginal women in South Western Sydney are 5.3 times more likely to report smoking during pregnancy than non-Aboriginal women. Smoking remains the leading cause of preventable death in NSW, accounting for around 5,200 deaths and 44,000 hospitalisations a year. The NSW Tobacco Strategy 2012-2017 has a focus on reducing smoking rates in Aboriginal and some culturally and linguistically diverse (CALD) communities, where rates are significantly above the state average.

Excessive alcohol consumption is a major risk factor for morbidity and mortality in Australia. It is a major cause for conditions such as cirrhosis and cancer of the liver, breast and some other cancers, stroke and CVD disease, road traffic accidents, memory lapse, falls and suicide. 23.8% of residents report **drinking alcohol** at risky levels i.e. in excess of 2 drinks per day. Risky alcohol consumption was higher than the NSW average in Campbelltown, Camden and Wollondilly LGAs.

These behaviours are reflected, to some extent, in the profile of hospital patients. In 2011, the death rate for alcohol related causes was higher than the NSW rate (16.5 compared to 15.6 per 100,000 people, respectively). In the period 2011-12 and 2012-13, local residents had lower rates of alcohol attributable hospitalisations compared to the state. However, the rate of alcohol attributable hospitalisations for the local Aboriginal population was significantly higher than for the non-Aboriginal population (982.9 per 100,000 population compared to 522.1 respectively). [11, 12]

What were patients concerned about?

- obesity
- diabetes
- cardiovascular problems
- mental health
- drug addiction
- smoking and alcohol
- aged care
- cancer
- waiting times and lack of services
- healthy lifestyles

Risk behaviours also include avoiding participation in prevention programs such as screening and vaccination, and low use of services. Participation in these programs is covered under the specific health problems in the sections to follow.

Avoidable, Treatable and Preventable Mortality and Hospitalisations

Potentially avoidable deaths refer to premature deaths (people aged under 75 years), that theoretically could have been avoided given current understanding of causation, and available disease prevention means and health care. Potentially avoidable deaths can be further differentiated into conditions where death can be averted by prevention ('preventable') or by treatment ('amenable'). Amenable conditions are defined as those from which it is reasonable to expect death to be averted even after condition has developed, through early detection and effective treatment. Preventable conditions include those for which there are effective means of preventing the condition from occurring, e.g. where the aetiology is to a considerable extent related to lifestyle factors.

In 2011, two-thirds of premature deaths were classified as potentially avoidable. Almost 80% of deaths in south western Sydney can be attributed to cardiovascular disease, neoplasms – malignant cancers, respiratory diseases and injury and poisoning. In 2010-11, 1,230 local residents died from potentially avoidable deaths from causes that were preventable and amenable to health care, with higher rates in the region (152.1) compared to NSW (145.8). Rates in Campbelltown LGA (121.6) and Wollondilly LGA (117.6) were significantly higher than the state. Aboriginal people died from

potentially avoidable deaths at a rate around 2.2 times higher than non-Aboriginal people in the years 2008 to 2011.[12]

Potentially preventable hospitalisations or ambulatory care sensitive conditions are those 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. Between 2011 and 2013 there were 308,217 hospitalisations of local residents. The rate was significantly higher than the NSW average in Camden and Campbelltown LGAs, and lower than the state average in Fairfield, Wingecarribee, Bankstown and Wollondilly LGAs. Approximately 7% of hospitalisations were potentially preventable (21,290), with a significantly higher rate in Campbelltown LGA than the state average and a significantly lower rate in Fairfield and Wollondilly LGAs. The age standardised rate of potentially preventable hospitalisations was higher for Aboriginal residents than for all residents in South Western Sydney (3561.6 compared to 2416.8).[11, 12]

Rates for potentially preventable hospitalisations per 100,000 population for a number of conditions were much higher locally compared with NSW rates. These include congestive heart failure (SWS:203, NSW:176.5), asthma (SWS:190.2, NSW:177.3), ear nose and throat infections (SWS:182.0, NSW:156.9), iron deficiency anaemia (SWS:130.8, NSW:116.9) and vaccine preventable diseases (SWS:26.9, NSW: 14.5).

Rates per 100,000 population were also higher locally compared with NSW for diabetes complications (SWS: 123.3, NSW: 120.4), influenza and pneumonia (SWS: 73.8, NSW: 65.5), and gangrene (SWS:16.0, NSW:14.2).

Specific Health Problems

Cardiovascular disease (CVD) is the term used for heart, stroke and blood vessel diseases. It is the leading cause of death in Australia, with 45,600 deaths attributed to CVD in Australia in 2011. The CVD death rates were highest in the lowest socioeconomic group. The CVD death rate in 2009-11 for Indigenous Australians was 1.4 times that for non-Indigenous Australians. In 2010-11, 1,427 local residents aged 25-74 years died from cardiovascular disease, a rate of 173.9 per 100,000 slightly below the rate of 177.0 for NSW. However, in Campbelltown LGA, the death rate was higher than the NSW rate (248.9 compared with 235.9 per 100,000 population respectively). Stroke rates locally are slightly lower than NSW overall (44.1 compared to 45.8 per 100,000 population respectively).

A large proportion of hospitalisations are attributable to cardiovascular disease. In 2010-11, there were 4,763 hospitalisations for coronary heart disease and 1,962 hospitalisations for stroke. The rate of coronary heart disease hospitalisations was significantly higher than the NSW rate in Campbelltown LGA but significantly lower in Bankstown, Fairfield, Liverpool and Wingecarribee LGAs. In 2011-12 there were 16,368 CVD hospitalisations in the region, with the rate of 1,911.7 per 100,000 population locally which is below the rate of 1,953.1 for the rest of NSW. Hospitalisation rates for coronary revascularisation procedures were higher locally than NSW overall (211.4 compared with 182.8 per 100,000 people).[11, 12]

Diabetes is a common chronic condition characterised by high blood glucose (sugar) levels. The two main types of diabetes are type 1 (insulin dependent) and type 2 diabetes which occurs mostly in people aged 50 years and over and is linked to being overweight or obese and having a family history of the condition. Gestational diabetes is another form of the condition that affects women during pregnancy, who may have had no prior diagnosis of diabetes. This condition usually abates after giving birth, but is a risk factor for developing type 2 diabetes later in life.

Diabetes prevalence increases with age and socioeconomic disadvantage and is more prevalent in men, Aboriginal people and those from Mediterranean countries. The *Atlas of Diabetes Prevalence by LGA*[13] indicates that diabetes prevalence in the region from 2000-2011 increased by 158% from

20,594 to 53,132 people. Fairfield LGA had the highest rate in the region at 7.2% (13,535 people), followed by Campbelltown LGA at 6.8% (9,894 people), Liverpool LGA at 6.4% (11,548 people) and Bankstown LGA at 6.2% (11,375 people). The lowest rates were in Camden LGA at 4.6% (2,625 people), Wingecarribee LGA at 4.7% (2,105 people) and Wollondilly LGA at 4.7% (2,050).[21] Diabetes prevalence will continue to rise with population ageing and a greater life span for people living with diabetes.

In 2011, there were 293 diabetes related deaths (underlying causes or associated causes) in the region, the death rate (35.4 per 100,000 people) was higher than NSW (29.2 per 100,000 people). The rate of hospitalisations was also higher (154.1 compared with 144.7 for NSW per 100,000 population respectively) in 2010-11 and was the greatest among Aboriginal residents. Combined data for 2009-10 and 2010-11, indicates that the highest rate of hospitalisations were for Liverpool, Campbelltown and Bankstown residents and the lowest was in the Wingecarribee LGA.[11]

Chronic Kidney Disease (CKD) affects 1 in 9 Australian adults and 90% of kidney function can be lost before experiencing any symptoms. The major causes of CKD are diabetes and high blood pressure and it is also a major risk factor for cardiovascular disease. Early detection and treatment can reduce the progression of the disease, lower associated cardiovascular risk by up to 50% and may also improve quality of life. Over 2007 – 2011, 3,769 people in NSW were treated for kidney disease including 557 local residents (14.8% of the total). Rates per 100,000 people were higher than NSW (10.7) in all LGAs except Camden and Wollondilly and were particularly high in Fairfield (16.3).[14] Dialysis hospitalisation rates in 2012-13 were higher in the region than in NSW (5,359.1 compared to 4,194.1 per 100,000 people).

Cancer is the leading cause of death in Australia and is a major cause of death and disability in South Western Sydney. The *Cancer Institute NSW Incidence and Mortality Projections 2011-2021* report indicates that there will be approximately 40,000 new cases of cancer in NSW per year and that this number will rise to over 45,000 cases by 2016 and rise to approximately 51,000 by 2021, a 42% increase. [86] The major cancer sites of prostate (17%), bowel (13%), breast (12%), melanoma of the skin (10%) and lung (8%) will account for 60% of total new cases of cancer.[15] In SWS, the increase is expected to be 63%, the highest increase of any region. By 2016, it is expected that the number of new cases locally will be 4,470 and by 2021 5,300 cases –this represents 10% of the NSW cancer population. Incidence rates for lung cancer were significantly higher than the state for males. Stomach and liver cancer rates were significantly higher than the state in both males and females. Between 2006 and 2021, the projected increase in cancer deaths locally is 21%.

There are rapidly increasing rates of primary liver cancer in NSW, 80% of which are associated with chronic viral hepatitis. It is estimated that 1 in 3 people living with chronic hepatitis B in Australia are undiagnosed. Without appropriate monitoring and treatment, one in four people with chronic hepatitis B will die of liver cancer or liver failure.[87] Standardised liver cancer mortality rates are higher locally than NSW (at 6 and 4.1 per 100,000 population respectively) and highest in Fairfield and Liverpool LGAs at (8.2 and 6.8 per 100,000 population respectively).

The National Bowel Cancer Screening Program (NBCSP)[16] which identifies colorectal cancer through a faecal occult blood test, was implemented in mid-2006. Synthetic projections by the Public Health Information Development Unit (PHIDU) showed that in 2011-12 in NSW, 33.1% of people aged over 50 years were screened. In 2013, the bowel screening participation rate in South Western Sydney was 29.1%, lower than the overall NSW participation rate of 31.6%. The annual bowel screening participation rate was lower in all LGAs except Wingecarribee (33.4%) (Liverpool 26.7%, Campbelltown 27.7%, Bankstown 29.1%, Fairfield 30.5%, Camden 31.0% and Wollondilly 31.0%).

Breast cancer affects one in nine Australian women. It can occur at any age, but is most common in women over the age of 60. Screening mammography is provided as a free service for women aged 50-74 through the Breast Screen Australia Program. In 2012-2013 only 46.8% of local women aged

50-69 years participated in breast cancer screening programs. This falls short of the NSW average of 51.7% and the NSW target of 70%. Biennial breast screening participation rates are lower than the state rate in all LGAs except Wollondilly (53.1%) (Camden 41.6%, Liverpool 43.0%, Campbelltown 45.2%, Bankstown 47.0%, Fairfield 49.9% and Wingecarribee 51.4%).

Cervical Screening aims to prevent cervical cancer by detecting early pre-cancerous changes in the cervix. The National Cervical Screening Program currently recommends all women aged between 18 and 70 who have ever been sexually active have regular Pap tests. NSW Health data indicates that 52.2% of local women aged 20-69 years were screened for cervical cancer biannually (2012-2013), less than the state average of 57.7%. Biennial cervical screening participation rates are lower than the state in all LGAs except Wingecarribee (58.1%) (Camden 46.7%, Campbelltown 47.3%, Liverpool 51.0%, Bankstown 54.3%, Fairfield 55.2% and Wollondilly 55.9%).

Respiratory Diseases include lung cancer, asthma, chronic obstructive pulmonary disease (COPD), asbestosis and influenza/pneumonia. In 2012-13, 16,123 local residents were hospitalised for respiratory disease, at a rate of 1,776.8 per 100,000 people compared with a rate of 1,641.1 for NSW. In 2010-11, Aboriginal residents were hospitalised at a substantially higher rate than the rest of the local population (2,189.5 compared with 1,505.7 per 100.000 population respectively).[11, 12]

COPD hospitalisation rates in the period 2009-10 to 2010-11 were significantly higher in Campbelltown, Liverpool and Fairfield LGAs. Synthetic projections produced by Public Health Information Development Unit (PHIDU) in 2011-13 indicate higher rates of COPD in Campbelltown (118), Wollondilly (113) and Wingecarribee (112) LGAs compared to the NSW rate (110).The region recorded higher influenza/pneumonia separation rates for children under 4 years of age but lower rates for people aged over 65 years and the total population compared with the rest of the state. These two age groups are still hospitalised at a significantly higher rate than the rest of the population. Asthma hospitalisation rates are also slightly higher than the rest of the state in all age groups.

Injury and Poisoning is the leading cause of death for people aged 1 – 45 years in NSW and is a major cause of death in South Western Sydney. The death rate is similar to the NSW rate. In 2006-07 in NSW, the most common causes of death due to injury were suicide (22%), falls (16%) and motor vehicle accidents (14%). In contrast, in South Western Sydney, suicide ranked highest (25%), followed by motor vehicle accidents (17%) and falls (12%), possibly reflecting the relatively younger local age structure. [11, 12]

Hospitalisation rates for injury and poisoning in 2012-13 for local residents were slightly below the NSW rate (2,351.9 and 2,433.5 respectively). In 2011-12, the rate of hospitalisations for injury and poisonings for local Aboriginal residents was higher than for South Western Sydney residents overall (5,392.6 and 4,160.7 per 100,000 population respectively).

Falls are a major cause of harm to older people and fall-related injuries impose a substantial burden on the health care and aged care systems. About 38% of all injuries in South Western Sydney in 2011-12 were falls related compared to 43.5% in NSW.[94] The majority of falls among older people happen in and around their homes. In 2009, among older people who had fallen in the previous 12 months, over 65% indicated that they had most recently fallen in their home or yard.[95] South Western Sydney has a higher rate of fall related injury overnight stay hospitalisations for people aged 65 years and over compared with the State (3,402.80 and 3,051.5 smoothed rate per 100,000 population respectively) with a particularly high rate in Campbelltown and Liverpool LGAs (3,923.2 and 3,890.7 respectively). Only Wingecarribee LGA had a much lower rate of fall related injury overnight stay hospitalisations for people aged 65 years and over than NSW (2,308.2 compared with 3,051.5).[96]

The NSW Health Policy *Prevention of Falls and Harm from Falls among Older People: 2011-2015*, describes the actions that NSW Health will undertake to support the prevention of falls and fall-related

harm among older people. Actions will take place in three key domains: health promotion, NSW Health clinical services and NSW Health residential aged care services. The policy aims to reduce the incidence and severity of falls among older people and reduce the social, psychological and economic impact of falls on individuals, families and the community. NSW Health is implementing a number of initiatives to prevent falls and harm from falls among older people.[97]

Examples of current initiatives include:

- Stepping On: an evidence-based multidisciplinary falls prevention program to increase the confidence of older people in self-managing falls risks and establishing a regular habit of balance and strength exercise.
- Otago Home Based Exercise Program: a home based, individually tailored strength and balance retraining program that has been shown to reduce falls among frail older people.
- Staying Active and On Your Feet: a booklet that provides information and tips for staying active and preventing falls, along with a self-assessment checklist for falls risk.
- Active and Healthy website: a web-based resource for older people, their carers and health providers, that provides older people with information to locate falls prevention exercise programs in their local area, as well as information on ways to reduce falls.
- Implementation of national falls prevention best practice guidelines in NSW Health clinical and aged care services – adoption of the Australian Commission on Safety and Quality in Health Care guidelines in hospitals, community based services, multi-purpose services and State Government Residential Aged Care Facilities.

Mental Health disorders relate to behaviours and conditions which interfere with social functioning and capacity to negotiate daily life. Mental health conditions vary from short term, episodic illness to long term chronic illness. Mental health problems are also associated with higher rates of health risk factors, poorer physical health, and higher rates of deaths from many causes including suicide.

Although suicide rates have more than halved since 1997 there were still 62 suicides recorded for local residents in 2011, a rate below the state rate (7.3 and 8.0 per 100,000 population respectively). In 2012-13, there were 1,192 hospitalisations for local residents for intentional self-harm, translating to a rate of 135.3 per 100,000 people and less than the state rate of 144.2. For young people 15-24 years old, the hospitalisation rate for intentional self-harm was lower locally (240.9 per 100,000 population compared to 320.6 for NSW). The hospitalisation rate for local Aboriginal people was significantly higher for intentional self-harm than the rest of the local population for 15-24 year olds (603.9 compared to 304.6 per 100,000 population), and for all ages (367.6 compared to 136.5 per 100,000 population). In 2012, around 1% of NSW children and youth age 17 or under were prescribed psycho-stimulant medication for attention deficit hyperactivity disorders (ADHD). This is well below the estimated prevalence of ADHD. In 2013, around 11.2% of adults in SWS reported high or very high levels of psychological distress compared with the state rate of 9.8%.

Aside from same day treatments (3,935), major reasons for hospitalisations attributable to mental health conditions for local residents in 2010-11 were: schizophrenia (1,542); major affective disorders (837); personality disorders and acute reactions (646); other affective and somatoform disorders (458); poisoning/toxic effects of drugs and other substances (305); drug intoxication and withdrawal (232); and paranoia and acute psychiatric disorders (196). The hospitalisation rates in 2011-12 for mental and behavioural disorders for the Aboriginal population were more than 50% greater than for all local residents (2,284.9 and 1,047.4 per 100,000 population respectively). [20]

As part of a needs assessment for the Partners in Recovery (PIR) initiative, the relative utilisation of mental health facilities in SWSLHD for a long term stay of 3 weeks or longer was examined. All up, 1,967 longer term psychiatric separations were identified in 2011/12 for local residents. In order of magnitude, the major Diagnostic Related Groups (DRGs) represented were Schizophrenia Disorders (37%), Major Affective Disorders (24%) and Personality Disorders and Acute Reactions (11%). DRGs

relating to toxic effects and dependence on drugs and other substances were the next most common and were most evident for Camden and Campbelltown residents.

The utilisation rate of psychiatric facilities was not uniform across LGAs. Utilisation by Bankstown and Liverpool residents was similar to the proportionate population of the LGA. Utilisation by Campbelltown residents was much higher than the proportionate population. Utilisation by Wingecarribee, Fairfield and Camden residents was somewhat lower and was significantly lower for Wollondilly residents.

Synthetic projections undertaken by PHIDU in 2011-13 for mental and behavioural problems indicate a higher rate of hospitalisation in men in Wingecarribee LGA (102) compared with NSW (99), and higher rates in women in all LGAs compared with the NSW rate of 95 (Liverpool 96, Bankstown 97, Fairfield 101 and Campbelltown 112).[21]

Eating disorders are characterised by an unhealthy preoccupation with eating too much or too little, weight control, unhealthy weight loss strategies and unrealistic perceptions about body weight and shape. These disorders affect 9% of the population and the effects can be serious and potentially-life threatening. Health problems associated with these conditions include depression, anxiety, substance abuse, premature death, suicide and long term chronic health conditions.[22]

What were GPs concerned about?

- Diabetes
- Chronic diseases
- Mental health
- Hypertension
- Obesity
- Waiting times for surgery and outpatient services
- Communication
- Public mental health services

Oral health is important for overall health and wellbeing. The impact of oral disease comes from the main four conditions of tooth decay, gum disease, oral cancer and oral trauma. According to the Australian Institute of Health and Welfare (AIHW 2011) about 90% of all tooth loss can be attributed to tooth decay and gum disease. Tooth decay is amenable to prevention through good nutrition, exposure to fluoride, maintenance of adequate oral hygiene and access to regular dental visits. Oral Health is good overall in NSW; however some population sub-groups experience high rates of poor oral health. Across NSW in 2005-2007, approximately 5% of adults had all their natural teeth missing. This rate was slightly worse in Bankstown and Fairfield LGAs. Approximately 12% of the Australian adult population have decayed, missing or filled teeth, showing an improvement in oral health over a period of 20 years.[11, 23]

The *2007 NSW Child Dental Health Survey* indicated that approximately 60% of NSW children aged 5-6 years had no decay in their deciduous teeth. Children in this age group with the poorest dental health had 5 teeth affected. Children aged 11-12 years old were similar, with 65% having no decay but those with the worst dental health having 2.4 teeth affected by decay. Children with the worst oral health were Aboriginal children and those with mothers from a non-English speaking country and from lower socioeconomic groups.[24] South western Sydney children aged 5-15 years were less likely to visit a dental professional than the NSW average (66.5% compared with 74.8%).

The 2008-10 *NSW Adult Population Health Surveys* indicated that 56.8% of local residents visited a dental health professional in the previous 12 months, with only 47.5% indicating they had private health insurance to cover dental expenses. Both rates were lower than that of the State.[9]

Oral health promotion is closely linked with the prevention of chronic conditions. An integrated risk factor approach recognises that chronic diseases and conditions, such as overweight and obesity, heart disease, stroke, cancer, diabetes and oral disease share common risk factors, such as poor diets, smoking and alcohol use. *The National Oral Health Plan* further proposes a population health

approach to oral health.[85] Broad action areas to be pursued in the next 10 years are in service provision, fluoridation and oral health promotion, workforce mix and development, dental student education, research along with monitoring outcomes and infrastructure development.[84]

Some of the key challenges for improving oral health in South Western Sydney in the years ahead are the growing population, ageing population, increased demand for oral health services, improvements in technology, inequality in sharing health gains, a growing number of patients with chronic co-morbidities and costs associated with treatment services.[84]

Communicable Diseases are infectious diseases transmissible by direct contact with an affected individual or the individual's discharges, or by indirect means (such as by vector). Some diseases are preventable through the use of vaccines and others are easily treated. However, these diseases can have a significant impact on individuals (including death and long term disability). In 2012-13, there were 5,908 hospitalisations related to infectious diseases locally, representing 1.9% of all hospitalisations. This was higher than the state level of 1.6%.

Immunisation reduces morbidity and mortality caused by some communicable diseases. The *NSW Population Health Surveys 2010-12* indicate that vaccination of older adults against influenza in south western Sydney (70.5%) was similar to the NSW average (71%) and for pneumococcal disease (SWS: 49.0% and NSW: 49.9%).[9]

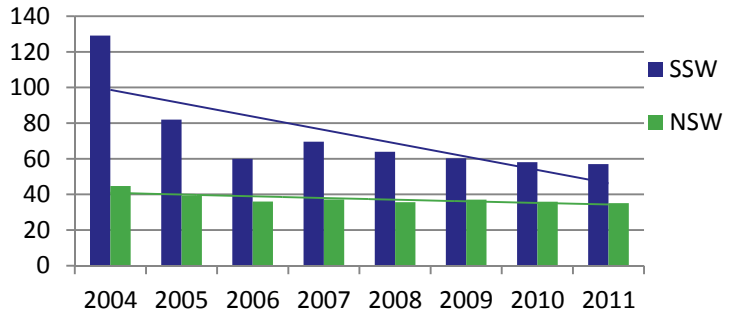
Emerging pathogens, such as swine influenza (H1N1), severe acute respiratory syndrome (SARS) and avian influenza cause illness and deaths. Strains of common microbes are expected to continue to develop resistance to previously effective drugs

Blood Borne Viruses

HIV prevalence was lower in the region in the period 2001– 2006, than in NSW (1.4 and 3.4 per 10,000 people respectively). However in recent years, the proportion of all NSW diagnoses from South Western Sydney has increased. As indicated by the NSW HIV/AIDS database, Communicable Diseases Branch, Health Protection NSW, in 2012 there were 30 new notifications of HIV, 7.3% of the total number people newly diagnosed with HIV living in NSW. Further information regarding HIV/AIDS and other sexually transmitted infections is provided in the *SSWAHS Strategic Framework for HIV/AIDS and Related Programs (HARP) Funded Services 2008 – 2012* .[25] Planning processes are currently underway to develop the SWSLHD Sexually Transmissible Infections (STIs) and HARP Plans 2015 - 2018. These plans will align service priorities with the goals and objectives of the SWSLHD Strategic Plan and will be guided by *the NSW HIV Strategy 2012-2015 A New Era and Sexually Transmissible Infections Plan 2014-2020*.

Viral hepatitis B is transmitted by infectious blood or body fluids, and transmission to babies in utero is a major route for infection in developing countries. Untreated, chronic hepatitis B will result in a 40% chance of premature death from cancer and liver failure. It is estimated that there are between 762 - 1,533 people in the region with chronic hepatitis B who are not on treatment, but should be. South western Sydney has more people living with hepatitis B than any other region in Australia. It is estimated that 13,513 people (1.61% of the population) are affected. In 2011 the highest prevalence was in Fairfield and Bankstown LGAs (5,061 and 3,167 people respectively). The relatively high prevalence of chronic hepatitis B in south western Sydney is impacted by the population profile of the region. Around three-quarters of people diagnosed with hepatitis B were born in countries with a high prevalence of the disease, including Vietnam, China, Cambodia, the Philippines and Fiji. A further 3.6% of those with chronic hepatitis B are Aboriginal or Pacific communities.

Figure 12: Hepatitis B rates in SWS
Source: South Western Sydney Local Health District, Public Health Unit, 2013



The *NSW Hepatitis B Strategy 2014-2020*[102] aims to maintain or increase the proportion of infants that are fully vaccinated against hepatitis B, reduce the proportion of people with chronic hepatitis B whose infection is undiagnosed and to increase the proportion of people with hepatitis B receiving anti-viral medication from 2.5% to 10%. The main target groups will be culturally and linguistically diverse people, Aboriginal people, people living with hepatitis B, babies whose mothers are hepatitis B positive and other unvaccinated adults at risk.

Hepatitis C is primarily spread by blood to blood contact, such as blood transfusions and intravenous drug use. The South Western Sydney region has the second highest number of people diagnosed with hepatitis C in NSW, with approximately a quarter of those with chronic hepatitis C not on treatment. 90% of new infections and 80% of existing infections are transmitted through intravenous drug use. Notification rates are highest in Fairfield, Campbelltown, Liverpool and Bankstown LGAs.

The *NSW Hepatitis C Strategy 2014-2020*[103] aims to reduce the proportion of people that report sharing injecting equipment in NSW by 25% and to increase the number of people accessing hepatitis C treatment in NSW by 10%. The strategy targets people who inject drugs, people living with hepatitis C, people in or recently in custodial sentences, Aboriginal people, culturally and linguistically diverse people, and young people who are now injectors or at risk of injecting.

Sexually Transmissible Infections (STIs)

Chlamydia is a sexually transmissible infection which can lead to infertility and other complications if left untreated. Although notifications for chlamydia appear relatively low, it is estimated that in NSW 75% of infections are not diagnosed. Between 2012 and 2013, there were 2,004 new cases of chlamydia in the region, a notification rate of 220.2 per 100,000 population which is significantly below the NSW rate of 297.6.

Gonorrhoea is a common sexually transmissible infection which can lead to pelvic inflammatory disease and infertility in women. Between 2011and 2012, there were 314 new cases of gonorrhoea in the region, a notification rate of 36.1 per 100,000 population, below the NSW rate of 49.8.

Syphilis is a highly infectious sexually transmissible infection, which if not treated can cause serious health problems for life, including chronic brain and heart disease. In 2011-12 there were 21 new cases of infectious syphilis locally, with the notification rate of 2.4 compared to 6.5 for NSW.

Human papilloma virus (HPV) is a very common sexually transmissible infection which usually causes no symptoms and does not cause any health problems. However, some high-risk HPV types can cause serious illness including cancer. Treatment for HPV is currently not available, however a vaccine called Gardasil has been developed that protects against the two high-risk and two low risk HPVs strains. The Australian Government operates a school based immunisation program for girls

and boys aged 12-13, and a catch-up program for boys aged 14-15. The immunisation rate for HPV for 15 year old girls was higher in south western Sydney (71%) than the NSW rate (69%).

(The supplementary data report-Health Indicators for the Communities of South Western Sydney and the Southern Highlands includes statistics on communicable diseases by LGA for the period 2004-2011).[26]

Arthritis and Osteoporosis are major causes of disability and chronic pain in Australia. People with these conditions require ongoing medical care and there are adverse implications for employment and earnings. While there are many forms of arthritis, the three most significant - osteoarthritis, rheumatoid arthritis and gout are responsible for more than 95 per cent of cases in Australia.

In 2012-13, there were 14,155 hospitalisations for musculoskeletal diseases locally; representing 4.5% of all hospitalisations compared to 4.9% of all NSW hospitalisations.

Synthetic projections for SWS undertaken by PHIDU in 2011-13 indicate that in Campbelltown (104), Wingecarribee and Wollondilly (103) LGAs, residents have slightly higher rates of musculoskeletal system diseases than the state rate (102). Campbelltown (108) and Bankstown (104) LGAs residents have higher rates of arthritis than the state (103). Fairfield (112), Bankstown (109), Liverpool (105) and Campbelltown (103) LGAs residents have higher rates of rheumatoid arthritis than the State (95). For osteoarthritis, Wingecarribee (104) and Wollondilly (102) LGAs residents have higher rates than the state (96) and Campbelltown women (112) have a higher rate of osteoporosis than the state (106).[21]

Dementia is the term used to describe the symptoms of a number of illnesses that affect the brain. The most common cause of dementia is Alzheimer's disease. Dementia causes a progressive decline in a person's thinking, behaviour and ability to perform everyday tasks. The risk of getting dementia increases with age, but it is not a normal part of aging. It has been identified as a key health issue at a State and National level. The *Dementia Across Australia: 2011-2050* report estimated that in 2011, approximately 91,000 people were living with dementia in NSW. It is projected that this will increase to 128,238 by 2020.[27] Previous unpublished projections in 2008, estimated prevalence in South Western Sydney to be 9,874 people (an increase of 39% over 10 years). Projections in 2010 indicate that by 2018 there will be 11,778 local residents with dementia.

Dementia places a significant burden on carers, the community based care system and the hospital system, primarily where dementia is a comorbidity linked to increased length of stay. Further information is contained in the *South Western Sydney Dementia Plan 2007 – 2010*.[28]

Drug and Alcohol Issues have been consistently identified by the community as a significant issue. The *2010 National Drug Strategy Household Survey*[29] indicates that illicit drug use across Australia is at 14.7% . It is most common in those aged 20 – 29 years, with marijuana/cannabis the most commonly used drug. The NSW target for illicit drug use is "containment below 15%".

People with drug and alcohol issues generally have a poorer physical and mental health status than the general community. When intoxicated, there is an increased risk of engaging in unsafe sex, injury and family violence or crime. Those with drug and alcohol issues are often those with a lower socioeconomic status and have specific health concerns such as mental health, oral health, blood borne viruses spread through unsafe injecting equipment, poor nutrition and the use of drugs or alcohol during pregnancy. More information on alcohol abuse is provided previously in this document, under the 'Health of Local Communities' section on page 19.

5. Priority Populations

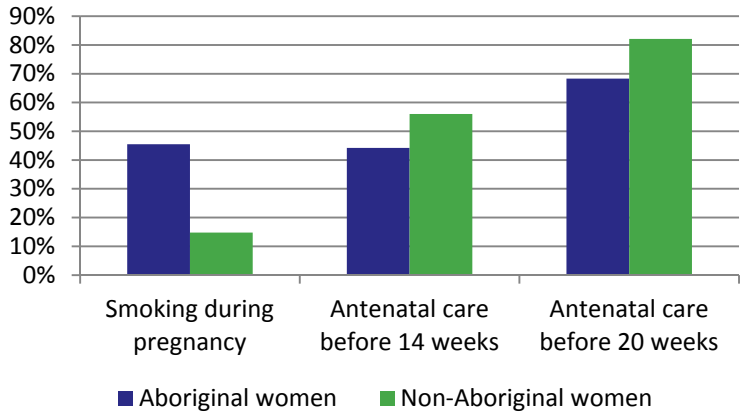
Local communities are not homogenous and comprise people of many ages, cultures and backgrounds. South Western Sydney has some of the most diverse communities in Australia with a large number of Aboriginal residents, an array of people from culturally and linguistically diverse communities, variation in socioeconomic status, metropolitan and rural communities, significant public housing estates and large numbers of people experiencing health and social disadvantage. The following provides an overview of the demographic characteristics of these various groups and where possible, provides information about their health status.

Pregnancy and the Newborn Period

Pregnancy and the newborn period is an important time for determining health outcomes in later years. In 2012, 81.9% of pregnant women in the region had a first antenatal visit before 20 weeks gestation, compared with 83.9% for NSW. Similarly, only 56% of women had a first antenatal visit before 14 weeks gestation, compared with 62% in NSW. Local government area data (2008-2010) indicates that all LGAs in South Western Sydney are performing poorly in terms of timely antenatal care. Fairfield LGA has the lowest rates of women seeking antenatal care before 14 weeks, followed by Bankstown and Campbelltown LGAs. [81]

In 2012, Aboriginal women in South Western Sydney were less likely to seek antenatal care before 14 weeks compared to non-Aboriginal women (44.2% compared with 56%). Similarly, only 68.3% of Aboriginal women received antenatal care before 20 weeks, compared with 82.1% of non-Aboriginal women.

Figure 13: Maternal health indicators in South Western Sydney for Aboriginal and Non-Aboriginal women *Source: Centre for Epidemiology and Evidence. NSW Mothers and Babies 2012. NSW Ministry of Health 2014*



Babies with a low birth weight (under 2.5kg) represented 6.2% of all local births in 2012. These babies are more likely to have developmental problems later in life, including learning difficulties, hearing and visual impairments, chronic respiratory problems and chronic diseases. [31] In 2012, there were 1,038 pre-term births recorded in the region, with a higher rate for Aboriginal women than non-Aboriginal women (11% % and 7.6% respectively). Prior to 2010, most preterm and low birth weight babies were born to teenage mothers, however in 2010 this changed to mothers over 35 years.

In 2012, 1,363 local women smoked during pregnancy. In 2008-2010, the prevalence of smoking was significantly higher than the state rate of (100) in every LGA, with the highest rates in Campbelltown (218.8), Wollondilly (155.6) and Wingecarribee (143.4). In NSW in 2012, the rates of smoking during pregnancy were much higher for Aboriginal women (46.2%) than non-Aboriginal women (9.8%).

Perinatal mortality is relatively high in the region compared to NSW (9.4 and 8.2 per 1,000 babies respectively), accounting for 126 deaths in 2012. In the period 2009-2011, the infant mortality rate for Aboriginal infants was 4.5, compared with 3.9 deaths for non-Aboriginal infants.

The *NSW Mothers and Babies Report 2012*[30] indicates that only 79.9% of babies in SWSLHD hospitals were reported to be fully breastfed on discharge compared to an average of 82.1% for the state. The Wingecarribee LGA had the highest percentage of mothers breastfeeding at the time of discharge (87.4%) and Campbelltown and Liverpool LGAs had the lowest rates, at 75.6%, and 78.6% respectively.

Gestational diabetes mellitus (GDM) is a significant problem in pregnancy and is affected by factors such as weight, age and ethnicity. Social factors such as education, income and how much an individual paid on their mortgage have also been associated with the risk of developing GDM. Mothers and their babies who develop GDM during pregnancy are 50% more likely than average to develop type 2 diabetes within 10-20 years if they do not maintain recommended healthy lifestyle changes post partum.[32] Six of the top ten postcodes ranked by GDM occurrence in NSW are in South Western Sydney, with Liverpool and Campbelltown LGAs in the top three. Local data indicates that 14% of all local babies born in the last two years were born to mothers with GDM, compared to 5.5 - 8.8% across Australia.[32, 33]

Children

Generally children are considered to be aged 0-14 years. In NSW, most children experience good health, with low morbidity and mortality. In the past decade, mortality for those aged 1-17 years has decreased across NSW, with less than 1 in every 1,000 dying with a disease or morbid condition. Significant health issues for young children include:

- In South Western Sydney, the crude infant mortality rate in 2011 was 3.5 per 1000 children, with the majority very young. This is the lowest rate over the last fifteen years. The leading causes of death were perinatal conditions (36%), congenital malformations (21%) and injury (17%). Between 2004 – 2006, the infant mortality rate was below the NSW average in all LGAs except Liverpool.[34,35]

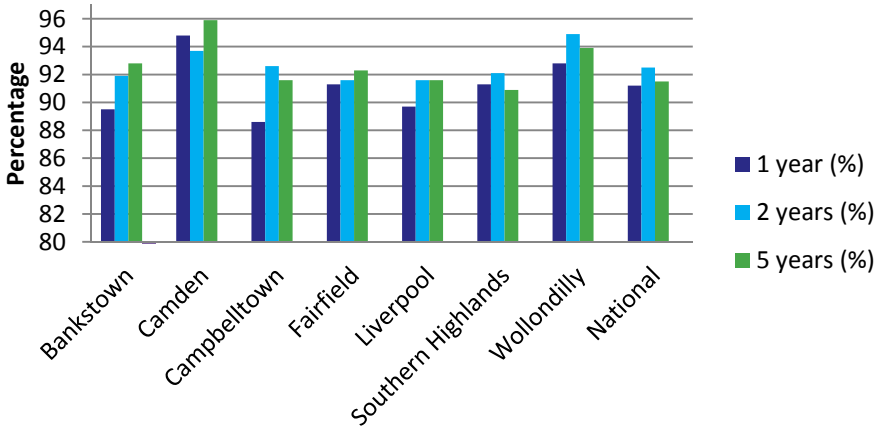
- The three most common injuries in NSW in children and young people requiring hospitalisation are falls; exposure to inanimate mechanical forces; and transport related injuries (1244, 755 and 519 respectively).Transport related injuries include pedestrian injuries, pedal cyclist injuries, motorcycle injuries, car related injuries as a driver or passenger, watercraft and aircraft related injuries, and other transport related injuries such as horse rider injuries.

- In children, accidental injury rates vary with gender with most injuries occurring more commonly in boys. The types of injury presentation vary between the age groups and are consistent with the developmental stage of the child. Disadvantaged children are generally at greater risk of injury. Non-accidental childhood injury can also result from child abuse and neglect.

- In 2011, 35.8% of NSW school students (12-17 years of age) surveyed, reported suffering an injury requiring medical attention in the 6 months prior to the survey. There was a 6% difference between males and females, with NSW males more likely to have been injured than females (39.2% compared to 33.2%). A similar gender difference was observed among the Sydney South West students surveyed, however the percentages of each sex in the South Western Sydney region suffering an injury requiring medical attention was slightly lower than the NSW average. The total percentage of South Western Sydney students injured and requiring medical attention was also slightly lower than the NSW average (32.6% compared with 35.8%). It should be noted that at the time, Sydney South West Area Health Service included students from both South Western Sydney LHD and Sydney LHD. [83]

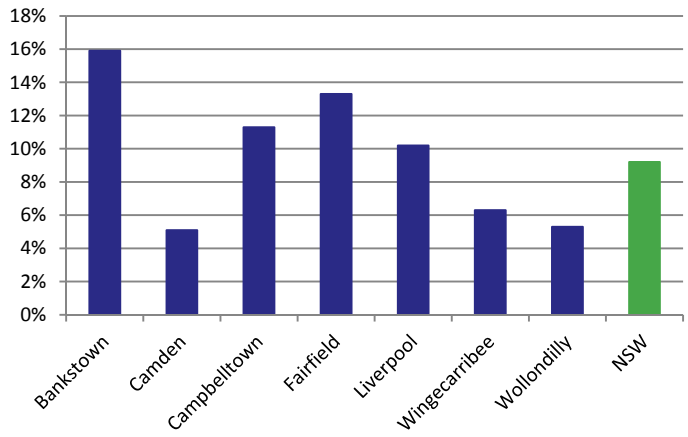
- Poor oral health, with 39% of the children aged 5-6 years screened in local primary schools showing evidence of past tooth decay.
- 16% of 0-17 year olds in NSW have a chronic condition or disability, such as asthma, autism, diabetes, physical or intellectual disability.
- A small number of children in 2010 in NSW still experience vaccine preventable diseases (4.4 per 1,000 children). In 2012-13, 92.5% of local children aged 5 years were fully immunised (with Aboriginal children at 94.5%). Vaccination rates vary by age group. At 1 and 2 years, immunisation rates for Aboriginal children were slightly lower than for the total population. In 1, 2 years and 5 year olds, immunisation rates were highest in Camden and Wollondilly LGAs.[37]

Figure 14: Children fully immunised by age and LGA (2012-13)
Source: National Health Performance Authority



- Food allergy occurs in almost 5% of NSW children, with Australia having one of the highest allergy prevalence rates in the world.[38]
- Overweight and obesity among NSW school students was 17.1% and 5.8% and less than half the children meet the Australian guideline for physical activity. There was a strong association between overweight and obesity and socioeconomic status.[39]
- In 2010/11, there were approximately 8,000 overnight separations for children aged 0-16 years (excluding babies in utero or newborn) from local acute hospitals. The largest number of separations were for children with respiratory illnesses i.e. croup, bronchitis and asthma. There were also 1,957 day only separations with the largest numbers for non-sub-specialty medicine, injuries to limbs - medical and surgical, and dentistry.
- The Australian Early Development Index (AEDI) considers five areas of early childhood development linked to positive long term educational, social and health outcomes: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. In 2012, higher levels of developmental vulnerability in two or more domains were identified in 5 year olds from Bankstown, Fairfield, Campbelltown and Liverpool LGAs (i.e. 15.9%, 13.3%, 11.3% and 10.2% respectively) compared to the NSW average of 9.2%. Reflecting pockets of disadvantage, children in the suburbs of Airds (26.3%), Sadlier (25.4%), Chester Hill (23.5%) and Bass Hill (22.8%) demonstrated the highest levels of vulnerability.[40]

Figure 15: Children developmentally vulnerable in two or more domains, South Western Sydney 2012
Source: Australian Early Development Index



Children at risk or who are placed in out of home care have increased risk of developing health problems. This includes poor nutrition, limited access to health services, exposure to violence, alcohol and/or drugs, issues with attachment and an increased likelihood of accidental injury (as a result of poor parental supervision). The *NSW Office of Communities Commission of Children and Young People Report* [41] indicated that that as at 30 June 2010, there were 1,955 children living in out of home care in the Metro South West Region of Community Services (11.2% of the state total). This was a slightly lower rate than the state. Aboriginal children are over represented in out of home care.

Young People

Young people are generally defined as aged 12/14 to 24 years. In Australia, young people generally report good health and use health services at a much lower rate than older people. Similar to other age groups, some young people have poorer health than their peers, usually those from disadvantaged groups.

The *Young Australians: Their Health and Wellbeing 2011* report [43] describes the main health issues for young Australians as: increasing rates of diabetes linked to low physical activity participation, inadequate fruit and vegetable intake and high levels of overweight/obesity; increasing rates of sexually transmitted infections, in particular chlamydia; high rates of mental disorders (particularly for psychoactive substance abuse, schizophrenia and depression); high road transport accident deaths for males; alcohol consumption at risky or high risk levels for short term or long term harm; high numbers of people as victims of violence related to alcohol or drug use; and poor oral health.

The report released by *Mission Australia and the Black Dog Institute (2014),* indicate that one in five young Australians are likely to experience mental illness, and less than 40% are comfortable seeking professional help.[88] The report found that the rate of mental illness among young Australians aged 15-19 was much higher among females and Aboriginal and Torres Strait Islanders, while young people with a disability were also overrepresented.[88] The report of the Chief Health Officer, *Health of Children and Young People (2014)*, indicates that there were just under 379,000 hospitalisations in 2012-13 among NSW children and young people aged 0−24 years.[89] The pattern and the number of hospitalisations varied markedly by age. Of hospitalisations in infants aged less than 1 year, most were for births (26.5%) or complications of birth (28.5%). Injury and poisoning was consistently a leading cause of hospitalisation among those aged 1−24 years (14.9%), varying between 8.3% for 1 year olds and 23.7% for 13 year olds. However, the underlying cause of injury or poisoning differs markedly by age. Hospitalisations due to infectious diseases, asthma and bronchiolitis declined rapidly with age. Conversely, hospitalisations due to mental and behavioural disorders increased with age. From 16 years onwards, hospitalisations due to factors related to pregnancy and childbirth became increasingly common in females relative to other causes.

Marginalised youth are those who are homeless, living in out of home care, carers, in contact with the criminal justice system, refugees, young parents and gay, lesbian, bisexual, transgender and intersex youths. These groups face significant health challenges and barriers.

According to the 2011 Census, 10,551 NSW children and young people aged 0–24 years were classified as homeless, a rate of 45 per 10,000 population, which is higher than the rate of homelessness in people aged 25 years and over (36 per 10,000 population). Across all ages, homelessness rates were highest among people aged 19–24 years (72 per 10,000).Census data is likely to under-estimate the extent of homelessness among young people, as youth who are homeless or "couch surfing" may be missed in these statistics. Studies show that 50 percent of young people accessing housing or homeless agencies have one or more identifiable mental health issues. Other health issues for homeless young people are hygiene, contraception, malnutrition, drug and alcohol dependence and sex work issues.[90]

Newly arrived young migrants and refugees may face barriers to health care access due to lack of awareness of services, language and cultural barriers and may experience learning difficulties, anxiety and post traumatic stress disorder.

Children and young people entering out of home care have poorer health outcomes in terms of visual defects, dental health, hearing impairments, speech development, immunisation and mental, emotional and behavioural health.

Smoking rates are high in South Western Sydney, particularly during pregnancy and for young mothers. Detailed local health information relating to young people is generally not available, however further information is available in the *Sydney South West Area Health Service Youth Health Plan 2009 – 2013*.[44]

Older People

Older people are more likely to report health problems and/or disability than those in younger age groups. The *Welfare of Older Australians at a Glance 2007* report [45] and NSW Ministry of Health reports describe the key health issues for older people as: low levels of physical activity and inadequate nutritional intake; high rates of osteoporosis and arthritis, knee and hip replacements and hip fractures - with associated risks of falls (falls incidence 27% in 2006/07) [46]; high blood pressure and high cholesterol - present in over half of people; high rates of chronic health conditions, including multiple conditions - associated links with poly-pharmacy; problems with vision, hearing, oral health and continence; end of life care issues in palliative care and advanced care planning; mental illness, particularly depression linked to social isolation and high rates of suicide (13% of suicides in 2005 were by people aged over 55); high rates of dementia; and reduced capacity to perform activities of daily living e.g. bathing, dressing and meal preparation.[45,46]

Studies on nutritional status indicate that a number of older people have poor diets, without adequate levels of fibre and vitamins and minerals.[47] Older people are particularly vulnerable to malnutrition as their nutritional requirements are not well defined and the process of ageing also affects other nutrient needs. Contributing factors to nutritional status in community settings may include physical problems such as dental problems or arthritis affecting capacity to open packaged foods, social isolation and lack of transport to shops. Malnutrition is also an issue in residential settings with 1 in 5 residents malnourished. Factors which contribute to this include a reduction in skeletal muscle mass and body weight, difficulty swallowing, reduced appetite, inadequate nutritional intake, depression and dementia.[48]

People in Rural Areas

The *Australian Classification of Local Government* categorises six of the seven local government areas in South Western Sydney as metropolitan or fringe areas, with Wingecarribee classified as a regional town. In terms of accessibly, the Accessibility/Remoteness Index of Australia (ARIA)[50]

classifications compare road distances to service centres and indicate that South Western Sydney LGAs are considered highly accessible when compared with the rest of the country. Some rural communities, however, are less accessible than others and in the region; Wollondilly and Wingecarribee LGAs have poorer access in outlying towns and properties. Camden, Campbelltown, Fairfield and Liverpool also have some less accessible areas, although this is expected to change as a result of the urban development.

The *National Strategic Framework for Rural and Remote Health*[104] outlines a series of goals to attain equitable health outcomes for people living in rural and remote areas of Australia. These include improved access to appropriate and comprehensive care; effective, appropriate and sustainable health care delivery; a skilled workforce; and collaborative service planning and development.

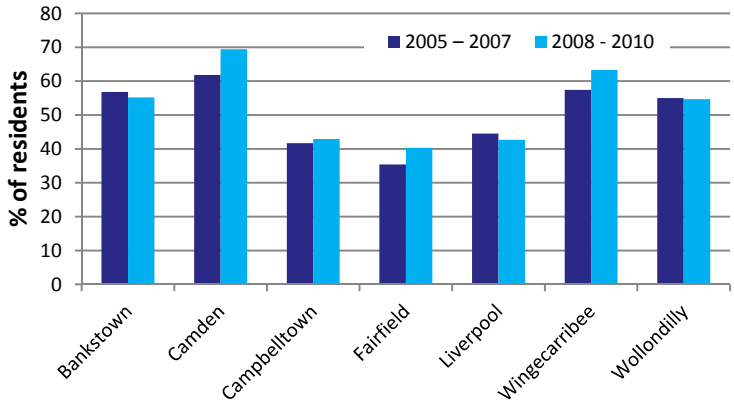
Local residents living in isolated areas report barriers related to access to transport. Provision of public transport is variable, particularly after hours and on weekends and the time and cost associated with travel also may impact access. As a result, residents in rural areas are more likely to own vehicles. The 2011 Census found that Wollondilly (96.7%), Camden (96.6%) and Wingecarribee (95%) residents have the highest levels of car ownership in the region, well above the NSW level of 89.6%.

Local residents living in isolated areas experience barriers related to access to health services. For example, general practitioners and private allied health services are often not available locally and the range of specialist services in public hospitals and privately is limited. Access to primary health care (and specialist services) has been identified as a specific problem in Wollondilly, compounded by the relative geographic isolation of its small towns and villages. Wingecarribee residents have reported difficulty accessing specialist medical care and the excessive time required to access services in other parts of South Western Sydney.

Socioeconomically Disadvantaged Communities

The 2010 *Population Health Survey*[51] indicates that local residents have lower levels of private health insurance (50.3%) than the NSW average (58.1%). NSW Population Health Surveys (2005/07 - 2008/10)[9] indicate that consistent with other indicators of access to health services, rates were lowest in Fairfield and Liverpool and highest in Camden and Wingecarribee LGAs.

Figure 16: Reported Rates of Private Health Insurance, South Western Sydney (2005-07, 2008-10)
Source: NSW Population Health Survey, HOIST 2012



The *NSW Chief Health Officer's Report (2010)*[11] identified that the health gains achieved over the past few decades have not been equally shared across the entire NSW population. It notes there is a gap between those with good and poor health. Whilst some of these differences are attributable to ageing, biological and/or lifestyle factors, social factors such as income, job and education status also play a critical role in health outcomes.

The World Health Organisation has identified the social determinants of health in the *Social Determinants of Health: The Solid Facts.*[52] Factors critical to overall health status are the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. The relationship between these factors and groups experiencing health disadvantage in NSW is summarised in the following.

Within pockets of the South Western Sydney, there are high concentrations of public housing. People in public housing often experience overall social disadvantage and have higher levels of physical and mental health problems, a history of incarceration, disability, drug and/or alcohol issues, with physical and/or social isolation. Almost 19% of the NSW public housing stock is located in south western Sydney [53] as described in Table 3.

In 2009-10, 69.5% of public housing in NSW was allocated to applicants assessed with the greatest need due to a combination of having a low income and experiencing homelessness; life or safety being at risk in their accommodation; having a health condition aggravated by housing; housing inappropriate to their needs; or very high rental housing costs.[54] It is recognised that this under-represents the size of the problem as it excludes those facing high rental costs in the private market.

In 2011, the median weekly household income in the region ranged from $1,022 in Fairfield to $2,199 in Liverpool, compared to the median weekly household income in NSW of $1,237. Three of the region's LGAs reported a median household income lower than NSW - Fairfield ($1,022), Bankstown ($1,091) and Wingecarribee ($1,094). Campbelltown LGA ($1,251) has a median household income which was similar to the state.[4]

Low income is linked to low educational attainment. The 2011 Census indicates that 40.8% of the region's population no longer attending school, were educated to a maximum of Year 10 or equivalent, compared with 37.1% for the state. All LGAs in the region were below the state average for completing Year 12 or equivalent. Of note is that Wollondilly LGA residents were least likely to have remained at school beyond Year 10, with 51.1% of residents indicating Year 10 or below educational attainment.[4]

Local unemployment at 7.2% was also higher than NSW level of 5.9%. Unemployment was above the state average in Fairfield (9.7%), Bankstown (7.6%), Campbelltown (7.4%) and Liverpool (7.0%). Low income is a barrier to accessing health services due to the cost for direct services, transport to services and treatment options, such as medications. Cost is also a barrier to other commodities which improve health, such as nutritious food and services which reduce social isolation.

Table 3: Public Housing Estates in South Western Sydney

Local Government Area	Number of public housing dwellings
Bankstown	6,282
Camden	367
Campbelltown	6,438
Fairfield	4,634
Liverpool	4,879
Wingecarribee	9
Wollondilly	18
South Western Sydney	22,627

Source: Family and Community Services – 2012/13 Housing NSW Open Access Information

The *NSW Chief Health Officer's Report* [11] identified that people with a low socio-economic status (SES) experience higher rates of potentially avoidable deaths and hospitalisations and have a lower life expectancy at birth and at age 65 years, when compared with those of a higher SES.

The National Council on Social Services has identified specific issues in relation to poor oral health (tooth decay and total tooth loss), high smoking rates and smoking related hospitalisations [55, 56]. Lower health literacy is also an issue at a prevention level, with later involvement in health care, difficulty reading dosage instructions, adherence to treatment and participation in screening and

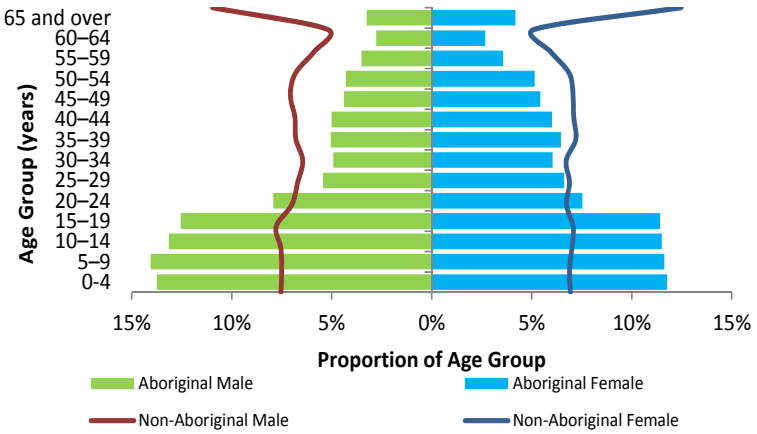
diagnostic tests.[57] The link between educational attainment and health literacy is a clear, with trends suggesting that people who possess higher levels of educational attainment also demonstrate higher rates of adequate or better health literacy skills.[57]

Aboriginal People and Torres Strait Islanders

South Western Sydney has the largest number of Aboriginal residents in metropolitan Sydney with 13,070 people identified as having an Aboriginal or Torres Strait Islander background in 2011. Most Aboriginal residents live in Campbelltown (4,729), Liverpool (2,676) and Bankstown (1,388) LGAs with the smallest number residing in Wingecarribee LGA (802).The proportion of Aboriginal residents overall is lower than NSW (1.6% and 2.5% respectively), however is higher for some areas, with 3.2% of the population of Campbelltown identifying as Indigenous. It is suspected that the number of Aboriginal and Torres Strait Islander residents in the region is higher; however barriers such as stigma and past experiences may prevent identification. In the health care setting, identification is achieved without the need to present substantiation. General practices are encouraged to routinely ask every patient if they identify as Aboriginal or Torres Strait Islander. Barriers to identification in primary health care include lack of a coordinated system for asking and recording responses of patients, lack of understanding about the need to ask, assumption that no Indigenous clients attend the service and reluctance to ask existing longstanding clients. [80]

The age profile for local Aboriginal people is markedly different to the rest of the population. In particular, it is strikingly younger with the proportion of Aboriginal children aged 0-9 years (25.5%) almost double that of non-Indigenous children (14.6%). The proportion of people aged 65+ years (3.7%) is around one third of the entire local population. This demographic is reflected in the figure following.

Figure 17: The age profile of Aboriginal communities in South Western Sydney (2011)
Source: ABC Census 2011



Aboriginal people are an at-risk population group and experience an overall lower health status and shorter life expectancy than the rest of the population. There are large disparities in estimated life expectancy and health outcomes between Aboriginal and non-Aboriginal people in NSW, with the gap in life expectancy estimated to be approximately 7-9 years for males and females (18-20 year gap in total). Multiple inter-related factors contribute to the poorer health status of Aboriginal people. The *NSW Chief Health Officer's Report 2010*[11] indicates that Aboriginal people in NSW:

- Are more likely to die at a young age (under 25 years) than the non-Aboriginal population (10% compared with 2%)
- Are more than three times as likely to die as a result of diabetes and one and a half times as likely to die from injury or poisoning than non-Aboriginal people

- Have an infant mortality rate (for babies born to Aboriginal mothers) which is almost twice the rate for babies in NSW overall. Rates of prematurity and low birth weight are also higher
- Are more likely to be admitted to hospital, primarily for renal dialysis, diabetes, chronic respiratory disease, cardiovascular diseases, injury and poisoning
- Have reported smoking rates and lung cancer rates around double the non-Aboriginal population
- Experience cervical cancer at around 4 times the rate of the non-Aboriginal population
- Are less likely to present to receive antenatal care before 20 weeks gestation (in 2012 69% of Aboriginal women received antenatal care before 20 weeks compared with 82% for the non-Aboriginal population).

Compared with other Indigenous people in NSW, Aboriginal people in South Western Sydney generally have better health. However their health is generally poorer than other residents in the region as a whole, with higher rates of potentially preventable hospitalisations including those attributable to diabetes, alcohol and smoking.

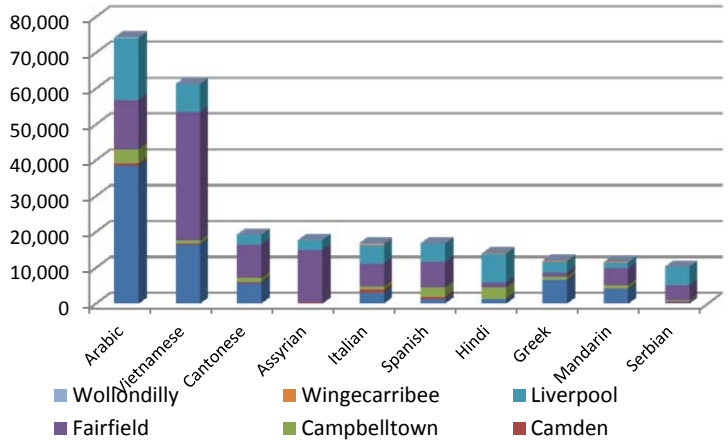
Culturally and Linguistically Diverse Communities

In 2011, 36% of residents were born overseas (compared with 26% for NSW). While 53% of people in Fairfield were born in another country, less than 16% of residents in Camden, Wollondilly and Wingecarribee LGAs were born overseas.

Across the region, 51% of local families speak English only at home (compared with 73% for NSW) and since 2006, an increasing proportion of families speak another language at home. Over 70% of families in Fairfield (131,162 people) speak a language other than English (LOTE) at home, whereas in Wollondilly and Wingecarribee the figure is less than 10%. Arabic is the most commonly spoken language other than English (over 74,000 people), followed by Vietnamese (over 61,000 people) and Cantonese (over 19,000 people). 40% of Arabic speaking people in NSW reside in this region. English ability in South Western Sydney varies, with 17.4% of Fairfield residents and 8.7% of Bankstown residents reporting they “speak English not well or not at all”.

Cultural groups can reside in distinct areas. For example, Assyrian speakers (from Iraq, Iran and Syria) primarily reside in Fairfield, whilst people speaking Korean and Indonesian primarily reside in Bankstown (see figure 18).

Figure 18: Main Languages Spoken in South Western Sydney
Source: ABC Census 2011



Almost 8,000 **humanitarian arrivals** settled in the region between 2008 and 2013 (37% of all NSW humanitarian arrivals).[58] The majority settled in Fairfield (4,249) and Liverpool (2,834).[58] The number

of people from Iraq was overwhelmingly the highest (approximately 74% of humanitarian entrants). Other major countries of origin included Iran, Egypt, China, Afghanistan, Burma and Ethiopia.

Humanitarian arrivals often have complex health problems related to their prior access to health care and/or their individual experiences of persecution or trauma. Due to these experiences, refugees in Australia have health needs that differ from the wider population including a higher prevalence of mental health conditions, specific infectious diseases, nutritional deficiencies, obstetric complications, and disability. Complex physical and psychological problems are often addressed only for the first time in Australia, with consequent demand on health and social services after arrival.[91]

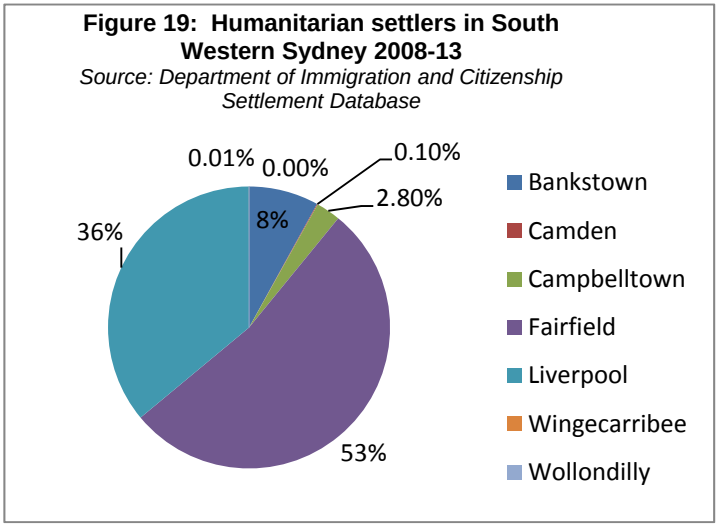
Across NSW, people from culturally and linguistically diverse communities generally have a better health profile than the Australian born population. This phenomenon has been explained by the 'healthy migrant effect', with health requirements and eligibility criteria ensuring that generally only those in good health migrate to Australia. However, there are some notable statistics of relevance to the main communities residing in this region. The *NSW Chief Health Officer's Report 2010* [11]indicates that:

- People from Lebanon are more likely to self-report they smoke, be overweight or obese, have diabetes, be hospitalised for coronary heart disease and cardiac revascularization procedures, have psychological distress and are less likely to receive antenatal care before 20 weeks than the Australian born population
- People from Iraq are more likely to be hospitalised for coronary heart disease and cardiac revascularization procedures. They are also less likely to receive antenatal care before 20 weeks than the Australian born population
- People from Vietnam have higher rates of tuberculosis and are less likely to receive antenatal care before 20 weeks than the Australian born population
- People born in India, China and Hong Kong have higher rates of tuberculosis than the Australian born population.

In terms of health related behaviours, people born overseas, tend to have a lower level of adequate physical activity than people born in Australia (45.2 % and 53.3% respectively), also overseas born communities report consumption of vegetables at half that of the consumption of Australian born people (5.3% compared with 10.9%), while fruit consumption is similar between two groups. Smoking prevalence among overseas born men is slightly higher than among Australian born men (21% and 20.6% respectively), while smoking prevalence in overseas born women is much lower than in Australian born women (7% and 14.8% respectively).

In terms of other health indicators, people born overseas perform better than the host population. Alcohol consumption levels in people born overseas are much lower than in Australian born people (12.6% and 32.2% respectively). In addition, people born overseas tend to be less overweight or obese than the Australian born population (40.4% and 55.3% respectively). The prevalence of high blood pressure and high cholesterol is lower in overseas born population than in Australian born people (21.4% and 30.6%, and 20.3% and 20.6% respectively), while

Figure 19: Humanitarian settlers in South Western Sydney 2008-13
Source: Department of Immigration and Citizenship Settlement Database



diabetes or high blood glucose level prevalence is lower in the Australian born population (8.1% and 9.0% respectively).

The psychological distress level is slightly higher in the Australian born population compared with people born in non-English speaking countries (9.3% and 10.3% respectively).[9]

People with Chronic Mental Illness and Their Children

Mental illness affects one in five people aged 16-85 years in Australia. Family members, friends and other associates are also affected by the illness.

The *National Survey of Mental Health and Wellbeing in Australia* [59] indicates that prevalence of mental illness is highest in the 16-24 age group (26%); and at any one time, 2-3% of the population will be affected by a severe mental illness, 4-5% by a moderate to severe mental illness and 9-10% by a moderate mental illness. In South Western Sydney this equates to 84,000 people with a mild problem, 40,000 with a moderate and 22,000 people with a severe problem. Mental illness ranks 4th as a major cause of life years lost, after heart attacks, stroke and cancer.

Recent research on Western Australian residents indicates that the life expectancy gap of people with mental health problems is 16 years for males and 12 years for females, with 80% of excess deaths associated with other health problems and conditions. [60] People with a mental illness are more likely to have poor physical health, while some physical illnesses also increase the risk of developing a mental illness. The *National Survey of Mental Health and Wellbeing in Australia* and the NSW Health *Physical Care of Mental Health Consumers* [61] guidelines indicate that people with a mental illness often engage in high health risk behaviours such as smoking, high alcohol and/or other drug consumption, poor nutrition, low levels of physical activity, high use of psychotropic medication and associated high risk social behaviours (such as unsafe sex and injurious activity). Use of licit and illicit drug and alcohol abuse has been frequently reported as a comorbidity in Australia (30%-80%). Drug and alcohol dependence is a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association (the fifth edition - DSM V) which is the standard classification of all mental health disorders, therefore everyone with dependence is considered as having a mental health condition.

These negative health behaviours, combined with an overall reduced level of access to the health system and poor health literacy, results in high rates of coronary heart disease, diabetes, cancers, infections, obesity, respiratory disease, dental disease and poor outcomes following acute episodes. In addition, a number of health and other conditions co-occur with mental illness, including intellectual disability, organic brain disorders (such as dementia) and alcohol and drug related problems.

Approximately 20% of Australian children have at least one parent with a mental illness. Children of parents with a mental illness are at higher risk than other children of having emotional, behavioural or mental health problems at some stage in their lives. The risk may be due to a combination of factors such as genetics, family situation and early life experiences.[62] These children may also experience barriers in accessing appropriate physical health services if they have no-one to monitor and manage their health appropriately.

People who are Homeless or in Insecure Housing

In excess of 3,600 people in the region are homeless with an additional 4,000 people living in crowded accommodation. Homelessness is particularly high in Fairfield and Bankstown LGAs.[4]

People who are homeless include those sleeping rough, living in caravan parks and boarding houses, staying with family and friends as their only housing option and those accessing the Specialist Homelessness Services program (SHS). The SHS Program is a joint Commonwealth and State program which provides funding for a range of support and accommodation services to assist people who are homeless or at risk of homelessness, including women and children affected by domestic

violence. These services include case management, support, outreach, advocacy, practical assistance and supported accommodation services, and linkages to other services such as health and housing. Community Services also provides fixed term funding. The 2011 Census identified 10,551 NSW children and young people aged 0–24 years as homeless (a rate of 45 per 10,000 population) and a rate of 36 per 10,000 among people aged 25 years and over as homeless. Across all ages, homelessness rates were highest among young adults aged 19–24 years (72 per 10,000). Children and young people are over represented among homeless people, comprising 37.4% of the total NSW homeless population. Census data is likely to under-estimate homelessness among young people, as youth who are homeless or "couch surfing" may be missed in these statistics.

The *Regional Homelessness Action Plan for Greater Western Sydney 2010 – 2014* [63] focuses on South Western Sydney excluding Wingecarribee. The report highlights that as at 2006:

- 1,774 people were homeless including 91(5%) who were Aboriginal
- The rate of homelessness in the South Western Sydney region was 20 per 10,000 population compared to 42 per 10,000 for NSW
- The majority of homeless households were in Bankstown (388) and Fairfield LGAs (325). Camden LGA had the least number of homeless households (11)
- Most homeless people in South Western Sydney were staying with friends (54%), followed by SHS accommodation (24%). Both of these are proportionately more than the state rate
- Local clients are generally younger than the state average and are more likely to be female, either alone or with children
- The primary reason people sought SHS accommodation in South Western Sydney was domestic violence (30% compared with 15% for NSW), time out from family and relationship breakdown. Eviction was also a reason in 7% of cases, compared with 4% for NSW
- Another 267 people in the region were marginal caravan park renters

The *Regional Homelessness Action Plan 2010 - 2014 Illawarra*[64] covers the Southern Highlands. It indicates that 184 people in Wingecarribee were homeless in 2006, one of the highest rates in the region.

People who are homeless experience numerous barriers in service access. They are also highly complex to support due to disengagement with the health sector; lack of a GP, Medicare card or health insurance; and no fixed address or contact details. Predominant health issues for those who are homeless include mental health problems, disability (psychiatric, intellectual, physical and sensory), self-harm behaviours, acquired brain injury, chronic illness, oral health problems, poor nutrition and food insecurity, drug and alcohol issues, high rates of communicable disease and bacterial infection and low adherence to treatment regimes.

In South Western Sydney, health issues which are significant for the large proportion of women escaping domestic violence situations include current and previous injury; experience of miscarriage; head injury and/or hearing/vision loss associated with blows to the head; depression; substance abuse; chronic illness associated with stress; sexual abuse and sexually transmitted infections. [65]

People with a Chronic Illness

The *National Health Performance Authority Healthy Communities Report* [66] identified that 46% of adults in south western Sydney report a long–term health condition i.e. the 5th highest of any metropolitan region in Australia.

By 2020, it is expected that 80% of the disease burden in Australia will be due to chronic disease. Chronic illnesses are prolonged conditions that often do not improve and are rarely cured completely. They include diabetes, dementia, chronic obstructive pulmonary disease (COPD), congestive heart failure and asthma. Many of these diseases result from lifestyle factors or social determinants of

health including poor nutrition, overweight/obesity, lack of physical activity and smoking. Others are caused by personal biological or genetic factors.

Because chronic illnesses can have a profound effect on the physical, emotional and mental well-being of individuals, many people experience difficulty in activities of daily living (including going to work) and in maintaining relationships. They require ongoing care and support to manage their disease and/or the disabilities which arise from that disease. Physical and mental health can be improved when appropriate medical treatment is provided and treatment regimes are adhered to.

Over 7 million Australians had at least 1 chronic disease in 2004-05, predominantly in older people.[67] Aboriginal people have a disproportionate experience of chronic disease compared with the general population.

People with Disabilities

Almost 48,000 people in south western Sydney reported in the 2011 Census that they had a profound or severe disability which required them to have assistance with at least 3 core activities i.e. 5.7% of the population, compared with 4.9% for NSW. The largest numbers of people with a disability reside in Fairfield (13,180) and Bankstown (11,279) LGAs. Wollondilly LGA has the least number of people with a disability (1,624).

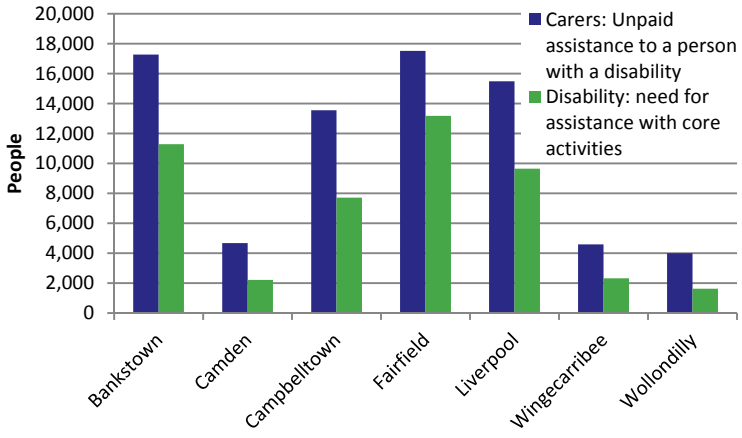
Disabilities include intellectual or physical issues, may be either congenital or acquired, and may be the result of a long term health issue or ageing. People with a disability often have higher levels of illness than the general population such as multiple chronic and complex care issues. They are also more likely than the general population to be under diagnosed or under treated and face significant barriers to accessing health services, including physical and financial barriers and discrimination.

The prevalence of disability in the community will rise in line with the ageing of the population. Consultations for the SSWAHS *Disability Action Plan 2008 – 2011*[68] indicated other barriers include the size and design of general practices and emergency departments, lack of coordination in addressing multiple health problems and lack of skills and comfort in treating people with disabilities.

National data indicates that amongst those aged 15–64 years with a specific long-term health condition, people with severe or profound disability were more likely to have diabetes and arthritis before the age of 25 years, and to be overweight or obese. [69]

Figure 20: People with Disabilities and Carers, South Western Sydney 2011

Source: Australian Bureau of Statistics, 2011 Census



Carers

Over 77,000 people in the region provide unpaid care or assistance to people with a disability, chronic long term health problem, or who are elderly. These include carers of people with dementia and mental health conditions. The proportion of local residents describing themselves as carers is the same as NSW (9.2%). Notably, there are 15,000 more people identifying as carers at 2011 than at 2006.The majority of carers are women and provide over 40 hours of unpaid care each week to people with a profound disability. Across the region and the state, there is approximately double the number of people reporting themselves as carers, as there are people reporting themselves as having a disability requiring assistance. The number of carers in South Western Sydney will increase in line with population growth and ageing.

Carers are integral partners in health care delivery in the planning and organising appointments and service access, assisting with activities of daily living, and treatment and compliance. Supporting carers in their role should result in reduced demands on the health care system.

Caring in the Community, Australia [70] reported that only 24% of carers are satisfied with their caring role and half reported sleep interruption as a result of their caring role. Some carers also identified themselves as having a stress related illness or considered themselves angry or resentful about their caring role.

People Engaged with the Criminal Justice System

The NSW Custody Statistics: Quarterly Update, December 2013,[100] reported that the adult prison population increased by 6.9% between July 2012 and December 2013. The NSW Custody Statistics: June quarterly update 2014 reports that about 10,515 people were in custody at the time. Around 20% of all offenders resided in Sydney and South Western Sydney prior to custody, with Aboriginal people disproportionally represented (32.5% of men and 26.6% of women in custody identifying as Aboriginal compared to 2.5% in the general community).

The *2009 Inmate Health Survey* and the *2009 Young People in Custody Health Survey* highlight complex health and social needs for these groups. Inmates display high rates of smoking; drug and alcohol abuse; obesity/overweight; hepatitis C; emotional and mental health problems and chronic diseases. In addition, young people in custody have a higher rate of hepatitis B, hearing loss and hearing problems, intellectual disability, poor nutrition and oral health. Prior to incarceration, the majority of young offenders reported experience of child abuse or trauma, placement in foster care before the age of 16 years and parents that have been in prison. [92, 93]

Juvenile offenders are usually in custody for a period of up to one week, and health services need to engage promptly with this at risk group. For adults, systems operate to link people to mainstream health services on release, it is important to meet their immediate needs post release as this period is identified as critical in relation to issues such as suicide and drug/alcohol relapse.

Up to 80% of prisoners are incarcerated due to drug use or drug related crimes. There are some health focused programs which address drug health issues. The Local Health District runs MERIT (Magistrates Early Referral into Treatment) and Drug Court Program. Post release, ongoing demand and high priority access to opioid treatment programs (OTP) will require a holistic approach to address multiple health problems. Health professionals may need training and pathways to specialist support, in order to develop confidence and skills to treat these issues in their patients. [101]

6. Health Care Services

Primary Health Care Services

There are 410 general practices in south western Sydney. Of these, 227 practices are solo GP services (55%) and the remaining 183 practices are group practices of 2 or more GPs. Of these group practices, 23% contain 6 or more GPs. The highest proportion of solo practitioners are located in the Fairfield LGA, comprising 68% of Fairfield practices, followed by Bankstown LGA (60%).

51% of practices in the region are accredited or registered for accreditation through the Royal Australian College of General Practitioners (RACGP) Standards for General Practice, 4th Edition. Practice accreditation is an independent assessment of the quality of healthcare and its conformance to these standards. General practice accreditation is voluntary.

51% of practices are computer based, with the remaining practices using either combination systems or fully paper based systems. Combination describes the presence of a computer with medical software; however patient notes are still largely paper based with the software generally used for printing scripts or referral letters. The region still has significant numbers of practices that are fully paper based, at close to 20%.

General Practitioners (GPs)

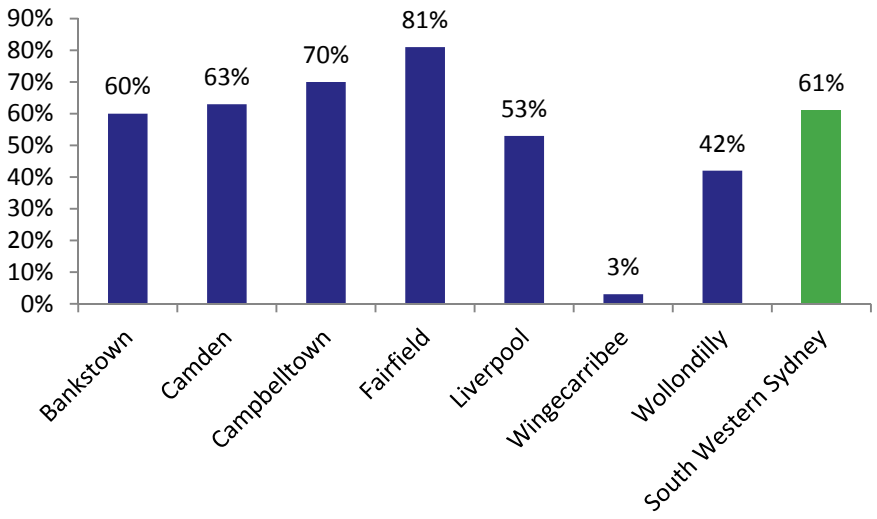
There are 978 GPs practising in the South Western Sydney region and 31% of these GPs are female. The GP workforce is aging. Approximately 28% of GPs are aged 40-49 years, 28% are aged between 50-59 years, and 26% are aged 60-69 years. Fairfield LGA has the highest proportion of GPs aged over 60 years, approximately 49% of the GP population.

The GP population is ethnically and linguistically diverse. 61% of GPs in South Western Sydney speak a language other than English and 20% of GPs speak 2 or more languages other than English. The largest proportion of GPs speaking a language other than English is in Fairfield LGA, where 81% of GPs are multilingual. Figure 21 displays the breakdown of GPs speaking a language other than English. The most common language spoken was Arabic (22%), followed by Vietnamese (19%), Hindi (16%), Cantonese (13%) and Mandarin (12%).

The South West Sydney Health System includes

- 979 GPs working from 410 practices and 282 practice nurses
- 211 pharmacies
- 1,300 private allied health providers
- 298 dentists
- 4 private hospitals and 7 private day centres
- 6 public hospitals and 5 affiliated services
- 6 Emergency departments
- 20+ community health facilities
- 1 National Aboriginal Community Controlled Health Organisation (NACCHO) and 1 Aboriginal family practice
- Targeted health services include: Women's Health Centres and Immigrant Women's Health Service; BreastScreen NSW; Headspace
- 22 non-government organisations funded by NSW Health
- 58 residential aged care facilities providing 5,769 places
- Support for people with mental health problems via Housing and Accommodation Support Initiative (HASI)

Figure 21: Percentage of GPs speaking a language other than English by LGA
Source: South Western Sydney Medicare Local (SWSML) Chili database



South Western Sydney Medicare Local has one of the highest GP to patient ratios in NSW, however there is vast variability across the region. The ratio being as high as 1 GP to 568 people in Wingecarribee LGA, to as low as 1 GP to 2,220 people in Wollondilly LGA, although this calculation does not consider whether the GP works full-time or part-time. A higher proportion of GPs working part-time would decrease patient access.

The region has the highest number of full-time work equivalent (FWE) GPs in NSW. This data unfortunately is not available at an LGA level, which would indicate the variability across the region. The region also has a high rate of Medicare bulk billed services provided to patients (the second highest occasions of bulk billed service of any Medicare Local region in Australia).[66]

Table 4: GP to Population Ratio (October 2014)
Source: South Western Sydney Medicare Local (SWSML) Chili database

LGA	Number of GPs (headcount)	GP headcount :population
Bankstown	205	930
Camden	67	871
Campbelltown	215	703
Fairfield	211	932
Liverpool	180	1045
Wingecarribee	81	568
Wollondilly	20	2220
South Western Sydney	979	894

Practice Nurses

There are 282 practice nurses employed in south western Sydney across 126 practices. Employment of practice nurses is highest in Wingecarribee and Campbelltown LGAs (61% and 55% of practices employing a practice nurse respectively). The greatest number of nurses is in Campbelltown and Liverpool LGAs with 88 and 53 general practice nurses respectively. 85% of practice nurses in south western Sydney are registered nurses.

GP Unit at Fairfield Hospital

The academic GP Unit is a GP registrar training and undergraduate teaching practice. It is located at Fairfield Hospital, and provides opportunities for training in GP research and education.

After Hours Services

After hours is defined as before 8:00 am and after 6:00pm on weekdays; before 8am and after 12:00pm on Saturdays and all day Sunday and public holidays. The after hours period can be further categorised as sociable and unsociable periods. Sociable after hours covers the period 6pm and 11pm, while the unsociable after hours period is from 11pm to 7am. After hours access to healthcare remains a concern for the community and health care providers. There are a number of services available to South Western Sydney residents during the after hours period.

Sydney Medical Service (SMS) Co-operative Ltd is a locally based 'bulk billing' Medical Deputising Service. SMS offers an after-hours Medical Deputising service for member doctors across metropolitan Sydney and is the main provider in South Western Sydney. The service is available to patients who are unable to see their GP within normal surgery hours or who have a medical condition which cannot wait until the next day. Medical staff are all general practitioners who have full registration in NSW and have experience in general practice. Experienced after-hours telephonists take the patient's call and pass on the details to the nearest available locum, along with the appropriate notes and history of visits if the patient has been seen previously. Medical reports are completed by the locum doctor at the time of consultation and sent to the patient's routine GP within 24 hours. The Sydney Medical Service has attained accreditation under the Royal Australian College of General Practitioners (RACGP) Standards.

SMS operates weekdays 6pm to 8am, Saturday 12 noon to 8am, and Sunday and Public holidays from 8 am to 8am. It covers both the sociable and unsociable after hours period. The service is utilised by 363 practices across the Bankstown, Liverpool, Fairfield, Campbelltown, Camden and Wollondilly LGAs. SMS is not currently available in Wingecarribee LGA.

Australian Locum Medical Services (ALMS) and **National Home Doctor Service (NHDS)** are two additional Medical Deputising Services (MDS) currently expanding within the region. They also operate during the sociable and unsociable after hours period. Both of these MDS's cover Bankstown, Fairfield, Liverpool and Campbelltown LGAs only.

Liverpool GP After Hours Clinic is a purpose built GP surgery located within the grounds of Liverpool Hospital adjacent to the Emergency Department. It is a walk in service, with no appointment required. The service is primarily for patients who are not classified as emergencies, and who are unable to wait until the next business day to attend their regular GP. Patients who are unable to attend the clinic and who require a house call are referred to the Deputising Medical Service operated by the Sydney Medical Service. The clinic operates weekdays 6pm to 11pm (sociable after hours), Saturday: 1pm to 11pm, and Sunday and Public holidays 9 am to 11pm.

Macarthur (Campbelltown) GP After Hours Service is operated by GPs from the Campbelltown LGA and is located within the grounds of Campbelltown Hospital near the Emergency Department. It is a walk in service, with no appointment required for patients. Any presentations assessed as requiring emergency care are referred to the Emergency Department. There are no arrangements in place for home visitation. The clinic operates weekdays 6pm to 10pm, Saturday, Sunday and Public holidays: 2pm to 10pm.

Southern Highlands (SH) GP After Hours Service Clinic is located at the rear of the Southern Highlands Private Hospital, adjacent to the Bowral Public Hospital and approximately 80 metres from the Emergency Department. X-ray and pathology facilities are available during clinic hours close by. The service is available as a walk in service with no appointment. The service operates Saturday 3pm to 5pm and Sunday & Public holidays 10 am to midday and 3pm to 5pm. The Service also provides a

GP phone call service for advice, organising home visiting as required and visits to residential aged care facilities.

The **after hours GP helpline** is an additional service of *healthdirect Australia*, supplementing existing after hours medical services and providing advice at night, weekends and public holidays. Callers are first assessed by registered nurses and based on their symptoms at the time of the call, may be transferred to an after hours GP for further advice.

While there are no 24 hour medical clinics, many private general practices provide routine appointments for some part of the after hours period. Across the region, 49% of practices are open for some part of the after hours period. The highest demand period for after hours care is weekdays between 6pm and 11pm and Sunday 8am to 6pm. The percentage of practices open from 6pm weekdays onwards, for at least 30 minutes, is 23%. This sharp decline in availability may drive after hours service and emergency department demand.

Aboriginal Specific Medical Services

Tharawal Aboriginal Medical Service is located at 187 Riverside Drive, Airds and caters to Aboriginal people and their partners. It provides a range of primary healthcare services with general practitioners, nurses and allied health providers. Tharawal promotes comprehensive health assessments and utilises a chronic care nurse to streamline and coordinate the care of chronically ill patients. Additionally, a number of clinics and specialist services are available.

114 Family Practice is a medical centre located at 114 Moore St, Liverpool and provides a primary health care service to Aboriginal people through GPs and practices nurses.

Marumali is located at 114 Moore St, Liverpool and operates as a health brokerage for Aboriginal people. The service employs outreach workers to liaise with Aboriginal patients, initiate health assessments and provide pathways for patients to access a GP. The service may then assist patients to access allied health and specialist services deemed appropriate by the patient's GP.

Kari Aboriginal Resources Incorporated is located in Liverpool and provides support to the Aboriginal community with a specialised focus on Aboriginal children, young people and families. The service provides support to children in out of home care and their carers, and provides a range of community services. The Brighter Futures Program which operates at Kari provides ongoing case management for families with children under 8 years old who face specific challenges such as domestic violence, parental drug and alcohol misuse, mental health concerns or minimal family support. The service also offers a comprehensive assessment service for children and young people called ‘The Clinic’.

Other services employ an Aboriginal specific case or outreach worker. For example, SWSLHD Youth Health Services employ Aboriginal Youth Health Promotion Workers to engage and improve health access and health literacy for Aboriginal young people and their families. Other services providing Aboriginal liaison staff include Headspace, Centrelink, Medicare office and the SWSLHD Browne Street Mental Health Centre.

South Western Sydney Medicare Local (SWSML)

The role of SWSML is to be the key body for integrated, quality primary health care services in South Western Sydney. In addition to working with primary health providers, local hospitals and health services and local agencies, SWSML provides a range of direct clinical services to patients. These include:

- Chronic Disease Management and Prevention provides for individuals and groups dietician and exercise physiology services aimed at utilising lifestyle changes to reduce health risk factors and

manage common chronic diseases such as obesity, diabetes, cardiovascular risk factors, cancer arthritis, chronic pain and polycystic ovarian syndrome. Services are bulk billed where applicable.

- Chronic Care Activity Program (CAP) in the Southern Highlands is an exercise program provided for GP referred patients with chronic illness. The service provides a medically prescribed exercise program including three supervised exercise sessions per week for 3 months.
- Access to Allied Psychological Services (ATAPS) provides brokerage of psychological support services to financially disadvantaged patients with a mental health issue of mild to moderate severity. Eligible patients are able to access the program at no cost with a referral and Mental Health Treatment Plan from their GP.
- (ATAPS) Child Mental Health Service provides psychological support services to children of financially disadvantaged families at risk of or with a diagnosed mental health issue, behavioural or emotional problem of mild to moderate severity. Eligible patients are able to access the program at no cost with a referral from a Psychiatrist, GP, School Counsellor, Early Childhood Centre Director or Allied Health Professional working for a non-government organisation. A Child Treatment Plan is required at the time of referral from a GP or before the second appointment with the treating allied health professional for those referred by people other than GPs.
- Suicide Prevention Service provides psychological services to patients at low to moderate risk of suicide or self-harm. Eligible patients are able to access the program at no cost. Face to face service is provided by an allied health professional within 72 hours of referral. Telephone based support is available 24 hours, seven days per week.
- Rural Diabetes Program provides diabetes education and management services to all diabetes patients referred by GPs (Types I and II, GDM, PCOS and people at high risk of developing diabetes). The program is generated through a database called Cardiac which provides to GPs outcome reports and reports for those at high risk of hospitalisation and increasing diabetes complications. Community group education is also provided through the ComDiab Program which targets those affected or at risk of diabetes. Services are available to eligible patients at no cost. The program has engaged 92% of diabetics in the Southern Highlands that are registered with the National Diabetes Services Scheme.
- Coordinated Care and Supplementary Services Program provides services to patients who are Aboriginal or Torres Strait Islanders. Program provides care coordination on referral from the patient's GP with a limited amount of flexible funding to assist with access to other health services.
- Practice Nurse Program involves clinical support to patients provided by experienced registered nurses in the GP's surgeries. This service supports the GP's and their patients to ensure ongoing best practice chronic disease management.

Chemists and Community Pharmacies

There are approximately 211 pharmacies in South Western Sydney. Only one pharmacy in the suburb of Wetherill Park is open 24 hours a day, 7 days per week. The Bankstown LGA has the highest concentration of pharmacies, with 59 outlets, followed closely by the Fairfield LGA with 49 outlets.

Targeted programs which community pharmacies may be involved in include: Home Medicines Reviews (HMR) which can assist people of any age who live at home, improve their medication management and the NSW Government Pharmacy Incentive Scheme which involves dispensing pharmacotherapies, immunisation, blister packs and equipment.

Opioid Treatment Therapy can be provided by local general practitioners or through SWSLHD Opioid Treatment Program clinics. In South Western Sydney there are 35 GPs who have completed Opioid Treatment Program accreditation. A further 21 GPs have not completed the accreditation course and are limited to prescribing opioid treatment to a maximum of 5 patients.

Allied Health Professionals

There are around 1,300 unique private allied health providers across the region, operating from 575 sites.

The highest number of allied health providers in the region is psychologists (271). Bankstown and Campbelltown LGAs have the highest quantity of allied health providers, with a combined total of 45% of all allied health providers registered with the SWSML. Wollondilly LGA has significantly fewer allied health providers than any other LGA, at 20 providers, and is the only region which has no private exercise physiologist, audiologist and podiatry services. There are some public allied health services available through the Local Health District's Wollondilly Community Health Centre

The most common business structure for allied health providers is a single site (53% of providers), followed by multiple sites (33%), co-location in general practice (11%) and home visits (5%).

Dentists

There are 298 dentists in the region practicing from 187 sites. The highest number of dentists is in Fairfield LGA at 74, followed by Bankstown with 56 dentists. Wollondilly LGA has the poorest dentist to patient ratio of South Western Sydney, with 1 dentist for every 11,100 people. The highest dentist to patient ratio is in Camden LGA, with 1 dentist to every 1,945 people.

Ambulance Services

The Ambulance Service of NSW provides time critical emergency and urgent out of hospital care including at the scene, transport to a hospital or other health facility and transport between facilities. Services include telephone advice and referral; assessment and service provision in the residence or at the scene; and treatment and transportation. It also provides non-emergency transport for scheduled appointments and procedures to a limited number of patients. Ambulance Stations are located at Bankstown, Fairfield, Liverpool, Green Valley, Macquarie Fields, Campbelltown, Camden, Picton, Bowral, Canyonleigh and Bundanoon.

In May 2014, the NSW Ambulance launched the Extended Care Paramedic Service in South Western Sydney. Extended Care Paramedics assess patients who call 000 and decide on the most clinically appropriate treatment needed. Treatment options include treatment and discharge or initiation to non-emergency department care including referral to the patient's GP, co-located GP clinics or hospital and community health based services.

Emergency Departments

Emergency Departments are located in the six public hospitals in South Western Sydney - Bankstown-Lidcombe Hospital, Bowral and District Hospital, Camden Hospital, Campbelltown Hospital, Fairfield Hospital and Liverpool Hospital. They operate 24 hours/seven days a week for people with a serious illness or injury requiring urgent attention. In 2013/14, there were 227,534 attendances to these services. There are no private emergency services in South Western Sydney.

Public Hospitals, Community Health Services and Affiliated Health Organisations

There are six public hospitals under the control of South Western Sydney Local Health District: Bankstown-Lidcombe Hospital; Bowral and District Hospital; Camden Hospital; Campbelltown Hospital; Fairfield Hospital; and Liverpool Hospital. The hospitals vary in size, type of services, and level of specialisation (classification and role). Liverpool is the principal referral hospital for the region, providing highly specialised services. Bankstown-Lidcombe is also a principal referral centre providing a smaller range of specialised services. Campbelltown and Fairfield Hospitals are major metropolitan hospitals and Camden and Bowral and District hospitals provide distant or rural services.

In addition, there are five affiliated health organisations (not-for profit organisations) which provide specialised public health services: Braeside Hospital at Prairiewood specialises in rehabilitation, palliative care and older persons' mental health; Karitane at Carramar specialises in early intervention services and education programs to families with children up to five years; the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) at Carramar provides treatment and rehabilitation to survivors of torture and trauma; Scarba South West Sydney provides an outreach child protection service based at Ingleburn; and Carrington Centennial Care at Camden provides residential aged care, assisted living services and support services for older people.

These services operate as a network providing specialist health services in acute and subacute (post-acute) inpatient and outpatient care in ambulatory settings.

SWSLHD Community Health Services

Community health centres are located across the region and provide services from birth to older age. The work of Community Health Services within SWSLHD is multi-dimensional, covering prevention, early detection and intervention for health problems or risks; ongoing care of chronic and complex conditions in collaboration with specialised services; and community acute/post acute care (CAPAC). The major centres are located in:

- Bankstown LGA- Bankstown Community Health Centre, Meredith Street and the Corner Youth Health Service
- Fairfield LGA -Cabramatta, Fairfield and Prairiewood Community Health Centres and the Fairfield Liverpool Youth Health Team (FLYHT)
- Liverpool LGA - Liverpool, Hoxton Park and Miller Community Health Centres, Bigge Park Centre and The Hub. Also on the Liverpool Hospital campus are the services of Child Protection Counselling Services, Multicultural Health, Women's Health, Community Paediatrics, HIV and Related Program (HARP) Health Promotion Team
- Campbelltown LGA - Campbelltown, Ingleburn and Rosemeadow Community Health Centres, Traxside Youth Health Service and Campbelltown Mental Health Service
- Camden LGA - Narellan Community Health Centre at Narellan
- Wollondilly LGA - Wollondilly Community Health Centre at Tahmoor
- Wingecarribee LGA - Wingecarribee Community Health Centre at Bowral

Services are also provided through smaller centres and facilities including early childhood services, dental clinics and respite centres.

Services and teams include Early Childhood Health Services; Child Adolescent and Family Health Services; Child Protection; Sexual Health Services; Women's Health Services; Sexual Assault Services; HIV/AIDS Community Services; Youth Services; Community Health Nursing; Counselling Services; Nutrition Services and Palliative Care Nursing. Some services include targeted interventions for population groups such as Aboriginal people and families at risk. In addition, other specialist services such as Drug and Alcohol, Mental Health, Population Health and Health Promotion, Dental Services, Aged Care and Rehabilitation, and Hospital outreach are provided through Community Health. The Triple I (Hub)- a centralised intake, information and intervention service delivering a streamlined method of referrals to Community Health Nursing and Aged and Chronic Care Services is also part of Community Health.

BreastScreen NSW operates across the region, with fixed screening locations in Bankstown, Bowral, Campbelltown and Liverpool, and mobile screening available from the Breast Screen mobile van.

SWSLHD Youth Health Services provide specialised multidisciplinary primary and targeted health services for marginalised and at risk young people aged 12-24 years. They often work in collaboration with mainstream health services (such as mental health, drug and alcohol, sexual health, etc.) and

NGOs (such as youth services and headspace) to provide holistic health services in a seamless "one stop shop" approach. Whilst young people in general experience good health, there are some specific populations of young people that experience poorer health outcomes. SWSLHD Youth Health Services provide specialised, multidisciplinary and targeted care. Services are provided in a developmentally appropriate and geographically accessible manner. Youth health services are also available at the Corner Health Centre in Bankstown, Fairfield-Liverpool Youth Health Team (FLYHT) in Fairfield and Traxside in Campbelltown.

Private Hospitals and Day Centres

Three private hospitals are in close proximity to local public hospitals. They provide 4% of private beds in NSW and about 10% of the beds in south western Sydney.

Sydney Southwest Private Hospital is located in Liverpool and operates 93 beds. Services include Anaesthesia, Intensive Care, General surgery, Gastroenterology & endoscopy, Gynaecology, Urology, Orthopaedics, Plastic, Reconstructive and Cosmetic Surgery, Ear, Nose & Throat Surgery, Paediatrics, Vascular Surgery, Oral & Dental Surgery, General Medical Care, Obstetrics, Special Care Nursery, Angiography, Pathology, Physiotherapy and Radiology. Mental health intervention and treatment is provided via an 18 bed psychiatric unit staffed by psychiatrists. Consulting suites are also provided.

Campbelltown Private Hospital is located in Campbelltown and operates 92 beds. Services include Anaesthesia, General Surgery, Gastroenterology and Endoscopy, Gynaecology, Urology, Orthopaedics, Ophthalmology, Plastic, Reconstructive and Cosmetic Surgery, Ear Nose and Throat Surgery, Paediatrics, Oral and Dental Surgery, General Medical Care, Rehabilitation, Sleep studies, Bariatric Surgery, Mental Health Services, Pathology and Diagnostic Imaging Additional services include Physiotherapy, Hydrotherapy pool, Medical consulting suites, and a Gymnasium.

Southern Highlands Private Hospital is located in Bowral and operates 71 beds. Services include Anaesthesia, Gastrointestinal Endoscopy, Medical, Paediatric, Rehabilitation and Surgical. Additional services include Physiotherapy, Hydrotherapy, Occupational Therapy, Dietetics, Speech Therapy, Clinical Psychology, Discharge Planning and a pre-admission clinic. Support services such as Radiology (x-ray and CAT scan) and Pathology are provided on site.

Northside Macarthur is a 36-bed private hospital specialising in the care of people with a mental illness. The clinic is located in Campbelltown CBD and provides inpatient care and day services. Professional support available includes Psychiatry, Psychology, Recreation Therapy and Specialist Nurse therapy.

There are also seven private day centres in the region representing 6.5% of day procedure centres in NSW.

- In Bankstown LGA, the Bankstown Primary Health Care Day Surgery provides Anaesthesia, Gastrointestinal Endoscopy and Surgical services
- In Fairfield LGA, the Boulevarde Day Surgical Centre at Fairfield Heights provides Anaesthesia, Gastrointestinal Endoscopy, Paediatric and Surgical services
- In Liverpool LGA, Genea Liverpool providing Anaesthesia and Surgical services; Liverpool Day Surgery at Moorebank provides Anaesthesia, Gastrointestinal Endoscopy, Paediatric and Surgical services. Liverpool Eye Surgery provides Anaesthesia, Paediatric and Surgical services; and South Western Endoscopy Centre provides Anaesthesia, Gastrointestinal and Endoscopy services
- In Wingecarribee LGA, Southern Highlands Private Hospital Specialist Centre at Bowral provides Chemotherapy

Non-Government Organisations Providing Health Care

A range of non-government organisations (NGOs) and groups offer specialised services and support. These organisations are funded from a range of sources including the NSW Ministry of Health and the Australian Government. The following does not list all services but provides an overview and includes general services.

In Mental Health, Headspace Centres located in Campbelltown and Liverpool provide mental health clinical and social support to clients aged 12 to 25 years. Headspace also provides services for general health, education, employment and alcohol and other drug services.

Other agencies providing mental health services include Lifeline Macarthur; New Horizons Enterprise Limited; Southern Highlands Bereavement Care; Day to Day Living in the Community; Housing and Accommodation Support Initiative (HASI); Beautiful Minds; Improving Mental Health and Wellbeing in Local Communities (NEAMI); ROAM Communities; Richmond PRA; Aftercare; Carer Assist; Care Connect; Compeer Friends Program; Consumer Activity Network - Hospital to Home Service and Phone Connections; Day-to-Day Living Program - Harmony House; GROW support group and residential program; Personal Helpers and Mentors Program; and Disability Trust

In Women's Health, services are provided through the Bankstown Women's Health Centre; Bankstown Older Women's Network, the Liverpool Older Women's Network; Liverpool Women's Health Centre; Wilma Women's Health Centre at Campbelltown; the Immigrant Women's Health Service (at Fairfield and Cabramatta); Family Planning NSW at Fairfield; the Benevolent Society Centre for Women's Health and Catholic Care Sydney. All these agencies provide a range of reproductive and sexual health services, counselling and family support.

In Drug and Alcohol, a range of treatments and interventions are provided by Cabramatta Community Centre; GROW Community; Mission Australia South West Youth Service; Odyssey House McGrath Foundation; Maryfields Day Recovery Centre; DRUM Youth Resource Centre; and Youth Solutions.

In **Aged Care and Rehabilitation**, services include the Commonwealth Carer Respite Centre (CCRC); Commonwealth Carelink programs; Headway Adult Development Program; Community Home Care Packages and Alzheimer's Australia.

A number of NGOs work directly with disadvantaged **children and families** in programs for early intervention and child wellbeing, child protection and out-of-home care, such as Uniting Care Burnside which operates the Family Referral Service; CatholicCare, Mission Australia, Vision and Brighter Future Programs.

General services include the Bankstown Community Transport (for health); Quest for Life Foundation; Southern Highlands Bereavement Services; and Carers NSW.

Health Promotion

Preventing health problems from developing is critical to the health and wellbeing of a community. General practitioners and practice nurses have an important role in promoting health and preventing disease at an individual patient level. This work is supported by the work of South Western Sydney Medicare Local, allied health providers and other health professionals who also work with individual patients, their families and groups. SWSLHD Population Health, including the Public Health Unit and the Health Promotion Unit, work at a community and population level to protect and promote the health of the local population. These services work in partnership with other agencies including local councils, schools, community services and childcare services to deliver a comprehensive range of high quality, evidence-based health programs aimed at developing health-promoting policy, environments and behaviours.

Targeted health promotion officers are also employed by a range of SWSLHD services including Youth Health, Sexual Health, Women's Health, The Hub at Miller, Multicultural Health, Community Nutrition, Child and Family Health services and Community Nursing.

Other Agencies and Community Services

There are other agencies which provide health services to specific populations or for specific health problems. For example, NSW Health and Ageing Disability and Home Care (ADHC) provide early intervention services such as therapy for children with developmental delay or disability and behavioural support services for children and adults with intellectual disability. ADHC also provides services to, older people and respite and support for carers and families. There will be some changes to the disability sector, and from July 2016 all people with a disability in NSW will transition to the National Disability Insurance Scheme (NDIS). Hearing services are provided by public and private professionals through the Australian Government Hearing Services Program.

A wide range of community services also support and assist residents who are vulnerable, including older people, people with disabilities, people with mental health conditions and Aboriginal people. They include Home and Community Care (HACC) services targeted to people with disabilities and frail older people such as Home Care and Community Transport; employment and social services for people with mental health conditions; settlement and migrant resource centres targeting non-English speaking communities; and support and early intervention services for children at risk. These services complement services provided by government agencies such as the NSW Department of Community Services, Housing and Education and Australian agencies such as Centrelink. They are important partners with primary and tertiary health services, enabling residents to maintain a healthy, active and productive life and engage in their communities.

Residential Aged Care Facilities (RACFs)

Older people who are no longer able to live within their own homes due to age related disability can be assessed by Aged Care Assessment Teams for entry into residential aged care facilities (RACFs). A number of changes to aged care were introduced in July 2014. Home Care Packages replaced Community Aged Care Packages and the distinction between high and low care beds was removed. The Aged Care Assessment Team (ACAT) no longer makes this distinction, and it is done by the RACF provider. High and low level residential care only applies to the residential care provided for respite purposes. There are sixty two RACFs in South Western Sydney providing 2,990 beds including 72 respite and 873 secure dementia beds. A list of RACFs is included in the data supplement document *Health Indicators for the Communities of South Western Sydney and the Southern Highlands*.

7. Factors Affecting Health Care

The term access is often used to describe factors or characteristics influencing the initial contact or use of services. Access to health is affected by factors such as education, employment and income and a range of systemic factors which also impact on the quality of health care. The information following was obtained from National Health Performance Authority reports[37, 66, 71], South Western Sydney Medicare Local data bases, audits, surveys and consultations with consumers, GPs and other health practitioners about the main barriers to health care in south western Sydney.

National data[66] indicates south western Sydney residents had the highest average number of GP attendances per annum (7.5) in Australia in 2012/13. Average expenditure per person on GP attendances was also the second highest nationally at $329.36 per person.[66]

Physical Access

Travel and physical access to health care was one of the most frequently raised concerns during the consultations, including the lack of parking and drop-off points for primary health care providers and to some public hospitals, particularly to Bankstown-Lidcombe and Campbelltown hospitals.

Due to relatively poor public transport, local residents generally have a higher dependence on private vehicles (69% compared to 62.6% in NSW). This is particularly true for residents in rural fringe areas of Wollondilly, Wingecarribee and Camden, and also Fairfield, where in excess of 70% of residents travel by car. Concerns were raised about the increased cost and time associated with travelling long distances to access specialist private and public health services, where these services are not available locally. These costs are aggravated by parking charges, particularly at the larger public hospitals (e.g. Liverpool, Bankstown-Lidcombe and Fairfield hospitals).

Infrequent trains and buses and limited after hours public transport impacts access for all communities to health care and healthy lifestyles. This is particularly an issue for disadvantaged groups including people living in public housing estates, older people, recent arrivals and people in rural fringe areas.

Supported Access

Community Transport is used by older people and people with disabilities to access a range of services including health care. Age standardised rates for community transport usage in 2010/11 indicate variable access to community transport with the highest use in geographically isolated areas.[72] Community transport services have consistently identified growth in demand for health related transport as a major problem[73]. In particular, the Macarthur Transport Symposium 2012[74] and NGO surveys indicate that services are concerned about their capacity to meet the exponential growth in demand for health related transport, reducing access to other basic services. Other concerns include timeliness of appointments, lack of coordinated approaches to health transport and significant distances travelled to access primary and tertiary health care, particularly for people in outlying areas. Physically larger medical practices with drop off areas or transit lounges, which provide their own transport, has been suggested as one way to address this issue.

Cost of Health Care

The 2011/12 National Health Performance Authority report[66] indicated the impact of cost of care on patient access to services. Patients reported that cost was least likely to be a barrier to GP services (reported by only 4% of residents). This may reflect the high proportion of GP attendances which were bulk billed e.g. 95.7%, the second highest nationally. Of note was that bulk billing was greatest in the eastern parts of the region and lowest in the southern rural areas. This was consistent with comments

from the patient surveys about after-hours access which focused on affordability, accessibility and availability of services.

The National Health Performance Authority report [66] also identified other health services where patients delayed or did not use the required service due to cost. Cost barriers were reported by 10% of residents in relation to medical specialists, the second highest rate in NSW; by 18% of residents in relation to dentists and hygienists; and by 10% of residents in filling a prescription. Local feedback from GPs, patients and other health providers supported these findings, with low socioeconomic status, low levels of private health insurance and increasing gap payments cited as contributing to the cost barrier. These barriers, together with limited funding through targeted Medicare programs, were also cited as causing substantial access barriers to allied health therapy services. These barriers increased demand on local and out of region public health services.

What were local agencies concerned about?

- Care for people with mental health problems
- Long waiting times
- Communication and collaboration
- Gaps in local services
- Distance to services
- Cost of services
- Lack of preventative focus

Health Service Availability

The number, location and hours of operation of service providers have a major impact on healthcare access. GP to population ratios were previously described under the heading General practitioners on page 43.

Patients reported that they liked services close to their home or services that were easily accessible in terms of working hours and waiting times, and services that bulk billed. A number of patients also indicated that they would like more options for a one stop shop healthcare service, providing a range of services in one location.

The 2011/12 National Health Performance Authority report [66] indicated that 21% of local patients reported that they waited longer than acceptable for a **GP appointment**. Although this was less than in other metropolitan regions, local community consultations have raised concerns with extended waiting times for booked GP appointments, walk-ins and appointment management. In Wollondilly LGA, the concerns focus on the undersupply of GPs and other primary health services and the impact that this has on access and travel. GPs across the region have also indicated that they are unable to provide enough appointments to meet patient demand.

Approximately 12% of residents in 2011/12 reported that they visited an **emergency department** in the preceding 12 months. This was similar to other metropolitan regions.[66] Emergency departments in the region are not yet meeting the NSW target of 71% of all patients to leave emergency departments within four hours. Performance at most hospitals has substantially improved over the last year. [75]

Across NSW 95% of patients requiring **planned (elective) surgery** are treated on time. Public hospitals in South Western Sydney meet this overall benchmark. This is true for all surgical categories except Category 3 non-urgent cases in some hospitals. Median waiting times for elective surgery vary by speciality and hospital. [72]

Approximately 33% of residents in 2011/12 reported that they saw a **medical specialist** in the preceding 12 months. [66] 27% of residents however reported waiting longer than acceptable for the specialist, the highest response in metropolitan Sydney. This reflected feedback from local residents, GPs and other health providers.

Local data indicates GP satisfaction with private specialist services is higher than with public hospital and community health services. Waiting times were an issue for 42% of GPs, particularly for day surgery and specialist appointments. Gaps in public mental health services (including community mental health) were an additional source of concern.

Patients, GPs and specialists in public hospitals report poorer availability of private and public medical specialist services and lack of information about services available. Specific issues identified for hospital based services include lengthy waiting times for some medical speciality clinics, limited service outlets with some specialties only available at Liverpool or at best three hospitals, poor transparency about service criteria and limited capacity for GP referrals. Centralisation of services (and lack of specialist services at the local hospital) is particularly problematic for rural residents, people who do not own a car and people who remain largely within their immediate LGA e.g. residents of Fairfield and Bankstown LGAs.

An audit of public health services (February 2013) indicated that factors such as the type of health problem (and priorities), the patient's age, intervention required and location can influence the waiting time. Various approaches have been used to manage waiting times including triage systems, service prioritisation, limiting treatment time, group treatment and for children, working through schools and preschools.

Approximately 44% of residents in 2011/12 reported that they saw a **dentist or hygienist** in the preceding 12 months. [66] This was a substantially lower proportion than in other parts of metropolitan Sydney. Public dental clinics are located in all LGAs, with waiting times meeting NSW Health benchmark targets for all eligible patients except those requiring non-urgent check-ups (February 2013). To meet these targets, however some patients may have travelled outside their immediate area.

There is no national data on waiting times to access **allied health practitioners**. Anecdotally, there appears to be minimal waiting times to access private allied health professionals, however, as indicated by the audit of public health services, demand for public allied health services is high and depending on patient need, delays of up to 16 months can be experienced.

After Hours Services

In 2013/14, there were 107,476 presentations to after hour medical services i.e. Sydney Medical Service, emergency departments (triage categories 4 and 5) and After Hours GP services. More than half of all after hours services were through Emergency Departments (63%) followed by the Medical Deputising Service (22%) and the Liverpool GP After Hours Clinic (8%).

LGAs with the highest rate of ED department use in the after hours period (category 4 and 5 admissions) were Wingecarribee residents (131 per 1,000), Wollondilly (96 per 1,000) and Campbelltown (90 per 1,000). Campbelltown ED was the busiest ED during the after hours period for category 4 and 5 admissions, seeing 25% of presentations. Liverpool was the second busiest ED, with 20% of the total of presentations. Specific concerns identified in consultations focused on affordability and accessibility, information and education about after hours services and need for greater diversity of services.[76]

Specialist health services and community members have identified after hours services as problematic, particularly in rural areas. Transfer of care between the business hours GP and after hours services has been highlighted also as a particular issue for people with complex health conditions such as palliative care patients.

SWSLHD Emergency Departments

Between July 2013 and June 2014, there were 227,534 emergency department (ED) presentations in the SWSLHD. Out of these:

- 46% were in a non-urgent triage category 4 (treatment acuity within 60 minutes) and triage category 5 (treatment acuity within 120 minutes)
- about one third were potentially avoidable GP type presentations. Potentially avoidable GP type presentations are defined as presentations to public hospital emergency departments in principal referral and specialist women's and children's hospitals (peer group A) and large hospitals (peer group B), where the patient was in a triage category 4 or 5 and not arriving by ambulance or by police or correctional vehicle, and was not admitted to the hospital, was not referred to another hospital, and did not die.
- 31% were presented at Liverpool Hospital, 25% at Campbelltown Hospital, 17.5% at Bankstown –Lidcombe Hospital, 14% at Fairfield Hospital, 7% at Bowral and District Hospital, and 5.3% at Camden Hospital
- 37% were in the under 25s age group and 20% in the over 65s age group.

SWSLHD Outpatient Care

SWSLHD provides a number of medical and surgical services through its Outpatient services. In total, there were 736,083 non-admitted patient occasions of service (NAPOOS) provided through the SWSLHD facilities in a six month period (July-December 2014).Out of these:

- 42 % were in Liverpool Hospital, 20% in the Macarthur hospitals (Campbelltown and Camden), 14% in Bankstown-Lidcombe Hospital, 7% in Fairfield Hospital, 2.5% in Bowral and District Hospital and under 1% in Braeside Hospital and Karitane
- 13% were provided by Community Health outside SWSLHD hospitals and less than 1% by Aged Care
- about 1/5th were mental health related services for all three age groups: child and adolescents, adult and general, and older people
- 17% were radiation and oncology services including consultation, planning and simulation, and treatment. Other services included obstetrics related services (9%), family and child health (6%), primary health care services (5%), aged care services (4%), physiotherapy and speech pathology-general each (2%).

The above presented data for SWSLHD emergency departments and outpatient services should be considered with caution due to variations in reporting practices, missing data and data entry errors.

Targeted Access and Support

Targeted and tailored health programs and services have been developed to improve the health of groups in the community with poorer health outcomes including Aboriginal people, older people, people living in rural areas, younger people and people from disadvantaged communities. The Medicare Practice Incentives Programs (PIP) provide incentives to general practices to focus their attention on specific populations or activities. There are also long standing services which provide specific populations with targeted care. The following summarises these services.

Aboriginal Specific Services include Tharawal Aboriginal Medical Service, the 114 Family Medical Practice and a brokerage service, Marumali. SWSML operates a Closing the Gap Program and a Care Coordination and Supplementary Services Program for Aboriginal clients. GPs can access the Medicare PIP Indigenous Health Incentive to improve health care for Aboriginal people. SWSLHD employs Aboriginal Health Workers (and in some cases provides targeted Aboriginal specific programs through outreach) in early childhood, drug health, mental health, sexual health, chronic disease and inpatient services. These services tend to be well utilised and have improved the health of the community.

Specific issues identified through various consultations include: need for stronger promotion of healthy lifestyles in Aboriginal communities; a more culturally sensitive health workforce; need for targeted access across a broader range of mainstream specialist services; lack of inpatient hospital liaison at Bankstown-Lidcombe Hospital (subsequently addressed in 2014); need for improved clinical support for the Aboriginal health workforce; and difficulties in recruiting Aboriginal people with health qualifications or interest in health services. An overarching component of the consultations was the need for services to develop trust and rapport with the Aboriginal community to enable access to health care.

GPs, paediatricians, early childhood and school nurses and allied health professionals have important roles in screening, assessing and treating **children** with a range of health problems including disabilities and developmental delay. The Medicare Healthy Kids Check, Helping Children with Autism Program and Better Start for Children with Disability Initiative provide the structure for GPs to identify problems in children earlier and to refer children with disabilities to private allied health practitioners. These initiatives build on early identification, assessment and treatment clinics and services provided through local public hospitals and community health centres, and specialised services provided by or funded through the Department of Ageing and Disability.

Strengths in the region include a well-developed children's service network (including tertiary support through Karitane), the evidence based sustained nurse home visiting program (SNHVP) and the growing expertise and range of children's medical assessment services in Campbelltown and Camden Hospitals. Concerns identified focus on: the increasing levels of overweight and obesity in children; variable skills and knowledge of GPs in managing asthma and identifying developmental delay in children; the need to continue to promote early intervention; lengthy waiting times for therapy services for children, which can be compounded by parent delay or reluctance to seek a diagnosis early ; the limited number of therapy sessions allowed privately through Medicare incentive programs; the need for stronger child protection action; and the lack of a Paediatric Hospital within the region, despite an extremely large child population. Feedback suggests that these barriers can often lead to families missing out on funding and support for long term intervention.

Primary health care services for **young people** are provided predominantly by GPs. Youth health services, such as Traxside and The Corner, have increasingly been reoriented to those young people who are at most risk. There is also a strong community sector which engages with young people and provides additional support and referral. Concerns focus on the need for a greater preventative health focus on younger people as a means to develop positive life-long health behaviours; a stronger focus on health literacy in this age group; the variable appropriateness of general practice approaches for young people, and the lack of services to support the transition for young people with chronic health conditions from the care of the Sydney Children's hospitals to adult services. Access to appropriate sexual health advice and intervention was a concern for services. This included STI testing, HPV vaccination, access to information about preventing STI transmission and issues of consent and sexual rights.

Young people tend to be consistently underrepresented in general practice consultations. According to the Australian Medical Association (AMA) Position Statement: The Health of Young People (2013), some real and perceived barriers to young people's access to general practice can include lack of financial independence, lack of autonomy, inadequate access to transport, communication difficulties, lack of experience or information, cultural differences, time and geographical location.
In **Mental Health,** the GP Mental Health Treatment items in the Medicare Benefits Schedule (MBS) provide a structured framework for GPs to develop plans for patients with mental disorders and to refer them to psychiatrists and to allied health practitioners who are registered to provide mental health related interventions. Funded mental health programs are available for people with an established GP Mental Health Treatment Plan. These programs include the Access to Allied

Psychological Services Program (ATAPS) administered by SWSML, and the Better Access Program administered by Medicare. The availability of these funded programs has improved access for people with mental health conditions to private psychiatrists and allied health professionals however data from 2009/10 indicates variable use of Mental Health Care Plans by GPs, at levels above the NSW rate in Wingecarribee and Campbelltown LGAs and below in all other LGAs. Data also indicate variable referral to and/or access to psychiatrists and allied health professionals across South Western Sydney, with interventions highest in Wingecarribee and lowest in Fairfield and Liverpool.

Headspace provides medical and allied health services to 12-25 year olds with a focus on early identification and intervention of mental health problems. Centres are available in Liverpool and Campbelltown. Also targeting young people is the mental health promotion program Mind Matters which operates in local high schools.

Mental health inpatient units are located at Bankstown-Lidcombe, Liverpool and Campbelltown hospitals (with a specialised psychogeriatric unit at Braeside) and mental health community teams are located across the region. Specialised teams focus on perinatal needs; infants, children and adolescents; Aboriginal people; and older people. Anecdotally, readmission rates are similar to NSW targets however the targets to access community mental health services within seven days are not met.

As indicated in the previous chapter, support services are provided by many agencies. Services work well together however GPs, other health providers, patients, carers and community service providers identified mental health as a major issue for the region. Service issues include:

- in primary health care, lack of attention to the physical health of people with mental health conditions; variable skill level of GPs in working with patients; variable knowledge of the service system and targeted Medicare programs; lack of local private psychiatrists; a lack of focus on healthy lifestyle issues; poor knowledge by GPs about ATAPS and high cost to patients.
- in specialist mental health services, an inadequate number of mental health inpatient beds across all age groups, creating pressure for emergency departments and delays in accessing beds; gaps in community mental health services including early psychosis services and assertive follow-up for chronic patients, and difficulties in referring patients and accessing emergency assessments; and lack of case managers for those not on community treatment orders.
- in other specialist health services, the lack of a specific Psychiatric Emergency Care Centre (PECC) Unit in the Emergency Department at Bankstown-Lidcombe Hospital; poor attention to physical health needs; and the need for conditions to escalate before consumers can gain access to services.
- in community support services, variable access to living skills programs e.g. none at Bankstown and other community support services and gaps in services to support people who are homeless; variable competence of services to assist people with complex mental illnesses and varying inclusion and exclusion criteria between services complicating consumer and carer navigation.

Services and consumers also expressed concern about the stigmatisation and lack of understanding of mental health issues in the broader community. This was particularly an issue among culturally diverse populations where mental health problems are poorly accepted by the person with the mental health condition and the wider community.

GPs have a major role in the management of **chronic diseases** such as diabetes, asthma and cardiovascular disease. Participation in the Practice Incentive Program by local GPs, in areas such as the Diabetes Cycle of Care and Asthma, is relatively low. An issue for many practices is that proactive follow-up of patients is required; however they lack the systems, resources and technology needed for this to be achieved. The Connecting Care Program is well regarded by GPs and specialist health services, ensuring that patients are followed up and supported. Lifestyle programs such as the

Healthy Eating Activity and Lifestyle Program (HEAL™) for people who are overweight, Comdiab Diabetes Education Program and the Beat-it Plus lifestyle program at Camden are also well regarded and achieve positive results however their reach is limited. Organisations such as the Heart Foundation play an important role in prevention by organising, facilitating or partnering in local events and projects. Specialist services and clinics including rehabilitation programs are conducted through local hospitals.

Key issues identified include: need for better communication between GPs, community health and specialist services; poor out-of hours access to GP services: allied health support and availability; need for diabetes educators and nurses; the need to build capacity of GPs to provide recommended management; and capacity of primary care services to provide for specialist therapies such as anticoagulation (clexane, warfarin) and IV antibiotics.

For **people with cancer**, GPs provide an ongoing management and coordination role while the patient is undergoing active treatment, with treatment available through local public hospitals and Southern Highlands Private. The current focus of activity includes: a partnership between SWSML and the Cancer Council to promote follow-up of people with chronic Hepatitis B; a project focusing on improving communication with GPs; developing standardised discharge pathways for cancer patients; expansion of survivorship programs; development of improved care for palliative care patients; and the Healthy Me project focusing on a self-controlled record for patients to keep their results. Issues raised through consultations included the need for stronger promotion of screening to detect cancer earlier; better shared care follow-up after treatment; the lack of public services at Bankstown-Lidcombe Hospital and waiting times for cancer intervention in the public system. Aboriginal and culturally diverse communities also expressed limited support for cancer patients from their communities to overcome the stigma associated with a diagnosis. For palliative care patients, gaps identified included the need for additional palliative care services; access to timely medications especially after hours and death certification for palliative care clients at home; better patient handover of after-hours patients; and need for advanced care planning by the public supported by GPs.

GPs also have the major role in health care of **older people** in the community and share that management in residential aged care facilities (RACFs). Concerns raised included the increasing dependence of older people living in the community; uncertainty in the service sector created by changes in funding; the lack of inpatient and day only treatment services for the rehabilitation of older people; delays in assessments by Aged Care Assessment Teams (ACAT) and in some parts of the region lengthy delays in accessing RACF places (this is particularly problematic for people with challenging behaviours associated with dementia); lack of specific community packages e.g. Extended Aged Care at Home (EACH) Packages and closure of some services; flow on effects into the community service sector of delays in recruiting into specialist health positions; the impact of increasing levels of dementia on health and community services; low referral rates of older people with depression/anxiety to psychologists; variable capacity (skills and facilities) to treat and care for an ageing community, particularly older people with complex comorbidities; and limited availability of and referral to appropriate social support networks, exacerbated by limited and appropriate transport options.

Health providers catering for vulnerable groups rely heavily on community services to meet a range of personal and social support needs of patients. In general, people who use Home and Community Care (HACC) services are older and more dependent, requiring additional services to remain at home. Access to community transport is a significant issue in the south west with transport to medical appointments oversubscribed. Service utilisation data indicates that availability and use of HACC services varies across the region. Compared to the NSW rate, most LGAs support fewer clients per 1,000 people in case management, counselling, meal and nursing services. Local government areas with larger communities of CALD residents have poorer utilisation of HACC services than in LGAs

which are predominantly English speaking such as Campbelltown, Wollondilly and to a lesser extent Wingecarribee. LGA's HACC clients are more likely also to live with carers (30%) compared to other NSW residents (21%) perhaps reflecting cultural expectations for care and the younger aged profile of the region.

In residential aged care facilities, the National Health Performance Authority report [66] indicates that in 2011/12, the average number of GPs attendances in RACFs among patients who saw a GP at least once was 14.7 attendances.[66] Although this was higher than many other metropolitan regions, it was lower than regions with a similar demographic and accessibility profile. RACFs identified the main health issues of their residents as pain and pain management; falls; challenging behaviour associated with delirium and dementia; respiratory and urinary tract infections; medication management; chronic illness and diabetes. Most indicated that they were able to access a General Practitioner (GP) during business hours and felt that their facilities were well-serviced. Key issues identified include: the GP workload and practice commitments as a barrier to obtaining timely GP services; waiting times after hours for RACFs in outlying areas; access to specialised services such as dental care and optometry in the facility and transport to and from hospitals; and timely assessment and management (including non-pharmacological) of dementia and depression. SWSLHD provides a range of specialist support for RACFs however a more coordinated approach is required.

For **people with disabilities**, the major concerns of the community and providers include focus on under-diagnosis of health problems; variable experience of health professionals in treating and caring for people with disabilities; lack of long term accommodation for younger people with disabilities (i.e. those who are 50+ years old) which creates bed blockages in hospital and fails to meet individual needs for stability and a community setting; lack of on-going service models for younger people with an acquired physical disability/brain injury e.g. packaged care/ access to allied health services; the lack of coordinated access to hospital for people requiring multiple treatments; poor management of people with multiple problems in emergency departments and service implications of the introduction of the National Disability Insurance Scheme which is perceived to affect the quality of services. Other concerns related to the poor availability of health related transport suitable for people living with a disability, lack of social support for attending appointments and the issue of mental health support for people living with a disability and their carers.

A local strength for people from **culturally and linguistically diverse** backgrounds is the number of GP's who speak a language other than English with approximately 61% speaking at least one language other than English. Within the metropolitan sector, Liverpool LGA has the lowest proportion of GPs speaking a language other than English, at 53%. Interestingly, there is a significantly higher proportion of GPs in Liverpool LGA with a client number for the Translating and Interpreting Service (86%) compared to other LGAs.

A further strength is the presence of targeted health services such as the Immigrant Women's Health Centre, the NSW Refugee Health Service (based in Liverpool), STARTTS and SWSLHD Multicultural Health services. Concerns identified include: the cultural competence (and skills) of health professionals; lack of flexibility in where, when and how services are provided; lack of targeting by mainstream health services to meet the needs of these communities; underutilisation of the Translating and Interpreting Service by GPs and variable use and difficulty accessing interpreters within the public health system; and in some cases, the knowledge of overseas trained health professionals of the broader Australian health system. A further issue is ensuring that there are sufficient female practitioners to meet the cultural requirements of women of CALD backgrounds who will only access female practitioners. Smoking cessation resources and programs are an example of services that need to be tailored to the community due to the cultural differences in smoking practices. Using the Hookah or pipes for example is believed by the community to be a safe alternative to cigarettes, or the cultural barriers associated with asking guests to smoke outside or away from children.

There are few targeted primary or specialist health services for **people who are homeless**. GPs may develop plans under Medicare mental health items; and mental health and social work services in the public health system provide support. A regional interagency operates to strengthen the service network however the lack of specific support and housing services are significant gaps.

There is an undersupply of GPs who are willing to be opioid prescribers for **people with drug health issues**. Other concerns relate to management of physical health e.g. management of hepatitis and mental health comorbidities and early diagnosis and intervention. There are also gaps in public Opioid Treatment Programs in Fairfield and Wingecarribee which results in greater travel and/or cost for patients.

Health Promotion and Prevention

Consumers identified the major health problems in their community as obesity and overweight, diabetes, cardiovascular problems, mental health issues, aged care related issues, drug addictions, smoking and alcohol consumption. A number of these health conditions and behaviours can be improved by changes in lifestyle. The community reported that factors such as high accessibility of fast food outlets, having a sedentary lifestyle and not being able to afford healthy food and exercise faciltities as significant concerns. Contributing to these problems were long working hours, unemployment and lack of motivation, the quality of local parks, concerns about safety, need for affordable gym fees, language barriers and knowledge on healthy eating. Patients identified a need for patient education around preventative health via GP interaction, support groups, written information and national health campaigns. All stakeholders indicated that GPs should have a stronger role in prevention and early intervention.

Programs such as the *HEAL™ Program* and *Preventive Evidence into Practice (PEP) Standards of Care* are effective tools for primary practice to adopt in supporting patients to adopt healthy lifestyles. [77] Options to broaden the reach of the HEAL™ program have been identified as a way of improving access, including providing culturally specific services (utilising interpreters) and education services in the local community. Use of brief intervention tools, although effective, require ongoing GP education and support.

SWSLHD Population Health Services have a major role in health promotion. Local councils and other agencies also play an important role in health promotion. Feedback from community agencies about the work of these services and specific programs and activities undertaken was positive and expanding preventative health programs was recommended. Broadening early intervention programs, increasing education programs and engaging in projects which targeted specific communities were recommended approaches, with a focus on issues such as overweight and obesity, food security and tobacco. A collaborative partnership approach was seen to be most effective in addressing broader health needs.

Information

Lack of knowledge of available services was identified by patients, GPs, other health professionals and community services as a significant problem, hampered by the complex service system, lack of formal care pathways and comprehensive flexible directories, complex referral systems, under-recognition by GPs of funded services e.g. allied health (supported by Medicare data reflecting poorer utilisation of some services). Service promotion (prevention, treatment, community) and targeting disadvantaged communities was an issue.

There was considerable comment about the health literacy of the community i.e. the ability of people to gain access to, understand and use health information to maintain and improve their health. Health literacy can impact on timeliness in seeking help, compliance with treatment and understanding medical advice, and capacity to engage in healthy activities and lifestyle. This is a significant concern for local residents.

There is no local data about health literacy however national data from 2006 suggests that only 40% of the population have adequate or better health literacy skills, with factors such as age, employment status, income, education, and English skills impacting on overall literacy. With pockets of considerable disadvantage, factors such as variable reading and numeracy skills, large non-English speaking communities with language and cultural barriers and considerable differences in internet access (i.e. 25.3% in homes in Fairfield) are specific barriers for individuals. Other concerns focused on environmental factors such as the way information is presented (i.e. communication style, jargon and illustrations), how consumers are engaged and empowered in their health care and how policies are implemented. These factors make it more difficult for people to navigate, understand and use health services and information and reflect those identified across Australia. [57]

Communication

Many consumers were satisfied with care provided by their health provider; however communication was frequently cited as an issue by consumers and carers and was seen to be affected by limited appointment time, attitudes, and poor knowledge of the patient, privacy laws, insufficient explanation, English skill and manner.

Communication between professionals i.e. primary and specialist providers and community services was also identified as an issue, marked by a lack of/ ineffective communication at transfer of care/referral i.e. hospital admission and discharge and ongoing care. Feedback from specialists was reported by GPs as a significant enabler for the provision of quality care. Patient discharge letters also scored highly as quality care enablers. A lack of availability of discharge letters (electronically and in hard copy) and inability to access hospital test results electronically adversely impacts on coordinated and integrated care. Respect is an issue for all - patients and professionals.

Use of Information Technology

Access to an electronic health record will improve patient care and residents have indicated interest in this technology (with ensured privacy). Although 32% of practices are capable of interacting with the Personally Controlled Electronic Health Record (PCEHR) system, meaningful use of the including use of technology infrastructure has been identified as an issue for many GPs. The PCEHR is seen by the community as a promising tool to improve communication between providers, however barriers to uptake include limited general practice utilisation and promotion of the tool, limited public campaigns promoting uptake in vulnerable communities, difficulty navigating patient set up of the tool and limited awareness of its existence. Out of 22 items surveyed, patient registration for the PCEHR was scored by GPs as the poorest enabler to quality care.

Technology uptake by allied health professionals is mixed. Over 90% of allied health professionals surveyed in 2013 respondents have a work internet and email, 64% use patient SMSs and 57% use electronic billing. Only one in three however send or receive electronic reports or electronically record patient progress. Knowledge about the PCEHR is limited with 54% of AHP unaware of the benefits of the PCEHR and a further 11% not interested. Of note is that only 3% of allied health professionals receive an electronic discharge summary from the local hospital.[78]
Access to hospital records, including electronic discharge letters and test results was identified by GPs and public health specialists as the barrier to seamless care and a source of increased costs.

Business Model

The Business Model used in primary health care is variable. Cost per patient is amongst the highest in Australia possibly reflecting the higher community need, greater level of disadvantage and higher levels of bulk billing in some parts of the region. GP remuneration has improved however concerns were raised by solo GPs without a nurse of the feasibility of delivery of chronic disease management services and poor remuneration for home visiting, particularly when the GP chooses to take another person with them for security. Home visiting is generally provided to existing patients that have a high

need for this service. GPs reported significant barriers to providing service to patients including remuneration and working long hours within the practice with little time to travel off-site. GPs nationwide have expressed concerns about the introduction of the Australian government's proposed GP co-payment, and its impact on service delivery and patient access to care.

Consumers were largely very satisfied with the service provided by their GP. Some consumers expressed a preference for one-stop shop type arrangements so they could have their health needs met in one location.

The SWSML Practice Support Team provides business, IT and management support to local GP practices. GPs identified that information technology and support to meet the RACGP accreditation standards are most valued. Allied health professional (AHP) satisfaction with industry support in business management, is mainly low-moderate (59%). The AHP business model is mixed with some relying heavily on Medicare item numbers with a gap fee and/or private insurance with a gap fee, impacting significantly on individual patients. A significant hindrance on bulk billing service provision is that there are no item numbers under Medicare that provide preventative intervention opportunities. The priority given to chronic illness means patients must have an existing condition for referral.

Interagency Collaboration, Engagement and Communication

Although there are good examples of health involvement in local interagencies, the need for stronger interagency collaboration, engagement and communication in planning, data sharing and service delivery is a major concern of local agencies and GPs. GPs and SWSML were seen to be a pivotal part of this process.

Quality of Care

There is a need to strengthen workforce capacity of all healthcare professionals and service providers, to use evidence and national guidelines, with additional effort required for specific communities. In 2014, 51% of practices within the region were accredited or registered for accreditation using the Royal Australian College of General Practitioners (RACGP) 4th Edition standards. Most commonly cited barriers to the uptake of accreditation and maintaining accreditation include the potential cost of upgrading equipment or facilities and lack of time and resources to implement the standards. In addition, the human resources components of the 4th edition standards are seen by many practitioners to be onerous and less relevant to smaller practices with 2-3 staff members.

Workforce

The consultations and data analysis identified a range of significant issues:

- Unequal distribution of primary health care services across the region, with significant gaps in the number of GPs in Wollondilly. A specialised needs assessment was undertaken in 2014 in Wollondilly Shire in partnership with council, the community and providers to address the unique challenges faced by the community.
- Practice nurses are utilised predominantly in Wingecarribee practices (61% of practices). There is also a high concentration of nurses in the Campbelltown and Liverpool LGAs (88 and 53 nurses respectively). 85% of nurses are registered nurses. Demand for registered nurses is particularly high, with a number of practices unable to fill vacancies. Enrolled nurses and endorsed enrolled nurses are required to work under the supervision of an RN employed by the same organisation. This makes it difficult for practices to retain nurses when the RN workforce in primary care is limited. Primary care work can provide benefits to nurses, including more flexible working hours.
- The allied health workforce is relatively young i.e. approximately 45% are less than 40 years. This group has a greater need for business support including service promotion.

- Rapid population growth projected over the next 10-20 years for South Western Sydney together with a rapidly ageing community will drive demand for new primary health care services, particularly in Greenfield developments. In addition, ageing of the workforce is an issue, particularly in Fairfield. Succession planning and strategies to build the workforce need to be developed now.
- Expectations of work life balance are changing and it is anticipated that GPs in the future will not want to work the extended hours that are currently practiced.
- Historically, the health workforce in South Western Sydney has come from universities such as University of New South Wales, University of Sydney, University of Technology, Sydney, and Wollongong University. The University of Western Sydney is developing; however a stronger presence providing undergraduate education in medicine, nursing and some allied health professions with a developing post graduate program. This offers new opportunities for developing and retaining a local workforce.
- Medical training opportunities are insufficient to meet growing population. Compared to previously; the number of general practice placements for registrars does not meet demand.
- There is currently an oversupply of nursing and allied health graduates and insufficient capacity to provide adequate clinical supervision during training and in the early post graduate years
- GP education needs are well met through continuing education programs operated through SWSML; and by professional bodies for allied health practitioners. Nurses have indicated a need for education in specific skills such as ECG interpretation, diabetes education and immunisation accreditation. SWSML have responded by providing a nurse specific education session each month.

The issues facing primary health care are similar to those in the public health sector. There are opportunities for SWSML and SWSLHD to work together to address these issues.

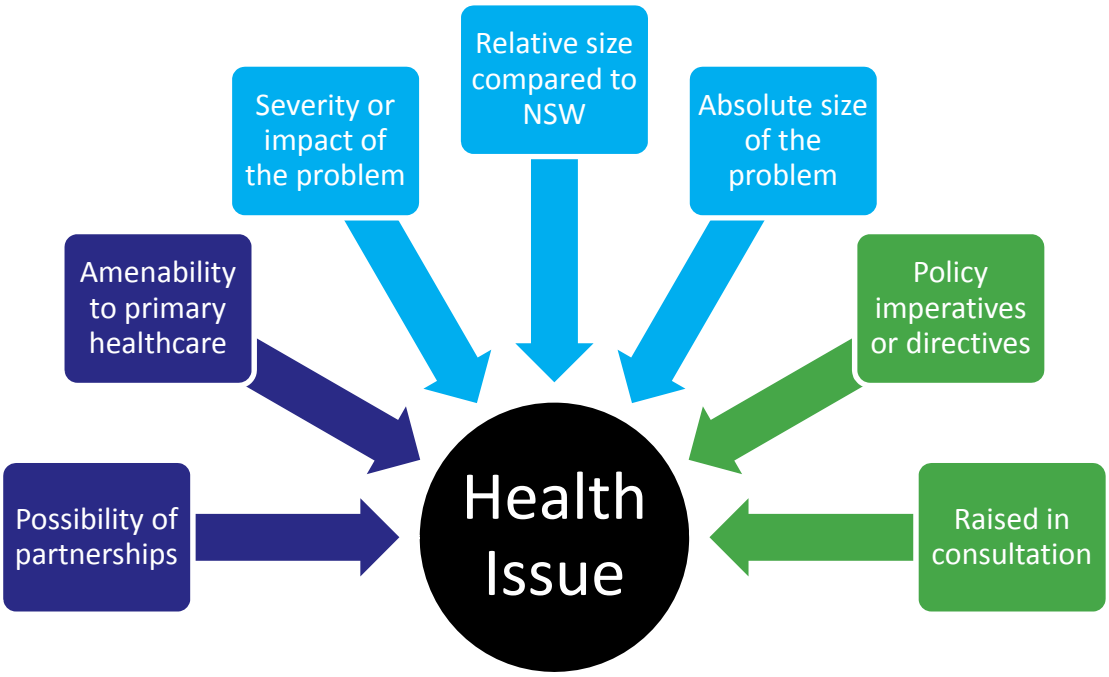
Levers

Key levers to improve health outcomes are:

- Formal processes between SWSML and SWSLHD to improve integration, with agreement to jointly fund shared initiatives. SWSLHD clinicians and management see primary health care as a major means to reduce unnecessary patient admissions and prevent long term health problems
- Access to discretionary funds enabling SWSML to allocate funds according to effectiveness and need.
- Several priorities identified through the needs assessment are in the SWSML strategic plan and funded through the Australian Government
- SWSML strongly advocates for GPs to remain at the forefront of primary health care.
- Priorities selected were informed by input from the community and service providers. These groups are interested in ensuring that strategies work and that they contribute to success of strategies.
- There is growing evidence of effectiveness of some interventions. This included lifestyle interventions and developing care pathways for each health problem (streamlining care, improving outcomes and increasing communication).

8. Directions to Improve the Health of Local Communities

It is not feasible or realistic to address health and systemic problems that have developed over decades or lifetimes in a single year. A modified *Hanlon Method for Prioritising Health Problems* was used to identify areas in which improvement in health status or service provision could be achieved. Seven explicitly defined criteria, reflected in the diagram following, were used to identify initial priorities within each of three themes: Health Problems; Targets Groups; and Systemic Issues.



Using a rating scale of 1-5, sixty issues and problems identified through the needs assessment were rated against these criteria. Priorities were Mental Health; Overweight and Obesity; Tobacco; Chronic Disease - targeting Diabetes and Cardiovascular Disease; Cancer; Maternity and Children; Information; and Workforce.

Working groups comprising a variety of stakeholders identified potential strategies to address each priority. These strategies were then considered using the criteria of best evidence and cost effectiveness. These priorities were submitted to the Department of Health in 2013 as the interim population health needs assessment.

In 2013-2014, these priorities and strategies were fed back to the community, health professionals and services providers. Comment was also sought from targeted population groups including service providers and community members associated with the Aboriginal community, culturally and linguistically diverse groups and refugee and humanitarian entrants, people living with a disability, people living with a mental illness, aged populations, youth and children. As a result of this feedback an additional 3 priorities were incorporated.

Thirteen priority areas for action have been identified in this needs assessment:

1. Mental Health
2. Overweight and Obesity
3. Tobacco Control
4. Chronic Disease: Diabetes and Cardiovascular Disease
5. Cancer
6. Pregnancy and the Early Years
7. Strengthening Prevention
8. Advocacy
9. Information
10. Workforce
11. Aboriginal Health
12. Aged Care
13. Culturally and Linguistically Diverse Populations

Working parties were reconvened and reviewed strategies in light of best practice evidence. This review was overseen by the Population Health Needs Assessment Steering Committee who have guided the process since its inception in late 2012. The following pages detail each priority area and the associated strategies.

Priority Area 1 Mental Health

What is the issue?

Mental Health was identified by all stakeholders as a major issue.

There are significant local concerns about the quantum of mental health support services available, comprehensiveness of the care provided and the variability of coordination.

13.6% of health survey respondents report high or very high levels of psychological distress (compared with 11.2% for NSW).

People who experience mental illness also experience poorer physical health than the general population with higher rates of chronic disease.

What can we do?

- Enhance communication protocols between South Western Sydney Local Health District and local GPs
- Develop a conjoint professional development program including hospital grand rounds, site visits, joint CPD sessions, forums, conferences and committees with cross-sectoral representation, including support for GPs to acheive level 1 and 2 mental health training
- Identify opportunities to work collaboratively on projects to benefit consumers with mental illness in South Western Sydney and their carers, for example implementing care pathways

How will we know if we've been successful?

- A reduction in the number of mental health bed days and readmissions
- A reduction in the number of people reporting high or very high psychological distress
- Increase in GP mental health treatment plans developed
- Improvement in satisfaction of GPs with communication with specialists

Priority Area 2 Overweight and Obesity

What is the issue?

Overweight and obesity are major concerns of patients and general practitioners.

Being overweight or obese is stongly associated with several chronic diseases including type 2 diabetes, cardiovascular disease and some cancers, and with mental health issues and eating disorders.

21.8% of residents report they are obese and a further 34.1% report that they are overweight based on their height and weight. Rates are particularly high among people from some culturally and linguistically diverse backgrounds.

What can we do?

- In partnership with multicultural service providers, SWSLHD clinicians and Aboriginal service providers, identify communities most at risk from overweight and obesity
- Provide targeted and tailored HEAL™ programs to communities at high and very high risk of overweight and obesity such as people of identified CALD communities and people living in disadvantaged areas

How will we know if we've been successful?

- A greater number of people from high risk communities participate in the HEAL™ program and demonstrate effective lifestyle practices
- Improvement in biomedical and self reported indicators among program participants
- Increased referrals from people from disadvantaged, CALD and Aboriginal communities

Priority Area 3 Tobacco Control

What is the issue?

There are higher levels of smoking in the general population and significantly higher levels of smoking during pregnancy in all LGAs, compared with NSW.

Smoking rates are higher still for some populations including Aboriginal people, men within some CALD communities, people with mental health problems and people from disadvantaged communities.

There is a higher level of smoking attributable hospitalisations in the region compared to the State average.

What can we do?

- Provide education, training and tools to GPs, practice nurses, allied health and Aboriginal and CALD specific professionals in the "1 minute intervention" program
- Develop localised 'quit smoking' referral pathways, incorporating patient resources with specialised pathways for target populations such as culturally and linguistically diverse communities, Aboriginal people and pregnant women

How will we know if we've been successful?

- Local residents reduce their consumption of tobacco and/or stop smoking
- Health professionals are supported in implementing evidence based interventions
- Proportion of patients with their smoking status recorded in their GPs clinical software increases
- Reduction in the number of women in local maternity units reporting they smoke

Priority Area 4 Chronic Disease: Diabetes and Cardiovascular Disease

What is the issue?

Cardiovascular disease is the highest cause of mortality in local residents, with high rates of treatable hospitalisations.

Diabetes rates are higher for the region than the NSW average.

Diabetes is a major cause of preventable hospitalisations.

There are very high rates of gestational diabetes mellitus (GDM).

What can we do?

- Improve the management of people with diabetes. Ensure this includes a focus on pregnant women with gestational diabetes mellitus (GDM), Aboriginal communities and various culturally diverse groups with high prevalence of diabetes
- Develop diabetes care pathways for high risk groups, including shared processes, protocols, tools and guidelines to support implementation of the diabetes care pathway
- Progressively develop care pathways for cardiovascular disease

How will we know if we've been successful?

- Increased uptake of the diabetes cycle of care
- Reduction in the number of low risk patients presenting to specialist services
- educed rate of hospitalisations for diabetes complications
- A clear care pathway is used by all health practitioners for cardiovascular disease and diabetes with clearly defined processes for referral, assessment and ongoing management

Priority Area 5 Cancer

What is the issue?

Cancer is a major cause of mortality and morbidity in the region and there are particularly high rates of some cancers in south western Sydney.

Five cancers accounted for more than 50% of all new cancer cases locally: Prostate cancer, Colorectal cancer, Breast cancer, Lung cancer and Melanoma.

Substantial growth in cancers is expected with the ageing of the community and existing specialist services will not be able to keep up with demand.

Management of people requiring palliative care can be improved, particularly with care increasingly provided in the community.

What can we do?

- Establish a communication protocol based on research into effective communication between SWSLHD and the primary care sector
- Develop conjoint professional development programs involving hospital grand rounds, site visits, joint CPD sessions, forums, conferences and committees with cross-sectoral representation
- Progressively develop care pathways for high prevalence cancers and end of life care

How will we know if we've been successful?

- Clear delineation of primary health care and specialist roles
- Existence and uptake of care pathways
- Increased uptake of communication protocols
- Patients with cancer indicate greater satisfaction with care and care partnerships
- Increased knowledge about health services and complimentary therapies

Priority Area 6 Pregnancy and the Early Years

What is the issue?

Local region is underperfoming on a range of indicators including engagement in antenatal care at 14 and 20 weeks, smoking during pregnancy, low birth weight and perinatal mortality.

A higher proportion of children, particularly in Bankstown, Fairfield, Campbelltown and Liverpool LGAs are developmentally ill-prepared for school (compared to NSW).

General practititioner requirements for support for managing childhood health problems and avenues for specialist referral require identification.

What can we do?

- Develop strategies to increase GP antenatal shared care program participation
- Develop communication protocols between SWSLHD and the primary care sector about high risk pregnancies
- Promote existing GP SWSLHD communication systems and ehealth to general practice
- Build primary health care workforce (GP and Practice Nurse) capacity to undertake the Healthy Kids Check
- Scope and promote existing referral pathways and evidence based guidelines for children with developmental delay

How will we know if we've been successful?

- Pregnant women receive appropriate and coordinated support during pregnancy
- Children with problems requiring specialist medical or allied health intervention and support are identified and receive timely, appropriate and coordinated referral and intervention
- GPs report improved communication regarding patients
- There is an increase in the number of Healthy Kids Check Medicare items completed
- Improved engagement in antenatal care at 14 and 21 weeks

Priority Area 7 Strengthen Prevention

What is the issue?

Overall local residents have elevated rates of behaviours such as smoking, low exercise and unhealthy food consumption which are linked to poorer health status.

A prevention and early intervention approach will address multiple health priorities: including Obesity , Tobacco use, Chronic disease – diabetes and cardiovascular disease, Cancer, Mental health and prority populations including pregnant women, children, Aboriginal people, older people and people from culturally and linguistically diverse backgrounds.

Consumers placed high value on the provision of preventative health advice from their GP.

What can we do?

- Develop and amend existing training programs for the "5As" (Ask; Assess; Advise/Agree; Assist and Arrange) preventative health framework, and provide education, training and resources to general practitioners and practice nurses in the use of the tool
- Audit performance regularly and provide feedback to individual practices and the sector as a whole

How will we know if we've been successful?

- A reduction in the number of local residents who engage in risky health behaviours
- An increase in the number of health professional who consistently use the tool
- Audits indicate an increase in identification of lifestyle risk behaviours

Priority Area 8 Advocacy

What is the issue?

The community and health professionals identified a range of health problems which are impacted by factors relating to the environment and other issues.

South Western Sydney Medicare Local has an important and independent role in advocating for the health of the local community and working at a population level to address these issues.

What can we do?

- Develop a portfolio of systematic advocacy topics
- Participate in other advocacy opportunites opportunistically or as requested

How will we know if we've been successful?

- Participation in forums where broader health issues are discussed and advocacy is identified
- Increased number of advocacy activities and positive outcomes

Priority Area 9 Information

What is the issue?

All primary health and specialist public and private health care providers identified lack of access to a common health record and diagnostic tests as the major barrier to effective health care. They also felt that it was a major cause of duplication and increased health care costs.

A number of directories are available, however directories are frequently out of date, not user friendly and difficult to maintain.

What can we do?

- Continue support and education to primary health care providers about the personally controlled electronic health record (PCEHR)
- Work with SWSLHD to provide access for GPs to hospital tests and health records and promote availability of SWSLHD IT initiatives such as the electronic discharge summary to all primary health care providers
- Develop a service map of health and community service providers, leveraging the contents of existing directories

How will we know if we've been successful?

- Better patient coordination and care via the personally controlled electronic health record (PCEHR) irrespective of where patients seek help
- The existence of a service map/directory with up to date information
- GPs can access hospital based records and test results, reducing the need to reorder tests
- Increased uptake of technologies to share information between the primary care sector and local health district services
- Communication across health care teams improves

Priority Area 10 Workforce

What is the issue?

Local data indicates an undersupply of GPs, gaps in private and public medical, mental health, allied health and specialists services.

Data also indicates an older workforce for some professions and within some local government areas and difficulty attracting health professionals to public and private sectors.

Targeted recruitment and workforce development is required to meet current and future needs.

What can we do?

- In collaboration with the SWSLHD, UWS and other universities, RTOs and Tharawal AMS, identify and develop workforce strategies for South Western Sydney which includes provision for innovative approaches to placements for the healthcare workforce
- Promote and recruit suitable training practices
- Undertake workforce planning around specialties and identify solutions to diversify the workforce
- Undertake a specialised needs assessment of the workforce needs of Wollondilly local government area in partnership with local council, health care providers and the LHD

How will we know if we've been successful?

- The quantum of primary health care providers is similar to the NSW average with practitioners working reasonable hours
- Greater opportunities for student placements in primary care and opportunities to collocate undergraduates to strengthen multidisciplinary team work
- In the longer term, an increasing number of general practitioners and private specialists who have established their own practice or join a practice in the region
- Needs assessment of Wollondilly workforce undertaken and strategies implemented

Priority Area 11 Aboriginal Health

What is the issue?

The Aboriginal Community experience poorer health outcomes on a range of indicators when compared to the non-Indigenous population. There is the gap in life expectancy estimated to be approximately 7-9 years for Aboriginal people compared with non-Indigenous people.

There is a large Aboriginal community in South Western Sydney. The community report barriers to health care access at primary, secondary and tertiary settings, however primary care has the most significant role to play in lifetime illness prevention and management. Evidence suggests that if services are culturally aware and sensitive, access will be improved.

What can we do?

- Partner with local Aboriginal health services to deliver cultural awareness training for primary health care
- Develop a practice based audit program of cultural sensitivity based on the "Ways of Thinking, Ways of Doing" research conducted by UNSW

How will we know if we've been successful?

- Uptake of Aboriginal specific Medicare item numbers and services improves
- GP and other primary health care providers have greater knowledge about culturally sensitive practice
- Audits conducted in general practice demonstrate greater implementation of culturally sensitive practice and a greater propotion of patients with their Indigenous status recorded

Priority Area 12 Aged Care

What is the issue?

There is a growing aged population in south western Sydney. Older people have complex and multiple care needs which can be difficult to successfully manage.

There is a lack of private geriatricians and other aged care specialists in the area, and support for managing aged patients is limited. The general practice setting has a key role as the care coordinator for older people.

What can we do?

- Undertake a needs assessment of GP professional development needs around aged care
- Develop and implement CPD program and resources and explore opportunities for GP post graduate education in aged care
- Build on success of existing Southern Highlands aged care program and expand to the entire region
- Build on work in Bankstown focusing on communication between service providers

How will we know if we've been successful?

- The number of GPs visiting residential aged care facilities increases
- GPs are supported to develop their skills and knowledge in the field of aged care
- Reduced readmission rates of older people to SWSLHD hospitals

Priority Area 13 Culturally and Linguistically Diverse Communities

What is the issue?

There is a high proportion of people living in South Western Sydney who come from a culturally diverse background. In 2011, 36% of South West Sydney residents were born overseas, compared with 26% for NSW.

Some community members prefer to access healthcare services that they deem to be culturally appropriate, however there is currently little publically available information on provider languages or specialties.

The Translating and Interpreting Service has minimal uptake nationallyCulturally appropriate care may reduce barriers to access for culturally and linguistically diverese communities.

What can we do?

- Further develop existing map of bilingual service providers and provide listing to relevant NGOs and multicultural services
- Develop and provide training to primary health care practitioners regarding best practice use of interpreters and culturally sensitive practice
- Promote and provide training in the use of the Translating and Interpreting Service, Doctors Priority Line

How will we know if we've been successful?

- A list of healthcare providers speaking a second language is available and is provided to relevant services
- Community members can access cuturally appropriate health care
- Increased awareness of primary health care providers who speak a language other than English
- Increased uptake of the Translating and Intepreting Service within primary health care

9. The Next Steps

The Comprehensive Needs Assessment is a culmination of 18 months of consultation, data analysis and evidence review. The next steps in the process include:

- Providing feedback on the outcomes of this work to the stakeholders that have been involved to date, as well as to the broader community. This will be achieved by a communication strategy which will include community and provider forums, media releases, engagement with local politicians to highlight outcomes of the needs assessment that are relevant to their electorate and on-going community engagement via South Western Sydney Medicare Local's community participation team.
- Engagement with relevant partners to assist with the implementation and progression of strategies. This engagement will take the form of targeted partnerships and liaison; and community and working party membership.
- Evaluation of the needs assessment process. This will include evaluating the success of deliberative activities such as the steering committee and strategy development working parties, as well as inviting feedback on the outcomes of the needs assessment from a wide audience

10. Appendices

Appendix A Terms of Reference of the Steering Committee

1. PURPOSE

- To oversee and guide the development of a needs assessment for South Western Sydney Medicare Local

2. OBJECTIVES

- Advise on the structure and conduct of the needs assessment process
- Identify key statistical data and other information about local communities (existing or required) to inform the needs assessment and provide assistance in obtaining this information
- Identify strengths and gaps in current primary health care service provision and broader health service system
- Identify and provide advice on evidence regarding best practice to address health issues and concerns identified for local communities
- Advise on the community consultation process to be undertaken in the development of the Plan
- Provide advice regarding the most effective ways for prioritising health issues and strategies
- Undertake initial culling of issues and strategy identification
- Ensure an integrated planning outcome is achieved which takes into account service provision in the community; access and equity; current and potential partnerships with the broader health and human service sector; innovation and use of evidence; cost effectiveness and priority investment; and sustainability.
- Contribute to the identification of priorities and strategies to address local needs

3. RESPONSIBLITIES OF STEERING COMMITTEE MEMBERS

- Attendance at steering committee meetings
- Providing information and advice in areas of members expertise
- Reviewing and commenting on issues papers and planning updates provided for the steering committee
- Proactively providing information and advice on evidence based practice/ research to inform the process
- Supporting the consultation process and providing feedback
- Working with the South Western Sydney Medicare Local Board in identifying priorities and actions

4. MEMBERSHIP

Terms of Office
Committee members attend meetings between December 2012 and May 2014. After this time the committee terms of reference will be reviewed.

5. MEETINGS

5.1 Notice of Meetings and Special Meetings
Committee members are informed of the meeting dates at the previous meeting and also one week prior.

5.2 Quorum
50% of the committee membership plus one

5.3 Frequency
Meetings are held on the 2nd Thursday of every month for the period between November 2012 and November 2014, to inform the development of a comprehensive needs assessment. After this time the Terms of Reference will be reviewed.

6. REPORTING RELATIONSHIPS

The steering committee reports to the board of SWSML as required.

7. EVALUATION

Committee members will complete an annual survey regarding the Committee's performance and a 1 page annual report of achievements. This will go to the Clinical Council and the Contract Management Committee.

Appendix B Sources of Information

Please note, for some indicators most recent data releases are only available at region level. A breakdown of LGA data is available for the previous reporting period within the Data Supplement.

Geographic: from local councils, the NSW Department of Local Government, NSW Department of Tourism, Australian Classification of Local Government, and various websites

Population: including demographic data from the ABS 2021 Census of Population and Housing, Estimated Resident Population (ERP) 2011 and Socio-economic Indexes for Areas (SEIFA 2011); Australian Government Departments - Immigration and Citizenship, Education Employment and Workforce Relations; Housing NSW; NSW Bureau of Crime Statistics. Also population projections from the NSW Ministry of Health and NSW Department of Planning

Health Status: including

- Mortality and morbidity data from the NSW Ministry of Health including Chief Health Officers Report, NSW Admitted Patient Data Collection, ABS Mortality data 2003-2007, HOIST; NSW Central Cancer Registry; PHIDU for chronic disease synthetic projections; reports and websites e.g. Access Economics reports on dementia, Atlas of Diabetes Prevalence by Local Government Area; and local research/presentations e.g. diabetes, childhood injury
- Behavioural risk factors from the NSW Population Health Survey 2010
- Births and Early Year Data from the Australian Bureau of Statistics Births; NSW Perinatal Data Collection; PHIDU for Childhood Immunisation Status; ABS Mortality for Childhood deaths; 2012 Australian Early Development Index; and reports e.g. NSW Child Death Review Team
- Screening from PHIDU for Bowel Cancer, NSW Pap Test Register, Cancer Institute NSW and Health Outcomes Information & Statistical Toolkit (HOIST)
- Target Group data from the NSW Admitted Patient Data Collection, ABS population estimates and literature
- Social determinants of health data from ABS data , NSW Housing Department, and advice from the SWSLHD Population Health Directorate (specifically the Health Promotion Unit)

Policy: including Australian and NSW Government policy and health priorities; and SWSML policy, priorities and contractual obligations with the Australian Government

Service Utilisation: including primary health data from PHIDU for the Australian Government Department of Health and Ageing, Medicare Data, Primary Health Care Research & Information Service (PHC RIS), National Health Performance Authority; SWSML After Hours Primary Medical Care Needs Analysis Report 2013; Insurance rates - PHIDU for the Senate Community Affairs Legislation Committee; public hospital data – NSW Emergency Department Information System, NSW Health Flow Info 2010-11, one-off surveys e.g. waiting times of SWSLHD outpatient and community services, hospital performance including timelines and separations from the NSW Bureau of Health Information , and patient experience reports; RACF Data (PHIDU for the Australian Government Department of Health and Ageing); NSW Aged Care Hospital Census; reports e.g. Australian Government Residential Aged Care Report; and Community Service i.e. PHIDU HACC service information
Clinical Best Practice: Research from Australian and international journals and websites.

Workforce: including primary practice data from the SWSML Chilli data base (GPs and Practice Nurses); ehealth readiness data bases; SWSML surveys; and telephone books

Clinical Best Practice: Research from Australian and international journals and websites.

Workforce: including primary practice data from the SWSML Chilli data base (GPs and Practice Nurses); ehealth readiness data bases; SWSML surveys; and telephone books

Stakeholders: including more than 1300 people/organisations about the primary care and the broader health system via:

- Surveys of the non-government health workforce, specifically the SWSML Allied Health Survey 2012, completed by 247 allied health practitioners (including speech pathologists, psychologists, social workers, dentists, etc. and a Practice Nurse Survey (April 2013) completed by 20 nurses
- Meetings (8) in Bowral, Campbelltown, Liverpool, Fairfield and Bankstown (April 2012) with 113 residents comprising SWSLHD Consumer and Community Network representatives, carers of people with mental health problems, hospital volunteers, school students and community organization representatives; and a Patient Survey completed by 402 people at local surgeries (early 2013).
- Three rounds of information/consultation meetings with local NGOs in April 2012, August 2013 and September 2014. Sessions were held in three locations across the region each round. Each round attracted around 60 attendees (180 contacts made)
- An Agency Survey completed by 64 Government and Non-government agencies (April 2012)
- A Residential Aged Care Facility (RACF) Survey completed by 12 RACFs (February 2013). In addition, focus groups for the After Hours Needs Assessment (with limited attendance) and surveys SWSLHD services to identify support provided to RACFs.
- A focus group with 13 General Practice staff (April 2012), a General Practitioner Survey completed by 36 GPs (March/April 2013) and ad hoc meetings with GPs over time to discuss a range of issues.
- A survey of SWSLHD Clinical Streams & Facilities completed by 30 services. In addition, meetings were held with each of the Directors of SWSLHD clinical services.
- SWSML managers/staff were surveyed about existing programs in April 2013
- Two rounds of working group meetings. The first round with 8 working groups, and the second with 11 working groups. Comprising GPs, consumers, and SWSML, NGO and SWSLHD representatives who met in April/May 2013 and March 2014 to detail the service environment and identify strategies for action.
- 290 people representing vulnerable populations engaged face to face via interview or interagency meetings.
- 103 de-identified client profiles, sourced from organisations providing services to people with mental illness and face to face consultation with around 20 consumers engaged with local day-to-day living programs.
- Opportunity for comment on initial report provided to 918 local general practitioners
- Opportunity for comment on initial report provided to 33 Local Health District streams or services

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ADHD	Attention Deficit Hyperactivity Disorders
AH	After hours
AHP	Allied Health Professional
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ATAPS	Access to Allied Psychological Services
CALD	Culturally and Linguistically Diverse
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CVD	Cardiovascular disease
DRGs	Diagnostic Related Groups
DSM	Diagnostic and Statistical Manual of Mental Disorders
EACH	Extended Aged Care at Home
ECG	Electrocardiogram
ED	Emergency Department
EN	Enrolled Nurse
GDM	Gestational Diabetes Mellitus
GP	General Practitioner
LGA	Local Government Area
HACC	Home and Community Care
HARP	HIV/AIDS and Related Programs
HEAL	Healthy Eating Activity and Lifestyle
HMR	Home Medicines Review
HPV	Human Papilloma Virus
IRSD	Index of Relative Socioeconomic Disadvantage
IT	Information Technology
IV	Intravenous
NBCSP	National Bowel Cancer Screening Program

NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisations
NHPA	National Health Performance Authority
MBS	Medicare Benefits Schedule
MDS	Medical Deputising Service
MERIT	Magistrates Early Referral into Treatment
OTP	Opioid Treatment Program
PCEHR	Personally Controlled Electronic Health Record
PECC	Psychiatric Emergency Care Centre
PEP	Preventative Evidence into Practice
PHIDU	Public Health Information Unit
PHN	Primary Health Network
PIP	Practice Incentive Program
PIR	Partners in Recovery
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RN	Registered Nurse
RTO	Registered Training Organisation
SEIFA	Socio-economic Indexes for Disadvantage
SHS	Specialist Homelessness Services
SES	Socioeconomic Status
SNHVP	Sustained Nurse Home Visiting Program
SSWAHS	Sydney South West Area Health Service (now SWSLHD)
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
STIs	Sexually Transmissible Infections
SWS	South West Sydney
SWSLHD	South Western Sydney Local Health District
SWSML	South Western Sydney Medicare Local
TIS	Translating and Interpreting Service
UNSW	University of NSW
UWS	University of Western Sydney
UTS	University of Technology Sydney

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