Illawarra Shoalhaven Local Health District

NSW GOVERNMENT

Priority Populations Profile in the Illawarra and Shoalhaven

February 2026

Priority Populations Profile

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More information

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Copyright and disclaimer

Acknowledgement of Country

Illawarra Shoalhaven Local Health District acknowledges that our health district is located on the unceded lands of the Aboriginal people who are the Traditional Custodians of the NSW South Coast. We pay respect to the wisdom of Elders both past and present, and Aboriginal communities of today. ISLHD is committed to improving Aboriginal Health outcomes by eliminating racism and providing culturally safe health services for our Aboriginal communities.

ISLHD acknowledges the sacred interconnectedness, and intimate relationships that Aboriginal people have with this landscape, its waterways, winds and all living things, and that this connection to Country, is an innate part of identity, health, wellbeing and healing for all Aboriginal peoples.

ISLHD acknowledges its role in the historical effects of colonisation, and in subsequent colonial policies that have, and continue to have, effects on the health and wellbeing of Aboriginal people of this District, as it commits to a journey of learning, truth telling and healing.

Foreword

The Illawarra Shoalhaven Local Health District (ISLHD) covers an area of approximately 5,687 square kilometres, from Helensburgh in the north, to North Durras in the south. ISLHD is responsible for providing and coordinating public health services and programs for over 420,000 people across the region.

To tailor care and services appropriately, ISLHD must understand the unique and complex needs of our population, including those who face heightened challenges and barriers to health care. Certain population groups within the District experience marked disadvantage and inequity related to the determinants of health, access to services, experiences within the health system, and their overall health outcomes.

As outlined in the *ISLHD Strategic Delivery Plan 2023-2028*, a key priority for ISLHD is to support the community to achieve and maintain good health across all stages of life. Achieving this requires strong, sustained cross-sector partnerships that address the social, environmental and economic determinants of health, while empowering individuals to make informed decisions about their wellbeing.

The Priority Populations Profile underpins this work by providing a shared evidence base for ISLHD and its partners. By presenting comprehensive demographic data and insights into our community's priority populations, the Profile informs coordinated planning, service design and collaborative action. It ensures that health services and programs are responsive, equitable and aligned to the needs of the entire population.

It is recognised that not all population groups are reflected within this Profile. Facilities, services, and programs within ISLHD will continuously monitor and evaluate the utilisation of our services and respond to emerging needs as they arise. Readers should also refer to the companion report to this profile, the *ISLHD Health Inequities Report*, for further information about variation in key indicators across the District, particularly across small geographic areas.

Unless otherwise stated or referenced, the primary data source for this profile was the ABS Census 2021.[1] The data and information provided within this document is intended to help shape health services and programs to be responsive to the needs of our community, ensuring programs and services for prevention and care are accessible to all.

Statement of committment

We acknowledge those who have come before, and continue to be, the caretakers and custodians of this land.

Aboriginal people are the First Nations people of New South Wales and have lived in the Illawarra and Shoalhaven region for over 65,000 years; cultures, lores, ceremonies and connection to the land and waterways are strong and enduring.

Respect is extended to elders past and present; especially those affected so unjustly by local health policies. We apologise unreservedly for the profound effects of those stolen from their families, we are deeply sorrowed by the deep hurt, the physical, emotional, and spiritual damage, and the ongoing intergenerational trauma of Aboriginal peoples today.

We recognise that history has resulted in a lack of trust by many Aboriginal peoples and we highly value and will continue to work in true partnership with local Aboriginal community-controlled services. We remain committed to work in genuine partnerships with Aboriginal peoples, communities, services, and survivors of the Stolen Generations.

The gaps in Indigenous health are unacceptable. Quality data will be sourced and used for open and honest accountability, and to inform excellent and safe clinical practice.

Racism will not be tolerated in the Illawarra Shoalhaven Local Health District and will be challenged. We will find ways to overcome institutional racism created by history.

We are committed to providing a culturally safe and welcoming environment for patients and will support staff to feel culturally secure and safe within our services.

We commit to furthering professional development of all staff in acquiring a better understanding of culture and how to best support the cultural wellbeing of Aboriginal colleagues and patients.

We acknowledge the vital importance of Aboriginal language and its relationship to spiritual wellbeing and will seek to work with local peoples to incorporate language and naming throughout our services and the system.

The Illawarra Shoalhaven Local Health District acknowledges the principles of the Uluru Statement of the Heart. We share aspirations for a fair and truthful relationship and a better future for our children based on justice and determination through truth telling. We recognise that when Aboriginal people have power over their destiny, their children will flourish and will walk in two worlds and their culture will be a gift to this country.

Contents

3. Population Overview

The Illawarra Shoalhaven Local Health District (ISLHD) is home to a rich and enduring Aboriginal history that stretches back tens of thousands of years. The District has been, and continues to be, home to a broad diversity of Aboriginal people and communities. There are a range of languages, customs, and stories, which are deeply linked to the landforms and waterways of the region.

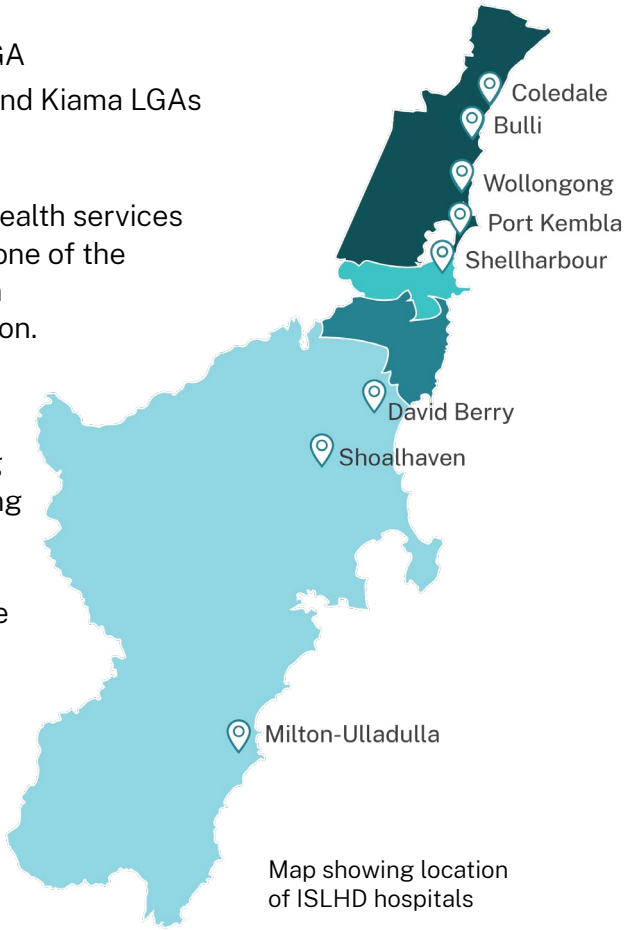
The region's natural setting is the backdrop to a mix of coastal, urban and rural lifestyles. Residential areas are concentrated along a narrow coastal strip extending from Helensburgh in the north, to North Durras in the south.

The region has over 420,000 residents, living in the Local Government Areas (LGAs) of Wollongong, Kiama, Shellharbour and Shoalhaven. This report will refer to three distinct areas of the District:

- Northern Illawarra: encompassing the Wollongong LGA
- Southern Illawarra: encompassing the Shellharbour and Kiama LGAs
- Shoalhaven: encompassing the Shoalhaven LGA

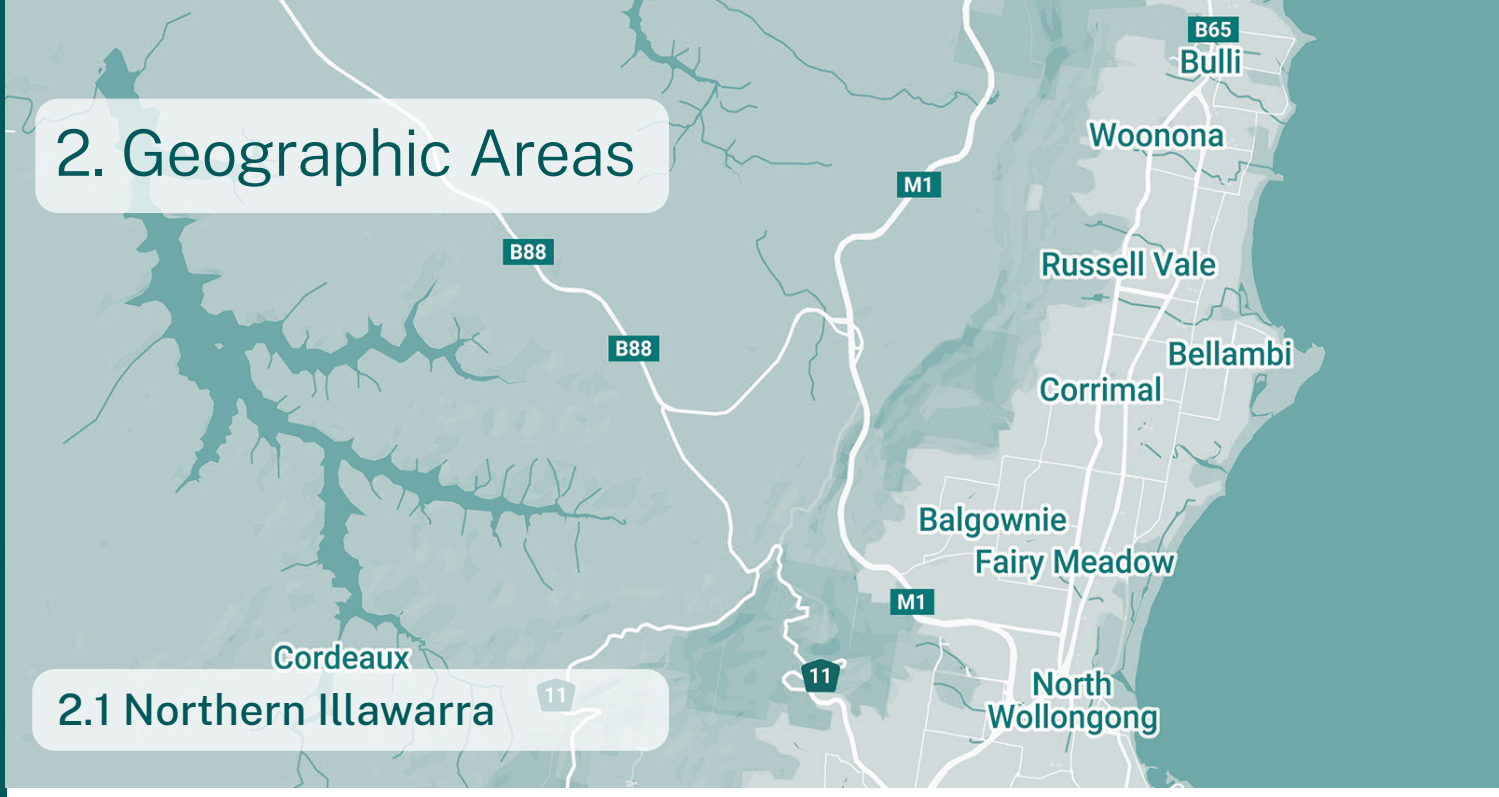
In addition to the hospitals, ISLHD operates community health services from approximately 59 locations across the District. It is one of the region's largest employers with a workforce of more than 7,300 staff and an annual expense budget of over $1 billion.

ISLHD, like many healthcare organisations across the world, faces a unique set of circumstances that require strategic approaches and innovative solutions. Increasing demands placed on the system from a growing and ageing population present a major challenge now and into the future. The District's population is anticipated to grow from over 420,000 people in 2021 to over 570,000 people in 2041. The over 65 age group is projected to grow from 91,000 people in 2021 to 130,000 people in 2041. Proportionally, this group will go from 21% to 23% of the total population. ISLHD must strive to find ways to address the strain on resources, ensure timely access to care, and provide comprehensive services to our diverse community.

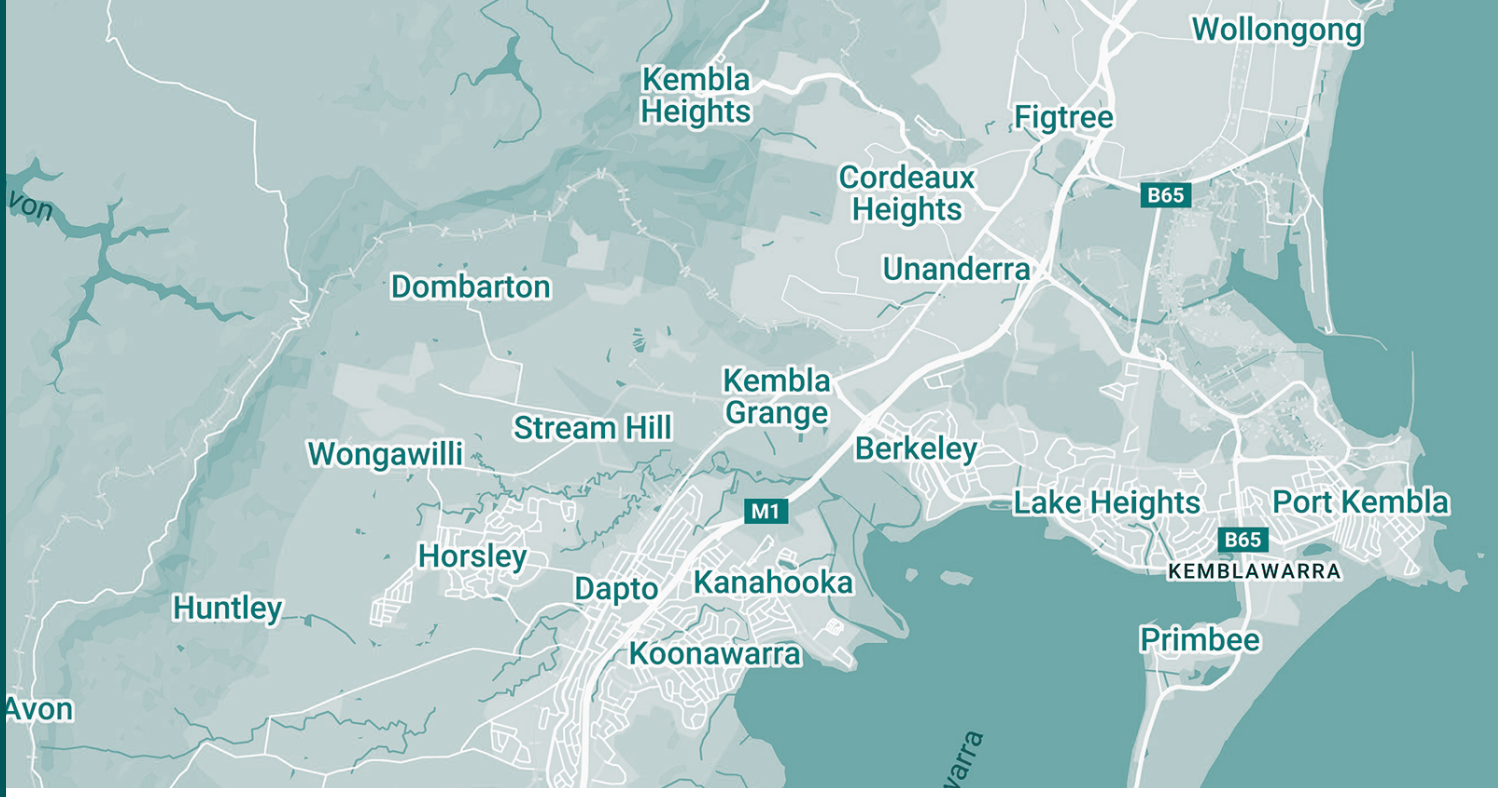


Map showing location of ISLHD hospitals

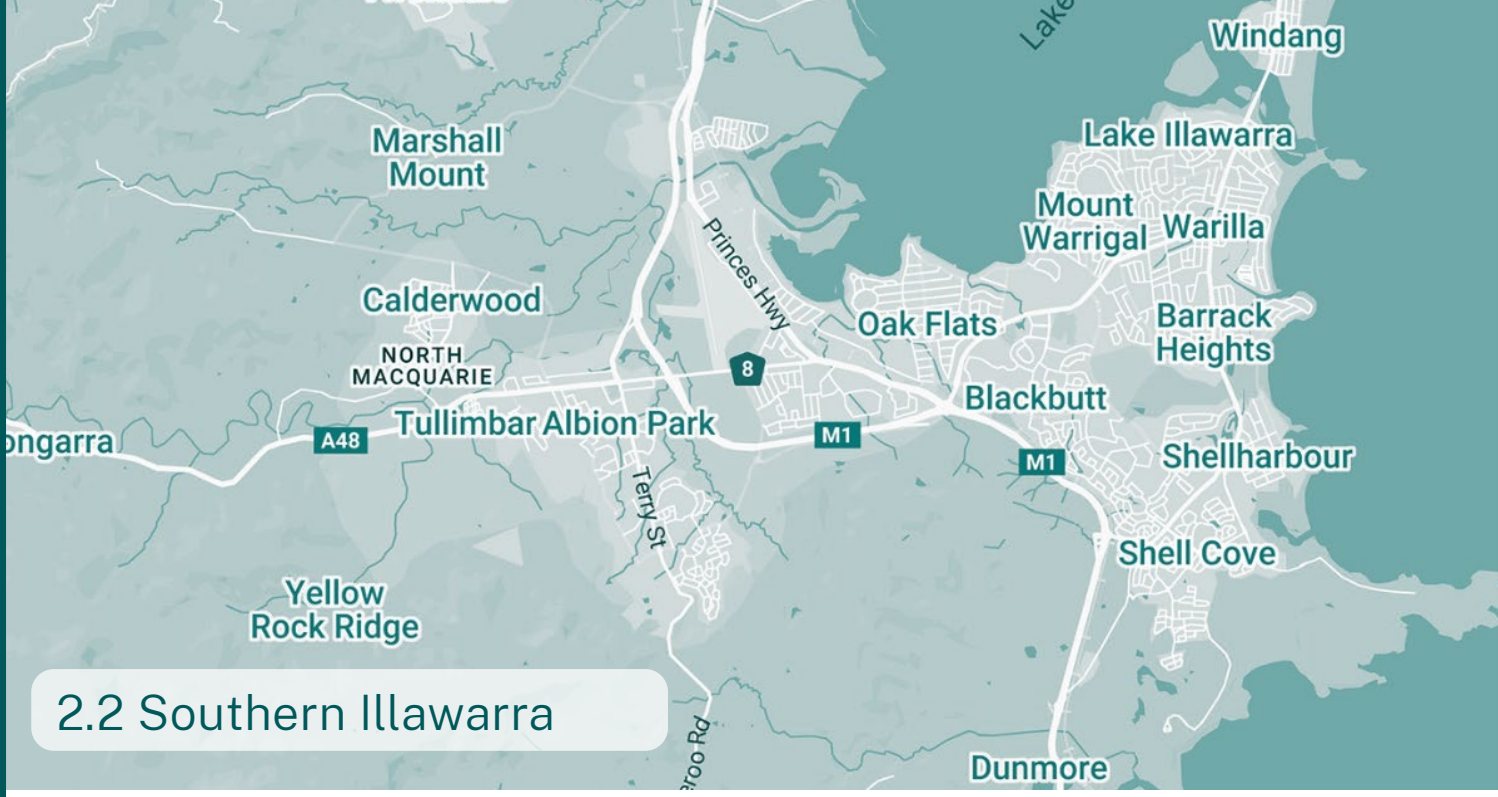
2. Geographic Areas



Total population	In 2021, there were 214,564 people living in the Northern Illawarra.
Aboriginal people	An estimated 6,945 Northern Illawarra residents identified as Aboriginal, representing 3.2% of the local population and 38% of the total Aboriginal population within ISLHD.
Carers	23,219 people (13%) aged over 15 years, provided unpaid assistance to a person with a disability, health condition, or due to old age, and 59% of these carers were female. Of all carers in ISLHD, 50% reside in the Northern Illawarra.
Children under five years of age	There were 12,083 children aged under five years representing 6% of the population.
Multicultural diversity	30,446 people (14%) were born overseas in a predominantly non-English speaking country. The top 10 non-English speaking countries of birth for residents of the Northern Illawarra are North Macedonia, Italy, India, China, Philippines, Germany, Vietnam, Croatia, Thailand, and Lebanon. 43,387 people (20%) speak a language other than English at home, including 4,496 people (2.2% of those aged five years and over) with poor English proficiency. The top 10 languages other than English spoken at home for residents of the Northern Illawarra are Macedonian, Arabic, Italian, Mandarin, Spanish, Greek, Serbian, Vietnamese, Portuguese, and Turkish.



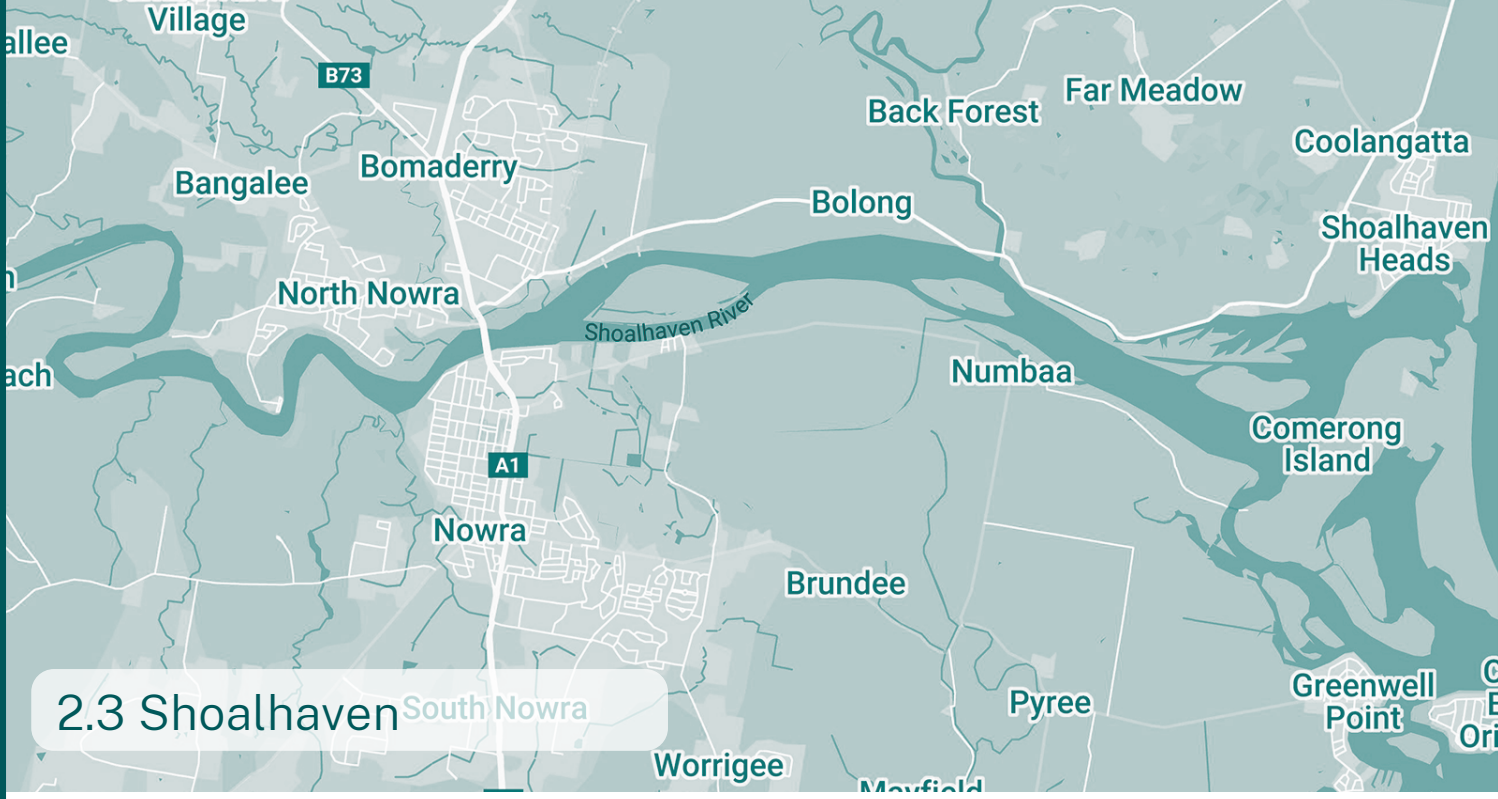
People with disability	14,462 people (7%) identified that they need assistance with core activities.
People experiencing housing stress or homelessness	In 2021, 822 people (0.4%) identified as experiencing homelessness. 9,538 households (20%) were experiencing mortgage or rental stress.
People with low socioeconomic status	60,204 people (34%) had an income of $499 or less per week. 50% of people in the District with a low income reside in the Northern Illawarra.
People with long-term health conditions	66,126 residents (31%) had one or more long-term health conditions. Of which, 7,689 residents (4%) had three or more long-term health conditions. The top five long-term health conditions include mental health conditions, arthritis, asthma, diabetes and heart disease.
Older people	39,968 residents (19%) were aged 65 and over and 5,754 (3%) are aged 85 and over.
Young people	28,816 residents (13%) were aged between 15 and 24 years.



2.2 Southern Illawarra

Total population	In 2021, there were 99,345 people living in the Southern Illawarra
Aboriginal people	An estimated 4,343 Southern Illawarra residents identified as Aboriginal, representing 4.4% of the local population and 24% of the total Aboriginal population within ISLHD.
Carers	10,837 people (13%) aged over 15 years, provided unpaid assistance to a person with a disability, health condition, or due to old age, and 60% of these carers were female. Of all carers in ISLHD, 23% reside in the Southern Illawarra.
Children under five years of age	There were 5,740 children aged under five years, representing 6% of the population.
Multicultural diversity	8,360 people (8.4%) were born overseas in a predominantly non-English speaking country. The top 10 non-English speaking countries of birth for residents are North Macedonia, Germany, Philippines, Italy, India, Malta, Netherlands, Chile, Croatia and Thailand. 13,184 people (13%) speak a language other than English at home, including 875 people (0.9% of those aged five years and over) with poor English proficiency. The top 10 languages other than English spoken at home are Macedonian, Spanish, Italian, Turkish, Greek, Arabic, Serbian, Portuguese, Croatian, and German.

People with disability	6,607 people (7%) identified that they need assistance with core activities.
People experiencing housing stress or homelessness	199 people (0.2%) identified as experiencing homelessness. 3,882 households (18%) were experiencing mortgage or rental stress.
People with low socioeconomic status	27,188 people (34%) had an income of $499 or less per week. 22% of people in the District with a low income reside in the Southern Illawarra.
People with long-term health conditions	31,877 residents (32%) had one or more long-term health conditions. Of which, 3,769 residents (4%) had three or more long-term health conditions. The top five long-term health conditions include mental health conditions, arthritis, asthma, diabetes and heart disease.
Older people	20,336 residents (21%) were aged 65 and over with 2,472 (2.5%) aged over 85.
Young people	11,641 residents (12%) were aged between 15 and 24 years.



2.3 Shoalhaven

Total population	In 2021, there were 108,531 people living the the Shoalhaven.
Aboriginal people	An estimated 7067 Shoalhaven residents identified as Aboriginal, representing 6.5% of the local population and 39% of the total Aboriginal population within ISLHD.
Carers	12,837 people (14%) over the age of 15 years, provided unpaid assistance to a person with a disability, health condition, or due to old age, and 59% of these carers were female. Of all carers in ISLHD, 27% reside in the Shoalhaven.
Multicultural diversity	6,683 people (6.2%) were born overseas in a predominantly non-English speaking country. The top 10 non-English speaking countries of birth are North Macedonia, Philippines, Germany, India, Netherlands, Italy, China, Malta, Thailand, and Croatia. 12,598 people (16%) speak a language other than English at home, including 402 people (0.4% of those aged five years and over) with poor English proficiency. The top 10 languages other than English spoken at home are Greek, Spanish, Italian, German, Tagalog, Mandarin, Cantonese, Thai, Nepali, and Croatian.
Children under five years of age	There were 5,448 children aged under five years representing 5% of the population.

People with disability	8,780 people (8%) identified that they need assistance with core activities.
People experiencing housing stress or homelessness	279 people (0.3%) identified as experiencing homelessness. 5,291 households (24%) were experiencing mortgage or rental stress.
People with low socioeconomic status	33,851 people (37%) had an income of $499 or less per week. 28% of people in the District with a low income reside in the Shoalhaven.
People with long-term health conditions	39,827 Shoalhaven residents (37%) had one or more long-term health conditions. Of which, 5,933 residents (5%) had three or more long-term health conditions. The top five long-term health conditions include mental health conditions, arthritis, asthma, diabetes, and heart disease.
Older people	30,418 residents (28%) were aged 65 and over. 3,504 (3.2%) were aged over 85.
Young people	10,217 residents (9%) were aged between 15 and 24 years.

3. Age Groups

3.1 Children

In 2023, there were 5,040 births across the District.[2]
In 2021, there were 23,171 children (aged under five), representing 5.5% of ISLHD's population.
There were 2,077 Aboriginal children, representing 8.9% of children.
In 2021, the Australia Early Development Census estimated that one in 10 children under five years were developmentally vulnerable across two or more early childhood development domains (physical, social, emotional, communication/ general knowledge, language/ cognitive).[3]
57% of children were identified as being developmentally on track across all five early childhood development domains.[3]

The first 2000 days of a child's life, including the period from conception to approximately five and a half years of age, are crucial for their overall development. During this time, a child's brain undergoes rapid growth. It is an optimal time for learning and development, as the brain is highly responsive to external stimuli. Proper nutrition, positive interactions, and a stimulating environment can significantly influence cognitive, emotional, and social development, setting the foundation for lifelong health and learning.

Research aligned with the NSW Health First 2000 Days Framework shows that children starting school with undetected and/or under-managed health, psychosocial and developmental vulnerabilities can experience poor academic, behavioural, social, physical and mental health outcomes. This highlights the need for universal access to health and developmental surveillance, and quality early childhood education and care.[4] In practice, this means 'eliciting and attending to parents' concerns', making accurate and informative longitudinal observations on children, obtaining a relevant developmental history and ensuring timely identification and intervention for any health, wellbeing and developmental problems.[5]

Many families with young children experience multiple barriers to accessing and benefiting from health services. These include Aboriginal families, low-income families, families from multicultural backgrounds, children in Out-of-Home Care, and children and families experiencing violence, abuse and neglect. Effective prevention and early intervention are the most promising strategies for changing the life trajectories of children. At a population level, this requires flexible and responsive systems that are equipped to deliver preventative interventions and respond early and effectively to emerging issues and challenges.[6]

The companion report to this profile, the *Illawarra Shoalhaven Health Inequities Report* provides further information about inequities in developmental vulnerabilities across ISLHD.

3.2 Young People

In 2021, 50,674 young people (aged 15 to 24 years) lived in ISLHD, representing 12% of the population.

There were 3,498 Aboriginal young people, representing 5% of residents aged 15 to 24 years.

6,206 young people were born overseas, representing 12% of the population.

The top five non-English speaking countries of birth were India, China, Thailand, Philippines and Vietnam.

10,850 young people (21%) reported they had one or more long-term health conditions.

117 young people (0.2%) had three or more long-term health conditions.

The top five most prevalent long-term health burdens were mental health conditions, asthma, diabetes, arthritis, and cancer.

Over 13% of young people (6,829) reported a long-term mental health condition.

6% of young people (2,812) provided unpaid assistance to a person who was elderly, had a disability, or another health condition.

ISLHD had a small population of young parents, with 1,114 females (5%) aged under 24 years having one or more children.

Adolescence and young adulthood are critical and dynamic periods in a person's life, marked by major psychosocial and physical changes. Young people experience a range of unique health and wellbeing issues that differ from those of younger children and older adults.

Although most young people self-report being in excellent, very good or good health, some young people, particularly those from priority populations, experience poorer health and wellbeing outcomes and increased barriers to accessing health services.[7] These include young people who are Aboriginal, those experiencing homelessness, LGBTIQ+ people, those with an Out-of-Home Care experience, refugees or newly arrived migrants, people with disabilities or chronic health conditions, carers and young parents as well as young people who have experienced family, peer or intimate partner violence.[8]

This life stage offers a key opportunity for services to provide early intervention for health issues and to be accessible and responsive to young people's needs.

Mental health challenges remain a key issue for young people nationally. They are the predominant cause of the burden of disease for people aged 15 to 24 years, with suicide being the leading cause of death among this age group.[9,10] Rates of psychological distress experienced by young people are also increasing, with over one quarter (26.6%) of young people reporting psychological distress in 2020 compared with one in five (18.6%) in 2012.[11]

The COVID-19 pandemic has had a particular impact on the health and wellbeing of young people. Compared with older age groups, young people have experienced high rates of psychological distress, social disconnection, educational disruption, unemployment, housing stress and family and domestic violence.[12]

Furthermore, vaping has emerged as a significant health issue for young people. One-third of young people in Australia aged 16 to 24 years have used vaping products.[13] Daily and regular use among this age group has doubled in recent years from 4.5% in 2019-2020 to 11% in 2020-2021.[14]

3.3 Older People

In 2021, 90,722 ISLHD residents (22%) were over the age of 65. This is an increase from 78,815 people (20%) in 2016.

The proportion of those aged over 65 varies across the District:

- 39,968 people (19%) in the Northern Illawarra
- 20,336 people (20%) in the Southern Illawarra
- 30,418 people (28%) in the Shoalhaven

1,217 Aboriginal people in ISLHD were aged 65 years and over, representing 1.3% of the population in this age group.

34,348 ISLHD residents aged over 65 (29%) were born overseas.

The top five non-English speaking countries of birth were Italy, North Macedonia, Germany, Netherlands and Greece.

55,401 people aged over 65 (61%) reported one or more long-term health conditions. Of these, 13,717 people (15%) had three or more long-term health conditions. The top five most prevalent long-term health conditions were arthritis, heart disease, diabetes, cancer, and mental health conditions.

16,714 ISLHD residents aged over 65 (18%) and 5,646 residents aged over 85 (48%) required assistance with core activities. For those aged 65 years and over, 13% provided unpaid assistance to a person who was elderly, had a disability, or a health condition.

The prevalence of chronic health conditions and rate of hospitalisation increases markedly with age. In 2022-23, 49% of admissions and 63% of bed days in ISLHD hospitals were patients aged over 65.[15] As the number of people in this age group grows, so too does the demand on health and social supports including hospitals, community health providers, GPs, allied health, residential aged care facilities, and community aged care services.

The majority of older people (age 65 years and over) in NSW live in the community, with 4.4% living in residential aged care.[16] The aged care sector in Australia has faced significant challenges in recent years, including inadequate staffing, poor quality of care, and insufficient regulatory oversight. The funding model for residential aged care has been criticised for not providing sufficient resources to meet the growing demands of an ageing population.[17] This is being acutely felt in ISLHD with the number of residential aged care places for those aged over 80 falling by approximately 15% over the last 10 years.[18] Similarly, the demand for Commonwealth Home Support Packages is far outstripping supply. Not only is there an extensive waiting list to receive a package, but many people who do have a package are struggling to find appropriate community aged care providers. This is particularly the case in rural and regional areas.[19]

The strain on the residential and community aged care sector has a significant impact on the public health system. When appropriate supports are not in place to allow older people to live independently at home and in the community, it can often lead to increased emergency department presentations and hospital admissions. Similarly, the lack of available aged care beds can result in elderly patients remaining in hospital for extended periods. This can lead to suboptimal health outcomes such as hospital-acquired infections, physical deconditioning, and mental health issues due to the lack of a familiar environment. The Royal Commission into Aged Care Quality and Safety has affirmed the urgent need for comprehensive reform to address these issues and ensure that Australia's elderly population receives the high-quality care they deserve.[16]

4. Aboriginal and Torres Strait Islander People

In 2021, an estimated 18,355 ISLHD residents were Aboriginal, representing 4.3% of the population.[20]

Place of residence for Aboriginal people across the District:[20]

- Northern Illawarra: 6,945 people, 3.2% of the total population.
- Southern Illawarra: 4,343 people, 4.4% of the total population.
- Shoalhaven: 7,067 people, 6.5% of the total population.

The Aboriginal population is relatively young, with a median age of 20 to 24 years (as compared to the total population's median age of 30 to 34 years).

One in 20 Aboriginal people in the District reported three or more long-term health conditions (as compared to one in 25 in the total population). The most prevalent conditions were mental health conditions, asthma, arthritis, diabetes and heart disease.

According to the latest Closing the Gap annual report by the Productivity Commission, of the 19 targets for Aboriginal and Torres Strait Islanders: [23,24]

- Four are on track: more babies have a healthy birthweight, more children are enrolled in preschool, more adults are employed, and legal rights to land and seas have improved.
- Four have deteriorated: fewer children are developmentally on track, more children are in out-of-home care, more adults are imprisoned, and suicide rates are higher.

Historical and ongoing systemic discrimination and marginalisation have significantly impacted the health of Aboriginal and Torres Strait Islander people. The legacy of colonisation, including the forced removal of children from their families, has had lasting effects on mental and physical health outcomes. Intergenerational trauma, loss of cultural identity, and ongoing racism contribute to high rates of mental health issues, substance abuse, and suicide.[21]

Aboriginal and Torres Strait Islander people in Australia continue to experience health disparities that are deeply rooted in systemic inequities. These disparities are evident across a wide range of health indicators, including life expectancy, chronic disease prevalence, infant mortality rates, and access to healthcare. According to data from the Australian Institute of Health and Welfare (AIHW), the gap in life expectancy between Aboriginal and non-Aboriginal people is around 8 to 10 years.[22] This difference can be attributed to various factors, including higher rates of chronic illnesses such as diabetes, cardiovascular disease, and respiratory conditions.

The AIHW has estimated 35% of the health gap between First Nations and other Australians explained by social determinants (such as inadequate housing, limited access to education, and higher rates of poverty) and a further 30% by selected health risk factors (including smoking, nutrition, physical activity, alcohol, and high blood pressure). Disparities in access to healthcare services, along with cultural insensitivity and mistrust of the healthcare system, can further deter Aboriginal people from seeking timely medical care.

ISLHD collaborates with Aboriginal Community Controlled Health Organisations (ACCHOs) in supporting culturally safe, community-led care. Through the *NSW Connecting with Country Framework*, collaboration with local Aboriginal communities is strengthened in planning and delivering culturally grounded, sustainable health projects. Aboriginal leadership, shared decision-making, and increased Aboriginal employment are essential to building culturally responsive services. A workforce informed by cultural humility, trauma-informed practice, and the ongoing impacts of colonisation fosters trust and supports holistic wellbeing, shaping health systems that honour Aboriginal healing traditions.

5. Socially Disadvantaged Groups

5.1 Low Socioeconomic Status

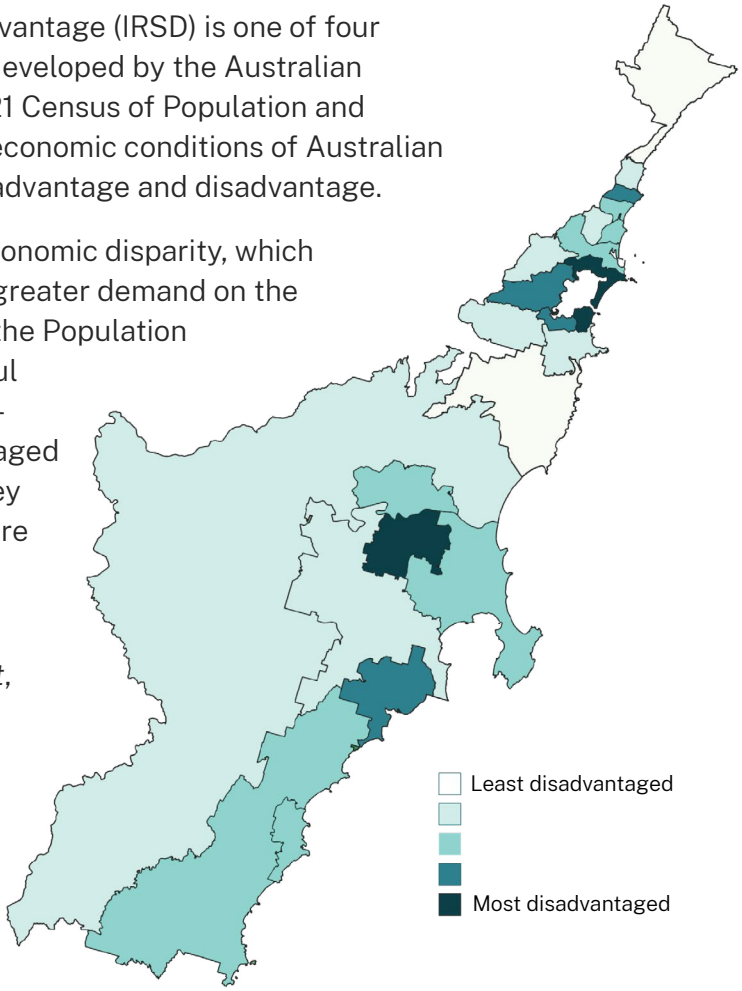
In 2021, 35% of people in ISLHD (121,234) reported a personal weekly income of $499 or less ($26,000 annually), compared to 3.5% (12,154) who reported a personal weekly income of $3,000 or more ($156,000 annually).
9,400 people were unemployed, representing 4.2% of the labour force aged over the age of 15.
One in 10 households lived in social housing.
39,361 people had not completed Year 10, representing 11% of the population aged over 15 years no longer attending school.

The social determinants of health are the non-medical factors that influence health outcomes. They include the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Health and wellbeing outcomes across the world follow a social gradient: the lower the socioeconomic position, the poorer the health.[25]

The Index of Relative Socio-economic Disadvantage (IRSD) is one of four Socio-Economic Indexes for Areas (SEIFA) developed by the Australian Bureau of Statistics (ABS) following the 2021 Census of Population and Housing. It provides a measure of the socioeconomic conditions of Australian communities, highlighting areas of relative advantage and disadvantage.

Across ISLHD, there is considerable socioeconomic disparity, which contributes to poorer health outcomes and greater demand on the health system. At one end of the spectrum, the Population Health Areas (PHAs) of Helensburgh/Thirroul - Austinmer–Coalcliff, and Kiama - Jamberoo - Gerringong rank among the least disadvantaged in Australia. In contrast, the PHAs of Berkeley - Warrawong - Windang, Warilla, and Nowra are among the most disadvantaged nationally.[26]

The companion report to this profile, *Illawarra Shoalhaven Health Inequities Report*, provides detailed information on variations in health determinants (socioeconomic, environmental, and behavioural) across the District.



Map: Index of Relative Socioeconomic Disadvantage. See Appendix 1 for a detailed map.

5.2 People Experiencing Homelessness and Housing Stress

In 2021, an estimated 1,484 people were experiencing homelessness in ISLHD, representing 0.4% of the population. This was an increase of 189 people since 2016.[27]

Homelessness is experienced across the District:

- 828 people in the Northern Illawarra (0.4%)
- 227 people in the Southern Illawarra (0.2%)
- 429 people in the Shoalhaven (0.4%)

The ABS definition of homelessness used here includes people living: in improvised dwellings, tents or sleeping out; in supported accommodation for the homeless; temporarily with other households; in boarding houses; other temporary lodgings; or "severely" crowded dwellings.

3,766 households were experiencing mortgage stress, representing 8% of households with a mortgage.

14,945 households were experiencing rental stress, representing 34% of households who were renting.

The ABS definition of mortgage and rental stress is: lower income households (bottom 40% of Australia's income distribution) that spend more than 30% of their gross income on housing.

Housing affordability for both purchasing and renting is challenging to quantify across the District. Estimates are provided here on the proportion of housing available for households on a moderate income:

- Wollongong LGA: 5.6% of dwellings to purchase and 38.9% of dwellings to rent.[28]
- Shellharbour LGA: 3.7% of dwellings to purchase and 19.5% of dwellings to rent.[29]
- Shoalhaven LGA: 5.3% of dwellings to purchase and 59.4% of dwellings to rent.[30]

The *State Environmental Planning Policy (Housing) 2021* definition of moderate household income level is: the income of 80-120% of households in NSW (Sydney or rest of NSW).

In 2021, 18,440 people (5%) lived in crowded dwellings.

The ABS definition of "severely crowded dwellings" is: requiring four or more additional bedrooms to accommodate residents (considered a form of homelessness), and of "other crowded dwellings" is requiring three additional bedrooms (considered to be marginally housed, potentially at risk of homelessness).

One in four households in ISLHD (41,314) were lone person households.

The estimates of homelessness were likely influenced by two factors related to the 2021 Census being conducted during the COVID-19 pandemic:

1. During lockdowns, Census field staff were limited in their ability to conduct complete counts, particularly of people experiencing homelessness.
2. The NSW government provided increased assistance for people experiencing primary homelessness, enabling access to emergency accommodation in hotels.

Additionally, the post-pandemic rise in the cost of living, including significant increases to rental and mortgage repayments, is not entirely captured by this report. It is likely that the number of people impacted by homelessness and housing stress in ISLHD is higher than has been represented here.

Homelessness and housing stress have a significant impact on physical and mental health outcomes, often working in a cyclical nature. Poor living conditions can lead to a high prevalence of acute and chronic illnesses, including respiratory infections, skin diseases, and gastrointestinal disorders. Additionally, chronic diseases such as hypertension, diabetes, and cardiovascular conditions often go untreated or are poorly managed, exacerbating the severity. The lack of stable housing also hinders the ability to follow prescribed treatments and maintain regular medical appointments, contributing to further deterioration of health outcomes.[31] Moreover, the stigma associated with homelessness and housing stress often results in discriminatory treatment within healthcare systems, reducing the quality and accessibility of care.

The stress of finding shelter, food, and safety can exacerbate existing mental health conditions and lead to the development of new issues such as depression, anxiety, and substance abuse disorders. People experiencing homelessness and housing stress frequently encounter violence, trauma, and social isolation, which further compound psychological hardship. This can be particularly damaging for children, affecting their development and academic performance, and potentially leading to long-term mental health concerns.[32]

The high proportion of lone-person households in ISLHD is also a cause for concern. From a socioeconomic perspective, the increased costs of rents, mortgages, utilities, and maintenance expenses are not shared with others, leading to higher individual costs. Social isolation and loneliness, which may be associated with living alone, have been linked to premature death, poor physical and mental health, greater psychological distress, and general dissatisfaction with life. Loneliness among Australians was already a concerning issue before the COVID-19 pandemic, to the extent that in 2022 it was described as one of the most pressing public health priorities in Australia.[33]

6. Multicultural Communities

In 2021, ISLHD had over 95,000 residents who were born overseas, representing 23% of the total population. 45,489 of these people (11% of the total population) were born in predominantly non-English speaking countries.

The top 10 predominantly non-English speaking countries of birth were North Macedonia, India, Italy, Philippines, China, Germany, Vietnam, Croatia, Thailand, and Lebanon.

More than 16% of residents spoke a language other than English at home. The top 10 languages other than English spoken at home were Macedonian, Italian, Arabic, Spanish, Mandarin, Serbian, Portuguese, Vietnamese, Greek and Croatian.

5,773 residents born overseas reported poor English proficiency, i.e. speaking English 'not well' or 'not at all' (1.4% of population aged five years and over).

213,149 residents (51%) identified as being Christian with the dominant branches being Catholic (22%), Anglican (15%), Eastern Orthodox (3%), Uniting (2.5%) and Presbyterian (2%).

Other prominent religions included Islam (1.6%), Buddhism (1%), and Hinduism (0.7%).

166,199 people (39%) did not associate with any religion.

Since 2011, 1,887 people have arrived in the District as either refugees or asylum seekers.[34]

The top five countries of birth were Syria, Iraq, Myanmar, the Democratic Republic of Congo, and Thailand.

The top five languages spoken were Arabic, Swahili, Karen, Eastern Kayah, and Farsi (Persian).

ISLHD is currently experiencing significant changes in its multicultural makeup. Historically, migration to the region primarily involved people from the United Kingdom and Ireland, followed by other European countries after World War II. While migration from the United Kingdom and Ireland has remained steady, migration has declined from other European nations. Additionally, long-term residents originally from Europe are gradually passing away. This trend is reflected in the 2016 and 2021 Census data, which show a decrease in the number of people born in Italy, the Netherlands, Greece, Malta, and Croatia.

Migration from countries in southern and eastern Asia increased between 2016 and 2021. Increases were particularly seen among people born in India, Pakistan, the Philippines, Thailand, and Vietnam. The main exception to this trend was a decrease in Chinese-born residents during the same period. (However, much of this can be attributed to the Census occurring during the COVID-19 pandemic and the strict immigration criteria particularly impacting international students coming to Australia).

The shift in countries of birth is also reflected in changes from 2016 to 2021 in the languages spoken at home across ISLHD. There were decreases in those speaking Italian, Greek, Croatian, and Polish, and increases in those speaking Filipino, Thai, Tagalog, Vietnamese, Bengali, Hindi, Punjabi, Urdu, and Arabic. The full extent of cultural and linguistic change in the region is unlikely to be fully understood until the release of the 2026 Census.

English proficiency has profound implications for many people born overseas in terms of awareness of and ease of access to services, employment, and many other aspects of society. Women and older people in particular may not develop proficiency in English and some may return to speaking the language of their birthplace as they age.

The health of people from multicultural backgrounds can be affected by poor access to health services and lack of appropriate information to make informed decisions.

Factors that can contribute to poor health and wellbeing outcomes include:

- Lack of cultural competency within health service providers
- Limited English language proficiency and inadequate access to interpreters
- Lack of knowledge of the health care system, particularly primary health care, preventative health, community health and mental health services
- Differing knowledge of health issues, cultural practices and health beliefs
- Isolation and absence of social and family support networks
- Stigma around certain health issues
- Previous negative experiences with a healthcare system, whether that be overseas or after migration to Australia
- Past and ongoing experiences of psychological trauma.[34]

7. Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer (LGBTIQ+)

The absence of relevant questions about sexuality, gender, and intersex variation in population-level data collection, including in the ABS Census, makes it difficult to determine the number of LGBTIQ+ people living in NSW and subsequently in ISLHD. However, this is expected to change in the 2026 Census.

In 2016, an estimated 3.4% of the NSW population aged 18 years and over identified as non-heterosexual.[36]

Research in the United States has estimated the transgender population to be 0.6% of adults. In NSW, this would equate to approximately 35,000 transgender people aged 18 years and over.[37]

Figures for intersex people are highly contested; however, a review of medical literature estimates between 1% and 2% of people are intersex.[38]

In NSW, LGBTIQ+ people rate their overall health lower than the general population. People who rated their health as excellent, very good or good:[39]

- General population: 86%
- Gay, bisexual and queer men: 74%
- Lesbian, bisexual and queer women: 67%
- Transgender and gender diverse people: 50%
- Intersex people: 41%

In 2018, an estimated two-thirds of LGBT people in NSW reported experiencing a mental health condition. A quarter reported suicidal thoughts, and almost one in 10 reported self-harm at some stage in their lives.[39]

It is important to acknowledge that LGBTIQ+ people are not a homogenous population. Each group within the acronym has unique health needs and experiences, and these needs should be recognised and respected for each individual. These groups are not mutually exclusive, for example, someone may be both transgender and gay. Common health impacts, however, can be seen across all groups, particularly in relation to the effects of stigma and discrimination.[39]

To achieve improved health outcomes for the diversity of LGBTIQ+ people and communities, ISLHD and the broader NSW Health system must take action. In doing so, it is essential to work in partnership with LGBTIQ+ people and organisations, making co-design a key principle and feature in addressing the needs, service access, and quality healthcare experiences.

The *NSW LGBTIQ+ Health Strategy* provides direction to all NSW Health organisations and staff so that the best care can be delivered to LGBTIQ+ people to support optimal health and wellbeing.[39]

The NSW LGBTIQ+ Health Strategy highlights several adverse health outcomes that may affect LGBTIQ+ individuals and communities, including:

Lesbian, bisexual and queer women:

- Higher mental health issues, particularly for younger women.
- Harmful patterns of alcohol and other drug use.
- Exposure to particularly high levels of violence, abuse and neglect.

Gay, bisexual and queer men:

- Poorer sexual health and harmful patterns of alcohol and other drug use.
- Mental health issues particularly affect younger gay, bisexual, and queer men and those living in regional areas.

Transgender and gender diverse people:

- Negative mental health impacts due to experiences of transphobia, discrimination, social stressors, and isolation.
- Exposure to high levels of sexual, domestic, and family violence.
- Challenges and barriers to accessing fertility care and support.
- High rates of autism spectrum disorder.

Intersex people:

- A range of physiological conditions, neurological conditions and fertility issues related to their intersex variation.
- May experience health issues relating to previous medical interventions.
- Mental health vulnerabilities due to stigma and minority stress.

8. People with Long-term Illness and Chronic Disease

8.1 People with Long-term Health Conditions

In 2021, 137,830 ISLHD residents (33%) had one or more long-term health conditions.

17,391 residents (4%) reported three or more long-term health conditions.

The prevalence of long-term health conditions differs across the District:

Northern Illawarra:

- 66,126 (31%) had one or more long-term health conditions.
- 7,869 (4%) had three or more long-term health conditions.

Southern Illawarra:

- 31,877 (32%) had one or more long-term health conditions.
- 3,769 (4%) had three or more long-term health conditions.

Shoalhaven:

- 39,827 (37%) had one or more long-term health conditions.
- 5,933 (5%) had three or more long-term health conditions.

The top 10 identified long-term health conditions for ISLHD residents are outlined below:

Long-term condition	Persons	Proportion of population
Arthritis	48,725	12%
Mental health conditions	43,926	10%
Asthma	37,061	9%
Diabetes	22,094	5%
Heart disease	19,673	5%
Cancer (including remission)	15,014	4%
Lung condition (including COPD or emphysema)	10,197	2%
Kidney disease	5,818	1%
Stroke	5,012	1%
Dementia (including Alzheimer's)	3,993	1%

Long-term health conditions are the leading causes of illness, disability, and death, comprising almost two-thirds of the burden of disease in Australia.[40] As this report highlights, there is significant disparity in the health outcomes faced by different population groups within ISLHD. These groups can be based on culture, age, geography, and socioeconomic status. The people with the poorest health outcomes often fit into multiple priority groups with a complex interplay of social determinants influencing health behaviours, access to resources, and overall quality of life.[41]

The *NSW Health Services Act 1997* stipulates the role of LHDs is to promote, protect and maintain the health of the community.[42]

The *NSW Future Health Strategy* has a key focus area to ensure people are healthy and well, and the *ISLHD Strategic Delivery Plan* outlines ISLHD's commitment to support our community to maintain good health throughout their entire life, from before birth to old age.[43,44]

Despite a push towards tackling health inequities, the complicated relationship between social determinants continues to challenge conventional policy. Efforts to support people to be healthy and well, and to address the social determinants cannot be achieved in isolation and require us to work collaboratively across health disciplines and with partner agencies and organisations.[42]

8.2 People with Disability

In 2018, an estimated 73,228 ISLHD residents (17%) had a disability. This included 25,486 people (6%) with a profound or severe core activity limitation and 47,742 people (11%) with a moderate or mild core activity limitation.[44]

The *ABS Survey of Disability, Ageing and Carers* defines a person with disability as having "any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for six months or more".

In 2021, 29,849 residents had a need for assistance with core activities, representing 7% of the population.

In 2024, 11,139 residents (2.6%) were National Disability Insurance Scheme (NDIS) participants.

The top five primary disabilities among NDIS participants were: autism, intellectual disability, psychosocial disability, developmental delay, and hearing impairment.[46]

There are 8,205 registered NDIS providers operating in the District. The number of providers per NDIS participant is lower in ISLHD compared with the rest of NSW, and lower in the Shoalhaven than in the Illawarra. This is reflected in the lower utilisation rate by Shoalhaven participants, who receive an average of $3,000 less in annual funds compared to other participants in the District.[46]

People with disabilities often face significant health challenges that are multifaceted and intertwined with the social determinants of health. Physical health issues are common among individuals with disabilities, who often experience secondary conditions related to their primary disability. Chronic conditions such as diabetes, cardiovascular diseases, and obesity are more prevalent among people with disabilities and are often linked to modifiable health risk factors such as a poor diet, insufficient physical activity, and tobacco smoking.[47] The psychological impact of living with a disability, compounded by societal stigma and discrimination, can lead to higher rates of mental health conditions. Social isolation and reduced participation in community activities further exacerbates these challenges.

Access to both physical and mental health services is often inadequate, with barriers such as physical access, lack of tailored programs, and healthcare providers having insufficient training in disability-specific needs. Additionally, there are often financial barriers, including higher healthcare costs and inadequate NDIS coverage. Communication barriers also play a role, particularly for individuals with sensory disabilities. These obstacles contribute to disparities in health outcomes and overall lower quality of life for people with disabilities, underscoring the need for systemic changes to ensure equitable healthcare access and provision.

9. Carers

In 2018, an estimated 50,312 ISLHD residents were carers, representing 14% of the population aged over 15-years.[45]

The *ABS Survey of Disability, Ageing and Carers* defines a carer as "a person who provides any informal assistance (help or supervision) to people with disability or older people (aged 65 years and over)."

In 2021, 46,389 residents aged over 15-years (13% of population) were providing unpaid assistance to a person with a disability, health condition or due to old age. The majority of these people were female (59%).

29,849 people required assistance with core activities, representing 7% of the total population.

89,833 people aged over 15-years (26%) provided unpaid childcare, with the majority being female (57%).

One in three households with children (18,753) were single parent families.

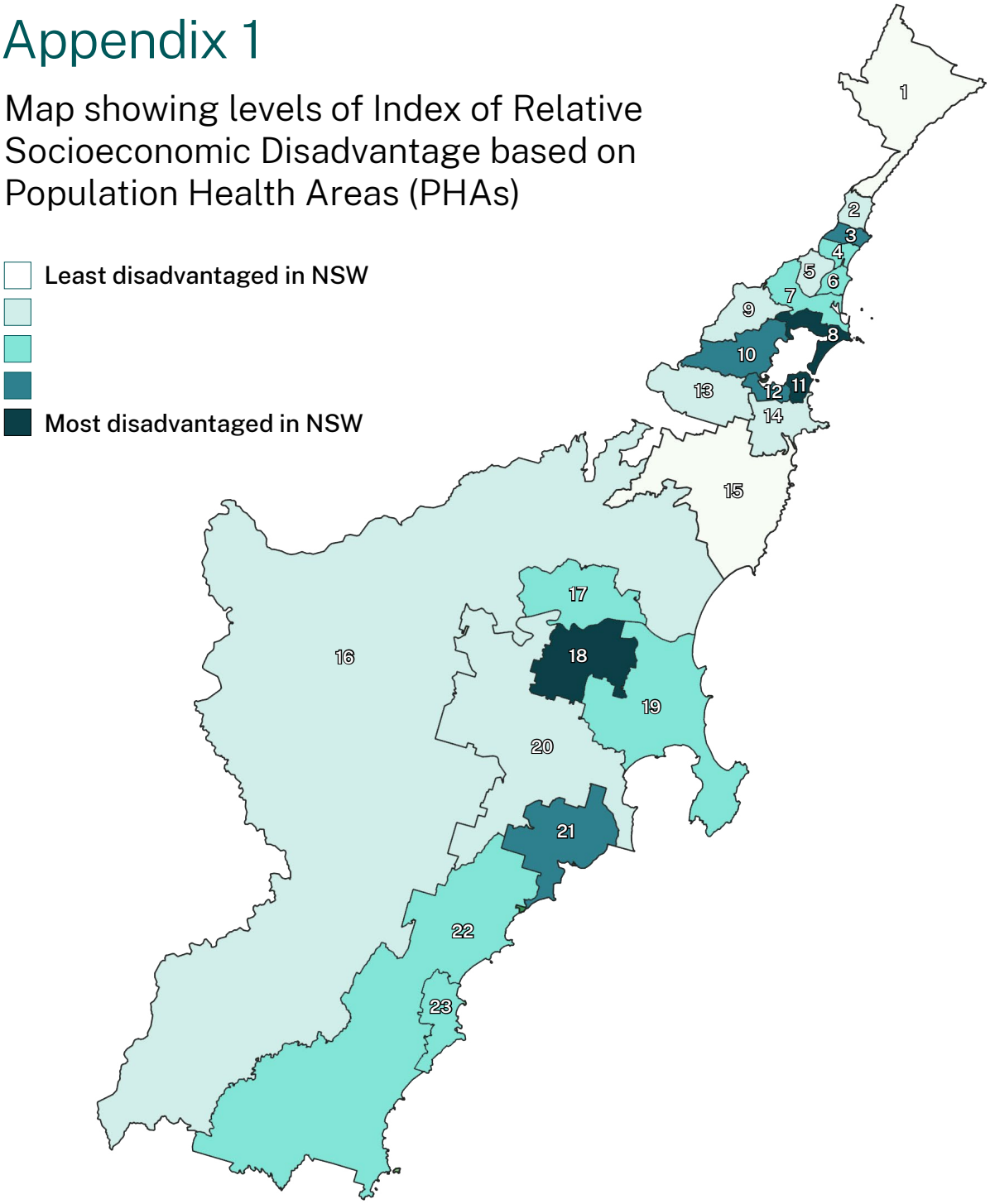
People become carers in different ways. For some, the role develops gradually, with responsibilities increasing as a person's health and independence decline over time. For others, it begins suddenly, after a health crisis or accident. It is not uncommon for carers to feel they have little choice in taking on the role. Even in large families, the responsibility for providing care often falls to one individual rather than being shared. In some cases, there may be only one person available to provide care.[48]

Every caring situation is different. Some carers provide 24-hour nursing to a family member with high care needs. Others support people who are relatively independent but may need someone to keep an eye on them or help them with daily tasks. Most carers offer comfort, encouragement, and reassurance to the person they care for, oversee their health and wellbeing, monitor their safety, and help them remain as independent as possible.[48]

Often, the extent of support provided by carers is not immediately apparent to those around them. Caring for a family member or friend can be very rewarding, but it also has its challenges. Without adequate support, caring responsibilities can become overwhelming, impacting carers' health and wellbeing, limiting their ability to participate in paid work, family life and social and community activities.[48]

10. Appendix 1

Map showing levels of Index of Relative Socioeconomic Disadvantage based on Population Health Areas (PHAs)



ID	PHA	ID	PHA	ID	PHA
1	Helensburgh/ Thirroul - Austinmer - Coalcliff	9	Horsley - Kembla Grange	17	North Nowra - Bomaderry
2	Woonona - Bulli - Russell Vale	10	Dapto - Avondale	18	Nowra
3	Corrimal - Tarrawanna - Bellambi	11	Warilla	19	Callala Bay - Currarong, Culburra Beach
4	Balgownie - Fairy Meadow	12	Albion Park Rail/ Shellharbour - Oak Flats	20	Huskisson - Tomerong
5	Figtree - Keiraville	13	Albion Park - Macquarie Pass	21	St Georges Basin - Erowal Bay
6	Wollongong	14	Shellharbour - Flinders	22	Ulladulla Region
7	Unanderra - Mount Kembla	15	Kiama - Jamberoo - Gerringong	23	Ulladulla
8	Berkeley - Warrawong - Windang	16	Berry - Kangaroo Valley		

10. Appendix 2

District sub-areas	Northern Illawarra	Southern Illawarra	Shoalhaven	ISLHD	NSW
Local Government Areas	**Wollongong LGA**	**Shellharbour + Kiama LGA**	**Shoalhaven LGA**	**All Illawarra Shoalhaven LGAs**	**NSW**
Total resident population (2021 ABS Census)	**214,700**	**99,462**	**108,550**	**422,712**	
Age groups (2021 ABS Census)					
▪ Children < 5 years	12,083 (5.7%)	5,740 (6.0%)	5,448 (5.2%)	23,271 (5.5%)	5.8%
▪ Youth 15-24 years	14,177 (14.2%)	11,641 (12.3%)	10,217 (9.9%)	36,035 (8.5%)	12.6%
▪ Older 65+ years	39,968 (18.3%)	20,336 (20.5%)	30,418 (28.1%)	90,722 (21.5%	17.5%
▪ Older 85+ years	5,754 (2.6%)	2,472 (2.4%)	3,504 (3.2%)	11,730 (2.7%)	2.2%
Aboriginal and Torres Strait Islanders (2021 ABS Census)	6,945 (3.2%)	4,343 (4.4%)	7,067 (6.5%)	18,355 (4.3%)	3.4%
Socioeconomic disadvantage (2021 ABS Census)					
▪ Personal weekly income <$500 (% working population)	60,204 (34.0%)	27,188 (33.6%)	33,851 (37.1%)	121,243 (34.7%)	31.9%
▪ Homeless (% of total population)	822 (0.4%)	227 (0.2%)	429 (0.4%)	1,484 (0.4%)	0.5%
▪ Housing stress (% of total rented and private dwellings)	9,538 (19.9%)	3,882 (18.0%)	5,291 (24.2%)	18,711 (20.5%)	18.7%
Multicultural communities					
▪ Born overseas in predominantly non-English-speaking country (% of total population)	30,446 (14.2%)	8,360 (8.4%)	6,683 (6.2%)	45,489 (10.8%)	23.0%
▪ Speak language other than English (% of total population)	43,387 (20.2%)	13,184 (13.3%)	12,598 (11.6%)	69,169 (16.4%)	29.5%
▪ Born overseas reporting poor English proficiency (% of population aged 5 years+)	4,496 (2.2%)	875 (0.9%)	402 (0.4%)	5,773 (1.4%)	4.0%
People with long-term health conditions					
▪ 1+ conditions (% of total population)	66,126 (30.8%)	31,877 (32.0%)	39,827 (36.7%)	137,841 (31.9%)	26.1%
▪ 3+ conditions (% of total population)	7,689 (3.6%)	3,769 (3.8%)	5,933 (5.5%)	17,391 (4.1%)	2.9%
People living with disability					
▪ Need assistance with core activities (% of total population)	14,458 (6.7%)	6,613 (6.7%)	8,783 (8.1%)	29,854 (7.1%)	5.8%
Carers (2021 ABS Census)					
▪ Unpaid assistance to person with a disability (% of population 15+ years)	23,219 (13.1%)	10,837 (13.4%)	12,837 (13.5%)	46,389 (13.3%)	11.5%

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