

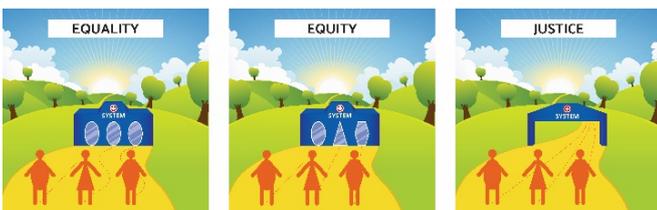
## Multicultural health inequity

Australians generally enjoy good health. However, good health is not shared equally. There are significant differences in rates of death and disease, life expectancy, self-perceived health, health behaviours, health risk factors and health service utilization.

These 'health inequities' are associated with differences in education, occupation, income, employment status, rurality, Aboriginality and gender. They are also associated with ethnicity, culture, migration history and experiences of racism.

Health inequity is the unjust differences in health that are preventable and unnecessary. Health inequities are systemic differences in health that could be avoided.

Working on fixing the systems that create health inequity is the core business of World Wellness Group.



In the 'equality' scenario on the graphic, the one-size-fits-all approach means that people who cannot access or utilize services for cultural, linguistic, access or other reasons, are locked out of the service system. Although such systems can be described as 'universal access', in reality they tend to advantage people whose literacy skills and values are consistent with the mainstream

health system and further disadvantage those that are not [1].

The structural inequalities that disadvantage people from culturally and linguistically diverse backgrounds are complex and poorly documented in Australia in particular. Some of the outcomes of this disadvantage include:

- **Health literacy:** people from CALD backgrounds have lower levels of health literacy than the general population - approximately 74% of migrant and refugee groups have lower levels of health literacy compared to the general Australian population (59%). [2] For older CALD people it is even worse: while 17.4 per cent of 65–74 year olds in the broader population have 'adequate' health literacy levels, only 3.4 per cent of CALD individuals in the same age group have adequate health literacy levels. [3]
- **Health screening:** numerous Australian studies have found lower participation in health screening programs amongst overseas-born Australians.
  - Participants in one large Australian study who reported speaking a language other than English at home, the odds of reporting a test for bowel cancer within the previous 5 years was up to 40% lower than for English-only speakers. The rate of reporting a mammogram for women born in East Asia and North Africa/Middle East were half those for Australian-born women. The odds of a man born in East Asia reporting a PSA test were lower by 60%.
  - Men from Oceania, East Asia, Southeast Asia, South and Central Asia Western Europe, Central and East Europe and the

**#healthequityjustice**

admin@worldwellnessgroup.org.au  
www.worldwellnessgroup.org.au

33 Stoneham Street, Stones Corner QLD, 4120  
P: (07) 3333 2100 F: (07) 3397 1358

ABN | 95154368804



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Middle East/North Africa reported significantly lower levels of bowel test use than Australian-born participants in an Australian study.

- o BreastScreen Australia reports that women who spoke a language other than English at home participated in their program at a rate of 6% lower than those who speak only English at home (Breast Screen Australia monitoring report 2012-2013). In Queensland this trend is also reported - in 2015–2016, 56% of women aged 50–74 years participated in the BreastScreen Queensland program. Among women from CALD backgrounds it was 53%.<sup>[4]</sup>
- **Health protection:** Overseas-born Queenslanders from non-English speaking countries have some of the highest rates of vaccine-preventable hospitalisations as presented in the table. Promoting the benefits of vaccination and implementing pro-active vaccination programs in multicultural communities is urgent.

Queensland population by region of birth	Qld vaccine preventable PPH compared to Australia born (2003-2007)
<b>Oceania</b>	91% higher
<b>Samoa</b>	
<b>North Africa</b>	350% higher
<b>North East Asia</b>	230% higher (males) and 76% higher for total
<b>S E Asia</b>	220% higher (males) and 50% higher (females)

- **Lifestyle modification:** *Tobacco smoking.* Data on tobacco smoking amongst CALD populations in Australia is unreliable. This is mainly due to lack of cultural competency in

health research methodology and reporting. For example, the Australian Institute of Health and Welfare <sup>[5]</sup> reports that CALD populations have a much lower prevalence of tobacco smoking (5.9%) than Australia born residents (12.8%). Aggregating all overseas born populations into one very heterogeneous population group is flawed from a policy, research and program perspective. It masks the significant differences in prevalence between CALD populations and reduces the entire overseas-born population to one prevalence rate. In contrast, Tobacco in Australia reports on studies conducted in Sydney which found almost 50% of Chinese and Vietnamese born men smoked daily and when disaggregating national data-sets by region of birth, populations born in New Zealand, Oceania, North Africa and Middle East have significantly higher rates of tobacco smoking than Australia born.<sup>[6]</sup> Further work is required in this area.

- **Lifestyle modification:** *Healthy weight* - like tobacco smoking research, there is little reliable data on healthy weight among immigrants in Australia. One recent comprehensive Queensland study <sup>[7]</sup> did find differences across ethnic groups, age at immigration groups, deprived neighbourhood groups and length of residence in Australia and concluded that the results demonstrated that all immigrants to Australia are at risk of overweight and obesity over time. Obesity prevention approaches tailored to the needs of ethnic groups most vulnerable to obesity are a priority, as are interventions that commence

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in the early-mid settlement period, and those directed at families arriving with children and adolescents. It was also recommended that further research with immigrant and ethnic minority groups would assist in understanding the drivers of ethnic inequalities in obesity in Australia. There is some older data about obesity amongst particular ethnic groups living in Queensland, particularly those born in Oceania and Southern and Eastern Europe. [8]

- **Preventable hospitalisations:** available Queensland data is old but it is the best available at present. It shows some significant differences amongst certain population groups. In Queensland during the period 2003-07, the NESC population had a 20 per cent higher hospitalisation rate for vaccine preventable conditions compared to the MESC population. Hospitalisations for individual geographic regional groups 2003-07 were [9]:
  - all causes – Oceania 14 per cent higher, North Africa females 13 per cent higher
  - total potentially preventable - Oceania 9 per cent higher
  - chronic potentially preventable – Oceania 32 per cent higher, Middle East 22 per cent higher, North Africa males 13 per cent higher
  - acute PPH – North Africa 17 per cent higher
  - vaccine preventable – North Africa 350 per cent higher, Oceania 91 per cent higher, North East Asia 76 per cent higher
  - asthma – Oceania 41 per cent higher, New Zealand 12 per cent higher

- coronary heart disease – Southern and Central Asia males 9 per cent higher, Oceania females 12 per cent higher, Middle East total 15 per cent higher
- diabetes – Oceania 46 per cent higher, North Africa 27 per cent higher, Middle East female 40 per cent higher
- heart failure – Middle East 210 per cent higher, Oceania 31 per cent higher, Southern and Eastern Europe 24 per cent higher

World Wellness Group is working with Queensland Health to improve health data collection and reporting and it is acknowledged that this best available data is now extremely dated.