Factsheet

World Wellness Group

Multicultural population health needs - what do we know?

Health needs - published health data

(a) Availability of multicultural health data in Australia is poor (2) with well evidenced challenges in datasets not collecting appropriate indicators and not reporting what is collected (3).
(b)Primary Health Networks, use Primary Sense to extract data from general practices. Primary Sense cannot extract the indicators that identify multicultural populations and therefore primary care access cannot be accurately mapped in Australia based directly on primary service data.
(c) Some studies show that migrants living in Australia are significantly less likely to report a chronic condition than the Australia-born population (3)

(d) From national data, we know the following about health in multicultural communities who were born overseas:

- Migrants arrive with better health than the native-born population (due to immigration health screening) and the health of many populations declines the longer they are in Australia resulting in higher prevalence of chronic conditions than the Australia-born population in some communities(2).
- Using Census data, the AIHW also reported that migrants who have lower English proficiency, experience a higher prevalence of chronic disease (2).
- There were significant disparities in mortality rates faced by multicultural communities during the COVID-19 pandemic (4).
- The better physical health advantage of recently settled migrants does not apply to mental health (5).
- There is an association between the gross domestic product (GDP) of the birth country, with the healthy migrant effect being negatively associated with migrant groups who are from low GDP countries than those from high GDP countries (6).

(e)Available Queensland Health state-based data on mortality and potentially preventable hospitalisations (PPH) showed the greatest disparities for (7):

- Vaccine preventable hospitalisations which were higher for seven overseas born regions than Australia-born. Highest were Somalia (11.3X higher); Sudan (8.8X higher); Tonga, Samoa, Eritrea, Cook Islands (6x higher).
- Chronic health conditions PPH were higher for many communities, particularly Oceania born (Samoa, Tonga, Cook Islands 2X higher); Middle East (Syria 2.8X higher); Somalia (2X higher) and Serbia (2x higher).
- Overall, hospitalisation rates were higher for regions of Oceania, Middle East and North Africa.

f) AIHW data reported that self-reported long-term health conditions by humanitarian entrants is at higher rates than other permanent migrants and lower than the rest of the Australian population (8). They reported higher rates of diabetes, kidney disease, stroke, heart disease and dementia and lower rates of arthritis, asthma, chronic lung conditions and mental health conditions compared to the rest of the Australian population.

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(g) The poor mental health of Australian asylum seekers is well documented with markedly elevated rates of mental distress including post-traumatic stress, depression and anxiety among people seeking asylum compared with compatriot refugees with permanent residency status (9). They also experience poor physical health due to poor or interrupted access to healthcare, prolonged deprivation in extreme living conditions and marginalisation. The social determinants of health include financial vulnerability, destitution, homelessness, job insecurity and risk of exploitation (10).

(h) In Brisbane, the Metro North Hospital and Health Service CALD Community Data report reported (11):

- Three Pacific Islander communities (Samoa, Fiji and Papua New Guinea) while relatively small populations in size, were in the top 9 COB groups for admitted patients episodes.
- India, Philippines and China-born were the fastest growing and largest among admitted patients.
- Italy, Germany and Netherlands born were the remainder largest groups and represent the ageing populations in Brisbane North.

(i) The Metro North Local Area Needs Assessment report identified that CALD communities are more likely to experience a higher prevalence of certain health conditions and that CALD communities experience barriers to domestic and family violence services (12)

(j) Research from Australia and overseas indicates that migrant and refugee populations are at high risk of mental health conditions. In Australia multicultural patients have more involuntary admissions to hospitals and present later at an acute and crisis stage (13,14).A Queensland study which compared the use of community treatment orders (CTOs) and forensic orders (FO) found that nearly half (48.8%) of individuals born overseas from non-European backgrounds were treated under involuntary community treatment compared to a third (33.4%) who were from English speaking or European backgrounds. The study suggested that there could be a bias towards treating patients with mental illness from a CALD background, particularly those from non-European backgrounds (15).

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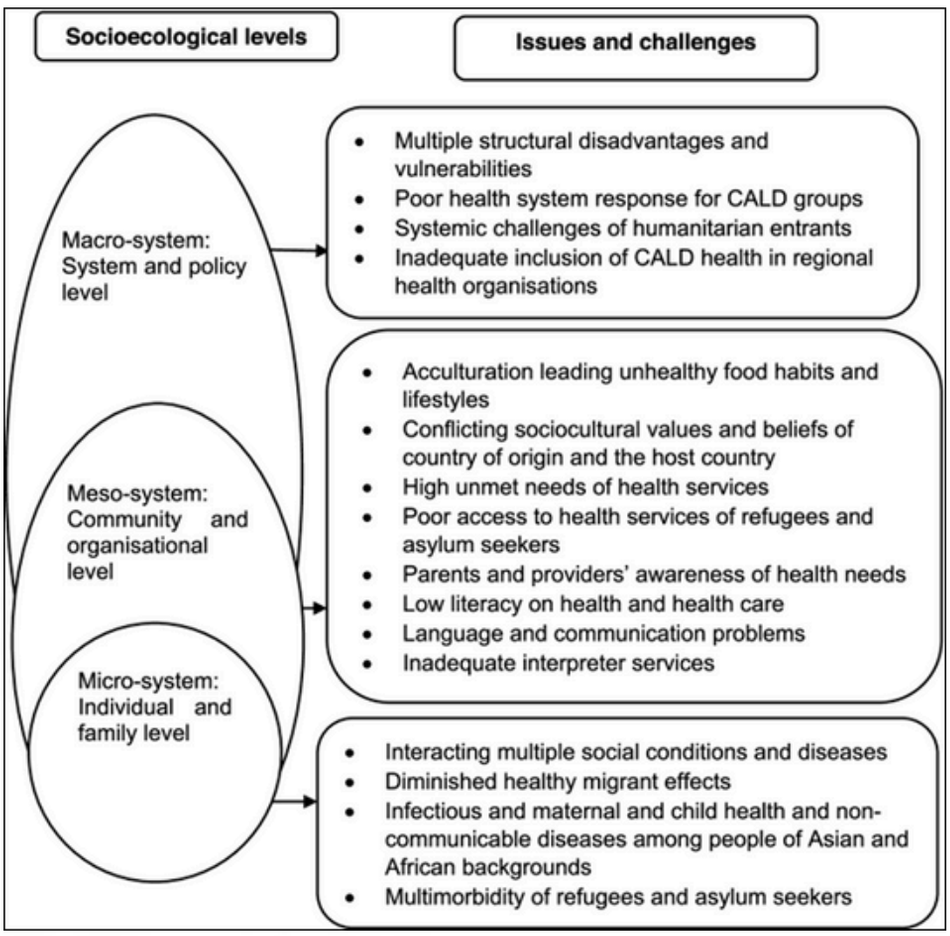
Identified barriers

(a) **Multilevel barriers to primary health services:** In an Australian literature review that documented barriers to health access among multicultural communities, it was found that barriers occur at different levels: Individual and family level barriers were related to interacting social and health conditions, poor health and health service literacy, multimorbidity, and some groups having higher risk of infectious diseases and risks. Community and organisational level challenges were acculturation leading to unhealthy food behaviours and lifestyles, language and communication problems, inadequate interpreter services, and poor cultural competency of providers. Finally, challenges at systems and policy levels included multiple structural disadvantages and vulnerabilities, inadequate health systems and lack of services to address the needs of multicultural populations (5). The figure below presents the key barriers at these levels.



Source: (5)

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(b)**The social determinants of health** further compound service access and should be factored into service and program design (16–18). They include language and cultural barriers, low health literacy, difficulties in navigating the health system, under-employment, socio-economic barriers, racism, discrimination, xenophobia and migration experiences (5,16,19–21).

(c) **Barriers among refugees:** AIHW reports that humanitarian entrants face many barriers to accessing timely and appropriate health care, including (8):

- Limited English proficiency
- Financial barriers
- Low educational achievement
- Varying degrees of health literacy
- Varying cultural and health beliefs
- Competing settlement priorities

(d) The same report found that humanitarian entrants had GP attendances around 40% higher than the Australian population and pathology services 20% higher. Specialist attendances and optometry services were lower (25% and 14% respectively). The higher GP attendance rates were attributed to refugee health programs facilitating access to primary care.

(e) **People seeking asylum face multiple and complex policy-generated barriers** to primary health care with the primary barrier being either no or interrupted access to Medicare. In Queensland this is partially augmented via the Asylum Seeker and Refugee Assistance program which is Queensland Government funded (22). The Queensland Government also has a policy of providing public healthcare access for people seeking asylum that provides free access to services through public hospitals including medical, surgery, allied health, mental health, pathology, radiology, cardiology and maternity. General practice access is unavailable without access to Medicare unless the patient pays. There are some clinics throughout Australia, including locally World Wellness Health & Medical Clinic that provide pro-bono GP access, medication support and access to radiology/pathology. Mater Refugee Complex Care Clinic also provides some access to GP services, psychiatry and paediatric services.

(f) **Language barriers to primary care:** One Australian study found interpreter usage for patients with low English proficiency is less than 1 in 100 (0.97%) in Medicare-funded consultations (23). Patients with low English proficiency are at risk of receiving fewer clinical interactions, being less informed of care processes, and having a very large volume of information given in a shorter period of time when an interpreter is present. There is an attitude that families be used as interpreters in the first instance (24).

(g) **Cultural barriers to primary care**: Literature highlights cultural factors such as feeling unsafe, having culturally based communication gaps, having culturally determined health explanatory models and cultural concordance (25)

(h) **Racism and discrimination**: The experience of racism and discrimination in Australian healthcare services is well evidenced and acts as a barrier to service access and internationally is seen as a determinant of health (5,26,27). Locally, discrimination was identified by young people in a survey conducted by Pasifika Families as their fifth biggest challenge and they had experience it in various settings (28).

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(i) **Health and health system literacy barriers**: Lower health literacy and health system literacy is evidence in various reports and studies (5,25,29). In one study, poor health literacy among multicultural populations, such as difficulties in searching and understanding health information, and seeking the right services at the right time, were significant barriers to effective navigation and utilisation of health services. Factors leading to low health literacy included language and communication problems, the complexity of the Australian health system, and poor availability of multilingual health materials to health providers and community members (21).
(j)**Barriers to mental health services:** mental health data for the multicultural population is limited and often omitted from Queensland published data report (for example (7). A 2023 Queensland Health commissioned report on strengthening Queensland Health MHAOD services for people from CALD backgrounds found that the key drivers that require attention include racism and stigma, limited understanding of how CALD people understand and experience MHAOD care, lack of CALD data, historically siloed systems and broader resource constraints. The report also detailed "A pattern of late, complex and crisis presentations" which is consistent with national data.
(k) A Victorian study detailed CALD consumers' help-seeking attitudes and found that mental health was perceived as a crisis and that seeking help was considered complicated due to lack of knowledge about the illness, whom and where to approach for help and the belief that mental illness is a Western concept (14).
(a)**At the systemic level,** Australian health policy and services have not addressed the needs of multicultural communities (5,17). There is no federal multicultural health policy and Queensland Health is currently developing a Multicultural Health Policy and Action Plan. Within PHNs there has been no funding stream for multicultural health. To date initiatives have been mainly project driven rather than investment in long-term services to tackle health inequities.
(l)**Additional systemic barriers** that impact people's equitable access to health services include visa status, Medicare eligibility, service cost, geographical availability, language support provision and service design that does not respond to cultural, religious, and gender factors. Understanding these barriers is critical to ascertaining the level of equitable access to timely universal healthcare including those that are created at a structural level by health-related policy decisions and regulations.

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Identified enablers

(a)**Improving health literacy and health system literacy** is a primary enabler to increasing access. One South Australian study into mental health service access supported the need for education on mental health problems and services for African migrants to improve their understanding and recognition of the issues and their access to available MHSs.
(b)**Navigation programs and services** to timely and appropriate health services (30,31). Culturally targeted and delivered navigation has the potential to effectively serve as the primary entry point to health services for a large population with diverse needs (32).
(c)**Responding to cultural and religious needs in healthcare:** The findings in a South Australian study into mental health service access indicated the need to address sociocultural and religious aspects or practices and perceptions which influence health seeking behaviours Improving MHS provision by providing culturally safe services was also identified and many models of embedding a culturally focused workforce exist. World Wellness Group uses one such model (Multicultural Peer Support Workers). In a survey of 102 young people in Moreton Bay, Pasifika Families found that connecting to culture and community was the number one enabler found to improve young people's wellbeing (28).
(d)**Responding to social determinants of health:** addressing structural challenges needs a holistic policy intervention such as improving social determinants of health (e.g., improving living and working conditions and reducing socioeconomic disparities) of multicultural populations, which requires a high level political commitment and beyond health service scope (5) but inclusion of social determinant impact in service design is within scope.
(e) **Multicultural workforce:**

- Multicultural health workers/staff are essential to embedding their lived experience as migrants and promote trust and reduce stigma in health services targeting multicultural communities (33). Concordance between the GP and patient by ethnicity, culture or language was found to be highly effective in facilitating delivery of mental healthcare to multicultural patients (34). Australian studies show that migrants select their GP based on their cultural/linguistic background to reduce apprehension about their ability to communicate and understand medical advice (35).
- Various multicultural support worker roles exist in Australia including Multicultural Peer Support Workers, Bilingual Education Workers, Bi-cultural Workers and work has progressed in how to invest in and grow this workforce in Australia (36). This workforce is essential to reducing cultural barriers to access and improving culturally appropriate healthcare and have been trialled in general practice settings (37). Many models exist overseas (38,39).

(f) **Cultural capability of health workers**: GPs in one study identified their difficulties in recognising initial psychiatric symptoms, challenges associated with communicating a mental illness diagnosis and problems with using interpreters. In another study GPs regarded culture as just one of many important factors and did not believe cultural competence training was necessary. This study recommended formal training (40).

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(g) **Multicultural lived experience and co-design:** using participatory methods to engage multicultural service users in the design of programs and services and embedding their lived experience in planning, governance, delivery and evaluation (41,42)
(h) **Language services:** Existing health services can be strengthened by ensuring multilingual health resources and onsite interpreters (5,23). Greater access to and use of professional interpreters provides the opportunity for communication, reassurance and earlier evaluation and treatment where necessary (24)
(i) **System level enablers:** Embed multicultural expertise in frameworks, processes and decision-making for service planning and delivery; partner with local community groups to to inform service planning; conduct CALD specific research to support service planning and policy including linking data; development of multicultural health minimum dataset (43). Other enablers are removing policy generated barriers such as visa eligibility and cost.

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