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Chapter 5

Queensland Health

Exploring the health of culturally and linguistically diverse (CALD) populations in Queensland: 2016–17 to 2019–20



Queensland
Government

5. Discussion and conclusion

CALD populations in Queensland and in Australia are greatly diverse, with many different cultures, languages and migration pathways. While this diversity brings cultural depth and richness to our society, it can also pose challenges for achieving equitable health access for all. This is particularly the case where disparities are not apparent in data or measured, nor their underlying causes well-understood.

Many health data collections—nationally and at a state level—have inadequate indicators for cultural or linguistic diversity and migration status to support identifying disparities. In some cases, data that is collected is not high enough in quality to analyse or might not have enough observations to draw conclusions at a meaningful population level. This limits further research and exploration that can aid understanding of any underlying causes of disparity.

This report seeks to provide a picture of potential health disparities in overseas-born CALD populations in Queensland to prompt further discussion and exploration on what this means for healthcare provision to these populations. The findings provide a platform for more targeted, evidence-based health interventions for those population groups with worse health outcomes.

Collecting CALD data is just one step in a multifaceted and complex web of factors that are required to alleviate health care inequalities⁶⁵. However, improved visibility of CALD populations in outcomes data is an effective starting point to enable this.

Analysis at the aggregate level: NESB and MESB populations

The overseas-born population in Queensland is not a homogenous population, and from a health perspective, there appears to be limited commonalities in outcomes across the populations born in NESB countries.

Had the study limited its analysis to the aggregated NESB population, the report would have drawn the conclusion that people born in NESB countries generally have better health outcomes than Australian-born people. This is not an inaccurate conclusion. However, analysis at this level clearly masks the differences in health outcomes for individual population groups, which are apparent when data analysis is disaggregated further by geography of birth. The policy risk of relying on such an aggregated analysis is that certain populations with concerning disparities in health outcomes become invisible, and consequently do not receive the attention or response that they may need.

⁶⁵ Marcus K, Balasubramanian M, Short S, Sohn W. Culturally and linguistically diverse (CALD): terminology and standards in reducing healthcare inequalities. *Australian and New Zealand Journal of Public Health*. 2022 Feb. Available from: <https://www.proquest.com/openview/32936207d3f227c66cd6db527bc56a3e/1?pq-origsite=gscholar&cbl=37917>

Findings at a disaggregated level

Other Oceania and Antarctica region

In this report, Queensland residents born in the Other Oceania and Antarctica region (includes Pasifika communities) consistently recorded worse health outcomes than the Australian-born population in most categories analysed in this report.

Literature has identified a range of social issues affecting health outcomes for Pasifika communities in Australia, including socioeconomic status, poor access to health services, unemployment, poor housing and low education levels. These issues increase their risks for chronic diseases^{66,67}. Pasifika community perception of health is heavily influenced by their cultural and religious beliefs, which should be reinforced when engaging with them to improve their general health and wellbeing⁶⁸.

A deep dive into the recent 2021 Census indicated that for Queensland residents born in Samoa, Tonga and Cook Islands (countries from the Other Oceania and Antarctica region):

- most are not Australian citizens
- most have year 12 as highest level of education compared to those born in Australia, who have bachelor's degree level and above as highest education
- most are casual laborers compared to those identified as 'professionals', mostly among those born in Australia
- most have long-term health conditions (e.g. diabetes, kidney disease, heart disease, stroke) that were higher compared to Australian-born⁶⁹.

These disparities relate to the social determinants of health that influence health-seeking behaviour and outcomes.

⁶⁶ Queensland Health. Queensland Health response to Pacific Islander and Māori health needs assessment. 2011. Brisbane: Queensland

⁶⁷ Mhrshahi S, Vaughan L, Fa'avale N, De Silva Weliange S, Manu-Sione I, Schubert, L. Evaluation of the Good Start Program: A healthy eating and physical activity intervention for Maori and Pacific Islander children living in Queensland, Australia. 2017. BMC Public Health. Available from: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3977-x>

⁶⁸ South Western Sydney Local Health District. Pacific communities health needs assessment. 2019 July. Available from: https://www.swslhd.health.nsw.gov.au/populationhealth/PH_promotion/pdf/Publications/Pacific%20Communities%20Health%20Needs%20Assessment%20Report_Final%2012July2019.pdf

⁶⁹ Australian Bureau of Statistics. People in Queensland who were born in Samoa. 2021 Census Country of birth QuickStats. ABS. Canberra. Available from: https://www.abs.gov.au/census/find-census-data/quickstats/2021/1505_3

North African and Middle East regions

This current Queensland Health study also identified that Queensland residents born in North African and Middle East regions also reported worse outcomes when compared to the Australian-born population, especially for potentially preventable hospitalisations.

The study does not explore the migration status of the CALD population. However, it can be assumed that a significant proportion of Queensland residents born in North African and Middle East regions are people from a refugee background. In recent years, humanitarian arrivals to Queensland have come mostly from countries such as Afghanistan, Bhutan, Ethiopia, Iran, Iraq, Myanmar, Pakistan, Sudan, Somalia and Syria⁷⁰. Most of the listed countries are in the Middle East and North African regions. People from refugee backgrounds are more likely to face unique physical, mental, emotional, social, cultural and spiritual challenges because of their experiences. At the same time, settling in Queensland presents a whole set of new challenges, including navigating a different health system and accessing the healthcare they need.

Opportunities to analyse outcomes and develop culturally safe and targeted services

The study factually explores data and does not investigate the potential reasons or any underlying causes of these outcomes. The findings provide a starting point for further discussion, research and exploration to better understand what the outcomes mean in the context of service delivery, health promotion and policy responses for populations with poorer health outcomes.

They present an opportunity to engage with these populations on health issues to better understand underlying factors and whether these communities might need more targeted responses to improve outcomes. According to Brach & Fraser, culturally safe and competent services translate into better health for CALD populations through the impact they have on factors including improved communication channels, increased trust in the health system, greater knowledge about health and services in CALD communities and expanded cultural understanding within the health system⁷¹. They also reduce 'wastage' with regards to investment in approaches that might not have the same impact.

⁷⁰ Queensland Health. Refugee Health and Wellbeing Policy and Action Plan 2022-2027. 2022 Dec. Brisbane.

Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0033/1197447/Refugee-Health-and-Wellbeing-Policy-and-Action-Plan-2022-2027.pdf

⁷¹ Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. 2000.

Medical Care Research and Review. Available from: <https://pubmed.ncbi.nlm.nih.gov/11092163/>

Data collection and reporting frequency

Data underpins the appropriate targeting of prevention strategies. More regular reporting on CALD health outcomes is needed to provide a comprehensive and informative evidence base. CALD populations change over time, so regular analysis is needed to have a more current understanding of outcomes. Queensland has consistently recorded strong population growth for many years and recorded a net overseas migration of 28,625 persons for the year 2019–20⁷², a figure partially impacted by the COVID-19 pandemic with international border closures.

The ABS (2022b) recommends the ‘Standards for Statistics on Cultural and Language Diversity’ (the Standards) to standardise the collection and reporting of information on CALD populations. The Standards include a Minimum Core set of indicators *including country of birth of person, main language other than English spoken at home, proficiency in spoken English and Indigenous status*. The Standards also recommend a set of non-core indicators, which includes *year of arrival in Australia*⁷³.

While these standards exist, their use in national health data collections could be improved to better understand diverse CALD populations and identify their specific needs⁷⁴.

The Queensland Multicultural Policy requires Queensland Government agencies to collect information on the following three minimum indicators relating to persons from CALD backgrounds: country of birth, preferred language and whether an interpreter service is required⁷⁵. Another desirable indicator recommended is Ethnicity (or cultural identity).

Queensland Health’s service usage datasets do not collect the core set of four variables as specified by ABS. However, they do collect the required indicators under the Queensland Multicultural Policy. Country of birth is the most widely collected data that captures CALD status of the clients. While other data is collected, such as interpreter service required and preferred language, these indicators are not as widely populated in health data as country of birth. This can inhibit analysis.

⁷² Queensland Government Statistician’s Office. Overseas migration, Queensland, 2019–20. 2021. Available from <https://www.qgso.qld.gov.au/issues/2971/overseas-migration-qlld-2019-20.pdf>:

⁷³ Australian Bureau of Statistics. Standards for Statistics on Cultural and Language Diversity. 2022 Feb [cited 08 March 2023]. ABS: Canberra. Available from: <https://www.abs.gov.au/statistics/standards/standards-statistics-cultural-and-language-diversity/latest-release#:~:text=The%20Minimum%20Core%20Set%20of,Spoken%20English%20%E2%80%93%20see%20Language%20Standards>

⁷⁴ Australian Institute of Health and Welfare. Culturally and linguistically diverse populations. 2018. AIHW Canberra. Available from: <https://www.aihw.gov.au/getmedia/f3ba8e92-afb3-46d6-b64c-ebfc9c1f945d/aihw-aus-221-chapter-5-3.pdf.aspx>

⁷⁵ Queensland Government. Our Story, Our Future, Queensland Multicultural Policy. 2018. Department of Children, Youth Justice and Multicultural Affairs. Available from: www.cyjma.qld.gov.au/resources/dcsyw/multicultural-affairs/policy-governance/multicultural-policy.pdf

CALD health is a complex concept, and understanding the full picture requires a range of information. Considerations for potential future CALD data projects in Queensland may include a deeper exploration of data on relevant issues, including mental health, maternity and childbirth, and analysis of data outcomes at the Hospital and Health Service (HHS) level. This will ensure even more targeted interventions. Analysis of other data elements that Queensland Health collects—whether an interpreter service is required and preferred language—could be undertaken as a proxy for understanding how language barriers might influence health outcomes. To have sufficient data to analyse, more work is needed to improve data collection on CALD indicators.

Data linkage opportunities

Queensland Health uses data linkage across its own datasets. However, there are emerging opportunities to support more nuanced analysis of health outcomes for CALD populations, using a broader range of datasets and indicators.

The ABS Multi-Agency Data Integration Project (MADIP) (2021c) is a potential option to enable this. MADIP is a secure data asset combining information from various Australian Government datasets. The project aims to provide whole-of-life insights about various population groups in Australia, such as the interactions between their characteristics, use of services like healthcare and education and outcomes like improved

health and employment⁷⁶. It would potentially allow further investigation of the relationships between PPH and disease prevalence, use of primary health care, use of medicines and overall health outcomes⁷⁷. Further, the Australian Government recently announced that it will begin collecting ethnicity data through the next Census to measure diversity more meaningfully in Australia.

This approach to data linkage has potential to enable a more nuanced analysis of health outcomes for CALD populations in Queensland, potentially on indicators such as ethnicity, migration, year of arrival and language spoken at home. Collecting such data will create greater visibility of CALD populations that we cannot currently measure and help health service providers and practitioners measure health outcomes effectively⁷⁸.

A national approach

A nationally consistent approach to measuring and analysing health outcomes for CALD populations would be beneficial to enable comparability across jurisdictions and support further research. This is consistent with the *National Health Reform Agreement (NHRA) Long-term Health Reforms Roadmap reform priority 'Enhance Health Data'*. The aim for this priority is to ensure the data generated by Australia's health system drives better health outcomes and delivers effective, safe and efficient health care for all Australians⁷⁹.

⁷⁶ Australian Bureau of Statistics. Multi-Agency Data Integration Project (MADIP). ABS Canberra.

Available from: <https://www.abs.gov.au/about/data-services/data-integration/integrated-data/multi-agency-data-integration-project-madip>

⁷⁷ Australian Institute of Health and Welfare. Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18.

Feb 2020 [cited 08 March 2023]. Available from: <https://www.aihw.gov.au/reports/primary-health-care/disparities-in-potentially-preventable-hospitalisations-australia/summary>

⁷⁸ Federation of Ethnic Communities' Councils of Australia. Annual report 2021/22. 2022.

Available from: <https://fecca.org.au/wp-content/uploads/2022/12/FECCA-Annual-Report-2021-2022.pdf>

⁷⁹ National Health Reform Agreement (NHRA) Long-term Health Reforms Roadmap, 2021, Australian Health Ministers. Available from: <https://www.health.gov.au/sites/default/files/documents/2021/10/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap.pdf>