March 2023

# Introduction

Queensland Health

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

Queensland Government

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Published by the State of Queensland



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## In appreciation

Queensland Health is grateful for the financial assistance received through the Health Innovation Fund provided by the Australian Government.

Queensland Health expresses our gratitude to all those involved in the analysis and authoring of this report, especially within the Disability and Multicultural Health Unit (System Policy Branch) and Statistical Services Branch.

## Acknowledgement

Queensland Health respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional and Cultural Custodians of the lands on which we live and work to deliver health care to all Queenslanders and recognises the continuation of First Nations peoples' cultures and connection to the lands, waters and communities across Queensland.

# Foreword

Queensland Health is committed to ensuring our public health system supports an inclusive and equitable society. Identifying populations that have poorer health outcomes is necessary to providing an equitable health service for all Queenslanders. As such, it is essential that we understand the needs of our culturally and linguistically diverse (CALD) populations.

*Exploring the health of CALD populations in Queensland: 2016–17 to 2019–20* provides a robust, detailed analysis of existing Queensland CALD health data, highlighting disparities in health outcomes for Queenslanders born overseas compared to their Australian-born counterparts. The report is a significant step towards improving the visibility of CALD populations in health data and improving our understanding of the health of CALD communities.

The findings highlight the diversity of CALD populations in Queensland, which is reflected in differences in health outcomes. Queensland Health welcomes the report's insights and its contribution to enabling more evidence-based healthcare. We look forward to further engagement with CALD communities and health stakeholders on the findings of this report and working together to improve the health of Queensland's CALD populations.

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# 1. Introduction

Internationally, it is recognised that the experience of migration is a determinant of health and wellbeing, and refugees and migrants remain among the most vulnerable and neglected members of many societies[1]. The health outcomes of Australian migrant populations are highly diverse and are influenced by their migration pathways[2]. Their health and wellbeing are further influenced by determinants such as education, income, housing, access to services and linguistic, cultural, legal and other barriers as well as the interaction of these factors during their life course[2].

Australia's population includes many people who were born overseas, have a parent born overseas or speak a variety of languages. Together, these groups of people are known as culturally and linguistically diverse (CALD) populations. There is no universally accepted or official operational definition of CALD, and there are diverse approaches to identifying and reporting on CALD populations. The Australian Bureau of Statistics (ABS) defines the CALD population mainly by country of birth, language spoken at home, English proficiency and other characteristics including year of arrival in Australia, parents' country of birth and religious affiliation. As the First Nations peoples of Australia, Aboriginal and Torres Strait Islander populations are not included in descriptions of CALD populations.

Queensland is a culturally and linguistically diverse state. The recent 2021 Census showed that more than one in five Queensland residents were born overseas (22.7 per cent of the Queensland population). The proportion of people in Queensland who were born overseas has increased significantly over time. In 1971, 12.3 per cent of people were born overseas, increasing to 21.6 per cent in 2016 and 22.7 per cent in 2021[3]. The 2021 Census also indicated that Queenslanders speak more than 300 different languages. People from CALD backgrounds do not represent a homogenous group, and there is a vast diversity within the CALD population.

[1] World Health Organisation. World report on the health of refugees and migrants, Geneva; 2022. 344p. Available from: www.who.int/publications/i/item/9789240054462

[2] Australian Institute of Health and Welfare. Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper. Canberra: Australian Institute of Health and Welfare; 2022. 116p. Available from: www.aihw.gov.au/reports/cald-australians/reporting-health-cald-populations/summary

[3] Australian Bureau of Statistics. Snapshot of Queensland. Canberra: ABS; 2022. Available from: www.abs.gov.au/articles/snapshot-qld-2021

Over the last 20 years, due to the growth in diversity in Australia, there has been a significant increase in research to understand the challenges and barriers that CALD populations have faced in the context of health care. Multiple studies have reported that people from CALD backgrounds experience health disparities. This results from challenges including language and cultural barriers, low health literacy, difficulties in navigating the health system, socio-economic barriers and discrimination[4 5 6]. These significant barriers inhibit them from seeking and accessing appropriate health services, leading to poorer health outcomes.

The COVID-19 pandemic highlighted barriers to accessing health care services and information, as well as the disproportionate impact this had on refugee and migrant communities. The recent COVID-19 mortality data in Australia, released by ABS in November 2022, showed that over the course of the pandemic, those born overseas had a higher death rate when compared to those born in Australia[7]. The report further pointed out that during the Delta wave, over 70 per cent of people who died from COVID-19 were born overseas.

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[4] Henderson, Saras & Kendall, Elizabeth. Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: Exploring the need for improvement in health service delivery. Australian journal of primary health. 2011; 17 (2): 195-201. Available from: www.researchgate.net/publication/51195660_Culturally_and_linguistically_diverse_peoples%27_knowledge_of_accessibility_and_utilisation_of_health_services_Exploring_the_need_for_improvement_in_health_service_delivery

[5] Javanparast S, Naqvi SKA, Mwanri L. Health service access and utilisation amongst culturally and linguistically diverse populations in regional South Australia: a qualitative study. Rural Remote Health. 2020; 20 (4); Available from: pubmed.ncbi.nlm.nih.gov/33207914/

[6] Khatri, R.B., Assefa, Y. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. BMC Public Health. 2022; 22, 880. Available from: bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-13256-z

[7] Australian Bureau of Statistics. COVID-19 Mortality by wave. Canberra; ABS, 2022. Available from: www.abs.gov.au/articles/covid-19-mortality-wave.

## ‘Healthy migrant effect’

The ‘healthy migrant effect’ is a widely cited phenomenon across various literature, including epidemiology and the social sciences, with many competing explanations[8]. There is some evidence suggesting that some migrant populations appear to have a better health status compared to non-migrants during their early years of migration, which diminishes over time with length of residence in the host country[9] [10]. Some studies have suggested that the ‘healthy migrant effect’ at the time of arrival points to positive health selection. This is due to a combination of factors including strict eligibility requirements, migration health screening checks and migrant self-selection, especially for those under the skilled migration pathway[11] [12] [13]. Several factors may cause health to deteriorate over time, such as limited culturally appropriate services, language barriers, negative effects of acculturation, social isolation and poor socioeconomic status[14] [15] [16].

With Australia having diverse pathways to migrate, the ‘healthy migrant effect’ might not be applicable to all migrant groups.
A longitudinal design study followed native-born individuals and migrants of different lengths of residence in Australia over time. Findings showed that the existence of a ‘healthy migrant effect’ was observed for migrants from English speaking countries but not for those migrating from non-English speaking countries[17].
The study also showed that the length of residence in Australia does not appear to be universal across all health measures and migrant groups. Instead, it varies according to the measure of health and specific migrant group under consideration.

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[8] Kennedy, Steven & Kidd, Michael & Mcdonald, Ted & Biddle, Nicholas. The Healthy Immigrant Effect: Patterns and Evidence from Four Countries. Journal of International Migration and Integration. 2014; 16 (2). Available from: www.researchgate.net/publication/271406601_The_Healthy_Immigrant_Effect_Patterns_and_Evidence_from_Four_Countries

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[10] Khatri, R.B., Assefa, Y. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. BMC Public Health. 2022; 22, 880. Available from: bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-13256-z

[11] Crimmins EM, Kim JK, Alley DE, Karlamangla A, Seeman T. Hispanic paradox in biological risk profiles. Am J Public Health. 2007; 97 (7); 1305-10. Available from: pubmed.ncbi.nlm.nih.gov/17538054/

[12] Treas J, Gubernskaya Z. , Chapter 7 - Immigration, Aging, and the Life Course. In: Editor(s) George LK, Ferraro KF, Handbook of Aging and the Social Sciences. 8 Edition, Academic Press; 2016. Pages 143-161. Available from: www.sciencedirect.com/science/article/pii/B978012417235700007X?via%3Dihub

[13] Australian Institute of Health and Welfare. Chronic health conditions among culturally and linguistically diverse Australians. AIHW; 2021 (updated 08 February 2023). Available from: www.aihw.gov.au/reports/cald-australians/chronic-conditions-cald-2021/contents/background

[14] Gee EM, Kobayashi KM, Prus SG. Examining the healthy immigrant effect in mid- to later life: findings from the Canadian Community Health Survey. Can J Aging. 2004; 23 (1): 61-9. Available from: pubmed.ncbi.nlm.nih.gov/15660311/

[15] Antecol H, Bedard K. Unhealthy assimilation: why do immigrants converge to American health status levels? Demography. 2006; 43 (2); 337-60. Available from: pubmed.ncbi.nlm.nih.gov/16889132/

[16] Neuman, S. Are immigrants healthier than native residents?. IZA World of Labor. 2014: 108. Available from: https://wol.iza.org/articles/are-immigrants-healthier-than-native-residents

[17] Jatrana S, Richardson K, Pasupuleti SSR. Investigating the Dynamics of Migration and Health in Australia: A Longitudinal Study. Eur J Popul. 2018; 34 (4); 519-565. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC6241155/

This finding is supported by another study conducted in Australia, highlighting that the 'healthy migrant effect' may have limited applicability for a broad range of health outcomes and populations[18].

The blanket term 'migrant' captures forcibly displaced migrants and people from a refugee background. People from a refugee background have unique and complex migration experiences and frequently face additional barriers that impact their capacity to access health information and services, including low health literacy and language difficulties[19]. These challenges increase their socioeconomic vulnerabilities with flow-on effects for health, leading to poorer health outcomes in this cohort[20].

## Queensland Health – previous study of CALD populations

Over 10 years ago, Queensland Health analysed the differences in health status for death and hospitalisation rates among Queensland residents during the period 2003–04 and 2007–08 based on country of birth (by region) classification[21]. With the diversity of Queensland communities growing and changing over time, it is crucial to update our understanding of the health outcomes of our current population to address evolving and emerging health needs.

[18] Lee R. Does the healthy immigrant effect apply to mental health? Examining the effects of immigrant generation and racial and ethnic background among Australian adults. SSM Popul Health. 2019: 7 (11). Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC6595271/

[19] Abbas M, Aloudat T, Bartolomei J. et al. Migrant and refugee populations: a public health and policy perspective on a continuing global crisis. Antimicrob Resist Infect Control 7. 2018; 113. Available from: aricjournal.biomedcentral.com/articles/10.1186/s13756-018-0403-4

[20] World Health Organisation. World report on the health of refugees and migrants, Geneva; 2022. 344p. Available from: www.who.int/publications/i/item/9789240054462

[21] Endo T, Watson M, Jardine A, Bright M, & Macleod S. Death and hospitalisation rates by country of birth in Queensland #2: All-causes. Country of Birth Data Analysis Report. Australia, Queensland Health; 2011. Available from https://www.health.qld.gov.au/__data/assets/pdf_file/0028/354583/report2.pdf

## Current study by Queensland Health

In 2021, Queensland Health received Australian Government funding through the Health Innovation Fund to undertake a detailed analysis of existing CALD-related data collected by Queensland Health and publish a report, and potentially other materials, that could be used to inform future healthcare decisions.

This study seeks to update and broaden the previous analysis to help identify potential disparities in health outcomes for CALD populations born overseas living in Queensland, compared with people born in Australia. The study takes a robust approach in analysing existing data collected by Queensland Health, with a view to informing policy responses and promoting more equitable service delivery.

The study separates findings for CALD populations born overseas into those born in countries that are mainly English speaking and those born in countries that are not mainly English speaking. It refers to them as 'mainly English speaking backgrounds (MESB)' and 'non-English speaking backgrounds (NESB)', and compares them with Australian-born Queensland residents. It should be noted that this grouping does not reflect proficiency in English, length of stay in Australia or preferred language. The diversity within the Australian-born population is unable to be considered, due to a lack of data available that can inform this analysis.

Where possible, the study disaggregated the MESB and NESB groups into geographic regions of birth and countries of birth.

This study analysed and reported on the following variables:

1. Potentially preventable hospitalisations and related subcategories (vaccine-preventable, acute and chronic conditions)
2. Hospitalisation rates: all-causes
3. Death rates: all-causes
4. Potentially avoidable deaths.

Across the data analysed, the results of the broader (MESB and NESB) aggregate groupings disguised the diversity of findings at the level of region and country of birth, particularly within NESB populations.

The potentially preventable hospitalisations variable provided the richest source of observations for analysis at a disaggregated region or country of birth level and against subcategories.

Due to small numbers of observations for the range of specific causes for hospitalisation rates, death rates and potentially avoidable deaths, there is no categorisation or analysis by cause. Further information and findings on the above variables will be discussed in the following chapters.

Finally, this study should be referred to as a factual exploration of available data. The report does not explain why certain trends are observed. This study seeks to enable evidence-based health service planning and should not be interpreted (or attributed) as performance indicators for the communities presented in this report.