

Australians generally enjoy good health. However, good health is not shared equally. There are significant differences in the health of different populations of Australians, including differences in rates of death and disease, life expectancy, self perceived health, health behaviours, health risk factors and health service utilisation (Public Health Association of Australia, 2008). These 'health inequities' are associated with differences in education, occupation, income, employment status, rurality, ethnicity, Aboriginality and gender.

The term 'health inequality' generally refers to differences in health attributable to biological variations or free choice. These differences may not be possible to change (World Health Organisation, 2012) .

'Health inequity' generally refers to differences in health attributable to the external environment and conditions mainly outside the control of individuals. In this case, the uneven distribution of resources, access or circumstances may also be unjust and unfair. These inequalities in health therefore lead to inequity in health (World Health Organisation, 2012).

## *Health literacy*

The 2006 Adult Literacy and Life Skills Survey (ALLS) contained 191 health-related items across four domains (health promotion, health protection, disease prevention and systems navigation) (Australian Bureau of Statistics, 2006). For each of these domains, proficiency was measured on a scale. Scores were grouped into five skill levels with level one the lowest and level five the highest. The ALLS found particular factors influenced people's health literacy. These included education, occupation, parental characteristics, and English as a second language. Only 26 per cent of those born in a mainly non-English speaking country achieved Level three or above. Examining the literacy skills of people whose first language was not English, 36 per cent of this group achieved scores at Level 3 or above on the prose scale and 38 per cent on the document scale, compared to 54 per cent and 53 per cent respectively for the general population.

## *Access to health services*

Studies indicate that many people from migrant and refugee backgrounds experience barriers to accessing health services and the health service system in general (Henderson, 2011; Queensland Health, 2011). A lack of cultural competency within the health system, cultural barriers, language barriers and low health literacy are some of the factors that impact on health service access.

Low mental health service use was also found in a Victorian study (Stolk, Minas, & Klimidis, 2008). The reasons given for the low mental health service use were inconclusive due to the absence of reliable Australian epidemiological studies into the community prevalence of mental illness in migrant populations. (There authors were not able to assess whether service usage was proportional to mental illness prevalence.) The authors concluded that low service use could be due to a range of access barriers and also psychological factors in ethnic communities.

Lower access to screening services is also reported. In 2005-06 females in the target breast-screening population (50-69 years) who spoke a language other than English at home were less likely than English-speaking females to participate in breast screening: 45 per cent and 59 per cent respectively (Australian Institute of Health and Welfare, 2010).

## *Mortality*

Nationally, it is reported that overseas-born populations as a group, have a lower mortality rate than Australia-born (Australian Institute of Health and Welfare, 2010). However, at the country-of-birth level, there are some

differences . Compared with the relevant death rate among Australian-born people, death rates for overseas-born people were higher for (Australian Institute of Health and Welfare, 2010):

- lung cancer among those born in the Netherlands, and the United Kingdom and Ireland
- diabetes among those born in Germany, Greece, India, Italy, Lebanon and Poland
- coronary heart disease among those born in Poland
- influenza and pneumonia among those born in the United Kingdom and Ireland.

In Queensland during the period 2003-07, people born in a non-English speaking country (NESC) had a 25 per cent higher death rate for diabetes than people born in a mainly-English speaking country (MESC). Queensland death rates for individual geographic regional groups 2003-07 were:

- total avoidable deaths- Oceania 24 per cent higher for females, Oceania 15 per cent higher for total (males and females)
- diabetes deaths - Oceania 230 per cent higher for total, Southern and Eastern Europe 52 per cent higher for total

### *Hospitalisations*

At a national level, it is reported that overseas born Australians are hospitalised at a lower rate than their Australia-born counterparts (Australian Institute of Health and Welfare, 2008). However, despite this general finding, overseas-born Australian are hospitalised at significantly higher rates for a number of health conditions. These conditions, and the countries of birth with higher rates, include (Australian Institute of Health and Welfare, 2008):

- tuberculosis—India, Vietnam, Philippines, China
- lung cancer—United Kingdom and Ireland
- diabetes—Greece, India, Italy, Vietnam
- heart attack—India
- heart failure—Italy, Greece, Poland
- dialysis—Greece, Italy, Vietnam, Philippines, Croatia, India.

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 (Jardine, Endo, Watson, Bright, & MacLeod, 2011).

Hospitalisations for individual geographic regional groups 2003-07 were:

- 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.

### *Mental health*

At a national level, it is reported that overseas-born people are much less likely to report ever having a mental disorder (lifetime mental disorder) compared to those born in Australia (Australian Institute of Health and Welfare, 2010).

In Queensland there is little published data available on the mental health of migrant and refugee populations. A series of needs assessments with Queensland Pacific Islands populations did find possible higher use of mental health services in some communities and mental health issues also featured in community focus groups (Queensland Health, 2011). For example, Queensland mental health service snap-shot data (July 2008) showed Fiji-born as the ninth largest group of overseas-born of consumers. This ninth ranking is disproportionate from population size, as the Fiji-born population ranked 17th in population size among overseas born populations (Queensland Health, 2011).

An analysis of Victorian 2004/05 mental health service data found (Stolk, Minas, & Klimidis, 2008):

- NESB clients were older on average than Australia-born clients, and a higher proportion of NESB clients had no education or a primary education only.
- The majority of ethnic communities showed lower treated prevalence than the Australia-born population, but there was marked variation between communities.
- NESB clients had a higher number of case managed contacts than Australia-born clients.
- Higher proportions of NESB community clients were diagnosed with a psychosis and conversely, significantly fewer were diagnosed with less severe disorders. Treated prevalence of all diagnoses however, was lower for NESB populations than the Australia-born.
- NESB clients were more likely to be living with family members and less likely to be living alone than Australia-born clients.
- A higher percentage of NESB than Australia-born community clients were admitted to acute inpatient units.

In acute inpatient services the Victorian study found:

- Treated prevalence for the majority of ethnic communities was again significantly lower than for the Australia-born population.
- NESB inpatients were more likely to have been admitted involuntarily than Australia-born inpatients. However, NESB patients diagnosed with schizophrenia or mood disorders were more likely to be admitted involuntarily than those diagnosed with less severe disorders.
- A higher percentage of NESB patients were diagnosed with schizophrenia, while significantly fewer were diagnosed with the less severe disorders.
- NESB patients had fewer readmissions, but duration of NESB admissions was significantly longer than that of the Australia-born.

### *Participation and representation in health research*

In a recent systematic review of articles published in three major Australian healthcare journals, it was found that a total of 2.2 per cent of articles were based on multicultural health issues (Pamela W Garrett, 2010). Considering that it is estimated that around 5.5 million Australians were born overseas, this is an enormous under-representation.

The other challenge in research is that overseas-born Australians, although extremely diverse, are often placed into a single category - overseas born. Such studies often show that migrants have a better health status as a group. In some better studies, the overseas-born group is disaggregated into NESB and MESB categories and in the most useful studies, populations are further disaggregated into regional or countries of birth groups. A recent Queensland Health study highlighted that by only examining the overseas-born as one aggregated group, many health differences are masked (Jardine, Endo, Watson, Bright, & MacLeod, 2011), which leads to a misrepresentation of migrant and refugee health.

The exclusion and misrepresentation of migrants and refugees in health research can also further contribute to health inequities.

### Works cited

- Australian Bureau of Statistics. (2006). *Adult Life Skills and Literacy Survey, Summary Results*. Retrieved February 1, 2012, from Australian Bureau of Statistics: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20%28Reissue%29?OpenDocument>
- Australian Institute of Health and Welfare. (2008). *Australia's Health 2008*. Canberra: Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare. (2010). *Australia's Health 2010*. Canberra: Australian Institute of Health and Welfare.
- Henderson, S. a. (2011). 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*, , 195-201.
- Jardine, A., Endo, T., Watson, M., Bright, M., & MacLeod, S.-L. (2011). *Death and hospitalisation rates in Queensland by country of birth*. Brisbane: Queensland Health.
- Pamela W Garrett, H. G. (2010). Representations and coverage of non-English-speaking immigrants and multicultural issues in three major Australian health care publications. *Australia and New Zealand Health Policy* 7:1 .
- Public Health Association of Australia. (2008). *Health Inequities Policy*. Retrieved February 1, 2012, from Public Health Association of Australia: <http://www.phaa.net.au/>
- Queensland Health. (2011). *Queensland Health response to Pacific Islander and Maori health needs assessment*. Brisbane: Queensland Government.
- Queensland Health. (2011). *The health of Queensland's Fijian population 2009*. . Brisbane: Queensland Government.
- Stolk, Y., Minas, I., & Klimidis, S. (2008). *Access to mental health services in Victoria: a focus on ethnic communities*. Melbourne: Victorian Transcultural Psychiatry Unit.
- World Health Organisation. (2012). *Health Impact Assessment Glossary of Terms*. Retrieved February 1, 2012, from World Health Organisation: <http://www.who.int/hia/about/glos/en/index1.html>

---

©Copyright, World Wellness Group, 2012

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968.

Published by World Wellness Group, 28 Dibly Street, Woolloongabba, Queensland, 4102, Australia.

Published on [www.worldwellnessgroup.org.au](http://www.worldwellnessgroup.org.au)

Citation information: Chand, M (2012). *Health equity in Australia with a focus on culturally diverse populations - a summary article*. Brisbane. World Wellness Group.