



5.3 Culturally and linguistically diverse populations

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. The Australian Bureau of Statistics (ABS) defines the CALD population mainly by country of birth, language spoken at home, English proficiency, or other characteristics (including year of arrival in Australia), parents' country of birth and religious affiliation (ABS 1999). Country of birth is the most common data element among AIHW health data collections (in 12 data collections, see Supplementary Table S5.3.4) and is used in this snapshot.

According to the 2016 Census of Population and Housing, almost half of Australians (45% or 10.6 million) were either born overseas (26% or 6.2 million) or had one or both parents who were born overseas (19% or 4.5 million) (ABS 2017a).

In 2016, the most common overseas countries of birth were:



England
3.9% (908,000)



New Zealand
2.2% (518,000)



China
2.2% (510,000)



India
1.9% (455,000)

Source: ABS 2017a.

Over 300 languages are spoken in Australia:

- 1 in 5 (21%) people speak a non-English language at home
- English is not the first language for 15% or 3.5 million people
- English is not spoken at home for 0.5% or 117,000 people.

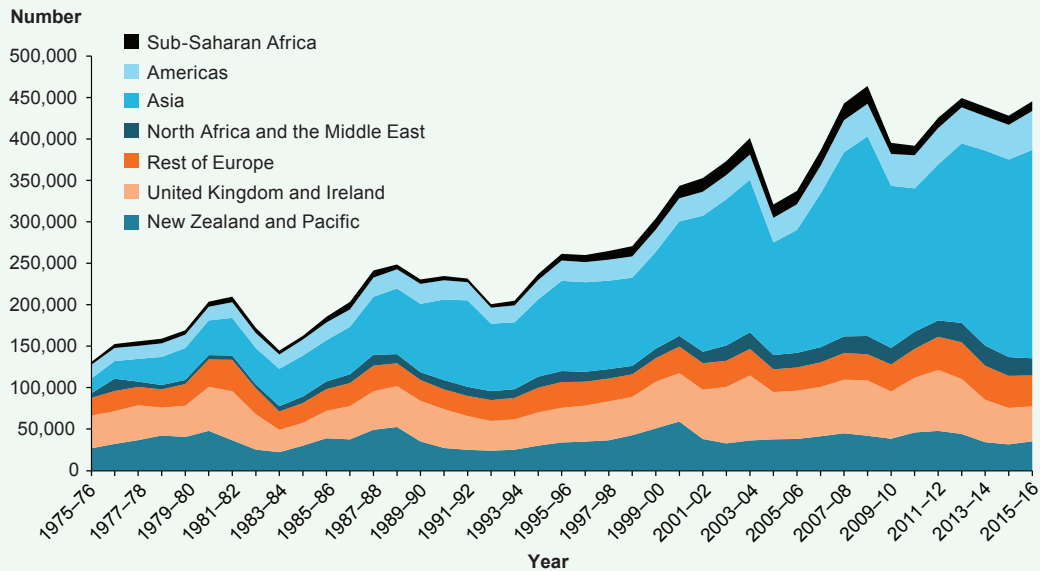
Sources: ABS 2017a, 2017b.

Migration patterns have varied over time, both in the number of migrants and the country or region where people previously lived. After World War II, there was an increase in European (non-United Kingdom) migrants coming to Australia (Hugo 2004); from the mid-70s, the number of migrants from Asia began to increase. This growth in migrants from Asia has continued over the last four decades. Over the same period, the majority of European migrants arriving in Australia previously resided in the UK and Ireland (Figure 5.3.1).





Figure 5.3.1: Migrant arrival to Australia, by region of last residence, 1975-76 to 2015-16



Sources: ABS 2017c, 2018; Table S5.3.1.

Health differentials

Nearly one-quarter of Australians are first-generation immigrants and they make up a large section of Australia's CALD population. Research in several countries with high immigrant populations, including Australia, has found that migrant populations are often healthier than native-born populations (Kennedy et al. 2014). Compared with the Australian-born population, some immigrants have been found to have lower mortality rates and self-reported chronic conditions (Jatrana et al. 2014; Kennedy et al. 2007). For example, immigrants from Africa, the Middle East and India reported to have fewer chronic conditions compared with Australian-born individuals. This pattern is known as the 'healthy migrant effect'. It is often explained by the health screenings that host countries require before people migrate, and immigrants having a higher health and wealth status to be able to physically and financially migrate to another country (Kennedy et al. 2014).

This healthy migrant effect can disappear after immigrants have lived in Australia for a long time (Jatrana et al. 2017). A longitudinal study found that when immigrant groups from non-English speaking countries had been in Australia for more than 10 years, their mental health and self-assessed health were worse than that for Australian-born individuals (Jatrana et al. 2017).

Conversely, immigrants from English-speaking countries were found to have advantages related to physical health, mental health and self-assessed health. English proficiency had an effect on the difference in health between populations, as a language barrier could hinder an individual's access to health services. It can also have an impact on employment, which has broader socioeconomic implications.



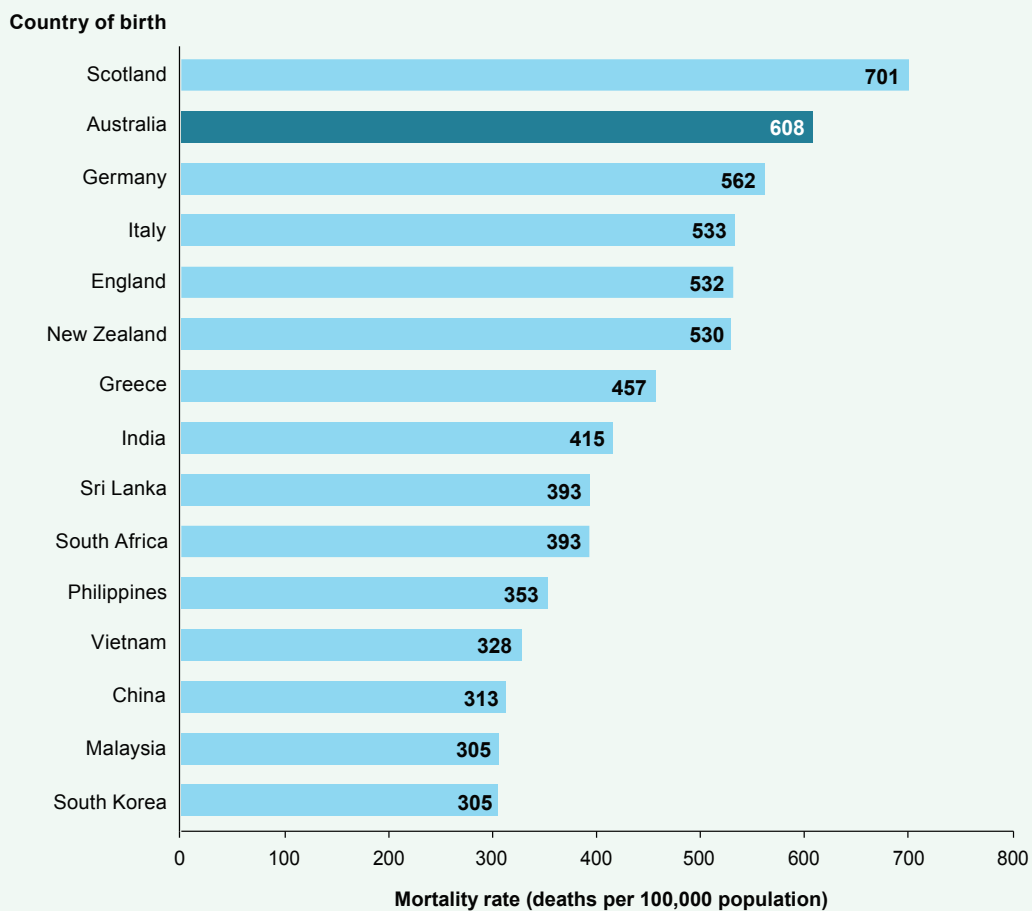


Mortality

Figure 5.3.2 shows age-standardised mortality rates (for any cause of death) among the most common countries of birth reported in the 2016 Census. Consistent with the healthy migrant effect, people born in some Asian countries had the lowest rates of mortality due to any cause (including South Korea, Malaysia and China). Scottish-born people had the highest all-cause mortality rates (701 per 100,000 population), which was higher than Australian-born people (608 per 100,000).

While the all-cause mortality rates in Figure 5.3.2 show the healthy migrant effect, after looking at cause-specific mortality (Supplementary Table S5.3.2), this effect does not seem to apply across the board for all CALD populations, as the populations are not homogeneous. For example, people born in the Philippines had the highest mortality rate due to cerebrovascular disease (42 per 100,000 population) but had the third lowest mortality rate due to chronic obstructive pulmonary disorder (COPD) (4.8 per 100,000).

Figure 5.3.2: Age-standardised all-cause mortality rate, by country of birth, 2016



Source: National Mortality Database; Table S5.3.2.





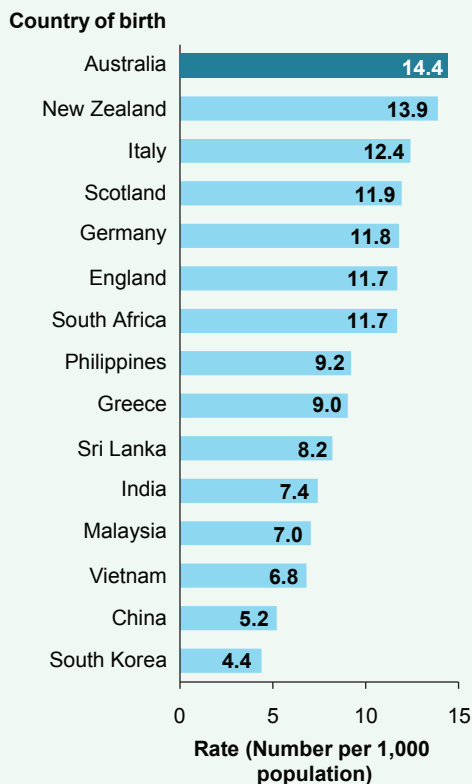
Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) allow for an examination of hospitalisations that could be considered to be largely preventable if timely and adequate care were provided through population health services, primary care and outpatient services. High rates of PPHs can indicate decreased access to primary care or continuing care support (AHMAC 2017).

Figures 5.3.3 and 5.3.4 both show similar patterns among all PPHs and PPHs due to chronic conditions, for the most common countries of birth reported in the 2016 Census. Compared with Australian-born people, people born in Asian countries had lower age-standardised rates of PPHs (4.4 per 1,000 population among South Korean-born, and 5.2 per 1,000 among Chinese-born). Individuals born in Australia and New Zealand had the highest PPH rates (14.4 and 13.9 per 1,000 population, respectively). People born in Italy, Scotland and Germany also had higher rates.

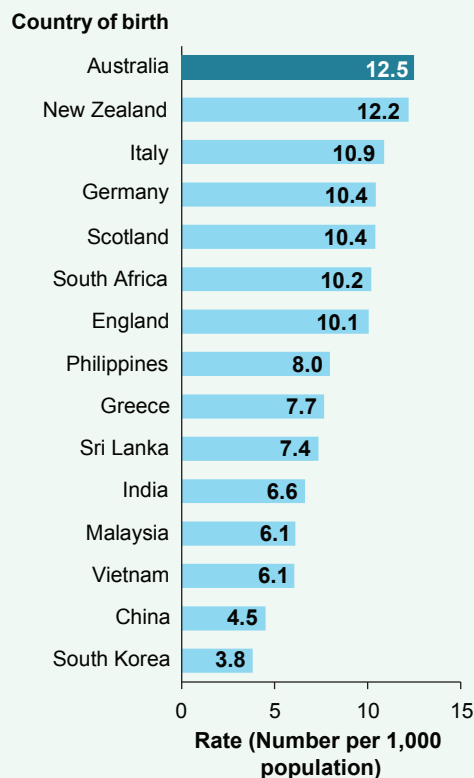
Among Italian- and Greek-born people, among PPHs due to chronic conditions, the most common conditions were congestive cardiac failure (CCF) and COPD. Among Chinese- and Vietnamese-born people, PPHs were most common for anaemia and CCF (Figure 5.3.4).

Figure 5.3.3: Age-standardised PPH rate, by country of birth, 2015–16



Sources: National Hospital Morbidity Database; Table S5.3.3.

Figure 5.3.4: Age-standardised PPH rate for chronic conditions, by country of birth, 2015–16



Sources: National Hospital Morbidity Database; Table S5.3.3.





Refugee health

For immigrants from some countries—especially refugees—migration can be a source of trauma, and refugees have been found to have high rates of mental health problems (FECCA 2015; Schweitzer et al. 2011; Shawyer et al. 2017; Sheikh-Mohammed et al. 2006; Steel et al. 2009). Refugees in Melbourne were found to be 3.1 times more likely to have a mental disorder and twice as likely to have post-traumatic stress disorder (PTSD) compared with Australian-born individuals (Shawyer et al. 2017). Rates of PTSD, depression, and anxiety were 3–4 times higher among Tamil asylum seekers than other immigrants (Minas et al. 2013). As well, Iraqi and sub-Saharan African refugees in Australia were found to have lower levels of mental health literacy compared with the general Australian population, indicating that targeted mental health promotion would benefit these refugee populations (Sheikh-Mohammed et al. 2006; Slewa-Younan et al. 2014).

The refugee subsection of the CALD population is particularly vulnerable. Being able to identify and understand the specific needs of refugees is essential to improving their health status in Australia. States and territories have refugee health networks, and most have programs that include a focus on mental health service. Programs include screening, assisting survivors of torture and trauma, delivering community health outreach for newly settled refugees, and providing an initial point of contact to the health system.

What is missing from the picture?

The ABS has a set of Standards for Statistics on Cultural and Language Diversity that includes a Minimum Core Set of Cultural and Language Indicators: country of birth, main language other than English spoken at home, and proficiency in English. While these standards exist, their use in national health data collections could be improved to better understand diverse CALD populations and identify their specific needs. As well, it would be useful to have more information related to how long individuals have been in Australia, language use patterns, their need for an interpreter, parents' country of birth, and refugee status.

Language barriers can lead to an under-representation of CALD people where English is used in surveys or is required for self-reported information.

Where do I go for more information?

The online report *Older Australia at a glance* touches on older CALD people, and an evaluation of CALD measures in a variety of data sets and assessment instruments can be found in the report *Cultural and linguistic diversity measures in aged care*.





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