



Metro North Hospital and Health Service *Putting people first*

Culturally and Linguistically Diverse Community Data – Metro North Hospital and Health Service

Data on CALD communities for needs identification and planning

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Introduction

Metro North Hospital and Health Service (MNHHS) established a Cultural Diversity Coordinator role in January 2018 to coordinate strategic action and improve outcomes for Metro North's culturally and linguistically diverse (CALD) consumers and communities.

To improve outcomes and access in CALD communities and develop a targeted plan of action, it is important to understand the current environment through review and analysis of the most recent data sources available – both within existing hospital, state and national sources. Through this process, the needs of both the community and the organisation can be understood.

Purpose

The purpose of this report is to present what is known about culturally and linguistically diverse (CALD) communities drawing from population health data and research alongside Metro North Hospital and Health Service (MNHHS) episode, admission, inpatient and interpreter data. Analysis of these datasets provides a picture of the CALD community profile in the Metro North catchment and a basis for further consultation, action planning and prioritisation.

Scope

This project is focused on MNHHS hospital data, usage and patterns accessing the most recent available data sources. While some mental health indicators are reported here, the scope is focused primarily on non-mental health and hospitalisation data, hospital admission and interpreter data. Queensland Health Non-Admitted Patient Data and wait lists were not included. For this reason, it does not capture the number of CALD patients presenting but not being admitted or discharging against medical advice or referred on to community-based services. This is a gap that requires further exploration.

The main sources of hospitalisation data have been derived from the following sources:

- Queensland Hospital Admitted Patient Data Collection by mainly non-English speaking country of birth, larger region grouping, language and interpreter, by facility and by standard classification of episode of care – supplied by Statistical Services Branch, Department of Health
- HCBCIS data – a collation of data on occasions of service, outpatients, inpatients and Emergency Departments by country of birth, interpreter required and provided and by language, held by Health Funding and Analysis Unit.
- Metro North Interpreter Services Data – provides summary data on interpreter services required by language, services provided, costs, missed appointments and gaps in interpreter service capacity.

There are anomalies in datasets; however, together these sources provide a picture of CALD consumers across MNHHS, in facility and clinical areas, as well as indications of disproportionality where some communities while small and younger are over-represented in hospital data.

However, the following data limitations should be noted:

- ESM System used for outpatient appointments at RBWH does not collect language
- Data collection in Queensland Hospital Admitted Patient Data (QHAPD) represents episodes of care and not individual patients. This data should be treated with caution.
- Where possible, overall and highest numbers are provided but rates and comparisons are not available.
- Standard ethnicity data collection not yet integrated into RiskMan.

Data Limitations

Within the health system, there are significant limitations in terms of developing the evidence base and understanding of CALD consumers and community health needs. These occur at different levels from research through to epidemiological studies through to patient feedback collection systems.

- Many non-English speaking background patients are excluded from much published literature due to study limitations and insufficient support and funding. As a result, there is a limited evidence base and what evidence base has been established may not be sensitive to local community contexts or needs.
- Current systems for collecting CALD patient feedback have yet to be fully implemented. RiskMan for example has only begun to integrate the minimum data standard for appropriate collection of CALD data. This system barrier, along with cultural barriers that mean some CALD consumers are less likely to raise issues or understand the standard of care they should expect, makes it hard to have a complete picture of the needs within the community and the organisation.
- Epidemiological data is limited in Queensland. While the Chief Health Officer reports of the health of Queenslanders and potentially preventable hospitalisation data, data is not available for rates of CALD Potentially Preventable Hospitalisations (PPH) or routinely analysed and reported. In 2008, the state-wide Multicultural Health Service worked closely with CHO epidemiologists and health statisticians to undertake targeted CALD Community health needs assessments. These were based on QHAPD for potentially preventable admissions and included cultural epidemiology and migrant health trends and projections for eight Pacific Islander communities, Indian Queenslanders, Vietnamese and Italian Queenslanders. More recent reports were undertaken and published in 2011. These reports are based on 2003-4 hospital admission data and are state-wide. Many of these findings are likely to be relevant. This data is summarised and contextualised against more recent data specific to MNHHS.

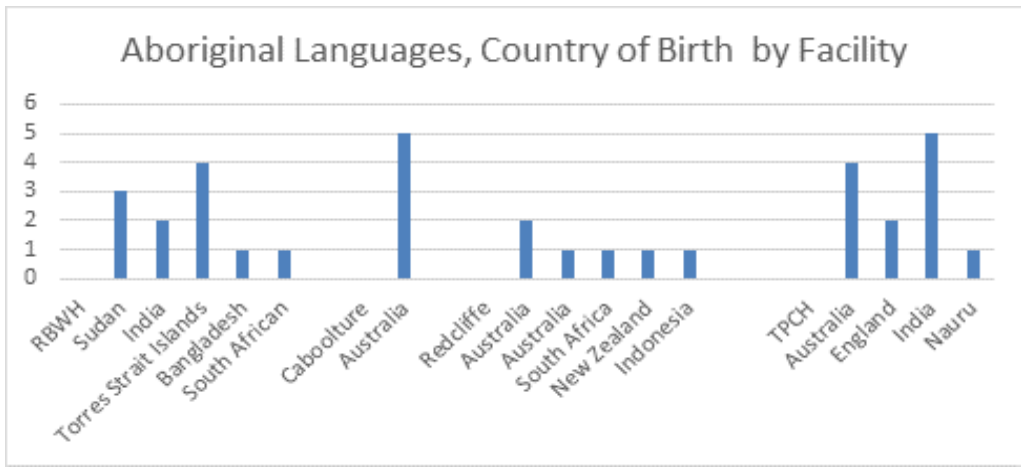
Data quality and integrity

Ethnicity data collection and classification errors reveal a need to improve, standardise and educate around CALD data.

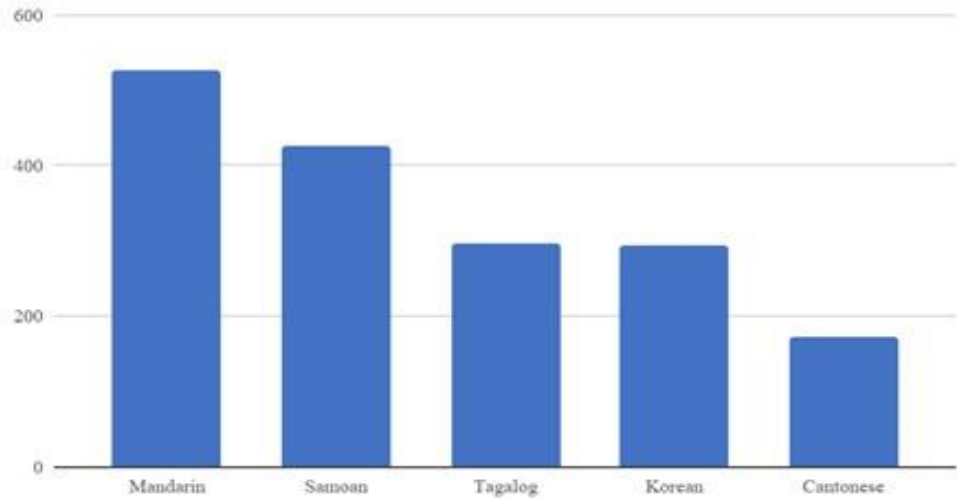
- Data collection methods mask indicators of ethnicity and language needs. For instance, New Zealand-born is the highest country of birth in the Metro North CaRE survey and is one of the highest overseas-born communities in Brisbane North; however, it is not known how many of these are Maori or Pacific Islander since current systems capture country of birth but cultural or ethnic identity.
- In language and interpreter service data, there are “African” or “Asian” languages. The category of “Other” non-Australian born is also used.

Below is a sample of some of the issues that may lead to underrepresentation or misrepresentation of CALD consumers.

Table 1: Summary of hospital data issues

Data Issue Type	Details / Example
Aboriginal Languages recording and definition	 <p>Figure 1: Sample of Aboriginal Languages by Country of Birth, and Facility, 2014-18. Source: HBCIS</p> <p>Issues may arise:</p>

Data Issue Type	Details / Example																
	<ul style="list-style-type: none"> Non-Aboriginal people viewed as Aboriginal Aboriginal language not further specified Some CALD people grouped under Aboriginal language and not provided correct interpreter. Some non-Indigenous people may identify as Aboriginal or Torres Strait Islander (for example people from Papua New Guinea.) 																
Asian language not elsewhere defined	<ul style="list-style-type: none"> Classification and grouping CALD consumers together. People may not specify country of birth on admission or may not be recorded accurately. <div data-bbox="370 604 1228 1025"> <p>"Asian Language not elsewhere defined", Country of birth, MNHHS ED data, 2014-18</p> <table border="1"> <thead> <tr> <th>Country of Birth</th> <th>Count (approx.)</th> </tr> </thead> <tbody> <tr> <td>India</td> <td>160</td> </tr> <tr> <td>Nepal</td> <td>120</td> </tr> <tr> <td>Burma</td> <td>115</td> </tr> <tr> <td>Bhutan</td> <td>55</td> </tr> </tbody> </table> </div> <p>Figure 2: Asian Languages not elsewhere defined, by COB, MNHHS ED data 2014-18. Source: HBCIS.</p>	Country of Birth	Count (approx.)	India	160	Nepal	120	Burma	115	Bhutan	55						
Country of Birth	Count (approx.)																
India	160																
Nepal	120																
Burma	115																
Bhutan	55																
Arabic (includes Lebanese)	<ul style="list-style-type: none"> Arabic-speaking countries are diverse and include a range of countries. Looking at this indicator on its own would mask difference in country of origin. <div data-bbox="370 1240 1350 1733"> <table border="1"> <thead> <tr> <th>Country</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Iraq</td> <td>30%</td> </tr> <tr> <td>Saudi Arabia</td> <td>25%</td> </tr> <tr> <td>Sudan</td> <td>21%</td> </tr> <tr> <td>Syria</td> <td>14%</td> </tr> <tr> <td>Egypt</td> <td>4%</td> </tr> <tr> <td>Liberia</td> <td>3%</td> </tr> <tr> <td>Lebanon</td> <td>3%</td> </tr> </tbody> </table> </div> <p>Figure 3: Countries of Birth for Arabic-speaking patients, MNHHS ED (note that Sudan and South Sudan are combined).</p>	Country	Percentage	Iraq	30%	Saudi Arabia	25%	Sudan	21%	Syria	14%	Egypt	4%	Liberia	3%	Lebanon	3%
Country	Percentage																
Iraq	30%																
Saudi Arabia	25%																
Sudan	21%																
Syria	14%																
Egypt	4%																
Liberia	3%																
Lebanon	3%																
African, not elsewhere defined	<ul style="list-style-type: none"> People may not specify country of birth on admission. For some African people, they may identify with South Sudan; however, their birth certificate may state "Sudan". Some may have spent long years in refugee camps in other countries such as Kenya. 																

Data Issue Type	Details / Example												
	<ul style="list-style-type: none"> In examining “African not elsewhere defined” in MNHHS Occasion of service data, Sudanese is the most frequent country of birth in this category. 												
“Other mainly non-English speaking” country of birth “Inadequately described “/” “Not stated”	<ul style="list-style-type: none"> Not recorded on admission or not stated. Includes situations where the response is inadequate to assign a code or where it is not possible to ask this question or a response to be provided. 												
New Zealand-born	<ul style="list-style-type: none"> New Zealand is one of Queensland’s largest sources of migrants, with 4% of the population being born in New Zealand. Twenty-one per cent (21%) of migrants from New Zealand identify as either Maori or Polynesian. The Redcliffe and Caboolture regions have the highest numbers of New Zealand born people living in the Metro North catchment area representing 44% of this population (16,908 people) compared to TPCH with 12,691 people (33%) and RBWH with 8549 people (23%). The majority of people born in Samoa, within Metro North, also reside in Redcliffe Caboolture (908 people). The question of ethnicity is not recorded in the system and this masks Maori or other Pacific Islanders who have entered Australia via New Zealand and may have higher needs. MNHHS ED Data shows that NZ hospital admissions categorised as culturally and linguistically diverse speak predominantly Maori followed by Sign Language, and Samoan. <p style="text-align: center;">Languages spoken, Caboolture SSA 3,</p>  <table border="1"> <caption>Languages spoken, Caboolture SSA 3</caption> <thead> <tr> <th>Language</th> <th>Number of people (approx.)</th> </tr> </thead> <tbody> <tr> <td>Mandarin</td> <td>520</td> </tr> <tr> <td>Samoan</td> <td>420</td> </tr> <tr> <td>Tagalog</td> <td>300</td> </tr> <tr> <td>Korean</td> <td>300</td> </tr> <tr> <td>Cantonese</td> <td>180</td> </tr> </tbody> </table> <p>Figure 4: Languages other than English (LOTE), Caboolture, 2016. Source: ABS 2016 Census</p>	Language	Number of people (approx.)	Mandarin	520	Samoan	420	Tagalog	300	Korean	300	Cantonese	180
Language	Number of people (approx.)												
Mandarin	520												
Samoan	420												
Tagalog	300												
Korean	300												
Cantonese	180												

Data Issue Type	Details / Example
	<p>Figure 5: Diversity of Caboolture, country of birth. Source: ABS 2016 Census.</p> <ul style="list-style-type: none"> It is therefore important to examine COB and Language together and this is highlighted in the example of New Zealand-born patients.
Australian born – first generation	<ul style="list-style-type: none"> There are a number of Australian-born patients who speak a language other than English. 1,310 ED admissions, while Australian-born, are categorised as CALD for the language other than English spoken.
Nationality/ country of birth as indicator of identify	<ul style="list-style-type: none"> Some refugee communities do not have a country of birth due to geopolitical changes or may have been born in a refugee camp in transit. For example, South Sudan is the newest country which many Sudanese may identify with, but it did not exist when they were born. Some ethnic groups exist across country borders or as a sub-population within countries such as Kurds from Iraq or Turkey.¹
Australian South Sea Islander	<ul style="list-style-type: none"> Australian South Sea Islanders are the Australian-born descendants of predominantly Melanesian people who were brought to Queensland from eighty Pacific Islands, but primarily Vanuatu and the Solomon Islands. They were brought to work in Queensland as a source of cheap labour to work in Queensland's primary industries in the mid to late 19th century. Some people were tricked into working in Queensland, some were kidnapped or "blackbirded" and others moved to Queensland to earn money. The people who worked in the sugar industry were poorly treated and many were held in conditions of slavery. This group was officially recognised by the Queensland government in the year 2000. Limited information on the health of ASSI people suggests a high burden of chronic disease. The official recognition statement introduced in 2000 led to the integration of data collection standard for Australian South Sea Islanders in government agencies.

¹ A comprehensive review of data collection standards in the WA Health System outlines national and international practices and issues. Forrest S (2018). [Review of Cultural and Linguistic Diversity \(CaLD\) Data Collection Practices in the WA Health System 2018. Department of Health, Western Australia.](#)

Data Issue Type	Details / Example
	<p>Issues around 'false positive' were emerging in the field when this data element was introduced (for example, people born in Pacific Islands identifying with the category of Australian South Sea Islander.)</p> <ul style="list-style-type: none"> The Department of Aboriginal and Torres Strait Islander and Multicultural Affairs conducted an Australian South Sea Islander community survey in early 2014. The community survey reported a small number of Australian South Sea Islanders reside or identify in the Brisbane North area. This field is not integrated in MNHHS data collection systems.

Summary of Data Issues and Limitations

- Queensland Health has developed an Ethnicity Data Element to provide a standard and promote consistency of ethnicity information collection across systems. It proposes that patient self-identification should be supported, and identity never assumed. To supplement the minimum data elements collected, the following question is recommended for inclusion, in written forms or verbally:

"Which ethnic group do you belong to or identify with?"

- Other indicators such as ancestry are used by the Western Australian Department of Health and the Australian Bureau of Statistics. The ABS Standards for Statistics on Cultural and Language Diversity include four minimum variables: Country of birth, Main Language other than English Spoken at Home, Proficiency in Spoken English and Indigenous Status. The full set includes Ancestry, Country of Birth of Parents, First Language Spoke, Main Language Spoken at Home, Religious Affiliation and Year of Arrival in Australia.
- Interpret Service Required and Preferred language are also included in both the Australian and Queensland Data Dictionary and classification standards.
- It is important to use and analyse different data indicators in combination to improve understanding of community needs.
- Year of arrival may help understand changes in migrant community health over time, and increased sensitivity to newly-arrived communities.

Cultural and Linguistic Diversity demographics – Queensland and Brisbane

The diversity of Brisbane North is increasing rapidly and is greater than the diversity of Queensland:

- In Queensland in 2016, 71.1% of people were born in Australia. The most common countries of birth were New Zealand 4.3%, England 3.8%, India 1.0%, and China (excludes SARs and Taiwan) 1.0%. 81.2% of people only spoke English at home. Other languages spoken at home included Mandarin 1.5%, Vietnamese 0.6%, Cantonese 0.5%, Spanish 0.4% and Italian 0.4%.
- The 2016 Census data shows that in Brisbane North (which does not fully capture MNHHS catchment), 70.5% of people were born in Australia and 79.5% of people in the Brisbane North region only spoke English at home. The most common countries of birth were New Zealand 3.9%, England 3.2%, India 3.1%, Philippines 1.6% and China (excludes SARs and Taiwan) 0.9%. The most common languages other than English (LOTE) spoken at home are Punjabi, Mandarin, Italian, Hindi and Tagalog.

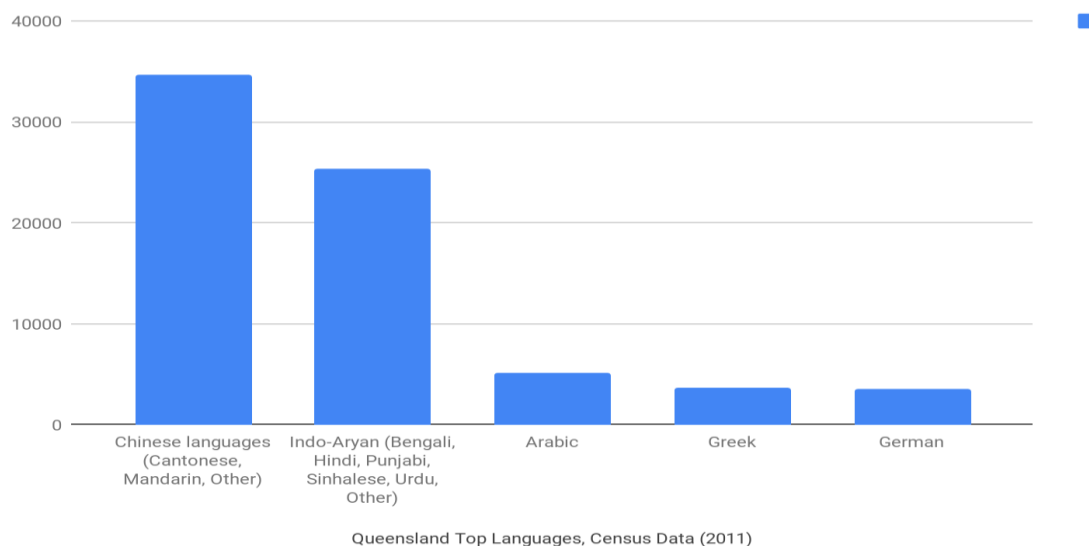


Figure 6: Top Languages. Source: Queensland 2011 Census

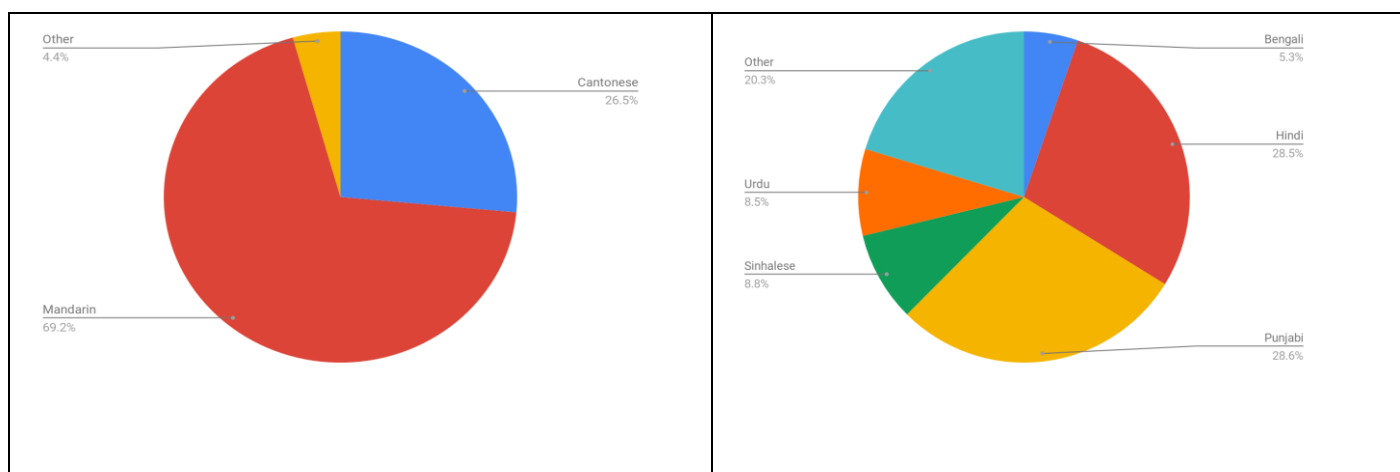


Figure 7: Chinese Languages (left) and Indo-Aryan languages (right). Source: Queensland, 2011 Census

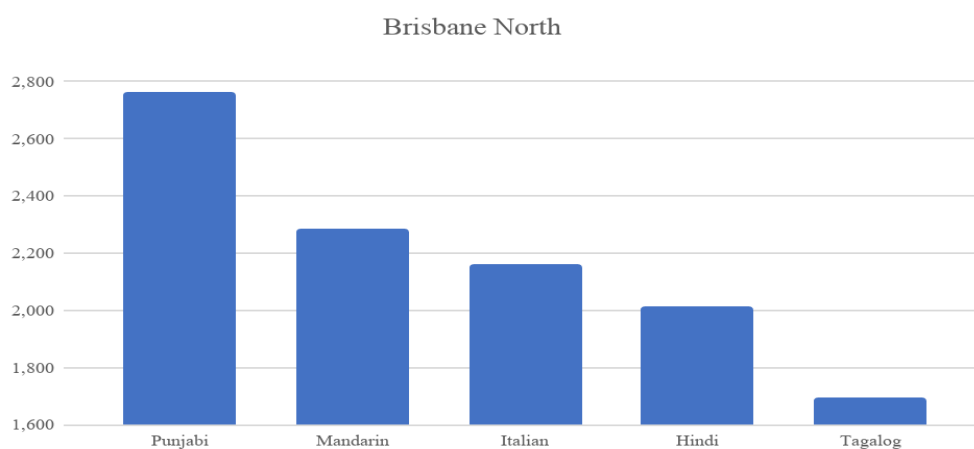


Figure 8: Top Languages other than English spoken at home, Brisbane North. Source: ABS 2016 Census.

Brisbane North and Brisbane South

- Historically, Brisbane South has had a higher CALD population, but that distinction is rapidly changing. Similar profile in terms of the migrant communities across Brisbane North and South. In Brisbane South, 57.9% of people were born in Australia. The most common countries of birth were China (excludes SARs and Taiwan) 5.8%, India 3.4%, New Zealand 3.3%, England 2.5% and Taiwan 2.1%. 62.5% of people in Brisbane South only spoke English at home. Other languages spoken at home included Mandarin 8.7%, Cantonese 3.0%, Korean 1.9%, Punjabi 1.5% and Vietnamese 1.4%. The main differences are the Filipino community on the northside, Vietnamese and Taiwanese on the south side.

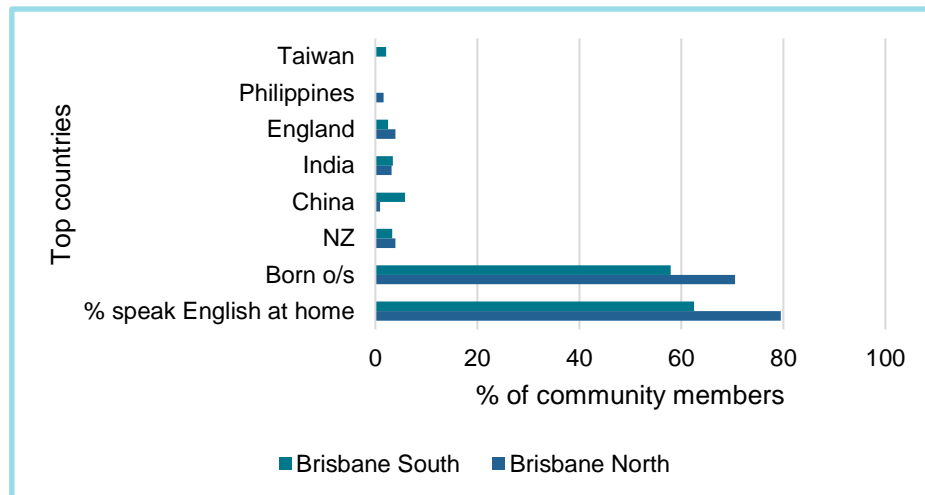


Figure 9: Comparison of CALD population born overseas, ABS 2016 Census.

- In terms of humanitarian and refugee settlement, Brisbane North is now overtaking Brisbane South as settlement locations for communities as the data below clearly shows. This data reflects the main communities that as of June 2018 are the highest CALD refugee communities being settled on the northside (Syrian, Iraqi, Myanmar as well smaller numbers from Ethiopia, Congo and Bhutan).
- In May 2018, the highest communities being settled in Brisbane were from Eritrea, Congo, Iraq, Myanmar and Syria. The humanitarian entrant arrivals anticipated as of 30 June 2018 were triple the numbers on previous years up to 275.

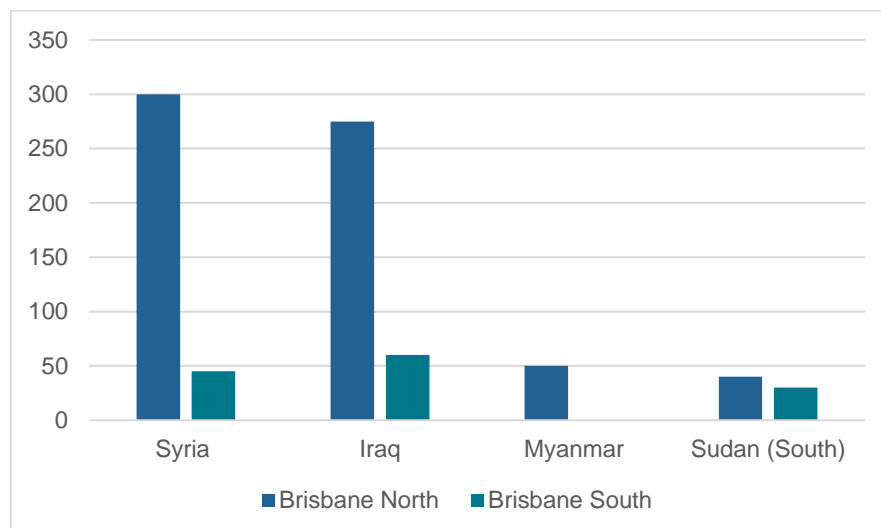


Figure 10: Highest refugee and humanitarian entrant communities, Brisbane North and South, 2016-17.
Source: Refugee Health Connect

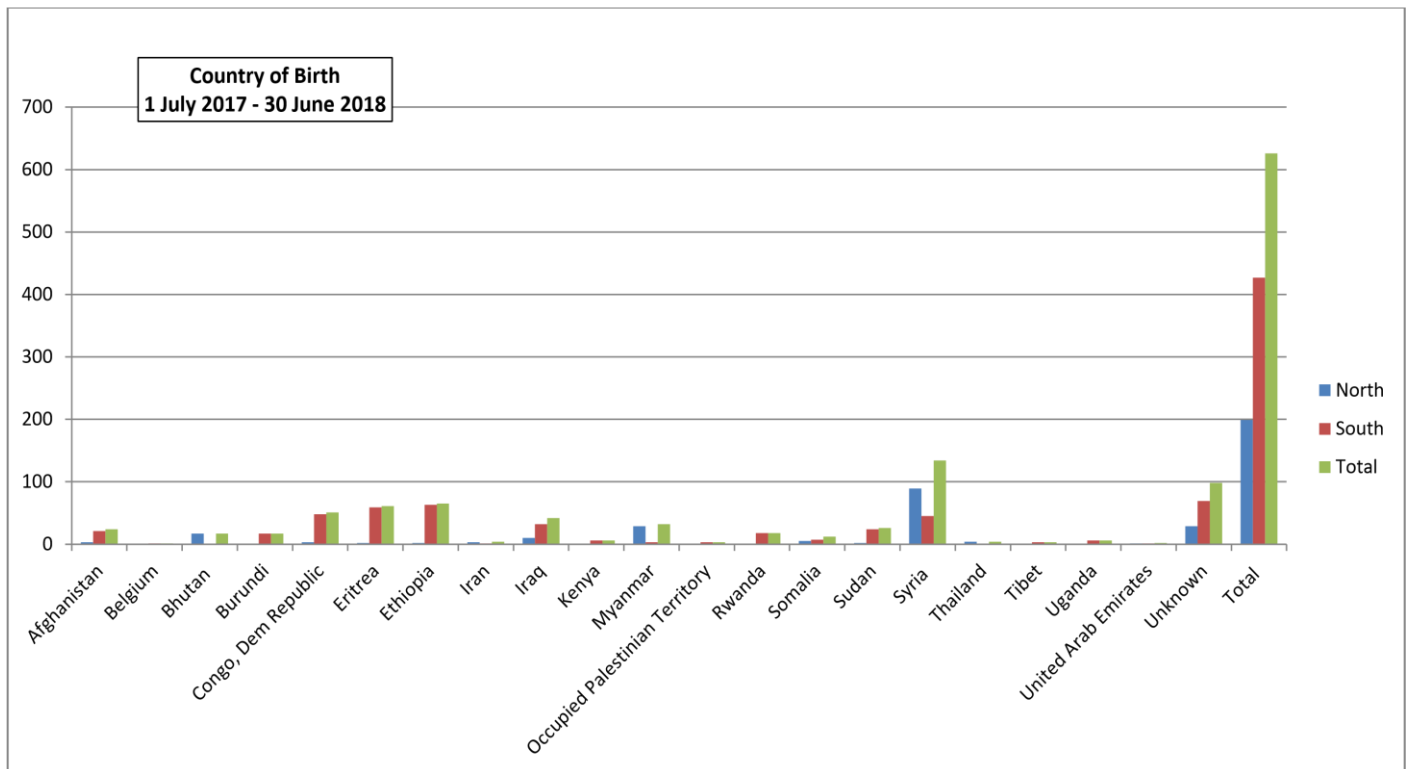


Figure 11: Country of birth of refugee and humanitarian arrivals, 2017-18, living in Brisbane North and South.
Source: Refugee Health Network QLD.

- Pockets within the Brisbane North region that can be identified as key settlement suburbs for newly arrived refugee increasing on the northside in areas such as Brendale, Bracken Ridge, Strathpine, Stafford Heights, and Wavell Heights. In previous years, Taigum, Zillmere, Fitzgibbon Everton Park and Nundah were key suburbs for refugee settlement program which is reflected in the most recent census data.

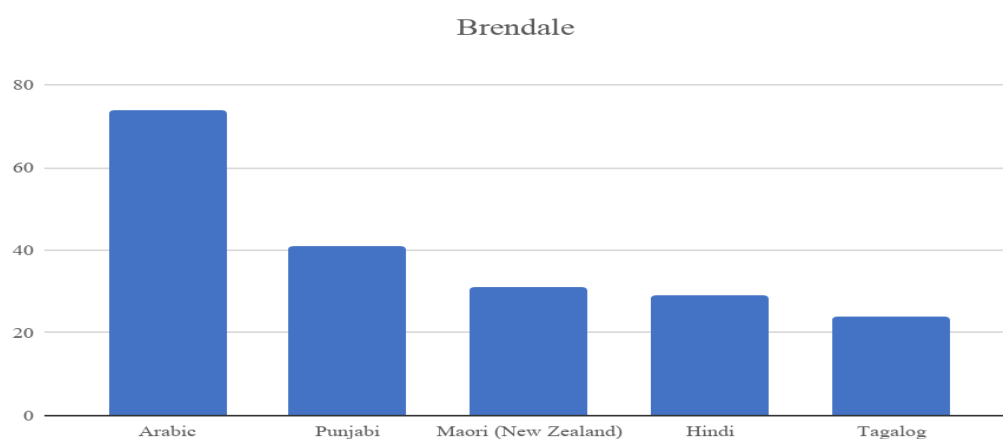


Figure 12: LOTE, Brendale, 2016: Source ABS 2016 Census.

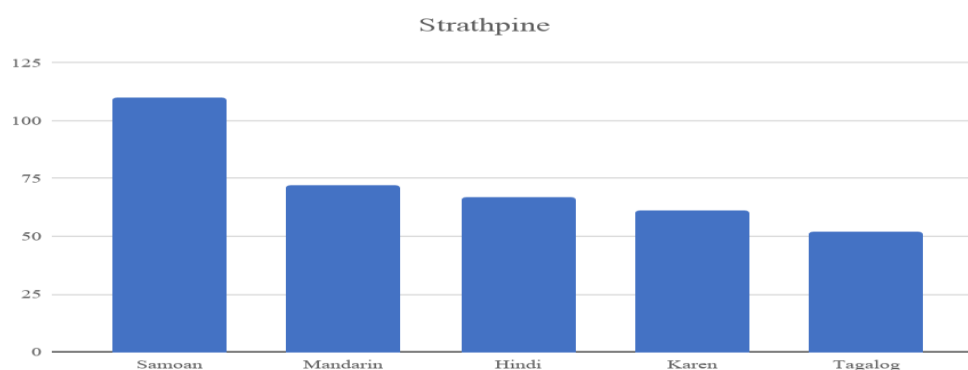


Figure 13: LOTE, Strathpine, 2016. Source ABS Census 2016

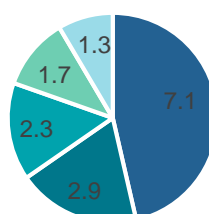
Other migrant groups in Brisbane North

- While the profile is changing in Brisbane North, there are less obvious community hubs and neighbourhoods than in Brisbane South and the communities tend to more dispersed. For example, on the southside, the Vietnamese community makes up 15-16% of the population in Inala and Darra; Chinese are 8-10% of the population in Sunnybank Hills and Calamvale.
- However, there are pockets emerging on the north side: the Korean community comprises around 7% of the Brisbane City population; Iranians are 8% of Pinkenba and the Indian community is around 5% (Chermside and Chermside West). In Herston, 50.4% of people were born in Australia. The most common countries of birth were China (excludes SARs and Taiwan) 6.5%, England 2.8%, Vietnam 2.5%, New Zealand 2.2% and India 2.2%. 57.7% of people only spoke English at home. Other languages spoken at home included Mandarin 7.1%, Vietnamese 2.9%, Cantonese 2.3%, Bengali 1.7% and Spanish 1.3%.

Suburbs with identifiable communities are shown below, with Brisbane North suburbs highlighted in blue.

Brisbane Suburb	CALD community	Percentage of population
Inala / Darra	Vietnam	16
Brisbane City North	Korea	6.6
Pinkenba	Iran	8
Sunnybank Hill	Chinese	9
Herston	Chinese	6.5
Chermside / Chermside West	India	5

Languages other than English spoken at home (percentage), Herston, 2016



■ Mandarin ■ Vietnamese ■ Cantonese ■ Bengali ■ Spanish

Figure 14: LOTE, Herston, 2016

- SBS has produced an [interactive visual map](#) that shows country of birth by suburb. Note that this is based on 2011 Census Data

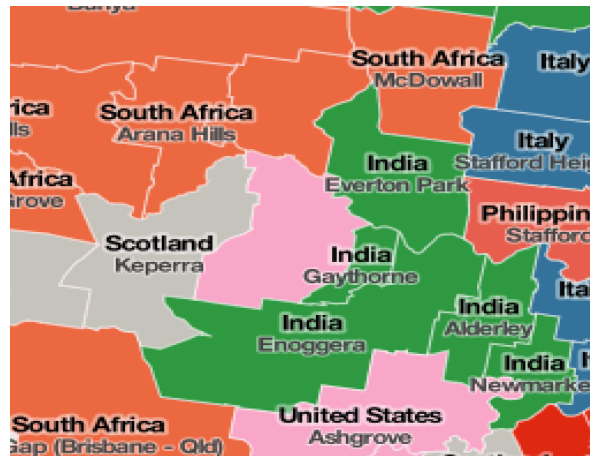


Figure 15: Clip of SBS Interactive Map

- The [2016 Census Data “Quick Stats”](#) is also searchable by suburb. Further in the report catchment data from Caboolture, Redcliffe, The Prince Charles Hospital and Royal Brisbane Women’s Hospital will be detailed. Below is the data reported in the Joint Health Needs Assessment, based on 2011 Census data.

CALD Health Patterns in Queensland and Australia

The following section outlines disparities and inequities identified in the literature and issues that impact health and wellbeing. Determinants of health include a range of socioeconomic and cultural factors that may impact on CALD consumer and communities' engagement and access to health. As noted by Renzaho "physical and mental health is affected by many factors, including the pre-migration environment in country of origin, the timing or wave of migration, the migration stream category and the degree of integration in Australia."² Sensitivity to current pre-migration and local community environments are therefore important consideration for health organisations.

Research undertaken by Brisbane North PHN has shown that those from culturally and linguistically diverse populations and who speak a first language other than English, typically experience problems accessing and navigating health services which can negatively impact upon their health and wellbeing.

Through research and consultation with multicultural health and social service sectors, approaches and interventions have been developed focusing on the highest needs in CALD communities in Queensland and tailored to the specific issues for refugee and asylum-seeking communities, older and younger communities, gender-specific and mental health

New Zealanders and New Zealand-born Pacific Islanders in Queensland

- Following a needs assessment of Pacific Islander communities in Queensland in 2010, in July 2014, MNHHS Public Health Unit undertook a health needs assessment for Australian South Sea Islanders and Pacific Islanders which confirmed the health profile of Pacific Islander communities in Brisbane North.
- Queensland Health established a dedicated Pacific Islander multicultural health workforce within LCCH – the Good Start Program – in response to these findings. The Good Start Program is statewide working with schools and families.
- Consultation with Metro South HHS and LCCHS where significant investment has occurred to work with Pacific Islander families confirms that the Pacific Islander community are less likely to engage in preventative health, have low literacy and social determinants of poor health, and are presenting at hospital at a higher acuity for chronic disease such as diabetes.
- Pacific Islanders come from three main regions in the Pacific – Melanesia (including Papua New Guinea, the Indonesian provinces of Papua and West Irian Java, New Caledonia, Vanuatu, Fiji and the Solomon Islands); Micronesia (the Marianas, Guam, Wake Island, Palau, the Marshall Islands, Kiribati, Nauru, and the Federated States of Micronesia); and Polynesia c). Polynesia is the largest of the three zones.
- Maori people do not belong under the Pacific Islander title because they are the Indigenous people of New Zealand.
- The TransTasman Agreement was established between Australia and New Zealand to allow citizens of each country to visit, live and work freely between the two countries, with permanent residence and associated entitlements. When the migration flow became imbalanced, with many New Zealanders relocating to Australia, the Australian Government made policy changes to restrict New Zealanders entitlements as Australian residents. This change was introduced to reduce responsibility for social security payments to New Zealanders residing in Australia and to deter the number who were unlikely to meet criteria for skilled migration. The other intention was to restrict "third country" movements, with a significant number of Trans-Tasman arrivals originating from Polynesian countries, firstly migrating to New Zealand and then to Australia after gaining New Zealand citizenship.
- These changes have results in two types of New Zealanders – those who arrived before 28 February 2001 and having resided in Australia for 12 months prior – who are given protected Special Category Visas (SCV). Those coming after are giving unprotected SCV status.
- The impacts of these changes have been unevenly felt by Pacific Islander and Maori New Zealanders.³ A community partnership project of Logan City Council and Griffith University documents the following issues:

² Migration and the healthy migrant effect in Australia: current knowledge, gaps and opportunity for future research. In A. M. N. Renzaho (Ed.), *Globalisation, Migration and Health: Challenges and Opportunities* (pp. 363-389), 2016.

³ Kearney and Donaghy, [Bridges and barriers to success for Pacific Islanders completing their first year at an Australian university.](#)"

- an increasing number of New Zealand citizens of Pacific Islander heritage living in financial hardship, due to their ineligibility and limited understanding of entitlements to government services and benefits.
 - intergenerational disadvantage as children of unprotected SCV holders are not entitled to apply for university HECS/ HELP loan.⁴
 - aged and disability support barriers with restrictions imposed on access to pensions, including the Age Pension and Disability Support Pension with significant length of residency eligibility (ten years). In some cases, Disability Support Pension can be accessed immediately if the impairment causing inability to work while a person was an Australian resident.
 - The Commonwealth Seniors Health Card which provides concessions for medicine, transport and other benefits is limited to after two years of arrival for protected SCV holders.
 - New Zealanders (protected and non-protected SCV holders) who are residing in Australia are eligible for Medicare and may be issued with a Medicare card upon presentation of documentation proving residence.
 - New Zealand residents visiting Australia are also entitled to services as public patients in a public hospital (including outpatient services) for medically necessary treatment and prescription medicines which are subsidised under the PBS.⁵
 - The NDIS is determined by the definition of “Australian resident” used in the Social Security Act and this excludes some New Zealanders.⁶
- Three Pacific Islander communities – Samoan, Fijian and Papua New Guinea – together are comprising the highest episodes of care amongst MNHHS CALD communities. Note that the graph below shows Metro North Pacific Islander residents with some episodes of care outside MNHHS in other facilities. People of Oceania region account for second highest episodes of care in renal /nephrology services in MNHHS in 2017. They are also recorded as a high group in cardiology.

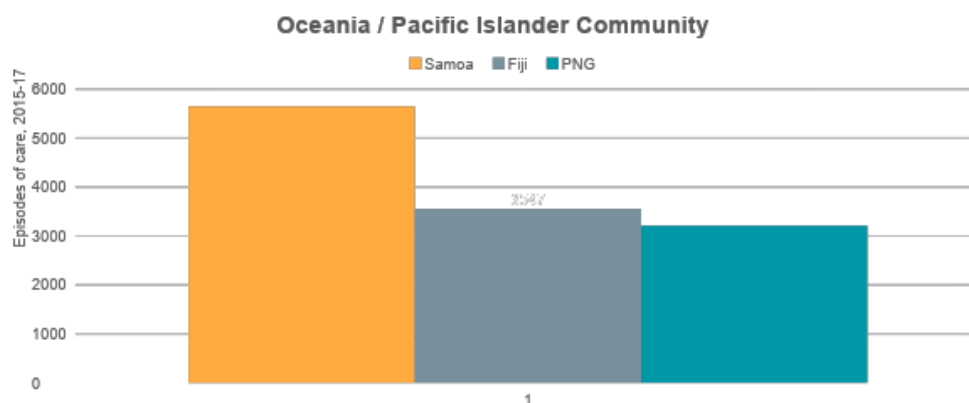


Figure 16: Overall MNHHS Episodes of Care- Pacific Islander consumers and communities. Source: QHAPD

⁴ See Chenoweth, Lesley, “Pacific Islanders and education: is Australia an ‘unlucky country’?” The Conversation, 2014.

⁵ Occasional Paper No. 1 - Understanding and Improving Outcomes for Pacific Islander People: A Logan Context, February 2016:

⁶ <https://theconversation.com/new-zealands-bondi-bludger-and-other-australian-myths-22391> .

Older migrant populations and carers

In 2011, 36% of people aged 65 and over were born outside Australia, with 61% of these people born in non-English speaking countries. Reflecting early post-war migration, Italian (23%) and Greek (14%) are the two most commonly spoken languages other than English for people aged 65 and over.⁷

According to the Commonwealth Department of Health and Ageing, CALD communities in Australia that will have large percentages moving from 70-80 to 80+ by 2021: Italy, Germany, Netherlands, Greece, Croatia.⁸ Using three social indicators of high care needs for CALD populations ('need for assistance with core activities of daily living'; 'living alone', and 'speaks a language other than English and does not speak English well or at all'), the following trends were identified:

- the birthplace groups that had higher than average rates of 'needs for assistance' for people aged 70 years and over with rates 10% above the average were: Poland (37.2% - rising to 50.8% for the 80+ years group); Vietnam (41% - rising to 56% for the 80+ group) and Ukraine (45.9% - rising to 56.3% for the 80+ group).
- Greece rose from 32.4% for the 70+ years age group to be one of the few 10% over the average in the 80+ years group with 54.9% needing assistance with core activities, and the Philippines rose from 29.1% for the 70+ aged group to 57.4% for the 80+ age group.
- The pattern of low English proficiency is most predominant within newer migrant groups. Within the CALD birthplace groups for people aged 70+ years in Queensland there are three birthplace groups that have very high rates of their population who cannot speak English well or not at all: Vietnam (82.4%); China (59.2%) and Japan (42.7%). Others that are almost twice the average rate include: Spain (35.8%); Greece (32%) and Finland (34%). These six birthplace groups are also the highest on the 80+ years subgroup
- Two birthplace groups for the 70+ years cohort have more than 30% of their populations living alone: Ukraine (34.5%) and Poland (32.1%). Vietnam was only country that had less than 10% of its population living alone in the 70+ age group cohort (8.4%) and in the 80+ subgroup (5.7%). The two countries where the rate of living alone actually falls when looking only at the older 80+ year age group: Vietnam (8.4% to 5.7%) and the Philippines (21.2% to 14.8%).
- Anglicare South Queensland has identified that many CALD communities do not identify with the concepts of 'aged care' and 'carer'. Aged care is not well understood, perceived as something negative and stigmatised. Many are less likely to engage in help-seeking behaviours and regard looking after their elders as entirely a family responsibility. Carer stress may be exacerbated for many second-generation CALD community members.

The Italian community is the oldest in age in MNHHS. The graph below shows the oldest CALD consumers for all episodes in MNHHS. This is in line with the demographic trends noted above.

⁷ AIHW [Older Australians at a Glance, April 2017](#).

⁸ [Demographic Data for Australia's Older Culturally and Linguistically Diverse Population by State and Territory and by Aged Care Planning Regions](#)

80+ year old CALD consumers, MNHHS admission by language and interpreter required, 2015-17

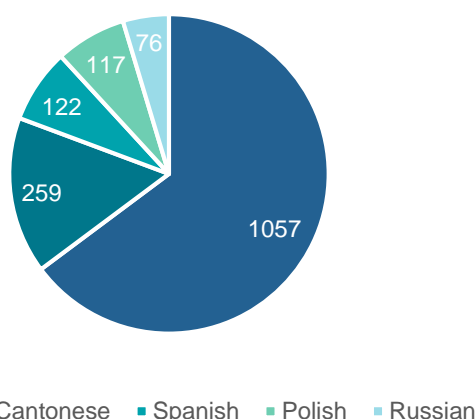


Figure 17: Oldest CALD patients, MNHHS, 2015-17. Source: QHAPD

New migrant populations with younger age profile

Queensland Hospital admission data reveals that, by language, Arabic, Punjabi, Karen, Mandarin, Persian/ Farsi are amongst the highest CALD groups with the youngest age profiles. This reflects newer migrant communities such as Indian and Chinese and refugee and asylum-seeker: Arabic, Karen, Persian/Farsi. “Asian not elsewhere Inc” may also mean those from Myanmar such as Rohingya community members.

Table 2: Breakdown of CALD hospital interpreter service by age, ranked by language group

0-10	10-19	20-29	30-39
Arabic Including Lebanese Mandarin Asian - Not Elsewhere Inc. Punjabi Karen	Arabic Including Lebanese Persian / Farsi Karen Filipino Mandarin	Punjabi Arabic Including Lebanese Asian - Not Elsewhere Inc. Mandarin Hindi	Dinka Mandarin Spanish Asian - Not Elsewhere Inc. Persian / Farsi

CALD youth may experience increased intergenerational conflict due to competing cultural norms. Their English literacy may be better than their parents which may place increased pressure on them to act as interpreters and to mediate information and relationships which may impact dynamics in the family. Issues at school and within their peer group may result in poor social and emotional wellbeing through feeling a sense of not belonging or fitting in. Experiences of racism may also have an impact on CALD youth emotionally, socially, and financially.

Second-generation Australians

- Second-generation Australians, born in Australia with parents born overseas, may experience a range of stressors relating to additional carer and support roles. Children of refugee background Queenslanders may have gained benefits through access to health and education systems but may also face intercultural stress, experience discrimination and negative community attitudes towards refugees, and increased caring roles in relation to their parents.
- Skilled migrants are more likely to have employment and career opportunities and financial advantages. Skilled and other migrants who select to move to Australia are also more likely to have personal behaviours and resources such as good mental health, resilience and optimism. These protective factors known as the “healthy migrant effect” may dissipate over time or generations when expectations and experiences diverge, and the healthy lifestyles associated with migrants’ countries of birth are not sustained in Australia’s more sedentary, high-caloric food culture.

“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.”⁹

Refugee and Asylum-seeking background communities

- Refugee and asylum seekers, by contrast with other self-selecting migrant groups, are not in Australia by choice and have likely endured extreme physical, emotional and psychological distress and harm. Some have experienced trauma of war, genocide, torture and trauma.¹⁰ Lack of control and agency through prolonged refugee and asylum-seeking processes are, similarly, aspects that affect people’s mental and emotional health and wellbeing, short and long-term.
- Across MNHHS adolescent psychiatric admissions to hospital reveal numbers from refugee background regions, particularly Middle Eastern region countries, Eastern Europe (including Russian), South Asian region (India, Pakistan, Nepal and Bangladesh), and North Africa, particularly Sudanese.
- Vitamin and nutritional deficiencies are health issues in some refugee background communities as are communicable and vaccine-preventable diseases which have been identified as higher the rate than Australian-born Queenslanders.¹¹
- Health and system literacy and other priorities such as housing, education and employment mean people of refugee background may not prioritise health needs. Additional barriers such as costs, transport, childcare and lack of knowledge may also be factors in newly arrived and refugee health outcomes.
- Trust and perceptions of feeling safe and welcome in health services are especially important to newly-arrived refugee Queenslanders and their engagement with health providers. The role of peers or ‘brokers’ can facilitate engagement.¹²
- Cultural beliefs may prevent access or engagement in areas such as mental health, sexual health, aged care and palliative care. The need for culturally-tailored services, appropriate health information and proactive engagement are important.
- In Brisbane North, there has been a sharp increase in referrals to Brisbane North GPs via the coordination Refugee Health Connect. From no referrals to Brisbane North in 2014 to 800 referrals in 2017-18.

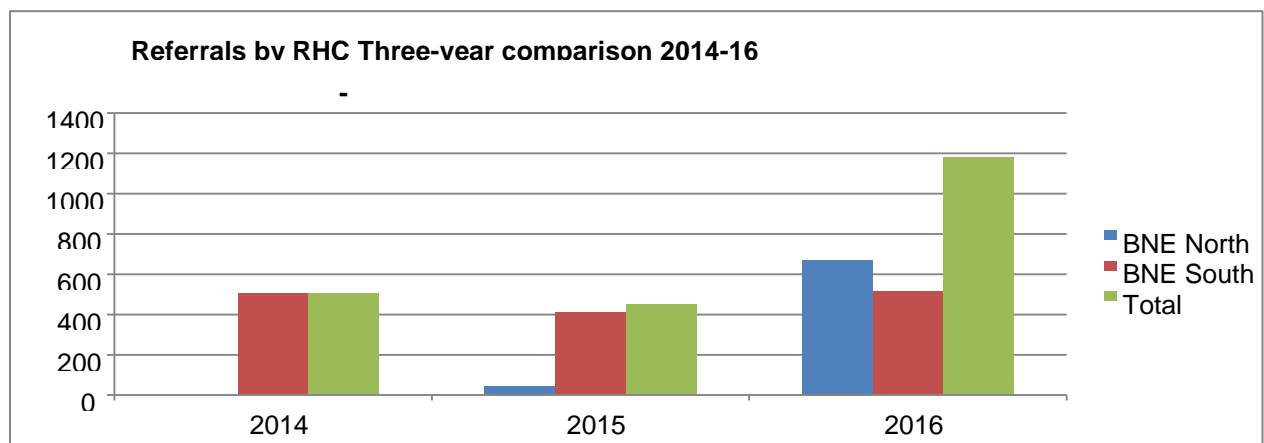


Figure 18: Referrals by Refugee Health Connect by address. Source: Refugee Health Connect

⁹ Jatana et al. “Nativity, duration of residence and chronic health conditions in Australia: Do trends converge towards the native-born population?” Social Science & Medicine 119 (2014).

¹⁰ 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 F, “The mental health status of refugees and asylum seekers attending a refugee health clinic including comparisons with a matched sample of Australian-born residents.” BMC Psychiatry 17:76). Rates of PTSD, depression, and anxiety were 3 to 4 times higher among Tamil asylum seekers than other immigrants (Minas H, et al, 2013. Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. International Journal of Mental Health Systems 2013: 7:23). More info is available in the Metro North CALD Mental Health Needs Assessment report and its response and recommendations.

¹¹ Mohamud Sheikh-Mohammed, C Raina MacIntyre, Nicholas J Wood, Julie Leask and David Isaacs. Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. Med J Aust 2006; 185 (11): 594-597

¹² Peterson, P, Sackey, D, Correa-Velz, I, and Kay, M. [“Building Trust: Delivering healthcare to newly arrived refugees”](#) Mater Online.

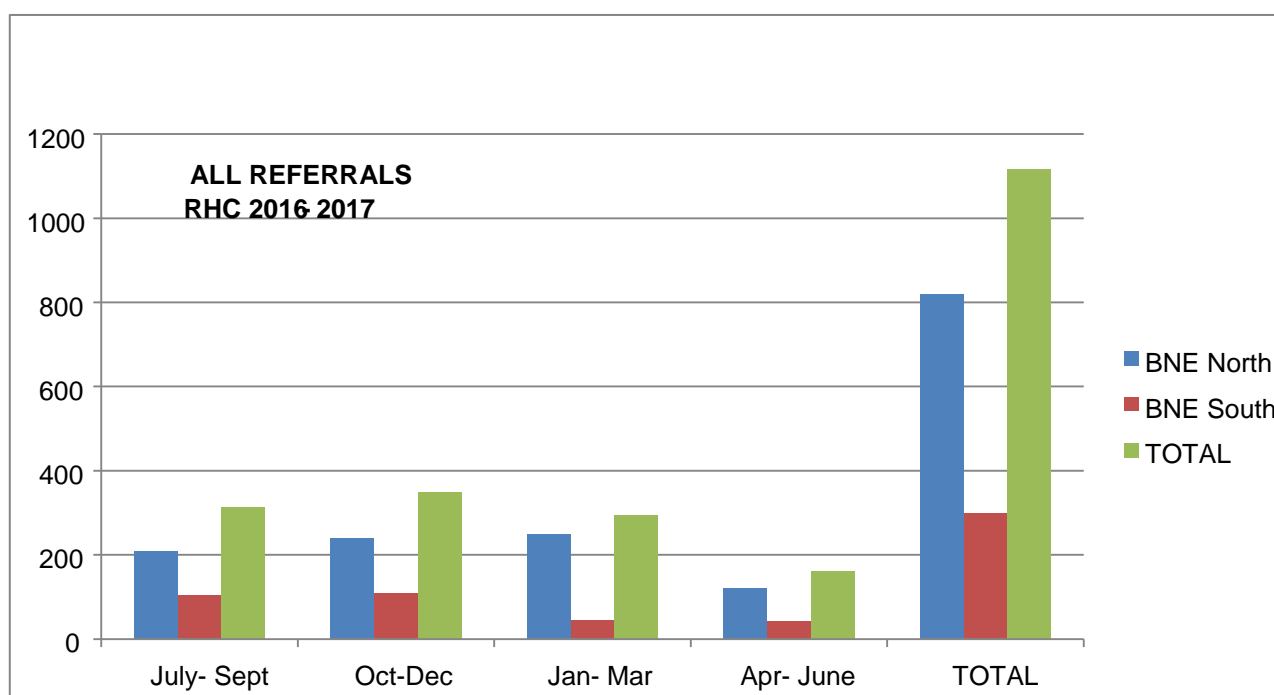


Figure 19: Refugee Health Connect referrals Brisbane North and South, 2016-17

Gender and multicultural health

- In obstetric admissions, the top CALD groups are from the South Asian region (predominantly Indian but also include Sri Lanka, Nepal, Pakistan, Bangladesh and Bhutan).
- National and state clinical guidelines and education for female genital mutilation were developed in response to a need for better support for clinicians working with African women who have experienced FGM.
- The national cervical screening program has developed a range of tools for women who have never engaged in screening with culturally-relevant material.
- A CALD Women's Breast Health resource was developed in MNHHS to overcome barriers to screening.
- For many CALD communities, gender-specific health care is important for men and women's health issues.
- CALD men may be less likely to seek help for their health.

Sexual health

- As noted above, there is a need to improve awareness and education in sexual health in CALD communities due to lack of information or stigma.
- ECCQ's Hepatitis, HIV/AIDS and Sexual Health Program works with culturally and linguistically diverse communities across Queensland to improve access to hepatitis, HIV/AIDS, and sexual health information and services.
- A project underway between University of Queensland and Metro North Public Health Unit is working with CALD men who have sex with men focusing on students and those who are travelling between their country of origin and Queensland and engaging in unprotected sex.

Population Health Data

- Epidemiological data is limited in Queensland. While the Chief Health Officer reports of the health of Queenslanders and potentially preventable hospitalisation data, current data is not available for rates of CALD Potentially Preventable Hospitalisations (PPH) or routinely analysed and reported.
- In 2008-09, the Queensland Multicultural Health Service worked closely with CHO epidemiologists and health statisticians to undertake targeted CALD Community health needs assessments. These were based on hospitalisations for potentially preventable admissions and included cultural epidemiology and migrant health trends and projections for eight Pacific Islander communities, Indian Queenslanders, Vietnamese and Italian Queenslanders. More recent reports were undertaken and published in 2011-12. These reports are based on 2007-08, hospital admission data and are state-wide. Many of these findings are likely to be relevant.
- The 2016 CHO Report indicates that 9 of the 16 HHSs had higher PPH rates than the state average for CALD populations. MNHHS was ranked lowest out of 15 HHSs for percentage of hospitalisations that were PPH. The top contributors to PPH were diabetes complications, UTIs and cellulitis, together accounting for 46% of PPH. People from a range of CALD backgrounds have higher rates of diabetes and diabetes related hospitalisations.

In Queensland, during the period 2003-07, people born in a non-English speaking country (NESC) had a 25 % 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 % higher for females, Oceania 15 % higher for total (males and females)
- diabetes deaths: Oceania 230 % higher for total, Southern and Eastern Europe 52 % higher for total.

Hospitalisations

- At a national level, the Australian Institute of Health and Welfare (AIHW) reports that overseas born Australians are hospitalised at a lower rate than their Australia-born counterparts. However, despite this general finding, overseas-born Australian are hospitalised at significantly higher rates for several health conditions. These conditions, and the countries of birth with higher rates, include:
 - 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.
 - 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).
 - Italian, German, English, New Zealand and Greek Australians have the highest rates after Australian and Scottish-born Australians in age-standardised mortality rates.
 - 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).¹³

In Queensland during the period 2003-07, the non-English speaking population had a 20 % higher hospitalisation rate for vaccine preventable conditions compared to the mainly English-speaking population. Hospitalisations for individual geographic regional groups in Queensland 2003-07 were:

- all causes: Oceania 14 % higher and for North Africa females 13 % higher
- PPHs: total potentially preventable: Oceania 9% higher; chronic potentially preventable: Oceania 32% higher, Middle East 22% higher, North Africa males 13% higher; acute PPH: North Africa 17 % higher; vaccine preventable: North Africa 350% higher, Oceania 91% higher, North East Asia 76% higher.
- asthma: Oceania 41% higher and New Zealand 12% higher; coronary heart disease: Southern and Central Asia males 9% higher, Oceania females 12% higher, Middle East total 15% higher

¹³ Australian Institute of Health and Welfare, 2018. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW. <https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.aspx?inline=true>

- diabetes: Oceania 46 % higher, North Africa 27 % higher, Middle East female 40 % higher; heart failure: Middle East 210 % higher, Oceania 31 % higher, Southern and Eastern Europe 24 % higher.¹⁴

Comparisons between health disparities, Australia and Queensland

Below is a summary of health disparities, comparing Australian and Queensland CALD data, reflecting similar issues and confirming MNHHS CALD community health needs.

Table 3: Summary of CALD health disparities, Australia and Queensland

Australia	Queensland
<p>Women born in Sub-Saharan Africa had highest age-standardised mortality rate (10.6 deaths / 100,000 females) compared to 7.2 / 100,000 for Australian-born women for ovarian cancer. (Ovarian Cancer, 2010)</p> <p>Men and women 25 years and over, born in South Pacific, had 2-3 times the hospitalisation rates for diabetes and diabetes-related limb amputations (National Diabetes Mortality Database)</p> <p>Italian, German, English, New Zealand and Greek have the highest rates after Australian and Scottish-born in age-standardised mortality rates (AIHW 2018).</p> <p>Among Italian- and Greek-born people, among PPHs due to chronic conditions, the most common conditions were congestive cardiac failure (CCF) and COPD. were congestive cardiac failure (CCF) and COPD. Among Chinese- and Vietnamese-born people, PPHs were most common for anaemia and CCF (AIHW 2018)</p>	<p>Rate of avoidable death for females born in region of Oceania: 25% higher than Australian-born</p> <p>People born in Oceanic and North African regions had comparatively higher rates of potentially preventable hospitalisation (PPHs) and higher rates of chronic PPHs.</p> <p>Higher rates of death for diabetes for Queensland males born in Oceania region (3 times the rate of death due to diabetes compared to Australian born) and for males and females born in Southern and Eastern Europe regions (45 % and 60 % higher).</p> <p>Those born in Middle East had 15 % higher hospitalisation rate for CHD</p> <p>Vaccine-preventable diseases were higher for North African, Oceania, South-East and North-East Asians.</p> <p>Italian community had high rates of PPHs.</p>

CALD Epidemiological Report Findings

Below is a summary of reports on specific CALD communities published in 2010. The data is Queensland-wide is drawn from hospital admission data between 2006-08 and community consultation.

Community	Findings	Relevance for MNHHS
<p>The Health of Italy-born Queenslanders</p> <p>Italian Queensland Community is an older age profile and one of the longer-established communities.</p>	<ul style="list-style-type: none"> 24.9% more admissions for potentially preventable hospital admissions Higher rates of hospitalisations for diabetes-related complications Standardised separation for diabetes related complications - 64% higher 	<ul style="list-style-type: none"> Italian (23%) and Greek (14%) are the two most commonly spoken languages other than English for people aged 65 and over in Australia. This reflects early post-war migration patterns. Italian is one of the top interpreter language services provided in MNHHS across a number of areas. Queensland Health Admitted Patient Data reflects older people of Southern Europe as top CALD consumer group for renal / nephrology.

¹⁴ Jardine, Endo, Watson, Bright, & MacLeod, Country of Birth Data Analysis Reports #1-3, Chief Health Officer, 2011. A summary document is available at https://www.health.qld.gov.au/_data/assets/pdf_file/0033/388527/health-data-summary.pdf

Community	Findings	Relevance for MNHHS
		<ul style="list-style-type: none"> The Italian community is also the highest in general medicine and emergency episodes of care, RBWH, 2015-17.
<p>The Health of India-born Queenslanders, 2010.</p> <p>India-born Queensland population is a younger age profile and one of the newest and fastest-growing communities in Queensland.</p>	<ul style="list-style-type: none"> Overall, in 2008, Indian-Queenslanders were healthier than Queensland-born population. More established Indian migrant communities (internationally such as in the UK, and nationally such as Melbourne- have a disproportionately higher burden of chronic disease such as diabetes and heart disease.) The Australian Indian population was found to have higher mortality for diabetes and hospitalisations for diabetes, heart attack, renal dialysis and tuberculosis compared to the Australia-born population. Indian community is diverse in terms of language, education and religious beliefs and practices. Complementary and culturally traditional health beliefs (e.g. Ayurveda) are integrated into medical practice in India. Indian women traditionally have significant post-natal support. Other health-related practices around dying require consideration for palliative care. Mental health tends to be stigmatised, particularly for older Indians 	<ul style="list-style-type: none"> The Indian population is one of the fastest growing communities in Queensland. In MNHHS, Hindi and Punjabi are two of the largest languages other than English spoken; however, request for interpreter is relatively low for this community. The Indian-born population accounts for the most episodes of care in MNHHS 2015-17 (8533 episodes of care). Indian women account for the highest episodes of obstetric care at the RBWH.
<p>The Health of Vietnam-born Queenslanders</p> <p>Vietnamese Queensland Community has a mixed age profile. However, the first wave of post-War Vietnamese refugees is now an older ageing community.</p>	<p>Gendered maternal health care issues emerged in the data:</p> <ul style="list-style-type: none"> Vietnamese Queensland women have much lower rates of exclusive breastfeeding than Queensland-born. Statistically significant lower rate of pre-term births for Vietnamese community 	<ul style="list-style-type: none"> Vietnamese community are diverse in age but are an emerging ageing community in Queensland. The Australian Department of Health identify two “new” ageing communities of note, with specific and emerging needs: Vietnam and China. Vietnamese older people are less likely to speak English well but less likely to live alone and more likely to have family support. Vietnamese consumers are also amongst the growing CALD consumer groups in renal / nephrology at RBWH in 2017. Vietnamese are the 6th highest CALD group in ED episodes of care, RBWH over the past four years.

Community	Findings	Relevance for MNHHS
<p>Pacific Islander Queensland community health (2009)</p> <p>Includes health assessments of Samoan, Cook Islanders, Tongan, Fijian, Papua New Guinean and Indian-Fijian:</p> <p>Pacific Islander and Australian South Sea Islander Needs assessment, MNHHS Public Health Unit, 2014</p>	<p>Data was for all Queensland hospital separations, 2007-08, and not disaggregated to HHS level.</p> <ul style="list-style-type: none"> • Samoan community: 1.5 times higher for total deaths and two times higher for avoidable death and for hospitalisation separation rates between seven times (diabetes complications) and two times higher for some conditions • Cook Islander: nine times higher hospitalisation separation rates for diabetes complications and 1.3 for other condition • Tongan: six times higher for diabetes complications • Fijian: two times higher for coronary heart disease and diabetes complications • Adverse social determinants of health - higher rates of interpersonal violence, social marginalisation, poverty, inadequate housing /overcrowded housing, educational barriers. • Health services found to be inaccessible to Pacific Islander communities, low health literacy and engagement in preventative health, low 'help seeking behaviours', communication barriers and socio-cultural beliefs – for example, stoicism and fatalism about health. 	<ul style="list-style-type: none"> • In 2017, patients from Polynesian region account for the second highest episodes of renal/ nephrology-coded care in MNHHS (222 episodes of care). • Fijian, Samoan, Papua New Guinean are represented in the top episodes of care and admissions by people born in mainly non-English speaking countries (2015-17) and in interpreter service requests. • PNG is a small community however accounts for the ninth highest episodes of care in Queensland Health admitted patient data, 2015-17, amongst CALD patients. Samoan is the fourth in the table of patient admitted data and Fijian is seventh. • Tongan community is the third highest consumer group in RBWH inpatients for extracorporeal dialysis. • A recent report in 2014 undertaken by the Metro North Public Health Unit examining MNHHS data confirmed the Queensland report. It focused on preventative health behaviours, and chronic disease risks in the community.
<p>The CALD Physical Activity Engagement Project</p>	<p>The project worked with a range of CALD Queensland communities to identify barriers to engagement with physical activity opportunities.</p> <p>The project demonstrated that there was significantly low health literacy in communities and increased barriers such as cost, transport, childcare and knowledge of activities and recreational opportunities. Many CALD communities preferred informal community and family-based activities.</p> <p>Muslim women had particularly low rates of physical activity participation. The transition to Australia from Africa for Sudanese community presented many difficulties in terms of change of diet and lifestyle and stress relating to mothering in a different cultural context.</p>	<ul style="list-style-type: none"> • The National Partnership Agreement on Preventative Health funded the Healthy Connections Partnership Program in Brisbane City Council to work with CALD communities to develop, fund and engage community members in the types of activities that they preferred and to overcome some of the identified barriers.

Metro North Hospital and Health Service Admitted Patient Episodes of Care

This section of the report presents data with areas of high CALD consumers and selects samples that reflect the earlier reported data and trends.

Between 2015-17, people born outside Australia in mainly non-English speaking countries accounted for 94,176 admitted patient episodes of care, or 13% of all admissions. For this calculation, those born in English-speaking countries are not included nor does it include Australian-born who may speak a first language other than English. This figure includes a small percentage of MNHHS residents who received care in other HHS but excludes those from other catchments who received in MNHHS.

It does not include Australian-born, or those born in New Zealand. As noted before, New Zealand is one of Queensland's largest sources of migrants, with 4% of the population being born in New Zealand. Twenty-one per cent (21%) of migrants from New Zealand identify as either Maori or Polynesian. The Redcliffe and Caboolture regions have the highest numbers of New Zealand born people living in the Metro North catchment area representing 44% of this population (16,908 people) compared to TPCH with 12,691people (33%) and RBWH with 8549 people (23%). The majority of people born in Samoa, within Metro North, also reside in Redcliffe Caboolture (908 people).'

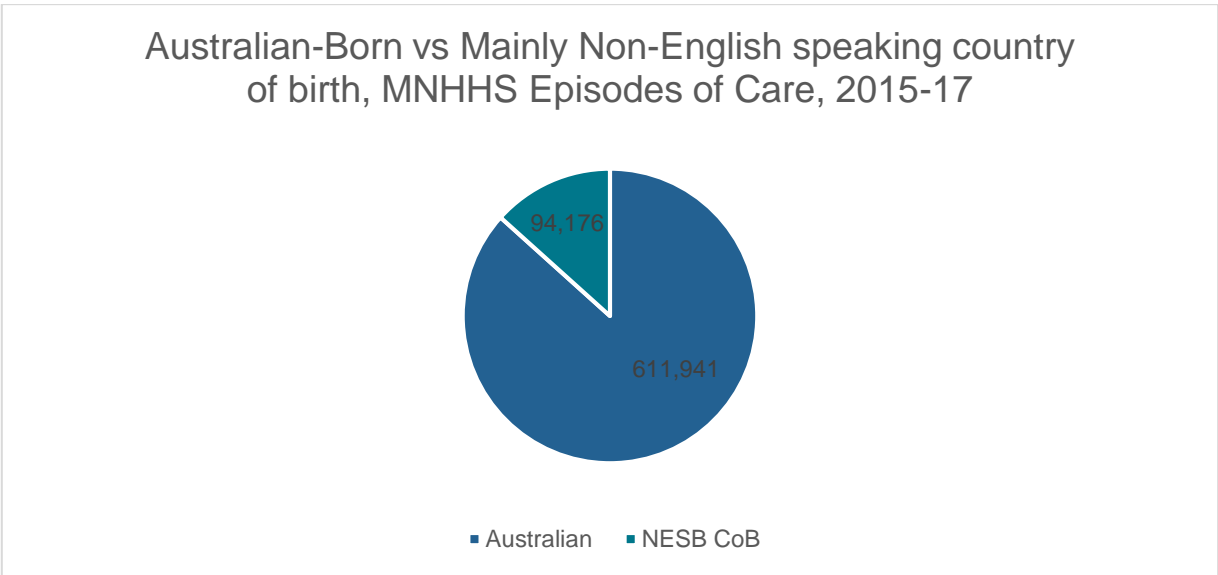


Figure 20: Australian-born vs mainly non-English speaking countries of birth MNHHS admitted patient episodes of care, 2015-17. Source: QHAPD

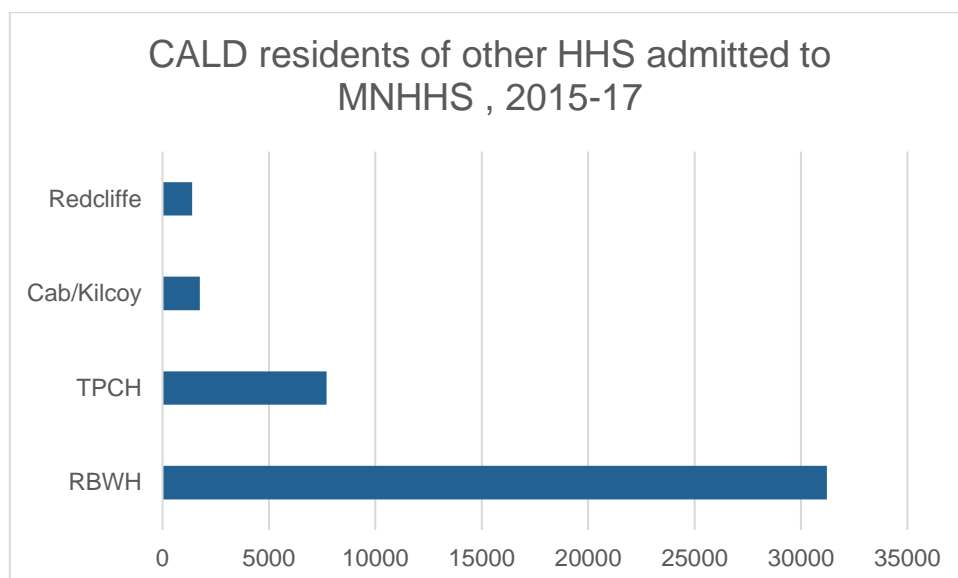


Figure 21: CALD residents of HHS admitted to MNHHS 2015-17. Source: QHAPD

Below represents a breakdown of admissions by facility for one year (2017). The Royal Brisbane Women's Hospital has the largest share, followed by the Prince Charles Hospital, Redcliffe, Caboolture and Kilcoy.

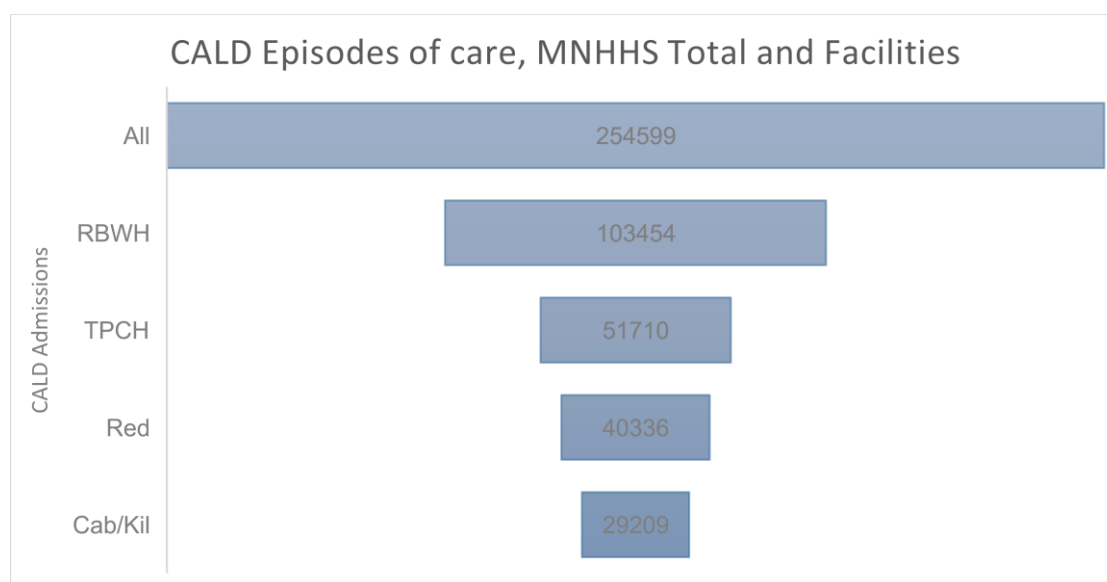


Figure 22: CALD Admission, All and by facility, 2017. Source: QHAPD

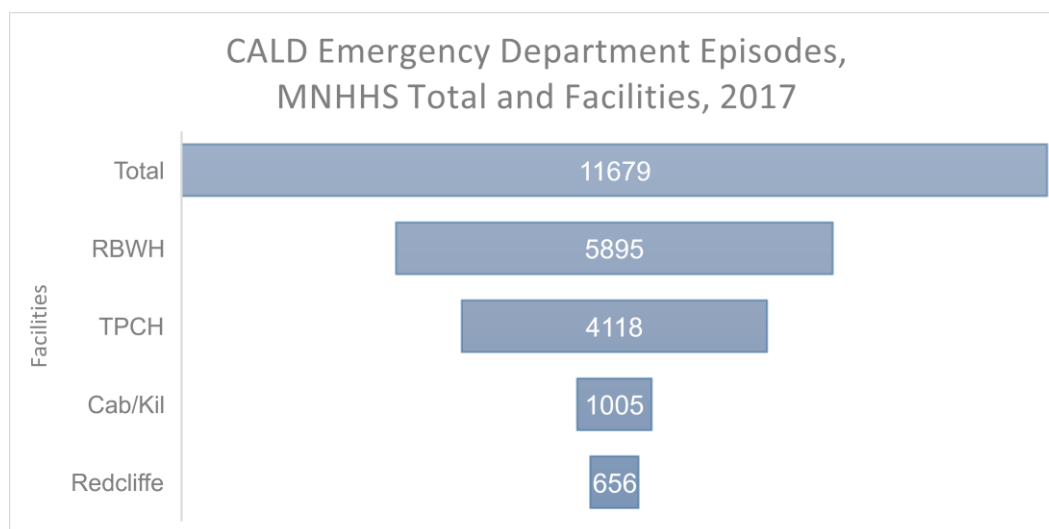


Figure 23: CALD ED Occasions of care, MNHHS Totals and by Facilities 2017. Source HBCIS

CALD admitted patient episodes

Below are the top admissions by country of birth across MNHHS. 86 mainly non-English speaking countries of birth are recorded. As noted earlier, three Pacific Islander communities, representing small communities, are reflected in the top CALD community groups as are the newest and fastest growing and communities – India and China – and the ageing CALD communities of Italy and Netherlands.

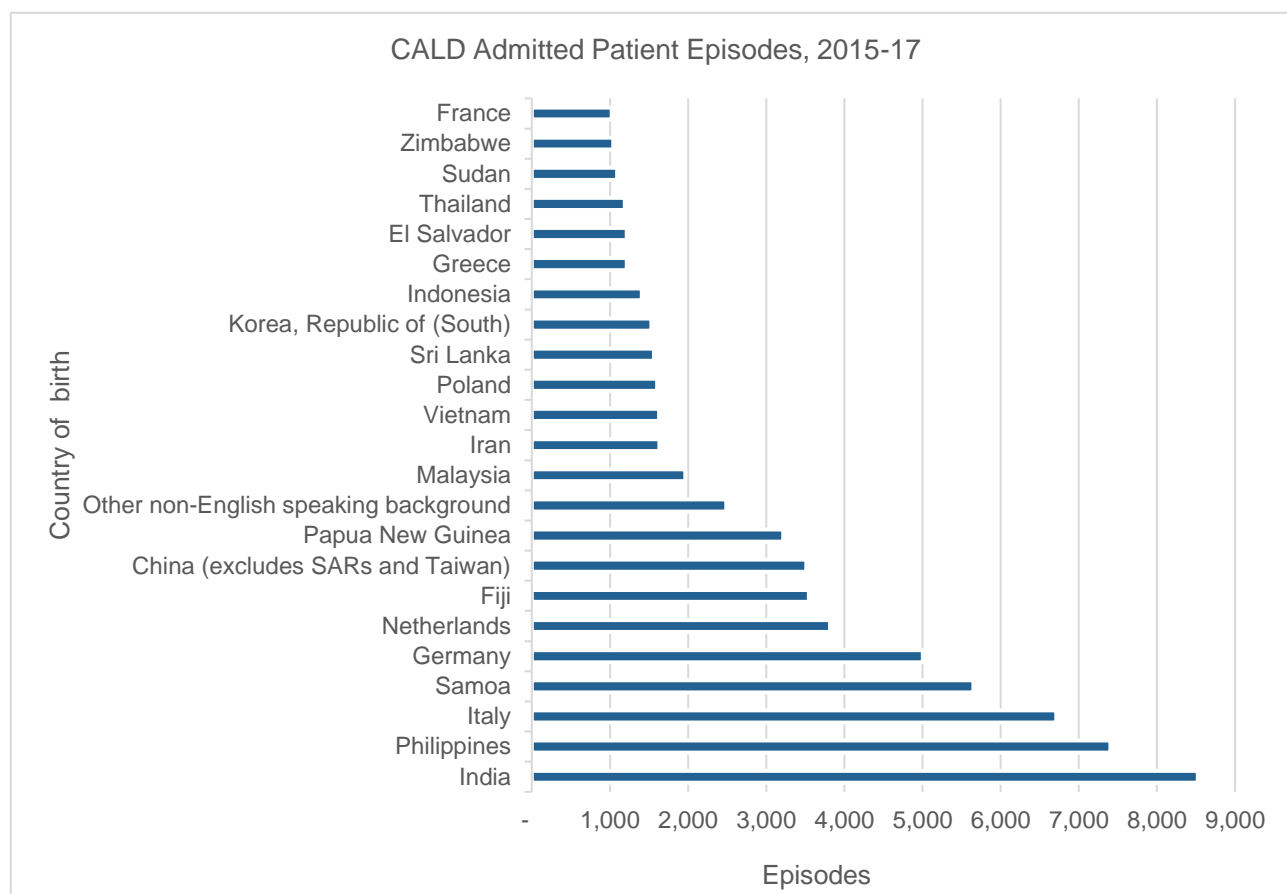


Figure 24: Overall CALD MNHHS Admissions by Country of birth, 2015-17: Source QHAPD.

Below are the top episodes of CALD care, by top languages. Examining episodes by language Spanish appears in the top groups given the number of countries of birth with Spanish. The Spanish -speaking countries of birth are diverse in MNHHS.

Total episodes by language, MNHHS, 2017

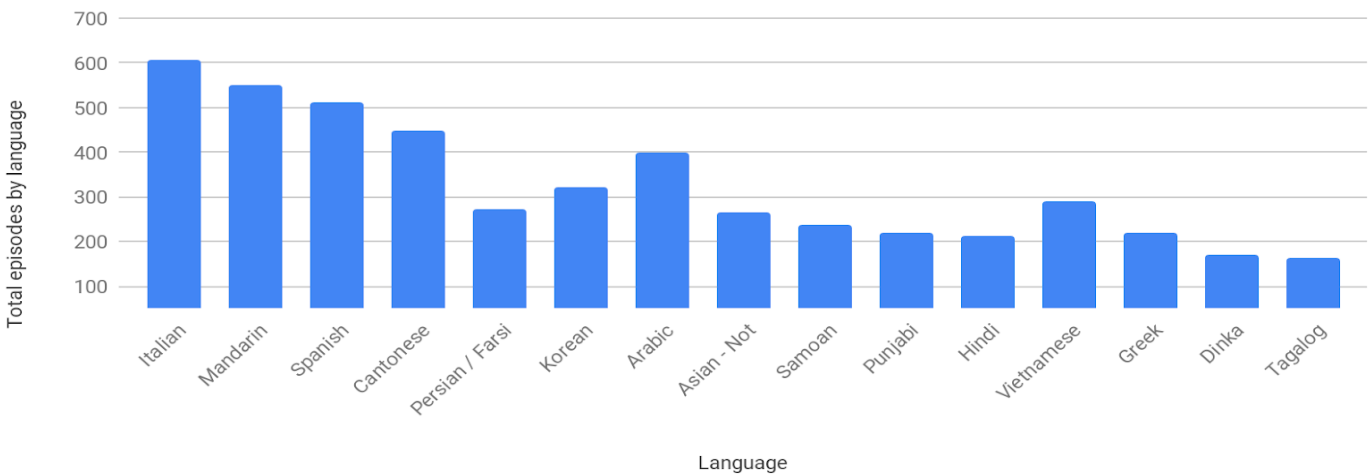


Figure 25: Episodes by language and interpreter required, MNHHS, 2017. Source: QHAPD

Interpreter Service Data

The Queensland Hospital Admitted Patient Data collection shows a relatively low number of CALD identified patients requiring interpreters with only 17% of mainly non-English speaking background patients flagged as requiring an interpreter. In 5 % of CALD admitted patients, whether an interpreter was required is reported as “unsure” or “unknown.”

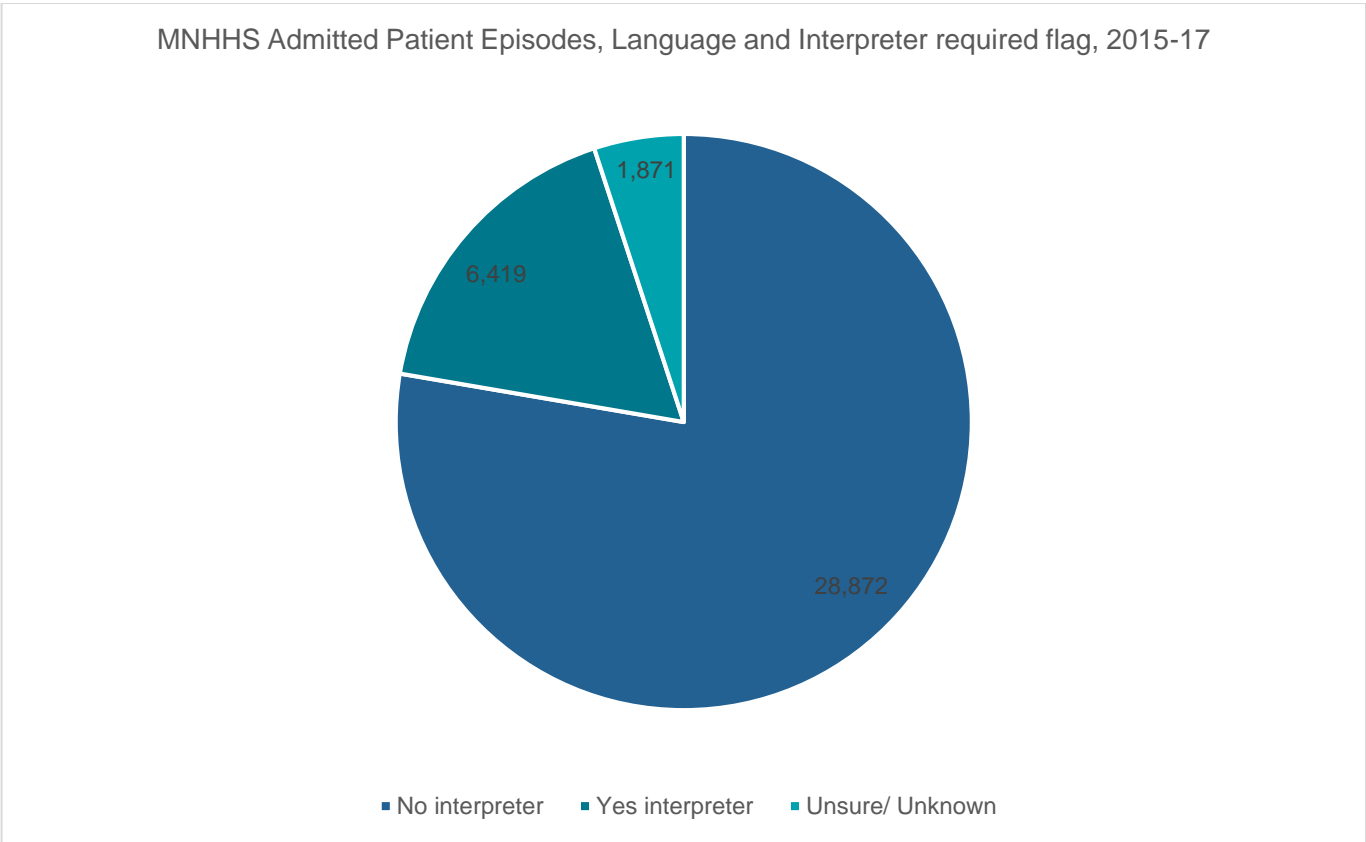


Figure 26: CALD Admitted Patients by language and interpreter flag, 2015-17. Source: QHPAD

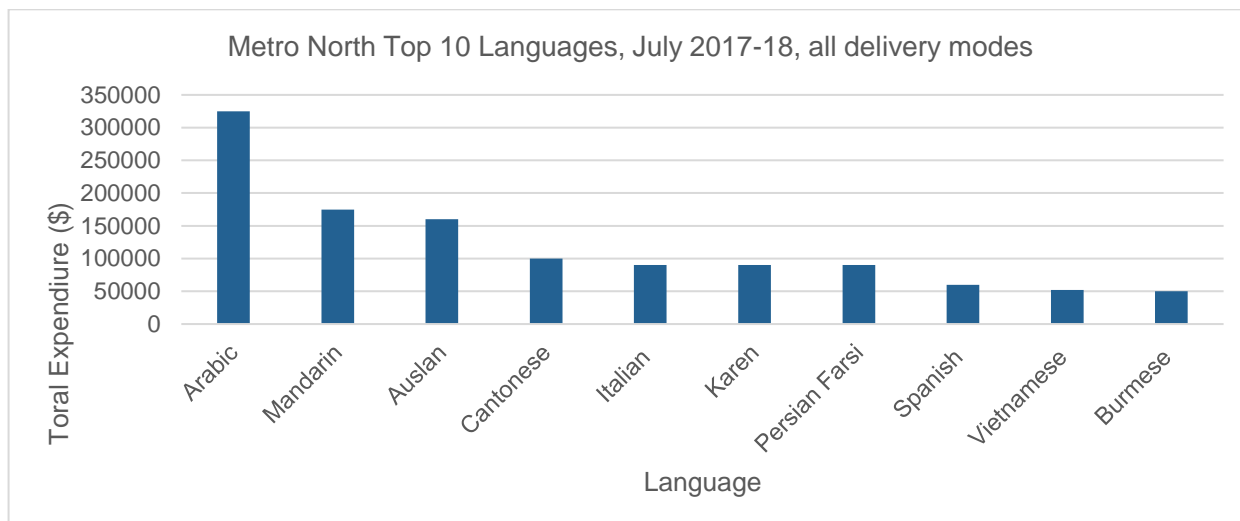


Figure 27: Interpreter Service Expenditure for the top 10 language, MNHHS, 2017-18.
Source: Metro North Interpreter Service

Interpreter Service Data

- There has been a steady increase in interpreter service usage from 2015-17. From July 2017 – June 2018 for all delivery modes in MNHHS the total spend on interpreters was \$2,313,204. Metro North Interpreter Service reports an 11% growth from 2015-16 followed by 21% increase in 2017. From January to June 2018, Metro North has used 9,300 interpreters representing a 12% growth in six months.
- Four per cent of interpreter services are cancelled annually at a cost of \$85,000 per annum. Auslan is the language with the highest cancellation. Accessibility issues have been identified for Arabic, Nepali, Thai, Vietnamese and Italian where demand for face-to-face interpreters is outstripping the number available.

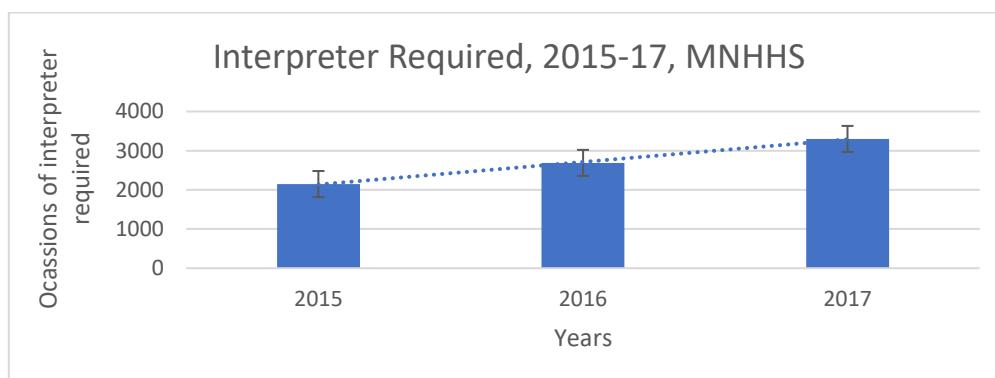


Figure 28: Interpreter demand growth, 2015-17. Source: Metro North Interpreter Service

The data below, shows the top interpreter languages required from 2015-17. The top seven languages are consistent. Demand for Vietnamese, Arabic and Dinka patients have increased the most from 2015 to 2017.

Preferred Language	Interpreter required 2015	Interpreter required 2016	Interpreter required 2017
Italian	332	405	350
Mandarin	277	372	357
Spanish	195	260	288
Cantonese	130	186	357

Persian / Farsi	146	176	163
Korean	167	226	181
Arabic Including Lebanese	92	121	245
Asian - Not Elsewhere Inc.	104	111	107
Punjabi	81	48	89
Hindi	55	61	55
Vietnamese	66	76	248
Sign Language	93	162	121
Dinka	26	120	146

Interpreter Service Demand, 2014-18, by occasions of service

The following table has extracted data in MNHHS occasion of care data, in inpatients, outpatients and emergency department. Common to all settings are Korean, Asian ("not elsewhere inc. / defined"), Dinka, Polish and Russian.

Table 4: Interpreter service by outpatient, inpatient and emergency department

Data source	Interpreter Service Demand	Country of Birth
Outpatient Occasions of Service, TPCH, Caboolture, Redcliffe and Kilcoy only (excludes RBWH)	<ol style="list-style-type: none"> 1. Asian (not elsewhere inc.) 2. Polish 3. Dinka 4. Burmese 5. Russian 6. Korean 7. Hungarian 8. Unknown/ Inadequately described 9. Fijian 10. Japanese 	<ol style="list-style-type: none"> 1. Poland 2. Australia 3. Burma 4. India 5. Sudan 6. Korea – South 7. Russia – Federation 8. Fiji 9. Hungary 10. Japan
MNHHS ED Presentations by Language (all Metro North facilities)	<ol style="list-style-type: none"> 1. Italian 2. Mandarin 3. Asian (not elsewhere defined) 4. Spanish 5. Arabic (includes Lebanese) 6. Cantonese 7. Sign Language (Auslan?) 8. Hindi 9. Korean 10. Chinese (not elsewhere defined) 	<ol style="list-style-type: none"> 1. Italy 2. Australia 3. China (excl SARS and Taiwan) 4. India 5. Korea – South 6. Burma 7. Vietnam 8. Sudan 9. Poland 10. Fiji
Inpatient	<ol style="list-style-type: none"> 1. Korean 2. Not Stated 3. Aboriginal languages 4. Asian (not elsewhere incl.) 5. Dinka 6. Polish 7. Japanese 8. Russian 9. Burmese 10. Tongan 	<ol style="list-style-type: none"> 1. Korea -South 2. Australia 3. Sudan 4. Poland 5. Burma 6. Japan 7. India 8. Not stated 9. Russian -Federation 10. Tonga

Areas of High interpreter usage MNHHS

Below represents the highest interpreter services usage by areas, across MNHHS.

Highest % Interpreter Usage 2014-17	
Clinical area	Occasions of service
Maternity (includes antenatal clinic/ Maternity outpatients, birthing and maternity ward data)	6287
Specialist outpatients	5453
Gastroenterology	2173
Emergency department	1716
Dental	1631
Cancer care/ oncology	1541
Medical imaging	1541
Gynaecology	1539
Orthopaedics	1180
Heart & Lung (TPCH only)	750
Mental health (adult)	552

In terms of community-based services, the table below shows the areas of high interpreter service use.

Highest % Interpreter Usage 2014 - 2017	
Metro North Community Service	Occasions of Service
Pine Rivers Community Health	734
Chermside Community Health Centre	434
Pine Rivers Community Mental Health	355
Nundah Community Mental Health	345
Chermside Community Mental Health	287
Biala sexual Health and AIDS Unit	275
Nundah Community Health	148
Northwest Community Health Unit	135
Brighton Community Health	96
Biala Alcohol & Drug Service	51
Malaleuca Clinic	41

Episodes of care by standard unit on admission

Below represent top CALD group by standard unit on admission. Episodes of care does not reflect individual consumers as one consumer could have multiple episodes.

In terms of admissions by standard admission unit the following are the top reasons for CALD patient admissions across MNHSS. Below represents data grouped by the top five regions of birth and top five admission areas showing the highest areas are renal/ nephrology, obstetrics and emergency department. Note that oncology medical data is from two years (2016-17) as it was not one of the higher admission areas in 2015.

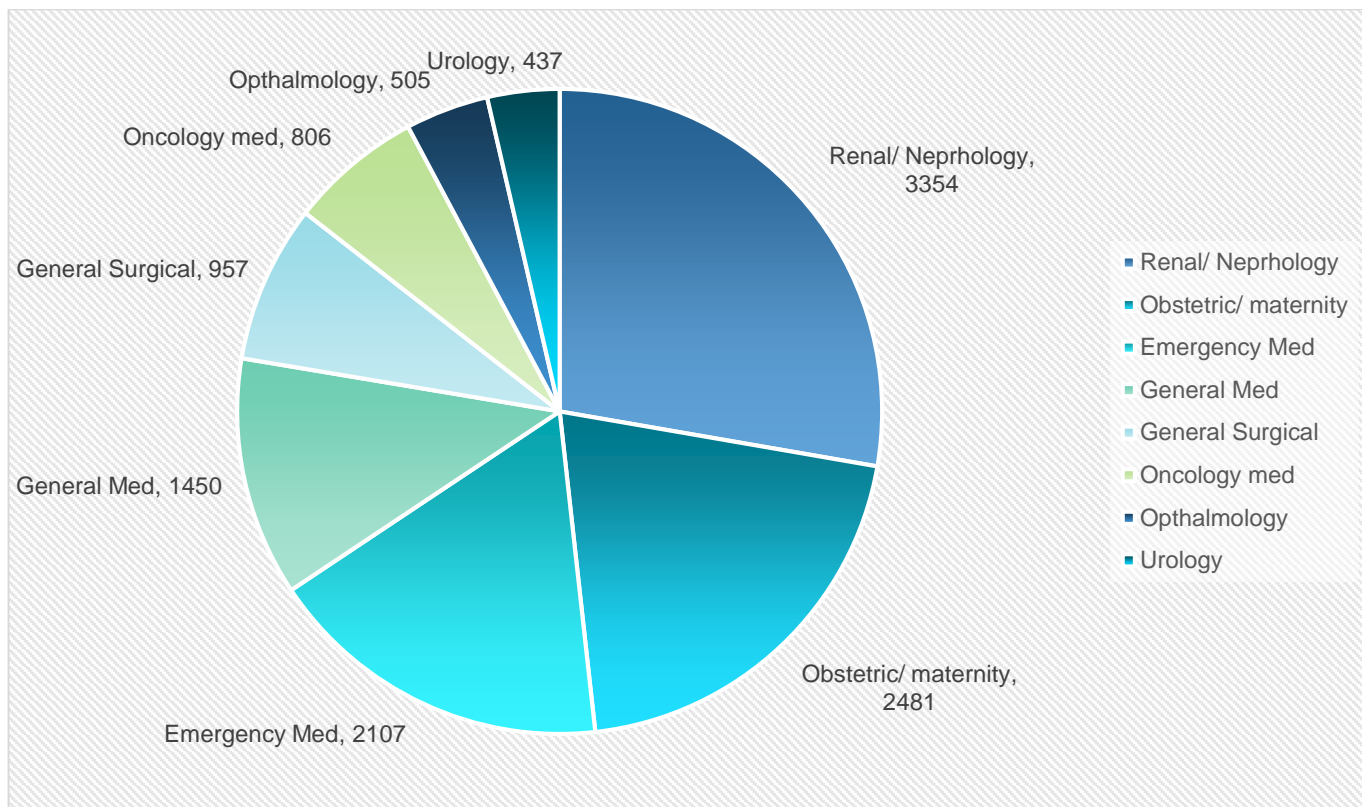


Figure 29: Highest areas of CALD patient admissions by standard admission unit and region of birth. QHAPD

When cross-referencing this data with relevant services in the top areas, the following specific CALD communities are amongst the highest CALD consumer groups.

CALD Episode of care, Renal/ Nephrology, RBWH, 2015-17

- People born in China account for 21% of all admissions for renal / nephrology at RBWH, 2015-17 with Chinese born consumers tripling the number of episodes of care from 2015 to 2017.
- The Samoan, Korean, El Salvadorian and Sudanese communities are relatively small communities with high admission rates in this area.
- The Italian community is an ageing population. Detailed analysis of the Italian community in 2010 showed standardised separation for diabetes related complications was 64% higher across all Queensland hospitals.

- As noted, the need analysis of Pacific Islander communities undertaken in 2010 found Samoans were 1.5 times higher for total deaths and two times higher for avoidable death and for hospitalisation separation rates between seven times (diabetes complications).

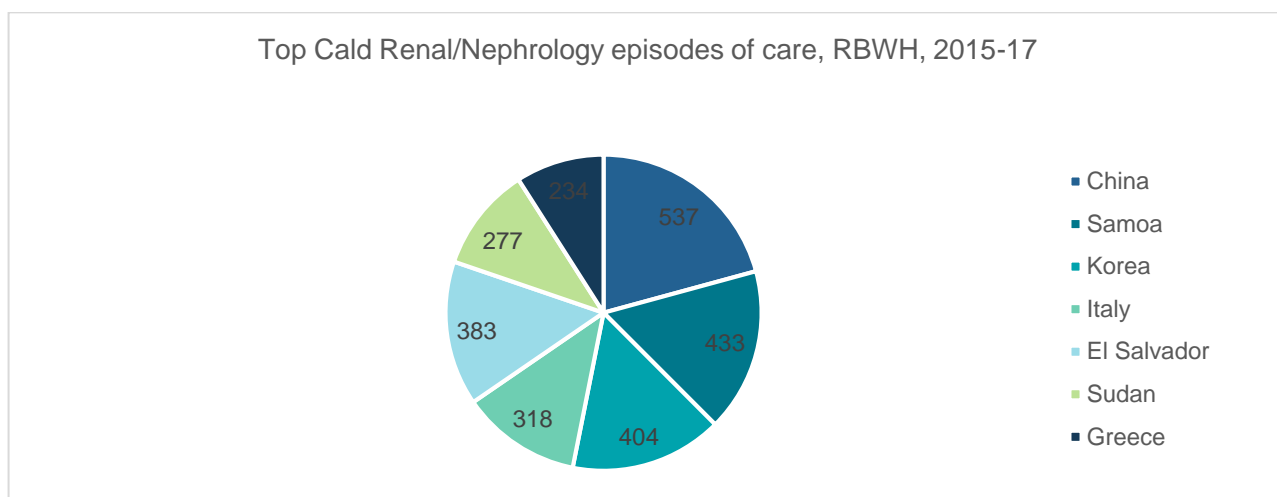


Figure 30: CALD Episodes of Renal/ Nephrology, RBWH, 2015-17. Source: QHAPD

Below shows the CALD consumers, by country of birth, that are on the increase since 2015. The Chinese community is showing a steady pattern of growth. The Vietnamese community has significant age diversity but there is an increasingly ageing Vietnamese community.

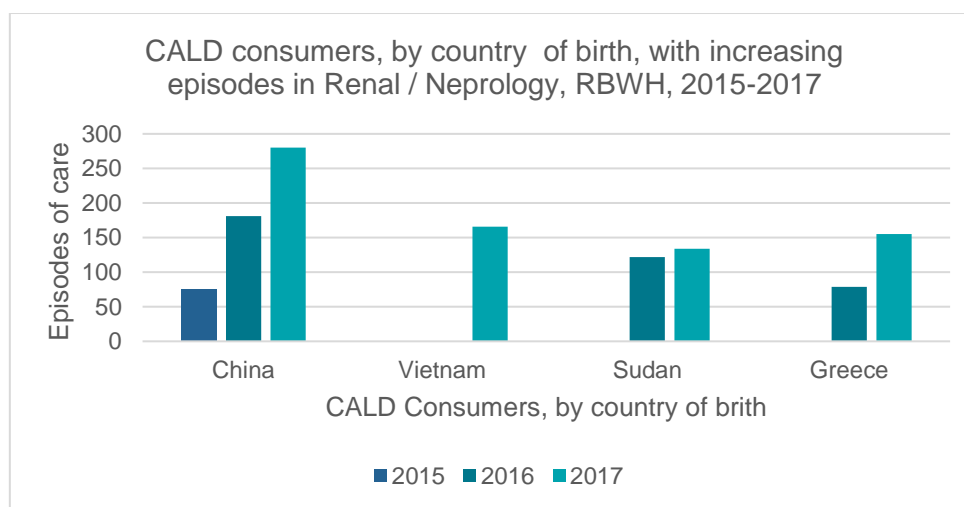


Figure 31: Growing CALD consumer episodes of care, Renal/ Nephrology, RBWH, 2015-17: Source QHAPD

In examining inpatient data at the Royal Brisbane Women's Hospital, there are 5,336 CALD inpatient occasions of service with the highest concentrated in "extracorporeal dialysis" (1585) by diagnosis. Amongst these occasions of care and removing Torres Strait Islanders included in the inpatient data reporting, the top CALD groups by language grouping are Korean, Dinkan and Tongan. Of all CALD consumers (and excluding Torres Strait Islanders, the highest community), Korean account for 65% of these inpatient occasions of care, Dinka account for 24.8% and Tongan 0.8%.

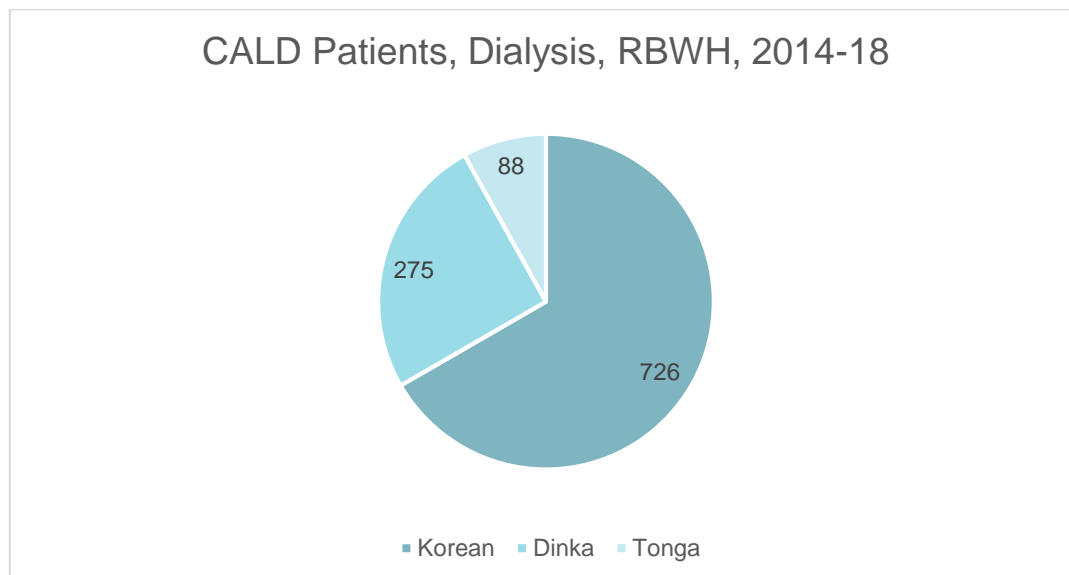


Figure 32: Occasion of care, by admission diagnosis and country of birth, RBWH 2015-17. Source: QHPAD

Obstetric Episodes of Care

The Indian born consumers represent by far the largest community in obstetrics at RBWH 2015-17. There are refugee origin communities represented in this area: Iran, Myanmar, Bangladesh, Nepal and Sudan. Below represents the highest number but there is significant diversity with around 54 different countries of birth in this category of admission for Metro North, in any year.

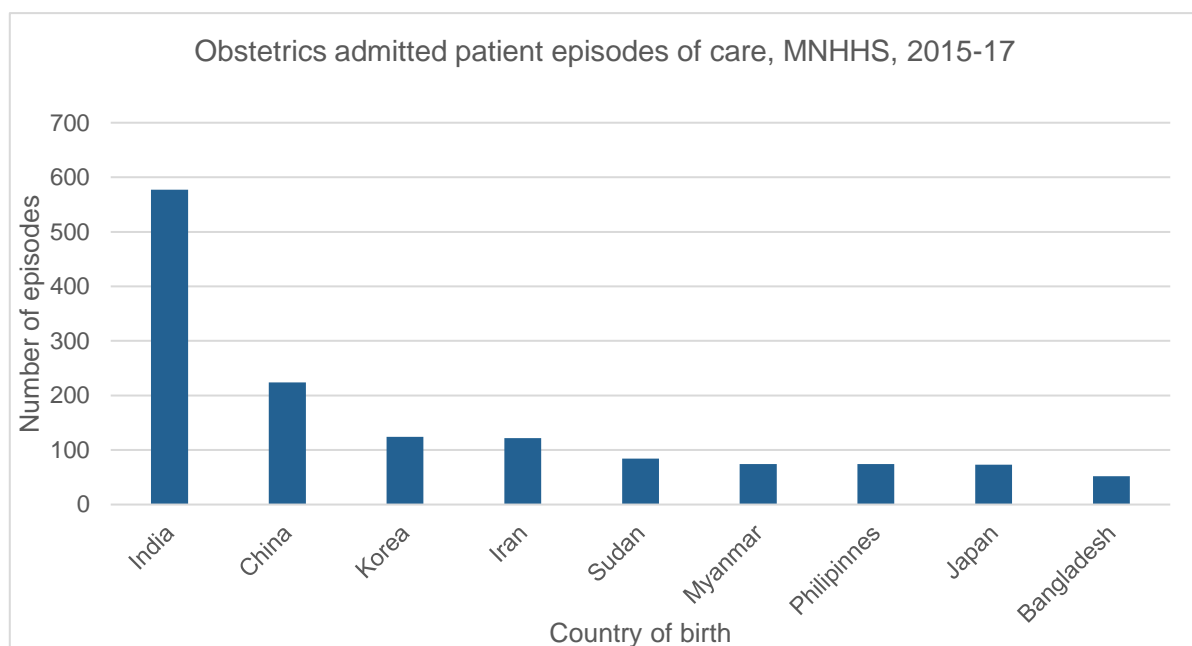


Figure 33: Top CALD Obstetric episode of care, RBWH, 2015-17. Source: QHPAD

Episodes of Emergency Department care

Below reflect the emergency episodes of care by language.

The Italian community represents the highest CALD consumer group in Emergency Department presentations across MNHHS. Note that this only includes top CALD communities, not all.

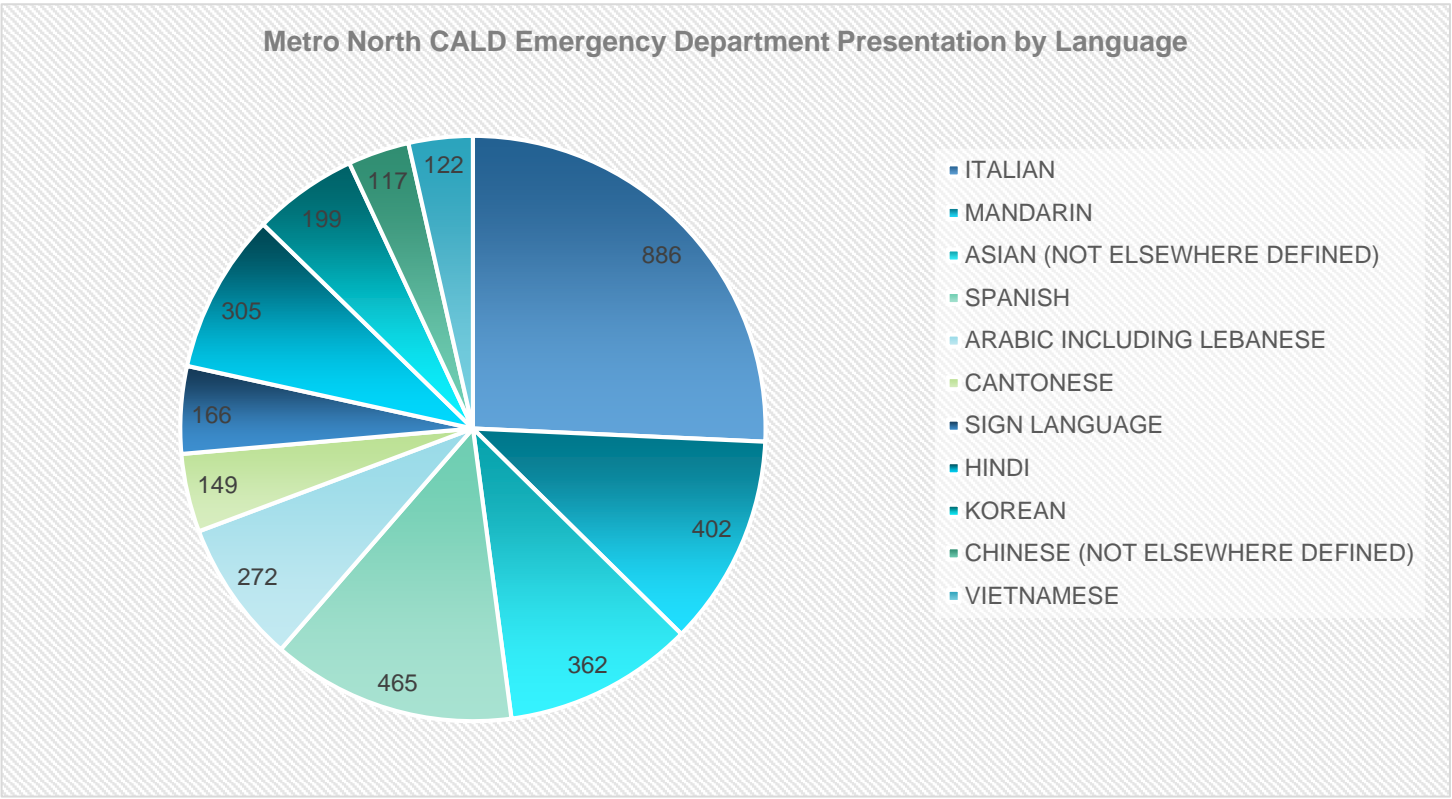


Figure 34: MNHHS Emergency Department by language, 2014-18. Source: HBCIS.

Cardiology episodes of care

Below represents cardiology episode of care at the Prince Charles Hospital and Royal Brisbane Women’s Hospital.

The numbers are smaller and presented as percentages only.

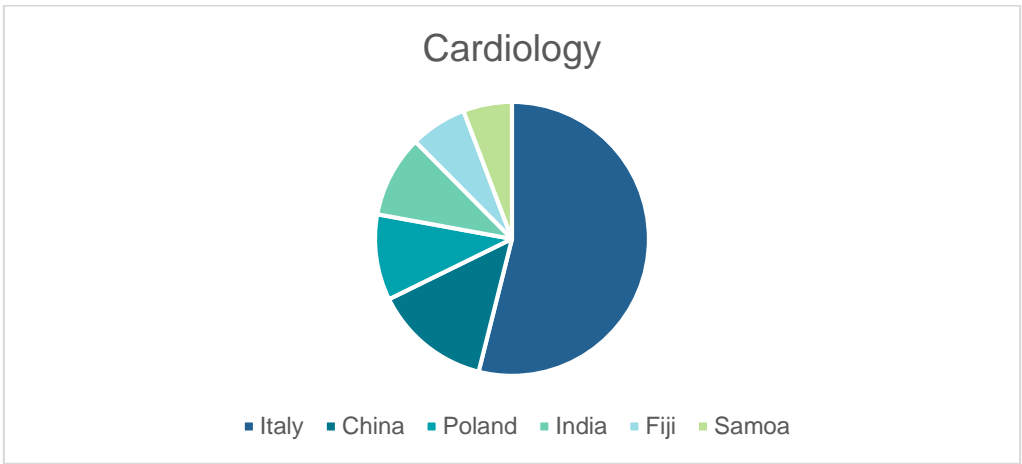


Figure 35: Cardiology episodes of care, TPCH and RBWH, 2015-17. Source: QHAPD.

Haematology episodes of care

There are a number of older European countries represented in haematology in Metro North. The four nations pictured below are the highest with even numbers for each Below represents the highest CALD consumers in Haematology.

The Syrian community is a recent refugee community. There is little information on the health needs of this community. Given the small numbers the data is presented in percentages.

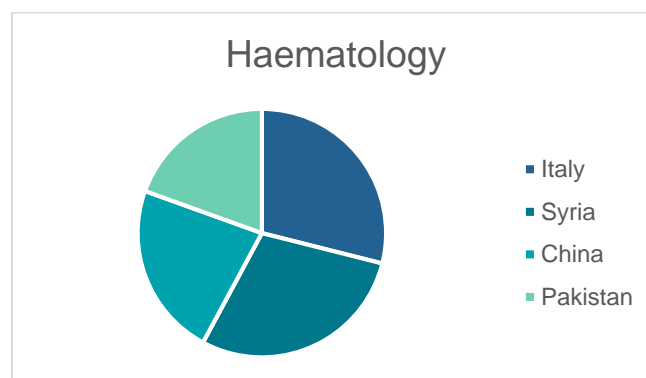


Figure 36: Haematology care, MNHHS, 2015-17. Source: QHAPD.

Summary of CALD consumer patterns: what does the data tell us?

Italian

- High CALD community / consumer group in multiple areas: general medicine, emergency medicine, renal/nephrology, cardiology and haematology,
- Oldest community in MNHHS with aged care / carer needs.

Indian

- High numbers of episodes of care overall and in maternity, general and emergency.
- Cardiology may be an area of concern.
- Low interpreter demand for highest CALD episodes could suggest higher levels of English proficiency.

Pacific Islander communities

- Fiji, Samoan, PNG and Tongan communities overrepresented in cardiology, renal/ nephrology
- Overrepresented in overall episodes of care in MNHHS, 2015-17.

Chinese

- 3rd highest in MNHHS ED presentation and is amongst the highest CALD community admitted in clinical areas of
 - cardiology
 - renal / nephrology
 - obstetric / maternity
 - emergency medicine
 - hematology
 - oncology (medical)
 - general surgical
 - ophthalmology
 - 'other'.

Sudanese

- Sudanese women in maternity / obstetrics across RBWH, Caboolture and Redcliffe.
- Overrepresented in renal / nephrology and diabetes (dialysis)
- Growth in interpreter demand for Dinka in MNHHS 2015-17.

Korean (South)

- Overrepresented in renal / nephrology / diabetes
- Represented across inpatients, outpatients and emergency.

Philippines

- Second highest episodes of care in MNHHS patient admitted data from 2015-17, overall.
- Represented in diverse areas from cardiology to maternity but not disproportionately or in the highest consumer group.

Refugee background communities are also evident in many interpreter services and occasion of care:

- Karen language (Rohingya)
- Myanmar
- Burmese
- Arabic (representing a number of countries of origin such as Syria, Iran, Sudan)
- Persian / Farsi

Discussion

From this analysis of data, while limited, a picture of CALD community needs in MNHHS is emerging and requires consideration of tailored responses and community engagement focused on the following communities and issues:

- Pacific Islander community needs are evident and require continued and urgent action. Partnerships with Metro South and Children's Health where considerable focus and resources have been invested and can be readily replicable in MNHHS should form part of MNHHS's response along with dedicated resources and strategies for MNHHS.
- Older Italian community and new ageing communities from China and Vietnam have a range of support needs, as they age, to keep healthy at home.
- Newer communities with high use of services include Chinese, Korean, Filipino and Indian. While many of these communities may be skilled and student migrant populations, there is also considerable differences within the community and assumptions of good health cannot be made. The Korean and Chinese communities were found to be highly represented in areas such as cardiology and renal/ nephrology.
- Refugee communities particularly Iran, Iraq, Syrian, Myanmar and African communities – Sudanese, Ethiopian, Congolese – require further understanding and dedicated resources. It appears that some of the communities have chronic disease risk profiles and are presenting with greater acuity in areas such as dialysis.
- Community health promotion and education should be tailored to some of the high CALD consumer groups in clinical areas that suggest the need for improved chronic disease risk management. Existing programs such as Multicultural health chronic disease programs (for example ECCQ's *My Health4Life*) delivers community programs to Vietnamese, Arabic, Chinese and Pacific Islander communities, focusing on adults assessed as being at high risk of developing type 2 diabetes or cardiovascular disease (heart disease and stroke).
- The community and school-based Good Start Program focuses on Pacific Islander and Maori children.
- System navigation is critical for these communities as part of their overall settlement and orientation to the community and to different health and community services and systems available. The Syrian community is the fastest growing in Brisbane North and dedicated engagement should occur in partnership with Multicultural Development Australia, Refugee Health Network QLD and QPASTT. Two most recent cases referred to MNHHS's Cultural Diversity Coordinator involved Syrians. In one case, a pregnant woman with her husband left hospital (against medical advice) without understanding what they were consenting to. In the second case, a woman newly diagnosed with cancer did not understand what it meant.
- Mental health of young CALD people requires similar focus, understanding, and engagement with dedicated refugee mental health programs, and investigation of peer models.
- At an organisational level, there is a need to strengthen the visibility and sharing of initiatives, needs identified and engagement already underway. A range of MNHHS multicultural health activities have been identified:
 - CALD needs identification projects have been undertaken for mental health, Pacific Islander and Australian South Sea Islander communities with limited shared understanding of the themes and issues, follow-up and response implemented.
 - Some translated resources online but these are not consolidated in one location but rather scattered across multiple MNHHS websites with no clear sight on the use and uptake of these resources.
 - Interpreter service data and reports while comprehensive clearly articulate areas for quality improvement and identification of underservice for some CALD consumers where the pool of interpreters is low.
 - A CALD Breast Screening resource was developed through LINK funding and needs further translation in the community.
 - Redcliffe Hospital has begun work with the Pacific Islander community to develop dedicated culturally-appropriate strategies.
- The lack of understanding of initiatives, their sustainability, outcomes and diffusion, is an indication of the need to build MNHHS' cultural competency at an organisational level.

Next steps

Frameworks for understanding CALD community needs have been embedded in health organisations with large or growing CALD communities, with a focus on health equity and rights. This enables a focus on the interrelated historical, personal, economic, social and cultural factors of health and experiences related to migration, asylum-seeking, settlement, and acculturation with the understanding of the diversity within communities as well as the shared humanity across all communities. Such frameworks support organisations to develop sensitivity and the ability to rapidly respond to emerging and variable needs within and across communities, sensitive to those most vulnerable and at-risk.

Framing health within a rights and inequities framework is important to this flexible approach. The World Health Organisation provides the following distinction:

“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. ‘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.”

Globally, health rights and health equity-based approaches have been established in health organisations. Metro South’s Health Equity and Access Unit is an example in Queensland and operates by working to address factors that affect vulnerable populations and harnessing the collective effort and understanding of teams and communities working with homeless, Aboriginal and Torres Strait Islander, culturally and linguistically diverse and people with disabilities.

These dedicated teams are important to drive and coordinate action, but it is a shared responsibility that needs to be owned across MNHHS in all Directorates and clinical and non-clinical areas. Queensland Health developed an evidence-based organisational cultural competency framework to guide HHS, focused on eight outcome areas, to guide the assessment and strategic planning of a multicultural health agenda for MNHHS. This framework is focused on building capacity.¹⁵

An outcome of the adaptation of this framework is the co-design and delivery of tailored models of care and services for CALD consumers and communities. Working across community health and social sectors and with consumers is critical to achieving this outcome.

Queensland Health Organisational Cultural Competency Framework

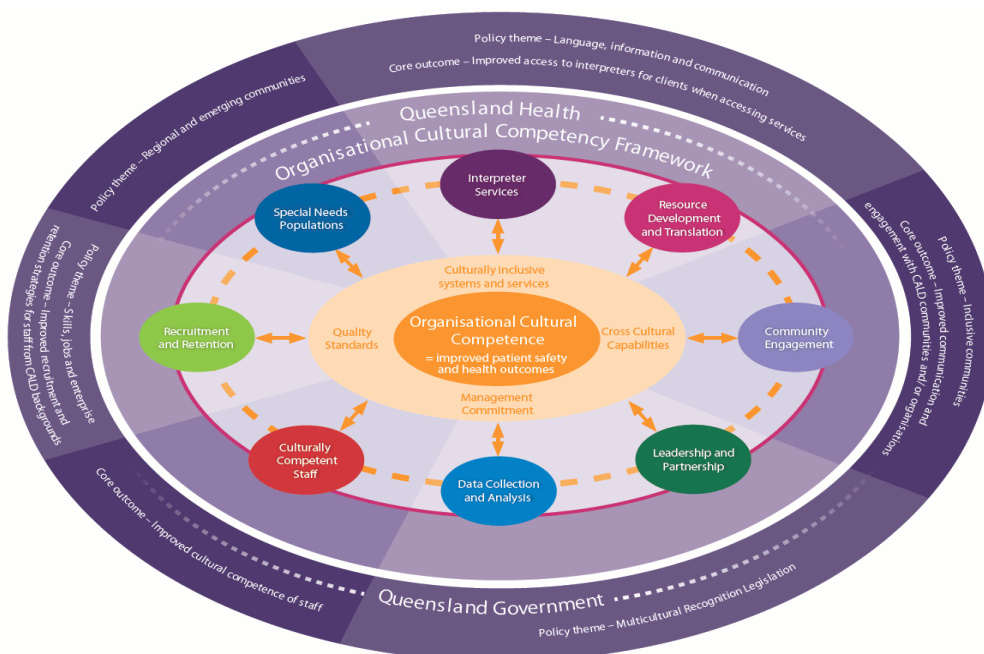


Figure 37: Queensland Health Organisational Cultural Competency Framework

¹⁵ An organisational cultural competency framework relevant to mental health services has been adapted for Metro North Mental Health.

The Queensland Health Organisational Cultural Competency Framework eight action areas



Central to all these areas and a resulting outcome is the co-design and delivery of models of care and services, relevant to local CALD community needs.

