phn
EASTERN MELBOURNE

An Australian Government Initiative

Health Needs Assessment: Multicultural communities

DECEMBER 2024

Acknowledgement

Eastern Melbourne PHN acknowledges the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present. EMPHN is committed to the healing of Country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.

Contributors

We acknowledge the generous and invaluable sharing of knowledge from a diverse group of community organisations and healthcare professionals across the Eastern Melbourne catchment. We acknowledge your tireless efforts to meet the needs of consumers and patients, and thank you for giving your time to assist with this health needs assessment.

We also acknowledge the generous sharing of knowledge of those with lived experience, whom for privacy reasons cannot be named in this report. Your knowledge, experiences and voices have shaped this health needs assessment.

Stakeholder consultation

1. Australian Multicultural Community Services
2. CHAOS Network
3. Croydon Baptist Church
4. DPV Health
5. Eastern Community Legal Centre
6. Eastern Health Multicultural Services
7. Eastern Melbourne PHN
8. Ethnic Communities' Council of Victoria
9. Migrant Information Centre
10. Multicultural Centre for Women's Health
11. Whittlesea Community Connections

Number of community members consulted

23 service provider representatives

156 people in workshops and at site visits

50 survey responses

Contents

About us

The Eastern Melbourne Primary Health Network (EMPHN) is one of 31 PHNs funded by the Australian Government to improve the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.

PHNs also work towards improving local care coordination to ensure people receive the right care, in the right place, at the right time.

Each PHN regularly undertakes regional health needs assessments, to identify and understand the evolving health challenges and priorities within their community. This involves gathering quantitative and qualitative data to analyse the population's characteristics, their health experiences, and the availability and accessibility of healthcare services. The findings are then synthesised and prioritised to inform local health planning and decision-making.

This HNA assists the EMPHN to better understand the health needs of people from multicultural communities across the eastern Melbourne region.

It draws on the rich expertise of community organisations, healthcare professionals, peak bodies and other specialist services across the catchment, along with the important voices and knowledge of those with lived experience.

The insights gathered through community consultations highlight the importance of building an inclusive healthcare system that not only improves service navigation and language access but also fosters trust and empathy. By listening to and respecting the unique needs of multicultural communities, we can create a healthcare system that truly supports everyone, ensuring that all individuals feel seen, heard, and cared for, regardless of their background.

Introduction

People from diverse cultural backgrounds can face complex barriers preventing access to necessary healthcare. At the heart of these challenges is the need for a healthcare system that not only provides medical treatment but also fosters a sense of belonging, trust, and cultural understanding.

Throughout the consultation phase of this Health Needs Assessment, we heard from many people from diverse cultural backgrounds across the Eastern Melbourne region who shared difficult experiences navigating the Australian healthcare system.

But we also heard of the many positive experiences, most of which were community-led.

Community leaders told us of the specific and nuanced challenges faced by the people they represented. They understood specific issues and nuances in their communities and in many cases, had been effectively advocating or acting for change for many years.

Yet, they spoke of there being much work to do – 'there is always more'.

Elders spoke of their concern for ageing populations who rely on carers they cannot communicate with in their language. Of newly arrived community members navigating a system that still, after decades, is hard to understand. They spoke of their concern for young people and their mental health.

Community organisations shared their rich knowledge of the diverse needs of the many multicultural communities across the Eastern Melbourne region. They gave their time without hesitation, hopeful we could work together to deliver better health outcomes for people they work with, day in and day out.

Health professionals spoke of a system under pressure, yet had a willingness to work collaboratively towards a better way.

The insights from this assessment make it clear; healthcare is not just about treating illness. It's about listening, respecting, and understanding. It's about building a system that makes every person feel seen, heard, and cared for, regardless of their background.

There are opportunities to enhance the region's healthcare system so that it's truly inclusive – where commissioners, funders, services and clinicians actively work to reduce or remove language and cultural barriers, ensure care is affordable and accessible, and place empathy and respect at the system's core.

A snapshot of the EMPHN community

EMPHN is home to **1.6 million residents**.

More than **10,000 First Nations Peoples** live in the region.

The **population is growing rapidly**, particularly in the northern Whittlesea and Mitchell LGAs.

Murrindindi and Boroondara have the highest proportions of people who **live alone**, and across the catchment **8 percent** of people **live alone**.

Relatively **greater disadvantage** is found in Whittlesea, Murrindindi and Mitchell.

33% of EMPHN residents born overseas

Sources: Australian Bureau of Statistics (ABS) – data by region. 2021 census https://dbr.abs.gov.au

Where we work

We work across all or part of the 12 local government areas (LGAs) below.

These LGAs are entirely within EMPHN's catchment:

- City of Banyule
- City of Knox
- City of Monash
- Shire of Nillumbik
- City of Whittlesea
- City of Boroondara
- City of Manningham
- City of Maroondah
- City of Whitehorse

EMPHN's catchment also covers part of:

- Shire of Mitchell (35% of population)
- Shire of Murrindindi (27% of population)
- Shire of Yarra Ranges (portion which falls outside the EMPHN catchment is largely uninhabited national park)

Methodology

We honoured the voices of those with lived experience throughout this Health Needs Assessment.

Extensive stakeholder and community engagement was complemented by data analysis on the regional population and its health service use. This captured the complexity of health needs for multicultural communities and ensured a broad perspective was taken.

A review of relevant local, state and national literature.

Data analysis and interpretation of all available local, state and national data – including but not limited to ABS Census and Longitudinal data and the Australian Institute of Health and Welfare.

Significant stakeholder engagement with service providers, community organisations and health care professionals.

Extensive consultation with people from diverse cultural backgrounds.

Community surveys – translated where required to ensure respondents could participate in language.

Service mapping.

Literature review

The aim of the literature review was to explore and summarise relevant published information and data relating to the health needs of people from multicultural communities across Australia and Melbourne.

We looked at:

- Current government policies in Victoria and Australia.
- Missing information and data.
- How people access healthcare and what makes it difficult.
- Ways to make primary care (like GP visits) more culturally safe and accessible, especially for better health outcomes.

The Australian Institute of Health and Welfare (Chronic health conditions among culturally and linguistically diverse Australians, 2021, Background — Australian Institute of Health and Welfare (aihw.gov.au)
cautions that:

- The health of multicultural communities is a highly complex product of many factors (environmental, economic, genetic and socio-cultural) both from their home country and Australia, as well as their migration experience, and that this cannot be captured consistently in data.
- There is no universally agreed definition of what it means to be from a multicultural background and therefore identifying and reporting is inconsistent.

Nevertheless, there is substantial evidence that people from diverse cultural backgrounds may face greater challenges when seeking to access the health and welfare system including language barriers, lower health literacy, discrimination/racism, and difficulty navigating an unfamiliar services system. These challenges can lead to poorer health outcomes.

Literature review findings

Many people require an interpreter

Chinese (Mandarin, Cantonese) and Greek speakers most often require an interpreter (70%) at hospital emergency departments (EDs).

Similar for admissions, including 75–80% of Arabic speakers who are admitted. Three quarters (75%–80%) of Arabic speakers required interpreted at hospital admission.

Many culturally diverse consumers are unaware of the role and importance of accredited interpreters in health services.

They often prefer family members to interpret and are unaware of the risks such as misinterpreting of medical information.

Diminishing healthy migrant effect

Newly arrived migrants tend to have better health status than Australian-born populations due to health checks and services during the migration process.

This health can diminish over time due to a range of issues including service cost, lack of awareness of services, mistrust of services e. g. lack of cultural competence and experiences of discrimination, language barriers, low uptake of screening and preventative healthcare, the stress of living in a new country, trauma exposure before migration, and limited ability to use occupational skills in their new country of residence.

Dementia, heart disease, diabetes and kidney disease become more prevalent over time after migration.

People born in European countries are at higher risk of chronic conditions and have higher associated mortality rates.

Mental health and trauma-informed care

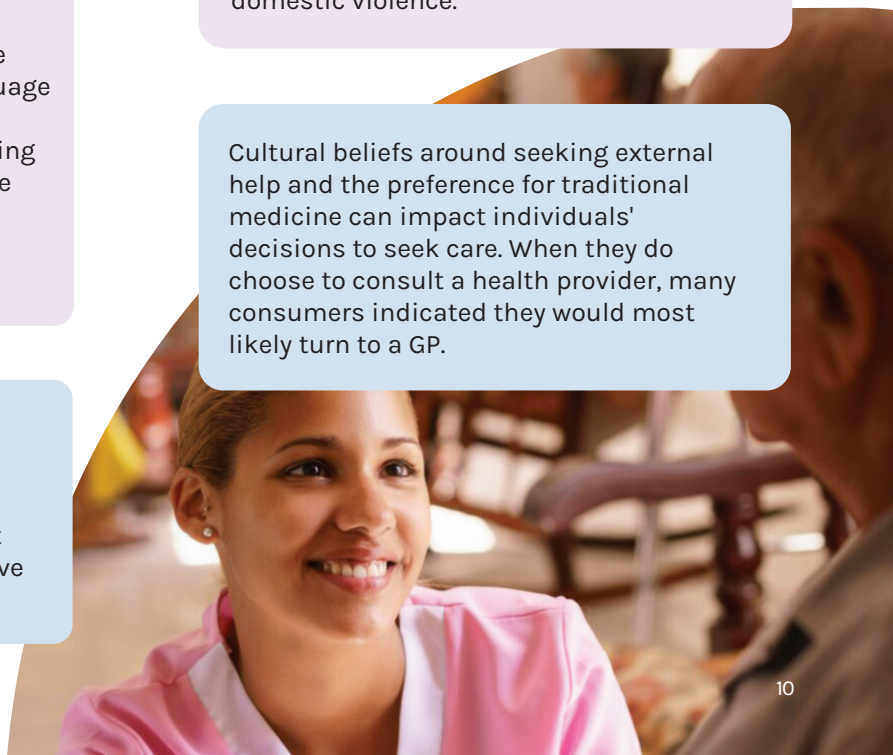
Mental illness is common, particularly among refugees and asylum seekers. Seeking assistance for mental illness is less common than in non-multicultural communities.

Culturally safe, trauma-informed care is an essential skill for health providers when working with migrants. Trauma occurs pre-settlement (e.g. war, displacement) and post-settlement (e.g. family violence) and can have profound impacts on both mental health and physical health (e.g. chronic pain).

Cultural norms and cultural safety

In some cultures there are powerful disincentives to engage the health system due to shame and stigma associated with health status including (but not limited to) mental health, sexual health, women's health, and domestic violence.

Cultural beliefs around seeking external help and the preference for traditional medicine can impact individuals' decisions to seek care. When they do choose to consult a health provider, many consumers indicated they would most likely turn to a GP.



Multiculturalism across the Eastern Melbourne region

Our diverse communities

Summary:

- People from multicultural communities have lower median incomes compared with the non-multicultural community (median incomes of $725 and $900 per week, respectively).
- Multicultural communities represent a high proportion of the population in the northern growth corridor (Thomastown, South Morang, Wollert) and established east (Box Hill to Oakleigh).
- Arthritis (6%), asthma (5%) and diabetes (5%) are the most common long-term health conditions among multicultural communities. Notably, diabetes is significantly more common within multicultural communities within EMPHN.

Top 5 countries of birth (other than Australia)

1. **Chinese Asia (Includes Mongolia)** 113,220

2. **Southern Asia** 88,636

3. **Maritime South-East Asia** 54,917

4. **United Kingdom, Channel Islands and Isle of Man** 47,847

5. **South Eastern Europe** 34,512

Top 5 languages spoken at home (other than English)

1. **Chinese*** 11.7%

2. **Indo-Aryan*** 4.9%

3. **Greek** 2.6%

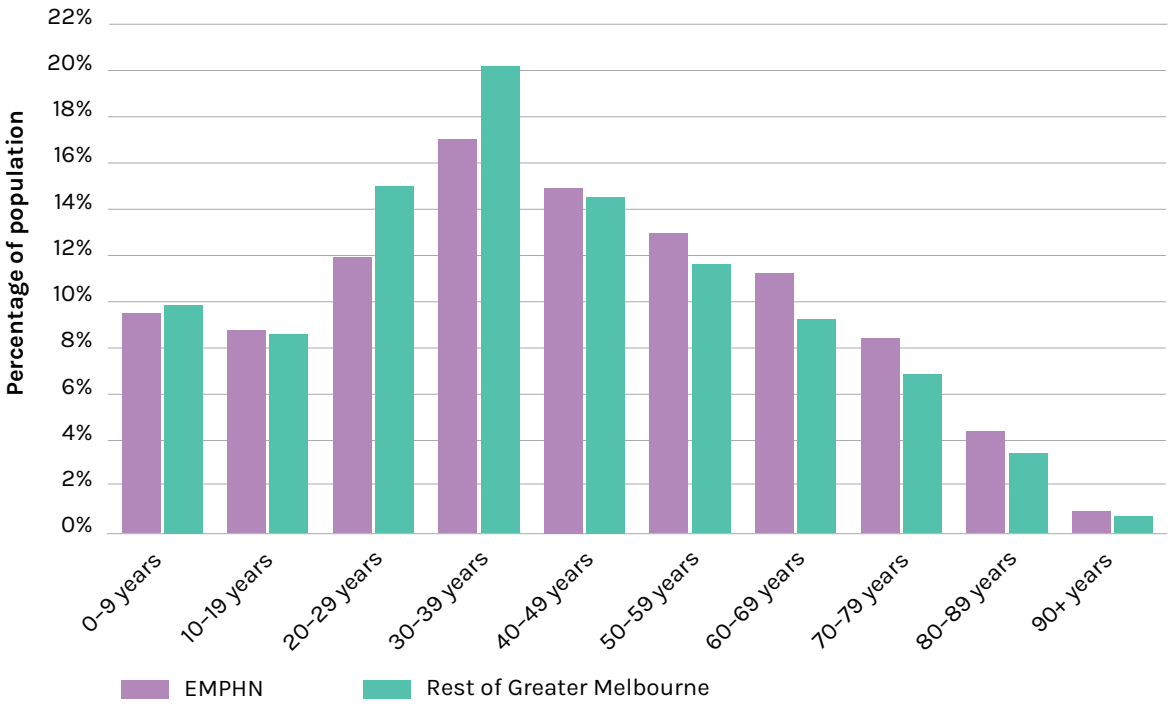
4. **Italian** 1.8%

5. **Dravidian*** 1.5%

*** Languages included:**

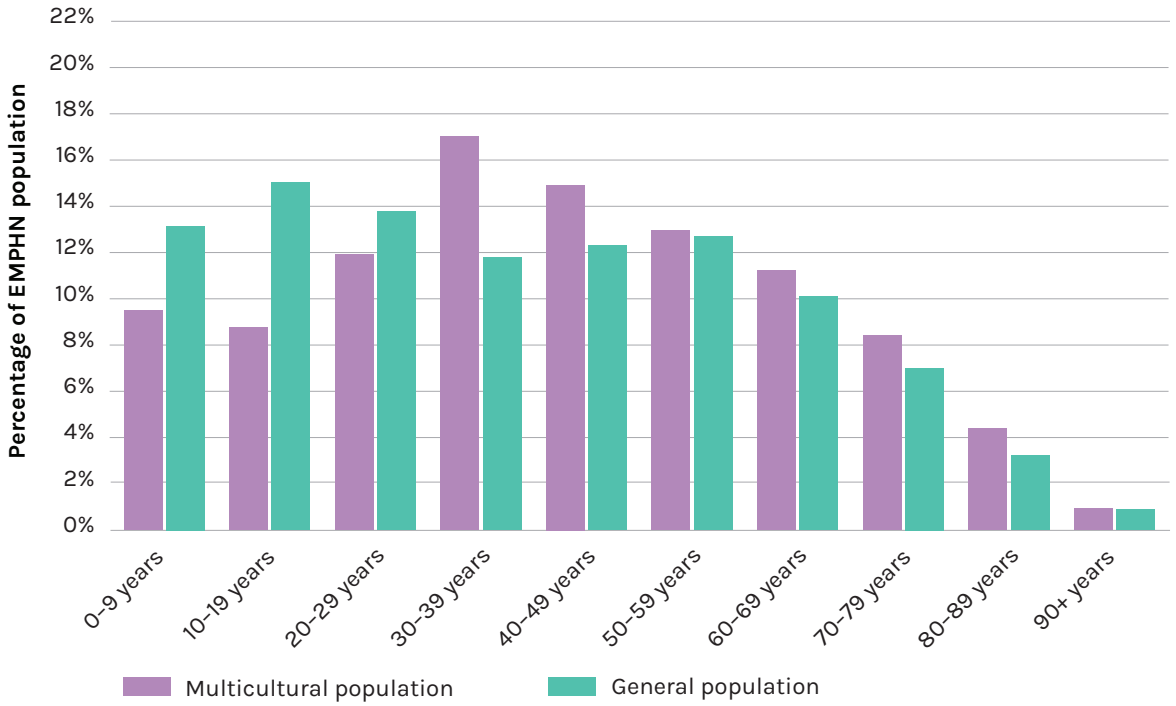
- Chinese: Mandarin, Cantonese, Hokkien and Teochew.
- Indo-Aryan: Hindi, Punjabi, Gujarati, Urdu and Bengali.
- Dravidian: Tamil, Telugu and Malayalam.

EMPHN has a higher proportion of residents aged 45+ compared with the rest of Melbourne.



Source: ABS Census 2021.

There is a higher proportion of multicultural people aged 30–89 living in the EMPHN catchment compared with the non-multicultural population.

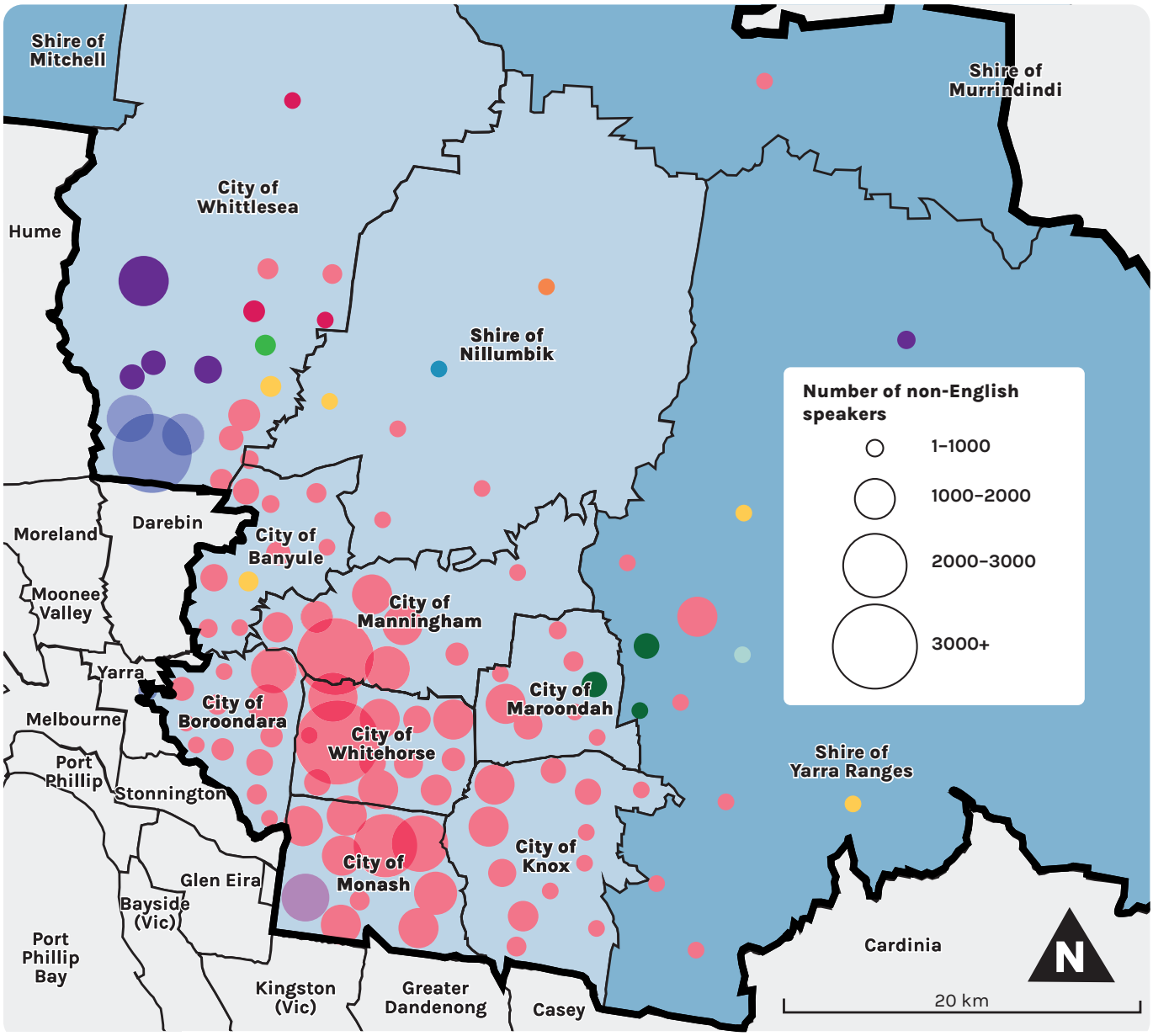


Source: ABS Census 2021.

Where we live

The following data illustrates the significant multicultural populations living within Eastern Melbourne. Approximately a third of people in Eastern Melbourne do not speak English at home, and more than a third were born overseas. The region is home to a rich diversity of heritages including Chinese, Vietnamese, Indo-Aryan, southern European, Arabic and Mon-Khmer.

Areas with high numbers of people born overseas reporting poor English proficiency (2021 census) were Glen Waverley East and West (Monash LGA) (6,568), Lalor/Thomastown (Whittlesea LGA) (5,353), Box Hill/Box Hill North (Whitehorse LGA) (4,729) and Epping/Wollert (Whittlesea LGA) (3,014).



These LGAs are entirely within EMPHN's catchment:
City of Banyule
City of Knox
City of Monash
Shire of Nillumbik
City Of Whittlesea
City of Boroondara
City of Manningham
City of Whitehorse

LEGEND

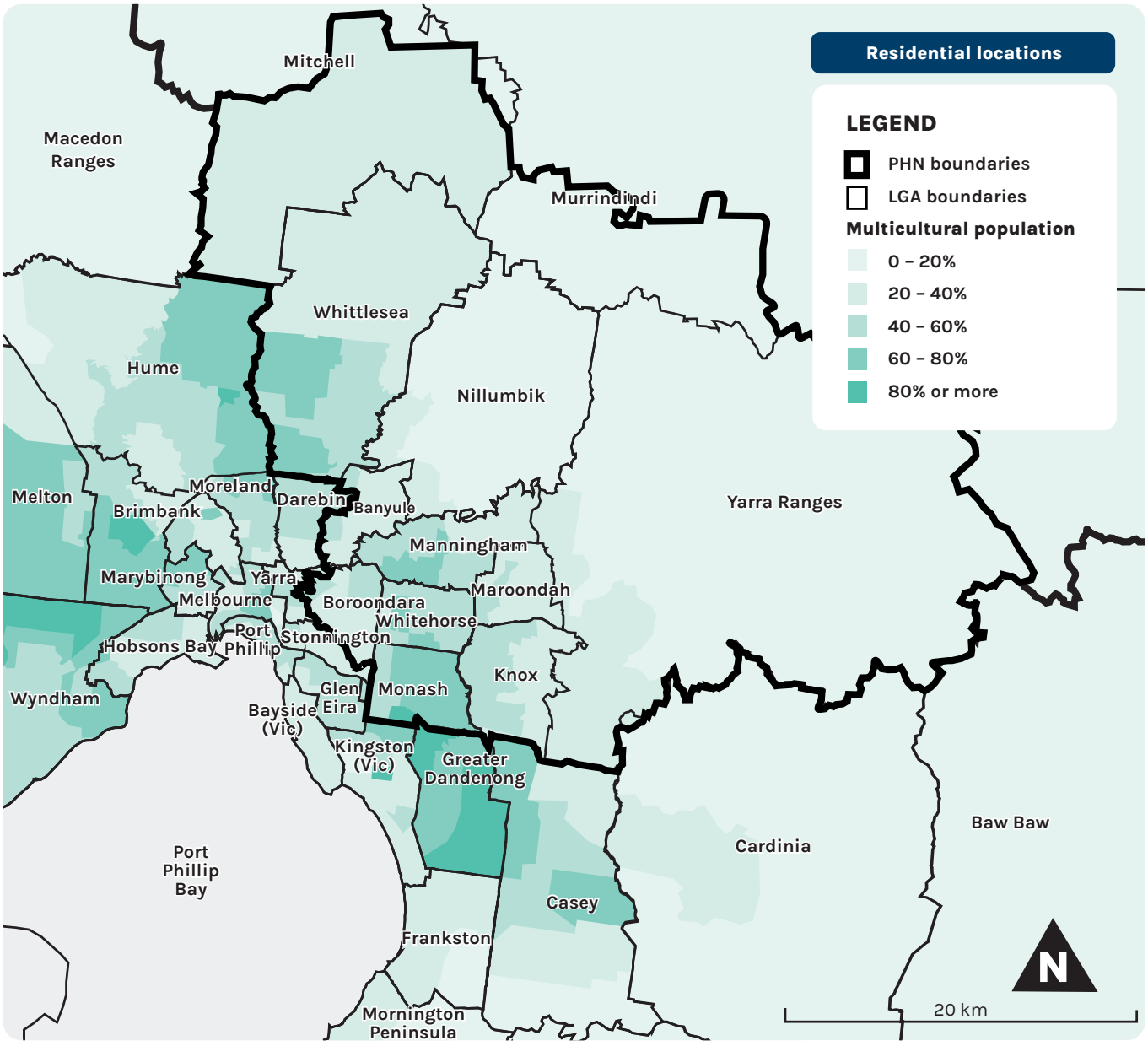
- PHN Boundaries
- LGA Boundaries

Most Common Languages Spoken

- Arabic
- Chin Haka
- Greek
- Italian
- Macedonian
- Mandarin
- Mon
- Punjabi
- Sinhalese
- Thai
- Vietnames

EMPHN's catchment:
Shire of Mitchell (35% population), Shire of Murrindi (27% of population), Shire Of Yarra Ranges (portion which falls outside of the EMPHN catchment is largely uninhabited national park).

Percentage of EMPHN population who are people from multicultural communities, 2021



Source: ABS Census 2021 (2-digit level BPLP Country of Birth of Person; 2-digit level LANP Language Used at Home).

The highest proportions of people from multicultural backgrounds are in the Local Government Areas of Monash, Manningham, Whittlesea and Whitehorse.

Growth in numbers is particularly strong in Whittlesea.

	Number of multicultural individuals			% of total LGA population
	2016	2021	Change	2021
Banyule	36,915	39,727	7.6%	32.7%
Boroondara	63,505	67,434	6.2%	41.6%
Knox	55,510	63,216	13.9%	41.3%
Manningham	59,510	69,143	16.2%	57.5%
Maroondah	29,833	34,331	15.1%	31.0%
Mitchell*	2,798	5,683	103.1%	26.6%
Monash	104,238	113,727	9.1%	65.2%
Murrindindi*	445	482	8.3%	12.9%
Nillumbik	11,864	12,653	6.7%	20.8%
Whitehorse	73,875	84,114	13.9%	51.8%
Whittlesea	97,100	117,713	21.2%	54.2%
Yarra Ranges*	27,391	29,641	8.2%	19.9%
Total	**562,984**	**637,864**	**13.3%**	**43.8%**

Source: ABS Census 2016 and 2021 (2-digit level BPLP Country of Birth of Person; 2-digit level LANP Language Used at Home).
Note: * Indicates parts of the LGA fall outside the EMPHN boundary, and therefore their full population is not captured in this table.

The languages we speak

The **top 10 languages** were **consistent** (with different rankings) between **EMPHN** and the **rest of Melbourne**.

EMPHN has a **smaller** proportion of residents with **limited English proficiency** compared to **Greater Melbourne**.

Excluding English, **Chinese** and **Indo-Aryan** languages are the most common languages spoken at home.

Of those who have limited English proficiency, **most speak Chinese at home**, and are concentrated in the eastern areas of EMPHN (LGAs of Knox, Monash, Whitehorse, and Manningham).

There is considerable linguistic diversity across EMPHN, with over a **third of the population** speaking a language other than English at home.

Languages were defined using the Australian Standard Classification of Languages and reported at the 2-digit level.

EMPHN			Rest of Greater Melbourne		
Language	Population who speak at home	% of total population	Language	Population who speak at home	% of total population
English	971,648	66.4%	English	2,031,373	63.1%
Chinese	170,956	11.7%	Indo-Aryan	242,896	7.6%
Indo-Aryan	72,376	4.9%	Chinese	137,650	4.3%
Greek	37,670	2.6%	Mon-Khmer	113,383	3.5%
Italian	26,540	1.8%	Middle Eastern Semitic Languages	91,920	2.9%
Dravidian	22,557	1.5%	Greek	65,996	2.1%
Middle Eastern Semitic Languages	22,358	1.5%	Dravidian	61,217	1.9%
South Slavic	19,901	1.4%	Southeast Asian Austronesian Languages	57,785	1.8%
Mon-Khmer	19,014	1.3%	Italian	57,106	1.8%
Southeast Asian Austronesian Languages	15,723	1.1%	South Slavic	49,484	1.5%

Source: ABS Census 2021 (2-digit level LANP Language Used at Home).

Where we were born

EMPHN has a slightly lower proportion of residents born overseas compared to the rest of Greater Melbourne – 33% versus 35%.

The most common regions for country of birth are Eastern and Southern Asia, and the top 10 birthplaces are similar to those of Greater Melbourne, though ranked differently.

EMPHN's total population, compared to the rest of Greater Melbourne:

- Has significantly more people born in Chinese Asia (7.7% versus 2.7%).
- Has fewer people born in Southern Asia (6.0% versus 8.6%).
- Has a lower number of people born in Mainland South-East Asia (1.8% versus 3.5%).
- Has a lower number of people born in the Middle East (1.9% versus 2.5%).

EMPHN			Rest of Greater Melbourne		
Country of birth	Population	% of total population	Country of birth	Population	% of total population
Australia (includes External Territories)	955,744	65.1%	Australia (includes External Territories)	1,991,419	61.6%
Chinese Asia (includes Mongolia)	113,220	7.7%	Southern Asia	278,023	8.6%
Southern Asia	88,636	6.0%	United Kingdom, Channel Islands and Isle of Man	114,035	3.5%
Maritime South-East Asia	54,917	3.7%	Mainland South-East Asia	111,957	3.5%
United Kingdom, Channel Islands and Isle of Man	47,847	3.3%	Maritime South-East Asia	103,443	3.2%
South Eastern Europe	34,512	2.4%	Chinese Asia (includes Mongolia)	87,747	2.7%
Middle East	27,558	1.9%	South Eastern Europe	82,218	2.5%
Mainland South-East Asia	26,683	1.8%	Middle East	80,556	2.5%
Southern Europe	22,203	1.5%	New Zealand	65,517	2.0%
New Zealand	17,419	1.2%	Southern Europe	57,110	1.8%

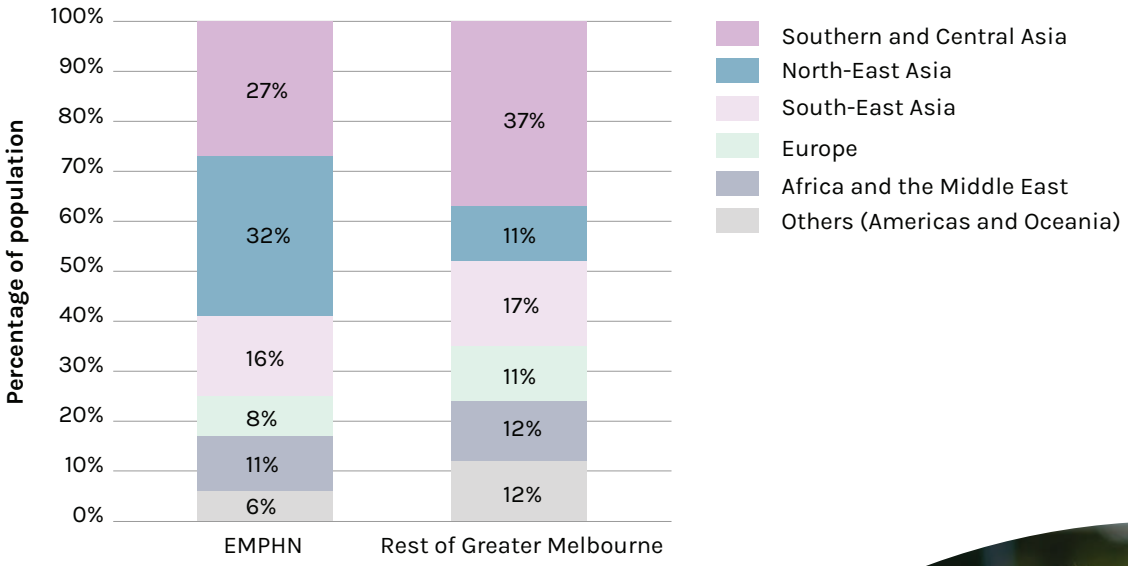
Source: ABS Census 2021 (2-digit level BPLP Country of Birth of Person).

Our recent migrants

EMPHN is experiencing significant recent migration from Southern and Central Asia (including Bangladesh and India) and North-East Asia (including China, Japan and Korea).

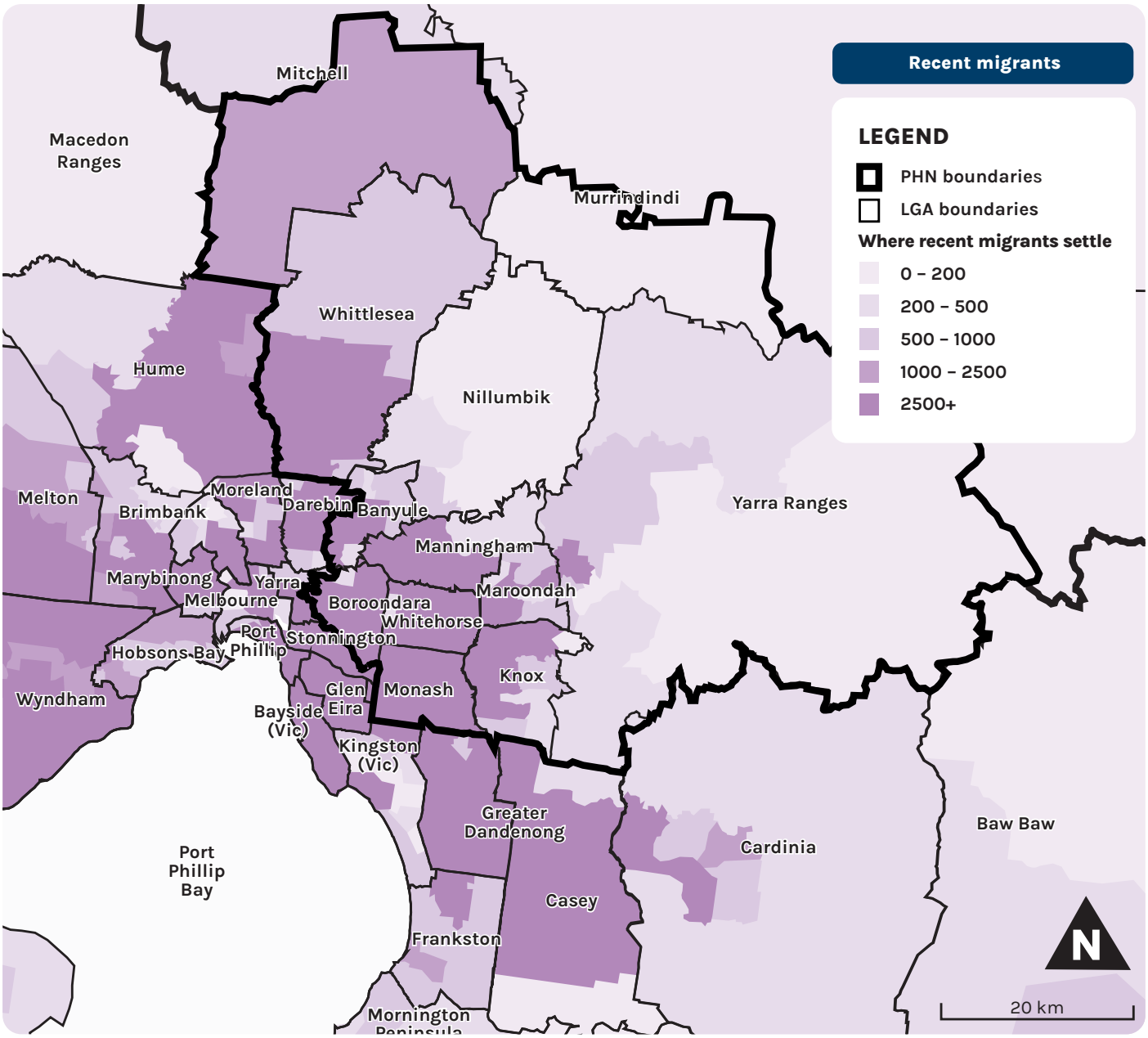
- Recent migrants to Australia who now live in EMPHN are most likely to be from Southern and Central Asia (including Bangladesh and India), followed by North-East Asia (including China, Japan and Korea).
- The cities of Monash, Whittlesea, Whitehorse and parts of Maroondah in particular include higher rates of settlement of recent migrants.
- Maroondah has the highest number of Humanitarian Visa arrivals (2017–18) with the top countries of birth being Myanmar, Iran, Malaysia and Pakistan.

Country of birth of recent migrants, 2021



Source: ABS Census 2021 (1-digit level BPLP Country of Birth of Person).

Recent migrants by place of residence, 2021



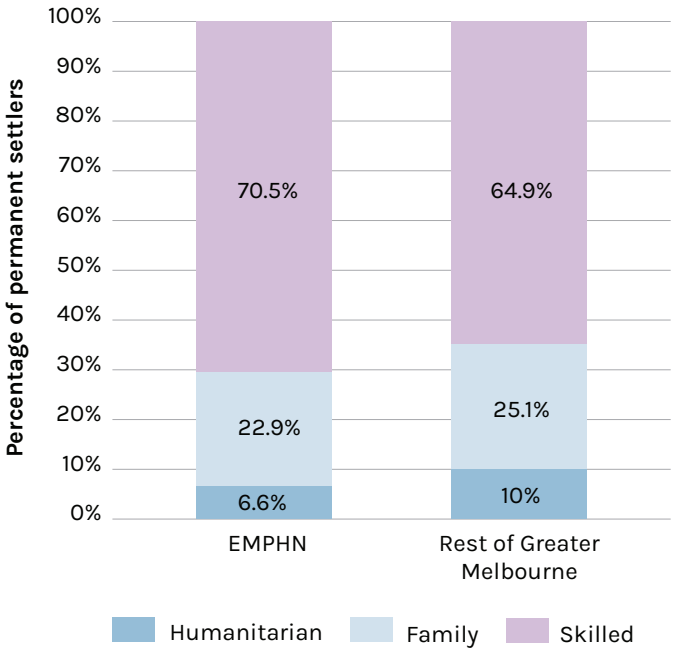
Source: ABS Census 2021 (YARRP Year of Arrival in Australia (ranges).

Why people move to Australia

Migrants choose to move to Australia for several reasons, including family connections, economic opportunities, or seeking refuge. This presents different needs and challenges regarding access to healthcare of those settling in Greater Melbourne. In 2023, the EMPHN region had:

- A significantly higher proportion of skilled migrants than the rest of Greater Melbourne.
- A significantly lower proportion of humanitarian/refugee migrants.

Percentage of permanent settlers by visa type, 2023



Source: Australian Government Department of Home Affairs (2024).

Our faith

Religious beliefs and practices can significantly influence patients' health behaviours, treatment preferences, and engagement with the healthcare system.

The most common religious affiliation across both Greater Melbourne and EMPHN is Christianity, followed by those with no religious affiliation.

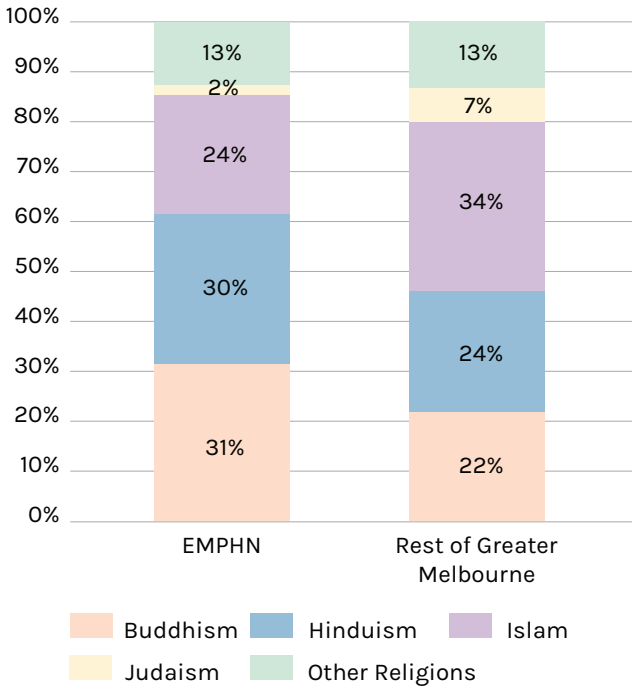
After Christianity and no religious affiliation, Buddhism and Hinduism are the most common religions in EMPHN.

This contrasts with the rest of Greater Melbourne, where Islam is more prevalent (noting that it still comprises 24% of EMPHN's population with a non-Christian religious affiliation).

Religion affiliations across EMPHN:

- Christianity 45%
- No religion 43%
- Buddhism 3.7%
- Hinduism 3.6%
- Islam 2.8%
- Judaism 0.2%
- Other religions 1.6%

EMPHN religious affiliations, excluding Christianity and no religion



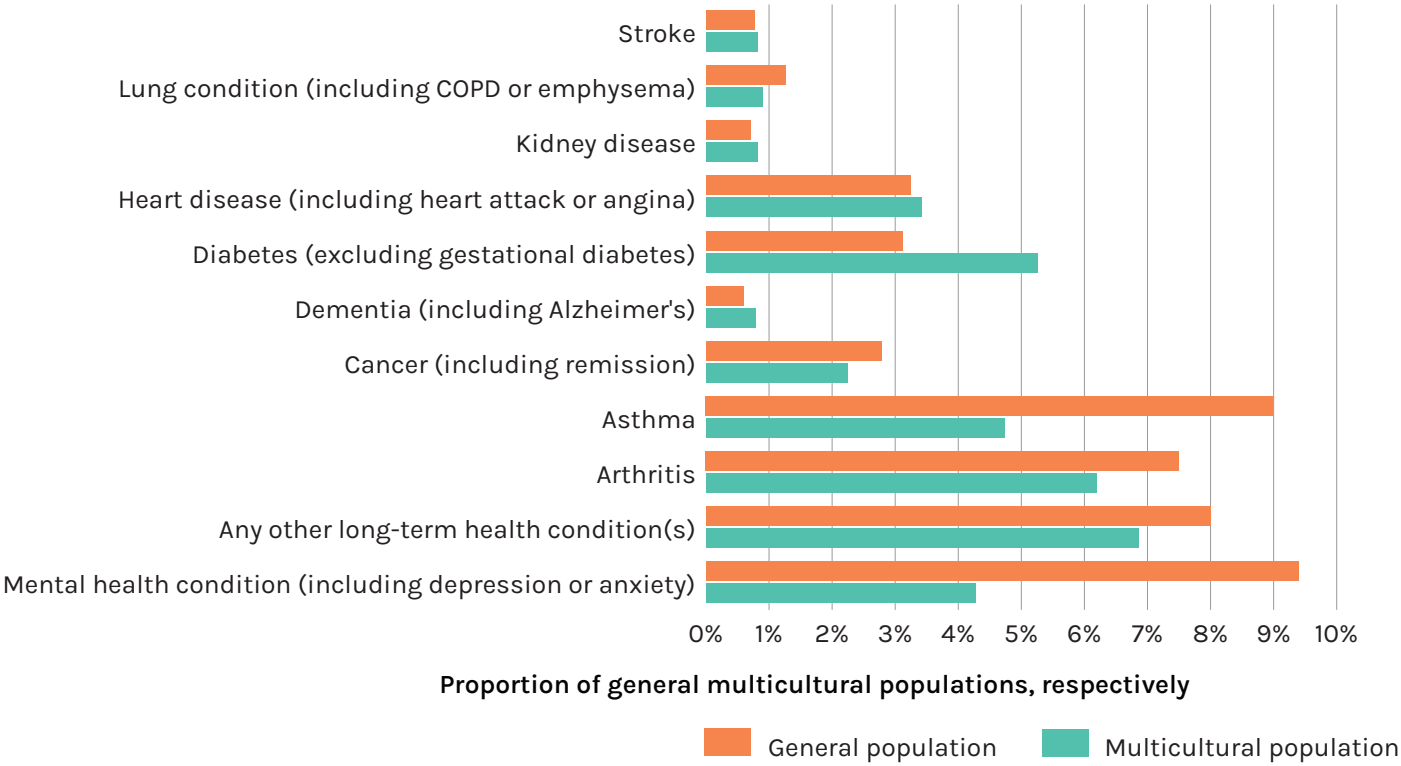
This graph reflects the religious affiliations of the 12% of people across EMPHN who do not identify as Christian or having no religion.

Source: ABS Census 2021 (1-digit level RELP Religious Affiliation).

Our health

- Arthritis, asthma, and diabetes are the most common health conditions reported by multicultural peoples.
- Rates of diabetes are much higher in multicultural communities, due to risk factors and age profiles. Community health services report diabetes is the most common reason for attendance by multicultural people.
- Only 4% of people from a multicultural background report mental health conditions (versus 9% in the general community).
- In EMPHN, 6.2% of people from multicultural backgrounds report a need for assistance with core activities, versus 5.4% of people from non-multicultural backgrounds. This is comparable with other areas of Greater Melbourne. Source: ABS Census 2021 (ASSNP Core Activity Need for Assistance).

Long-term health conditions of multicultural and general population, EMPHN, 2021



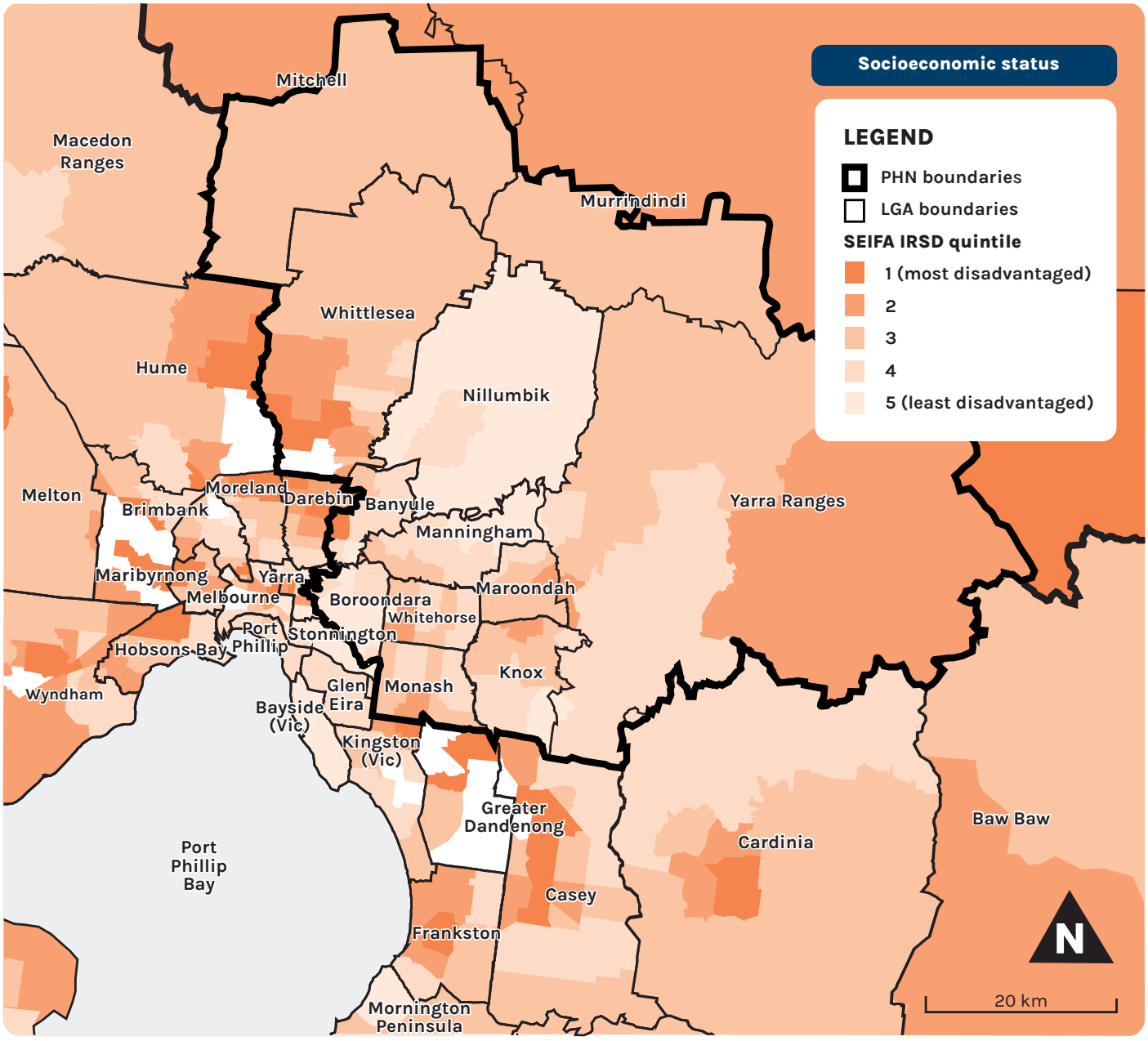
Source: ABS Census 2021 (LTHP Type of Long-term Health Condition).

Income and socioeconomic status

People from diverse cultural backgrounds may face additional barriers accessing healthcare due to language barriers, lower health literacy, cost of services and being unfamiliar with the Australian healthcare system.

Spatial patterns of disadvantage (based on several factors including income, education, occupation) vary considerably across the EMPHN catchment, with areas of disadvantage primarily in the north.

SEIFA IRSD scores by SA2, Greater Melbourne, 2021



Source: ABS Socio-Economic Indexes for Areas (SEIFA) Australia 2021 (Index of Relative Socio-economic Disadvantage (IRSD)).

Multicultural communities and the healthcare system

Navigating the healthcare system can be particularly challenging for people from multicultural communities due to language barriers, lower health literacy, and unfamiliarity with the system. Different medical needs, and cultural factors can require tailored assistance.

The following section examines health service data (emergency departments, hospital admissions, community health, and primary mental healthcare) to understand the needs of the multicultural population within EMPHN, and areas of acute need.

This section draws on hospital and health service data that sometimes defines a person as from a multicultural background based on their stated preferred language. The previous section used reported language spoken at home, or born overseas.

Language barriers and the need for interpreters are among the most common challenges faced by multicultural individuals when accessing healthcare.

Difficulty communicating symptoms and understanding medical advice can compromise care, making the availability of interpreters critical.

Hospitals within the EMPHN catchment (FY22–23):

- For emergency department admissions, Chinese-speakers (Mandarin, Cantonese) and Greek speakers were more likely to require an interpreter.
- In contrast less than 40% of Indo-Aryan speakers required and interpreter.
- More than 80% of people admitted to hospital who spoke Mandarin, Cantonese or Vietnamese required an interpreter.

Emergency Department admissions FY22–23; Top 10 preferred languages and percentage of those who required an interpreter

Preferred language	% who require an interpreter
Mandarin	73%
Greek	71%
Italian	63%
Arabic	59%
Cantonese	76%
Macedonian	68%
Persian (excluding Dari)	59%
Vietnamese	69%
Punjabi	37%
Hindi	40%

Source: Victorian Emergency Minimum Dataset (2024).

Health conditions and service use

The most common reason for hospital admissions for people born overseas was related to diseases and disorders of the kidney and urinary tract. (Note that repeat admissions for dialysis may result in multiple admissions). These admissions were much higher for people born overseas than those born in Australia. Most of these admissions were people born in Greece, Italy and China.

This diagnosis group includes the following conditions (amongst others) — chronic kidney disease, acute kidney injury, kidney stones, urinary tract infections, urinary incontinence.

Some of the major risk factors for kidney and urinary tract diseases and disorders include diabetes, high blood pressure, family history of similar disease, older age, use of tobacco, dehydration, pregnancy/ childbirth, menopause, ageing and obesity.

Of the non-English speaking population who attend a community health provider for a health-related issue, 50% do so in relation to diabetes (compared to only 16% of the English-speaking population).

Both hospital and community health data suggest that community-based health providers have an important role to play in supporting people who have, or are at risk of diabetes from multicultural communities.

Top 8 diagnosis groups of health service usage, FY22–FY23

Major diagnosis group	Born overseas	Born in Australia
Diseases & Disorders of the Kidney & Urinary Tract	29.8%	17.7%
Diseases & Disorders of the Digestive System	9.7%	11.4%
Neoplastic Disorders (Haematological & Solid Neoplasms)	9.2%	7.7%
Diseases & Disorders of the Circulatory System	7.1%	6.2%
Diseases & Disorders of the Musculoskeletal System & Connective Tissue	6.0%	6.9%
Diseases & Disorders of the Nervous System	5.7%	7.2%
Diseases & Disorders of the Respiratory System	4.6%	5.8%
Pregnancy, Childbirth & the Puerperium	4.3%	4.4%

Source: Victorian Emergency Minimum Dataset (2024).

Top non-Australian countries of birth: admitted with diseases and disorders of the kidney and urinary tract, FY22–FY23

Country of birth	% of those admitted with diseases and disorders of the kidney and urinary tract
Greece	6.4%
Italy	5.5%
China (excludes SARs and Taiwan)	3.6%
England	2.5%
India	2.5%
Malaysia	2.2%
Vietnam	2.1%

Source: Victorian Admitted Episodes Dataset (2024).

Health conditions and service use

A higher percentage of the population admitted for issues relating to the circulatory system, are born overseas compared to people born in Australia.

- This includes diseases of the heart (e.g. coronary artery disease); of the blood vessels (e.g. stroke); blood disorders (e.g. hypertention, high cholesterol); and lymphedema
- Some of the major risk factors for circulatory disease include poor diet, lack of physical activity, use of tobacco, obesity, excessive alcohol consumption and stress.

Source: Victorian Emergency Minimum Dataset (2024).

Non-English speakers were much less likely to report anxiety disorders, compared to 17% of English-speaking population. Seeking assistance for depression is similarly lower – 5% for non-English speakers compared to 10% for English speakers.

Top 8 health-related reasons for Community Health Service attendance for people who speak a language other than English, FY22–23

Reason for attendance	Speaks a language other than English	Speaks English
Diabetes	53.0%	16.7%
Glucose control	19.8%	6.9%
Anxiety disorders and phobias	6.5%	18.2%
Depression	5.7%	10.2%
Other mood disorders	4.0%	8.2%
Stress	3.0%	9.6%
Behavioural problems	2.3%	3.6%
Other endocrine, nutritional and metabolic diseases	1.3%	0.7%

Source: Community Health Minimum Dataset (2024).

Health conditions and service use

Community Health Services' data shows low self-reporting of mental health conditions, however data for refugees and asylum seekers shows that mental health conditions were regularly part of the reasons people received assistance.

Refugees and asylum seekers were far more likely than non-refugees to seek assistance in relation to finance, adjusting to health conditions, family violence (adult), housing, other mental, mood and behavioural disorders, pregnancy, and endocrine / nutritional / metabolic diseases.

Top 8 health-related reasons for Community Health Service attendance for refugees FY22–23

Reason for attendance (excluding refugee issues)	Refugee	Not a refugee or asylum seeker
Finance and material resources	29.1%	5.6%
Family violence – Victim (adult)	15.4%	6.1%
Other housing issue	14.8%	1.4%
Depression	10.8%	8.6%
Anxiety disorders and phobias	7.9%	14.8%
Stress	7.2%	8.0%
Other Mental and behavioural disorders	3.1%	0.6%
Other mood disorders	2.1%	1.6%

Source: Community Health Minimum Dataset (2024).

Top 7 mental health-related reasons for Community Health Service attendance for people from multicultural communties, FY22–FY23

Reason for attendance	Anxiety	Depression	Mental health, other
Anxiety disorders and phobias	68	16	16
Depression	20	124	
Family violence – Victim (adult)	92	39	
Other mood disorders NEC		75	
Pregnancy-related		30	
Refugee Issues		54	
Social isolation or exclusion	133		6,925

Source: Community Health Minimum Dataset (2024).

Top 3 health-related reasons for Community Health Service attendance for asylum seekers, FY22–FY23

Reason for attendance (excluding refugee issues)	Asylum seeker	Not a refugee or asylum seeker
Pregnancy-related	62.1%	17.7%
Adjustment to health condition	19.2%	4.5%
Other Endocrine, nutritional and metabolic diseases	18.6%	0.9%

Source: Community Health Minimum Dataset (2024).

What our communities told us

To understand the health needs of people from the diverse multicultural communities across the EMPHN catchment, we spoke with many people and organisations across Eastern Melbourne.

To inform this needs assessment, we:

- **Surveyed 50 people from multicultural backgrounds** reaching people from diverse backgrounds including China, Greece, Italy, Argentina, Philippines, United States of America, Afghanistan, Lebanon, Malaysia, Syria and Switzerland.
- **Conducted cross cultural workshops** in partnership with community-based organisations. Community participants represented the following population groups:
  - Chinese (including Taiwan): 15
  - Polish: 20
  - Sri Lankan, Persian, Indian, Burmese, Bangladeshi: 11
  - Arabic, Burmese, Somali and Dari: 11
  - Arabic (Iran, Iraq, Syria, Lebanon, Afghanistan, Portugal): 20
  - Hakha-Chin (Myanmar): 21
  - Persian (Iran): 22
  - Karen (Myanmar): 11
  - Greek: 11
  - Multicultural people experiencing homelessness: 24

Language barriers / interpreting

Consumers reported:

- Difficulty finding healthcare providers who speak their native language.
- Findings interpreters who understand and can communicate medical terminology is difficult, leading many to rely on family members for interpretation.

> It's hard to find a doctor who understands my language... I feel lost.

> I don't feel comfortable calling a doctor; it's too hard to explain my problem.

> Sometimes interpreters are angry and rude.

Wait time for services

Consumers reported:

- Long wait times to see some medical practitioners.
- Long wait time for some interpreters.
- Long wait times for hospital ED services.
- Experiencing ongoing pain while waiting for surgery.

> I waited a year for my knee surgery. It's so painful and I can't take it anymore.

> Sometimes have to leave or reschedule the appointment because they can't get an interpreter.

> Many interpreters cannot understand the medical terms, quality of interpreting is not up to standard.

Digital health

Consumers reported:

- Language barriers and limited technology literacy leading to a lack of comfort using digital services.
- A preference for in-person care.

> We prefer face to face appointments with the doctor and the interpreter, given the language barrier issue.

> [Telephone services] Often we can't understand them and or they can't understand us. And then they hang up. So we call again, and then they get angry.

> I called Doctor On Call... I had to wait for ages. I was so worried, so I went to hospital.

Mental health

Consumers reported:

- Cultural beliefs and norms, and stigma, impacting some communities' willingness to access care.
- Poor understanding of where to find mental health support.

> We are unaware of counsellors but would like to know what services are available.

> Our community is shy to explain our problems at home – not just to mainstream medical people.

> When a GP refers us to a specialist or a mental health worker – is it also bulk billed or do you have to pay? We don't know.. so we don't go.

Financial barriers

Consumers reported:

- Avoiding care, due to cost.
- Dental and medical specialist services usually entail out-of-pocket costs.

> I can't afford the gap fees; it makes me avoid going altogether.

> Because of reduced bulk-billing, people are putting off going to the doctor, taking longer to follow things up, things are getting more acute, which becomes a larger burden.

Difficulty navigating the health system

Consumers reported:

- Not having anyone available to help them understand what services are available.
- New arrivals having particular difficulty.

> No one helps you find services or to know what's out there.

> We go to the GP for everything, but we don't know much about mental health options.

Discrimination

Consumers reported:

- Sometimes feeling judged, or treated differently in health services, due to their cultural background.

> I felt judged when I explained my health issues. It made me reluctant to return.

> I had an interpreter on the phone with a doctor about my back pain.. the doctor dismissed it and said you'll be fine... I was really upset.

> I waited for hours, and when my kids were noisy, the receptionist scolded me. It made me feel unwelcome.

General practice

Access to multilingual GPs

- Consumers from multicultural backgrounds said they relied on GPs for front line care, and to help them navigate the health system.
- They also said it was difficult to use interpreters; and often relied on family members to interpret if their GP did not speak their language.
- Communities report better access to health professionals who speak Arabic, Polish, Iranian and Chinese, while Greek, Hakha Chin and Karen communities struggle to find professionals who can communicate effectively in their languages.

Through direct interviews and a survey of GPs across the EMPHN region, we heard:

- Practices **advertise languages spoken** by clinicians through signage, websites, social media, and online booking platforms.
- Patient **language proficiency is assessed** when patient and GP preferred languages differ.
- **Multiple methods are used for interpreting** including using family members, bilingual staff, and phone services e.g. Translating and Interpreting Service (TIS).
- The **TIS has drawbacks** including wait times for rarer languages, and perceived poor interpreting of medical terminology and advice. Languages where improved TIS services would be are Arabic, Chinese, Greek, Italian, Persian, and Dutch.
- **Bilingual staff** can greatly assist as interpreters and primary providers.

Recommendations

Core principles

The core principles of healthcare for people in diverse multicultural communities must centre on collaboration, cultural safety, and empathy.

By co-designing healthcare services with each community, we ensure care is tailored to unique needs and experiences – recognising that all communities have their own journeys and stories to tell.

It is essential that services are culturally safe, offering care that respects and understands diverse backgrounds, and are delivered in the patient's preferred language. Adopting a trauma-informed approach helps create a supportive environment where individuals feel heard, valued, and safe, particularly for people with experiences of displacement or adversity.

These principles foster a healthcare system that is inclusive, compassionate, and truly responsive to the needs of all communities.

Remove language barriers to access healthcare

- Increase consumer access to interpreting services to ensure all language interpreting is available.
- Increase the availability of face-to-face services through bicultural workers and health system navigators, in language.
- Work with healthdirect to enable consumers to search for GPs by languages spoken.
- Promote consistent in-language health system communication materials and resources.

Work in partnership with multicultural organisations and mainstream health services on health promoting initiatives

- Promote culturally safe, non-stigmatising and affordable primary, medical specialist, allied and oral health care.
- Promote the importance of regular primary care health checks to consumers.
- Improve service coordination through bicultural workers and health system navigators in language.
- Address lengthy wait times for GPs, medical specialists and hospital services.

Improve access to mental health services

- Targeted, culturally safe community awareness campaigns.
- Equip GPs with information about appropriate and accessible mental health services that cater to diverse cultural needs.
- Ensure cost-effective access to these services, delivered in consumers' preferred languages.

Strengthen understanding and trust of digital health tools

- Ensure digital tools are linguistically accessible and promoted in language.
- Work with communities to build digital literacy.
- Adopt focused, in language strategies to onboard communities.

Monitor the changing cultural demographics across the catchment to ensure people from diverse backgrounds can access healthcare when and where they need it.

The opportunity

There's a growing opportunity to improve healthcare access and equity for the many and diverse multicultural communities in Eastern Melbourne.

While challenges such as language barriers, financial constraints, and cultural misunderstandings exist, there's a clear path forward to create a more inclusive and equitable healthcare system.

This Health Needs Assessment identifies that the health needs of our multicultural communities are centred on three key areas: communication; culturally-safe and appropriate services; and health system navigation.

Prioritising communication can help remove language barriers and ensure effective patient-provider interactions.

An inclusive person centred healthcare system empowers multicultural communities through removing barriers to communication.

Working in partnership with community organisations and leaders and established networks – recognising each diverse community has their own nuanced knowledge, experience and understanding of the healthcare system.

Bicultural workers and health system navigators are critical in linking communities with services.

Breaking down barriers and promoting health equity, we can improve the health and well-being of all people, from all communities.

Limitations

This health needs assessment does not include the direct voices of children and young people, with older family members and community leaders often speaking on their behalf. This reliance on older generations may not fully capture the unique health needs and challenges faced by younger people.

Multicultural health is complex and multifaceted, with different systems impacting each diverse community in varying ways. This broad scope makes it challenging to comprehensively address all aspects within a single health needs assessment. Therefore, there is a need for a more in-depth analysis of and consultation with specific communities to better understand and cater for distinct health requirements.

Obtaining detailed information for individuals without identification or Medicare cards presents a significant challenge. This limitation hinders the comprehensive assessment of health needs within multicultural communities, potentially leaving out a significant portion of the population from the data collection process.

The 2021 census data, collected by the Australian Bureau of Statistics (ABS) during the COVID-19 pandemic, may not fully reflect the current demographic landscape. The pandemic-related border closures have led to an increase in new arrivals over the past 12 months, and this demographic shift may not be accurately represented in the collected data.

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