Migration Council AUSTRALIA

THE HEALTH OUTCOMES OF MIGRANTS: A LITERATURE REVIEW

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Australia's population is diverse culturally and linguistically with 28.1% of the population being born overseas as at June 2014 (Australian Bureau of Statistics, 2013-14). This figure has increased in the last ten years by around 5% indicating on current trends, increasing diversity will continue into the future.

General health levels for migrants are higher than they are for Australian born citizens. However this can vary according to specific illnesses or cases. Migrants from non-English speaking countries experience language and cultural barriers in accessing health facilities, services and information particularly in mental health areas. Those on temporary visas in Australia do not have access to the public health system and have to seek protection in another form, leaving them potentially vulnerable to exploitation. For the elderly migrant population, which is a relatively large proportion of migrants in Australia, it is vital that information and services are provided which are culturally and linguistically appropriate and targeted to specific communities.

Differences in health outcomes between migrants and Australian born residents

In Australia, almost all migrants enjoy better health on arrival to the country in comparison to the Australian born population. A person's migration or refugee status is recognized as a socioeconomic characteristic that can affect their health outcomes. The term 'better health' reflects the findings that migrants have lower death and hospitalisation rates, longer life expectancy and lower occurrences of lifestyle related risk factors (AIHW, 2002). This overall better health of migrants is referred to as the 'healthy migrant effect'. This health advantage experienced by migrants when they arrive to Australia is said to decline the longer their stay, to levels more in line with Australian born residents.

The 'healthy migrant effect' can be partly attributed to the eligibility criteria that migrants are subject to before granted entry into Australia. These criteria ensure only those who satisfy the health requirements are allowed into Australia as the government seeks to protect the Australian population from health and safety risks, control public expenditure on health and ensure the accessibility of health care for Australian citizens

(Submission from the Department of Immigration and Citizenship, Submission 66). These are the stated aims of the health requirement.

The healthy migrant effect may also be attributed to the fact that 85% of migrants in Australia live in urban areas (ABS, 2011). This is significant given the gap in the life expectancy of those living in major cities and inner regional areas, compared to those in outer regional and remote areas (OECD 2015). Along with this discrepancy in life expectancy, rural Australians have a higher prevalence of cancer and chronic disease rates and mental health problems.

Migrants experience all cause death rates 10-15% lower than Australian born persons (AIHW, 2011). Those from non-English speaking countries are however more likely to report needing assistance with activities related to mobility, self care and communication and to have lower health literacy rates. In specific cases some population groups experience higher rates of illness in comparison to Australian born residents. These include:

- Females in the United Kingdom and Ireland have higher rates of cancer mortality.
- Males and Females from the United Kingdom, Ireland and the Netherlands have higher rates of lung cancer mortality.
- Males and Females from Asia have higher rates of diabetes.

(AIHW, 2011)

There are numerous barriers that migrants experience in accessing and utilising the health care system and facilities available to them. Primarily, cultural and language barriers are the most difficult to overcome, particularly for non-English speaking migrants. For non-English speaking migrants, they have greater difficulties understanding and accessing health information and facilities and as a result participate less in health services. Various migrant populations may be reluctant to use the available health services due to cultural differences, perceived racism or misunderstandings of the facilities. One example of decreased participation levels was reported by BreastScreen Australia who reported that women who spoke a language other than English at home participated in their program at a rate of 6% lower than those who speak only English at home (Breast Screen Australia monitoring report 2012-2013). Given current migration trends, language barriers will continue to be a substantial concern in the future.

Language and cultural barriers are also highly relevant for mental health. Non-English speaking migrants are reported to be less likely to communicate that they have a mental health disorder compared to Australian born residents (AIHW, 2010). The prevalence of reported mental health disorders of English speaking migrants and Australian born residents is approximately equal. The various differences in stigma relating to mental health issues across different cultures may influence the reporting rate and be a barrier for migrants in accessing information and assistance. The recent Framework for Mental Health in Multicultural Australia is designed to recognise cultural responsiveness and improve service delivery for Culturally and Linguistically Diverse (CALD) communities (Mental Health in Multicultural Australia, 2014).

Policy issues for migrant health

Migrants with permanent visas are able to access the public health system as Australian born residents after a 104 week waiting period. Migrants with temporary visas are ineligible for Medicare and are required to hold private health insurance.

The two most common temporary visa categories in Australia are international student visas and temporary skilled work visas, more commonly known as the 457 visa, which requires an employer to sponsor the worker. Both of these categories require migrants to hold some type of health insurance.

All overseas students undertaking formal studies in Australia, with a student visa, must take out Overseas Student Health Cover (OSHC), which can assist in covering hospital and medical treatment costs and is valid for up to five years. Those students from Belgium, Norway and those covered by CSN International or Kammarkollegiet in Sweden will be exempt from taking over OSHC as they are considered to have met 'adequate insurance' requirements based on the Reciprocal Health Care Agreements (RHCA) between Australia and those countries.

Migrants who hold a 457 visa are required to have private health insurance, as they are not provided with assistance under Medicare. Past reviews of the program have found there may be circumstances where employees are unwilling to access medical assistance or support where workplaces are unsafe for a variety of reasons (Visa Subclass 457 Integrity Review, 2008). In particular, those who are from non-English speaking backgrounds are likely to find it difficult to access information regarding their rights.

Some temporary migrants are entitled to public healthcare under the RHCA framework. This means migrants who hold a range of visas from New Zealand, the United Kingdom, Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway have access to assistance for the cost of essential medical treatment and some subsidised medicines and health services in Australia. The extent of entitlements available to individuals will differ according to which country they are from.

In regards to migrants with a disability, the policy surrounding this area has changed as Australia's international obligations have changed. The ratification of the Convention on the Rights of Persons with a Disability in 2008 has driven this policy development.

One policy used by governments to achieve cost effectiveness for healthcare in Australia is the Significant Cost Threshold. If a visa applicant, before they arrive in Australia, is expected to cost the public system more than $35,000, their visa application may be denied (Inquiry into the Migration Treatment of Disability, 2012). This Threshold has increased in recent years.

Ageing Migrant Population

Migrants make up a relatively large proportion of Australia's ageing population.
In June 2013, 37 per cent of Australians aged 65 and over were migrants, compared to 28 per cent of the total Australian population. Of these older migrants, about

one third are from English speaking countries with two-thirds from non-English speaking countries (AIHW, 2014).

This group largely came to Australia in the post World War II era from the United Kingdom, Poland, Italy, Greece and other European countries. Their English language skills therefore differ depending on their country of origin. Some of those from non-English speaking countries have experienced loss of English language as they revert back to their native language (Thomas, 2003).

One factor affecting mental health for older migrants is their support networks. Many older migrants have family members across a number of countries. This dispersion of family may have a detrimental impact on their mental health. In addition, the language problems outlined above may cause older migrants to become socially isolated.

The Aged Care Act 1997 identified CALD groups as being a special needs group to be given special consideration in the planning and delivery of aged care services. Of particular importance is how facilities, services and information can be culturally sensitive and available in a range of languages. Many cultural norms inherent to migrant populations reflect the idea that care is to be provided by the family within the home. This places a large amount of pressure on the relevant family members. The Productivity Commission found in 2011 people from CALD communities are more likely to access a service if it is targeted to their community (Productivity Commission Report, 2011). This is in contrast to the general population.

As the composition of Australia's migrant population continues to change, aged care services must remain culturally and linguistically sensitive and appropriate.

Australia's migrant population overall has better health rates than those of Australian born residents, as reflected in the 'healthy migrant effect'. Despite this, cultural and language barriers continue to be a source of difficulty for non-English speaking migrants. Those on temporary visas are forced to make arrangements for either private health insurance or OSHC. Recent improvements in the policy regarding disabled migrants have eased the difficulties for this group, however barriers still exist. Cultural and linguistic sensitive services and information, which are targeted to specific communities, are important in enhancing older migrants usage of services and their overall health.

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