SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT

2014-2016
IMPLEMENTATION PLAN
FOR HEALTHY CULTURALLY DIVERSE COMMUNITIES

Working together to improve the health and wellbeing of our community
2014-2016 SESLHD Implementation Plan for Healthy Culturally Diverse Communities

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Prepared by the Multicultural Health Service, South Eastern Sydney Local Health District

November 2014

A note on the language used in this plan

In accordance with recommendations made by the Community Relations Commission, the term “culturally and linguistically diverse” is used throughout this document. This is commonly used as a broad descriptor for consumers and communities who differ according to religion, race, language and ethnicity, but excluding those whose ancestry is Anglo-Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander. In some instances where the discussion relates specifically to language spoken, “people from a non-English speaking background/country” is also used. Out of respect and to avoid confusion, abbreviations such as CALD and NESB have been avoided. For more information, please refer to http://www.crc.nsw.gov.au/multicultural_policies_and_services_program_formally_eaps/terminology
FOREWORD

Our District has a strong and vibrant multicultural heritage. More than one in three of our residents were born overseas, with almost three-quarters of these coming from non-English speaking countries. More than one in three of the babies delivered in our hospitals are born to mothers from non-English speaking countries, many of whom have only recently arrived in Australia. Refugees, international students, young adults from developing Asian countries and ageing European post-World War II migrants are just some of the many cohorts of people who bring a breadth and depth of cultural and linguistic diversity to our District.

We must ensure that our commitment to quality care includes strategies that will more effectively engage and serve these consumers and communities. In particular:

- Practical issues such as improved access to interpreter services are of utmost importance if we are to genuinely deliver the “person-centred care” described in *A road map to the delivery of excellence*, released by the SESLHD Board earlier this year.
- More reliable and robust data, collected routinely and reported openly and regularly, are necessary for us to better understand the issues and deliver more equitable and accountable services.
- Our workforce requires better training and ongoing support to understand, recognise and address issues such as poor health literacy, cultural determinants of risk and health behaviour, and the clinical and legal imperatives for facilitating improved access to interpreter services.
- A broader scope of targeted action in primary health, chronic disease care and health promotion can establish the foundation for positive health outcomes long into the future.

*The NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012 – 2016* describes a vision for an equitable health system where cultural and linguistic diversity is at the heart of service planning, service delivery and policy development. That vision is translated into this local implementation plan. It outlines priority actions, specific objectives, stakeholders and partnerships, and indicators to measure our success.

I look forward to the successful implementation of this plan, as an integral part of the SESLHD vision of “working together to improve the health and wellbeing of our community”.

Mr GERRY MARR
SESLHD Chief Executive
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREWORD</td>
<td>3</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>5</td>
</tr>
<tr>
<td>THE SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT</td>
<td>7</td>
</tr>
<tr>
<td>THE STRATEGIC CONTEXT</td>
<td>9</td>
</tr>
<tr>
<td>The NSW Policy</td>
<td>9</td>
</tr>
<tr>
<td>Mandatory requirements for Local Health Districts</td>
<td>10</td>
</tr>
<tr>
<td>Some important key concepts</td>
<td>11</td>
</tr>
<tr>
<td>Health needs of culturally and linguistically diverse consumers and communities</td>
<td>12</td>
</tr>
<tr>
<td>MULTICULTURAL HEALTH IN SESLHD</td>
<td>13</td>
</tr>
<tr>
<td>A profile of our local communities</td>
<td>13</td>
</tr>
<tr>
<td>Health service data</td>
<td>19</td>
</tr>
<tr>
<td>The SESLHD Multicultural Health Service</td>
<td>25</td>
</tr>
<tr>
<td>Diversity Health Coordinators</td>
<td>25</td>
</tr>
<tr>
<td>WHAT WE WILL DO</td>
<td>26</td>
</tr>
<tr>
<td>The planning process</td>
<td>26</td>
</tr>
<tr>
<td>Priority 1: Professional health care interpreters</td>
<td>28</td>
</tr>
<tr>
<td>Priority 2: Our workforce</td>
<td>29</td>
</tr>
<tr>
<td>Priority 3: Consumer and community engagement</td>
<td>30</td>
</tr>
<tr>
<td>Priority 4: Data and reporting</td>
<td>31</td>
</tr>
<tr>
<td>Priority 5: Priority health issues</td>
<td>32</td>
</tr>
<tr>
<td>Priority 6: Priority groups</td>
<td>33</td>
</tr>
<tr>
<td>DELIVERING THE PLAN</td>
<td>34</td>
</tr>
<tr>
<td>QUICK-REFERENCE SUMMARY OF BOARD-APPROVED KPIS</td>
<td>35</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>36</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>37</td>
</tr>
<tr>
<td>Appendix A: SESLHD Refugee Health Implementation Plan 2011-2016</td>
<td>37</td>
</tr>
<tr>
<td>Appendix B: Additional data – country of birth</td>
<td>39</td>
</tr>
<tr>
<td>Appendix C: Additional data – language spoken at home</td>
<td>41</td>
</tr>
<tr>
<td>Appendix D: Additional data – population profile by age and gender</td>
<td>42</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012 –2016 is the strategic state-wide policy for improving the health of NSW consumers and communities from culturally and linguistically diverse backgrounds. The vision of the NSW Policy is an equitable health system that ensures that cultural and linguistic diversity is at the heart of service planning, service delivery and policy development. That vision is reflected in this local implementation plan, which has been developed in strategic alignment with NSW priorities and narrowed to a focus on local action to meet the needs of culturally and linguistically diverse consumers and communities across SESLHD.

A profile of our local communities

SESLHD has a large population of people who were born overseas. Of the total resident population of just over 800,000 people, 274,189 (37%) were born overseas, including 199,444 (27%) people born in a non-English speaking country.

- SESLHD has 1½ times the percentage of people born overseas (37%) as compared to NSW (25%).
- Over 38,000 people are from China, almost four times the second largest group (from Greece).
- Nearly half of all SESLHD residents who speak a language other than English at home speak either Mandarin, Greek, Cantonese or Arabic.
- With proportionally less children* and more older people, the age profile of those born overseas in non-English speaking countries is markedly different to those born in Australia. Migrants who arrived after World War II are now in their senior years. Over one in three SESLHD residents aged 65+ is from a non-English speaking country. (*less as a proportion of the population, despite generally larger family sizes).
- The prioritisation of young adults (18-35) under current migration policies means that many migrants are having children relatively soon after their arrival in Australia. Though recorded as “Born in Australia”, these children are from families with culturally and linguistically diverse backgrounds, many of whom are non-English speaking, and may have poor health literacy within the Australian system.

Use of SESLHD health services

During the 2011-12 financial year, there were 156,191 hospital inpatient episodes in SESLHD public hospitals. Just over one-third (54,198; 35%) of these were for patients born overseas in non-English speaking countries.

- Of those inpatient episodes for people born overseas in a non-English speaking country, the most were from Greece, China, Egypt, Lebanon and Italy.
- At the community level, the largest group of SESLHD residents born in non-English speaking countries comes from China, at nearly four times the second largest group, from Greece. Yet in terms of inpatient episodes, Greece ranks the highest, almost double to China. This in part reflects the ageing of post-World War II migrants as compared to relatively more recent and younger arrivals from Asian countries.
- Preference was stated for a language other than English during the admission process of 1 in 5 SESLHD inpatient episodes in 2011-12. Five languages account for over half of these: Greek, Arabic, Macedonian, Cantonese and Mandarin. The full top 10 accounts for greater than 75% of the total group.
- Although 30,526 patients stated a preference for a language other than English, only 5,813 (19%) of these were subsequently recorded in the inpatient database as requiring an interpreter. How many of these actually received the service is difficult to determine due to data issues, but sample file audits...
undertaken for this planning highlighted gaps both in data quality and service delivery, and confirmed that a greater focus is required to ensure that the needs of non-English speaking patients are being adequately identified, recorded and addressed.

- This requires immediate attention regarding consent in particular. Consent without a professional health care interpreter may not be a valid consent. Nor is it valid if it is obtained through a child or family member, other patient, visitor or staff acting as an interpreter. Access to professional health care interpreters in particular for matters of consent is therefore a high priority of this plan.
- The age profile of inpatients born overseas in non-English speaking countries again reflects the migrant cohorts described earlier, notably the ageing population of those who migrated to Australia after World War II.
- For the three public hospitals with maternity units across SESLHD, 36% (4,385) of all births in 2011-2012 were to a mother born in a non-English speaking country, with the top five being China, Indonesia, Bangladesh, Lebanon and Philippines. Mothers from non-English speaking countries (particularly recent arrivals which are reflected here) are often less aware of the services available, and may present to services late in pregnancy.

Priorities for action in SESLHD

In late 2012, the SESLHD Board requested that key performance indicators (KPIs) be developed to provide clear directions for local action and investment. These address the use of professional health care interpreters, workforce development, consumer engagement and consultation, hospital performance, and health behaviours, with relevance to community-based health promotion and preventive clinical care.

This plan brings together these Board-endorsed KPIs, the strategic context as described in the NSW Policy, and local priorities for action that reflect the profile of our local communities, current service use and gaps. Wide consultation has been undertaken to determine broad themes of action to enable and build the capacity of our health system to better meet the needs of people from culturally and linguistically diverse backgrounds, and targeted actions to address priority health issues and groups. In summary, the six priorities of this plan are as follows:

1. We will facilitate increased access to professional health care interpreters to improve clinical service delivery and patient outcomes.
2. We will build the capacity of our workforce to identify and meet the needs of culturally and linguistically diverse consumers and communities.
3. We will work more effectively with culturally and linguistically diverse consumers and communities.
4. We will improve our data and reporting to better understand and meet the needs of culturally and linguistically diverse communities.
5. We will address specific health issues that are priorities for action within culturally and linguistically diverse communities.
6. We will consider the needs of the diverse groups within and across our local communities.

A rationale for each is described, along with specific objectives, stakeholders and indicators.

Delivering the plan

Delivery of this plan will be overseen by the SESLHD Multicultural Health Service, with support from the facility-based Diversity Health Coordinators, and reporting to the Ambulatory and Primary Health Care leadership and District Executive Team. The existing Multicultural Health Stakeholder Advisory Committee will provide guidance and facilitate consultation with local culturally and linguistically diverse communities.
THE SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT

The South Eastern Sydney Local Health District covers nine NSW Local Government Areas from Sydney’s Central Business District to the Royal National Park in the South. The District also provides a key role in assisting residents of Lord Howe Island and Norfolk Island with access to hospital and health services.

With a total population of over 840,000 people, the District has many culturally and linguistically diverse communities within a complex mix of highly urbanised areas, industrialised areas and low density suburban development areas in the south. The services provided across the District include population health programs and services; ambulatory, primary health care and community services; hospital inpatient and outpatient services, and imaging and pathology, among others. Facilities include six public hospitals and associated health services: Prince of Wales; Royal Hospital for Women; St George; Sutherland; Sydney / Sydney Eye; and Gower Wilson Memorial on Lord Howe Island.

The District also provides one public residential aged care facility (Garrawarra Centre), and oversees two third schedule health facilities: War Memorial Hospital (third schedule with Uniting Care) and Calvary Healthcare (third schedule with Little Company of Mary Health Care).

Other public health facilities located in the South Eastern Sydney region that are not part of the South Eastern Sydney Local Health District include Sydney Children’s Hospital (Randwick), St Vincent’s Hospital (Darlinghurst) and Sacred Heart Hospice. There are a growing number of private health care facilities. At the time of writing, the Primary Health Care Organisations were Eastern Sydney and South Eastern Sydney Medicare Local (pending restructure to Primary Health Networks).
A number of fundamental principles guide our decisions on the directions and actions to take with regard to the development and delivery of health care within the District. These are outlined in the *SES LHD Strategy 2012-2017 and Health Care Services Plan*. A comprehensive District-wide Planning Framework underpins and informs planning decisions.

The Pillars and their main roles are:

**Agency for Clinical Innovation (ACI)** – design and implementation of models of care and improved patient pathways.

**Clinical Excellence Commission (CEC)** – policy and strategy related to system-wide improvement of quality and safety.

**Health Education Training Institute (HETI)** – leadership, undergraduate, vocational training in addition to postgraduate services.

**Bureau of Health Information (BHI)** – independent reporting on the performance of the NSW public health system.

**NSW Kids and Families** – statutory health corporation that champions the health interests of children and young people.

**Cancer Institute NSW** – a NSW State government funded agency established to lessen the impact of cancer in NSW.

The **Sydney Metropolitan Local Aboriginal Health Partnership** involves the Aboriginal Medical Service Co-operative Ltd at Redfern, the SESLHD and two other Local Health Districts (Sydney and Northern Sydney) to ensure that the expertise of Sydney Metropolitan Aboriginal community is brought to health care processes.

Shared services include HealthShare NSW, eHealth NSW, NSW Health Pathology and Health Infrastructure NSW.

**Other Local Health Districts** closely linked with SESLHD include: geographically and/or functionally defined LHDs which have services provided by the SESLHD.

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Figure 1: South Eastern Sydney Local Health District planning framework

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*The Pillars* and their main roles are:

**Agency for Clinical Innovation (ACI)** – design and implementation of models of care and improved patient pathways.

**Clinical Excellence Commission (CEC)** – policy and strategy related to system-wide improvement of quality and safety.

**Health Education Training Institute (HETI)** – leadership, undergraduate, vocational training in addition to postgraduate services.

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Shared services include HealthShare NSW, eHealth NSW, NSW Health Pathology and Health Infrastructure NSW.

**Other Local Health Districts** closely linked with SESLHD include: geographically and/or functionally defined LHDs which have services provided by the SESLHD.
THE STRATEGIC CONTEXT

The NSW Policy

The NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012 –2016 (hereafter referred to as the NSW Policy) is the strategic state-wide policy for improving the health of NSW consumers and communities from culturally and linguistically diverse backgrounds. Its principles are that:

- People from culturally, religiously and linguistically diverse backgrounds will have access to appropriate health information.
- People from culturally, religiously and linguistically diverse backgrounds will have access to quality health services that recognise and respect their linguistic, cultural and religious needs.
- Health policies, programs and services will respond in an appropriate way to the health needs of people from culturally, religiously and linguistically diverse backgrounds.
- People from culturally, religiously and linguistically diverse backgrounds will have an opportunity to contribute to decisions about health services that affect them.
- Multicultural health programs and services will be evidence-based and/or support best practice in the provision of health services in a culturally, religiously and linguistically diverse society.

The NSW Policy’s key priorities are described within three themes: enabling priorities, priority health issues and priority groups.

Enabling priorities relate to the capacity of the NSW health system to effectively identify and meet the specific needs of culturally and linguistically diverse groups, and to address health inequities experienced by those groups. Priority health issues will vary from District to District, and from one community to the next. Prevention approaches across the spectrum from primary health promotion to more effective management of chronic conditions all require consideration in this context. Priority groups will also vary markedly across NSW. But broader issues also require attention, such as ageing, new arrivals, refugees and maternal and child health.

This plan has been developed in broad strategic alignment with these priority themes, and narrowed to a focus of action based on local needs.

It is also written to be in strategic alignment with the SESLHD Refugee Health Implementation Plan 2011-2016 (see Appendix A) which is the local response to the NSW Refugee Health Plan 2011-2016. These documents address the health needs of refugees and asylum seekers, with many similar principles and priorities to those herein. The implementation of these policies and plans will be coordinated with these synergies in mind.

The vision of the NSW Policy is an equitable health system that ensures that cultural and linguistic diversity is at the heart of service planning, service delivery and policy development.
Mandatory requirements for Local Health Districts

Mandatory actions for Local Health Districts (LHDs) under the NSW Policy are to:

- Maintain and continue to improve the capacity of the NSW Health system to effectively identify and meet the specific needs of all culturally, religiously and linguistically diverse groups in NSW
- Identify and effectively address the high prevalence of behavioural risk factors and disease types amongst specific ethnic groups and
- Identify the factors contributing to increased vulnerability in some groups so that actions can be developed to bring individual health outcomes to at least the level of their own communities and then to an optimal standard.

More specifically, the governance and process requirements of policy implementation for LHDs are described in Table 1.

Table 1: Governance and process requirements of the NSW Policy

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<tr>
<th>Requirement as per NSW Policy Document</th>
<th>SESLHD Implementation</th>
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<tr>
<td>Nominate the Executive Officer responsible for the implementation of the NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities and reporting for the purpose of the Multicultural Policies and Services Program (MPSP)</td>
<td>Director Ambulatory and Primary Health Care</td>
</tr>
<tr>
<td>Nominate the officer responsible for promoting and implementing the NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities and the health service’s multicultural health plan, and who will report directly to the relevant health organisation’s executive for multicultural health</td>
<td>Manager, Multicultural Health Service</td>
</tr>
<tr>
<td>Delegate substantive responsibility to a manager who will develop and oversee the relevant health organisation’s multicultural policy and planning of initiatives with staffing which is responsive to client needs</td>
<td>Multicultural Health Service to oversee this, reporting routinely to the Ambulatory and Primary Health Care Directorate, the District Executive and the SESLHD Board</td>
</tr>
<tr>
<td>Develop a health service multicultural forward plan and maintain capacity to implement initiatives under it and the NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities</td>
<td>Multicultural Health Service to provide lead in the planning process, in consultation with relevant SESLHD personnel, notably the Diversity Health Coordinators, Ambulatory and Primary Health Care Directorate and other key stakeholders as specifically identified in this plan</td>
</tr>
<tr>
<td>Establish and/or maintain a health service Multicultural Committee to assist implementation of multicultural health initiatives and provide input into the service planning process</td>
<td>Exists as the Multicultural Health Stakeholder Advisory Committee. Chaired by Deputy Director Ambulatory and Primary Health Care, secretariat support provided by the Multicultural Health Service.</td>
</tr>
<tr>
<td>Report annually to the Ministry of Health</td>
<td>To be coordinated by the Multicultural Health Service</td>
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Some important key concepts

The unedited text in Table 2 is drawn directly from the NSW Policy (see Definitions of Key Concepts, page 31) and provides a useful overview of some of the key concepts that underpin this plan.

### Table 2: Some important key terms

<table>
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<tr>
<th>Cultural and linguistic diversity</th>
<th>Multiculturalism</th>
<th>Cultural competence</th>
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| **Cultural and linguistic diversity** refers to the wide range of cultural groups that make up the Australian population and Australian communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. The term ‘culturally and linguistically diverse background’ is used to reflect intergenerational and contextual issues, not just the migrant experience. The term culturally and linguistically diverse is used in its broadest, most inclusive sense and it acknowledges the role that background, experience, length of stay, inter- and transgenerational issues and diversity within and between communities play, along with language and culture, in forming diversity. | **Multiculturalism** recognises, values and promotes the contributions of the diverse cultural heritages and ancestries of all people. A multicultural society is one that continually evolves and is strengthened by the contribution of its diverse peoples. Within the NSW Government context, the first two NSW principles of multiculturalism outline that:
(a) The people of New South Wales are of different linguistic, religious, racial and ethnic backgrounds who, either individually or in community with other members of their respective groups, are free to profess, practise and maintain their own linguistic, religious, racial and ethnic heritage.
(b) All individuals in New South Wales, irrespective of their linguistic, religious, racial and ethnic backgrounds, should demonstrate a unified commitment to Australia, its interests and future and should recognise the importance of shared values governed by the rule of law within a democratic framework. | **Cultural competence** is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. Cultural competence is much more than awareness of cultural differences, as it focuses, for example, on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services. To become more culturally competent, a system needs to:
- Value diversity
- Have the capacity for cultural self-assessment
- Be conscious of the dynamics that occur when cultures interact
- Institutionalise cultural knowledge, and
- Adapt service delivery so that it reflects an understanding of the diversity between and within cultures. |
Health needs of culturally and linguistically diverse consumers and communities

The health and health needs of people from culturally and linguistically diverse backgrounds are related to many things. The migrant experience is a complex one. Learning a new language, learning and adapting to a new culture, and potentially being separated from a supportive family, community and social networks are all daunting prospects for anyone – even if the move to Australia has been long-planned and hoped for. For refugees, these challenges may be additionally compounded by the ongoing psychological impacts of having experienced trauma, and the often sudden and dramatic circumstances in which their move to Australia was made.

Experiences of racism and discrimination can have a profound effect, both in the short and long term. A sense of disempowerment, and issues related to service access and equity are all commonly described aspects of the migrant and refugee experience. More specific issues such as age at the time of migration and whether it was voluntary or involuntary all add to the complexity of issues. Cultural practices, beliefs and behaviours may also have profound impacts on both physical and psychological health and well-being. Health behaviours which are common-place in Australian society, such as seeking medical advice and support throughout pregnancy, are not necessarily adopted by new arrivals. Some may not even be aware that such services exist. How can you benefit from services if you do not understand them, how to access them, or are not even aware that they are available to you?

Health literacy is therefore an important issue to consider. People from culturally and linguistically diverse backgrounds often have low levels of health literacy – that is, the ability to obtain, process, and understand health information needed to make informed health decisions. Low health literacy is associated with:

- Poorer health knowledge and comprehension of health messages
- Lower use of preventive health care (e.g., mammography and immunisations)
- Higher use of acute care (e.g., emergency care and hospitalisations)
- Poorer self-management of chronic diseases (e.g., use of medicines)
- Overall poorer health outcomes.

Analysing those health outcomes can be problematic, however. People from culturally and linguistically diverse backgrounds are not a homogenous group. Refugees, international students, young people from developing Asian countries and ageing European post-World War II migrants are completely different cohorts of people with different lifestyles, risks, health issues and needs. Grouping all people who were born overseas for the sake of singular reporting can be misleading. Indeed, what is known as the “healthy migrant effect” is a confounding factor: being in good health is generally a selection criterion for migration. However such advantages are known to diminish the longer that a person lives in Australia.

A closer examination of the data is therefore necessary. This is challenging, as few population health datasets have adequate sample sizes to explore this in any detail. This in itself is a cause for discussion and future improvements. At the NSW level, reports such as the 2010 Report of the New South Wales Chief Health Officer nonetheless have demonstrated higher health risks for specific populations, such as current smoking (notably people born in Lebanon), overweight and obesity (males born in Lebanon; females born in Italy, Lebanon and Greece), diabetes (people born in Italy, Greece, Germany and Lebanon), coronary heart disease hospitalisations (Fiji, Lebanon, Iraq and Sri Lanka) and late presentation to antenatal services (mothers born in Lebanon, New Zealand, Fiji, Iraq, Pakistan, Korea, China, Indonesia, Vietnam and the Philippines). Similar patterns of risk may be evident in SESLHD and warrant closer investigation.
MULTICULTURAL HEALTH IN SESLHD

A profile of our local communities

Data for the following community profile are drawn from the 2011 Census. It should be noted that some bias and/or errors may be more likely for people from culturally and linguistically diverse backgrounds. For example, proficiency in English may be deliberately over-reported by some people, due to perceived implications such as social status. Such limitations should be acknowledged when interpreting these data.

“Country of Birth” is categorised as follows:

- **Born in Australia** includes those born in Australia and its external territories.
- **Born Overseas in an English Speaking Country** includes people born in New Zealand, the United Kingdom and its external territories, Ireland, Canada, the United States of America, South Africa and Zimbabwe.
- **Born Overseas in a Non-English Speaking Country** includes people born in all other countries.
- **Not Stated** were excluded.

The SESLHD is divided geographically into two sectors and three community clusters (Figure 2). Note that the colours shown in this figure are repeated throughout this document for easy reference to each cluster.

- The **Northern Sector** has the same boundaries as the **Eastern Community Cluster**, and is made up of Woollahra, Waverley, Randwick and Botany Bay local government areas (LGAs), as well as the Sydney Inner and Sydney East Statistical Local Areas of the City of Sydney LGA.
- The **Southern Sector** is divided into two community clusters. **St George Community Cluster** includes Rockdale, Kogarah and Hurstville LGAs. **Sutherland Community Cluster** contains the Sutherland LGA.

![Figure 2: SESLHD by Sector and Community Cluster](image-url)
COUNTRY OF BIRTH

SESLHD has a large population of people who were born overseas (Figure 3). Of the total population of just over 800,000 people, 274,189 (37%) were born overseas, including 199,444 (27%) people born in a non-English speaking country. See Appendix B for more detailed data, including a full breakdown by community cluster.

**SESLHD has 1 ½ times the percentage of people born overseas as compared to NSW (37% versus 25%).**

The largest migrant populations in SESLHD are in the Eastern and St George community clusters (Figure 4, Figure 5). As a proportion of their respective communities:

- **3 of every 10 residents (29%)** in the Eastern Community Cluster were born in a non-English speaking country
- **4 of every 10 residents (40%)** in the St George Community Cluster were born in a non-English speaking country
- **1 of every 10 residents (10%)** in the Sutherland Community Cluster was born in a non-English speaking country

Figure 3: Country of Birth, All SESLHD residents
Source: Australian Bureau of Statistics, 2011 Census
The top three English-speaking countries of birth for overseas born residents of SESLHD are England, New Zealand and South Africa. Figure 6 shows the Top 10 non-English speaking countries of birth for residents of SESLHD. Appendix B provides more detailed data for both.

With over 38,000 people, the largest population is from China, almost four times the next largest group (Greece).

By community cluster, the top non-English speaking countries of birth are:

- **Eastern**
  - China
  - Indonesia
  - Hong Kong

- **St George**
  - China
  - Greece
  - Macedonia

- **Sutherland**
  - China
  - Italy
  - Greece

Figure 6: Top 10 non-English speaking countries of birth, SESLHD residents
Source: Australian Bureau of Statistics, 2011 Census
LANGUAGE SPOKEN AT HOME

Almost a quarter of a million SESLHD residents (240,555 people or 32% of the resident population) speak a language other than English at home. The ten most common languages spoken are shown in Figure 7. Appendix C provides more detailed data.

By community cluster, the top languages are:

- **Eastern**
  - Mandarin
  - Greek
  - Cantonese

- **St George**
  - Mandarin
  - Cantonese
  - Greek

- **Sutherland**
  - Greek
  - Arabic
  - Cantonese

**Nearly half of all SESLHD residents who speak a language other than English at home speak either Mandarin, Greek, Cantonese or Arabic.**

### Figure 7: Top 10 non-English languages spoken at home, SESLHD residents

Source: Australian Bureau of Statistics, 2011 Census
One factor in this age profile is differing migration policies over time. Large numbers of migrants came to Australia after World War II, mostly from European countries. They are now in their senior years. Today’s migration policies prioritise economic growth productivity and are less restrictive regarding country of origin, and consequently the largest groups are young adults (18-35 years) from Asian countries. Most of their children are born here, and thus are included as Australian-born in these statistics.

The complex issues of ageing are further compounded for many people from a non-English speaking background. Loss of English language proficiency is common, and older people from refugee backgrounds or those that have experienced war and conflict may experience additional confusion and distress related to intrusive memories of those traumatic experiences.

Whilst 27% SESLHD residents were born overseas in a non-English speaking country, this increases to 35% of those aged 65 and over across the District, and is substantially higher in some local areas (Figure 8).

Additional gender and age data including population pyramids are provided in Appendix D.
NEW ARRIVALS

Each year about 8,000 people migrate from overseas into the SESLHD catchment area, although this number can vary considerably from year to year. As described earlier, the majority of newly arrived migrants are aged 18-35 years of age as the primary purpose of the migration program is to support economic productivity. Migrants arrive from many countries, but largely from China and India. The majority of new arrivals in SESLHD settle in the St George area.

Just over half of SESLHD permanent migrants arrive under the Skilled Migration Program. A small number arrive as refugees, and the rest arrive under the family reunion program. There are considerable numbers of temporary migrants living in the District, especially international students, due to the proximity to universities and the city.

Newer arrivals are likely to have a limited understanding of the Australian health care system, limited English skills, fewer financial resources and little or no social support.

REFUGEES

Whilst refugees make up a relatively small proportion of new arrivals, their vulnerability in the health context is considerable. Having smaller numbers may mean further social isolation as it is harder to reach them and they have little community infrastructure to draw on.

SESLHD also has considerable numbers of older refugees who have arrived some years ago. These include holocaust survivors and their families, and people born in Lebanon and Vietnam.

GROWING AND EMERGING COMMUNITIES

South Pacific Islanders and Maori people are a large and growing cultural group in SESLHD. There are around 5,000 SESLHD residents who identify as Maori, and a near equal number of people who were born on a South Pacific Island.

Rapidly emerging communities include people from India, Bangladesh, Nepal, Thailand and Japan, the majority of which are young families. Smaller and newly arrived communities often have limited community infrastructure to support them and referrals to ethnic specific services are very limited or impossible as services do not exist.

The prioritisation of young adults (18-35) under current migration policies means that many migrants are having their children relatively soon after their arrival in Australia.

Though statistically recorded as “Born in Australia”, these children are in fact from culturally and linguistically diverse backgrounds, many with non-English speaking parents with low health literacy.

This has significant implications for local maternity and child health services.
Health service data

Local health service data describing inpatient episodes were sourced from SESLHD records for the 2011-12 financial year period. Interpreter use data were sourced from the external services that provide these personnel for the same period.

It is important to note that:

- These data are for inpatient episodes, not individual people.
- This refers only to the public health system inpatients – that is, inpatient episodes from Prince of Wales Hospital, Royal Hospital for Women, St George Hospital, Sutherland Hospital, Sydney/Sydney Eye Hospital, War Memorial Hospital and Calvary Hospital (Figure 9). St Vincent’s Hospital is excluded from these analyses, as it is managed separately as part of different health network.
- Whilst the community profile provided earlier describes residents of SESLHD, it should be noted that around 20% of inpatient episodes are for people who live outside SESLHD.

Figure 9: Public hospitals included in the following analyses, and proportion of total inpatient episodes at each hospital.
At the community level, the largest group of SESLHD residents born in non-English speaking countries comes from China, at nearly four times the second largest group, from Greece. Yet in terms of inpatient episodes, Greece ranks the highest, almost double to China. This in part reflects the ageing of post-World War II migrants.

During the 2011-12 financial year, there were 156,191 hospital inpatient episodes in SESLHD public hospitals. Just over one-third (54,198, 35%) of these were for patients born overseas in non-English speaking countries (Figure 10).

Of those inpatient episodes for people born overseas in a non-English speaking country, the most were from Greece, China, Egypt, Lebanon and Italy (Figure 11).
Inpatient Episodes by Preferred Language

Of the 54,198 inpatient episodes where the patient was from a non-English speaking country of birth, 56% (30,526) indicated during the admission process that a language other than English was preferred (or 20% of all episodes). The top 10 preferred languages other than English are shown in Figure 12.

Preference was stated for a language other than English in 1 in 5 of all SESLHD inpatient episodes in 2011-12.

Five languages account for over half of these: Greek, Arabic, Macedonian, Cantonese and Mandarin.

The full Top 10 account for >75%.

**Figure 12: Top 10 preferred languages other than English, SESLHD inpatient episodes 2011-12**

Source: SESLHD Hospital Inpatient Data, 2011-12

Was an Interpreter Required?

Data clarity and data quality issues become apparent when attempting to answer this question. On the inpatient episodes database, the field of “Interpreter required” records either “Y” for Yes, or is left blank. Therefore it is impossible to determine whether a blank response meant “No – interpreter not required” or if this was not asked/not otherwise clinically considered, or if it was requested/deemed necessary but not then recorded in the patient file.

Although 30,526 patients stated a preference for a language other than English at admission, only 5,813 (19%) of these were subsequently recorded in the inpatient database as requiring an interpreter.

Greek, Macedonian, Arabic and Russian accounted for over 50% of the interpreter languages requested for these 5,813 inpatient episodes. Cantonese and Mandarin were not amongst this most-requested group, despite being amongst the most common preferred languages (see previous Figure 12).
USE OF PROFESSIONAL HEALTH CARE INTERPRETERS

It is NSW Government Policy that professional health care interpreters be used to facilitate communication with people who are not fluent in English. The use of professional interpreters allows health professionals to fulfil their duty of care, including obtaining valid consent.

Consent without a professional health care interpreter may not be a valid consent. Nor is it valid if it is obtained through a child or family member, other patient, visitor or staff acting as an interpreter.

It is extremely difficult to determine levels of current service provision and whether needs are being met. A number of complicated data issues include the following:

- The external services that provide professional health care interpreters record their service data in a different system and using a different methodology to SESLHD inpatient statistics.
- Each interaction within the same appointment (e.g., patient, nurse, doctor) is recorded as a separate occasion of service, confounding the value of any attempt to match N occasions of service (interpreter data) to N inpatient episodes (SESLHD data).
- This is further confounded by the fact that an inpatient will often require multiple appointments during their stay.

In short, there is no reliable way to determine whether the 5,813 inpatient episodes recorded as requiring a professional health care interpreter actually received one, or for what aspect/s of their care this occurred.

In an effort to provide at least some insights to aid this planning process, sample file audits were undertaken in some SESLHD hospitals, specifically looking at provision of a professional health care interpreter regarding consent for surgery where “interpreter needed” was recorded on the patient file. The audits highlighted gaps both in data quality and service delivery, and confirmed that a greater focus is required to ensure that the needs of non-English speaking patients are being adequately identified, recorded and addressed. In particular, future efforts should address:

- Clarification of the difference between “preferred language” as recorded upon admission and “interpreter needed” as recorded in the inpatient database. Which is the more meaningful measure of patient need, and should be used for service planning and reporting? Regardless of what may have been recorded during admission, clinical staff need to re-assess the need for an interpreter within the health setting.
- Improvements to data quality regarding “interpreter needed” as recorded by clinical staff. As noted earlier, a blank field in the current database may mean considered and determined to not be required or not considered.
- Efforts to better align SESLHD inpatient data and interpreter service data in order to provide a meaningful indicator of whether or not non-English speaking inpatients are receiving the services that they require, particularly in terms of issues such as providing informed consent.
- Similar considerations should be applied in other (non inpatient) settings – see later in document.
The age profile of inpatients born overseas in non-English speaking countries again reflects the migrant cohorts described earlier, notably the ageing population of those who migrated to Australia after World War II.

**AGE PROFILE OF INPATIENTS BY COUNTRY OF BIRTH**

Figure 13: Age profile of inpatients born in Australia.  
Source: SESLHD Hospital Inpatient Data, 2011-12

Figure 14: Age profile of inpatients born overseas in a non-English speaking country. NB some data points are too small to be visible at this scale. Source: SESLHD Hospital Inpatient Data, 2011-12

**MATERNITY RATES**

For the three public hospitals with Maternity Units across SESLHD, 36% (4,385) of all births in 2011-2012 were to a mother born in a non-English speaking country, with the top five being China, Indonesia, Bangladesh, Lebanon and Philippines. This is related to current immigration policies which favour younger migrants (as related to economic productivity).

For every 10 births at **St George Hospital**, 5 (50%) were to mothers from a non-English speaking country.  
Top 5 countries: China, Lebanon, Nepal, Bangladesh, India

For every 10 births at **The Royal Hospital for Women**, 3 (34%) were to mothers from a non-English speaking country.  
Top 5 countries: China, Indonesia, Bangladesh, Thailand, Russian Fed

For every 10 births at **Sutherland Hospital**, 2 (17%) were to mothers from a non-English speaking country.  
Top 5 countries: China, Philippines, India, Thailand, Japan

**Mothers from non-English speaking countries (particularly recent arrivals) are often less aware of the services available, and may present to services late in pregnancy.**
ADDITIONAL DATA FROM NON-INPATIENT SETTINGS

The provision of appropriate care in inpatient settings is of course essential. But additional discussion is also warranted for other, non-inpatient settings. Unfortunately the data currently available do not provide a clear nor reliable description of the whole patient population, nor their needs and the services currently being delivered. This lack of quality data in itself requires urgent attention, as well as broader service planning and delivery issues.

CHIME data, whilst not comprehensive, provide the best current overview. For the same 2011-2012 period as described earlier for inpatient episodes, CHIME has 5,482 medical records for clients who spoke a language other than English (note that this is different to occasions of service).

Accounting for 76% of these 5,482 medical records, the top 10 countries of birth were:

1. Australia*
2. Greece
3. China
4. Italy
5. Macedonia
6. Lebanon
7. Egypt
8. Russian Federation
9. Cyprus
10. Croatia

Accounting for 71% of these 5,482 medical records, the top 10 languages spoken were:

1. Greek
2. Mandarin
3. Arabic
4. Italian
5. Cantonese
6. Macedonian
7. Spanish
8. Russian
9. Nepali
10. Croatian

* As all of the records reported on this page are from non-English speaking patients, why are Australian-born people shown here? On first glance, this might appear to be an error. But as shown in earlier data, many of the babies delivered in SESLHD hospitals are born to mothers from non-English speaking countries. These babies and young children access SESLHD services with their non-English speaking parents, and thus appear in these records as non-English speaking themselves. This was confirmed by checking that the majority of these records were indeed from paediatric and early childhood services.

Many different services are represented in these data. Early childhood services were the most common, along with other paediatric services. A second cluster of services was noted that provide care for older people, such as relevant community health and nursing services. This again reflects the age profile of migrants that was discussed earlier, particularly the ageing migrant population.

As with inpatient records, substantial data quality issues make it impossible to determine whether access to interpreter services is adequately met. As in the inpatient setting, the current database does not adequately distinguish between interpreter not needed versus need not determined, and patient data cannot be linked to interpreter service delivery. The issues described earlier apply equally in this setting, and require attention.
The SESLHD Multicultural Health Service

The SESLHD Multicultural Health Service (MHS) is a District unit providing leadership in multicultural health to facilitate equitable care for people from culturally and linguistically diverse communities. We aim to ensure that health care within SESLHD is responsive to community needs, and takes into consideration cultural and linguistic backgrounds, communication barriers and migration pathways. Drivers for the work of the MHS are the community itself, requirements under NSW legislation with the *Community Relations in a Multicultural Society Act 2000* and the NSW Policy which is the basis of this plan. The work of the MHS focuses on:

- Enhancing the capacity of the health system to identify and meet the needs of culturally and linguistically diverse consumers and communities, and addressing any health inequities.
- Identifying and effectively addressing the high prevalence of risk factors and disease types amongst specific groups.
- Addressing the health issues that particularly impact on specific groups, including families, children and young people, older people, refugees, and those with chronic and complex health conditions.

The MHS conducts its work through two main domains: (1) Working within the SESLHD to enhance the capacity of the health system to meet the needs of culturally and linguistically diverse consumers and communities and to respond to policies and accountability requirements, and (2) Working with communities to raise awareness of health issues and how to access appropriate services.

The service works within five program areas: communication, community programs, learning, research and workforce development, policy, evaluation and planning, and refugee health.

**Diversity Health Coordinators**

The MHS is complemented by hospital based Diversity Health Coordinators (DHCs), health care interpreter services, and designated multicultural health positions across the SESLHD. The role of the DHCs is to put strategies in place in their services to enhance access to local health services and increase capacity of staff and the facilities to respond to cultural diversity. The focus of DHCs includes the implementation of relevant policies at the local level, quality improvement activities, community outreach programs and partnership initiatives, aimed at improving access, health literacy and health outcomes in people of culturally and linguistically diverse backgrounds, people with disabilities, carers and other disadvantaged groups.
WHAT WE WILL DO

The planning process

In late 2012, the SESLHD Board requested that key performance indicators (KPIs) be developed to provide clear directions for local action and investment. These address:

- The use of professional health care interpreters
- Workforce development
- Consumer engagement and consultation
- Hospital performance
- Health behaviours, with relevance to community-based health promotion and preventive clinical care

Throughout 2013, indicators were developed and refined through extensive consultation processes with District Clinical and Quality Council, the District Executive Team, Ambulatory and Primary Health Care leadership, Diversity Health Coordinators, Multicultural Health Service staff, the Multicultural Health Stakeholder Advisory Committee, and other local key stakeholders. The final KPIs (provided in full later in this document – see page 35) were endorsed by the SESLHD Board in December 2013.

This plan was subsequently developed to describe how these KPIs will be met, within the overarching strategic framework of the NSW Policy, which runs to 2016. Due to the KPI development process being undertaken first, this plan is for 2014-16. Further consultation has been undertaken including planning sessions and broader opportunities for key stakeholders to have input. It is not designed to reflect all the local work in multicultural health. Rather, it is designed to highlight major areas of focus and future direction at a strategic level. It identifies a range of activities and enablers to fulfil our key commitments in multicultural health. Within that context, three key strategic concepts were identified (Figure 15).

![Figure 15: Key Strategic Concepts](image)

In response to these strategic issues, and echoing the strategic priorities of the NSW Policy, the plan is summarised in Figure 16. Detailed objectives, actions, stakeholders and indicators are then described.
Enable

Priority 1.
We will facilitate increased access to professional health care interpreters to improve clinical service delivery and patient outcomes.

Priority 2.
We will build the capacity of our workforce to identify and meet the needs of culturally and linguistically diverse consumers and communities.

Priority 3.
We will work more effectively with culturally and linguistically diverse consumers and communities.

Priority 4.
We will improve our data and reporting to better understand and meet the needs of culturally and linguistically diverse consumers and communities.

Target

Priority 5.
We will identify and address the specific health issues that are priorities for action within our culturally and linguistically diverse communities.

Priority 6.
We will consider the needs of the diverse groups within and across our local communities, and develop appropriately targeted strategies accordingly.

Achieve

NSW Policy Vision:
An equitable health system that ensures that cultural and linguistic diversity is at the heart of service planning, service delivery and policy development.

Figure 16: The plan at a glance
Priority 1: Professional health care interpreters

We will facilitate increased access to professional health care interpreters to improve clinical service delivery and patient outcomes.

<table>
<thead>
<tr>
<th>Why is this important?</th>
<th>What will we do in SESLHD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is NSW Government Policy that professional health care interpreters be used to facilitate communication with people who are not fluent in English. Consent without a professional health care interpreter may not be a valid consent. Nor is it valid if it is obtained through a child or family member, other patient, visitor or staff acting as an interpreter. Yet quality assurance audits highlighted gaps both in data quality and actual access to professional health care interpreters, and confirmed that a greater focus is required to ensure that this need is adequately identified, recorded and addressed. This is an urgent priority. The use of professional interpreters allows health professionals to fulfil their duty of care. There is also good evidence that the use of professional interpreters improves the quality of clinical consultations, and patients’ compliance with treatment.</td>
<td><strong>Objective 1.1 Increase use of professional health care interpreters for provision of informed consent where “interpreter needed” identified.</strong> 1.1.1 Educate staff regarding the use of professional health care interpreters so that they are accurately able to identify the need for an interpreter and effectively use one. 1.1.2 Ensure that interpreter services are promoted appropriately. 1.1.3 Embed audits in standard auditing processes in hospitals, following pilot audits in each hospital. Ensure that a standardised audit methodology (including standard measures) is agreed upon to ensure consistency across the District. 1.1.4 Refine methodologies based on audits and seek relevant endorsement and commitment. 1.1.5 Disseminate methodologies across the District. 1.1.6 Ensure that all policies, training and practice are consistent with NSW Health PD2006_053 <em>Standard Procedures for Working with Health Care Interpreters</em>. 1.1.7 Advocate for and support appropriate training and ongoing support for professional healthcare interpreters, particularly when working in difficult settings such as dementia and end of life care (NB interpreters are not SESLHD employees). 1.1.8 Include and record appropriate procedures for bilingual staff gaining valid consent where language skills are sufficient for that purpose.</td>
</tr>
</tbody>
</table>

**Key drivers, stakeholders and partnerships**

Delivery of these actions will rely on commitment from and effective partnerships between (but not limited to) the following: Clinical Governance Unit, facility-based medico-legal teams, Directors of Clinical/Medical Services, clinical staff involved in consent procedures and interpreter services, Multicultural Health Service, Diversity Health Coordinators. It will also include broader partnerships such as those with Primary Health Networks and primary health care providers.

**How will we measure our performance?**

- *Percentage of clients having a professional health care interpreter involved in provision of consent where ‘interpreter needed’ is identified in their record. A preliminary baseline shows a need for increased compliance with policy.*

* KPI from the priority list endorsed by the SESLHD Board, Dec 2013. Full list provided on p35.
Priority 2: Our workforce

We will build the capacity of our workforce to identify and meet the needs of culturally and linguistically diverse consumers and communities.

Why is this important?
As highlighted in the NSW Policy, action is required across the entire NSW public health care system to build healthy culturally diverse communities. This is not the responsibility of one small specialist team, but of our entire health care system.

Therefore building the capacity of the SESLHD workforce to identify and address cultural needs is a high priority, through learning, research and workforce development strategies, as well as more culturally appropriate models of health care.

What will we do in SESLHD?

**Objective 2.1 Increase the number of staff that attend endorsed cultural competency training programs.**

2.1.1 Develop the SESLHD Multicultural Training Strategy incorporating a wide range of learning options.
2.1.2 Undertake ongoing analysis of attendance to prioritise and target training for groups of staff.
2.1.3 Collect, analyse and respond to feedback and evaluation of training.
2.1.4 Explore ways in which to increase relevant workforce development opportunities, such as incorporating relevant content into routine LHD mandatory training and performance management systems.

**Objective 2.2 Increase the inclusion of cultural diversity issues in locally conducted health research.**

2.2.1 Promote more active consideration of cultural and linguistic diversity issues when planning locally conducted health research (eg through ethics processes, research design and indicators).
2.2.2 Support specific local research projects to build the evidence base relevant to this plan and these issues.

**Objective 2.3 Support the health service to develop models of care and tailored approaches to deliver culturally appropriate care.**

2.3.1 Develop policies, pathways and models of care that factor in the needs of local communities and represent best practice in appropriate care for culturally and linguistically diverse consumers.
2.3.2 Utilise the potential that bilingual staff bring to the organisation and consider targeted recruitment to reflect the consumer profile.

Key drivers, stakeholders and partnerships

Delivery of these actions will rely on commitment from and effective partnerships between (but not limited to) the following: People and Culture Team and by extension, the Health Education and Training Institute (HETI), Nursing Education Research Units, Nursing Educator leads, Medical Educators, Multicultural Health Service, Diversity Health Coordinators, local researchers and the SESLHD Human Research Ethics Committee.

How will we measure our performance?

- *Number of staff that attend multicultural training programs each year, in addition to standard corporate orientation. Baseline 2012-2013: 601 staff attended training. Targets: 650 staff in 2013/14; 700 staff 2014/15; 750 staff in 2015/16.
- Number of local research projects that include consideration of culturally and linguistically diverse populations and relevant data collection.
- Evidence of consideration of cultural and linguistic diversity in policies, pathways and models of care.

*KPI from the priority list endorsed by the SESLHD Board, Dec 2013. Full list provided on p35.
## Priority 3: Consumer and community engagement

We will work more effectively with culturally and linguistically diverse consumers and communities.

### Why is this important?

The CORE Values of NSW Health (Collaboration, Openness, Respect and Empowerment) emphasise the importance of community engagement and involvement in health care. As described in *National Standard 2: Partnering with Consumers*, all consumers have a right to be appropriately informed and involved in their health services, and a range of benefits for consumers, the wider community, and the health system itself have been demonstrated.

To this end, SESLHD will ensure there are mechanisms in place to actively engage with consumers and the community in order to meet their needs, and develop culturally appropriate health care services.

### What will we do in SESLHD?

#### Objective 3.1 Increase capacity for the District to engage and consult effectively with culturally and linguistically diverse consumers.

3.1.1 Ensure that all SESLHD committees and strategies that are developed to comply with National Safety and Quality Health Service Standards (notably *Standard 2: Partnering with Consumers*) routinely and systematically include consideration of cultural and linguistic diversity.

3.1.2 Develop new and innovative approaches to engaging with and communicating health messages to local culturally and linguistically diverse communities.

3.1.3 Ensure that communications capacity and quality continues to improve the health literacy and wellbeing of culturally and linguistically diverse communities (translations, way finding, websites, patient information in languages other than English, newsletter articles, staff information etc).

3.1.4 Focus on newly arrived communities through the implementation of specific projects.

3.1.5 Explore Consumer and Advisory Committee processes to identify opportunities to embed an increased understanding of needs of consumers from culturally and linguistically diverse backgrounds.

3.1.6 Develop strategies and training materials in relation to consumer engagement and consultation frameworks, as developed by the District.

### Key drivers, stakeholders and partnerships

Delivery of these actions will rely on commitment from and effective partnerships between (but not limited to) the following: Multicultural Health Service, Diversity Health Coordinators, Community Partnership Officers, Patient Safety and Community Feedback Manager (Clinical Governance Unit) and facility based Community Advisory Committees.

### How will we measure our performance?

- *Percentage of all new members on Consumer and Advisory Committees across the District receiving induction training that includes information on culturally and linguistically diverse communities relevant to SESLHD (Stage 1). Target = 80%.*

- Number of new projects targeting health literacy and consumer engagement in place across the District.

- *Further specific KPIs to be decided post development of District consumer engagement and consultation frameworks.*

*KPI from the priority list endorsed by the SESLHD Board, Dec 2013. Full list provided on p35.*
## Priority 4: Data and reporting

We will improve our data and reporting to better understand and meet the needs of culturally and linguistically diverse communities.

### Why is this important?

Relevant, reliable and timely data are essential to the management and improvement of health care services. Being able to accurately describe relevant issues provides an essential insight to what must be done, and ongoing monitoring of key performance indicators allows us to track our progress and further improve outcomes.

For example, performance reports usually report *total* population data in relation to key health indicators. But it is only by reporting separately for people born in non-English speaking countries that we will obtain a more accurate understanding of the health inequities experienced by these groups, and be able to address them.

### What will we do in SESLHD?

#### Objective 4.1 Provide timely and relevant population data.

1. **4.1.1** Work with the SESLHD Directorate of Planning and Population Health to identify key data to describe the local communities (eg from Census data) and ensure that reports are produced in a timely manner to aid service planning.

2. **4.1.2** Work with the SESLHD Directorate of Planning and Population Health to ensure that routine reports of key population health indicators (eg smoking rates, falls in older people, diabetes prevalence etc) include analyses by country of birth and/or language spoken, as appropriate.

3. **4.1.3** Work with population-based services such as Public Health and Health Promotion to ensure that relevant projects incorporate country of birth and/or language spoken data and indicators, wherever possible.

#### Objective 4.2 Provide timely and relevant service delivery data.

1. **4.2.1** Work with the SESLHD Clinical Governance and Business Intelligence and Efficiency Units to enhance the accuracy of ethnicity-related data collection across clinical services.

2. **4.2.2** Produce relevant, reliable and timely datasets for hospital and community health systems to aid service planning.

3. **4.2.3** Identify and target variance in access, activity or flow for the culturally and linguistically diverse population born in Australia/English speaking country on key measures identified in the District Performance Agreement.

### Key drivers, stakeholders and partnerships

Delivery of these actions will rely on commitment from and effective partnerships between (but not limited to) the following: Directorate of Planning and Population Health, Clinical Governance Unit, Business Intelligence and Efficiency Unit, clinical facilities, Diversity Health Coordinators, Multicultural Health Service. Potential exists for broader linkages to state-based groups such as the Bureau of Health Information.

### How will we measure our performance?

- **Year 1**, develop a report card of relevant hospital performance indicators to investigate the variance between culturally and linguistically diverse population and Australian/English country born population.
- **Year 2**, develop two KPIs to target hospital performance based on data analysis of variance.
- Develop a demographic factsheet for the District within 6 months of the release of high level ABS Census data for people from culturally and linguistically diverse backgrounds.
- Routinely report on population health indicators by country of birth and/or language spoken, as appropriate.

*KPI from the priority list endorsed by the SESLHD Board, Dec 2013. Full list provided on p35.*
# Priority 5: Priority health issues

We will address specific health issues that are priorities for action within culturally and linguistically diverse communities.

## Why is this important?

Action is required to address the high prevalence of risk factors and disease types amongst specific ethnic groups.

For example, tobacco smoking, the leading cause of preventable disease and death in Australia[^18], is a serious issue in certain culturally and linguistically diverse communities. This is discussed in greater detail in the [SESLHD Plan for the Prevention of Smoking and Harm from Smoking 2014-2019][19], with which this plan is closely aligned.

Likewise, diabetes is known to be more prevalent in certain communities including people from China, our largest migrant group[^20].

As well as the health behaviour of individuals, a focus on system response and system management is essential to provide a comprehensive approach to these priority health issues.

## What will we do in SESLHD?

### Objective 5.1 Contribute to the planning, implementation and evaluation of preventive programs across SESLHD to include a greater consideration of issues within culturally and linguistically diverse communities.

5.1.1 Use relevant data (see Priority 4) to identify high risk communities and the health issues affecting them.

5.2.2 Work with the SESLHD Health Promotion and Public Health teams to incorporate appropriate strategies into their programs.

### Objective 5.2 Design and undertake specific projects to address identified areas of need.

5.2.1 Commit to a minimum of three programs targeting priority health issues running in any year across SESLHD. This will commence with:

- Strategies to increase participation in diabetes self-management programs.
- Culturally-specific pulmonary exercise programs for Chinese and Greek communities, with a focus on the efficacy of language specific service delivery and/or a bilingual support worker.
- A feasibility study to address smoking behaviour in the Arabic speaking communities to identify if there are sufficient pathways to reach and influence the community.

### Key drivers, stakeholders and partnerships

Delivery of these actions will rely on commitment from and effective partnerships between (but not limited to) the following: Population-based services such as Health Promotion and Public Health, Chronic Disease Management Program, facility-based diabetes units, SESLHD Smoke-Free Health Facilities Steering Committee, Diversity Health Coordinators, Multicultural Health Service, Primary Health Networks and providers.

### How will we measure our performance?

- A minimum of three programs targeting priority health issues running in any year across SESLHD, commencing with:
  - *Diabetes: Number and percentage (relative to overall population) of people from culturally and linguistically diverse backgrounds with diabetes participating in self-management programs.
  - *Pulmonary Rehabilitation: Participation rates in culturally-specific pulmonary exercise programs.
  - *Smoking: Completion of feasibility study and development of relevant implementation plan, as relevant to the issues described in this document and the [SESLHD Plan for the Prevention of Smoking and Harm from Smoking][20].

[^18]: KPI from the priority list endorsed by the SESLHD Board, Dec 2013. Full list provided on p35.
## Priority 6: Priority groups

**We will consider the needs of the diverse groups within and across our local communities.**

### Why is this important?

As described earlier, people from culturally and linguistically diverse backgrounds are not a homogenous group. For example, refugees, international students, young people from developing Asian countries and ageing European post-World War II migrants are completely different cohorts of people with different lifestyles, risks, health issues and needs.

A more specific focus is required to meet the needs of different groups within our communities, to design and deliver appropriate strategies. The vulnerability of specific groups needs to be taken into account as some groups may have multiple and complex health care needs, and complex social, language and cultural issues impacting on their ability to access services.

### What will we do in SESLHD?

**Objective 6.1 Deliver targeted strategies to meet the needs of specific groups.**

- **6.1.1** Implement strategies of the *SESLHD Refugee Health Implementation Plan*.
- **6.1.2** Develop and implement projects for new and emerging communities, e.g., Bangladeshi, Nepalese.
- **6.1.3** Target programs to address the needs of families and children, including domestic violence prevention.
- **6.1.4** Target programs to ageing culturally and linguistically diverse communities and increase awareness of staff about the local ageing multicultural population, including their carers.

**Objective 6.2 Ensure broader consideration of different groups across all SESLHD service planning.**

- **6.2.1** Work with the SESLHD Directorate of Planning and Population Health to identify and advocate for relevant attention to the needs of more vulnerable groups in service planning. These may include:
  - Refugees
  - Newly arrived and emerging groups
  - Women, families and children
  - Ageing communities and their carers
  - People with limited English proficiency skills
  - Asylum seekers

### Key drivers, stakeholders and partnerships

Delivery of these actions will rely on commitment from and effective partnerships between (but not limited to) the following: Directorate of Planning and Population, Health Promotion Team, Child, Youth, Women and Families Health Team, Refugee Health Coordination Group, Carers Program and relevant disability services, local Migrant Resource Centres, Primary Health Networks and providers, the Multicultural Health Stakeholder Advisory Committee, Diversity Health Coordinators, Multicultural Health Service.

### How will we measure our performance?

- Appropriate levels of activity within each of the targeted programs/projects described in Objective 6.1.
- SESLHD plans will be reviewed to identify whether cultural and linguistic considerations have been included.
DELIVERING THE PLAN

Delivery of the plan will be overseen by the SESLHD Multicultural Health Service, with support from the facility-based Diversity Health Coordinators, and reporting to the Ambulatory and Primary Health Care leadership and District Executive Team.

The existing Multicultural Health Stakeholder Advisory Committee will provide guidance and facilitate consultation with local culturally and linguistically diverse communities (Figure 17).

A reporting framework and timetable will be established, including regular reports to the Board, and interim reports to the Ambulatory and Primary Health Care Directorate and District Executive Team.

Appropriate communication strategies will be developed to ensure the engagement of and regular contact with other key stakeholders.

Figure 17: Governance structure for delivery of this plan
## Professional Health Care Interpreters

Percentage of clients having a professional health care interpreter involved in provision of consent where ‘interpreter needed’ is identified in their record. A preliminary baseline shows a need for increased compliance with policy.

## Workforce Development

Number of staff that attend multicultural training programs each year, in addition to standard corporate orientation.

Baseline 2012-2013: 601 staff attended training.

Targets: 650 staff in 2013/14; 700 staff 2014/15; 750 staff in 2015/16.

## Consumer Engagement & Consultation

Percentage of all new members on Consumer and Advisory Committees across the District receiving induction training that includes information on culturally and linguistically diverse communities relevant to SESLHD (Stage 1).

Target= 80%

Further specific KPIs to be decided post development of District consumer engagement and consultation frameworks.

## Hospital Performance

Year 1, develop a report card of relevant hospital performance indicators to investigate the variance between culturally and linguistically diverse population and Australian/English country born population.

Year 2, develop two KPIs to target hospital performance based on data analysis of variance.

## Health Behaviour

Minimum three activities addressing health behaviours in progress every year, commencing with:

- Diabetes: Number and percentage of people from culturally and linguistically diverse backgrounds with diabetes participating in self-management programs.
- Pulmonary Rehabilitation: Participation rates in culturally specific pulmonary exercise programs.
- Smoking: Completion of feasibility study and development of relevant implementation plan.
REFERENCES


This document has been written to be in strategic alignment with the SESLHD Refugee Health Implementation Plan 2011-2016\(^2\), which is the local response to the NSW Refugee Health Plan 2011-2016\(^3\). These documents address the health needs of refugees and asylum seekers, with many similar underpinning principles to those described herein. The strategic priorities are:

1. To develop health policies and plans which prioritise and are inclusive of refugee health.
2. To ensure, in collaboration with General Practitioners and other partners, universal access to health assessment and assertive follow-up for all newly arrived refugee and humanitarian entrants.
3. To promote refugee health and wellbeing.
4. To provide high quality specialised refugee health services
5. To develop specific targeted responses to refugee need within mainstream services.
6. To foster the provision of high quality mainstream care to refugees.
7. To foster research and evaluation relevant to the health of refugees.
8. To monitor and evaluate the NSW Refugee Health Plan 2011–2016.

The implementation of these two local plans will be coordinated and communicated appropriately to maximise the natural synergies between them, whilst maintaining their important individual purpose and priorities.
Plan excerpt (Executive Summary)

The South Eastern Sydney Local Health District Refugee Health Implementation Plan has been developed in response to the NSW Refugee Health Plan 2011-2016 which outlines eight strategic priorities and included a best practice model for refugee healthcare. Central to the best practice model are Refugee Health Nurses who conduct on-arrival health assessments with follow up comprehensive health assessments by General Practitioners (GPs) or specialised refugee health clinics.

In 2011-12, the NSW government allocated $1.5 million dollars per annum to expand the program of Refugee Health Nurses (RHNS) across NSW. As a result, in metropolitan Sydney, the NSW Refugee Health Service (RHS) has increased the pool of Refugee Health Nurses and expanded their outreach services. This included a population based allocation of FTE 0.2 of outreach services to South Eastern Sydney Local Health District (SESLHD).

The former South Eastern Sydney Illawarra Health (SESIH) demonstrated a significant interest in and commitment to the health of refugees. The achievements of the SESIH Refugee Health Program are summarised in this document.

The refugee population in SESLHD is characterised by a small but significant number of new Humanitarian arrivals per year (approximately 150 people) from countries such as China, Iran, Iraq, Egypt and Bangladesh. There is also a significant older refugee population, particularly in the Eastern Suburbs.

Key partners in developing and delivering the initiatives of the SESLHD Refugee Health Implementation Plan are:

- SESLHD Multicultural Health Service
- Sydney Children's Hospital Network, Randwick Campus
- NSW Refugee Health Service
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
- Asylum Seeker Centre of New South Wales
- Settlement services
- Primary health care providers and organisations
- Health Language Services
- Diversity Health Coordinators in SESLHD hospital facilities
- Child Youth Women and Family Health
- Key services within SESLHD, including Women’s Health, Public Health Unit, Infectious Diseases, Mental Health, Maternal and Child Health, Youth Health, Sexual Health, Oral Health, Chest Clinics, Aged Care
- Consumer representatives/community members/advocates

The immediate priorities identified in the SESLHD Refugee Health Implementation Plan are:

- to establish a SESLHD Refugee Health Coordination Group (RHCG) to oversee the implementation of the plan
- to implement the best practice model of refugee healthcare in SESLHD
- to continue to implement the targeted health screening in Beverley Hills Intensive English Centre
- to continue the longitudinal study of refugee children in their first three years of settlement
- to conduct a forum on the health needs of older refugees
Appendix B: Additional data – country of birth

Table 3: Country of birth
Source: Australian Bureau of Statistics, 2011 Census

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Eastern</th>
<th>St George</th>
<th>Sutherland</th>
<th>All SESLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Born in Australia</td>
<td>179,813</td>
<td>56.3%</td>
<td>121,144</td>
<td>55.2%</td>
</tr>
<tr>
<td>Born Overseas</td>
<td>139,288</td>
<td>43.7%</td>
<td>98,341</td>
<td>44.8%</td>
</tr>
<tr>
<td>Subset: Born in an English speaking</td>
<td>47,720</td>
<td>15.0%</td>
<td>10,766</td>
<td>4.9%</td>
</tr>
<tr>
<td>Country</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subset: Born in a Non-English</td>
<td>91,568</td>
<td>28.7%</td>
<td>87,575</td>
<td>39.9%</td>
</tr>
<tr>
<td>Speaking Country</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Stated</td>
<td>36,502</td>
<td></td>
<td>12,516</td>
<td></td>
</tr>
<tr>
<td>TOTAL PERSONS</td>
<td>355,603</td>
<td></td>
<td>232,001</td>
<td></td>
</tr>
</tbody>
</table>

All percentages shown are of total persons minus Not stated.

Table 4: Top 10 English speaking overseas countries of birth (sequence as ranked within total SESLHD)
Source: Australian Bureau of Statistics, 2011 Census

<table>
<thead>
<tr>
<th>N People</th>
<th>Eastern</th>
<th>St George</th>
<th>Sutherland</th>
<th>All SESLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1. England</td>
<td>17,945</td>
<td>37.6%</td>
<td>3,593</td>
<td>33.4%</td>
</tr>
<tr>
<td>2. New Zealand</td>
<td>9,581</td>
<td>20.1%</td>
<td>4,079</td>
<td>37.9%</td>
</tr>
<tr>
<td>3. South Africa</td>
<td>7,036</td>
<td>14.7%</td>
<td>736</td>
<td>6.8%</td>
</tr>
<tr>
<td>4. Ireland</td>
<td>4,647</td>
<td>9.7%</td>
<td>518</td>
<td>4.8%</td>
</tr>
<tr>
<td>5. United States of America</td>
<td>3,606</td>
<td>7.6%</td>
<td>516</td>
<td>4.8%</td>
</tr>
<tr>
<td>6. Scotland</td>
<td>2,057</td>
<td>4.3%</td>
<td>636</td>
<td>5.9%</td>
</tr>
<tr>
<td>7. Canada</td>
<td>1,330</td>
<td>2.8%</td>
<td>255</td>
<td>2.4%</td>
</tr>
<tr>
<td>8. Wales</td>
<td>532</td>
<td>1.1%</td>
<td>120</td>
<td>1.1%</td>
</tr>
<tr>
<td>9. Nthn Ireland</td>
<td>521</td>
<td>1.1%</td>
<td>118</td>
<td>1.1%</td>
</tr>
<tr>
<td>10. Zimbabwe</td>
<td>370</td>
<td>0.8%</td>
<td>179</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
**Table 5: Top 20 non-English speaking countries of birth (sequence as ranked within total SESLHD)**

Source: Australian Bureau of Statistics, 2011 Census

<table>
<thead>
<tr>
<th>N People</th>
<th>Eastern</th>
<th>St George</th>
<th>Sutherland</th>
<th>All SESLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>91,568</td>
<td>87,575</td>
<td>20,301</td>
<td></td>
<td>199,444</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-English Speaking</th>
<th>N People</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. China</td>
<td>11731</td>
<td>12.8%</td>
<td>24646</td>
<td>28.1%</td>
<td>1795</td>
<td>8.8%</td>
<td>38172</td>
<td>19.1%</td>
</tr>
<tr>
<td>2. Greece</td>
<td>3150</td>
<td>3.4%</td>
<td>5443</td>
<td>6.2%</td>
<td>1032</td>
<td>5.1%</td>
<td>9625</td>
<td>4.8%</td>
</tr>
<tr>
<td>3. Indonesia</td>
<td>6287</td>
<td>6.9%</td>
<td>2265</td>
<td>2.6%</td>
<td>418</td>
<td>2.1%</td>
<td>8970</td>
<td>4.5%</td>
</tr>
<tr>
<td>4. Hong Kong</td>
<td>3556</td>
<td>3.9%</td>
<td>4402</td>
<td>5.0%</td>
<td>674</td>
<td>3.3%</td>
<td>8632</td>
<td>4.3%</td>
</tr>
<tr>
<td>5. India</td>
<td>2983</td>
<td>3.3%</td>
<td>3112</td>
<td>3.6%</td>
<td>947</td>
<td>4.7%</td>
<td>7042</td>
<td>3.5%</td>
</tr>
<tr>
<td>6. Philippines</td>
<td>2902</td>
<td>3.2%</td>
<td>3005</td>
<td>3.4%</td>
<td>923</td>
<td>4.5%</td>
<td>6830</td>
<td>3.4%</td>
</tr>
<tr>
<td>7. Italy</td>
<td>2673</td>
<td>2.9%</td>
<td>2480</td>
<td>2.8%</td>
<td>1156</td>
<td>5.7%</td>
<td>6309</td>
<td>3.2%</td>
</tr>
<tr>
<td>8. Lebanon</td>
<td>872</td>
<td>1.0%</td>
<td>4459</td>
<td>5.1%</td>
<td>610</td>
<td>3.0%</td>
<td>5941</td>
<td>3.0%</td>
</tr>
<tr>
<td>9. Malaysia</td>
<td>3443</td>
<td>3.8%</td>
<td>1623</td>
<td>1.9%</td>
<td>540</td>
<td>2.7%</td>
<td>5606</td>
<td>2.8%</td>
</tr>
<tr>
<td>10. Macedonia</td>
<td>177</td>
<td>0.2%</td>
<td>4740</td>
<td>5.4%</td>
<td>577</td>
<td>2.8%</td>
<td>5494</td>
<td>2.8%</td>
</tr>
<tr>
<td>11. Egypt</td>
<td>1412</td>
<td>1.5%</td>
<td>2738</td>
<td>3.1%</td>
<td>862</td>
<td>4.2%</td>
<td>5012</td>
<td>2.5%</td>
</tr>
<tr>
<td>12. Thailand</td>
<td>3617</td>
<td>4.0%</td>
<td>879</td>
<td>1.0%</td>
<td>317</td>
<td>1.6%</td>
<td>4813</td>
<td>2.4%</td>
</tr>
<tr>
<td>13. Nepal</td>
<td>509</td>
<td>0.6%</td>
<td>3818</td>
<td>4.4%</td>
<td>69</td>
<td>0.3%</td>
<td>4396</td>
<td>2.2%</td>
</tr>
<tr>
<td>14. Germany</td>
<td>2479</td>
<td>2.7%</td>
<td>574</td>
<td>0.7%</td>
<td>916</td>
<td>4.5%</td>
<td>3969</td>
<td>2.0%</td>
</tr>
<tr>
<td>15. Bangladesh</td>
<td>1704</td>
<td>1.9%</td>
<td>2081</td>
<td>2.4%</td>
<td>77</td>
<td>0.4%</td>
<td>3862</td>
<td>1.9%</td>
</tr>
<tr>
<td>16. South Korea</td>
<td>2764</td>
<td>3.0%</td>
<td>749</td>
<td>0.9%</td>
<td>199</td>
<td>1.0%</td>
<td>3712</td>
<td>1.9%</td>
</tr>
<tr>
<td>17. Vietnam</td>
<td>1607</td>
<td>1.8%</td>
<td>1652</td>
<td>1.9%</td>
<td>391</td>
<td>1.9%</td>
<td>3650</td>
<td>1.8%</td>
</tr>
<tr>
<td>18. France</td>
<td>2315</td>
<td>2.5%</td>
<td>200</td>
<td>0.2%</td>
<td>192</td>
<td>0.9%</td>
<td>2707</td>
<td>1.4%</td>
</tr>
<tr>
<td>19. Fiji</td>
<td>901</td>
<td>1.0%</td>
<td>1385</td>
<td>1.6%</td>
<td>372</td>
<td>1.8%</td>
<td>2658</td>
<td>1.3%</td>
</tr>
<tr>
<td>20. Russian Fed</td>
<td>1776</td>
<td>1.9%</td>
<td>491</td>
<td>0.6%</td>
<td>363</td>
<td>1.8%</td>
<td>2630</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

**Lord Howe Island** is part of the SESLHD. Less than 5% of Lord Howe Island residents were born in a non-English speaking country. If required, however, interpreter services are available by telephone.
## Appendix C: Additional data – language spoken at home

### Table 6: Top 20 languages spoken at home (sequence as ranked within total SESLHD)

Source: Australian Bureau of Statistics, 2011 Census

<table>
<thead>
<tr>
<th>Language</th>
<th>N People who speak a non-English language at home</th>
<th>Eastern</th>
<th>St George</th>
<th>Sutherland</th>
<th>All SESLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>96,913</td>
<td>119,289</td>
<td>24,353</td>
<td>240,555</td>
</tr>
<tr>
<td>Mandarin</td>
<td>11739</td>
<td>19578</td>
<td>1580</td>
<td>32897</td>
<td>13.7%</td>
</tr>
<tr>
<td>Greek</td>
<td>9250</td>
<td>17276</td>
<td>4087</td>
<td>30613</td>
<td>12.7%</td>
</tr>
<tr>
<td>Cantonese</td>
<td>8727</td>
<td>18102</td>
<td>1992</td>
<td>28821</td>
<td>12.0%</td>
</tr>
<tr>
<td>Arabic</td>
<td>2764</td>
<td>13989</td>
<td>1996</td>
<td>18749</td>
<td>7.8%</td>
</tr>
<tr>
<td>Italian</td>
<td>4435</td>
<td>4218</td>
<td>1937</td>
<td>10590</td>
<td>4.4%</td>
</tr>
<tr>
<td>Spanish</td>
<td>5370</td>
<td>3449</td>
<td>1300</td>
<td>10119</td>
<td>4.2%</td>
</tr>
<tr>
<td>Macedonian</td>
<td>225</td>
<td>8232</td>
<td>1030</td>
<td>9487</td>
<td>3.9%</td>
</tr>
<tr>
<td>Indonesian</td>
<td>5835</td>
<td>2234</td>
<td>340</td>
<td>8409</td>
<td>3.5%</td>
</tr>
<tr>
<td>Russian</td>
<td>4741</td>
<td>1038</td>
<td>686</td>
<td>6465</td>
<td>2.7%</td>
</tr>
<tr>
<td>French</td>
<td>3814</td>
<td>461</td>
<td>494</td>
<td>4769</td>
<td>2.0%</td>
</tr>
<tr>
<td>Thai</td>
<td>3508</td>
<td>905</td>
<td>282</td>
<td>4695</td>
<td>2.0%</td>
</tr>
<tr>
<td>Bengali</td>
<td>2068</td>
<td>2330</td>
<td>103</td>
<td>4501</td>
<td>1.9%</td>
</tr>
<tr>
<td>Nepali</td>
<td>478</td>
<td>3933</td>
<td>75</td>
<td>4486</td>
<td>1.9%</td>
</tr>
<tr>
<td>Portuguese</td>
<td>2344</td>
<td>1223</td>
<td>399</td>
<td>3966</td>
<td>1.6%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1576</td>
<td>1654</td>
<td>446</td>
<td>3676</td>
<td>1.5%</td>
</tr>
<tr>
<td>Korean</td>
<td>2574</td>
<td>818</td>
<td>173</td>
<td>3565</td>
<td>1.5%</td>
</tr>
<tr>
<td>German</td>
<td>2323</td>
<td>416</td>
<td>738</td>
<td>3477</td>
<td>1.4%</td>
</tr>
<tr>
<td>Croatian</td>
<td>875</td>
<td>1924</td>
<td>631</td>
<td>3430</td>
<td>1.4%</td>
</tr>
<tr>
<td>Hindi</td>
<td>1273</td>
<td>1708</td>
<td>364</td>
<td>3345</td>
<td>1.4%</td>
</tr>
<tr>
<td>Tagalog</td>
<td>1265</td>
<td>1677</td>
<td>388</td>
<td>3330</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Appendix D: Additional data – population profile by age and gender

Figure 18: SESLHD population profile of people born in non-English speaking countries.
Source: Australian Bureau of Statistics, 2011 Census

Figure 19: SESLHD population profile of people born in Australia.
Source: Australian Bureau of Statistics, 2011 Census
Table 7: Top 5 Non-English Speaking Countries of Birth of people currently aged 65 and over, by Community Cluster and all SESLHD
Source: Australian Bureau of Statistics, 2011 Census

<table>
<thead>
<tr>
<th>Country</th>
<th>Eastern</th>
<th>St George</th>
<th>Sutherland</th>
<th>All SESLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greece</td>
<td>2,183</td>
<td>3,191</td>
<td>607</td>
<td>5,846</td>
</tr>
<tr>
<td>China</td>
<td>1,193</td>
<td>2,552</td>
<td>472</td>
<td>4,003</td>
</tr>
<tr>
<td>Italy</td>
<td>1,190</td>
<td>1,586</td>
<td>369</td>
<td>3,383</td>
</tr>
<tr>
<td>Hungary</td>
<td>904</td>
<td>1,292</td>
<td>314</td>
<td>1,966</td>
</tr>
<tr>
<td>Egypt</td>
<td>838</td>
<td>857</td>
<td>271</td>
<td>1,436</td>
</tr>
</tbody>
</table>