10 September 2025

The Productivity Commission
4 National Circuit
Barton ACT 2600, Australia

Mode of Submission: Online

YOUR REFERENCE: ETHNIC COMMUNITIES COUNCIL OF QUEENSLAND'S (ECCQ) CONTRIBUTION TO THE *'DELIVERING QUALITY CARE MORE EFFICIENTLY'* INQUIRY

Introduction

ECCQ notes that the Productivity Commission (PC) has been tasked by the Australian Government to undertake five inquiries to identify priority reforms under each of the five pillars of the Government's productivity growth agenda and formulate actionable recommendations to assist governments to make meaningful and measurable productivity-enhancing reforms.

The Commission has further been tasked to report on priority reforms in each of the areas under the Government's five pillar productivity growth agenda. Specifically, these are priority reforms which enhance productivity through:

a. Creating a more dynamic and resilient economy
b. Building a skilled and adaptable workforce
c. Harnessing data and digital technology
d. Delivering quality care more efficiently
e. Investing in cheaper, cleaner energy and the net zero transformation

This submission, which includes our additional input and suggestions outlined below, specifically relates to the '*Delivering Quality Care More Efficiently'* Inquiry (point d.).

Our Additional Input/Request

Throughout the 93 pages of *delivering quality care more efficiently* interim report, there is no mention of refugee and migrant health. With 30.7% of Australia's community being born overseas (ABS, 2024), this is a complete disregard for the health and care needs of almost a third of the country's population.

As such, ECCQ recommends the development of a dedicated prevention framework that is culturally and linguistically responsive, specifically tailored to the complex needs of migrant and refugee communities.

At the acute level, this framework will potentially enhance immediate health and wellbeing outcomes while also reducing long-term pressure on the broader health systems.

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The framework will further promote greater health equity among some of Australia's most vulnerable population groups by addressing barriers to healthcare access and encouraging the active participation of culturally and linguistically diverse (CALD) communities, including multicultural health professionals.

Background

Multicultural health promotions, including prevention programs, can be complex in nature because, within the migrant communities themselves, significant heterogeneity of health disparities exists in all key areas – chronic health, sexual health, bloodborne viruses, alcohol/drug addictions, and ageing, just to name a few (Renzaho et al. 2015).

Chronic Health

Based on genetic pre-dispositions and post-migration lifestyle changes, certain multicultural community groups are disproportionately affected by chronic health conditions, including but not limited to obesity and diabetes (Renzaho et al. 2015). Similarly, the 2024 Australian Institute of Health and Welfare's data indicates that several chronic health issues, including but not limited to dementia, heart, stroke, and kidney diseases exhibit disproportionately higher prevalence rates among individuals born outside Australia. For instance, Australians of Bangladeshi origin have the highest prevalence rates of diabetes and heart disease (12% and 4.6%, respectively) while individuals born in Polynesian countries like Tonga and Samoa have elevated rates of kidney disease, standing at 1.9% and 1.5%, respectively (Australian Institute of Health and Welfare 2024).

On the other hand, due to increased global unrests, civil wars and violent conflicts, refugee numbers have grown exponentially over the recent years. These numbers have historically posed major challenges to Australian services providers, particularly in relation to caring for the complex health and well-being needs of this highly vulnerable population (Kara & Stuart 2021). Paradoxically, while there is a positive relationship between the length of time lived in Australia and all other integration and settlement outcomes (employment, for example), evidence suggests that Individuals with low English proficiency who have resided in Australia for a long time have higher age-standardized prevalence of arthritis, asthma, mental health, and lung conditions.

In other words, the prevalence of chronic health conditions tends to increase with the length of time since arrival in Australia across most countries of birth (Australian Institute of Health and Welfare, 2024). This is potentially because multicultural communities, including migrants, asylum seekers, and refugees may find it difficult to access local and affordable specialized medical care through the mainstream services as providers lack experienced personnel, resources, and equipment. As such, they either must travel or remain untreated, making them dependent on relatives and friends for an extended period, and undermining their trust in the health systems (Georgeou et al. 2022).

Mental Health

ECCQ conducts periodic members' meetings, and community leaders have constantly made a point that mental health within migrant communities, especially refugees and asylum seekers, should be given the highest priority in research, policy, planning, prevention, and funding because these are some of the most vulnerable members of the society. For example, compared to migrants from other parts of the world, African refugees and asylum seekers have shown greater vulnerability to mental health challenges such as depression, post-traumatic stress disorder (PTSD), and anxiety. These population groups often experience significant stressors that increase their risk to these mental health problems, including the struggle with changing family structures and dynamics, different cultural expectations, and inadequate support systems (Botchway-Commey et al., 2024).

Refugees and asylum seekers also face gross violation of human rights before they arrive in Australia, further compromising their health and wellbeing. For example, the world has witnessed conflicts in several forms, which has enormously subjected many people to unprecedented levels of suffering throughout the recent decades. One of the major features of many conflicts around the world currently is gender-based violence, which has always been considered as a by-product of war, affecting mainly women and girls, particularly in places where rape has been used as a weapon of war and demonstration of power (Danjibo & Akinkuotu, 2019). From ECCQ's interactions with women from war-torn countries, we know that lives of vulnerable women and girls are essentially destroyed before they come to Australia, and it takes a long time to recover (Slewa-Younan, Krstanoska-Blazeska, Blignault, Reavley & Renzaho, 2022).

There is generally lower uptake of mental health services in refugee and migrant communities that need them the most. According to Slewa-Younan, Krstanoska-Blazeska, Blignault, Reavley and Renzaho (2022), help-seeking behaviours in culturally and linguistically diverse communities are directly affected by stigma towards mental illness and a range of adverse cultural practices. For example, in communities with collectivist values, there is a sense of self that is interconnected with family wellbeing, and consequently, there is a general perception that mental health issues will affect an individual's close circle and the community. That's why the so-called *'bringing shame to family/community' is a strong deterrent to disclosing mental health problems* (p.12), making some initiatives to tackle the critical issue within multicultural communities redundant.

Sexually Transmitted Diseases and Bloodborne Viruses

The number of notified sexually transmissible infections in Australia has generally increased over the last decade. Chlamydia was on top of the list of commonly notified STIs in 2023, with more than 109,000 notifications, followed by gonorrhoea with more than 40,000 notifications, and infectious syphilis, with over 6,400 notifications. The same year, there were over 7,600 hepatis C notifications. While the HIV notification rates have generally declined over the past decade, the threat caused by the disease remains serious (Australian Institute of Health 2024). Currently available data indicates that there were 555 new HIV diagnoses in Australia in 2022 (Kirby Institute 2023). In 2023, Queensland alone registered 158 HIV cases (Queensland Health 2024).

In typically Australian (and Queensland) context, STIs and BBVs disproportionally affect people from CALD backgrounds. For example, 72 % of people who were living with chronic hepatitis B in Australia in the period between 2018 and 2022 were either from CALD backgrounds or Aboriginal and Torres Strait Islander people. 61 percent; that is, most hepatitis B cases in Australia is found in people born overseas, particularly in hepatitis B endemic areas, with people born in North-East Asia (representing 21 per cent of people in Australia living with chronic hepatitis B), South-East Asia (17 per cent), Europe (8 per cent) and Sub-Saharan Africa (4 per cent) particularly vulnerable (Department of Health 2022). Similarly, there were 339 HIV cases previously diagnosed overseas with subsequent diagnostic testing conducted in Australia in 2022; 33% of which were in Victoria, 27% in New South Wales, and 24% in Queensland, that is, there were 183 new HIV cases detected in Queensland in 2022 and 83 of these were previously diagnosed overseas (Kirby Institute 2023).

CALD community members, particularly women with refugee background are at higher risk of BBVs and STIs because of the legacies of the refugee journeys, which generally expose women and girls to sexual abuses (Ngendakurio 2017). Alarmingly, migrants, asylum seekers and refugees from low- and middle-income countries who settle in high-income countries underutilise sexual and reproductive health services. This is because, evidence suggests, socio-cultural beliefs about sex and sexual health impedes sexual and reproductive health services' utilisation in these community groups due to shame and stigma associated with sex and sexual health. Besides, migrants from low- and middle-income countries often have limited knowledge about sexually transmitted infections, safe sex and contraception (Maheen, Chalmers, Khaw & McMichael 2020). There are also low testing rates among

CALD populations due to limited health seeking behaviour, lack of familiarity with health services, privacy and confidentiality concerns, and barriers associated with language, and migration status (Department of Health 2022).

That's why catering to needs of migrants, refugees and asylum seekers is complex and requires targeted and holistic approach as recommended in the 2023 National Hepatitis B Strategy, which specifically suggests a strengthened response to hepatitis B and other infectious diseases among people from culturally and linguistically diverse backgrounds to improve rates of diagnosis, links to treatment and ongoing care. That way, we can minimise the morbidity and mortality associated with chronic infectious diseases and prevent further transmissions (Department of health 2022). From ECCQ's work on the ground in Queensland, currently there is no prevention program in Queensland that supports CALD communities that are at low or medium risks of a range of health problems, which makes healthy ageing within these population groups unachievable.

Healthy Ageing Within Multicultural Communities

We need to place greater focus on ensuring that CALD communities age healthily. If people are not accessing the health system early enough, or their chronic conditions are not being identified and treated in time, the consequences are significant. Research consistently shows that CALD populations often face significant barriers in accessing healthcare services. These challenges include language and communication difficulties, limited health literacy, cultural misunderstandings or stigma, fear or mistrust of the healthcare system, and a lack of culturally appropriate services. Together, these barriers can result in delays in early diagnosis, treatment, and preventive care, ultimately leading to poorer health outcomes for individuals within these communities. Further, when these barriers such as stigma prevent them from seeking aged care services, even those delivered in the home, and they instead remain solely reliant on family care, the outcome is often unhealthy ageing.

This creates a downstream effect at the acute level, driving higher demand on hospital systems and shifting the burden onto state governments. This is because, when people—particularly from CALD backgrounds—do not access primary care early or manage chronic conditions effectively, it often leads to the worsening of preventable conditions. This results in higher use of emergency departments and unplanned hospital admissions. By contrast, this framework has the potential to enhance health and wellbeing outcomes, support earlier intervention, and reduce long-term pressure on the broader health system.

Therefore, ECCQ asks the Productivity Commission to include an additional recommendation that will see the health equity within some of the most vulnerable population groups in Australia (CALD Communities) enhanced, with long-term outcomes.

[redacted]
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