Every day, most Australian clinicians treat patients whose first language is not English. Nearly four million Australians speak 350 non-English languages, and 17% rate their spoken English as poor. To date, there has been little large scale Australian research into the health impacts of not speaking the country’s dominant language.

Studies on the relationship between linguistic diversity and health outcomes are methodologically challenging. Many have been criticised for their failure to adjust for socio-economic status, education, or English language proficiency, or for using country of birth as a proxy for language spoken at home. The prospective cohort study by Juergens and his colleagues, published in this issue of the *MJA*, adds to research on cardiovascular disease and language by analysing mortality 6 months after discharge from hospital. The authors found that mortality was higher in patients whose first language was not English.

Two broad sets of explanations are offered when interpreting differences in health outcomes associated with language: explanations related to socio-epidemiological determinants in the affected population, and explanations related to failures of health service responsiveness.

Although Australia’s immigrant population is heterogeneous, the cardiovascular risk factors in some populations warrant intensive primary and secondary preventive care. The two leading source regions for immigrants to Australia at present — China and South Asia — face escalating epidemics of diabetes. So rapid is the increase in prevalence that many communities do not have established strategies for managing patients with diabetes. Although the smoking rates among people whose first language is not English are overall lower than those of other Australians, some subpopulations have markedly higher rates.

Equally important is health literacy: the ability to obtain, read and understand health information. In the 2006 national health literacy survey, only 26% of those born in a non-English speaking country had adequate health literacy, compared with about 45% of those born in Australia or in an English-speaking country. Patients with low health literacy may struggle to read and interpret information on how and why to take their medications, the significance of new cardiovascular symptoms, and how to obtain emergency help when they need it. For patients who have experienced cardiovascular events, achieving parity in health literacy may require innovative methods of cardiovascular rehabilitation with language-competent health providers; for example, by employing remote technology, such as Skype, supported by written language information, such as that produced by the National Heart Foundation (http://heartfoundation.org.au/support/information-in-your-language).

Health literacy is the product of good communication between a clinician and their patient.
Despite being a largely migrant country, Australia is unusually monolingual. Four out of five of us can speak only English, making us the third most monolingual country in the world, after Brazil and Japan. There is an urgent need to develop and sustain health systems that are responsive to the needs of non-English-speaking Australians. A language-sensitive health system would ensure that complex health information, such as that provided before discharge from hospital or when explaining health interventions, such as cardiac catheterisation, is delivered comprehensibly, using language support resources.

We are a long way from achieving this. So great is the linguistic diversity of Australia that even multilingual doctors rarely find themselves sharing the language of their non-English-speaking patients. Hospitals cannot rely upon on-site interpreters to meet all the language needs of their patients. The Translating and Interpreting Service offers the most extensive telephone interpreting system in the world, providing doctors and pharmacists with rapid, 24-hour access to interpreters; this service does not, however, include Indigenous languages. Further, it is used in less than 1% of consultations by private practitioners with patients with limited English proficiency. We should also be able to reliably assess whether or not family members have the competence to adequately interpret for their relatives, when desired.

The challenge of meeting the needs of non-English speakers is a permanent one for Australia. The proportion of people over 65 years who have limited English proficiency increases at each census, reflecting the phenomenon of second language attrition as we age. The age group at greatest risk of cardiovascular disease is thus the one that may be struggling with diminishing English competence. Effective solutions will require us to develop culturally sensitive health promotion programs for cardiovascular disease, with a particular focus on diabetes as a comorbidity, and whole-of-system approaches which ensure that Australians who do not speak English as their first language can communicate clearly and confidently with their health care providers.

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