Dr Iolanda Principe

Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds

A Scoping Study for the Health Performance Council

September 2015

Table of Contents

1. Summary **3**

2. Introduction **14**

3. Background **15**

3.1 Previous Advice by the Health Performance Council
3.2 CALD Population Profile in South Australia

4. Increasing Challenges **17**

4.1 Older People from CALD Backgrounds
4.2 New and Emerging Communities

5. Priority Issues **24**

5.1 Inclusion and Empowerment
5.2 Access and Equity
5.3 Quality
5.4 Capacity Building

6. Conclusion **42**

Appendix A: Persons Consulted

References

1. Summary

Introduction

This scoping study was commissioned by the Health Performance Council to explore key issues in health care for culturally and linguistically diverse (CALD) populations in South Australia. It aims to identify current priority issues regarding appropriate care and quality of experience for people from CALD backgrounds through consultation with CALD peak bodies, advocacy groups and service providers, as well as a review of relevant information and research outcomes.

The scope of CALD populations for this study includes new and emerging communities (new migrants and refugees) and established CALD communities, with a focus on older people from CALD backgrounds. The scope does not include Aboriginal and Torres Strait Islanders whose needs, in health and wellbeing policy contexts at state and national levels, are considered separately rather than under the framework of cultural and linguistic diversity. CALD is the preferred term for many government and community agencies as a contemporary descriptor for ethnic communities.

The Australian Bureau of Statistics (ABS) defines cultural and linguistic diversity using three variables: country of birth; language other than English (LOTE) spoken at home; and English language proficiency. Other variables related to culture and language which may influence a person's health and access to health services include: ancestry, ethnic origin, religion, and preferred language.

Background

In 2014 the Health Performance Council (HPC) identified that people from cultural and linguistically diverse backgrounds are among the population groups believed to be missing out on accessing suitable services or gaining equitable health care outcomes. One of the issues is evidence and getting quality information.

The HPC provided advice to the Minister for Health that SA population health data collection and analysis be supplemented with purposeful sampling of specific population groups on a cyclic basis for routine reporting and that SA Health complements its existing mainstream survey with a consumer experience survey of CALD South Australians. In 2013, the HPC also recommended that SA Health train all staff in cultural competency, having found inadequacies in end of life care for CALD populations.

CALD Population Profile in South Australia

The 2011 Census showed that about 350,000 South Australians were born overseas (22%) and about 230,000 adults speak a language other than English at home. Migrant adults from non-English-speaking backgrounds make up nearly 13% of South Australia's population and nearly 25% when children of migrants are included. The main countries of origin are: Italy, India, China, Vietnam, Germany and Greece.

About 14.4% of the population speak a language other than English at home and 2.5% (about 40,000) of the population speak little English or not at all. Those persons who speak little English or not at all are usually older, have a lower educational attainment and have poorer health outcomes than the general population.

New arrivals in 2011 came mostly from China, India, Malaysia, Philippines, Afghanistan, Korea, South Africa and Indonesia. Most recently, migrants to SA in 2013-2014 included refugees and asylum seekers from Afghanistan, Bhutan, Iran, Myanmar/Burma, Nepal, Pakistan, Democratic Republic of Congo and several other African, Middle Eastern and Asian countries. Migration over the last couple of years has also included skilled migrants mainly from India, China, Philippines, Malaysia, Korea and Vietnam.

An important distinction when considering the health and wellbeing needs of people from CALD backgrounds is that they are not a homogenous group. There is 'diversity within diversity' and individuals may or may not have family and support networks or interact with or be associated with ethno-specific community groups. While living conditions and socio-economic status varies across populations, many people from CALD backgrounds have higher levels of disadvantage and other additional risk factors compared with Anglo-Australians. These include socio-economic disadvantage related to cultural translation difficulties and lower rates of access to services. Risk of unemployment for people from CALD backgrounds of working-age is compounded by language and other cultural barriers, poor recognition of overseas qualifications or prior skills, a tendency to be in unskilled roles and a lack of understanding and trust of government support. Traditional ethno-specific, cultural and religious views may affect or influence access to health services on the basis of gender and age.

The main findings of this scoping study below were developed through consultation with selected CALD peak bodies and advocacy agencies and ethno-specific and mainstream service providers to identify community perspectives and service challenges and achievements. This exploration was also informed by a review of relevant information and research outcomes but is not intended to present a complete literature review.

Increasing Challenges

Older People from CALD backgrounds

South Australia has a higher aged profile than other states and territories, and the CALD community (made up of primarily people from the large scale post-war migration as well as older migrant new arrivals) has a higher aged profile than the community overall.

In 2011, 18.5% of people aged over 65 living in SA were born in non-English-speaking countries. Nearly 60% of people aged over 65 were predominantly from Italy, Greece, Germany, Netherlands, Poland, Croatia, India, Vietnam, South Eastern Europe and Hungary; and more than 40% of the older CALD population was from smaller communities. The largest established older CALD communities in SA were from Italy and Greece, and the largest of the emerging older CALD communities were from Vietnam and China.

For older CALD people seeking work, employment risks are compounded by time and resources taken to re-train, the possibility of facing age discrimination as well as racial discrimination and the impact on personal confidence. Increased unemployment in both metropolitan and regional SA is being experienced and this is affecting where people reside in relation to family and support networks, as well as having direct economic impact.

There are substantial barriers for older people from CALD backgrounds to accessing health, aged care and community services. Inadequate provision of culturally sensitive services and coordinated support, and language are major barriers. Language is a major barrier even for established CALD communities as language, particularly English as an acquired language is lost with isolation, age and with conditions affecting memory.

Further challenges impacting on the health and aged care interface for South Australia are being experienced by the shift from the Commonwealth Home and Community Care Program (HACC) to the 'consumer directed' Commonwealth Home Support Program (CHSP) and My Aged Care as part of national aged care reform. There is an increased reliance on online information and registration for services, impacting on access for CALD populations. There is reported further complexity regarding access due to changes to conditions and processes as well as changes to the resources and service profile of community support agencies.

Comprehensive information about the specific range of service programs and the exact roles and responsibilities of State public health care providers and those of private sector/community primary health care providers in supporting the community to access these Commonwealth services needs to be available. In this age of online information and service access, greater support is required given the reduced access for the non-computer literate.

New and Emerging Communities

Census comparisons from 2006 and 2011 show the fastest growing birthplaces for South Australians are Bhutan, Nepal, Saudi Arabia, Democratic Republic of Congo and Myanmar though this is off a small population base. The largest new and emerging communities are from India, China, South Korea, Afghanistan and Sri

Lanka. The new and emerging CALD communities also include skilled migrants, international students, people in South Australia on working visas, and refugees. New arrivals also include asylum seekers (detainees or former detainees) in the community on temporary bridging visas waiting on determinations or other temporary visas and are therefore uncertain about their future. Many people within these populations may have had traumatic migration experiences.

Settlement services in SA have noticed an increase in complex medical health referrals and case support. New arrivals with disabilities and significant medical issues experience delays in accessing specialist and disability services. Delays are also being experienced due to overseas medical reports which are not accepted, leaving clients to wait for a report from an Australian specialist before acceptance of diagnosis of their condition. Refugees and asylum seekers may also have experienced torture and trauma and have particular issues with privacy, confidentiality of information and trust.

Smaller CALD populations lack critical mass and the community support networks of established CALD communities. It is considered by advocates and service providers that their needs tend to be overlooked and/or not properly addressed or supported systematically by mainstream health services. Families, young people and those living in rural South Australia are considered amongst the most vulnerable within these communities[i].

Mental Health

In addition to physical chronic diseases, including in particular the increasing risk and prevalence of diabetes, a major health issue for older persons from CALD backgrounds and the new and emerging communities is mental health.

Older people from CALD backgrounds have a higher risk of mental health issues than the population born in Australia and tend to present at later stages of illness compared to other older people. There is also a poor understanding and cultural stigma attached to dementia that leads to denial of the condition and or delayed diagnoses. Those who migrated to Australia at an older age, or who are from refugee background, face a higher risk of mental and physical health issues. Due to language and cultural barriers affecting access and equitable care, different pathways for mental health care and other health care needs are advocated for implementation at system-level across the continuum of care.

Priority Issues

Improvements in health care for people from CALD backgrounds over the last few decades in South Australia were reported to include recognition of cultural diversity

in some relevant policies and practices, language services, and a more culturally diverse health workforce. There have been effective CALD initiatives implemented in some acute care and primary care settings and a growth in CALD community advocacy and ethno-specific health, aged care and wellbeing service providers. Current reforms in health and aged care are considered to be creating further challenges to access to appropriate services, noting again that aged care is a Commonwealth-led matter that has important implications for the South Australian health system for the care of older people from CALD backgrounds.

The priority issues arising from consultations and other relevant research are presented below in the categories of the key principles of care for persons from CALD backgrounds: inclusion and empowerment; access and equity; quality and capacity building.

1. Inclusion and Empowerment

a. Unlike other Australian states, including Victoria, New South Wales and Queensland, the South Australian Government does not have a specific[ii] policy framework, action plan and reporting mechanism for health care services to people from CALD backgrounds. In 2011, the SA Department for Health and Ageing was no longer required to report on access and equity to the South Australian Multicultural and Ethnic Affairs Commission (SAMEAC) through Multicultural SA. While SA Health has developed and adopted various relevant policies, plans and standards that recognize cultural diversity and aim to address CALD needs, this gap in access and equity accountability is demonstrated by a strongly perceived lack of cross cultural competency across the health system, inconsistent practices and procedures across hospitals and other health services, and the lack of system-wide baseline data to measure and monitor performance in this area.

b. Advocacy support within the health system is considered critical for people from CALD backgrounds whose health and wellbeing needs are compounded by language and other cultural barriers. These needs cannot be supported by language services alone and require understanding of cultural and other circumstances for effective guidance and support where the patient is unaware or unable to access services on their own.

c. The prevailing view about the South Australian public health system is that, contrary to the principles of social inclusion, an inclusive approach to CALD population needs is not taken at the planning stage of any mainstream policy, program, services and systems development; that CALD population needs are on the periphery (that is, when time and resources permit and/or as 'afterthought') instead of being an intrinsic part of the planning and design at the outset to ensure equitable and appropriate care.

d. There is a perception that because CALD communities are smaller, more diverse and complex than dominant cultures, they are less important or even 'impossible' to address

specifically, although health outcomes may be worse than the general population due to compounded risk factors.

e. Many recommendations for improved communication have been offered when CALD community engagement has taken place, and while some changes have been made, overall it is considered that recommendations have been unable to be implemented, due mostly to complexity ('too hard') or time and resource constraints.

2. Access and Equity

Language and Culture

a. Overall cross cultural competency in hospital and other health services including mainstream general practice/community-based healthcare settings is considered to be poor, with lack of cultural sensitivity and competence and experiences of racism have been reported. Positive CALD consumer experiences appear to be reliant largely on the individual skills, experience and relevant cultural background of health workers.

b. *Effective communication with people from CALD backgrounds does not just involve language* – consideration needs to be given to a person's experience and cultural background for care to be provided appropriately. This would require advocacy support for individuals who are unable to communicate directly and effectively due to language and other cultural barriers.

c. Cultural competence and knowledge of personal history and context is important to the sensitive handling of health emergency situations for survivors of torture and trauma; and situations involving families and possible domestic violence and child protection issues.

d. Interpreters used for health care need upskilling: dealing with sensitive information and situations in ways that are appropriate for the individual and their family and cultural context, as well as training for health/medical settings; ensuring that information conveyed has been understood, particularly when giving literal interpretations of medical terminology; and should possess the necessary knowledge of the local health system.

e. Interpreters are required at all points of hospital care including emergency, pre-admission, consent, post-operative, discharge and for outpatient care but are not always provided/available or able to be arranged by people from CALD backgrounds without assistance.

f. The practice of booking interpreters is not consistent across hospitals and interpreters are not 'matched' to patients either for continuity or for analysis of use for reporting or evaluation.

g. Although there are difficulties for some CALD patients without interpreting assistance for first contact, outpatient interpreting services are usually more effectively arranged and resourced than inpatient requirements for interpreting services.

h. People from CALD backgrounds with little or no proficiency in English experience difficulty in filling out all the required hospital forms without assistance (multiple form requirements are considered to be increasing due to technology platform transitions and for continued care in different hospitals).

i. People from CALD backgrounds have difficulty accessing hospital transport assistance for outpatient appointments; procedures across hospitals and within outpatient clinics vary and can require unassisted first attendance, filling out forms for presentation at different areas of the hospital (and limited validity for each outpatient clinic appointment once approved, necessitating repeat process).

j. Patient needs may be overlooked where there is lack of involvement of family and/or carers; including during interpreter assisted/social worker interactions where they could assist with cultural and personal contexts.

k. It is claimed that compromised health and wellbeing outcomes and high risk of hospital re-admission for CALD patients are being experienced due to poor hospital discharge planning resulting from ineffective communication and/or responsiveness to personal and family circumstances. Ethno-specific community social support organisations are experiencing many requests for urgent assistance from patients or their families and services are more difficult to organise quickly when the patient has already been discharged. Anecdotal evidence exists of hospital re-admission due to lack of appropriate home care.

l. Limited time for GP consultations impacts greatly on the effectiveness of primary health care for patients with little or no English proficiency and other cultural characteristics that impact on effective communication and consultation outcomes, even with an interpreter/family or carer present. The quality of primary medical care for CALD patients can have service implications for the acute care health system.

m. There is an underutilisation of interpreting and translating services by GPs for their CALD patients; this is perceived as being due to time constraints and additional

complexity of client needs. Interpreter underutilisation can affect the quality of GP/patient communication and impact on health outcomes.

n. Translation of written hospital information and health and wellbeing information hard copy or online products from English into other languages is considered very important but should be one of the multi-pronged strategies for reaching diverse audiences. Individuals have varying levels of literacy in their own language and preferences for verbal and visual communications and may require customised assistance. Online technologies are considered ineffective, particularly for older people from CALD backgrounds even when there may be household internet access.

o. Health literacy is poor for people from CALD backgrounds: this includes understanding of healthy living and ageing well messages and information about how the health system works and how to use it and what services are available. There is a need for better 'upstream' interventions that address all aspects of health and wellbeing. For the distribution of key messages to CALD communities, working with ethno-specific cultural groups and the use of ethno-specific radio and television are the most effective mechanisms.

p. Effective community engagement with most people from CALD backgrounds is not possible when health services predominantly use telephone or internet-based communication; face-to-face focus groups is considered to be the most effective way to gain participation.

<u>Service Utilisation</u>

q. A comprehensive audit of all service use and performance data would be required to understand whether useful data exists on patients/clients from CALD backgrounds. Based on a review of available information, there does not appear to be any reportable culturally inclusive baseline data on which to assess disparities in quality of care, health outcomes or patient satisfaction for CALD populations.

r. Available hospital separation data contains Country of Birth although there are some gaps. Outpatient data are less reliable as an indicator of CALD population use as there are a greater number of entries for persons with an 'unknown' Country of Birth than those recorded as born in Australia or born overseas, as well as an absence of other relevant cultural and linguistic characteristics.

s. The SA Monitoring and Surveillance System (SAMSS) health survey is a telephone-based self-assessment survey with selective reach into CALD communities and with limited reporting ability for cultural diversity.

t. People from CALD backgrounds are less likely to access mental health services in both hospital and community-based mental health services. There is widespread underutilisation of mental health services by children in the general population and refugee children and adolescents are known to be at greater risk of developing mental health problems and have greater difficulty accessing mental health care.

u. Lower level of health service utilisation is not related to lower levels of need but rather to difficulties in understanding and accessing mainstream systems of care and lack of access to services that are culturally safe and appropriate. This situation is further complicated by lack of trust, social fear and the social stigma associated with mental illness.

v. Migrants that arrive unassisted or have had only time limited support may *"fall through the cracks"* and be without support mechanisms for access to health services while facing challenging physical, psychosocial and socioeconomic circumstances

w. Some new arrivals without free access to health care are known to self-medicate and may not seek any professional medical attention, or will prefer to wait in hospital emergency departments for assistance rather than visit General Practitioners.

x. There is significant underutilisation of the *Healthdirect Australia* telephone-based health advice and triage line by CALD populations, even with the facility for interpreter assistance.

y. There is reduced opportunity for people from CALD backgrounds to know about Advanced Care Directives (currently being addressed through a campaign by the Office of the Ageing) and additional challenges relating to access health and aged care services.

3. Quality

a. There was a strong need identified for comprehensive cross cultural competency training for health workers and other health service staff.

b. Consumer engagement with CALD populations regarding health services and health service engagement is limited when telephone and the internet mechanisms are used; face to face focus groups are seen as the most effective way to gain engagement; radio and television is known to work best for campaigns. Engagement directly with community members is important as well as working closely with ethno-specific cultural groups regarding key messages for communities.

c. There is an under-representation of CALD populations in consumer experience surveys and other feedback mechanisms, which are currently predominantly telephone-based and difficult for people with poor English proficiency to participate.

d. There is currently no mechanism in SA Health's Safety Learning System Consumer Feedback module which identifies the complainant as being from a CALD background (although this is being addressed); and there is an under-representation of persons from CALD backgrounds in Health and Community Services complaints. The latter is perceived as being due primarily to issues of trust (expectation of system 'collusion'), not being aware of the complaints process, how to access it, and more limited ability to engage.

4. Capacity Building

a. Health workforce cultural diversity is considered to be highly important and beneficial for consumer experience and culturally appropriate/sensitive health care for people from CALD backgrounds.

b. Clinicians from CALD backgrounds working in hospitals and general practice (particularly in rural South Australia) require greater personal support as well as engagement and encouragement within organisational management to foster and facilitate cultural competency in their service settings.

c. Innovative community-based approaches to health and well-being services for CALD populations could be used more effectively for individual and community benefit.

d. CALD community capacity could be understood better and factored into approaches for coordinated care, health workforce development and support. Health system links could be strengthened through partnerships that foster collaboration rather than competition.

Conclusion

While organisations and individuals that advocate on behalf of CALD communities acknowledge some health system improvements over several decades due to greater cultural awareness, the increased CALD profile of health workers, and greater CALD community participation, the ability of the health system to respond effectively to the needs of South Australians from CALD backgrounds is considered inadequate.

This situation of inadequacy has been significantly compounded by the changing CALD profile of older non-English-speaking people with increasing needs, and new and emerging communities with diverse and complex needs in difficult social and economic environments. A major issue for these communities is the need for improved psychosocial support and access to mental health services.

Further challenges are being experienced from current reform initiatives in health and aged care. In addition to changes to existing providers, services and procedures which directly affect CALD consumers, the impact of these reform initiatives includes what is considered to be a reduction in the capacity of community support organisations to assist with coordination of care, health literacy, navigation of health and aged care systems, and other related support services. These changes are perceived to be creating further difficulties for people from CALD backgrounds to access appropriate health and wellbeing services. Comprehensive information about the specific range of service programs and the exact roles and responsibilities of State public health care providers and those of private sector/community primary health care providers in supporting the community to access these Commonwealth services needs to be available. Good access to Commonwealth aged care programs and services is a critical issue for the older CALD communities as they are essential to supporting health and wellbeing.

There are many key issues in health care for people from CALD backgrounds, in the areas of inclusion and empowerment; access and equity; quality and capacity building. Although policies and services exist that aim to address the needs of CALD populations, there is no specific policy or strategic framework, accountability or advocacy across public health services. There is an absence of quality information and culturally inclusive baseline data on which to assess disparities in quality of care, health outcomes and patient experience.

2. Introduction

This scoping study was commissioned by the Health Performance Council to explore key issues in health care for culturally and linguistically diverse (CALD) populations in South Australia. It aims to identify current priority issues affecting appropriate care and quality of experience for people from CALD backgrounds.

The findings were developed through consultation with selected CALD peak and advocacy bodies and both ethno-specific and mainstream service providers to identify community perspectives and service challenges and achievements. The exploration also included a review of relevant information and research outcomes.

The scope of CALD populations for this study includes new and emerging communities, comprising new migrants and refugees, and established CALD communities, with a focus on older people from CALD backgrounds. The focus on older people is due to known complexities of an ageing population impacting on health care. The scope does not include Aboriginal and Torres Strait Islanders whose needs are considered separately in health and wellbeing policy contexts at state and national levels, rather than under the framework of cultural and linguistic diversity. CALD is the preferred term for many government and community agencies as a contemporary descriptor for ethnic communities[iii].

The Australian Bureau of Statistics (ABS) defines cultural and linguistic diversity using three variables: country of birth; language other than English (LOTE) spoken at home; and English language proficiency. Other variables related to culture and language which may influence a person's health and access to health services include: ancestry, ethnic origin, religion, and preferred language.

Relevant national strategies[iv], policies and standards recognise that people from CALD backgrounds are not a homogenous or uniform group. There is 'diversity within diversity', where the needs of different CALD communities and individuals within those communities vary considerably. Health charters[v] recognise diversity and that all individuals have the right to access health care that meets their needs. Individuals have the right to appropriate health care regardless of their cultural, linguistic or religious background.

The national guideline for cultural competency in health[vi] states that: *"in this culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at every level of the health system - systemic, organisation, professional and individual"*. Cultural competency is more than an awareness of cultural differences. It can be used to improve health and wellbeing by integrating culture into the delivery of health services.

3. Background

3.1 Previous Advice by the Health Performance Council

In 2014 the Health Performance Council identified that people from cultural and linguistically diverse backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes[vii]. The Health Performance Council provided advice to the Minister for Health that SA population health data collection and analysis be supplemented with purposeful sampling of specific population groups on a cyclic basis for routine reporting and that SA Health complements its existing mainstream survey with a consumer experience survey of CALD South Australians.

In 2013, the Health Performance Council also recommended that SA Health train all staff in cultural awareness, having found inadequacies in end of life care for CALD populations[viii] and relevant stalled implementation of the *Palliative Care Services Plan 2009-2016*.

3.2 CALD Population Profile in South Australia[ix]

The 2011 Census[x] found that:

- 22% (350,000) South Australians were born overseas (compared with 25% nationally)
- 13% of SA's population are migrant adults from non-English-speaking countries (15.7% nationally), nearly 25% when children of migrants are included
- 14.4% (230,000) speak a language other than English at home (compared with 18.2% nationally)
- 2.5% (39,931) do not speak English well or not at all (compared with 3% nationally).

South Australians come from about 200 countries, speak more than 200 languages (including Aboriginal languages) and believe in about 100 religions.

Migrant adults from non-English-speaking backgrounds make up nearly 13% of South Australia's population and nearly 25% when children of migrants are included.

The main countries of origin are: Italy, India, China, Vietnam, Germany and Greece. The main languages other than English spoken at home in Australia are Italian, Greek, Mandarin, Vietnamese, Cantonese, Arabic, German, Polish, Spanish, Punjabi and Hindi. The main non-English-speaking birthplaces of new arrivals in 2011 were China, India, Malaysia, Philippines, Afghanistan, Korea, South Africa and Indonesia.

2013-2014 Migration

A major challenge facing many countries is the protection of refugees who have been forced to leave their home. Between January 2013 and June 2014, a total of 2,174 Humanitarian[xi] entrants arrived in South Australia. They came from Afghanistan, Bhutan, Iran, Myanmar/Burma, Nepal, Pakistan, Democratic Republic of Congo and several other African, Middle Eastern and Asian countries.

Between January 2013 and June 2014, a total of 6,993 skilled migrants arrived in South Australia, mainly from India, Peoples Republic of China, Philippines, Malaysia, Republic of Korea, and Vietnam (including migrants from English-speaking countries) and a total of 8,077 Family stream migrants arrived in South Australia, mainly from People's Republic of China, India, Philippines, Vietnam, Afghanistan, and Thailand.

Migration accounts for nearly two-thirds of SA's population growth, the second highest nationally.

Census 2011 data for South Australia found that the top ten non-English speaking countries of birth are China, India, Italy, Vietnam, Philippines, Malaysia, Germany, Greece, Sri Lanka and Lebanon. Comparisons from 2006 and 2011 show the fastest growing birthplaces for South Australians are Bhutan, Nepal, Saudi Arabia, Democratic Republic of Congo and Myanmar.

Census 2011 data analysis[xii] for South Australia provides relevant information on aspects of the determinants of health which include income, employment, education, housing and living arrangements for people born overseas and speak a main language other than English at home, or do not speak English at home or are not proficient in English. Comprehensive community profiles[xiii] that use a range of SA research outcomes in addition to Census 2011 information are available of each population group. These include education enrolments in SA and main places of residence by Local Government Area, amongst other detailed demographic and cultural characteristics.

The Public Health Information Development Unit data for 2011: *Monitoring Inequality in South Australia* charts the Socio Economic Indexes for Areas (SEIFA) quintile of socio-economic disadvantage of area for each of the top ten non-English speaking countries of origin[xiv]. The three population groups with the highest inequality ratio of Quintile 5 (most disadvantaged) to 1 (least disadvantaged), by proportion of the South Australian population, are people born in Vietnam, the Philippines and India. Note that these are the three most disadvantaged only of the ten countries of origin with the highest proportion of the total South Australian population.

South Australia has a higher aged profile than other States and Territories. The CALD community has a higher aged profile than the community overall, due primarily to the large scale post-war migration as well as older migrant new arrivals over the last five years.

4. Increasing Challenges

While there are continuing and current issues regarding health care for people from CALD backgrounds, the increasing challenges identified from consultations and research relate mainly to older people and new and emerging CALD communities. These populations, including the health and welfare of asylum seekers in South Australia on temporary visas, specifically have been identified as priority concerns for the South Australian Multicultural and Ethnic Affairs Commission (SAMEAC).

4.1 Older People from CALD Backgrounds

By 2021, more than 30% of Australia's older population will have been born outside Australia. Migration analysis[xv] has shown that the age profile of South Australian overseas migrants in 2006 was older than that for Australia as a whole. South Australia had a higher proportion of its migrant population aged over 50 years compared to Australia. In 2011, 18.5% of people aged over 65 living in SA were born in non-main English-speaking countries[xvi].

Nearly 60% of people aged over 65 are predominantly from Italy, Greece, Germany, Netherlands, Poland, Croatia, India, Vietnam, South Eastern Europe and Hungary and more than 40% of the older CALD population are from smaller communities. The largest established older CALD communities in SA are from Italy and Greece, and the largest of the emerging older CALD communities are from Vietnam and China.

In March 2015, the Federation of Ethnic Communities' Councils of Australia (FECCA) released the *Review of Australian Research on Older People from Culturally and Linguistically Diverse Backgrounds*. FECCA collaborated with the Australian Population and Migration Research Centre at the University of Adelaide on this review in response to the sporadic research in this area. The review identified the existing research evidence base about older CALD Australians and identified gaps in the research on:

- older people from CALD backgrounds in general;
- older people from CALD backgrounds with dementia;
- ageing and mental health issues for people from CALD backgrounds; and
- CALD carers and carers of older people from CALD backgrounds.

The review emphasizes that older people from CALD backgrounds are not a homogeneous group and that meeting their needs is highly complex. It found that many older people from CALD backgrounds have higher levels of disadvantage and other risk factors compared with older Anglo-Australians. These risk factors include socioeconomic disadvantage, cultural translation difficulties, lack of exposure to Australian services and systems, and lower rates of access to services. It found that older people from CALD backgrounds have a higher risk of mental health issues than and tend to present at later stages of illness compared to other older people in Australia. Those who migrated to Australia at an older age or who are from refugee

background, face a higher risk of mental and physical health issues. Older migrants, in particular women, are recognized as ageing prematurely and experiencing social isolation. The University of Adelaide researchers have established a focus in South Australia for the identified gap areas, including research conducted in collaboration with the Office for the Ageing (OFTA), Department for Health and Ageing.

Many commonalities were found across all older Australians in preferences for ageing-well. These include, for example, the importance of maintaining health and independence. However, many older CALD Australians face circumstances that are different to those of other older Australians and this may have an impact on their ageing experience, and access to and use of services. The FECCA review found that ageing-well, including options for care when ageing, vary from culture to culture.

Language is a major barrier to accessing information and services for some older people from CALD backgrounds, even those who have lived in Australia for decades. Additionally, cultural world views and expectations may also be important barriers. It found that risk of unemployment for people from CALD background of working-age is compounded by language and other cultural barriers, poor recognition of overseas qualifications or prior skills, a tendency to be in unskilled roles and a lack of understanding and trust of government support. For older people, employment risks are further compounded by time and resources taken to re-train, the potential to face age discrimination and the impact of unemployment on personal confidence.

Poor understanding of dementia combined with cultural stigma leads to denial of the condition and/or delayed diagnoses for some older people from CALD backgrounds. Older people from CALD backgrounds are often excluded from dementia research due to language barriers, leading to gaps in the evidence base.

Another review finding was that the reliance of family is a 'myth' and that social isolation of older people from CALD backgrounds can result from the assumption they will be cared for by their family members.

There is evidence in South Australia from peak bodies and service providers who work with older people from CALD backgrounds to support the above view. There are substantial barriers to accessing health and community services as well as a lack of understanding from health service providers about providing culturally sensitive and competent care.

These barriers have been compounded by unemployment in both metropolitan and regional SA, having an impact on places of residence and proximity to family and support networks, as well as direct economic impact. Further challenges are being experienced by recent changes including the shift from the Commonwealth Home and Community Care Program (HACC) to the consumer directed Commonwealth Home Support Program (CHSP) and My Aged Care as part of national aged care reform. More than 23% of SA's CALD population were users of the HACC program. The challenges of these changes have been reflected in the outcomes of recent community consultations by advocacy organisations and ethno-specific service providers with CALD individuals and communities. Good access to Commonwealth

aged care programs and services is a critical issue for the older CALD communities as they are essential to supporting health and wellbeing.

South Australia's Ageing Plan, Prosperity through Longevity, recognises the diversity of our older population including its cultural diversity. Since the first post war migration wave (1945-1970), 144 CALD communities have settled in South Australia and while the needs of many established communities are well understood, less is known about new and emerging community groups. To identify what the current and future needs are, OFTA has commissioned the Multicultural Community Council of South Australia (MCCSA) to work closely with 20 community groups to identify what it means to actively age, and to live in a community that is age-friendly, from a CALD perspective.

Several service providers reported low uptake of Advanced Care Directives from people of CALD background. OFTA has collaborated with the South Australian Multicultural and Ethnic Affairs Council (SAMEAC), MCCSA and Multicultural Aged Care (MAC) and CALD community groups to develop a range of resources to assist people putting into writing their wishes around financial, medical and social arrangements. OFTA is targeting priority CALD populations of Italians, Greeks, Vietnamese and Polish with a campaign commenced in September 2015 with a *'Planning Ahead'* message using translated written materials and innovative video presentation (known as 'scinamation') to be viewed in community settings.

The need for improved health literacy for all CALD populations has been emphasized in consultations for this scoping study including for older persons with a high prevalence for chronic diseases that, it is believed, are more likely to be missing out on healthy ageing messages and government funded or subsidised activities that support better health and wellbeing. As an example of the latter, the Council of the Ageing SA (COTA SA) administers a program called *Strength for Life* (funded through the Department for Health and Ageing) which operates in almost 80 gyms and community centres throughout SA, including regional centres, for strength and balance training. COTA SA acknowledges that it has not been successful at accessing CALD and rural populations due to limited resources to adapt the program beyond mainstream, although is exploring trialling approaches in some areas in collaboration with selected community groups.

Falls prevention information and activities are part of health literacy aims for CALD populations. Initiatives supported by ethno-specific community organisations aim to educate and support older persons from CALD backgrounds to age healthily, with access to opportunities to change health profiles and prevent and manage chronic diseases by eating well, accessing fitness and maintaining social connections.

As part of the research into older people from CALD backgrounds, the FECCA review acknowledged the valuable role performed by carers in providing care and support. The review found that cultural resistance to formal aged care services in many CALD communities means that many older people from CALD backgrounds are themselves

a carer for a family member and many are 'hidden' carers who may not identify as carers. It also found that CALD carers can experience greater difficulty in accessing health and aged care services, and are more likely to experience barriers related to differences in language and culture. This was reflected also in consultations for this scoping study which found that carers of CALD background of all ages, and in particular older women, may not be receiving services and support for which they may be eligible.

Notably, nearly 14% of CALD South Australian males and females aged 15-19 years identified that they were providing unpaid care, help or assistance to a family member or others because of a disability, a long term illness or problems relating to old age[xvii]. Overall, 13.4% of South Australians are carers providing unpaid care, help or assistance to a family member or others. This is the highest proportion nationally.

An example of a service model for coordinated care and support with mainstream services for persons from a CALD background is Ethnic Link Services, UnitingCare Wesley Port Adelaide. It is funded through the Commonwealth Home Support Program to ensure that people from culturally and linguistically diverse backgrounds have access to support services that will assist them to remain living in their own homes. The target population is people from culturally and linguistically diverse backgrounds who are frail aged and younger people with a disability. Ethnic Link employs bilingual workers who through language assistance, advocate and link clients to services; provide information about available services; assist with correspondence; arrange medical and other appointment and help clients to participate in social and therapeutic activities.

4.2 New and Emerging Communities

The new and emerging communities are the new arrivals: skilled migrants, students, people in South Australia on working visas, and refugees. New arrivals also include asylum seekers (detainees or former detainees) in the community on temporary bridging visas waiting on determinations of longer term temporary visas or residency status. They are therefore uncertain about their future which includes the possibility that their application for permanent asylum may be rejected.

Recent national research found lack of coordination between services delivering focused primary health care to refugees with each other or with mainstream health care services. It supported a consistent national model for accessible and coordinated primary health care for refugees as best practice[xviii], due to compromised access to primary health care for refugees including language and cultural barriers, lack of familiarity with the health system, and problems with affordability of a range of services.

The Migrant Resource Centre SA (MRCSA), through the Commonwealth Government funded Humanitarian Settlement Strategy, supports new arrivals with health liaison, which includes linking them to local GPs or to the clinics and services run by the Migrant Health Service (Central Adelaide Local Health Network), funding the provision of ambulance cover for 12 months, advice about public transport services

and about community links using bi-lingual and other volunteers to support access to services. The MRCSA works closely with the Migrant Health Service (MHS) and specialist services such as Survivors of Torture and Trauma and Rehabilitation Services (STTARS).

The MRCSA provides settlement support as part of the new arrivals case management for Humanitarian migrants and refugees for 1-6 months and other support services for up to 5 years under the Settlement Support Grants program. Notably, an area of ongoing support is translation of letters received from hospitals and support from volunteers for interpreting/translating. Multicultural Youth SA and the Australian Refugee Association also provide ongoing support under the Settlement Support Grants program. Approximately 50% of new clients are referred to the MHS for health care and 50% to General Practitioners. The referrals to MHS are for clients with complex physical and psychosocial needs. These clients' needs make it more difficult for them to access mainstream primary health care services, which are often limited in their capacity to manage complex clients. However, there have been noted improvements in the capacity of some primary care providers over the last decade to provide complex care and support. Bi-lingual, bi-cultural GPs, particularly those who repeatedly consult with people from CALD backgrounds, are considered more likely to be providing effective and culturally appropriate care.

Eligibility criteria for MHS have narrowed over time and the service is only for recent arrivals rather than those who have been in SA longer. MHS sees refugees and asylum seekers within weeks after arrival, with an average of approximately 700 clients per annum.

Settled refugees find it difficult to access primary health care that matches their needs. Anecdotally, MRCSA clients may present at hospital emergency departments for medical care instead of seeing community GPs. The MRCSA and MHS provide advice on the appropriate use of emergency services and the MHS ensures all clients are referred to a community GP on discharge from hospital.

Upon arrival of new Humanitarian migrants and refugees via assisted programs, MRCSA receives health alerts from the Commonwealth Department of Immigration and Border Protection (DIBP) for certain conditions that may require early referral to a specialist health service or hospital. Some health conditions, however, may not become apparent until later when Humanitarian entrants and refugees are seen by the MHS or GPs. Notably, the demographic profile of new arrivals has changed in the last five years to include more older people and people with disabilities. The main health conditions encountered include chronic diseases, in particular the increasing prevalence of diabetes, hepatitis, AIDS and mental health issues. Refugees often have a unique and traumatic experience of migration. They may experience complex grief due to loss of home, isolation from family and also to torture and trauma. Clients with disabilities and significant medical issues experience delays in accessing specialist and disability services. Overseas medical

reports are not accepted and clients must wait for a report from an Australian specialist before acceptance of diagnosis of their condition.

STTARS supports a growing cohort of clients with complex physical and psychosocial needs, including asylum seekers with temporary visa status, who may not have any access to settlement services and limited access to health services. Some of the issues for clients include stigma regarding mental health, confidentiality of information and lack of trust of authorities, poor health literacy and recognition of need for medical assistance, and reluctance to be a burden on the health system in case that may impact negatively on their application for asylum. There is reported experience of culturally insensitive ambulance and emergency service health care rekindling past trauma, and poor skills of these service providers in dealing with family context (i.e. possible domestic violence, intergenerational conflict or child abuse).

The main areas of concern regarding health care for these populations is an increase in complex medical referrals, poor health literacy and understanding of the health care system, a perceived decrease in GP bulk-billing in some areas, the lack of time for effective GP consultations that might also require consultation with multiple family members, and minimal/no use of interpreter assistance (Doctors Priority Line). Written health information translated into other languages is not considered to be particularly effective as new arrivals may be illiterate in their own language.

Some of the skilled (or unskilled) migrants that come to South Australia on their own, rather than through a humanitarian/family, or other assisted program, are known to *"fall through the cracks in the system"*. They may have borrowed the money to get to Australia/SA, cannot find employment or no longer have the jobs they came to do, and have no structured support. There is little assistance that can be provided through the MRCSA in these circumstances but where possible it assists with community/volunteer links and provides some support to the families of skilled migrants who do not speak English. Anecdotally, some of these new migrants are known to self-medicate rather than go to a doctor, or are prepared to wait in a hospital emergency department for assistance. Skilled migrants who come here for work are mostly Middle Eastern (Afghan, Iranian) and African (Somalis, Eritrean).

The MRCSA has worked closely with the former metropolitan and country Medicare Locals (now Adelaide Primary Health Network and Country SA Primary Health Network) and GP clinics to identify and address gaps in primary health. The MRCSA has records of 80 general practice clinics in SA, including mental and allied health services, with doctors who work confidently with interpreter services and/or speak a second language to cater to the diverse cohorts of new arrivals. However, there is limited capacity for GPs to meet large families on one day and there is an inadequate number of GPs who speak a second language in the southern region.

The MRCSA has assisted the successful settlement in Mount Gambier of mainly Burmese, Congolese and Afghani people and Sikh in the Riverland, and provides health coordination in several regional areas. As is the case for most rural

populations, there is limited access to specialist services for complex needs. For example, although there is a hospital in Mount Gambier, clients travel to Adelaide or Victoria for treatment for HIV, specialist oncology and some surgical procedures.

Since 2005, an estimated 55% of all refugee new arrivals in SA have settled in northern Adelaide, living where there is affordable housing and where others of their community may have settled and where there are high numbers of migrants generally. Other main areas for settlement include western metropolitan suburbs and some regional/rural areas. The 2011 Census Socio-Economic Indexes for Areas (SEIFA) found that northern Adelaide is the most disadvantaged metropolitan area, then southern and western metropolitan areas.

The former Northern Adelaide Medicare Local established a program for CALD and Refugee Health to improve access to appropriate primary health care by increasing health literacy and health system knowledge of these populations and to improve the capacity of private general practice to provide effective care. The development of appropriate clinical pathways for mental health relevant to people from CALD backgrounds is a key area for attention regarding the Commonwealth's Access to Allied Psychological Services (ATAPS) as well as state-funded mental health services. The CALD and Refugee Health program, which is reported to have achieved successful outcomes to date, has continued since the establishment of the Metropolitan Primary Health Network in July 2014, through transition of delivery to the Northern Health Network. Currently, proposals are being developed for longer term funding and wider application.

Disease Prevalence and Health Disparities

By comparing the results for the *National Health Survey* in 2007-08 for Australian residents to that of 2004-05 survey, substantial changes in the prevalence of certain health conditions for each region of birth group can be identified[xix].

Between 2004-05 and 2007-08, there were some notable increases in the proportion of particular region of birth groups experiencing certain long term health conditions, including those born in:

- **Other Oceania –** the prevalence of heart, stroke and vascular disease more than doubled from 3.2% to 6.6%, and the prevalence of malignant neoplasms more than doubled from 0.7% to 1.6%
- **Southern and Eastern Europe –** the prevalence of heart, stroke and vascular disease more than doubled from 6.4% to 13%, and the prevalence of malignant neoplasms rose from 1.2% to 2.2%
- **North Africa and the Middle East -** the prevalence of heart, stroke and vascular disease rose from 3.6% to 6.6%.

The third edition of the *Social Health Atlas for South Australia*[xx] indicates that there are health conditions and risk behaviours that are disproportionately prevalent in particular population groups including:

- **Diabetes mellitus** for males and females born in European countries, and females born in countries in the Asian regions
- **Low immunisation rates** for the population born in a non-English speaking country (and resident for five years or more), and those in this group (any length of residence) with poor English proficiency
- **Lung cancer** for males born overseas (excluding those born in Asian regions), particularly those born in the UK and Southern Europe.

5. Priority Issues

Improvements in health care for people from CALD backgrounds over the last few decades in South Australia were reported to include greater recognition of cultural diversity in the population, CALD initiatives implemented in some acute and primary health care settings, language services and a more culturally diverse health workforce. There has also been growth in CALD community advocacy and ethno-specific health, aged care and wellbeing service providers. Overall, however, the ability of the health system to respond effectively to the needs of South Australians from CALD backgrounds is considered inadequate.

The priority issues arising from the consultations for this scoping study and from other research into the increasing challenges regarding healthcare for people from CALD backgrounds are presented below in the categories of the key principles of care for CALD populations[xxi]. These are: inclusion and empowerment; access and equity; quality, and capacity building.

5.1 Inclusion and Empowerment

In alignment with national multicultural policy[xxii] and the Australian Charter of Health Care Rights[xxiii], the South Australian Health and Community Services Complaints Commissioner's Charter of Rights 2011 is inclusive of the rights of people from CALD backgrounds and carers and advocates services that are culturally appropriate and respectful. The South Australian health system has several current policies and plans that acknowledge cultural diversity and include strategies for culturally appropriate health care. The Safety and Quality policies and standards create overarching requirements for health services and specific initiatives for CALD populations. SA Health policies and plans that address cultural diversity include, but are not limited to:

- South Australia's State Ageing Plan, Prosperity through Longevity 2014-2019
- South Australia's Mental Health and Wellbeing Policy 2010-2015
- Mental Health Services Pathways to Care Policy Directive and Guideline 2014
- South Australian Suicide Prevention Strategy 2012-2016
- Restraint and Seclusion in Mental Health Services Policy Guideline 2015
- Framework for Active Partnerships with Consumers and the Community 2012
- Language Services Provision: Operational Guideline for Health Units (last updated 2008)

Evaluation and internal reporting of performance regarding services to people from CALD backgrounds is not publically available but it does appear that there has not been a health system-wide, leadership driven, coordinated and integrated approach to planning, implementation, evaluation and reporting on access to services or

health outcomes specifically for people from CALD backgrounds. There is also a perceived lack of advocacy for CALD populations in public health services.

Over the past ten years, there have been CALD-specific strategies developed within parts of the health system (notably within the Royal Adelaide Hospital[xxiv]) and some positive actions effected towards culturally appropriate services in several hospitals and other health services. However, previous efforts towards developing and promulgating a system-wide strategic action plan for culturally inclusive health care have faltered, perceived as due to organisational change and lack of imperative. As a result, sustainability of good practice has suffered and positive CALD consumer experience has been largely reliant on the *"goodwill"* of individual health workers and ad hoc organisational attention. There are inconsistencies across hospitals in relevant practices and procedures that impact significantly on the experiences of people from CALD backgrounds and, overall, a perceived lack of cultural sensitivity in conduct.

The prevailing view of the South Australian health system is that an inclusive approach to CALD population needs is not taken at the planning stage of any mainstream policy, service or system development. This is considered to be a critical issue that significantly impacts on access and equity and contrasts with the principles of social inclusion.

The approach that is noted to have been repeated often within the health system is that of progressing mainstream initiatives and then only considering the needs of 'others' by inviting CALD consumer/community engagement when, and if, affordable in time and resources or as an apparent *"afterthought"*. The experience has been that while there may be an expressed desire and intent to be inclusive at some stage through communications and engagement, many of the recommendations made by CALD community representatives, if sought and obtained, are then unable to be implemented due to their complexity and cost and time constraints. A recent example given of this has been the CALD consultation regarding SA Health's reform program, *Transforming Health*. This approach is reflected clearly also by the gaps in data collection systems and consumer experience surveys where the need to account for and reflect CALD populations better has often been acknowledged but still in formative or tentative stages of planning or development.

The needs of people from CALD backgrounds are perceived to be treated on the periphery of mainstream programs and services instead of being an intrinsic part of the planning and design at the outset to ensure equitable and appropriate services. The relative smaller proportion of the population that are people from CALD backgrounds, with greater diversity and cultural complexity than other South Australians, should not be a reason for inadequate service. Health services aim to be accessible and equitable for all South Australians but this does not appear to be reflected in practice.

Selected State CALD Policies and Reporting Frameworks

South Australia's multicultural policy is administered by Multicultural South Australia (MSA), which encompasses South Australian Multicultural and Ethnic Affairs Commission (SAMEAC). The SAMEAC was established under the South Australian Multicultural and Ethnic Affairs Commission Act 1980 (SA) and its primary functions are to raise awareness and understanding about ethnic diversity in South Australia, and to advise government and public authorities about multiculturalism and ethnic affairs. Over time its functions have broadened to allow the Commission a stronger role in ethnic rights advocacy and strengthen its advisory role. Further amendments to the Act in 1989 increased the size of the Commission and provided a legislative basis for the establishment of multiculturalism as a public policy.

In South Australia currently there are currently no reporting requirements at state government level on access and service outcomes for people from CALD backgrounds under a multicultural policy framework. In 2011, government agencies including the SA Department for Health and Ageing were no longer required to report on access and equity to the MSA through SAMEAC.

The Australian states mentioned below have whole-of-health system policies, plans and reporting frameworks and also report annually at state government level to meet multicultural policy and planning frameworks that impact on all state government agencies. They also have whole-of-government language service policies for all state government agencies. SAMEAC has proposed the development of such a policy for South Australia but it has not yet been achieved.

Victoria

In 2012, the Victorian Department of Health and Human Services released its *Cultural Responsiveness Framework: Guidelines for Victorian Health Services* which encompasses a strategic and portfolio-wide approach. The framework is designed to improve and extend the cultural responsiveness performance of Victorian health services who report annually against six standards across the four quality and safety domains of *organisational effectiveness, risk management, consumer participation and effective workforce*.

The following standards bring together key legislative, policy, governance and accreditation frameworks which apply to all Victorian public hospitals, and align cultural responsiveness with quality and safety in health care delivery:

- Standard 1: A whole-of-organisation approach to cultural responsiveness is demonstrated.
- Standard 2: Leadership for cultural responsiveness is demonstrated by the health service.

- Standard 3: Accredited interpreters are provided to patients who require one
- Standard 4: Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices.
- Standard 5: CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis.
- Standard 6: Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness.

Health services are guided to achieve the standards by a range of measures and sub-measures which can be tailored to the needs of individual health services and their communities.

New South Wales

New South Wales Health has developed a strategic state-wide policy, *Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016*, for improving the health of NSW residents from CALD backgrounds. The Government's commitment is to ensure that public health services meet the needs of all New South Wales residents, regardless of their cultural origins or their English skills. The Policy and Implementation Plan uses evidence about multicultural health gained over the last decade and draws on state level policy requirements for the New South Wales Government's multicultural health policy direction.

Mandatory actions are required across three key areas of focus including: health system enabling priorities, priority health issues and priority groups. Work across these areas aim 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.

New South Wales Health reports annually on the mandatory actions in the Policy and Plan under the New South Wales Government's Multicultural Policies and Services Program.

Queensland

In 2012, Queensland Health published the Guideline for Multicultural Health Policy Implementation, which provided recommendations to Hospital and Health Services and Queensland Health Division regarding best practice for the implementation of the Queensland Multicultural Policy 2011-2014 (now the Cultural Diversity Plan released in 2014) as well as the Queensland Government Language Services Policy. The Guideline includes strategies for data collection and analysis to ensure appropriate data collection on health access and health outcomes for CALD communities; enabling improved service planning and service delivery, and implementing strategies to build cultural capability of the workforce and to recruit and retain a diverse workforce. Queensland Health reports on Guideline performance to meet whole-of-government reporting requirements.

Western Australia and Tasmania

Both Western Australia[xxv] and Tasmania[xxvi] state governments also have multicultural policies and language services policies for all government services. WA Health has a cultural diversity action plan for all health services that has its focus on equal opportunity in policies and services as well as workforce. It reports to the Commissioner for Equal Opportunity on targets that include workforce diversity. The Western Australian and Tasmanian Health Departments both have central organisational functions across all public health services to establish, maintain and monitor the multicultural health-related evidence-base, consult with multicultural communities and undertake research to understand best practice in the delivery of services. They provide advice on multicultural health and wellbeing issues and provide information, education and high level advocacy.

5.2 Access and Equity

5.2.1 Language and Culture

Language Services

Interpreters are needed by people from CALD backgrounds that have little or no proficiency in English. In hospital care, they are needed at all points of care including: emergency, pre-admission, consent; post-operative, discharge and outpatient care.

Interpreting and translating services are provided by hospitals but are not always accessible for inpatient and outpatient care, particularly when left up to the patient to make the necessary arrangements. For example, the outpatient confirmation letter requires telephone contact with hospital staff to advise that an interpreter needs to be booked. Other hospital letters, forms and brochures refer directly to the Interpreter and Translating Service telephone contact number for the patient to

make arrangements. Hospital staff assistance may not be provided for interpreter booking needs or for filling out forms and other processes, including the outpatient transport assistance process, that are difficult or impossible for people with little or no proficiency of English. Nevertheless, it needs to be noted that staff in Local Health Networks provide very good and organised access to interpreting services for clients and patients who need these services. Patients from CALD backgrounds also anecdotally report that staff members are very effective and respectful communicators and information is well understood even if interpreters and family are not present or they are not needed to interpret.

There was no data available on interpreter/translator use that is matched to patients and specific requirement but anecdotally it is known that outpatient interpreting services are more readily able to be provided than inpatient interpreting services at each of the required points of care.

While language services are a critical part of service provision to people from CALD backgrounds in SA that require these services, the skills and abilities of interpreters used are considered to be inadequate for healthcare settings and require upskilling. The areas for improvement include:

- dealing with sensitive information and situations in ways that are appropriate for the individual and their family and cultural context (including where gender-specific support may be required);
- ensuring that information conveyed has been understood, particularly when giving literal interpretations of medical terminology, seeking to be as effective as possible with communication and expression, and providing the requisite time to check comprehension;
- dealing with differing levels of proficiency in language/literacy and dialects spoken; and
- better knowledge of the local health system to provide appropriate advice and guidance, particularly regarding changed conditions and procedures.

Patient needs may be overlooked where there is lack of involvement of family and/or carers; including during interpreter assisted/social worker interactions where they may assist with cultural and personal contexts. SA Health's language services policy guideline[xxvii] advises the use of accredited interpreters rather than family members or others. Poorer outcomes may result if valuable contextual information is not sought to complement the role and skills of the interpreter, depending on what information is needed by health workers for optimal advice and services. Also, accredited interpreters may not be available for some of the required languages. Appropriate involvement of children and families is considered to be an important strategy for health workers for communication and support in health care.

Translation of written hospital information and health and wellbeing information products from English into other languages is considered very important but must be one of the multi-pronged strategies for reaching diverse audiences. Individuals have

varying levels of literacy in their own language and therefore have preferences for oral and visual communications, and may require customised assistance.

In addition to some translated resources in SA, there is much high quality translated health information available in Australia (e.g. NSW Health and Cancer Councils) which can be made available or be brought to the attention of patients' family members who may have Internet access.

A trial of CALD resources in Local Health Network Outpatient Departments is underway using cards and posters with the international interpreter symbol, and also trials for software translations in Italian, Greek and Vietnamese. SA Health's Safety and Quality Unit has a campaign planned specifically for CALD communities regarding rights and consumer feedback.

The use of online technologies for health and wellbeing information or other communications is considered to be ineffective for people of CALD backgrounds without English language skills and/or literacy in their own languages. This is particularly the case for older people who are unlikely to use computers at all, even where there may be household access. The use of telephone/video/digital technologies for interpreting and translating assistance, however, may assist in improving access to language services.

Language Service Providers

Interpreting and Translating services are provided for hospitals, general practices, pharmacies, allied health care providers and other government and non-government health and wellbeing providers. Both private and public interpreting service providers may be used.

The Australian Government Department of Social Services (DSS) provides a free interpreting service to non-English-speaking Australian citizens and permanent residents through specific service providers and through some approved incorporated community organisations.

The Commonwealth Government's national Translating and Interpreting Service (TIS) is used for all DSS eligible services. The TIS is also able to be used by these services for communicating with humanitarian/safe haven enterprise temporary visa holders.

The TIS service has access to 2600 interpreters and 160 languages and dialects. It can be used by private medical practitioners (General Practitioners and Medical Specialists) for Medicare eligible services and their reception staff to arrange appointments and provide results of medical tests, and also to pharmacies provided they are enrolled with TIS. Registration is necessary for the provider to use the service and a code is allocated to each registrant. Data on use of the TIS services is not publically available.

The service is also available for use by incorporated, not-for-profit, non-government, community-based organisations for casework and emergency services where the organisation does not receive substantial government funding to provide these

services to Australian citizens and permanent residents. Organisations that require language services (such as interpreting) and receive substantial government funding need to incorporate the cost of these services into their funding applications.

The 24/7 interpreting service available for use by GPs is known as the Doctors Priority Line 1300 131 450 and is provided through TIS. Practices are not required to report on the number of times or number of clients for whom they require the use of interpreters.

The TIS services is also used by the *Healthdirect Australia* nurses and call-handlers for the 24/7 telephone-based health advice/triage service.

South Australian health care interpreting services are provided also by the Interpreting and Translating Centre (ITC), Department of Communities and Social Inclusion. ITC employs a pool of approximately 300 interpreters with over 100 languages and dialects.

Other private interpreting and translating service providers used in South Australia include ONCALL and ABC.

SA Health's Language Services Policy Guideline requires interpreters to be accredited through the National Accreditation Authority for Interpreters and Translators (NAATI).

Cultural Competency

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 professionals to work effectively in cross-cultural situations[xxviii]. In 2006 the National Health and Medical Research Council released what is considered the leading national resource for cultural competency in health settings, *Cultural Competency in Health, A Guide for Policy, Partnerships and Participation.* This resource demonstrates how cultural competency can be more than an awareness of cultural differences, as it can be used to improve health and wellbeing by integrating culture into the delivery of health services.

Overall, cross cultural competency in hospital and mainstream general practice/community-based healthcare settings is considered to be poor, with lack of cultural sensitivity and experiences of racism. Positive CALD consumer experiences are known to be reliant largely on the individual skills, experience and relevant cultural background of health workers.

The concerns regarding some of the experiences of ineffective interpreter assistance relate to cultural competency, where effective communication and service to people in a health care setting requires more than assistance with literal interpretation and translation. It involves consideration of the person's experience and cultural background and appropriate responsiveness. There was strong emphasis on effective communication being more than literal interpretations or translations: *"it's not just about language".*

Cultural awareness training is included in induction training within some of SA Health's Local Health Networks but is very limited and there is little evidence available of cross cultural competency training relevant to working with CALD populations.

Regarding equity in health service planning, the Southgate Institute for Health, Society and Equity, Flinders University, in collaboration with other South Australian, interstate and international investigators, has commenced a three-year project funded by the National Health and Medical Research Council (NHMRC) to examine the extent to which Primary Health Networks incorporate equity, community participation and social determinants of health in their plans and programs. The research focus is on how Primary Health Networks address the health needs of people with mental illness, Aboriginal and Torres Strait Islander people, and migrants and refugees. The research team has conducted extensive community engagement and consultations with CALD community groups and service providers and is currently analysing all former SA Medicare Local comprehensive needs analyses and priorities.

Early indications from this research are that the needs of people from CALD backgrounds have not been a priority for most metropolitan and regional former Medicare Locals, due in part to relatively low population numbers and resource constraints.

5.2.2 Service Utilisation

A comprehensive audit of SA Health services for all patient/client activity identifying country of birth and other characteristics of CALD populations was not conducted as part of this scoping study. Available hospital admission data reviewed includes a record of country of birth in most cases although there are gaps where country of birth has not been recorded or not clearly defined and there is an absence of other CALD characteristics. SA Health outpatient data for 2014 show a greater number of 'unknown' entries for country of birth than where country of birth has been recorded.

SA Health's hospital separation data for 2014 shows that people born overseas are moderately over-represented at approximately 30% of total SA public hospital activity[xxix]. Table 1 below shows the country of birth of those born overseas and shows that up to one quarter were born in non-English-speaking countries. The main reasons for hospitalisation are: dialysis; rehabilitation; lens procedures; chest pain and childbirth for all patients born overseas. An average of 35% of all hospital admissions over the last five years that were due to falls at home or residential care were people born overseas and 70% of these in 2014 were people from non-English speaking countries.

Table 1:
Top 20 countries of birth of public hospital inpatients born overseas, 2014

Country of birth	no. seps.	% seps.
England	20,300	16.2%
Overseas Visitor	13,510	10.8%
Italy	11,008	8.8%
United Kingdom	10,336	8.3%
Greece	7,221	5.8%
Scotland	4,813	3.8%
Germany	4,327	3.5%
Inadequately Described	3,759	3.0%
India	3,502	2.8%
New Zealand	3,407	2.7%
Vietnam	3,123	2.5%
Netherlands	2,681	2.1%
Poland	2,412	1.9%
China	2,068	1.7%
Philippines	1,976	1.6%
Ireland	1,641	1.3%
Croatia	1,250	1.0%
United States of America	1,048	0.8%
Afghanistan	1,047	0.8%
South Africa	1,009	0.8%
Other	*24,779*	19.8%
TOTAL	**125,217**	**100.0%**

There is an underutilisation of mental health services in particular by CALD populations. Service providers and advocacy groups in SA acknowledge that people from CALD backgrounds are less likely to access mental health services in both hospital and community-based mental health services. This is reflected in available service usage data (although not comprehensive in identifying CALD use) and supported by research in SA as well as national research[xxx]. The FECCA review found that this lower level of service use is not related to lower levels of need but rather to difficulties in understanding and accessing mainstream systems of care and lack of access to services that are culturally safe and appropriate. There is a general lack of trust of service providers, and concern about the social stigma associated with mental health. The review also found that stigma regarding mental health was greater in some cultures and that it was unlikely that mainstream efforts to address stigma have much impact in CALD communities. However, some of these issues were not considered to be insurmountable with requisite changes in the system and care options.

Those who do reach services are more likely to be admitted involuntarily and tend to be hospitalised for longer and it appears that it is more likely that presentation is at the acute, crisis end of an episode. Mental health literacy is poor in some communities and there are vast cultural differences around concepts of mental

health although most cultures have some way of describing mental ill health or abnormal behaviour. These findings were supported by consultations undertaken for this study and also in the outcomes of community engagement undertaken in the last couple of years by the Department for Health and Ageing (Office of the Chief Psychiatrist) and the Country Health SA Local Health Network. The latter notably does have specific access and equity resources.

There is widespread underutilisation of mental health services by children in the general population and refugee children and adolescents are known to be at greater risk of developing mental health problems and have greater difficulty accessing mental health care. There is high youth unemployment, despite university qualifications gained locally in some cases, and hidden mental health conditions. The most commonly reported mental health problems in refugee children and adolescents are Post Traumatic Stress Disorder and depression.

Research conducted using a large sample of South Australian refugee children and adolescents found a prevalence rate of 7.1% of clinically relevant symptoms of depression as reported by parents[xxxi]. Of these, only 21.1% had accessed mental health services. The research found that 90% of the target population said they would not use mental health services due to lack of appropriateness and concluded that young refugees need improved access to culturally appropriate mental health care. Other research findings showed that females and adolescents who had been living in Australia longer showed higher resilience. One of the conclusions was that fostering resilience may be critical to efforts to prevent or reduce mental health problems in refugee adolescents. The researcher has noted that there is potential for improvement due to recent new national policies, standards, accreditation, resources and relevant health workforce education for future health workforce but there is still a high need to put policy into practice.

As part of a broader strategy to address youth mental health in rural SA, Mental Health Services in the Country Health SA Local Health Network (CHSALHN) established Youth Mental Health Services in the last 12 months which included CALD young people in the consultations. CHSALHN has had specific engagement with CALD rural communities over the last couple of years for mental health services (focus groups with CALD populations including refugees in Whyalla, South East, Riverland and Pt Pirie) and reports strategies to improve access and equity through evaluation of consumer experience, dedicated resources and training.

Culturally Inclusive Data

Although a comprehensive audit of all service use and performance data would be required to understand whether useful data exists on patients/clients from CALD backgrounds more broadly, there does not appear to be any publically available/reportable culturally inclusive baseline data on which to assess disparities in quality of care, health outcomes or patient satisfaction.

Currently there is limited qualitative and quantitative data relating to the health of specific CALD populations resident in South Australia. There is either incomplete or

inconsistent data or not available by small population groups to conclusively report on services to people from CALD backgrounds and health outcomes.

The SA Monitoring and Surveillance System (SAMSS) health survey is a telephone-based self-assessment survey with very limited reach into CALD communities. A specific data request made for this scoping study showed that 7.7% of respondents in 2011-2015 were from South Australians living in multi-lingual speaking households where English is not the main language spoken. These were mainly from European and Asian countries. About 44% of respondents reported at least one chronic health condition, with osteoporosis, arthritis and diabetes being the highest. At least one risk factor was reported by 56%, with overweight/obesity and insufficient activity the highest. Regarding service usage, 13% had not visited a GP in the last 12 months and 40% had visited another medical service in the past month.

Mental Health in Multicultural Australia (MHiMA)[xxxii] has found that there is a lack of prioritising consistent CALD data collection across national service systems and jurisdictions that enables meaningful analysis. This is reflected also in South Australian mental health service data collections. Given this situation, the Country Health SA Local Health Network, for example, does not use service data as an indicator of access for CALD communities and uses other methods to understand access and consumer experience. A CALD definition for service usage for Youth Mental Health Services is being considered for use for all CHSALHN Mental Health Services. MHiMA emphasizes that the availability of reliable and valid CALD data is essential for monitoring and delivering quality outcomes for all.

Statistics from the *Healthdirect Australia* health advice and triage service use and its regular telephone-based customer service survey consistently show an under-representation of CALD callers (including use of the interpreting service, i.e. approximately 1% of callers). This is most probably due to the telephone being the least likely access point for people with little or no proficiency in the English language, despite the availability of interpreter assistance.

GP Patient Data

There is an item in the GP Census under Ethnicity and in the Royal Australian College of General Practitioners' Standards for General Practices, 4th Edition that stipulates recording the ethnicity of the patient, i.e. -

> *RACGP Standards for General Practices, 4th Edition*[xxxiii]
> *Our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records. Our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records.*
> *Recording cultural background*
> *Practices in all clinical settings should work toward identifying and recording the cultural background of all patients since this background can be an important indication of clinical risk factors and can assist GPs in providing relevant care.*

In practice, however, this information may not be collected by the GP or administrative staff and therefore not included in the patient record. It is mandatory for GPs to record Aboriginal or Torres Strait Islander patients.

The Northern Health Network, through the previously mentioned CALD and Refugee program (commenced through the former Northern Adelaide Medicare Local) aims to support general practices to become better at recording the ethnicity and language spoken by their CALD patients/clients. The project is supporting general practices in the northern metropolitan area to increase their capacity to service the CALD established and emerging communities as well as responding to the need of increasing health literacy in these communities.

The Commonwealth-funded Adelaide Primary Health Network and Country SA Primary Health Network established in July 2015 have responsibilities for planning and monitoring access and equity for private primary medical and health care services in South Australia.

5.3 Quality

Training

Information on cultural competency training conducted across SA Health is not collected or reported centrally.

Information provided on cultural competency training shows that while general cultural awareness training has been conducted over the last couple of years as part of induction training within some of the Local Health Networks, cultural awareness or cross-cultural competency training is very limited, both in terms reach and content. General cultural awareness training includes Aboriginal cultural awareness and there specific workshops have been conducted and specialised training tools used with staff and health workers for Aboriginal cultural awareness. The only specific CALD cultural competency training reported was for the South East region through the Country Health SA Local Health Network.

SA Health staff and health workers have access to resources that support cultural awareness as well as tools for training which are available online.

As mentioned previously, the national guideline for cultural competency in health is *Cultural Competency in Health, A Guide for Policy, Partnerships and Participation, 2006* developed by the National Health and Medical Research Council. It comprises resources and tools for training.

The Mental Health in Multicultural Australia organisation has recently developed what is recognised also by mental health services in South Australia as the leading resource for improving mental health care for people from CALD backgrounds, the

Framework for Mental Health in Multicultural Australia: toward culturally inclusive service delivery, 2014. The Framework is mapped against relevant national policies and plans and is a resource for evaluating cultural responsiveness and enhancing delivery of services for CALD communities.

Consumer Engagement

For CALD populations, there is low telephone and internet use for information regarding health services and for health service engagement; face to face focus groups are seen as the most effective way to engage. Radio and television is considered to work best for campaigns as well as working with ethno-specific cultural groups.

The SA Health Safety and Quality Community Advisory Group (SQCAG) has two CALD representatives from Multicultural Communities Council SA and Seniors Information Service. These representatives are also on the CALD Consumer Experience Advisory Group. The SQCAG is currently not meeting while same representatives are participating on the Transforming Health Consumer and Community Engagement Forum.

Consumer Experience

SA Health's Safety Learning System Consumer Feedback module does not currently identify the complainant as being from a CALD background, although modifications to include this are planned.

There is an underrepresentation of people from CALD backgrounds in Health and Community Services complaints through the Health and Community Services Complaints Commissioner. This is perceived as being due primarily to lack of awareness of the complaints procedure, inability to proceed unassisted through the process and unwillingness due to issues of trust, with the expectation of system 'collusion' resulting in unfavourable personal outcome following engagement in the process.

5.4 Capacity Building

Cultural Diversity of the SA Health Workforce

The cultural diversity of the health workforce is considered to be one of the most important factors for the delivery of culturally appropriate/sensitive health care for people from CALD backgrounds. The presence of bi-lingual and bi-cultural health workers is considered to improve access and quality of experience, even when there is not a specific language or culture match, as there can be greater empathy and cultural sensitivity toward the patient/client. Strategically matching relatable cultural backgrounds of health workers and patients was suggested as a potential strategy to consider for implementation in hospitals and other health care settings.

An issue raised by several of the persons consulted for this study was the inadequate workplace support of health workers from CALD backgrounds working in hospitals and other health settings. As well as personal support, it was considered that better engagement with and encouragement of organisational management to foster and facilitate cultural competency in their service settings was necessary for better individual and community outcomes. Support in the workplace and from the community was expressed to be a major issue in particular for doctors in general practice and hospitals in regional areas, impacting on workforce retention.

Indicators of health workforce cultural diversity collected and reported by relevant agencies vary and there is limited published data for South Australia. Further detailed analysis is required that includes expanded variables where collected to gain a better picture of the cultural diversity of the SA health workforce. The following information with some indicators of cultural diversity is provided at a broad level and, where accessible, more specifically about the SA health workforce.

The 2011 Census found that a total of 99,273 people were employed in the industry of health care and social assistance, of which 26,977 (27.17%) were born overseas. As this includes people from main English-speaking countries, Table 2 provides information regarding the English language proficiency of those born overseas.

Table 2
Working Population Profiles – South Australia
People born overseas employed in health care and social assistance

Language proficiency	No.	%
Speaks English only	15,452	57.28%
Speaks other language at home and speaks English well	11,199	41.51%
Speaks other language and speaks English not well or not at all	221	.82%
Not stated	105	.39%
Total	26,977	100%

Source: ABS 2011 Census of Population and Housing

Between 2006 and 2011 there was an overall increase of about 25% of people employed in the industry of health care and social assistance and an increase of nearly 2% in the proportion of those born in countries other than Australia and New Zealand.

The Australian Health Practitioner Regulation Agency (AHPRA) collects data on individual health professionals, with Country of Birth recorded as part of the identification process and other information including Country of First Qualification and voluntary information regarding languages spoken collected via a survey. AHPRA does not publish information relating to cultural diversity as part of its regular statistics reporting. De-identified data collected by AHPRA is provided to the Australian Institute of Health and Welfare (AIHW) for its national health workforce collection which publishes information online regarding each health profession for South Australia.[xxxiv] The only indicator of cultural diversity in the published data is where initial qualification was gained in other countries.

Table 3 below shows the percentage of selected health professions in South Australia for that received their first professional qualification in countries other than Australia and New Zealand.

Table 3
AHIW Health Workforce South Australia 2013
% Initial Qualification Gained In 'Other' Countries

Health Profession	%
Medical Practitioners	25.5%
Nurses & Midwives	10.7%
Pharmacists	8%
Dentists	11.2%
Physiotherapists	7%
Chiropractors	15.7%
Podiatrists	4.5%

Source: National Health Workforce data set, detailed tables

The AHIW health workforce data below was provided by the SA Department for Health and Ageing. Data for 2014 is only available currently only for Nurses and Midwives. The percentage of Nurses and Midwives that gained their initial qualification in other countries has increased to 11.8% in 2014. Table 4 which follows shows a breakdown of main countries where the initial qualification was gained with a distinction between nurses and midwives and Table 5 shows Country of Birth. Note that the proportion of the total workforce means low percentages result from analysis but the tables give an indication of main cultural backgrounds represented.

Table 4: Employed Nurses and Midwives in South Australia
2014 AIHW Data Set

Initial Country of Qualification	Nurse /Midwife	Midwife	Nurse
Australia	88%	88%	85%
Canada			<1%
China		<1%	1%
England	4%	6%	3%
India	<1%	<1%	2%
Ireland	<1%	<1%	<1%
Malaysia			<1%
Middle East		<1%	<1%
New Zealand	<1%	<1%	1%
Other - Europe	<1%	<1%	<1%
Other Africa			<1%
Other Asia		<1%	<1%
Philippines			1%
Scotland	2%	2%	1%
South Africa	1%	<1%	<1%
South America			<1%
Sri Lanka			<1%
USA			<1%
Zimbabwe	<1%	<1%	<1%
Other	<1%	<1%	1%
Not Stated	2%	2%	4%

Table 5: Employed Nurses and Midwives in South Australia
2014 AIHW Data Set

Country of Birth	Nurse	Midwife	Nurse /Midwife
Australia	67%	80%	82%
China (excludes SARS and Taiwan)	2%	1%	
England	1%	1%	2%
Germany	1%	1%	
India	4%		
Malaysia	1%	1%	1%
Nepal	1%		
New Zealand	1%	1%	1%
Philippines	3%		
Scotland	1%	1%	
South Africa	1%		1%
United Kingdom	9%	10%	8%
Zimbabwe	1%		
Other (128 countries <1%)	8%	6%	6%

Cultural diversity of the workforce of SA Health's Health Units and the Department for Health and Ageing (the Department) is reported annually to the Office for the Public Sector, SA Department of the Premier and Cabinet[xxxv]. Health Unit workforce data for 2014, published by the Office for the Public Sector, shows up to 23% of all employees were born overseas and about 7% of these are multilingual. It is not mandatory for Department and Health Unit employees to provide country of birth or main language spoken at home. From an extract of workforce data provided by the Department on its 40,010 employees, as at 30 June 2015, 80% had provided their country of birth and 33% had provided their main language spoken at home. Below are the top ten countries of birth for non-English-speaking countries and the top ten main languages other than English spoken at home. Numbers of employees are provided rather than the low percentages of the total workforce. Information distinguishing health professionals and other employees was not available.

Table 6

SA Health employees: Top 10 Country of Birth and Main Language Spoken at Home 2015 Department for Health and Ageing

Top 10 Country of Birth	No. of People	Top 10 Main language spoken at home	No. of People
India	1027	Malayalam	271
Philippines	491	Mandarin	240
Malaysia	467	Hindi	209
China	457	Italian	178
Vietnam	178	Vietnamese	164
Germany	168	Cantonese	155
Poland	130	Greek	146
Singapore	128	Polish	103
Sri Lanka	127	Tamil	82
Italy	107	German	75

Community Capacity and Advocacy

Ethno-specific community organisations and service providers assist CALD populations, where individuals are aware and connected, with access to mainstream services and advocate for culturally appropriate care. Areas of healthcare assistance include coordination of care from multiple providers, health promotion and building capacity for health literacy as well as support services that enable access to health, wellbeing and aged care services. Some of these organisations develop staff and volunteer skills and can provide health workforce education and support for cultural competency.

The capacity of some CALD community service organisations is reported to have been negatively impacted by recent reform initiatives that have changed their service scope, service delivery profiles and resources. Greater participation in mainstream health and wellbeing services and strengthened partnerships, where collaboration rather than competition is fostered, are considered to be necessary to support CALD communities and consumers.

6. Conclusion

While organisations and individuals that advocate on behalf of CALD communities acknowledge some health system improvements over several decades due to greater cultural awareness, the increased CALD profile of health workers, and greater CALD community participation, the ability of the health system to respond effectively to the needs of South Australians from CALD backgrounds is considered inadequate.

This situation of inadequacy has been significantly compounded by the changing CALD profile of older non-English speaking people with increasing needs, and new and emerging communities with diverse and complex needs in difficult social and economic environments.

Further challenges are being experienced from current reform initiatives in health and aged care. In addition to changes to existing providers, services and procedures which directly affect CALD consumers, the impact of these reform initiatives includes what is considered to be a reduction in the capacity of community support organisations to assist with coordination of care, health literacy, navigation of health and aged care systems, and other related support services. These changes are perceived to be creating further difficulties for people from CALD backgrounds to access appropriate health and wellbeing services. Comprehensive information about the specific range of service programs and the exact roles and responsibilities of State public health care providers and those of private sector/community primary health care providers in supporting the community to access these Commonwealth services needs to be available. Good access to Commonwealth aged care programs and services is a critical issue for the older CALD communities as they are essential to supporting health and wellbeing.

There are many key issues in health care for people from CALD backgrounds, in the areas of inclusion and empowerment; access and equity; quality and capacity building. Although policies and services exist that aim to address the needs of CALD populations, there is no specific policy or strategic framework, accountability or advocacy across public health services. There is an absence of quality information and culturally inclusive baseline data on which to assess disparities in quality of care, health outcomes and patient experience.

Appendix A: Persons Consulted

- Kay Anastassiadis, Principal Policy Officer, SA Department for Health and Ageing
- Dr Kate Barnett, Deputy Director, Workplace Innovations and Social Research Centre, University of Adelaide
- Rosie Bonnin, Centre Coordinator, Geriatric Training and Research with Aged Care Centre (G-TRAC)
- Cynthia Caird, Manager, Community Services, Migrant Resource Centre of SA (via Eugenia Tsoulis, CEO)
- Antonietta Cardinale, Ageing Officer, Coordinating Italian Committee Inc.
- Kathrin Cock, Manager, Service Delivery and Partnerships, Survivors of Torture and Trauma and Rehabilitation Service (STTARS)
- Miriam Cocking, Access and Equity Officer, Seniors Information Service and Deputy President, Multicultural Communities Council of SA Inc.
- Rosa Colanero, CEO, Multicultural Aged Care
- Laurellee Cowan, Language Policy Liaison Manager, Translating and Interpreting Service (TIS National), Department of Immigration and Border Protection
- Eleonora Dal Grande, Senior Epidemiologist/Senior Research Associate, Population Research and Outcomes Studies (PROS), Discipline of Medicine, School of Medicine, Faculty of Health Sciences, University of Adelaide
- Jayne Dunn, Director Learning and Development, Central Adelaide Local Health Network (CALHN), SA Health
- Dr Helen Feist, Australian Population and Migration Centre, Adelaide University
- Janet Grant, Population Research and Outcome Studies, School of Medicine, Faculty of Health Sciences, Adelaide University
- Elizabeth Ho, Deputy Chairperson, Migrant Resource Centre and Member, Palliative Care SA Board
- Vicki Jacobs, Operations Manager, Primary Health Care, Central Adelaide Local Health Network (incorporating Migrant Health Service)
- Dr Sara Javanparast, Southgate Institute for Health, Society and Equity, Flinders University
- Kristin Johansson, Manager, Strategic Directions and Projects, Multicultural Communities Council of SA Inc.
- Tina Karanastasis, Senior Program Manager, Service Development, Ethnic Link Services (state-wide), UnitingCare Wesley, Port Adelaide and Deputy Chair, Federation of Ethnic Communities' Council of Australia
- Ali Krollig, Country SA Primary Health Network (via Kim Hosking, CEO)
- Helena Kyriazopolous, President, Multicultural Communities Council of SA

- Roger Lean, Manager, Community and Government Relations, Multicultural SA/South Australian Multicultural and Ethnic Affairs Commission
- Matt Lynagh, Manager Safety, Quality and Risk, Office of the Chief Psychologist, Department for Health and Ageing
- Grant Matthews, Manager, Resthaven Regional Assessment Service
- Michele McKinnon, Director, Safety and Quality, SA Department for Health and Ageing
- Ruth McPhail, Manager Operations/Director of Nursing, Mental Health Services, Country Health SA Local Health Network
- Stephanie Miller, CEO, Survivors of Torture and Trauma and Rehabilitation Service (STTARS)
- Jane Mussared, CEO, Council of The Ageing South Australia (COTA SA)
- Dr Lillian Mwrani, (SA African communities) Public Health, Flinders University (and Member, Migrant Resource Centre SA Board)
- Sageran Naidoo, Service Innovation Manager, Adelaide Primary Health Network
- Gill Norrington, Manager, Workforce Planning, Department for Health and Ageing
- Mary Patetsos, Member, Health Performance Council and Member, Multicultural Communities Council of SA
- Pat Ranieri, Senior Project officer, Safety and Quality, SA Department for Health and Ageing
- Bernarda Sanchez, CALD and Refugee Health Project Coordinator, Northern Health Network
- Steven Tully, Health and Community Services Complaints Commissioner
- Jeanette Walters, Manager Policy and Programs, Office for the Ageing, Department for Health and Ageing
- Tracey Watters, Director, Palliative Care SA
- Emma Willoughby, Consumer Consultant, Office of the Chief Psychiatrist, Department for Health and Ageing
- Dilky Wijeyekoon, Humanitarian Settlement Services Program Manager, Migrant Resource Centre of SA
- Jan Williams, Clinical Services Coordinator, Migrant Health Service
- Dr Tahereh Ziaian, School of Nursing and Midwifery, University of South Australia

References

[i] See Department for Communities and Social Inclusion regarding the expanded Multicultural Grants program at: http://multicultural.sa.gov.au/grants

[ii] The South Australian Government Universal Access and Inclusion Guidelines are a general policy framework that gives guidance on how and what strategies should be developed for disadvantaged communities. See: http://www.dcsi.sa.gov.au/about-us/key-strategies-and-plans

[iii] Ethnic Communities' Council of Victoria, Glossary of Terms, 2012

[iv] Commonwealth of Australia, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, 2012

[v] Health and Community Services Complaints Commissioner, *Charter of Health and Community Services Rights*, 2011

[vi] National Health & Medical Research Council, *Cultural Competency in Health, A Guide for Policy, Partnerships and Participation*, 2006

[vii] Health Performance Council of SA, *What's working, what's not, Review of the South Australian Health system Performance for 2011-2014*

[viii] Health Performance Council of SA, *Improving End of Life Care for South Australian*, 2013

[ix] Multicultural SA, Department of Communities and Social Inclusion: *http://www.multicultural.sa.gov.au*

[x] Australian Bureau of Statistics, *2011 Census of Population and Housing*

[xi] Department of Immigration and Citizenship, Humanitarian Program

[xii] Department of Immigration and Border Protection, *The People of South Australia*, 2014

[xiii] Multicultural SA, Department of Communities and Social Inclusion: *http://www.multicultural.sa.gov.au/communities-in-sa/community-profiles*

[xiv] http://www.adelaide.edu.au/phidu/current/graphs/sha-aust/quintiles/sa/countries-birth.html

[xv] Australian Bureau of Statistics, *Migration, Australia 2007-08*

[xvi] Australian Bureau of Statistics defines non-main English-speaking countries as Australia, Canada, Republic of Ireland, New Zealand, South Africa, United Kingdom, England, Scotland, Wales, North Ireland and USA

[xvii] Social Policy Research Centre, *Young carers: Social policy impacts of the caring responsibilities of children and young adults*, 2011

[xviii] Russell, G et al, Southern Academic Primary Care Research Unit, *Coordinated primary health care for refugees: a best practice framework for Australia.* Report to the Australian Primary Health Care Research Institute, 2013

[xix] Australian Bureau of Statistics, National Health Survey, 2006 and 2008, www.abs.gov.au

[xx] Glover J, Hetzel D, Glover D, Tennent S and Page A (2006) *A Social Health Atlas of Australia (Third Edition)*. Adelaide: The University of Adelaide.

[xxi] Commonwealth of Australia, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, 2012

[xxii] Department of Immigration and Citizenship (2011) *The People of Australia, Australia's Multicultural Policy*, <http://www.immi.gov.au/media/publications/multicultural/pdf_doc/people-of-australia-multicultural-policy-booklet.pdf>

[xxiii] Australian Commission on Safety and Quality in Health Care (2009) *Australian Charter of Health Care Rights*, <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/home>

[xxiv] Royal Adelaide Hospital, *Culturally Linguistically Diverse Action Plan 2007-2010*

[xxv] Western Australian Government, *Charter of Multiculturalism 2004*

[xxvi] Tasmanian Government, *Multicultural Policy 2014*

[xxvii] SA Health, Language Services Provision, Operational Guideline for Health Units, 2012

[xxviii] Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

[xxix] SA Health, Health Information Portal, *Hospital Separation data*, extracted 30 July 2015

[xxx] Raphael B (1997) Preface. In *Immigrants and Mental Health. An Epidemiological Analysis. (B McDonald, Z Steel, Eds)*, Transcultural Mental Health Centre, Sydney.

[xxxi] Ziaian, T, de Anstiss, H, Antoniou, G, Sawyer, M & Baghurst, P, *Depressive symptomatology and service utilisation among refugee children and adolescents living in South Australia*, Child and Adolescent Mental Health, 2011

[xxxii] Multicultural Mental Health in Australia, *www.mhima.org.au*

[xxxiii] http://www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/patient-health-records/

[xxxiv] www.aihw.gov.au/workforce/

[xxxv] http://publicsector.sa.gov.au/about/our-public-sector/dashboard/