MIGRANT & REFUGEE
WOMEN'S HEALTH PARTNERSHIP

February 2017

Submission to the development of the 5th edition RACGP *Standards for general practices*

Summary

Migrant and Refugee Women's Health Partnership (MRWHP) commends RACGP Standards Committee on placing the focus on patients and patient outcomes, and introducing specific indicators to ensure that practices work effectively with culturally and linguistically diverse patients, including through the utilisation of interpreting services.

<u>Cultural diversity considerations</u>

Australia is an ethnically, culturally and linguistically diverse nation. The proportion of Australians born overseas is now at the highest point in over 100 years. Approximately 6.6 million people, or 28 per cent of Australia's population, is comprised of migrants, and, since 2005-06, migration has been the main driver of Australia's population growth.[1] Currently, Australia accepts 190,000 permanent migrants every year, and an additional 13,750 refugees. Further, in 2015, the Australian Government committed to a one-off additional humanitarian intake over several years of 12,000 individuals from Syria and Iraq. There is also an increasing number of individuals who gain long-stay residence in Australia, including international students.

The increasing proportion of the overseas-born population has contributed to the growing linguistic diversity with the 2011 Census revealing that almost half (49%) of longer-standing migrants and 67% of recent arrivals spoke a language other than English at home.[2]

Migration and ethnicity-related factors are important social determinants of health. Migrants and refugees are frequently associated with impaired health and poor access to health services; there is evidence of inequalities in both the state of health and the accessibility of health services to these population cohorts.[3] Further, migrants and refugees are more exposed to social disadvantage and exclusion. However, it is important to note that this is an average tendency, which does not apply to all individuals, and there is great diversity within the cohort.

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[1] Migration Council Australia, *Migration in Focus: An Analysis of Recent Permanent Migration Census Data* (2015)
[2] Australian Bureau of Statistics, Reflecting a Nation: Stories from the 2011 Census (2012-13)
[3] Productivity Commission, *Report on Government Services 2017, Volume E: Health* (2017)

The state of health of migrants and their access to health care can vary widely between different groups, based on factors such as gender, age, pre-migration experiences, migration status, and other variables. These intersectional factors need to taken into account when applying a patient-centered lens to the Standards—in the context of patient access, experience and outcomes—to ensure responsiveness and appropriateness of care for migrants and refugees.

Cultural engagement and other measures to address barriers to access

While there may be some practical barriers to access, particularly in rural and regional areas, there is a range of cultural barriers that should be considered with a view to making health care more responsive to people's needs, circumstances, preferences and expectations:

Health literacy, health beliefs and help-seeking behaviour: Migrants' and refugees' views on health, notions of health problems and appropriateness of seeking help (and in what form), may diverge strongly from those of clinicians. These issues are usually formulated in terms of inadequate 'health literacy'. Migrants and refugees often lack knowledge and skills to navigate Australia's health care system. This includes the ability to locate the necessary information and negotiate the required care. Cultural engagement and fostering trust-based relationships between health services and migrant and refugee communities is key to enabling better access and experience.

Language: Limited English language proficiency in itself presents major obstacles to access. Patients with low English proficiency tend to have inadequate access to care and preventative services. Particular situations at risk of harm resulting from failure of interpreter-use include: consent for procedures, instruction of hospital discharge medications, and inappropriate use of family members as interpreters. There is sufficient research that highlights an urgent need for proactive service policies and health staff education around the appropriate use of language services.[4]

Delayed or inefficient care can result from ineffective communication between patients and medical professionals or care providers and the consequences of this can be serious for both the individual and the community; for example, there may be subsequent needs for more costly treatment and intervention, as well as serious risk of negatively impacting a patient's understanding of, and trust in, the health care system at large.

Culturally safe practice and effective communication with patients with limited English proficiency includes the ability to assess the need for engaging credentialed interpreters, to make necessary arrangements through an appropriate language services provider, and to work effectively with the interpreter to communicate with the patient. This is consistent with the Medical Board of Australia *Code of Conduct*.[5] In this regard, it is important to emphasise that, for patients from non-English speaking backgrounds, a patient's ability to engage in a general conversation in English does not equal their ability to discuss and understand health related matters, which may involved the use of complex terminology. Consideration should be given to factoring patients' language needs in the complaints management and open disclosure policy and practice.

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[4] Dr Janine Rowse, A/Professor Katrina Anderson, A/Professor Christine Phillips, Dr Brian Chan, *Critical case analysis of adverse events associated with failure to use interpreters for non-English speaking patients* (Australian National University Medical school, 2014)

[5] Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (2014)

We recommend that the final draft of the Standards emphasises the utilisation of interpreting services as required, when necessary (as opposed to "the preferred choice"), other than in exceptional circumstances such as medical emergencies. General practices must be made aware interpreters can be accessed free of charge—the Australian Government provides the Free Interpreting Service, through TIS National, to assist private medical practitioners (defined as General Practitioners and Medical Specialists, as per the Medical Board of Australia List) providing Medicare-rebatable services and their reception staff to arrange appointments and provide results of medical tests.

It is also critical to inform general practices of the importance of engaging accredited interpreters. Accreditation is an acknowledgement that an individual has demonstrated the ability to meet the professional standards required by the translation and interpreting industry, and it is provided by the National Accreditation Authority for Translators and Interpreters (NAATI) at various levels.[6] We note that there is currently no medical specialisation in interpreter accreditation standards, but measures are underway, as part of the *Improvements to NAATI Testing* project to implement a new NAATI certification model which will include a certified interpreter specialisation in health.[7]

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[6] https://www.naati.com.au/media/1109/outline_naati_credentials.pdf (accessed February 2017). Note: A new certification model will be implemented shortly.

[7] https://www.naati.com.au/media/1449/naati-certification-model-v47_november-2016.pdf (accessed February 2017)