MIGRANT & REFUGEE
WOMEN'S HEALTH PARTNERSHIP

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Submission to the Review of Australia's Health System Performance Information and Reporting Frameworks: Public Consultation Paper

Summary

The proposed framework for whole of health system performance information and reporting

Migrant and Refugee Women's Health Partnership (MRWHP) supports one overarching, whole of health system performance information and reporting framework.

With regards to Recommendation 2, we support the following characteristics of the optimal framework: expanding coverage of equity to become a lens across the whole framework; including analysis of consumer experience and satisfaction with the healthcare system; and ensuring the needs of different population are considered.

Further, we welcome the introduction of a deliberate cross-cutting focus on key populations, such as culturally and linguistically diverse communities, as an indicator supporting the combined framework (Recommendation 3).

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.[1] 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.

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 an equity lens across the framework. In this regard, it is important to emphasise that equity should be captured holistically—in the context of patient access, experience and outcomes—to ensure responsiveness and appropriateness of care for migrants and refugees.

Diversity within the culturally and linguistically diverse cohort is equally important when ensuring the consideration of the needs of different population groups. The accessibility domain of the framework, therefore, should consider various language

[1] Productivity Commission, *Report on Government Services 2017, Volume E: Health* (2017)

and cultural barriers that impact on migrants' and refugees' access to care 'at the right place and the right time', i.e. underrepresentation in attendance at preventative health services and overrepresentation in the use of acute and crisis services. A lack of health system literacy and knowledge of how to navigate consumer-model health services, combined with a lower level of awareness around screening and preventative health, result in inequalities in women's health outcomes.

For example, in 2013, women born overseas in predominantly non-English speaking countries were 10 per cent less likely to attend antenatal care early in pregnancy than women born in Australia. However, they were almost equally as likely as other mothers to attend seven or more antenatal visits throughout the course of the whole pregnancy.[2] Further, women from non-English speaking backgrounds can experience particular language, cultural and geographic barriers to accessing breast cancer screening. For the 24-month period 2014–2015, the participation rate for women aged 50–74 years was 49.1 per cent for NESB women (the national standardised participation rate was 53.2 per cent).[3]

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.[4]

Ineffective communication between patients and clinicians can result in delayed or inefficient care, subsequent need 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.

The proposed model for the collection, supply and use of health data

MRWHP supports a national model for the collection, supply and use of health data, noting in particular the design of data linked to purpose, common data standards and definitions, continuum of data collection to map data longitudinally, and fit-for-purpose and timely reporting (Recommendation 5).

Achieving health system performance that supports the consideration of, and responsiveness to, the needs of, inter alia, migrants and refugees requires accurate and consistent identification of these population groups across systems and jurisdictions. There are significant challenges in the current availability and quality of 'culturally and linguistically diverse' patient data. Some were identified by the Independent Hospital Pricing Authority's *Culturally and Linguistically Diverse Patient Costing Study Report*, undertaken with a view to informing a policy decision for whether an adjustment is warranted to the National Efficient Price (NEP) for CALD patients.

The study concluded that nationally consistent indicators for identification of CALD patients needed more development.[5] While there is a focus on language being the leading indicator of CALD patients, less emphasis is placed on the cultural needs of

[2] Australian Institute of Health and Welfare, *Australia's Health 2016* (2016)
[3] Productivity Commission, *Report on Government Services 2017, Volume E: Health* (2017)
[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] Independent Hospital Pricing Authority, *Culturally and Linguistically Diverse Patient Costing Study Report* (2015)

the patients. Further, the best available proxy for low English proficiency was "Interpreter Required" and, where this was not available, the "Preferred Language" field not being English was utilised.

The study recommended the development of nationally consistent CALD indicators to enable data to be collected and used in the costing and reporting process; and the collection and utilisation of patient level interpreter service costs across product types, to reflect the cost of these services attributable to specific patient episodes (the consultations for the study revealed that interpreter service costs were typically allocated as overhead across all patients and care types, and indicators such as "interpreter required" and "interpreter booked" were often inconsistently captured across sites and jurisdictions). A fundamental challenge in identifying whether an adjustment to the NEP model was required arose from the availability and quality of data to inform such a decision, i.e. the inconsistencies in collection of CALD patient data, and the costing methodologies used.

The Australian Institute of Health and Welfare report on cultural and linguistic diversity in aged care considered the importance of CALD identification for service design and delivery improvement. The report recommended that dataset should include, as a minimum, ABS measured 'Country of birth' and 'Main language spoken at home' (as a trigger for 'need for interpreter' and 'preferred sex of interpreter', and 'preferred language'). Further measures to augment the minimum would include ABS's 'Proficiency in spoken English', 'Year of arrival in Australia' and 'Religious affiliation'.

Where new data systems are under development, the report recommended that a group of value-added CALD measures be employed that will yield both: statistical measurement of cultural and linguistic diversity, which is classically derived from the ABS measures, providing for a broad analysis of diversity in a population; and direct evidence of actual or potential service need flowing from the cultural and linguistic diversity identified.

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