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FECCA Response to the Steering Group's Draft Recommendations on the Australian Government's Primary Health Care 10 Year Plan

The Federation of Ethnic Communities' Councils of Australia (FECCA) is the national peak body representing Australia's culturally and linguistically diverse (CALD) communities and their organisations. FECCA has over 20 member organisations that cover each State and Territory and are deeply linked to diverse communities across Australia's major cities and country towns.

FECCA has been proactively working on access and equity issues in aged and health care affecting CALD Australians. It is represented in the Aged Care Sector Committee and its Diversity Sub-Group, working collaboratively with the Department of Health (DoH) in developing and implementing the Diversity Framework and associated Action Plans. Since December 2020, FECCA is one of key peak bodies in the CALD COVID-19 Health Advisory Group working collaboratively with DoH on COVID-19 safety and the vaccination program.

FECCA would like to thank the Primary Health Reform Steering Group (Steering Group) for the opportunity to provide inputs to the *Draft Recommendations on the Australian Government's Primary Health Care 10 Year Plan*. FECCA also recognizes the Steering Group's proactive consultations especially, with CALD communities and with aged care sector stakeholders.

People from CALD backgrounds now form a significant proportion of the Australian population. [Attachment A](#) provides an overview of key demographic information derived from the 2016 Census.

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**FECCA Response to the Steering Group's Draft Recommendations
on the Australian Government's Primary Health Care 10 Year Plan**

In this response, FECCA would like to highlight the following key recommendations:

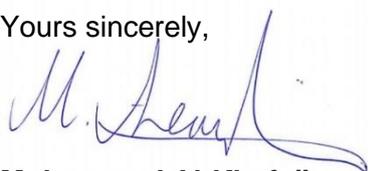
No.	FECCA Recommendations
1	That a cultural framework specifically, and a diversity framework, broadly be embedded in the Primary Health Care 10 Year Plan and in developing subsequent policies and programs to ensure equitable access and improved health outcomes for CALD Australians.
2	That a better understanding of the care ecosystem be pursued to enable a socially and community-oriented model that will support continuity of care.
3	That investments in culturally relevant health literacy and preventative health programs be prioritised to improve understanding of choice and control; engagement of the health care system; self-efficacy; and self-care.
4	That an overarching multicultural framework be embedded at all levels in the healthcare system with representations in advisory groups and consulting extensively to the multicultural communities.
5	That focus be provided on building the capability of health professionals to deliver culturally competent and appropriate primary health care.
6	That appropriate measures of cultural, ethnic, and linguistic diversity in data sets and research be included and people from culturally, ethnically, and linguistically diverse backgrounds be proactively included in primary health care research.
7	That access to effective language services be recognised as a fundamental right for all CALD Australians.

The succeeding pages present the details of our recommendations.

We look forward to collaborating with the Steering Committee and the Department of Health in finalizing the Plan and in engaging CALD communities along the process. FECCA has the capacity to assist and contribute further to this work and bring the required perspective of cultural, ethnic and linguistic diversity through its State, Territory and Regional members and its extensive multicultural partner network.

If you wish to discuss any aspect of this submission further, please do not hesitate to contact me at ceo@fecca.org.au

Yours sincerely,



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Person-centred health and care journey, focusing on one integrated system

Recommendation 1. That a cultural framework, specifically and a diversity framework, broadly be embedded in the Primary Health Care 10 Year Plan and in developing subsequent policies and programs to ensure equitable access and improved health outcomes for CALD Australians.

This means an overarching acknowledgement that culture influences a range of beliefs, values, and practices. It is widely agreed that culture impacts people's perceptions of health, wellness, illness, and death; beliefs about causes of disease; approaches to prevention and therapy; how illness and pain are experienced and expressed, where patients seek help; preferred treatment; and end of life issues.¹

While FECCA welcomes the paper's focus on health inequalities, health concerns of CALD people are not sufficiently touched upon in the draft recommendations. Issues like intersectionality, diversity and cultural competence are skated over or omitted.

Health systems often reflect the dominant culture. Health practitioners need to be aware of their own cultural beliefs and develop cultural competence which includes understanding possible differences between their views and those of their CALD patients. Cultural competence in health care includes the ability of practitioners to ask patients and their carers about their beliefs, values, and practice and to incorporate these learnings in diagnosis, care, and treatment planning.

The Australian mainstream model of patient-centred care is predicated on a notion of individual responsibility. However, many cultures adopt a more collectivist stance and decisions about health care may lie with others apart from the patient/consumer.

FECCA has also identified a missed opportunity in this draft: intersectionality. Public health researchers are increasingly acknowledging intersectionality as an important theoretical approach, providing a framework for investigating health inequalities by highlighting intersections of individuals' multiple identities within social systems of power that compound and exacerbate experiences of ill health.²

To better understand and capture the complex needs of people through the intersectionality lens, we need to consult and better understand the diverse needs of CALD people. FECCA recommends the notion of intersectionality should be embedded in the primary health system through further research and community consultation.

¹ Kahissay MH, Fenta TG, Boon H. Beliefs and perception of ill-health causation: a socio-cultural qualitative study in rural North-Eastern Ethiopia. *BMC Public Health*. 2017;17(1):124.

² López, N., and V. L. Gadsden. *Health inequities, social determinants, and intersectionality*, 2016.

To ensure that people from CALD backgrounds and with diverse life experiences have equitable access to quality care, recognizing and responding to diversity must be an integral part of the design and delivery of care, underpinning the new ten-year strategy. Intersectional analysis and response are needed to embed capacity to address different experiences of diversity in all programs and providers within the healthcare system.

Recommendation 2. That a better understanding of the care ecosystem be pursued to enable a socially and community-oriented model that will support culturally appropriate continuity of care.

FECCA welcomes the single primary health care destination to formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice. However, it is concerned that the draft recommendation requires a broader understanding of health and wellness in the community.

There is significant research demonstrating that among older people with complex needs for example, the neighbourhood, local services, and community where they live can determine their experience and delay their entrance to higher needs care.³ FECCA consultations with small, emerging communities and vulnerable groups such as people from refugee backgrounds provided similar insights.

The same study highlighted that, “Constrained social service spending may also lead directly to inefficient use of health care resources—for example, when patients are unable to be discharged from the hospital because of a lack of support available in the community.”

Access to transport, availability and accessibility of local services including primary health and allied health services, and the safety and connectedness of neighbourhoods are factors shaping positive community-based health and wellness.

A good care ecosystem would require effective interfaces with related systems—disability, social care, mental health, community care etc.

Address social determinants of health

The healthcare system must adopt and support upstream interventions that will address social factors influencing health choices and behaviours. This underscores the need to invest on building geographically based care ecosystem supported by a responsive healthcare, aged care, disability, mental health, allied health, and social care teams.

There is a need to orient systems around building intrinsic capacity by developing community initiatives such as community wellness centres, multicultural associations etc that offer healthy lifestyle programs, social engagement activities, health screenings are critical entry points.

³ The Commonwealth Fund International Experts Working Group on Patients with Complex Needs. [Designing a High-Performing Health Care System for Patients with Complex Needs: Ten Recommendations for Policymakers](#). September 2017.

They help build the knowledge and capability of people from CALD backgrounds to understand and engage the systems while they are well, not at the point of critical need or crisis.

A navigation system that is relevant to CALD communities

FECCA also believes that the healthcare system needs to embed cross-sector, cross-service navigation and whole of life support to achieve a holistic approach to individuals' needs and circumstances. Currently, there are separate navigation systems for aged care, disability etc leaving vulnerable people the onus of figuring out how each system works and if they can be connected to mitigate further stresses when they are managing acute health conditions and worse, needing critical care. FECCA consultations have shown that some CALD groups have problems navigating the Australian health care system or lack access to culturally appropriate health care, and this in turn results in the under-utilisation of many health services by CALD communities.

Navigation of these different systems should be embedded in the community and supported by primary healthcare teams. This approach to coordination/navigation would require building trusted relationships such as with cultural brokers throughout a person's health journey. For vulnerable members of the community this means a cohesive system that has mapped local needs, access to services, case management, among others.

It is essential that coordination/navigation is delivered by people with cultural expertise and knowledge of the system in practice. Within this, there is an imperative that health professionals understand that they need to work with not just the primary care recipients, but their carers and families as collective decision-making will often form part of how families from CALD backgrounds deal with important decisions.

Adding building blocks for future primary health care – better outcomes and care experience for all

Recommendation 3. That investments in culturally relevant health literacy and preventative health programs be prioritised to improve understanding of choice and control; engagement of the health care system; self-efficacy; and self-care.

Research has shown there is a strong association between being from a culturally and linguistically diverse background and low health literacy.⁴ Limited health literacy, compounded by language barriers, cultural bias, discrimination, and distrust of the government are core components of any prevention agenda for CALD people.

Absence of these key issues in the paper is deeply concerning to FECCA.

⁴ <https://www.aihw.gov.au/reports/australias-health/health-literacy>, accessed 25 September 2020

Poor health outcomes are reflection of the community's low level of health literacy: only one out four Australians aged 15 to 74 from speaking English as a second language background had adequate health literacy.⁵

Australians from CALD backgrounds often face an increased risk of negative outcomes in key public health areas such as smoking and alcohol use, obesity, food and nutrition, mental health, exercise and physical activity, chronic conditions and communicable diseases, and immunisation.⁶

Studies indicate that ten years after arrival, the healthy migrant effect can disappear mainly due to language barriers preventing access to health services.⁷ Some CALD communities continue to experience problems navigating the Australian health care system or lack access and confidence to culturally appropriate health care, and this in turn results in the underutilisation of many health services by CALD communities.⁸

Existing research and evidence also show that specific groups of CALD Australians have specific barriers to participation in prevention activities because of their cultural or linguistic identity, their migration history, and their integration experiences in Australia.⁹

Refugees have a low uptake of preventative screening for diseases such as cervical and breast cancers, for example. Assessment and screening processes need to be more opportunistic with proactive measures to target this group along with health promotion education specifically geared towards migrant and refugee communities.

In 2012-2013, BreastScreen Australia reported that women who spoke a language other than English at home participated in the program at a rate of 6% lower than those who spoke only English at home. This example of inequity in participation is concerning and should be addressed with the creation of more front-line CALD services and specific awareness campaigning to ensure CALD women and girls are adequately targeted in this priority area.

A life course approach needs to be in place especially when mapping risk factors across women's lifespan. Any consultation used to design services for women's health programs should ensure that CALD women are adequately represented to deliver outcomes for all women.

FECCA recommends that one of the prioritising efforts in this Strategy is to include CALD people in improving their health literacy through extensive consultations, cultural awareness training and community education. CALD consumers and communities need to be actively involved in identifying and developing health promotion strategies for health and well-being.

⁵ Ibid.

⁶ Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

Leadership and culture

Recommendation 4. That an overarching multicultural framework be embedded at all levels in the healthcare system with representations in advisory groups and consulting extensively to the multicultural communities.

Policymaking and practice need to reflect and respond to the social, economic, geographic, cultural, and linguistic diversity of diverse population groups and this requires stakeholder participation from the process of development to implementation.

It is critical to ensure CALD representation on health advisory committees and cease filtering the view of about half of stakeholders through other voices and priorities.

Public policy at the national level affirms access and equity principles in a host of documents such as *The Charter of Public Service in a Culturally Diverse Society*, emphasising that cultural diversity considerations should be incorporated into the strategic planning, policy development, budgeting, and reporting processes of service delivery.

Notwithstanding such charters and associated guidelines, the adoption of cultural competency frameworks and practices across the health system is inconsistent and ad hoc. Existing guidelines have no adequate evaluation framework and compliance system to remedy services that fail to meet cultural competency standards.

There is also a need to identify enablers in the system and recognise the importance of the interconnectedness of these enablers. For example, lack of a strong and effective leadership and governance may disable all the other enablers. The strategy should define institutional structures to drive any reforms across sectors, government, private sectors, and civil society.

FECCA acknowledges that community-based organisations have a critical role to play and the COVID-19 pandemic has highlighted this and recommends harnessing partnership with these organisations not only during a health crisis, but on a structural and institutional basis.

There is no national infrastructure or consumer peak body advocacy for CALD people in the primary and general health system. FECCA suggests that discussion of these issues to inform a comprehensive national response would be best achieved by the establishment of a peak body on CALD health with recognised representation from community groups and stakeholders.

Primary care workforce development and innovation

Recommendation 5. That focus be provided on building the capability of health professionals to deliver culturally competent and appropriate primary health care.

This means a CALD primary health workforce strategic plan is developed in meaningful collaboration with a broad range of stakeholders to recognise comparable qualifications and experience from overseas including international medical graduates (IMGs).

IMGs now comprise a significant part of the Australian workforce. However, their perspective on strategies to facilitate their effective integration into the Australian health care system have not been adequately explored.

FECCA welcomes the recommendations of the Steering Group with regards training of workers in a range of specific areas, including promoting primary health care as an attractive career pathway and foster greater mentorship in general practice and rural generalist

medicine. Such training should include IMGs as they are an important part of the primary health care workforce, and their competencies should be valued, fostered, and recognised.

The benefit of involving multicultural health professionals including IMGs is well known as important conduits to achieving high levels of understanding, treatment compliance and advance care planning with their patients. FECCA's several studies related to opioid usage among CALD communities and inclusion of CALD communities in the National Pancreatic Cancer Roadmap have identified that involvement of liaison and linkage personnel with the appropriate linguistic and cultural skills is an important enabler to achieving better results for consumers and their families.

Organisational culture, policies and practices that support workplace diversity are required in primary health care settings. This must include a greater level of support for and recognition of bilingual health workers. Bilingual staff in primary health care settings play a critical role in meeting the health and care needs of CALD consumers and communities.

It is essential organisational support is provided to bilingual workers to ensure that they are resourced appropriately and supported professionally to undertake their work. This includes strengthening professional standards and skills recognition and establishing stronger links between our bilingual workers and the primary health care system.

The current government policy of resettling some refugees in regional areas means that health services in regional Australia need improved strategies and resources for dealing with increasingly diverse consumers.

Cultural competency as a core skill

FECCA believes that staff development and training around cultural competency in primary health care service delivery must be mandated to be delivered on a regular basis by all service providers. This is particularly important considering the typical staff turnover within the primary

health care workforce. This training should provide specific attention to areas such as cultural competence for culturally and linguistically diverse groups; how to deliver culturally appropriate personal care; how to connect with communities who may assist with providing volunteer services to benefit and enhance CALD social connectedness.

Studies suggest that general practitioners who are not well equipped to deal with the sometimes acute and complex needs of refugees have simply closed the books to these clients.¹⁰ Training to support health professionals' work in a culturally sensitive manner needs to include greater training in the use of interpreters.

Investment in training that focuses on culturally appropriate care is imperative. This means the inclusion of diversity into core curriculum rather than as an add-on 'optional' subject. Training around culturally competent health care is often downgraded in the current health curriculum for medical students, and cultural competence training is often not prominent in the ongoing professional development of general practitioners.

FECCA believes there is a general need to increase cultural awareness training and education among health professionals, particularly within areas such as refugee health and in the use of translation and interpreting services. A component of cultural competence training needs to be around the use of interpreters.

Research, data, and continuous improvement of value to people, population, providers, and the health system

Recommendation 6. That appropriate measures of cultural, ethnic, and linguistic diversity in data sets and research be included and people from culturally, ethnically, and linguistically diverse backgrounds be proactively included in primary health care research.

FECCA acknowledges the Steering Committee's recommendations in research, data, and continuous improvement of value to people, population, providers, and the health system as it continues to be concerned over an identified gap in public health research for CALD communities.

In 2006, the National Health and Medical Research Council (NHMRC) have reported the systematic exclusion of CALD individuals and communities in research due to the challenges and additional investments required to ensure their participation.¹¹ In 2005, a literature review by the Centre for Culture, Ethnicity and Health (CEH) also noted a 'lack of sound methods for

¹⁰ Johnson, D., Zierch, A., and T. Burgess (2008) I don't think general practice should be the front line: Experiences of general practitioners working with refugees in South Australia. *Australian and New Zealand Health Policy* 5:20.

¹¹ NHMRC(2006). Cultural Competency in Health. Available: http://www.nhmrc.gov.au/publications/synopses/_files/hp19.pdf

data collection, study designs and interpretation of data evident in many public health research studies that refer to ethnicity'.¹²

These issues remain to this day.

Ensuring quantitative health data is gathered which is *inclusive of CALD communities* would enable disadvantaged subgroups to be identified, progress measured, and program approaches to be refined and modified accordingly. Qualitative research is further required to understand the barriers and enablers to primary health care, and to ensure that services are relevant to and resonant with local CALD communities.

To ensure primary health care is funded and delivered in a way that is evidence-based and responsive to local needs, data collection needs to be mandated for key health services. Such data should be disaggregated to indicate the needs and access issues that certain disadvantaged sub-groups may face in utilising primary health care services.

In a 2020 issues paper,¹³ FECCA identified current inadequacies in relation to Australia's data on cultural, ethnic, and linguistic diversity.

Australian research tends to rely on country of birth as the sole measure of ethnic diversity, mainly because this is usually the only variable available in datasets. Country of birth is an inadequate measure of ethnicity in certain individuals such as ethnic Chinese born Singapore, Indonesia or Malaysia, ethnic Indians born in countries such as Fiji, the United Kingdom or Uganda, displaced refugees born in other countries, and the growing population in Australia who are Australia-born but whose parents are migrants from a variety of ethnic backgrounds. Neither does country of birth capture other socially determined factors that can have a significant impact on inequalities in accessing quality health services.

Diversity data deficit puts into question the validity of many qualitative and quantitative studies into health and well-being issues affecting all Australians as majority of studies have excluded CALD voices by insisting on English language research tools providing no options for translated versions.

Research translation

FECCA would like to highlight that ensuring the translation of research findings into policy and practice remains an enduring challenge in the area of health care in general amongst CALD communities. Lack of information sharing on successful interventions for CALD communities has been cited as a limiting factor for sustained behaviour change, as has the failure to embed evidence-based standards into health care delivery and primary care settings.

¹² Adily, A. and Ward, J., Improving health among culturally diverse subgroups: an exploration of trade-offs and viewpoints among a regional population health workforce. *Health Promotion Journal of Australia*, 2005. 16(3): p. 207-212.

¹³ FECCA (2020) Issues Paper: IF WE DON'T COUNT IT... IT DOESN'T COUNT! Towards Consistent National Data Collection and Reporting on Cultural, Ethnic and Linguistic Diversity <https://fecca.org.au/wp-content/uploads/2020/10/CALD-DATA-ISSUES-PAPER-FINAL2.pdf>

It is essential that research outcomes for CALD communities inform primary care practice. FECCA believes the new ten-year strategy is an opportunity to provide an essential framework for the co-ordination of information gathering and dissemination of best practice at the national level. Ongoing consultations and partnerships with CALD communities and organisations is an essential element in data collection on the health needs, enablers and barriers to accessing primary health care services by CALD communities.

Implementation is integral to effective reform that delivers on the Quadruple Aim

Recommendation 7. That access to effective language services be recognised as a fundamental right for all CALD Australians.

Effective and efficient communication is key to successful implementation. The Steering Committee identified two key communication issues for people from CALD backgrounds in accessing primary health care: providing universal access to interpreter services to support safe and effective health care delivery; and tailoring services to CALD communities. This highlights the importance of using accredited interpreters to assist in such communication.

Access to language services is critical to the health outcomes of people from linguistically diverse backgrounds. At a minimum, people with linguistic diversity must be able to:

- Understand information about accessing primary healthcare and their rights;
- Make informed choices about their care, including giving informed consent, throughout their care; and
- Be understood when accessing services and providing feedback.

A health crisis such as the COVID-19 pandemic has laid bare and further exacerbated systemic weaknesses in this area causing increased vulnerability among the low income and vulnerable, non-English speaking migrants.

Miscommunication between clinicians and health consumers, due to either linguistic or cultural factors, has been shown to contribute to adverse health outcomes and to the disempowerment of CALD background individuals and communities. Critically, the low uptake of interpreting services within primary health care settings prevents the mutual exchange of information between the clinician and many CALD consumers and undermines the development of the clinician-consumer relationship that is pivotal to achieving people-centred care. Short consultation times further diminish the quality of people-centred care for CALD consumers with complex and chronic health conditions

Most information about health services, self-management and health promoting strategies are in English, or are directly translated from English into community languages without consideration of wider social and cultural issues. This in turn prevents CALD consumers and communities from making informed decisions about their health.

Existing self-management and health promoting activities have been criticised for targeting already active, health literate, and typically higher socio-economic status consumers, thereby excluding people with low language literacy, limited health literacy, or low economic resources.

It would be useful if clear guidance could be provided to assist practitioners in working with interpreters. This should include the use of plain or simple English and avoiding complex medical terminology, and of engaging with the interpreters to ensure understanding of the message.

This is particularly relevant at the point of diagnosis. A NSW study of interpreters required to convey a cancer diagnosis showed that it was not infrequent that the diagnosis was not conveyed accurately or at all. It was suggested that this was due to discomfort on the part of the interpreters. ASHM, a peak organisation of health professionals in Australia and New Zealand working in HIV, viral hepatitis and sexually transmissible infections faced similar issues and developed a resource for interpreters explain key concepts and terminology relating to blood borne viruses.¹⁴

The task of translating medical information is, however, complex as evidenced by concerns about the quality and accuracy of translations in recent Government information on COVID-19. Best practice indicates that the source document is in plain or simple English and that an

accredited translator be engaged. Many organisations fail to perform a second step which involved the commissioning of an independent backtranslation into English. Even fewer complete the important step of testing the translated material with the targeted communities to check that the key messages are in fact understood and are expressed in a culturally appropriate way.¹⁵

FECCA recommends that the government invests in the development of a Community Translation Assessment Panel to ensure that in-language health campaign and communications are appropriate and salient to communities.

¹⁴ https://ashm.org.au/resources/Interpreters_and_BBVs.pdf

¹⁵ <https://www.abc.net.au/news/2020-11-19/government-used-google-translate-for-nonsensical-covid-19-tweet/12897200>, accessed 17 July 2021.

Attachment A

Key CALD Demographics (Census 2016)

