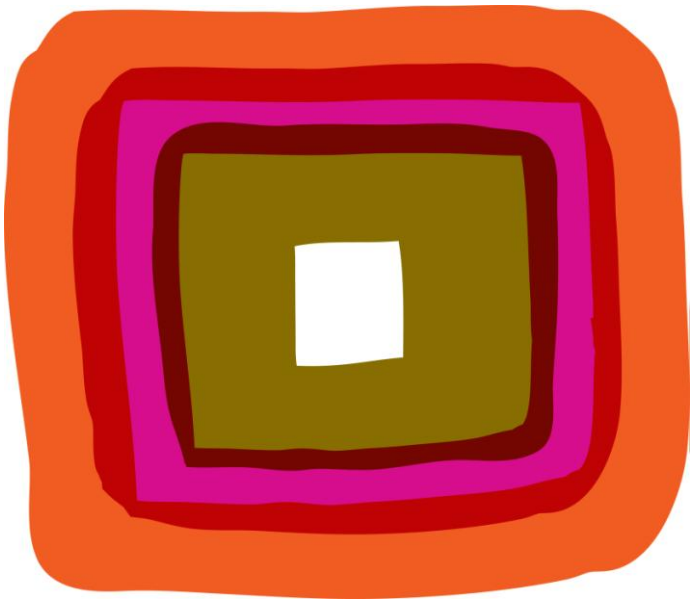
Australian Parliament
Joint Standing Committee on Migration
Submission no. 300

centre for culture, ethnicity & health

Submission Paper: Inquiry into Multiculturalism in Australia

Submission to the Joint Standing Committee on Migration

April 2011



Contact:
Michal Morris
Executive Manager, CEH
michalm@nrch.com.au
03 93429702

introduction

The **Centre for Culture, Ethnicity and Health** (CEH) is a national organisation that provides specialist information, training and support on cultural diversity and wellbeing.

Our clients are health and community service professionals and organisations who are committed to providing a culturally appropriate and high quality of care. We offer practical support and training to help them improve outcomes for culturally diverse clients and communities.

CEH welcomes the opportunity to make a submission on the important issue of multiculturalism in Australia. As a leader in culturally competent health development and training, CEH envisions an Australia where all have equitable access to health and care. We recognise the fundamental link between a harmonious community and a healthy one and hence strive to build a society where cultural, linguistic and social factors act as enablers rather than barriers to health and wellbeing.

The World Health Organisation's Constitution defines health as:

> *"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*[1]

It also states:

> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."*[2]

The Federal Government's Social Inclusion Agenda aims to ensure that all Australians can fully participate in the economy and community as dignified individuals with the right to shape their own lives. We believe that this must mean that no cultural, linguistic, social or religious barrier should prevent any Australian from being treated with respect and as an equal in our society. It is equally important that no Australian be denied access to the services afforded to everyone in our community, including the right to health and wellbeing.

Health and wellbeing are intrinsically connected to social inclusion. It is difficult to participate in the prosperity and life of the community without suitable access to health and health services. It is important to acknowledge a holistic definition of health that is much more than the absence of sickness and disease. It is about being accepted for who you are, feeling like a respected member of the community and being able to enjoy the autonomy that arises out of freedom from discrimination and exclusion. It is particularly important

[1] Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946.
[2] Ibid

for culturally and linguistically diverse (CALD) communities to be able to access culturally competent services to achieve a greater level of health, wellbeing and social participation.

Multicultural policy is a tool towards equity in an inclusive and harmonious society. To allow the inclusion of all Australians, we must provide tailored and culturally fluent services with an awareness of the relationship between health, wellbeing and social inclusion. This will work to address the disadvantage and discrimination that currently undermines social inclusion in our communities.

In order to strive towards greater levels of social participation and equity through multicultural policy, CEH has identified several key areas to be addressed:

- **Discrimination, Identity and Wellbeing**
- **Cultural Competency in Organisations and Service Delivery**
- **Information and Access to Health Services**
- **A Human Rights Approach**

We have identified key recommendations for each area and these are summarised at the end of this report.

---

discrimination, identity and wellbeing

Effects of Discrimination

There is increasing recognition that discrimination affecting those from diverse cultural backgrounds has a direct impact on health and wellbeing. An international review of 138 empirical quantitative studies of self-reported racism and health found a 72% positive association with negative mental health outcomes, a 36% positive association with negative physical health outcomes and a 62% positive association with health-related behaviours such as cigarette smoking, drugs and alcohol misuse.[3] The costs of this go beyond the individual – depression associated disability costs 14.9 billion annually and results in more than six working days lost each year.[4] Access to resources such as employment, income, social support, housing and education has been shown to have a strong link to health outcomes[5]. Additionally, the internalisation of negative stereotypes and attitudes has been found to be associated with a number of mental health and negative health-related behaviours.[6] Hence, it is imperative that we take a wider view of health and wellbeing which includes being free from racism, discrimination and social isolation.

[3] Paradies, Y. 'A systematic review of empirical research on self-reported racism and health', International *Journal of Epidemiology*, 35, 2006.
[4] beyondblue, *beyondblue: The way forward 2005-2010*, available at www.beyondblue.org.au.
[5] VicHealth, *VicHealth Position Statement on Health Inequalities*, 2005.
[6] Williams, D. and Williams-Morris, R. 'Racism and Mental Health: the African-American experience', *Ethnicity and Health*, 5(3/4), 2000.

Institutionalised Discrimination

Discrimination can also manifest on an institutional level. Significant proportions of people who were born in non-english speaking countries reported having experienced discrimination in institutional settings at some time:

- *Nearly two in five reported having experienced discrimination in the workplace;(Three times more than those born in Australia)*
- *30% had experienced discrimination in education; (Two times more than those born in Australia)*
- *18% reported having experienced discrimination in housing; (More than four times more than those born in Australia)*
- *19% reported experiencing discrimination in policing (More than three times more than those born in Australia)*[7]

CALD Communities

People born in non-English speaking countries are twice as likely to be treated with disrespect and to report incidences of name-calling or insults on the basis of their ethnicity/race.[8] Moreover, 56.1% of children from non-English speaking countries are involved in after school sports and cultural activity, compared with 72.7% of migrants from mainly English countries and 73.9% of Australian-born children.[9] People from refugee backgrounds have also been found to be allocated the lowest-level jobs regardless of formal qualifications, skills and experience.[10]

According to The Anti-Racism Research Project, about one-in-ten Australians have very problematic views on diversity and on ethnic differences. They believe that some races are naturally inferior or superior, and they believe in the need to keep groups separated.[11] There is also evidence that discrimination and a lack of cohesion is increasing in our society. The 2010 Scanlon Foundation *Mapping Social Cohesion* report found that 14% of respondents had 'experienced discrimination in the last 12 months because of their skin colour, ethnic origin, or religion'. This compares to 10% in 2009 and 9% in 2007.[12] Moreover, 25% of overseas-born people have reported in local-level surveys that they have been 'made to feel like they did not belong'.[13] The link between discrimination, social inclusion and health is strongly reflected in the wide body of research evidence surrounding these issues.

---

[7] VicHealth, *More than tolerance: Embracing diversity for health: Discrimination affecting migrant and refugee communities in Victoria, its health consequences, community attitudes and solutions – A summary report*, 2007.
[8] VicHealth, *Ethnic and Race-based Discrimination as a determinant of mental health and wellbeing*, 2008.
[9] Ibid.
[10] VicHealth, *More than tolerance*, 2007.
[11] University of Western Sydney, *The Anti-Racism Research Project*, 2008.
[12] Professor Andrew Markus, *Mapping Social Cohesion: The Scanlon Foundation Surveys Summary Report 2010*, Monash University, 2010.
[13] VicHealth, *Ethnic and Race-based discrimination*, 2008.

Social isolation because of cultural and language barriers is a significant issue and one that has often severe implications.

> *In a CEH program that works on issues around CALD communities and problem gambling, social isolation is identified as a significant causal factor for the over utilization of pokies, particularly for older ethnic community members with low English language proficiency.*

Our Australian society must work to erode discrimination and divisions in our communities while supporting the settlement needs of new migrants and refugees. The diversity of CALD communities is acting as a barrier towards the social and economic participation of these groups. This is damaging to their sense of identity, inclusion and ultimately, the health and wellbeing of these Australians. The relationship between marginalised communities and poor health outcomes must be kept in mind when formulating social policy.

Key Recommendations

1. **All government multicultural, social inclusion or anti-discrimination policies and programs should recognise the links between discrimination, social isolation and health.**

2. **The Social Inclusion Agenda should recognise that health is a cornerstone to social inclusion and reflect this in policies and programs.**

3. **Federal government should continue to support and enhance settlement programs and community education that work in unison to erode divisive views, promote positive social norms and support a harmonious society.**

4. **All governments should continue to develop and evolve strategies to deal with institutionalised discrimination in the workplace and in the public services.**

5. **The new focus of Australian multiculturalism, as practiced by The Department of Education, The Department of Immigration of Citizenship, community organisation, non-government organisations, and other relevant bodies on both federal and state levels, must work to broaden the conception of the Australian identity. This is imperative to dismantle dangerous notions of ethnic differences, to break down social barriers and to move towards a more inclusive society.**

cultural competency in organisations and service delivery

Defining Cultural Competency

Cultural competency is defined as:

> *"A set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals; enabling that system, agency or those professionals to work effectively in cross-cultural situations."*[14]

CEH sees cultural competency as a holistic service response that recognises the diverse cultural and linguistic needs of individual clients. Cultural competency is relevant in all service settings from the bricks and mortar of hospitals and community health centres to the less conventional approaches of outreach and community education programs. It offers a framework to assess and develop your organisation to ensure that all clients receive high quality and culturally appropriate care. Cultural competency can help to facilitate the inclusion and participation of culturally diverse groups and should form part of the social inclusion agenda.

We identify seven key domains of cultural competence:

Organisational Values
Embedding cultural competence as a core value of the organisation so it can be incorporated into every aspect of service and workplace management. Cultural integrity and competence must be located at levels of institution-based responsibility rather than individualised responsibility to ensure that adequate resources are allocated to staff.

Governance
An organisation-wide approach to planning, implementing and evaluating services for clients of culturally diverse backgrounds. Policies, systems, consultation and participation strategies need to guide the actions of the board, management, staff, volunteers and students, in order to ensure a consistent and responsive approach.

> *A study of diversity practices within private sector workplaces between 1971 and 2002 found significant increases in managerial ethical and racial diversity through structures that establish responsibility (action plans, strategic committees dedicated positions, networking and mentoring). Specifically, management/leadership support increases the*

[14] Cross et al, *Towards a Culturally Competent System of Care*, Vol.1, Georgetown University Child Development Centre, 1989.

sustainability and success of diversity programs by legitimising such initiatives and creating a culture that is committed to diversity.[15]

Planning, Monitoring and Evaluation
Cultural competence in planning, monitoring and evaluation results in services that effectively meet the needs of current clients and communities, and are flexible enough to respond to changing circumstances and emerging populations.

Communication
Culturally competent communication is critical for all aspects of service delivery. It can break down barriers, improve access to services and support better health outcomes for clients. It is equally critical for staff wellbeing and satisfaction.

Staff Development
All staff should have access to and support for ongoing skills development, training and knowledge to support culturally competent service delivery.

Organisational Infrastructure
Cultural competence requires financial and personnel resources. Without a supportive infrastructure, it may be considered an add-on rather than an integral part of core business. Careful planning is needed to make the best use of limited resources.

Services and Interventions
Services will be more effective if they acknowledge and work with clients' cultural knowledge, prior experience and frames of reference. The capacity of a service provider to improve a client's health and wellbeing status will be enhanced if the worker can integrate culture into practice.

Cultural competency is about changing, developing and responding to the cultural and linguistic needs of the client. It means that service delivery has to be flexible, adapting and changing to suit the target groups who are placed at the centre of the response. As a result, the client is more informed, will understand the context of the service sector, and utilise the service more appropriately.

CEH operates the Multicultural Health and Support Service, dealing with the sensitive matter of blood borne viruses and sexually transmitted disease. CEH tailors our information and programs to suit our culturally diverse clients because the failure to do so would mean that essential information and services are not delivered. This has involved modifying our programs to suit oral cultures, address cultural taboos and sensitivities and where it would be inappropriate to talk about sensitive issues in a mixed-gender group.

[15]Paradies, Y., Chandrakumar, L., Klocker, N., Frere, M., Webster, K., Burrell, M et al. *Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria*. Full Report, Melbourne, Victoria: Victorian Health Promotion Foundation, 2009.

Cultural competency will reduce the barriers that lead to poorer health and wellbeing outcomes for CALD communities while facilitating social inclusion in our multicultural society.

Key Recommendations

6. **Cultural competency should be incorporated in government, private and community organisations in order for it to be embedded into all aspects of an institution.**

7. **Government, community and private agencies should provide adequate resources to practice cultural competency in service delivery where the client is at the centre of the response.**

8. **Educational institutions, public and private service delivery agencies should integrate cross-cultural education into the training of all current and future professionals and provide opportunities for further on-the-job training.**

9. **Health policy should aim for sustained and strong relationships with a primary care provider to address issues of mistrust. This will be strengthened by providing opportunities to increase the proportion of underrepresented CALD groups among health professionals.**

10. **Health policy should promote the consistency and equity of care through evidence-based guidelines used to engage patients and their families.**

information and access to health services

Health Literacy

In 2006, the Australian Bureau of Statics undertook the first Australian audit of Adult Literacy and Life Skills. Health literacy is defined as:

> *The knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy*[16].

The audit used the scale of 5 domains - with level 1 being the lowest measured level of literacy and 5 the highest. The middle level 3 was regarded by the

[16] Australian Bureau of Statistics. Health Literacy, Australia 4233.0. Australian Government 2008.

survey developers, *as the minimum required for individuals to meet the complex demands of everyday life and work*.

The findings identified that 40% of those born in Australia achieved a health literacy rating of skill level 3 or above[17].

It is estimated *60% of Australians are functionally health illiterate*. While this seems low, health literacy for those born in a mainly non-English speaking country are even lower. Only 26% of migrants have a health literacy rating of 3 or higher.

Key Issues

Issues of communication, confusion and a lack of knowledge of the Australian health system along with logistical and settlement issues have been identified as the key issues for refugees accessing and utilising the health system.[18]

A Victorian Department of Human Services Report found that

> *"Refugees expressed that their most common difficulty related to language and communication, and that they would appreciate translated information about the health system in Australia, so they are able to more easily access services"*[19]

Another report found that 90% of CALD interviewees preferred to speak in their original language and reported discomfort speaking English to a health practitioner. What is most surprising is that the majority did not know that they had the right to use an interpreter and 80% had not been asked if they wanted to use an interpreter.[20]

As reported by the Refugee Council of Australia, the refusal or failure of GPs and specialists to use interpreters (even free telephone interpreter services) during consultations is a systematic problem.[21]

Implications

The effects of inadequate access to care include the poor exchange of information, loss of important cultural information, misunderstanding of medical instruction, poor shared decision-making, ethical compromises, decreased adherence with medication regimes, poor appointment attendance and decreased satisfaction with services.[22]

This leads to the under-utilisation of health services by CALD communities and hence poor health outcomes. This undermines a social inclusion agenda which recognises the relationship between health, wellbeing and social inclusion. It

---

[17] Ibid.
[18] Department of Human Services: Southern Metropolitan Region, *Understanding the client experience: Refugees accessing and utilising the health system in Australia*, 2009.
[19] Ibid.
[20] Plenty Valley Community Health Services, *Access and Equity for People Born in Non-English Speaking Countries*, 2000.
[21] Department of Human Services, *Understanding the client experience*, 2009.
[22] Smedley et al. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academy of Sciences, 2003.

means that some members of our community are not able to properly access the rights and services afforded to all Australians.

Key Recommendations:

11. **National policy development that supports the consistent use of interpreting services at critical points during healthcare service delivery and when requested.**

12. **Services should provide in-language information for new migrants, refugees and those with low English language proficiency, to ease settlement issues and provide information and access to the Australian health system and community.**

13. **Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions.**

A Human Rights Approach

In the recently released National Human Rights Consultation report,

> *"The Committee learnt that economic, social and cultural rights are important to the Australian community … The most basic economic and social rights - the rights to the highest attainable standard of health, to housing and to education - matter the most to Australians, and they matter most because they are the rights at greatest risk, especially for vulnerable groups in the community".*

Australians do not have a codified right to health. While Australia has signed many international agreements including the *Universal Declaration of* Human *Rights*, the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*, we have not incorporated them within the laws that govern us.

This right to health, while not codified has found a place within the quality and safety debate. In 2008 the Australian Health Ministers adopted *The Australian Charter of Healthcare Rights*, developed by the Australian Commission on Safety and Quality in Healthcare.[23] [24]

Recognition for different cultures as a core principle within the Charter bodes well for Australia's refugee and migrant communities; it is inclusive and opens the discussion about the type of services that are appropriate for all Australians. Moreover, by using a rights platform the Charter has a stronger

[23] The Commission was established by the Australian, State and Territory Governments to develop a national strategic framework and associated work program that will guide its efforts in improving safety and quality across the health care system in Australia

[24] The Australian Charter of Healthcare Rights, accessed at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_ACHR-roles/$File/17388-roles.pdf

focus on entitlements and recognises the responsibility of duty of care rather than one of needs.

Yet, the scope of influence of the Charter is limited because its attention is on the quality of the health care service received by a patient, their family or carer. It does not look at the causes of ill health or the social determinants of health, which include the conditions in which people are born, grow, live, work and age.

A broad interpretation of the right to health also requires a diversity lens – to explore how to create a response that includes the relevant linguistic and cultural considerations for both refugee and migrant communities. Health literacy, access to health and health service provision is different for many population groups across Australia. An entitlement approach to a broad interpretation of health would embed a standard that would need to incorporate these differences.

If a right to health was codified then Government would be compelled to promote and protect a standard of health that is broader and stronger then the universal, quality and safety standard we currently have. It would recognise the diverse health needs of a multicultural community; it would lead to greater equity, access and social inclusion; and it would be compelled to look at the health of the population in terms of holistically healthy citizens instead of symptomatically unwell clients.

Key Recommendations

14. **The Federal government must codify the right to health that is wider than the current standard, addressing issues of discrimination and exclusion, and focusing on the barriers to health in a multicultural society.**

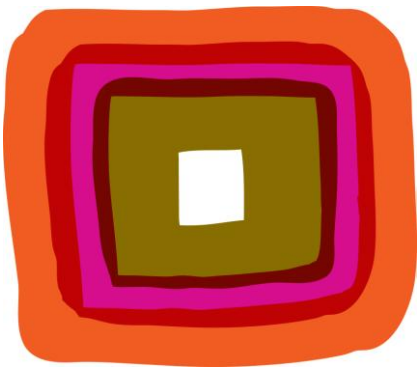
conclusion

> *Multiculturalism is about inviting every individual member of society to be everything they can be, and supporting each new arrival in overcoming whatever obstacles they face as they adjust to a new country and society and allowing them to flourish as individuals. It is a matter of liberalism.*
>
> – Chris Bowen, Minister for Immigration and Citizenship

Multiculturalism, social inclusion, health and wellbeing are all concepts that are intrinsically linked. We cannot hope to address disadvantage, strive towards greater levels of equity and allow new arrivals to flourish as individuals without recognising this.

In Australia, those from culturally and linguistically diverse backgrounds are significantly more likely to experience everyday discrimination due to their ethnic origin. They are more likely to have difficulties in understanding and accessing the public services that are provided to all Australians. They are more likely to feel socially marginalised and isolated from the wider community. They are also more likely to encounter prejudice and discrimination in public and institutionalised settings.

These are all issues of health and wellbeing and must be identified as being so. This holistic view is in line with both our multicultural and social inclusion agenda. It will allow us to address an inclusive society not only has the end itself, but as the means to a harmonious, healthy and diverse community.



Summary of Recommendations

1. **All government multicultural, social inclusion or anti-discrimination policies and programs should acknowledge the links between discrimination, social exclusion and health.**

2. **The Social Inclusion Agenda should acknowledge that health is a cornerstone to both social inclusion and economic participation.**

3. **The federal government should continue to support and enhance settlement programs and community education that work in unison to erode divisive views, promote positive social norms and support harmonious society.**

4. **All governments should continue to develop and evolve strategies to deal with institutionalised discrimination in the workplace and in the public services.**

5. **The new focus of Australian multiculturalism, as practiced by The Department of Education, the Department of Immigration of Citizenship, community organisations, non-government organisations, and other relevant bodies on both federal and state levels, must work to broaden the conception of the Australian identity. This is imperative to dismantle dangerous notions of ethnic differences, to break down social barriers and to move towards a more inclusive society.**

6. **Cultural competency and integrity should be incorporated in government, private and community organisations in order for it to be embedded into all aspects of an institution.**

7. **Government, community and private health services should provide adequate resources to practice cultural integrity in service delivery where the client is at the centre of the response.**

8. **Educational institutions, public and private health services should integrate cross-cultural education into the training of all current and future health professionals and provide opportunities for further on-the-job training.**

9. **Health policy should aim for sustained and strong relationships with a primary care provider to address issues of mistrust. This will be strengthened by providing opportunities to increase the proportion of underrepresented CALD groups among health professionals.**

10. **Health policy should promote the consistency and equity of care through evidence-based guidelines used to engage patients and their families.**

11. **National policy development that supports the consistent use of interpreting services at critical points during healthcare service delivery and when requested.**

12. **Healthcare services should provide in-language information for new migrants, refugees and those with low English language proficiency, to ease settlement issues and provide information and access to the Australian health system and community.**

13. **Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions.**

14. **The Federal Government must codify the right to health that is wider than the current standard, addressing issues of discrimination and exclusion, and focusing on the barriers to health in a multicultural society.**

Bibliography

Australian Bureau of Statistics. Health Literacy, Australia 4233.0. Australian Government 2008.

beyondblue, *beyondblue: The way forward 2005-2010,* available at www.beyondblue.org.au, 2005.

Cross et al, *Towards a Culturally Competent System of Care*, Vol.1, Georgetown University Child Development Centre, 1989.

Department of Human Services: Southern Metropolitan Region, *Understanding the* client *experience: Refugees accessing and utilising the health system in Australia*. May 2009.

Federation of Ethnic Communities' Councils of Australia, *"Different but Equal"* – FECCA's *National Multicultural Agenda*. November 2010.

Miller, A. 'Changing the face of the organisation: addressing the challenges of work in a multi-ethnic society', *Journal of Family Therapy*, 24, 2002.

Nelson, A. 'Unequal Treatment: report on the institute of medicine on racial and ethnic disparities in healthcare', *The Annals of Thoracic Surgery*, 76, 2003.

Paradies, Y. 'A systematic review of empirical research on self-reported racism and health', *International Journal of Epidemiology*, 35, 2006.

Paradies, Y., Chandrakumar, L., Klocker, N., Frere, M., Webster, K., Burrell, M et al. *Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria*. Full Report, Melbourne, Victoria: Victorian Health Promotion Foundation, 2009.

Plenty Valley Community Health Services, *Access and Equity For People Born in Non-English Speaking Countries: Research Report and Recommendations*. December 2000.

Professor Andrew Markus, *Mapping Social Cohesion: The Scanlon Foundation Surveys Summary Report 2010,* Monash University, 2010.

Smedley, B., Stith, A., and Nelson, A. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academy of Sciences, 2003.

University of Western Sydney, *Challenging Racism: The Anti-Racism Research Project*. 2010.

VicHealth, Ethnic and Race-Based Discrimination as a determinant of mental health and wellbeing. 2008.

VicHealth, More than tolerance: Embracing diversity for health: Discrimination affecting migrant and refugee communities in Victoria, its health consequences, community attitudes and solution – A summary report. 2007.

VicHealth, *Review of audit and assessment tools, programs and resources in workplace settings to prevent race-based discrimination and support diversity*. November 2010.

VicHealth, *VicHealth Position Statement on Health Inequalities*, 2005.
Williams, D. and Williams-Morris, R. 'Racism and Mental Health: the African-American experience', *Ethnicity and Health*, 5(3/4), 2000.

World Health Organization, Constitution of the World Health Organization. Accessed at: http://www.who.int/governance/eb/who_constitution_en.pdf

Centre for Culture, Ethnicity and Health
81-85 Barry Street
Carlton VIC 3053

Ph: +61 3 9342 9700
Fax +61 3 9342 9799
Email: enquiries@ceh.org.au