ethnic communities' council of victoria

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Australian Medical Association
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ECCV Submission to the Patient Charter

1. ECCV welcomes the opportunity to respond to the Patient Charter developed by the Australian Medical Association of Victoria.

2. ECCV's submission focuses on the accessibility of this Charter to our culturally and linguistically diverse (CALD) communities. The Charter will be relatively easy to understand for those Australians who have a reasonable level of English proficiency and an understanding of Australia's complicated health care system. However, it must be noted that a significant proportion of Australia's CALD population may struggle to access and/or to understand the Charter.

3. Research indicates that the ethnic over-65 population is increasing and is projected to comprise 38% of Melbourne's seniors by 2011 (Howe, 2006). Although Melbourne's ethnic older population is projected to be Australia's largest in this timeframe, many of Australia's cities and regional areas are also experiencing a significant population increase in CALD older people. As such, this is an issue which must be considered at a national level in relation to the planning and delivery of health services.

   The Patient Charter must recognise the fact that many CALD people do not have a high proficiency in English, nor can they successfully navigate the complex and multilayered healthcare system.

4. The Charter should be simplified so that its contents would be more clearly understood by Australians, many of who are not familiar with the nation's complicated healthcare system. The Charter should also be translated into appropriate community languages to ensure that our significant CALD population is catered for.

5. Furthermore, some CALD people may not be literate in their own spoken languages. ECCV recommends that a mechanism of publicity be explored by way of consultation with CALD communities. Information presented via the ethnic media and other audio and visual formats, as well as through posters and compact wallet sized cards of the diagram on page four are highly recommended.

6. The release of the Charter could also be accompanied by an extensive CALD community education campaign in order to assist CALD communities to understand the Charter. CALD seniors should be considered as a key target group, given this age group's higher reliance on the health care and hospital services. ECCV recommends that the AMA engage ethno-specific organisations to assist with this campaign.

   It is envisaged that a CALD community education campaign would include the active engagement of CALD community leaders in order to provide education on concepts such as 'discharge assessment' and 'case conferencing' and further inform them of the Patient Charter and its relation to the hospital and/or broader health care system. Further consultations with ethno-specific agencies would also be required.

7. ECCV recommends that where there is organisational capacity that ethno-specific service providers are resourced to employ case managers to carry out culturally and linguistically appropriate patient discharge planning and implementation. Ethno-specific organisations hold a great deal of expertise in understanding the social, cultural, language and religious needs of their respective communities. As such, they are well placed to act as case in this process.

8. ECCV questions the "5 Step Guide" in relation to where the onus of responsibility lies for initiating a clear line of communication between the referring GP and the treating hospital.

   Point one states that the patient

   > "can help establish a clear communication pathway between (the) GP and the treating hospital by keeping a record of (the) GP's contact details. This record should be presented to hospital staff when (the patient) arrive(s) at the outpatient clinic or the emergency department."

   As such, the onus is on the patient to provide contact details and initiate this communication process. This does not take into account that many patients and their companions will feel distressed in situations of ill health and that this distress can be heightened for CALD people who are not familiar with Australian service systems and have trouble understanding English.

   Further to this, point two notes that patients who are presenting themselves for pre-planned hospital admission are to produce a letter

of referral from their GP. This also may prove to be difficult in such a time of patient distress.

ECCV recommends that a system be explored whereby GP referrals are accessible electronically by hospitals. In this way, a patient needs only to provide their name and adequate identification as proof of their identity to reception staff creating a reduced risk of confusion and further distress for the patient.

9. Little mention is made of the times and points at which hospital staff are to arrange an interpreter to assist with communication issues between CALD patients with poor or insufficient English language skills and hospital staff. ECCV recommends that the Charter be revised to include this important information.

10. ECCV would like to state its concern of the "Discharge Risk Screening" process which is aimed to assist hospital staff to decide whether a patient has complex care needs that require active management after the patient is discharged. It is recommended that at the very least, an interpreter is engaged for CALD patients with low levels of English proficiency during this process, and that where possible, bicultural workers from ethno-specific organisations are engaged for this activity, for the same reasons as stated in point seven of this submission.

11. In conclusion, ECCV supports the Patient Charter and its objective to make it available and accessible to CALD groups. We would welcome AMA's consideration of these comments in relation to making the Charter more accessible and inclusive of the needs of our CALD population.