An Investment Not an Expense

Enhancing health literacy in culturally and linguistically diverse communities

ethnic communities' council of victoria

ECCV Policy Paper

The Ethnic Communities' Council of Victoria Inc. (ECCV) is the peak body for ethnic and multicultural organisations in Victoria. It is a community based, member driven organisation committed to empowering people from diverse multicultural backgrounds. We are proud to have been the key advocate for culturally diverse communities in Victoria since 1974. For over 35 years we have been the link between multicultural communities, government and the wider community.

The organisation advocates and lobbies all levels of government on behalf of multicultural communities in areas like human rights, access and equity, improving services, racism and discrimination, community harmony, employment, education and training, health and community services, disability, child protection law and justice, and arts and culture.

We also help build the capacity of new and emerging communities and develop policy on a wide range of issues including undertaking original research in collaboration with major tertiary institutions

Contents

"Healing is a matter of time, but it is sometimes also a matter of opportunity"

"The chief virtue that language can have is clearness, and nothing detracts from it so much as the use of unfamiliar words."

- Hippocrates

Acknowledgements

Abbreviations

ABS	-	Australian Bureau of Statistics
ACSQHC	-	Australian Commission on Safety and Quality in Health Care
AGWS	-	Australian Greek Welfare Society
CALD	-	Culturally and Linguistically Diverse
CEH	-	Centre for Culture Ethnicity and Health
COAG	-	Council of Australian Governments
ECCV	-	Ethnic Communities' Council of Victoria
EHealth	-	The use of electronic communication and information technology in healthcare
LOS	-	Length of stay
NES	-	Non-English Speaking
RDNS	-	Royal District Nursing Service
TALS	-	Transcultural and Language Services
TIS	-	Translating and Interpreting Services National

1. Foreword

For those who work in the area of health, or in the multicultural sector, the term health literacy will not be unfamiliar. Indeed, it would appear that, at least in recent times, this term arises whenever those with an interest in health and those with an interest in culturally diverse communities come together. By and large, the shared concern among these groups is the observably lower levels of health literacy in Victoria's culturally and linguistically diverse (CALD) communities.

There is a need to be clear that, in noting the above, we are not suggesting that those from CALD communities do not understand the concept of good health and wellbeing. It should also be noted that low health literacy is a problem that persists in all communities. What we aim to illuminate in this paper is the fact that, for those from CALD backgrounds, this problem is compounded by language and other access barriers. In addition to this, culturally diverse concepts of health and treatment may not fit easily with, or be understood by Western approaches. Similarly, CALD community members may not be familiar with, or trusting of the methods and remedies recommended to them in this country. All of this coalesces to provide a situation in which those from CALD communities are not engaging well with the healthcare system and with health related programs and messages.

To be health literate is to have knowledge and choice. CALD community members need access to the knowledge required to make informed choices in the Australian healthcare context. It is also important that their range of choice is expanded to include options that are responsive to their personal and cultural beliefs. For their part, health professionals need to be better encouraged and supported to gain the knowledge needed to understand and practice culturally responsive healthcare.

For all that might be said about the problems that can arise when diverse health beliefs interact, the fact remains that, when ill-health strikes, those who treat it and those who suffer it are joined in their objective to improve the situation. This shared ambition should always remain the focus. In keeping with this, consumers and healthcare workers must collaborate and negotiate in order to create a shared path to this mutual goal. It is our hope that this paper and the recommendations therein will act as a guide to fostering and maintaining these essential partnerships and for improving health literacy in a multicultural Victoria.

Joe Caputo OAM JP
Chairperson

Eddie Micallef
Deputy Chairperson Convenor of the ECCV Health Policy Subcommittee

2. Executive Summary

2.1. About the ECCV

The Ethnic Communities' Council of Victoria (ECCV) is the peak body for ethnic and multicultural organisations in Victoria. It is a community based, member driven organisation committed to empowering people from diverse multicultural backgrounds. We are proud to have been the key advocate for culturally diverse communities in Victoria since 1974. The organisation advocates and lobbies all levels of government on behalf of multicultural communities in areas like human rights, access and equity, racism and discrimination, community harmony, employment and education, health and community services and arts and culture. We advocate on any issue that is of concern to our members.

2.2. Project background and overview

In 2011, the ECCV Health Policy Subcommittee was made aware of increasing concern, emerging from health service providers, regarding the often very low levels of health literacy present within CALD communities. After much discussion around the reasons why this may be the case and the impacts this may have, the ECCV Health Policy Subcommittee established the ECCV Health Literacy Working Group.

This document is the outcome of the work and consultation undertaken by the ECCV Health Literacy Working Group. This paper aims to provide information and recommendations to the Victorian government, with a view to ensuring that the needs of CALD Victorians are considered in future policies and projects aimed at improving health literacy.

Low health literacy is a nation-wide problem and it is extremely costly to all Australians, both in the burden it brings to bear on our healthcare systems and in terms of human costs, such as reduced quality of life for the many Australians who could, potentially, be healthier. For CALD Victorians, the problem of low-health literacy needs to be tackled via targeted strategies and resources, as this is the only way to overcome exacerbating factors such as language and literacy barriers, differing cultural perceptions of health, culturally unresponsive services and the lifestyle upheavals that can accompany migration and settlement.

For the purposes of this paper the key issues identified have been divided into the following four core areas:

- Health literacy in the current policy context
- Language, literacy and health literacy
- Culture and health literacy
- Community capacity building for improved health literacy

The ECCV Health Literacy Working Group has developed a set of recommendations that are in keeping the last three core areas. These are detailed in the following section.

2.3. Summary of recommendations

Language, literacy and health literacy

The ECCV recommends:

1. That health service providers and healthcare organisations recognise the responsibility they have to identify health literacy barriers and to support consumers to become increasingly health literate, through the provision of accessible information, the utilisation of language services and a commitment to person-centred care.

2. That health information be produced in plain English and in a variety of formats, including audio-visual materials. Information should have minimal jargon and include diagrams, pictures and symbols wherever possible.

3. That health providers and funding bodies allocate appropriate resources to ensure that the source material used for translation is of supreme quality. This is required in order that there may be greater parity in the quality of information provided to both English speaking and non-English speaking Australians.

4. That health providers work collaboratively with CALD communities to ensure that translated material is culturally relevant and appropriate.

5. That consideration is given to the comprehension of all public written material in health settings (including signage, maps and directories) by people from non-English speaking backgrounds.

6. That the Victorian Health Translations Directory is resourced to include editorial control and quality checks on content, so that it may fulfil its potential as a clearing house for existing resources, with significant benefits for consumers and health professionals.

7. That the Victorian government provide the resources required to facilitate and enhance access to expert interpreting services in healthcare settings, via the methods identified by the Victorian Foundation for Survivors of Torture.[1]

8. That Victorian hospitals be provided with the resources required to establish and maintain specialist language service departments that are able to provide interpreting services and translations of the highest standard, as well as transcultural training, research and education opportunities.

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[1] Victorian Foundation for Survivors of Torture, (2012), *Exploring barriers and facilitators to the use of qualified interpreters in health: Discussion Paper April 2012,* Available [Online]; http://www.foundationhouse.org.au/announcements/discussion-paper-feedback-sought; Accessed: 22/05/2012.

Culture and health literacy

The ECCV recommends:

9. That all healthcare workers be required to undertake cultural competency training.

10. That the health sector and the multicultural sector be resourced in a manner that permits them to enhance cultural competency in healthcare, via partnership projects, cross-sectorial communication and knowledge sharing.

11. That more research is undertaken to provide an evidence base, in the Australian context, regarding health literacy and CALD communities.

Community capacity building for improved health literacy

The ECCV recommends:

12. That free, community based English language education opportunities be increased beyond the initial five-year settlement period and that CALD Victorians be offered the support needed to ensure that they do not experience reduced income or employability as a result of attending additional classes.

13. That ethno-specific and multicultural community organisations be provided with the resources necessary to support local, community specific, health based education initiatives, partnership projects and capacity building.

14. That Victoria's diversity be reflected on advisory boards/committees for primary and secondary care organisations such as Medicare Locals, Primary Care Partnerships and principal healthcare providers.

3. Introduction

3.1. Health literacy

For the purposes of this document, health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions".[2] Health literacy is a broad skill that often requires the simultaneous use of other literacy skill types, such as prose and document literacy, numeracy and problem solving skills.

Limited health literacy is an Australia-wide issue. In 2006 a considerable 59 per cent of Australians were found to have inadequate health literacy. A detailed breakdown of this data shows that limited health literacy is disproportionately demonstrated by older adults, those with lower levels of education, as well as lower socioeconomic and minority groups.[3]

People with inadequate health literacy have limited ability to search for and use health information, make informed decisions or maintain their basic health. Research demonstrates that there are strong correlations between low health literacy and less healthy behaviours, poorer self-management of chronic conditions, higher rates of hospitalisation, difficulty communicating with providers, and poorer health status in general.[4] Research also indicates that increasing health literacy is likely to reduce health costs through the prevention of illness and chronic disease. [5]

In light of all of the above, it is not surprising that policy makers are interested in how the matter of low health literacy might be addressed.

3.2. Health literacy and CALD communities

Victoria is one of Australia's most multicultural states, with 43.69 per cent of Victorians being either born overseas or having a parent who was born overseas. Victorians come from more than 200 countries, speak more than 230 languages and dialects and follow more than 120 religious faiths. Most of the overseas-born Victorians came to Australia as migrants, hoping to find a better life for themselves and their children. A significant number came to Australia as refugees, beginning with Europeans displaced by the Second World War, then refugees from the wars in Indo-China and more recently refugees from conflicts in the republics of the former Yugoslavia, the Horn of Africa, the Middle East and Afghanistan.[6]

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[2] U.S. Department of Health and Human Services. (2000). *Healthy People 2010* (2nd ed.) [with *Understanding and Improving Health* (vol.1) and *Objectives for Improving Health* (vol. 2)]. Washington, DC: U.S. Government Printing Office, as cited in, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, (2010), *National Action Plan to Improve Health Literacy.* Washington DC

[3] Australian Bureau of Statistics, (2009), *Australian Social Trends*, cat.no. 4102.0, Canberra

[4] Thomacos, N., (2009) *Health Literacy: Supporting Successful Interventions and Programs* [Presentation], Department of Health and Social Science, Monash University, Melbourne

[5] *Health literacy in Canada: A Healthy understanding,* (2008), Canadian Council on Learning, Ottawa
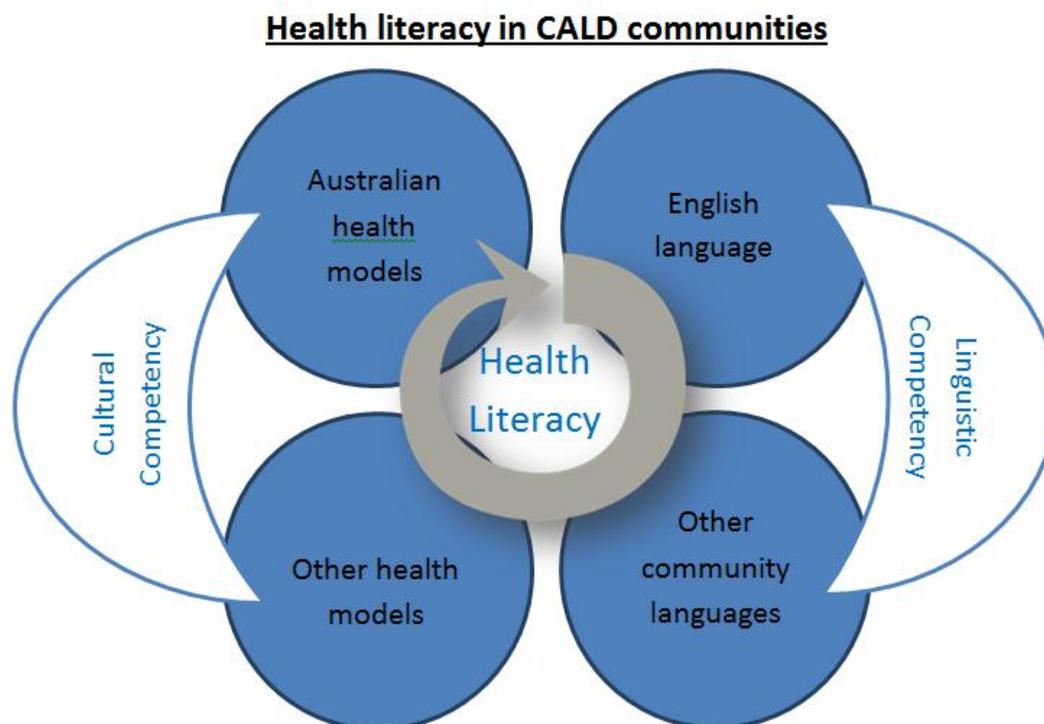
[6] *Population and Migration*, (2012), Victorian Multicultural Commission, Available [Online]; http://www.multicultural.vic.gov.au/population-and-migration; Accessed: 24/05/2012

As an 'at risk group', low health literacy is a major concern for Australia's multicultural population. Only 33 per cent of people born overseas have adequate or better health literacy compared to 43 per cent of the Australian-born population. This figure drops to 27 per cent for those who arrived in Australia during the past five years and to 26 per cent for people whose first language is not English.[7]

The impact of low health literacy on people from non-English speaking backgrounds means they are:

- less likely to access the services that they need
- less likely to understand issues related to their health
- more likely to experience social isolation, which can lead to damaging behaviours and negatively impact physical and mental health
- at risk of mismanaging their medication
- less likely to have an adequate understanding of health issues

As indicated by the diagram, a culturally competent healthcare system is essential to improved health literacy in CALD communities. Cultural competency training and education is the best way to support Australian healthcare workers and to facilitate improved understandings and positive interactions between diverse health models. Linguistic competency is a key element of cultural competency and sector feedback on this issue suggests that Victorian healthcare workers require enhanced support and training in this area.

Health literacy in CALD communities

Australian health models

English language

Cultural Competency

Linguistic Competency

Health Literacy

Other health models

Other community languages

[7] Australian Bureau of Statistics, *Australian Social Trends* 4102.0 June 2009

It has come to the ECCV's attention that many healthcare workers demonstrate a reluctance to work with interpreters. As such, in order to be more culturally competent, healthcare workers should be required to develop and demonstrate their ability to work constructively with language service providers. It also appears that many would benefit from being made better aware of their clients' right to language services and of the costs and dangers associated with the denial of this right. A culturally competent healthcare system is one in which CALD Australians have ready access to health information in their preferred language. It is also vital that CALD Australians have access to sufficient English-language education, which will increase their capacity to engage with health messages and services in the Australian context.

This paper will explore all of these issues make recommendations for future action. As already mentioned, the issues have been divided into the following four core areas:

- Health literacy in the current policy context
- Language, literacy and health literacy
- Culture and health literacy
- Community capacity building for improved health literacy

4. Health literacy in the current policy context

4.1. Victorian Context

Cultural Responsiveness Framework: Guidelines for Victorian Health Services, 2009
The cultural responsiveness framework is a practical guide used within the health sector. It is a tool which can be used to implement and measure cultural responsiveness. The framework articulates six standards for culturally responsive practice and specifies key performance measures to achieve the standards. The standards are linked to four broad domains of quality and safety; these are organisational effectiveness, risk management, consumer participation, and effective workforce.

The six standards are:

- A whole-of-organisation approach to cultural responsiveness is demonstrated
- Leadership for cultural responsiveness is demonstrated
- Accredited interpreters are provided to patients who require one
- Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices
- CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis
- Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness.

These standards combine key legislative, policy, governance and accreditation frameworks which apply to all Victorian public hospitals. They provide a strategy to align cultural responsiveness with quality and safety in healthcare delivery.[8]

Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan

The *Metropolitan Health Plan* establishes seven priority areas for the development and operation of the Victorian healthcare system. The following three areas are of most interest to this paper:

Developing a system that is responsive to people's needs

This priority area recognises that certain groups within the Victorian population, such as CALD communities, have specific needs that require particular attention when planning for the health system. The Plan states that:

> A culturally competent health care system will support efforts to increase the capacity of the health care system to design, implement, and evaluate culturally and linguistically competent services to address health disparities among populations from culturally and linguistically diverse (CALD) backgrounds and to promote health and mental health equity, including the development of a Refugee Health and Wellbeing Plan. (Not available at time of writing)[9]

It is noted that a responsive system requires, among other things, more sophisticated area-based planning to address local service gaps by matching services to local needs and specific population groups.[10]

Improving every Victorian's health status and experiences

The Plan states that a high priority has been placed on ensuring that the diverse communities of metropolitan Melbourne receive high-quality, safe and culturally sensitive health care.[11] It is noted that improving the health status of Victorians will require action to improve health literacy among the whole community. The plan acknowledges that support services, such as interpreters, should be available where needed. It is recognised that people require accurate and up to date information and a commitment is made to ensuring that information is accessible to patients and to carers. It is observed that people who are health literate will be healthier, empowered to make more informed decisions and to take greater responsibility for their health. It is acknowledged that this will require the development and implementation of a metropolitan wide strategy for improving people's health knowledge and supporting patient choices. It is stated that this strategy will focus on at risk patient cohorts including those for whom English is not their first language.[12]

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[8] *Cultural Responsiveness Framework*, (2009), Victorian Government Health Information, Available [Online];
http://www.health.vic.gov.au/cald/cultural-responsiveness-framework; Accessed: 10/05/2012
[9] Victorian Department of Health, (2011a), *Victorian Health Priorities Framework: Metropolitan Health Plan*, State Government of Victoria, Melbourne: 50
[10] Op. cit: 52
[11] Op. cit: 54
[12] Op. cit: 54-55

Expanding service, workforce and system capacity

The need for improved cultural responsiveness may be met by the commitment made in the Plan to prioritise the allocation of additional investment in workforce education, training, placements and role development.[13] It is posited that this investment will lead to a more interdisciplinary workforce with a more extensive range of skills, ensuring the workforce has the capacity to answer the needs of the community, and the workforce is distributed according to where its skills are needed.[14]

Overall the Plan predicts that by 2022 people will be more health literate, have the knowledge they and their carers need to make choices about their health management, and will be able to access high quality information and targeted local health programs.

Victorian Health Priorities Framework 2012-2022: Rural and Regional Health

The *Rural and Regional Health Plan* builds on many of the key actions outlined in the *Metropolitan Health Plan* and tailors specific strategies to ensure they are applicable to the rural and regional context.[15]

The plan aims to address several key challenges. Of most relevance to this paper are:

- Reducing the disparity in health behaviours and health outcomes among rural Victorians
- Addressing the social determinants and relative disadvantage experienced by some rural and regional communities (these are significant drivers of poorer health outcome and health status)
- Improving the health literacy of all rural and regional Victorians, with a particular focus on those most disadvantaged.

Well recognised by the Plan is the need to increase health literacy in regional and rural Victoria, especially among disadvantaged groups. It is proposed that the health status and wellbeing of regional and rural Victorians may be improved by addressing low levels of health literacy.[16] It is also noted that ensuring individuals have the requisite levels of health literacy and access to the necessary information about service availability can help to promote appropriate service use.[17]

Victorian Public Health and Wellbeing Plan 2011 – 2015

In terms of scope, this document describes public health as "what we, as a society, do collectively to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment, on populations rather than individuals, and on the factors and behaviour that cause illness and injury."[18] The Department of Health state that the "overall aim of this plan

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[13] Op. cit: 59

[14] ibid

[15] Victorian Department of Health, (2011b)*, Victorian Health Priorities Framework 2012-2022: Rural and Regional Health Plan*, State Government of Victoria, Melbourne:4

[16]Op. cit :28

[17] Humphreys JS, Mathews-Cowey S, Weinand HC 1997, 'Factors inaccessibility of general practice in rural Australia', *Medical Journal of Australia*, vol. 166, pp. 577–580, as cited in Victorian Department of Health, (2011b): 31

[18] Victorian Department of Health, (2011a), as cited in Victorian Department of Health, (2011c)*, Victorian Public Health and Wellbeing Plan 2011-2015*, State Government of Victoria, Melbourne: 14

is to improve the health and wellbeing of Victorians by engaging communities and strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government."[19]

The plan identifies priority settings to support the strengthening of preventive healthcare; these include local communities and environments, workplaces, early childhood and education settings, as well as health services. It is proposed that a "settings approach" to public health can address a variety of health concerns appropriate to the needs and capabilities of different population groups and that health information provided in flexible settings can be adapted to support development of relevant health literacy skills.[20]

The Plan establishes nine strategic directions for the prevention of ill-health in Victoria. It states that significant progress will be made in each of these directions by 2015. Perhaps of most relevance to this paper are the following:

- Increase the health literacy of all Victorians and support people to better manage their own health.
- Tailor interventions for priority populations to reduce disparities in health outcomes.

Within the Plan, low health literacy is considered as a major risk factor that may impact on the current and future health of Victorians.

The Plan recognises refugee and migrant communities as 'at-risk' population groups. It states that health disparities are "often exacerbated in groups for whom discrimination, social inclusion and access to services continue to be concerns. This includes … people from refugee or migrant backgrounds".[21]

The importance of partnerships is emphasised. It is posited that partnerships formed across a range of disciplines, sectors and institutions can assist in developing understandings and driving innovation. It is noted that partnering with communities in intervention design and implementation can ensure acceptance and support of new programs and help sustain improvements in individual and community wellbeing.[22]

4.2. National context

Low health literacy has been identified as an issue by the Australian Commission on Safety and Quality in Health Care (ACSQHC), which was created in 2006 to lead and coordinate healthcare safety and quality improvements in Australia.[23]

Increasing health literacy in one of the key actions identified in ACSQHC's Safety and Quality Framework for Health Care. ACSQHC note that this Framework "identifies a vision for safe and high quality care in

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[19] Victorian Department of Health, (2011c), *Victorian Public Health and Wellbeing Plan 2011-2015*, State Government of Victoria, Melbourne:14
[20] Op. cit: 43
[21] Op. cit: 25
[22] National Prevention Health Promotion and Public Health Council 2011, *National prevention and health promotion strategy*, US Department of Health and Human Services, Washington DC, as cited in, Victorian Department of Health, (2011c):39
[23] Australian Commission on safety and Quality in Health Care (2011), *Patient and Consumer Centred Care: Health Literacy*. Available [Online]: http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/. Accessed 29/06/2012.

Australia that is consumer centred, driven by information and organised for safety".[24] ACSQHC research and consultation has revealed that increased health literacy is essential to achieving this vision, with low health literacy identified as "a key risk to patient safety, healthcare quality and as a barrier to implementing patient-centred care". According to ACSQHC, recent research indicates that, in order to increase health literacy, "we need to look at strategies that focus on activities that minimise the complexity of healthcare as well as those that focus on improving individual skills".[25]

There are a number of recent national developments that have (as yet uncertain) implications for healthcare in Victoria. Most significantly, this includes the COAG National Health Reform agenda, including the rollout of Medicare Locals.[26]

4.3. International context

The challenge of low health literacy has also attracted concern internationally. For example, the United States has introduced a National Action Plan to improve health literacy.[27] The Action Plan strongly recognises the impact of language and culture on health literacy. It is based on the principles that (1) everyone has a right to health information that helps them make informed decisions and (2) health services should be delivered in ways that are understandable and beneficial to health, longevity and quality of life.[28] Support for adult education, English language instruction and culturally and linguistically appropriate health information services are key goals of the plan.

4.4. Summary

Stakeholders in the multicultural sector have observed that, by and large, these policy documents have a strong focus on increasing self-management and on enhancing the role of the individual in their own health management. While it is recognised that there are benefits to this approach and that empowering CALD community members is certainly desirable, those working in the area of multicultural health caution that this must not negate the responsibility of health service providers to communicate in a clear, culturally appropriate manner. As has been observed by the Centre for Culture Ethnicity and Health (CEH), "… health literacy is *not* about your client's capacity to reframe the debate and take ownership. The probability of our clients spontaneously changing is very, very small – the onus is on us, and how we communicate."[29] It is important that healthcare professionals accept this responsibility and that they are supported in the workplace via training, resourcing and overarching organisational and departmental commitments to providing all consumers with high quality and equal communication and care.

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[24] ibid
[25] ibid
[26] Victorian Department of Health, (2011c):9
[27] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, (2010), *National Action Plan to Improve Health Literacy*. Washington DC
[28] Op. cit: 1
[29] Morris, M., (2011), Cutting *Your Teeth on Health Literacy* [Seminar Presentation], Centre for Culture Ethnicity and Health, Melbourne: 7

5. Language, literacy and health literacy

The effective communication of health information is essential for improved health literacy. Data provided by the Australian Bureau of statistics (ABS) shows considerably lower levels of health literacy among people whose first language is not English.[30] In order for a persons' health literacy to be improved, they require access to health information that they are able to understand. Australia "is a multilingual nation and we need to move away from a pervasive monolingual mindset."[31] It is important that individuals and organisations in the health area also recognise and address the inherent assumptions and generalisations that prevent health information being understood by people from CALD backgrounds. This includes being aware of whether a person is literate in their first language, whether they speak a dialect, any significant differences in their cultural perceptions of health and their English proficiency. These factors should be considered regardless of the length of time a person has spent in Australia.

Compared to the rest of the world, Victoria is considerably advanced in the delivery of community language services. However, more should be done to meet the real demand for professional interpreters, as there is a considerable gap between need and provision. Sector feedback indicates that there are also significant gaps in the availability of quality translated material. Unfortunately, it is all too often reported that well-intentioned attempts to provide information in languages other than English are ineffective due to flawed translation processes.

There is considerable research and information about best practice in language services. Of note is the discussion paper *Exploring the Barriers and Facilitators to the Use of Qualified Interpreters in Health,* recently published by the Victorian Foundation for Survivors of Torture (Foundation House).[32] To avoid duplication and to remain within scope, this paper will address the key issues around language as they relate to improving CALD health literacy through effective service provision and response.

5.1. Translation and health literacy

It is not possible to produce quality written health information in community languages if the source material is of poor quality. Research shows that materials written in plain English and at a lower grade level result in better understanding and improved knowledge.[33] Quality source material has the double benefit of extending the reach of information in English, as well as producing a superior translation. However there is a need to exercise caution in linking the ability to comprehend language and that of comprehending complex concepts. Plain English should not preclude the communication of complex ideas and concepts. People from non-English speaking backgrounds have the right to receive the same level of information as English-speaking members of the Australian population.

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[30] Australian Bureau of Statistics, (2009*), Australian Social Trends*, cat.no. 4102.0, Canberra

[31] Clyne M., 'Multilingualism, Multiculturalism and Integration', in Jupp, J., Clyne, M., (2011), *Multiculturalism and Integration: A Harmonious Relationship,* ANU E Press, The Australian National University, Canberra: 60

[32] The Victorian Foundation for Survivors of Torture, (2012).

[33] Andrulis, D.P.; Brach, C., 'Integrating Literacy, Culture and Language to Improve Health Care Quality for Diverse Populations', *American Journal of Health Behaviour*, Sept/Oct 2007: 31, as cited by Morris, M., (2011).

It is also important that health information is culturally appropriate. Information based on Western cultural perceptions may have little meaning to some community groups and may be disregarded. Terminology can also be problematic in a cross-cultural context, as certain words, such as rehabilitation, are not used in some cultures. Difficulties defining terms can be related to varying cultural perceptions of health. This is discussed further in section six of this paper.

Feedback from the ethnic community sector highlights that many issues with translated material results from a lack of consultation with target communities before and during the translation process. This can often result in documents that even the bilingual staff, with their knowledge of the health system, find difficult to understand.

Many older people from non-English speaking backgrounds speak a dialect and may not understand standard translations. In addition, there are significant levels of illiteracy in the first language amongst communities of people from migrant backgrounds. The use of audio-visual technology or other innovative methods of communication can help to overcome language and literacy barriers in English and community languages. Similarly, including pictures, symbols and diagrams in health information can be very effective in improving understanding. We also need to better support non-English speaking Australians to more easily navigate our hospitals and other health spaces. Sector feedback indicates that many CALD Australians experience great stress and a lack of assistance when visiting a hospitals or clinics.

The Victorian Health Translations Directory has the potential to be a valuable online clearing house and to provide consumers with easy, fast access to translated health information. Collecting translated information into one location would benefit the health sector through improved resource sharing, reduction of duplication, easily identifiable gaps in information and independently quality checked information. Currently the directory is not quality checked and much of the content is out dated, which is a great concern.

CASE EXAMPLES — Developing quality multilingual and accessible resources

RDNS, AGWS and the Aspin Group

In 2011 the Royal District Nursing Service (RDNS) collaborated with the Australian Greek Welfare Society (AGWS) and the Aspin Group to develop a tool to help members of the Greek community with diabetes to understand and manage their condition. The *Information on Diabetes in Greek*[34] talking book is a multi-media tool that can be viewed on a computer. The book uses simple information sheets, short case studies and role plays. All the information is provided in Greek with the option of English translations. Readers have the choice of reading or listening to the information on screen, as well as hearing stories about how other Greek-Australians successfully manage their diabetes.

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34 Royal District Nursing Service (RDNS),(2011), Information on Diabetes in Greek, Available [Online];
http://www.rdns.com.au/media_and_resources/publications/Diabetes%20Talking%20Books/Greek/GreekDiabetes.html ; Accessed 01/07/2012

RDNS Translation Standards

The RDNS has developed ten translation standards[35], which can be used to measure the accuracy, quality and usability of translated material. The RDNS consider translated resources are considered to be up to standard when they:

- Develop the English text and test the translation with members of the LOTE speaking community
- Undertake a professional cultural and linguistic assessment of the English text in preparation for its translation
- Undertake a health professional assessment of the English text as appropriate
- Organise for the English text to be translated by a professional translator
- Undertake a professional cultural & linguistic assessment of the translation
- Organise for the translation to be proofread by a professional translator
- Include the title of the text in English on the translation
- Include the name of the target LOTE in English, on both the English text and the translation
- Distribute the translation in bilingual format – English and LOTE
- Monitor, evaluate and update the English text and the translation as part of an ongoing review program

The RDNS apply these standards to all translated material used by the organisation, whether it has been produced by the RDNS, or by an external agency.

Centre for Cultural Diversity and Ageing communication tools

The Centre for Cultural Diversity and Ageing has developed a range of multilingual resources for the Victorian aged care sector. These include a glossary of aged care terminology, in which around 1000 terms have been translated into 19 community languages to promote consistency of translations. Additionally they provide communication cards in a bilingual format in 19 languages. Designed as a tool for enhancing communication with people in their preferred language, the communication cards depict a wide range of daily activities and situations and can be used to prompt discussion, assist with directions and clarify a client's needs.

Diabetes Australia pictorial guides

In 2009, Diabetes Australia (Victoria) developed a series of pictorial guides. The guides convey messages of healthy eating, exercise, managing diabetes and foot care, using images and simple language that is easy to understand. The pictorial guides have been subsequently adapted through community consultation for the Greek, Italian, Arabic, Vietnamese and Chinese speaking communities, and have also been adapted for Aboriginal and Torres Strait Islander communities.

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35 Ayden, T., (2010), *Translation – Process or Product?* [Seminar Presentation], RDNS, Diversity in Health Conference, Melbourne. See also: RDNS Translation Standards ; Available [online]:
http://www.rdns.com.au/what_we_do/Initiatives/Documents/Translation%20Standards%20Poster.pdf. Accessed 1/07/2012

5.2. The ECCV recommends

1. That health service providers and healthcare organisations recognise the responsibility they have to identify health literacy barriers and to support consumers to become increasingly health literate, through the provision of accessible information, the utilisation of language services and a commitment to person-centred care.

2. That health information be produced in plain English and in a variety of formats, including audio-visual materials. Information should have minimal jargon and include diagrams, pictures and symbols wherever possible.

3. That health providers and funding bodies allocate appropriate resources to ensure that the source material used for translation is of supreme quality. This is required in order that there may be greater parity in the quality of information provided to both English speaking and non-English speaking Australians.

4. That health providers work collaboratively with CALD communities to ensure that translated material is culturally relevant and appropriate.

5. That consideration is given to the comprehension of all public written material in health settings (including signage, maps and directories) by people from non-English speaking backgrounds.

6. That the Victorian Health Translations Directory is resourced to include editorial control and quality checks on content, so that it may fulfil its potential as a clearing house for existing resources, with significant benefits for consumers and health professionals

5.3. Improved language services and health literacy

Many older adults from migrant backgrounds first experience interpreter services in a healthcare setting. All health service staff who engage with the public have a responsibility to communicate effectively with people who do not speak, or speak little English. As such, they need to understand how to work effectively with interpreters. Critically, feedback suggests that it is challenging to engage clinical staff in training for working with interpreters and on-the-ground practice is patchy. This raises concern regarding the quality of information that people from non-English speaking backgrounds receive. CALD consumers can be additionally disadvantaged if clinical consultation sessions are not lengthened to offset the time required for interpretation.

Sector feedback on this issue has revealed a desire for language services to be aligned, in terms of importance, with other allied health disciplines (such as physiotherapy, social work, occupational therapy, dietetics, podiatry and so on). Sector experts have observed that language services are, at best,

considered secondary disciplines. This occurs despite the fact that the bridging of communication and cultural gaps between clinician and patients requires a level of expertise comparable to that in other allied health fields.

Not using interpreting services, or working with unskilled interpreters, can seriously compromise patient health outcomes. Unfortunately, in the present context, 'linguistic diversity' frequently results in inequality, as non-English speaking patients are found to spend more time in hospital, be more likely to suffer adverse clinical reactions and have higher readmission and diagnostic testing rates. This strain on patients and services can be alleviated through access to professional interpreting services, as this enhances health outcomes for patients whose first language is not English.

Good language service provision is not just about 'interpreting', it is a multifaceted service with a focus on cultural competence, which is fundamental in the health context. Cultural competence requires a cultural shift within the hospital context; a full recognition that we are a diverse society with diverse needs, and that a 'one-size-fits-all' approach is counterproductive. Cultural competence goes hand-in-hand with patient-centred-care and requires a whole-of-organisation responsiveness to the diversity of contemporary Australian society.

In order to be culturally competent, hospitals must have language service departments that offer interpreting and translations of the highest standard, as well as transcultural training and research and education opportunities.[36] This requires that hospitals are able to commit to employing in-house professional interpreters as key hospital staff, rather than relying extensively on external agencies. It also requires that universities and higher education providers design degrees that, as well as producing high quality language service providers, also train graduates to be culturally competent communication experts. It is essential that hospitals, via their language service departments, involve CALD patients in all research projects. As mentioned earlier, nearly 44 per cent of Victorians where either born overseas, or have a parent who was. As such, when we talk about CALD people, we are dealing with a considerable part of who we are as Victorians. If research does not include CALD participants, it is not representative of who we are as a society.

Increased investment is needed to create and develop language services departments in all hospitals. At the moment there is still a considerable gap between the 'need for' and the provision of language services; hence Victorian hospitals are not *statistically* culturally competent. This is illustrated below, with relation to interpreter occasions of service at Northern Health, a key provider of public healthcare in Melbourne's highly multicultural northern region.

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[36] Zucchi, E., (2012), *Beyond Interpreting: the Case for a Language Services Discipline in the Health Context,* Culturally & Linguistically Diverse Communities Conference Presentation, Sydney.

CASE EXAMPLE — Interpreter Occasions of Service at Northern Health

During 2010-2011 there were 234,618 occasions of service ant Northern Health. Of these 100,849 (43 per cent) were for patients born in non-English speaking countries. This percentage is constant in the last three financial years. In the 2010-2011 financial year Northern Health provided 39,940 interpreter appointments out of 234,618 total occasions of service (17 per cent of all appointments). If it is assumed that not all overseas born patients need an interpreter, and we take a very conservative 22 per cent as a benchmark for patients requiring an interpreter (rather than 43 per cent), there is still a considerable gap between demand and supply. Hence the service provided is not *statistically culturally competent*.

	2008-09	2009-10	Variation from previous financial year	2010-11	Variation from previous financial year	2011-12 projection	2012-13 projection
Total appointments	233,839	248,074	+6.0%	234,618	-5.4%		
Interpreter requests (% of total appts)	27,501 (11.7%)	37,480 (15%)	+ 36.0%	39,940 (17%)	+6.5%	46,729 (20%)	51,618 (22%)
Patients born in NES countries (% total patients)	100,133 (43%)	108,207 (43.6%)		100,849 (43%)			

As can be seen from the table, the growth in demand is not a growth based on the catchment's population, but rather on the fact that, for a number of years, demand was under-serviced. Additionally, the health service also under-budgeted for language services; between 22 per cent and 30 per cent of all occasions of service require an interpreter, yet Northern Health is only able to budget for 17 per cent.

There is a chronic under-utilization of language services, and hospitals fail to budget appropriately. Language services are in fact seen as an expensive and a difficult to manage activity and as a problem, rather than a solution and an integral part of patient care. Emerging evidence at Northern Health demonstrates that increased investment in language services results in larger cost savings elsewhere, more detail on this matter is provided by the following case example.

CASE EXAMPLE — Northern Health Transcultural and Language Services Model

In 2007 Northern Health established a Transcultural and Language Services (TALS) Department. This was undertaken with the aim of increasing the cultural competence of the healthcare provider. The TALS Department provides the staff and patients of Northern Health with: interpreting services of the highest standard; translation of medical material; targeted cultural training for staff members; and research & education.

In addition to establishing an official TALS department, cultural competence was increased via:

- a review of policies and strategic plans, including the *Cultural Responsiveness Framework (2009)*
- a Cultural & Staff Diversity Committee
- increasing the number of in-house language staff from four in 2007 to 15.1 in 2011-12 (EFT)
- a series of transcultural staff training sessions
- a translations waiting list and database
- dedicated intranet and internet pages containing multilingual resources
- community partnerships
- an electronic monthly newsletter
- a policy to ensure that CALD Australians are included in all research projects
- student placements
- video-interpreting

Outcomes/Results

Factor	Jan–Jun 2007	Jun –Dec 2007	Jan –Jun 2008	Jul–Dec 2008	Jan–Jun 2009	Jul–Dec 2009	Jan–Jun 2010	Jul–Dec 2010	Jan– Jun 2011
In house EFTS	4		5		8		10.6		12.1
Interpreter requests	7,000	8,000	9,000	12,487	15,014	18,458	19,022	19,295	20,645
Training sessions			30		60		77		92
Translations			10		33		49		77
Unable to provide			5%+		4.4%		3.5%		3.4%
Average NES LOS	9.14	8.85	8.75	8.47	8.31	7.94	7.55	6.85	6.07

Northern Health found that, by increasing interpreter requests (from 17,000 in the 2007-08 financial year to almost 40,000 in the 2010-11 financial year), increasing in-house staff, providing transcultural training sessions and translated documents, they were able to reduce the length of stay (LOS) for CALD patients by almost three days. Northern Health is now able to see more patients every year than was previously possible, because patients spend less time in hospital; hence the unit cost per patient staying in hospital has dropped dramatically, while at the same time patient health has improved.

Hospitals and health services face challenges in responding to the needs of people from new and emerging communities. There is a shortage of appropriately qualified interpreters from new and emerging communities due to small population size, lower average level of English and earlier stage of interpreter training. In small communities, there is an increased likelihood that the client will know the interpreter, complicating and compromising the professional relationship. There is an ongoing need to address these issues for new and emerging communities.

Similarly, rural and regional Victoria, with dispersed CALD populations and significantly longer travel distances, faces ongoing issues with interpreter shortage. This is a situation in which telephone interpreting is vital. However, sector feedback indicates that, despite access to free services via the government funded Translating and Interpreting Services (TIS), there is a very low uptake in telephone interpreting services amongst primary health providers, particularly amongst General Practitioners. Sector consultation has also revealed that the further exploration and implementation of technological solutions, such as video interpreting, are increasingly critical in rural and remote settings.

CASE EXAMPLE — Good practice in telephone interpreting

Royal District Nursing Service (RDNS) Language Line[37]
The RDNS Language Line is run from the RDNS customer service centre and was established as a response to a problematic gap in the ability of non-English speaking clients to contact RDNS by phone. The Language Line service offers consumers and nurses with automatic and free access to professionally accredited telephone interpreting services. Individual Language Line phone numbers have been designated to the ten most requested RDNS client languages and in-language information is provided to RDNS consumers, informing them of the service. When a client dials a Language Line number they receive an in-language welcome message and the option to be connected to an interpreter. Alongside the ten designated Language Line numbers is an 'all other languages' number, whereby consumers can select any language and be connected to a telephone interpreter, on the spot. RDNS staff are encouraged to work with clients, in their homes, to ensure that they are familiar with this service.

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[37] Michael, J., (2012), *RDNS Language Line*, [Seminar Presentation], RDNS, National Cross Cultural Dementia Network, Canberra.

5.4. The ECCV recommends

7. That the Victorian government provide the resources required to facilitate and enhance access to expert interpreting services in healthcare settings, via the methods identified by the Victorian Foundation for Survivors of Torture.[38]

8. That Victorian hospitals be provided with the resources required to establish and maintain specialist language service departments that are able to provide interpreting services and translations of the highest standard, as well as transcultural training, research and education opportunities.

6. Culture and health literacy

Culture plays a huge part in a person's understanding of health. In order to improve health literacy in CALD communities, health providers need to have an understanding of different cultural beliefs and perceptions around health. This includes an understanding of culturally specific stigma that may be related to particular illnesses.

6.1. Stigma

To some degree, all cultures stigmatise particular illnesses. For example, throughout the world and across cultures, mental illness has a long history of stigma. It has been interpreted as an indicator of weakness, a cause for shame, and it is the subject of much fear and negative mythology. In many CALD communities, the widespread tendency to stigmatise illness may be exacerbated by particular cultural beliefs, a lack of health literacy and language barriers.

Stigma continues to surround health issues such as cancer and mental illness in many CALD communities. In such cases, people from CALD backgrounds may be reluctant to speak up about issues they experience, leaving symptoms untreated. The eventual trigger for seeking help is often a crisis and this delay has a serious impact on treatment and recovery options. Stigma needs to be addressed in order to increase health literacy around sensitive health issues. Perceptions of health issues vary between cultures and may not align with Anglo-Australian views. It is important that health providers understand how different cultural

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[38] Victorian Foundation for Survivors of Torture, (2012), *Exploring barriers and facilitators to the use of qualified interpreters in health: Discussion Paper April 2012,* Available [Online]; http://www.foundationhouse.org.au/announcements/discussion-paper-feedback-sought; Accessed: 22/05/2012.

groups view a particular health condition and that community-specific approaches to addressing stigma are developed.

6.2. Cultural practices and perceptions of health

Many people who migrate to Australia experience significant changes in their lifestyle. The lifestyle of a migrant's country of origin may have held inherent, unacknowledged health benefits that may be lost in Australia. For example, unhealthy diets may develop due to a lack of access to the ingredients of cultural food, as well as a lack of understanding regarding the negative impacts of some ingredients. Likewise, incidental daily levels of physical activity may decrease following migration, particularly if a person is not in the workforce or living a more sedentary lifestyle. These issues are particularly relevant to recent migrants from new and emerging communities.

Individuals from diverse cultures may not comprehend easy-to-read or translated information if Western constructs of health and healthcare are being assumed.[39] Health issues are often interpreted and treated differently in different communities. The extent to which service providers understand and respond to these cultural differences can affect the level of community engagement with the Victorian health system and how well health messages are received and understood. Many CALD community members feel that their cultural interpretations and treatments will be dismissed or judged by Australian health professionals. Some cultural beliefs, such as a focus on cure and treatment rather than prevention, can lead to issues such as doctor-shopping, abuse of antibiotics, and medication mismanagement.

In short, for many CALD people there is a feeling that health services and messages around health are neither relevant to, nor accepting of them. If we genuinely want to offer support to our communities, we must work hard to dispel these perceptions. A starting point is a health system that helps its workforce to recognise their own cultural perceptions of health, so that they are better able to recognise cultural difference where it occurs. This can be achieved through further development of cultural competency among health providers and greater community engagement.

CASE EXAMPLE — Cultural Competency and Community Engagement

Teeth Tales[40] is a community-based child oral health research project. It is being led by The University of Melbourne and the Merri Community Health Service in Melbourne. The project was developed in response to local refugee and migrant community concern regarding children's oral health. The initial stage of the project sought to address evidence gaps via qualitative research

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[39] Andrulis, D.P.; Brach, C., 'Integrating Literacy, Culture and Language to Improve Health Care Quality for Diverse Populations', *American Journal of Health Behaviour*, Sept/Oct 2007: 31, as cited by, Morris, M., (2011).

[40] *Teeth Tales: Applying the Learnings*, McCaughey Centre: VicHealth Centre for the Promotion of Mental Health and Community Wellbeing, Melbourne School of Population Health, University of Melbourne [Online];
:http://www.mccaugheycentre.unimelb.edu.au/research/current/intergenerational_health/teeth_tales; Accessed: 18/05/2012

exploring the social, cultural and environmental determinants of child oral health in refugee and migrant communities. As part of his process, mothers and grandmothers from Iraqi (Assyrian & Chaldean), Pakistani and Lebanese communities participated in focus groups and interviews. Also consulted were community leaders, cultural organisations, and dental and other health professionals. Project researchers worked with relevant ethno-specific agencies in order to recruit participants and to ensure that every element of the research process was culturally competent. This research informed the development of a culturally appropriate child oral health promotion and disease prevention program, which is the second phase of the Teeth Tales project. The second phase intervention program is currently being piloted in North Richmond, with the main intervention to be undertaken by Merri Community Health Services. The intervention program will include:

A peer education and support program: involving consultation with cultural organisations in order to recruit community members to be trained as peer educators. This will include training and education in child oral health and nutrition, accessing dental and health services and in the delivery of community education sessions. Once training is complete, peer educators will work and share knowledge with their respective communities, where they have existing social networks and rapport. In addition to this, group dental visits will be arranged, with a view to increasing community familiarity with the available dental and family support services.

A reorientation of dental and health services: involving a cultural competence review of local government and community health services, in order to identify organisational strengths and areas for improvement. The services undergoing this review will then be assisted to progress their organisation, in order to become more culturally competent at all organisational levels.

6.3. Cultural competency of service provision

A culturally competent health service is required if CALD communities are to be better supported to manage and make informed decisions about their health. The standards and measures provided by the *Cultural Responsiveness Framework: Guidelines for Victorian Health Services* (2009), is the guiding structure for Victorian health providers to develop cultural competency. It is important that cultural diversity policy is not restricted to this framework and that health providers include a cultural diversity response in generic policy around health literacy and recognise that the development of cultural competency is integral to increased health literacy in CALD communities. Feedback indicates that the inclusion of a cultural diversity approach is often an 'add-on' activity, or omitted in many projects, due to the additional cost or the complications that engaging with diverse groups can entail.

To delve deeply into cultural competency strategies would be beyond the scope of this paper. However, particular areas that have been highlighted in our consultations emphasise the ongoing need to train all health staff in cultural competency.

It needs to be noted that CALD carers often play a central role in how a client may understand a health condition and its treatment. Sector feedback suggests that the important role of CALD carers is often overlooked in Australian healthcare settings.[41]

It is also important that the multiple methods of communication that may be employed to improve health literacy be explored and utilised. This includes in-language and cultural radio and television broadcasts.

In addition to the above, there is a lack of evidence-based research on health literacy and cultural and linguistic diversity. It is important that we have a greater understanding of how language literacy, including reading level in clients' first language, impacts client health outcomes in both the short and longer terms. In a climate of restricted resources, it is essential that health providers and policy makers have access to information that measures the cost of inaction in this regard.

6.4. The ECCV recommends

9. That all healthcare workers be required to undertake cultural competency training.

10. That the health sector and the multicultural sector be resourced in a manner that permits them to enhance cultural competency in healthcare, via partnership projects, cross-sectorial communication and knowledge sharing.

11. That more research is undertaken to provide an evidence base, in the Australian context, regarding health literacy and CALD communities.

7. Community capacity building for improved health literacy

The primary responsibility for improving health literacy rests with health policy makers and service providers. This responsibility includes the creation of opportunities to empower CALD community members to better understand and manage their own health and to negotiate the Victorian healthcare system.

Feedback received by the ECCV indicates that many CALD community members desire extended access to the free, community-based English language education they receive during their initial settlement period. Enhanced English language education would greatly assist CALD community members as they interact with the healthcare system. However, attending additional classes may impose difficulties and these need to be considered and addressed. Many CALD Victorians may struggle to find the resources needed to

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[41] *National Cultural Competency Tool (NCCT) for Mental Health Services*, (2010), Multicultural Mental Health Australia, Parramatta, NSW.

attend classes on a regular basis and others will struggle to find the time to do so, due to work and family commitments. By undertaking additional English language classes, CALD Australians may find themselves disadvantaged when trying to secure work, or unable to work as much as they need to, due to the time commitment required to attend classes. It is not reasonable for CALD Australians to be penalised for learning English, be it through reduced income, or problems with gaining or maintaining employment. It is for all of these reasons that it has been suggested that those attending such classes should be financially supported, via a study payment. It has also been suggested that employers could receive compensation or incentives for providing the flexibility needed for employees to attend extended English-language classes.

The capacity of CALD communities to improve their health literacy can also increase via engagement with ethno-specific and multicultural community organisations. Such organisations are already well placed and regarded as trusted sources of information and support. As such, they are well located to bridge the gap that can exist between healthcare providers and CALD communities. In this local and familiar setting, CALD community members could benefit from programs that create greater familiarity with the Victorian healthcare system; this may include community information sessions, community visits from local healthcare providers and group excursions to local clinics and hospitals. This would be of particular benefit to those from new and emerging communities.

This level of engagement is particularly important if we are to ensure that CALD Victorians are not left behind by the "ehealth revolution".[42] Recent research emerging from Flinders University has revealed that certain societal groups, including those from refugee backgrounds, may encounter barriers to accessing digital and online health information, which is largely text based and can require specific skills and resources[43]. Dr Lareen Newman, a senior research fellow at Flinders University, has observed that "[i]n transferring things online, we are adding a lot of complexity for people that wasn't there before".[44] Dr Newman cautions that this could lead to people "opt[ing] out of the health system altogether".[45] The research suggests that one solution to this potential problem is to locate web access and support in places "where people already go … where people feel comfortable, and where they won't feel looked down on".[46] Multicultural and ethno-specific community organisations fit this profile and, with support, can provide access and assistance to their clientele. This can increase the capacity and participation of communities that may otherwise be excluded from innovations such as ehealth.

Local, community-based education programs may also be useful in raising awareness within CALD communities regarding individual rights in the healthcare context, with a particular focus on the right to understand information and to have an interpreter present. Education is also needed to overcome the reticence that some CALD community members display with regard to using interpreting services. This is often based on ill-founded shame and on the desire not to be perceived as a burden. These perceptions

[42] Gliddon, J., (2012) *Disadvantaged face ehealth challenges: report*. eHealthspace.org. Posted May 31. Available [online]: http://ehealthspace.org/news/disadvantaged-face-ehealth-challengesreport?utm_source=eHealthspace.org+Newsletter&utm_campaign=130b49af7d-This_Week_In_Health_06_June_201206_06_2012&utm_medium=email; Accessed: 28/06/2012
[43] ibid
[44] ibid
[45] ibid
[46] ibid

are not assisted by an apparent reluctance on the part of some clinicians to utilise interpreting services. Ethno-specific and multicultural agencies can potentially play a key role in dispelling such misperceptions by reinforcing the message that there is no shame in accepting or requesting an interpreter and by highlighting the fact that interpreters are mutually and equally beneficial to clients and clinicians.

Ethno-specific and multicultural community organisations are fundamental in the quest to raise health literacy in CALD communities. Partnerships with ethnic and multicultural welfare agencies are widely recommended by policy makers, with good reason. Unfortunately these organisations are chronically under-resourced, underfunded and undervalued. There is a risk that many of the organisations that serve smaller cultural groups will become unviable, leading to significant disadvantage for the communities concerned.

7.1. The ECCV recommends

12. That free, community based English language education opportunities be increased beyond the initial five-year settlement period and that CALD Victorians be offered the support needed to ensure that they do not experience reduced income or employability as a result of attending additional classes.

13. That ethno-specific and multicultural community organisations be provided with the resources necessary to support local, community specific, health based education initiatives, partnership projects and capacity building.

14. That Victoria's diversity be reflected on advisory boards/committees for primary and secondary care organisations such as Medicare Locals, Primary Care Partnerships and principal healthcare providers.

8. Conclusion

As previously noted, health literacy is a nation-wide problem which, at some level, affects us all. That said, some societal groups are more likely to live with lower health literacy. CALD Victorians are one such group. This is due to issues relating to language, literacy, culture and a lack of familiarity with the Victorian healthcare system. In addition to this, many CALD Victorians also experience multiple risk factors for lower health literacy, such as educational and socioeconomic barriers.

Low health literacy produces costs for all community members. It places increased pressure on our resources and our healthcare system. It also lowers the health status and quality of life of millions of

Australians. These costs can only be avoided if we work to raise health literacy levels in Australia. The ECCV maintains that a well-resourced, well targeted and cross-sectorial approach is needed in order to overcome the additional health literacy barriers that face CALD Victorians.

For CALD Victorians, increased health literacy requires access to clearly communicated, high quality information. We live in a highly diverse society. We need to ensure that our health service system understands and is understood by all who access it. We also need to have adequate language services in place to ensure that all Australians have access to the same level of information. In other words, our health services must be culturally competent.

Any effort to raise health literacy in CALD communities will require high-level community specific engagement, support and consultation. This is the most effective and dependable way to develop and ensure the level of cultural competency that is required. Local ethno-specific and multicultural organisations can also work to educate and build capacity within their communities and they need to be better supported in order to carry out this vital work.

The ECCV urges the Victorian government act on the recommendations that have been made in this policy paper, in order to support increased health literacy within CALD communities, so that all Victorians may be able to enjoy improved healthcare, reduced state expenditure and enhanced quality of life.

*"He who has health has hope
and he who has hope has everything"*

- Arabic Proverb

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