CASEMIX AND CULTURAL DIVERSITY:
WOMEN OF NESB IN THE HOSPITAL SETTING

by

Maree Pardy
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Casemix And Cultural Diversity
Women of NESB in the Hospital Setting

Maree Pardy

Despite Australia’s population diversity — almost 50% of the population consists of immigrants or their offspring — some of our major systems, (most notably the legal and health systems) have not responded well to changes in the population composition. If institutions are an embodiment of the dominant culture, then in many ways the health system is a salient symbol of the institutionalised discrimination that pervades ‘multicultural Australia’.

The Australian government has identified immigrants and specifically newly arrived immigrants from non English speaking backgrounds (NESB), as a group with special health needs, and except for Aborigines, the most disadvantaged among Australians in terms of health status and access to health care. (Better Health Commission: 1986) The National Health Strategy (1993) notes that the limited response by all levels of the health system has resulted in poor access to services and reduced quality of care for people of NESB.

For immigrant women, the stress and vulnerability created by this poor access and low quality of care is often exacerbated by class and gender inequalities both within their ‘communities’ and vis a vis the dominant culture. In a hospital setting for example, women of NESB endeavour to negotiate their way through a system that expresses the authority of the medical (Western and male) profession, in which English (and a highly technical one at that) is the language of transmission and where specific cultural forms of ‘knowing’ and ‘acting’ are often experienced as alien and inappropriate ways of providing services. Subsequently many women experience hospitals as traumatic, degrading and disempowering.

It is into this context that Casemix — a new funding and payment formula for hospitals is being introduced. A more thorough assessment of the impact of casemix funding on either the health status or the health experiences of women of NESB requires some analysis. This should focus on: the causes and consequences of ill health among NESB women; the culture of the health system; the social policy response to ethnic health issues; and the resources policies which inform and constrain standards of health care and quality of service in Australia.

Casemix and NESB Specified Grants

However, this discussion is limited to the provision of language services in the hospital setting. I do this because a crucial link exists between a person’s capacity to communicate and issues of access, equity and quality of care. It is important to note that in the design of the Casemix formula, the provision of language services and culturally relevant health care, were deemed not ‘clinically meaningful’ and have therefore been excluded from the Diagnosis Related Group (DRG) formula. A supplementary funding mechanism known as ‘NESB specified grants’ has been introduced in recognition that servicing patients from non English speaking backgrounds will incur additional costs.

In this paper it might prove useful to focus on the NESB grants as an instrument for gauging the capacity of casemix to improve access and quality of care and services for women of NESB. Antithetically, is the introduction of the NESB grants in danger of exacerbating existing failings of the public health system or alternatively will NESB grants be used by advocates of casemix to rest easy that at least some attempts are being made to address the needs of NESB people? In reality some of us fear that the NESB grants may serve merely to mask the structural and cultural barriers which persist in the hospital setting.

While it is acknowledged that the health difficulties experienced by women vary little between birthplace groups, there are some features of poor health experiences which are particular to women of NESB. These include higher rates of work-related illnesses and injuries and a greater incidence of poor mental and emotional health conditions. (NESB Women’s Health
The pre-migration experience of women is also an important factor in the health status of many women and is particularly significant for refugee women. While most people of NESB experience barriers to access because of differences in language and culture remain unaddressed, immigrant women appear particularly vulnerable in this regard. Communication and access to information are central to the provision of effective support and quality service. In the health system, effective communication is critical. It is recognised that "the inability to communicate fully, coupled with the lack of opportunities to learn English...produces the most stress in many NESB immigrant women." (Bottomley 1990)

Language Services and Quality Health Care

Language services are crucial to the provision of high quality health care. Problems associated with the inadequacy of language services in the public health system have been of growing concern to access and equity advocates. As noted by the National Health Strategy (1993) communication is essential when people have to describe symptoms and anxieties, and service providers have to be able to pass on diagnostic and treatment information.

The Health Department of Victoria (1991) provides evidence of poor quality treatment arising from poor communication — taking prescribed drugs without full knowledge of the side effects, receiving medical treatment without consent, being discharged with a serious condition, undergoing treatment at odds with cultural beliefs.

In research I have carried out for the Interpreting for Women Project, I spoke with more than 50 women about their experiences with interpreting services. The health system was identified by the women as the arena considered most critical for quality language services. Importantly when women were asked to give examples of their best and worst experiences with interpreting, it was the health system and overwhelmingly hospitals that women referred to in their examples. The research reveals the following:

- women continue to endure stressful and traumatic procedures without interpreters — the most notable of these was childbirth
- women underwent long periods without being able to communicate with nurses or doctors. Some recounted how they remained concerned, confused or in pain for long periods without being able to communicate with anybody
- hospitals seemed willing to work with interpreters when it was in the interest of the hospital or medical staff to do so. For example, many women reported that interpreters were requested when filling in forms to ensure that the medical records were correct. After this, women were often told by hospital staff that interpreters were not required
- the women interviewed had very clear ideas about the importance of the gender of the interpreter and the quality of interpreting. Women articulated a strong preference for female interpreters for gynecology and obstetrics and believed that they should have the right to a female interpreter. Women spoke of their difficulties in speaking openly in front of males and they "coped" by not asking questions of the doctors or nurses through the male interpreter. This meant that some women never had critical questions or concerns answered or addressed
- women reported that after having one or more bad experiences with interpreters they opted to no longer request the services of interpreters. This exacerbated the communication difficulties experienced by these women but they reasoned that it wasn’t as bad as having a male interpreter or an interpreter of poor quality, who was not sympathetic and had little sensitivity to the marginalisation experienced by NESB women in the health system
- hospital staff continue to request children to interpret for their parents. Most women feel extremely uncomfortable and constrained by this. Women reported that there were things they simply refused to discuss through their children and these issues remained unaddressed

Some Case Studies of Women in Hospitals

Maria

In the hospital the interpreter I had requested told me that I understood English quite well and that I didn’t really need an interpreter as much as others did. She told me next time to try without an interpreter. I told her I don’t understand some of the words the doctor says and I needed her to interpret exactly what the situation is...
So next time I tried. The doctor was quite good — he tried to speak simply, but for me it still wasn’t enough. I really did need the interpreter even though my English is not bad. I’m never sure whether my English will be good enough to understand the doctor. When you’re learning the language you’re not sure of your progress. You really need to have an interpreter.

Lina

I went to the hospital for a gall bladder operation. Ten days after the operation I developed an infection and also pneumonia. I was in hospital for a month. I decided after a while to ask for an interpreter because I had also developed some problems with my periods and I really wanted to discuss things with my doctor. They gave me a male interpreter — it was awful.

His language was not very good and I felt so embarrassed. I couldn’t speak freely and so I didn’t have a good discussion. I didn’t get the information I wanted. I really felt bad about it all.

Trang

At my hospital they usually work with interpreters. But I had my baby at night and there was no interpreter during my labour and birth. But when I went back to the ward there was an interpreter available at some time during the day. This is fine. I guess it’s not really important to have an interpreter during birth. If they speak very slowly I can guess and understand or else they make signs and can work it out. My friend came to the birth and she tried to be interpreter — but she is not very good at English, but better than nothing.

Siyा

When I went to give birth in hospital I wished they wouldn’t speak English to me. They look at me like they don’t like me. They keep speaking to me in English and I don’t understand. Then they get interpreter on the telephone. After that they don’t like to touch the phone. They wipe it with tissues. Is this racist?

Fatuma

In our religion we are not supposed to talk or greet a man. We (the male interpreter and me) were both embarrassed. The midwife was asking questions and explaining things — he was too shy to explain things and so I didn’t get the information I needed. Next time I asked for a Somali female interpreter but she was not so very good. After that they no longer booked an interpreter for me. They asked an interpreter working in the hospital to speak in French because I understand some French. This woman tried but said she could not remember her French very well. The midwife told me I didn’t really need an interpreter any more. This was OK but I couldn’t explain anything to her or ask her any questions. I had some problems all during the pregnancy but I couldn’t ask anyone in the hospital about them.

Also I really would like to have known about how it was going to be to have the baby and about those exercises. I learnt all about these things later but not before.

Siyा

Sometimes I say ‘yes’ to the doctor. Then later I think maybe I should have said ‘no’. So to be sure now whenever the doctor says ‘yes’ we say ‘no’.

Ethnic Health Policy

Ethnic health policy has led to some significant improvements in the health system, most notably the move from focusing on ethno-specific approaches to health outcomes to one which has located the responsibility with mainstream services to look at how it is that they can provide services in an accessible and equitable way. Indeed some hospitals have responded by undertaking ‘ethnic health audits’, the result of which has been the introduction of better language services, programs of cross cultural training and information for staff, the addition of bilingual workers to the hospital workforce and attempts to collect better data about languages spoken at home. Mention should also be made of the medical and nursing staff, who, aware of the consequences of poor communication between themselves and patients, have initiated discussions and projects to address these issues.

In general however, ethnic health policy, not unlike women’s health policy has remained on the margins of broad health policy and practice considerations — it has failed to become part of the mainstream. This has lead in most hospitals to ad hoc interventions in the form of projects and programs which are tacked on to existing practices. They are often implemented outside any general or integrated approach to the provision of quality services to a culturally diverse constituency. This often means that those staff who are required to practice in a culturally sensitive manner endeavour to do so without
any understanding or training in cross cultural health issues. Their workloads have increased due to shrinking resources and they work in an environment which attaches no value to reflecting critically on its own culture and how this might interact and conflict with the needs and aspirations of the patient. This has lead to what Garrett and Lin (1990) refer to as a "sidestepping" of ethnic and women's health issues.

The state government has introduced the NESB grants as a means of ensuring the provision of language and culturally relevant health care services within the casemix scenario. Apparently consideration was given to applying a cost weight to people of NESB to cover the higher costs of providing services. Such a weighting would presumably take account of the cost of interpreters, the added time spent with patients by hospital and medical staff and possible longer length of stay of people of NESB. However, not seen as 'clinically meaningful' the extra costs associated with such service provision are now to be covered by the NESB Specified Grants.

Are these grants yet another manifestation of the 'sidestepping' of ethnic health policy issues or do they represent some attempt at providing either encouragement or incentive to hospitals to improve the quality of service to their NESB clients? Or, will those hospitals that have received the grants simply go on doing as they're doing and account for the grants by itemising costs of existing services against the grant monies?

In order to answer some of these questions we need some acceptable benchmarks against which to measure the quality of health services to women of NESB. Key indicators could include:

- appropriate and accessible language services
- culturally appropriate information provision
- genuine consultation between health service providers and women of NESB
- cross cultural training programs for all staff

Before discussing the likelihood of these measures being introduced, or expanded where they are already in existence, it is useful to consider some of the detail of the NESB grants.

**Do NESB Grants Add Up?**

Expenditure of these funds is regulated by Clause 2.14.1 of the *Hospital Conditions of Funding 1993/94* which states:

"if the hospital is in receipt of a special grant for services to people from non English speaking backgrounds, the grant is subject to hospitals being able to demonstrate that at least the amounts allocated have been expended for relevant purposes such as interpreter services" (my emphasis)

Continuation of the grant in subsequent years is subject to this condition.

The grants have been determined on the basis of the size of the hospital and the number of "separations" (persons discharged from the hospital) of people of non English speaking backgrounds. Hospitals were ranked according to the number of NES separations at each hospital. Three main bands emerged covering 21 hospitals. Grants have thus been allocated in the following way.

<table>
<thead>
<tr>
<th>Separations</th>
<th>Grant Amount</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7,500 separations</td>
<td>$150,000</td>
<td>8</td>
</tr>
<tr>
<td>2,500 - 7,500 separations</td>
<td>$50,000</td>
<td>7</td>
</tr>
<tr>
<td>1,000 - 2,500 separations</td>
<td>$20,000</td>
<td>6</td>
</tr>
</tbody>
</table>

A cursory glance at these figures raises alarm bells at the arithmetic level as well as a general question about the rationale informing the level of allocation and what it is expected these sums could provide. At the arithmetic level, the hospital which has 7,501 separations is reimbursed at $20 per patient, while the hospital that has 7,500 separations is reimbursed at approximately $6.67 per patient. Such computations could go on, and in so doing highlight the disparities within the grant formula itself. Just what can be provided with these resources is another question. If it is assumed that interpreters cost $20 per hour (and this would be rock bottom prices) then those with 7,501 separations could provide each NESB patient with almost one hour of interpreting for the entire episode of treatment. Similarly those with 7,500 separations could provide just twenty minutes for the patient's entire hospital stay.

A number of other concerns have become apparent. One hospital which was already spending more than twice the level of its allocated grant on interpreting services feels it has been disadvantaged under this grant system and wonders at the incentive it has for continuing to pro-
vide services at existing, albeit inadequate, levels. For those in that hospital who have been advocating for an expansion of the hospital’s multicultural policies and programs, the NESB grants have been a demoralising blow.

It has been argued that the introduction of these grants may encourage hospitals which have never worked with interpreters or those who have paid little attention to the barriers in their hospitals to people of NESB, to begin thinking about developing more appropriate standards of service. There is some merit in this argument. However, its success will largely lie with clear guidelines about how the money should be spent and advice to these hospitals about procedures for developing appropriate ethnic health plans. It may also require the threat of sanctions against those who fail to take appropriate steps to improve the standard and quality of care to their NESB clients. This will very much depend on how the Department of Health chooses to view its role in ensuring that the health agencies it funds provide accessible and culturally relevant services to all Victorians.

At this stage the department’s interpretation of relevant purposes in the clause pertaining to the NESB grant remains unclear as does the means by which the department will make known to health agencies its expectations in relation to the expenditure of this grant. Further, while the department has committed itself to a review of the grants during 1993/94 there appears to be no mechanisms in place to monitor the expenditure of the grants nor any terms of reference for such a review.

Possible implications might include:

• the provision of interpreting services in isolation from an overall strategy of how to improve the agency’s performance in meeting the needs of its NESB constituency will be tokenistic and will entrench the sidestreaming of ethnic health issues

Hospitals may argue that the level of the grants is too low and when understood within the context of global budget cuts, the NESB grants represent no increase in resources at all. This is accepted. However, hospitals have been deafeningly silent on the need to improve the quality of service to their NESB clients. Perhaps somewhere below the surface they realise that although any improvement to quality of services (particularly to women of NESB) will require resources, it is the culture of the health system itself and the practices and attitudes of the major stakeholders in that system — the medical profession — which require a major process of self reflection and change. Whether the government sees a role for itself in encouraging or insisting on such a process may be a critical factor in the future delivery of health services.

Health Care in the Marketplace

This becomes all the more critical when one considers how pervasive the market and its attendant ideology is and the dangers inherent in this for the health system. Casemix, while arguably not in itself representing a market approach, was certainly developed within the contemporary social and economic context — one riven with more than a tinge of market ideology. For example, where hospitals are rewarded financially for ‘increased throughput’ in a ‘competitive’ environment and at a time when the public sector is being constantly compared to the private sector, the ‘market’ is the framework within which all services are trying to make it.

‘Increased throughput’ may not always be a bad thing, but while DRGs do not accommodate the language and cultural requisites of women from NESB (and this would probably apply to the requirements of a whole series of other consumer groups) the basis upon which hospitals are substantially funded has very little to do with the quality of service received by women of NESB. It has a lot to do with more ‘separations’ (discharges from hospital) more quickly. Within this context, what then are the incentives to provide high quality services to patients of NESB? Working with interpreters requires extra time. If the extra time required is not compensated then why, within a market context would the hospital be interested in adequately servicing NESB patients? This
time factor is excluded from all DRGs. This 'time' in fact comes to represent an obstacle to 'throughput' — it effectively slows down the process and impedes 'productivity.' If addressing the barriers to quality service, at its most basic level, requires a commitment to working with interpreters, taking time to ensure patients are fully informed and perhaps changing customary practices in hospitals, then these new practices appear to be in direct conflict with Casemix — in its current form.

I should also state that I am not necessarily arguing for the inclusion of language services and other culturally relevant services in the DRG. The past performance of many hospitals leaves little confidence that, even if the DRG weighted these services, the hospitals would actually provide the service anyway. While the NESB grants are woefully inadequate in ways other than just their monetary level, their separateness from the DRGs at least enables some monitoring of how the funds are used.

What then can we do?

All is not hopeless. The very introduction of the NESB grant is a tribute to the work of the many advocates who have worked tirelessly for improved quality of health services for people of NESB. It is significant that a new funding mechanism was introduced with a clear statement about the need for all state health services to be relevant to all Victorians and that a program of specified grants for NESB clients was introduced as part of the Casemix package. However, they (The policy makers) have yet to get it right. And it will largely be up to us — the consumers and the advocates — to ensure that eventually they do get it right.

We must

• remain vocal and vigilant about the need for the public health system and in particular the major health agencies to provide services within a framework of 'quality service for all — within a culturally diverse community.' Put simply if language, gender and cultural requirements are not met, the system is not providing appropriate services to up to 50% of our population

• become involved in the process of monitoring the expenditure of the NESB grants. Write to the hospitals that have received the grants and request information about how they are spending the money. A further question about how this expenditure relates to the hospital's overall ethnic and women's health strategies might reveal the degree to which the hospitals have incorporated access and equity into their strategic planning.

• pressure the state and commonwealth governments to shift from the current strategy of gentle persuasion to a more directive stance about the requirements of hospitals to provide quality services to women of NESB. Ask the state Minister to insist that all hospitals undertake ethnic health audits and implement changes as a condition of continued funding. (It is interesting to note that some hospital personnel have commented on how difficult it is to challenge the culture of the hospital when management receives no directives from government to do so.)

• pressure the Commonwealth government to introduce a Patients Charter of Rights and to ensure that the charter specifies that people have the right to receive health services in their preferred language.

• continue to enlist the support of those within hospitals who are committed to quality services to women of NESB. Forge alliances with them and work with them for change.

• document the experiences of women of NESB in the public health system. This will be extremely valuable when trying to demonstrate the need for change.

• challenge racism — it is not because someone comes from another country that they have problems with our health system. A system which refuses to provide services in an appropriate way to all members of our community is the real problem.

• always locate our demands within the broader context of needing to maintain a universal health care system in Australia. We need to see that any challenges to the universal nature of that system will be a major threat to the services able to be provided to women of NESB in the public health system.

• work with and support groups working on these issues - Health Issues Centre, Health sharing Women and the Centre for Ethnic Health.

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