Tensions between purported aims of healthcare policy in Australia and the delivery of health care services

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Abstract

The approach of many drug and alcohol (D&A) treatment services in Australia relies heavily upon Anglo-centric models of healthcare. However, there are policies for healthcare delivery in New South Wales (NSW) which clearly outline the inclusive principles by which services must conduct their business. These policies underpin claims that the Australian system guarantees universality of healthcare. The lived experience of many people from CALD backgrounds is, however, starkly at odds with such claims making. In this paper we explore how there is discrepancy between NSW policies outlining equity of access to services, and actual D&A service delivery. We look at two studies of worker practices and attitudes regarding CALD clients. These were both conducted by the Drug and Alcohol Multicultural Centre (DAMEC), one in 1997 and a pilot in 2007. Key issues emerging were the underutilisation of interpreter services and attitudes towards including non-English speaking people among service’s client populations. Comparisons highlight that there was little change from 1997 to 2007. The possible underlying reasons are discussed and recommendations are made for policy and practice that will better meet the needs of people from CALD backgrounds when they seek help for substance use issues.
Introduction

In this paper, we argue that, in many ways, already marginalised groups, such as those from culturally and linguistically diverse (CALD) backgrounds seeking drug and alcohol (D&A) treatments, are sublimated within a healthcare framework that is predominantly Anglo-centric in its approach. In 1997 DAMEC examined the access and equity issues in the drug and alcohol sector for clients from CALD backgrounds (Earnshaw, 1997). The research comprised interviews with fifty staff from seven D&A services located in the then South-East Sydney Area Health Service. Ten years on, in 2007, it was deemed timely for DAMEC to re-examine these issues from the perspective of health care workers, beginning with a pilot study. A total of twenty-nine D&A health professionals from non-government agencies, including fourteen managers, participated by completing an online questionnaire. The fourteen agencies were located in the inner west, south west and western Sydney. This discussion will draw on relevant policy positions of the NSW Department of Health (NSW Health), and compare the results of research conducted by the Drug and Alcohol Multicultural Education Centre (DAMEC) in 1997 and 2007 in order to examine how policy frameworks impact actual service provision in NSW.

Legislative and policy background

In New South Wales there are extensive legislative and policy directives promoting equitable access to health care services for people from culturally diverse backgrounds. Amendments to the Ethnic Affairs Commission Act (1979) provide the legislative foundation for ensuring equity. The amendments are based upon the progress made as a result of the Ethnic Affairs Policy Statements, during the ten years 1983 to 1993. The then NSW government endorsed the NSW Charter of Principles for a Culturally Diverse Society. By 1997, the four principles of this charter were proclaimed law\(^1\). The four principles outline the right of all members of the community to participate in and contribute to the State, but importantly that:

\(^1\) The principles, included as amendments to the *Ethnic Affairs Commission Act, 1979*, were passed by the NSW Lower House in November 1996, and proclaimed in February 1997
All individuals and public institutions should respect and accommodate the culture, language and religion of others within an Australian legal and institutional framework, where English is the primary language. (Section 3.1(b), *Ethnic Affairs Commission Act*, 1979)

Additionally, the amendments state that the policies of cultural and linguistic diversity are the policies of the State. As such, all NSW government agencies must comply with this legislative requirement. The policy implications for an agency such as NSW Department of Health are outlined in “*Enshrining the principles of cultural diversity in legislation*” and *Charter of Principles for a Culturally Diverse Society - Handbook* (1997).

At the outset of the *Caring for Mental Health in a Multicultural Society* (NSW Health, 1998), policy was issued that required service delivery to be provided “in a manner which is sensitive to their [implying the target population] cultural values, practices and language” in the context of “facilitating better co-ordination between mental health services and multicultural services to improve access and care to mental health services by people from culturally and linguistically diverse backgrounds” (NSW Health, 1998: 1). While there is currently no policy equivalent to *Caring for Mental Health in a Multicultural Society* for drug and alcohol services, issues of equity of access are however, broadly outlined in other policy and guideline documents such as that relating to the use of interpreters and, *The Management of People with a co-existing mental health and substance use disorder – Guidelines*, for example:

> Culturally appropriate and sensitive services need to be assured, particularly for people from culturally and linguistically diverse backgrounds (CALD) and people who may have particular needs relating to their language, cultural beliefs and practices (NSW Department of Health, 2000: 7).

This policy document strongly implies that every person who seeks treatment in a health care setting needs to be provided with an individualised service that recognises and accommodates the heterogeneity of their communities.
The above mentioned excerpts illustrate a definitive policy direction for all NSW government, and State majority-funded organisations, in inclusive service delivery to every member of the State. These policy directives and approaches to service delivery procedures have been used to stake a claim to universality\(^2\) in health service provision for all Australians\(^3\). For a range of complex and interacting reasons, the lived experience of many people from marginalised groups is however, at odds with the aims and purported outcomes of the policy, and does not necessarily reflect the outworking\(^4\) of the prescribed procedures. This will be evidenced through the following discussion which focuses on policies and practices related to the use of interpreting services among drug and alcohol agencies in NSW.

**Putting policy into practice – Interpreter services**

Such policies as those outlined above mandate for the implementation of strategies that may not be of universal benefit, but may have benefits specific for a particular population group. A key component of reaching into the non-mainstream is recognising language as a possible barrier to effective service delivery, and access to interpreters as a basic need for a client whose primary language is not English. In policy and practice, services are called to overcome this barrier when it presents:

Regardless of their (clients') language background, they can expect that their communication needs will be met by Government agencies through one of a variety of strategies.


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\(^2\) The term *universality* is often applied to conceptions of an Australian healthcare system, relative to healthcare systems requiring overt and compulsory insurance schemes. The term goes beyond merely free healthcare to include equity in access and level of care. For further discussion, see: Palmer and Short, 1989; De Voe and Short, 2003.

\(^3\) We use the term *Australian* here to denote Australian citizens and permanent residents. While we do not equate the Australian Medicare system with universal healthcare, we do recognise that people from nations with whom Australia has reciprocal healthcare system coverage, the United Kingdom of Great Britain and Northern Ireland for example, may have some access to the Medicare system.\(^5\)

\(^4\) For further discussion of the relevance of this term to a) communicative action (Habermas, 1987) in health care settings, see Greenhalgh, Robb and Scalmer (2006) and b) social policy initiatives and outcomes, see McVeigh and Rolston (2007).
The current policy of the NSW Health regarding the use of interpreters (*Interpreters – Standard Procedures for Working with Health Care Interpreters*, NSW Health, 2006) is specific in describing “the roles and functions of the Health Care Interpreter Service, situations in which interpreters must be used, what to do if an interpreter is not available, and the responsibilities of health care providers when using interpreters” (NSW Health, 2006). This mandatory policy directive applies to most D&A treatment services in New South Wales.5

In NSW, non-government D&A agencies accounted for 26% (68 of 262) of the government funded agencies supplying data for the 2006-2007 Alcohol and Other Drugs National Minimum Data Set (ATODS-NMDS) (AIHW, 2008). While the policy surrounding interpreters therefore also applies to these NGO services, these organisations are not included among HCIS’ clients, even though many of them are majority funded by NSW Health. The Health Care Interpreter Service (HCIS), based at Sydney West Area Health Service (SWAHS), is available only to Area Health Services, selected NGOs in SWAHS (none being D&A agencies), and selected medical, correctional and statewide services (NSW Health, 2007). The Service itself provides a comprehensive range of services in over 120 languages, including 24 hour on site and telephone interpreting, with specially trained NAATI accredited translators and interpreters (NSW Health, 2007).

Rather than using this health specialist service, the option for these NGO services is to instead use the Translating and Interpreting Service (TIS) National provided by The Department of Immigration and Citizenship (DIAC). TIS National provides both telephone and on-site interpreting on a fee-for-service basis. Non-profit, non-government, community-based organisations can apply to receive TIS services for free for non-English speaking Australian citizens or permanent residents. Organisations, however, must apply separately for every service delivered by their agency (DIAC, 2007). Government funded services are, however, not eligible for exemption from

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5 When a D&A service is majority funded by the NSW DoHHealth, the service is required to comply with health department policy directives.
interpreting fees, with funding needing to be sought from the funding agency (DIAC, 2007). This process therefore begins to become cumbersome and difficult for most services to navigate, especially since seeing non-English speaking clients is not usually factored into funding submissions, or seen as a priority as will become evident in below. Considering that usually an interpreter is sought on a reactive basis, this also means that there is not the required forewarning for money to be available to pay for TIS, or to apply for the exemption of charges, assuming that services are aware that they may eligible to receive free TIS services in the first place.

In light of this disparity between policy directives and the provision of accessible specialised interpreting services to agencies, it is perhaps not surprising that the use of interpreters in these services was found to be extremely limited. The use of interpreters, training in using interpreters and the willingness to engage with interpreters was negligible across the services studied by DAMEC in the 2007 pilot. Among these services only two identified that their clients were made aware of interpreter services as part of their standard procedures. Across all the fourteen services a total of only two clients had used an interpreter in the previous twelve months, with both of these clients coming from the two largest services who saw 200 plus clients per annum.

Problems experienced when accessing interpreter services may account for some of this negligible use. In 1997 38% of workers identified problems in using Interpreter Services, with comments relating to lack of availability, confidentiality issues and the interpreter not understanding D&A issues well enough to sufficiently communicate them to the client (Earnshaw, 1997:36). As the sample size was smaller in the 2007 pilot such issues were not addressed, however one manager did comment that they “have had issues with translating in the past and therefore we are hesitant in using interpreter services”. Further research is required to see whether those problems identified in 1997 are still an issue, and the extent to which previous experiences with interpreters limit their use among services.
From responses to the 2007 pilot, however, it would appear that the reasons for negligible use of interpreters is more complex and not just related to a lack of need or difficulty in finding and accessing appropriate interpreting services. Most managers surveyed in the pilot study stated that they had policies and procedures that related to discrimination, rights and responsibilities. Parallel to this however existed attitudes, such as those expressed by the following manager, which indicate that in practice, accommodating language differences was not seen as a basic right or procedure:

Because of the health provision nature of our services, it is essential that applicants be able to speak and understand English.

Workers were also largely ill-equipped to know how to work with an interpreter or interpreting services. Only two managers in the 2007 pilot said they had staff that had been trained, and the three workers who reported receiving training in working with interpreters all did so in 2000. These low numbers indicate that there has been no improvement since 1997 when 44% of workers suggested educating staff on cross cultural communication (including the use of interpreters) as a way of improving access for CALD clients (Earnshaw, 1997:34). Further, while the use of interpreters was negligible, language and communication were identified by workers as the main difficulties encountered when working with CALD clients. Overall 56% of workers identified language or communication issues as being the main barrier or difficulty in providing services to CALD clients, with no change since 1997 when 58% identified communication problems (Earnshaw, 1997:33). Workers in 2007 commented that English was not understood well by clients, and that they had “…difficulties understanding strong accents”.

While English may be the preferred language for the vast majority of clients, the language diversity amongst clients⁶ this is one area where the lived experience of many people from culturally and linguistically diverse backgrounds that seek help for substance and/or mental health disorders does not neatly fit within the framework that is

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⁶ When asked to nominate languages spoken amongst their clients, managers identified a total of 17 different languages other than English.
underpinned by the notion of a universal Australian healthcare system and supported by NSW legislation and Health policies.
**Bridging policy and practice**

This discordance between policy and practice is related to two intersecting issues. The first is the discordance between NSW Health policy directives that apply to NGOs and the provision of accessible services for these agencies to put such policy into practice. The second is the invisibility of CALD clients among workers’ perceptions of their potential client base and reluctance engage with CALD clients.

So what is the way forward in bridging this inconsistency between NSW Health policy and D&A service practice? Addressing the first issue is simpler than the second. Here the recommendation would be to include NSW Health funded NGO services among the clients of the HCIS, and ensuring that issues raised by workers in 1997 have since been rectified. This is unlikely to place an overwhelming burden on the Health Care Interpreting Service, since abovementioned results indicate that demand would be minimal. The process of including NSW Health funded NGO services should also include adequate training in the use of the HCIS. Orientation training and In Service training sessions are services already provided by the HCIS to their current clients. Putting these recommendations into practice would ensure that eligible NGO services have adequate training, support and appropriate access to interpreter services to enable their practice to align with NSW Health policy to which they are expected to comply. This brings us to the second, more complex, issue of changing attitudes within services.

One of the great difficulties for creating more inclusive services lies in balancing access and equity in service provision with individual client needs. Struggling to meet the needs of current referrals across the sector means that services are largely not looking to engage with harder to reach groups, leaving pockets of the population without adequate or equal access to specialist health care. When asked about promoting drug and alcohol services to CALD people, specifically other service types targeting CALD populations, in both 1997 and 2007 managers articulated an attitude of reluctance to

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7 These services included multicultural resource centres, CALD community groups, and bilingual welfare workers
“advertise for more clients” (Earnshaw, 1997:37). In 2007 one manager commented that:

The demand for our service is very high, our waiting list is very long, and whilst I see the importance of better meeting the needs of this client group, I am reluctant to undertake strategies to increase demand for our service.

One possible outcome of this attitude is that the mainstream are served first, and the fringe or minority need to navigate into this position, or have even less access to services. Changing such attitudes and approaches to service delivery is not as simple as creating more policies or services, as they stem from broader social constructions of Australian society. That is, the macro language of ‘Australian’ and positioning of culturally diverse groups as the ‘other’ translates into service delivery at a more micro level.\(^8\) The position of the ‘white Australian’ as the pervading image of what it means to be ‘Australian’ has been well documented (Tate, 2009 and Schech & Haggis, 2004), as has the invisibility to those in this dominant position toward their own consequent power and privilege (Green & Sonn, 2006 and Brodkin, 1999). Among other things, this position of dominance or power is reproduced through the way national identity and belonging are constructed (Hage, 1998), and through not recognising whiteness within antiracism practice (Moreton-Robinson, 2000). Furthermore, in order to maintain an ideal of social cohesion, “certain fundamental oppressions and systemic disadvantages may go unchallenged by a superficial form of multiculturalism” (Troyna, 1993 in Mansouri & Kamp, 2007), and as evidenced by the quote below, experiences and effects of racism in Australia are underestimated.

At the very least, this study’s findings suggest that the effects of racism on young Arab-Australians, particularly since the events of September 11, have been underestimated in educational research and practice. (Mansouri & Kamp, 2007:101). As identified by Vic Health in More than tolerance: Embracing diversity for health influences on attitudes and behaviours lie at multiple levels and:

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\(^8\) For further discussion of the Habermasian model and its implications for interpreted consultations see Scambler (2001) and Greenhalgh, Robb and Scambler (2006).
Changing attitudes and behaviours is an endeavour which is vital, but which is likely to reap results in the medium to longer term. In the meantime discrimination is pervasive and has significant health, social and economic consequences. (Vic Health, 2007:52)

Comparisons between worker responses from 1997 and 2007 show that bridging gaps between policy and practice will take time and be limited by broader social constructions of ‘Australian’ and cultural diversity within that. It is unrealistic to expect that practice at a service level will be completely aligned with NSW policy without a holistic range of strategies at multiple levels (individual, organisational, community and societal), as advocated for in the Vic Health 2007 report. In the shorter term, however, in order for service delivery to be increasingly inclusive, reflecting NSW state level legislation and policy, changes still need to occur in practice. This means positioning issues surrounding equity and access for CALD clients as part of normal service delivery, rather than approaching such issues as secondary or an afterthought once the mainstream have access to adequate services. In NSW, legislation and policy provide a solid platform for promoting equity in service delivery and addressing institutional and systemic discrimination. While attitudinal change is a long term endeavour, concrete changes can still occur to enable practice to more closely align with policy. Specifically, this can happen by NSW Health funded D&A NGO services having the same access to the Health Care Interpreting Service as their government counterparts, including orientation and training, alongside more accountability and support in translating mandatory policy directives into functional service delivery.

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