



Culturally and Linguistically Diverse Populations and Health in Canterbury

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Executive Summary

Canterbury is becoming increasingly diverse, especially in terms of language and ethnicity. In 1991, Pacific People, Asian and Other¹ ethnic groupings made up 4.1% of Christchurch City's total (Thorpe, Marr, & Richardson, 2007). By 2006 this had grown to 11.2% of the population, when there were approximately 161 different ethnic groups living in Christchurch including Irish, Filipino, Korean, Chinese, Somali and Indian. There are important differences between those from culturally and linguistically diverse (CALD) populations and those who view themselves as 'New Zealand European'. These differences include language, literacy, acculturation (see Appendix 1) and socio-economic status.

Due to the heterogeneity of the CALD population the health status of those from CALD populations is variable (Mehta, 2012); therefore there is a need for primary health care services and health promotion services to better understand how they can best meet the needs of the CALD population.

The overall aim of this report is to provide an evidence-based foundation to support the future delivery of primary health care and health promotion programmes to CALD populations.

Quantitative data was used to identify the health status and health service utilisation of people from CALD populations. A literature search was undertaken to identify barriers to accessing primary health care and health promotion as well as identifying effective models and strategies to removing these barriers. In addition 11 face to face and three telephone key stakeholder interviews were held to provide more information.

The barriers to primary health care and health promotion centred around three overarching themes, including difficulties in communication, the New Zealand health system and the wider determinants of health.

In order to break down the barriers of primary health care and health promotion it is necessary to first establish the foundations when developing any health care service. These are understanding the health needs of CALD populations and developing an overarching strategy for improving their health. While it may not be realistic to develop separate services for each community '*a model of flexible, personalised care that is part of mainstream healthcare*' is required (Lakhani 2008).

A culturally competent health care framework described by Anderson (2003) has been used to identify strategies to improve access to primary health care and health promotion as follows:

- Programmes to recruit and retain staff who reflect cultural diversity
- Use of interpreter services or bilingual providers
- Cultural competency training for healthcare providers
- Use of linguistically and culturally appropriate health education materials
- Culturally appropriate healthcare settings.

¹ Non-European, non-Māori

Introduction

Canterbury is becoming increasingly diverse, especially in terms of language and ethnicity. In 1991, culturally and linguistically diverse (CALD) populations (Pacific People, Asian and Other² ethnic groupings) made up 4.1% of Christchurch City's total (Thorpe, et al., 2007). By 2006 this had grown to 11.2% of the population, when there were approximately 161 different ethnic groups living in Christchurch, including Irish, Filipino, Korean, Chinese, Somali and Indian. It is anticipated that 2013 Census information describing the demographics of the population within the Canterbury District Health Board (CDHB) area will be available in mid-2014.

There are important differences within CALD populations and between CALD populations and those who view themselves as 'New Zealand European'. These differences include language, literacy, acculturation (see Appendix 1) and socio-economic status. Whether an individual was born in New Zealand or overseas also contributes to important differences.

While in this report the term 'CALD' has been used there is no intention to detract from the importance of the individual ethnicities or cultures but purely recognition of the diversity in Canterbury. There is also recognition that within specific cultures individuals themselves will have their own world views and will not all act the same or have the same beliefs.

Due to the heterogeneity of the CALD population the health status of those from CALD populations is variable (Mehta, 2012). Low utilisation of primary care services such as Green Prescriptions, sexual health services, primary mental health services and cervical screening has been identified in those from CALD populations (Bridgeford, Cook, Schluter, Begg, & Reid, 2013).

Primary health care and health promotion services are vital to maintaining and promoting the health of our populations. There is strong evidence that they are able to improve health outcomes and reduce health inequalities. In order to fully realise this, primary health care services need to be able to understand the needs of different groups including CALD populations within Canterbury. Therefore there is a need for primary health care services and health promotion services to better understand how they can best meet the needs of these communities.

Who are CALD?

Culturally and Linguistically Diverse populations have been defined as:

'People who do not speak English or Te Reo (Māori language) as their primary language, or who have been (or are being) raised in a different culture from the predominant one where they live.' (Ministry of Civil Defense and Emergency Management, 2013)

This is a grouping with populations of diverse characteristics. Typically it is not a grouping presented in analysis of different ethnic groups. In analysis the groupings most commonly used that make up the CALD population are Pacific peoples, Asian and MELAA. These groupings for analysis share some, though not always, similar characteristics and should not be seen as distinct ethnic groupings in themselves.

Within the CALD population are people who have come from a refugee background. In Canterbury these are predominantly from Bhutan, Somalia, Eritrea and Afghanistan. These groups are diverse ethnicities, but have in common experiences of dislocation from their homeland and frequently have had traumatic experiences, periods of deprivation and poor health care.

²Non-European, non-Māori

Overall Aim

The overall aim of this report is to provide an evidence-based foundation to support the future delivery of primary health care and health promotion programmes to CALD populations.

Objectives

The objectives of this report are to:

- Provide an overview of the health needs of CALD populations with a particular focus on health needs that are amenable to primary health care and health promotion approaches
- Identify barriers to accessing primary health care and health promotion programmes for CALD populations
- Identify models/systems of primary health care and health promotion programme delivery that are effective for CALD populations
- Identify strategies for primary health care and health promotion providers to improve access to services for CALD populations

Methodology

Mixed methods were used to develop this report including quantitative, qualitative and a literature review.

Quantitative

Quantitative data was first identified for the Canterbury population. Where this was unavailable, data on a subset of the Canterbury population was obtained. If data was unavailable for either of these populations then data was obtained from elsewhere in New Zealand.

Literature review

A literature search was undertaken to identify barriers to access, effective models and how to improve primary health care services and health promotion. MEDLINE, PROMED and Google Scholar were searched using terms such as culturally and linguistically diverse communities/populations, CALD, ethnic minorities, health, primary health care services and access. In addition, New Zealand literature was identified through web searches and key informants. Other international organisations' websites were also searched such as WHO, The King's Fund (UK), the Department of Health (UK) and the Race for Health (UK).

Qualitative

Key stakeholder interviews were also undertaken. Key themes explored during the interviews were as follows:

- What are the main health issues/needs for CALD populations?
- Do primary health services/health promotion work well for CALD populations? Why? Examples?
- What do you think are the barriers to primary health services/health promotion?
- How do you think access to primary health services/health promotion can be improved?
- Do you have any other comments?

Eleven face to face interviews were undertaken with those working with CALD populations in Christchurch. In addition one interview was carried out via telephone with a stakeholder from Ashburton and two interviews conducted via telephone with health professionals in Auckland and Waitemata.

Quantitative Results

Quantitative data for CALD populations was difficult to source in many cases. Data was found to be seldom reported at level 2 (see Appendix 2) according to the ethnicity protocols (Ministry of Health, 2004). Some data focused on specific populations such as Asian or MELAA and due to differing years of data analysis or different ethnicity grouping definitions they were difficult to compare. Where possible, Canterbury or sub-Canterbury population data has been presented. Where this was unavailable Auckland or New Zealand data has been shown. This section should be read alongside the Primary Health Care Reports produced by the Canterbury Primary Health Organisations (PHOs) on an annual basis.

Life Expectancy

Life expectancy is the number of years a person of a specific age is expected to live based on current morbidity and mortality trends. Women generally have a longer life expectancy than men.

Table 1 presents life expectancy at birth by ethnicity in Auckland. Chinese men and women both have the longest life expectancy followed by Other Asian, Indian, European/Other and Pacific peoples. It is important to note that the calculation of life expectancy is based on the assumption that population characteristics are stable over time, whereas Asian populations in Auckland are changing rapidly. There is no information available relating to the MELAA or other population groupings.

Table 1: Life expectancy at birth (in years) Auckland, 2010 (Mehta, 2012)

Ethnicity	Male	Female
European/Other	81	84
Māori	73	75
Pacific People	74	77
Chinese	87	89
Indian	83	86
Other Asian	83	87

Source: Northern DHB Support Agency

*European/Other refers to all European and non-Māori/Pacific/Asian peoples

Health Behaviours

Canterbury specific data regarding health behaviours for CALD populations is not currently available. The 2011-2012 New Zealand Health Survey provides a summary of lifestyle factors for adults and children separately (Ministry of Health, 2012a, 2012b, 2013a). It reports on European/Other, Māori, Pacific peoples and Asian ethnicity only. Detailed information on other ethnicities or populations such as MELAA is unavailable.

Nutrition

Fewer Asian (56%), Pacific peoples (54%) and Māori adults (49%) consumed the recommended daily serves of fruit compared to European/Other adults (60%). The percentage of Māori consuming the recommended daily servings of fruit was statistically significantly lower than non-Māori. Fewer Māori and Pacific adults were found to be eating the recommended daily servings of fruit in 2011-2012 compared to 2006-2007.

Fewer Asian (54%), Pacific (46%) and Māori (64%) adults consumed the recommended daily servings of vegetables compared to European/Other adults (72%). The percentage of Asian and Pacific adults consuming the recommended daily servings of vegetables was statistically significantly lower for non-Asian and non-Pacific adults respectively. Increased numbers of Māori men and Asian men were eating the recommended daily servings of vegetables in 2011-2012 compared to 2006-2007.

Fewer Pacific (83%) and Māori (82%) children ate breakfast at home in the past week compared to Asian (91%) and European children (90%).

Asian, Pacific and Māori children were more likely to drink fizzy drinks three or more times in the last week compared to non-Asian, non-Pacific, and non-Māori children respectively.

Pacific children were three times more likely to eat fast food compared to non-Pacific children. Māori children were two times more likely to eat fast food compared to non-Māori children.

Interviewees felt that there was a lack of knowledge regarding healthy food. In addition people from CALD populations may not know how to cook foods available in New Zealand. As a result they may continue to cook with traditional foods, some of which may be high in fat. Developing cooking skills in New Zealand foods may enable those from CALD populations to eat more healthily.

Physical Activity

Asian (39%) and Pacific adults (46%) participated in less physical activity compared to Māori adults (57%) and European/other adults (56%). This was statistically significant for both Asian and Pacific adults compared to non-Asian and non-Pacific adults respectively.

Obesity

Fewer Asian adults (16%) were obese³ compared to European/Other adults, whereas Pacific (62%) and Māori adults (44%) had higher levels of obesity. Asian adults had statistically significantly lower levels of obesity compared to non-Asian adults. However, there was a statistically significant increase in obesity in Asian adults since the 2006-2007 New Zealand Health Survey (11%). Pacific (62%) and Māori adults (44%) had statistically higher levels of obesity compared to non-Pacific and non-Māori adults respectively.

Seven percent of Asian children were found to be obese. Pacific children (23%) were three times more likely to be obese than non-Pacific children. Māori children (17%) were two times more likely to be obese than non-Māori children.

Interviewees felt that many of those from CALD populations who had moved to New Zealand tended to put on weight on arrival in New Zealand. This is thought to be due to low incomes, decreased physical activity as a result of a complete change in lifestyle and increased consumption of food high in fat and sugar. Currently there are no studies to confirm this observation.

Smoking

Similar numbers of Asian men (18%) and European/Other men (17%) were current smokers. However, fewer Asian women (3%) were current smokers compared to European/Other women (16%). More Māori men (38%) and Māori women (44%) and Pacific men (28%) and Pacific women (25%) were current smokers compared to European/Other men and women. The higher percentage of current smokers for Māori and Pacific adults was statistically significant compared to non-Māori, non-Pacific respectively. Anecdotally it has been suggested that smoking among those in CALD populations is greatly underreported.

³ Obesity is defined as a BMI of 30 or over based on the World Health Organisation's BMI cut off points for adults aged 18 years and over. For survey respondents 2-17, age and sex specific BMI cut-off points were used from the International Obesity Taskforce.

Alcohol

Fewer Asian adults (57%) and Pacific adults (58%) consumed alcohol in the past 12 months compared to the national average (80%). However, Pacific adults who had consumed alcohol in the last 12 months were more likely to have hazardous drinking patterns. Thirty-five percent of past-year Pacific drinkers consumed alcohol in a hazardous manner. This is 20% of all Pacific adults. Only eight percent of Asian past-year drinkers consumed alcohol in a hazardous manner. Anecdotally it has been suggested that alcohol consumption among those in CALD populations is greatly underreported.

Enrollment with Primary Care

Enrollment in PHOs benefits patients as it subsidises general practice fees, allows continuity of care and allows the patient to access some health promotion services. Table 2 presents general practice enrollment in Canterbury PHOs by ethnicity. In Canterbury, it is currently difficult to estimate the proportion of different ethnic groups that are enrolled due to out of date information on the resident population of Canterbury. When 2013 census data is released (mid-2014) for the CDHB area it is important that the proportion of enrolled population by ethnicity is determined.

Table 2. General practice enrollments in Canterbury, Quarter 2, 2013

Ethnicity	Number enrolled	Percentage of those enrolled
European	396517	81.4
Maori	33449	6.9
Pacific peoples	11464	2.4
Asian	29716	6.1
MELAA	4532	0.9
Other	6944	1.4
Unspecified	4262	0.9
Total	486884	100

Source: Planning and Funding. CDHB

It is interesting to note that an analysis of PHO enrollment in Auckland in 2006 found a variable proportion of enrollment between different ethnic groups. The percentage enrolled with a PHO was high in those from African (152%) and Middle Eastern (98%) countries, whereas those from Latin American (51%) countries had low levels of enrollment (Perumal, 2010). Those from Chinese and Indian ethnicities were also found to have lower levels of PHO enrollment than Europeans (Mehta, 2012).

Long Term Conditions

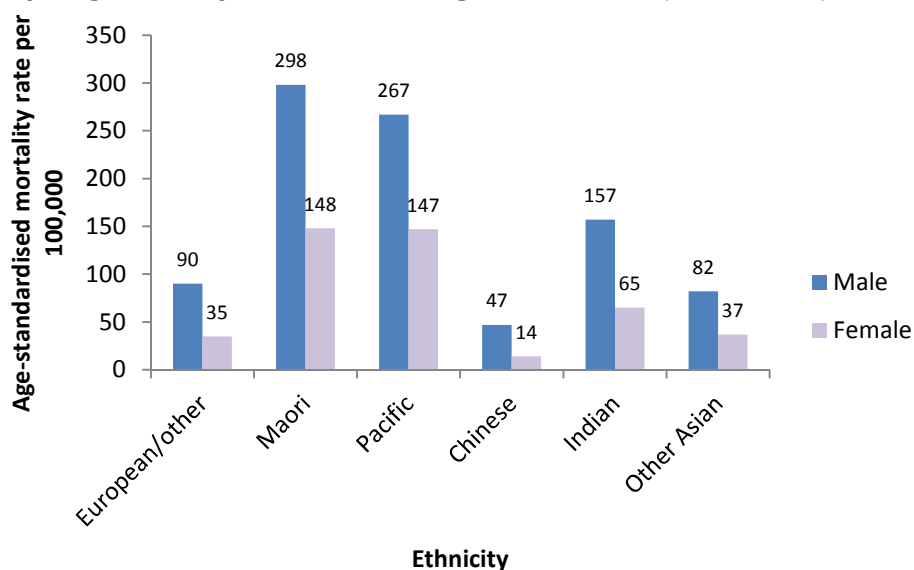
Cardiovascular disease

Cardiovascular disease is an important cause of morbidity and mortality across all population groups. Cardiovascular disease includes conditions such as coronary heart disease, stroke and peripheral vascular disease. CALD populations particularly affected are Indian and Pacific peoples. Chinese and Other Asian have lower or similar levels of cardiovascular disease as Europeans.

Figure 1 shows that Pacific and Indian men and women have higher levels of cardiovascular mortality compared to European/other men and these differences are statistically significant. For Pacific and Indian women this trend also exists, although the difference between Indian women and European/Other women is not significant. Chinese and Other Asian groups had lower levels of cardiovascular mortality compared to European/Other.

Prevalence for MELAA or other population groupings is not readily available.

Figure 1. Age standardised mortality rate for cardiovascular disease (per 100,000) among people aged 35-74 years, Auckland region, 2006-2008 (Mehta, 2012)



Source: National Minimum Dataset

European/Other refers to all European and non-Māori/Pacific/Asian peoples

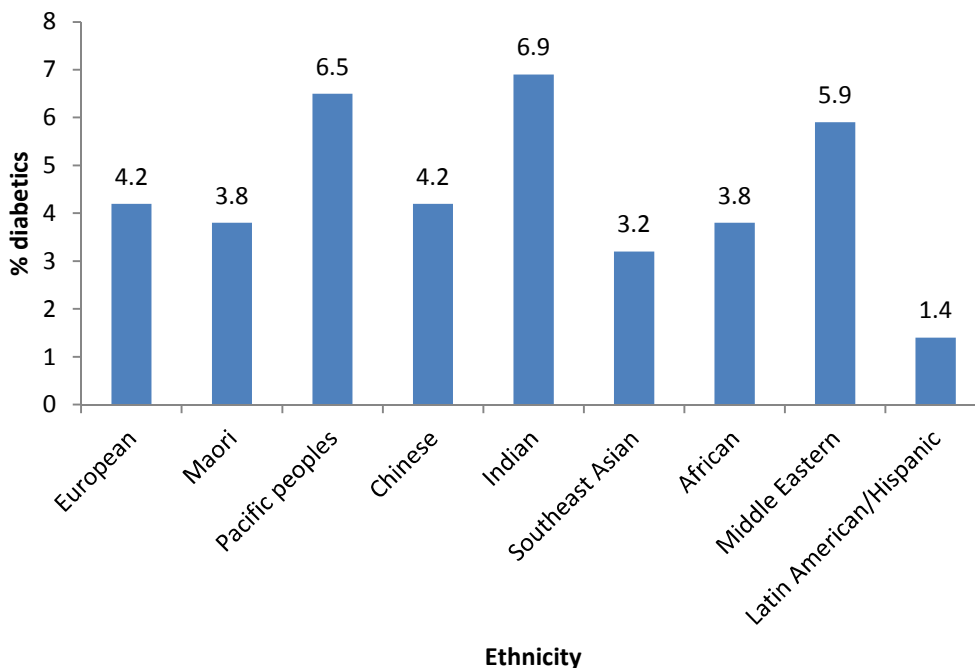
Diabetes

Diabetes is a condition which has multiple complications such as cardiovascular disease, peripheral vascular disease and stroke as well as kidney failure, neuropathy and vision loss. Like cardiovascular disease, diabetes is a problem in all populations but Pacific peoples, Indians and Middle Eastern people have the highest prevalence.

Diabetes prevalence has been estimated by the Virtual Diabetes Registry established by the Ministry of Health. Figure 2 shows that diabetes prevalence in Pacific people, Indian and Middle Eastern people is higher than in other ethnicities. This has also been found in Auckland where diabetes prevalence is 3.5% in African, 3.9% in Latin American and 5.5% in Middle Eastern people. For Indians the prevalence is approximately 11% and for Chinese approximately 4% (Mehta, 2012).

Interviewees felt that diabetes was occurring in increasingly younger age groups in CALD populations. They felt that diabetes management was especially difficult in those from CALD populations due to lack of engagement in treatment plans. As a result, diabetes was often poorly controlled and many of those from CALD populations were being started on insulin each week.

Figure 2. Diabetes prevalence in Canterbury 2013



Source: Virtual Diabetes Register, Ministry of Health (see Appendix 1)

Mental Health

Mental illness accounts for 15% of the total burden of disease in the developed world (Ministry of Health, 2013b). It is anticipated that by 2020 depression will become the second leading cause of disability.

The understanding, the meaning and the expression of mental illness varies greatly between different ethnic groups in CALD populations. Interviewees felt that there is a lot of stigma attached to mental illness and as a result it is not talked about. This leads to mental illness often being seen as an invalid diagnosis. Those from CALD populations can therefore be reluctant to see mental health professionals and mental health service utilisation may be low.

The 2011-2012 New Zealand Health Survey (Ministry of Health, 2012a) estimated the prevalence of common mental health disorders and psychological distress in New Zealand. Fewer Asian (4%) and Pacific people (7%) were diagnosed with depression, bipolar and or anxiety disorder compared to Māori (16%) and European/Other (19%). Fewer Asian (6.5%) and European/Other (4.9%) suffer from psychological distress compared to Māori (9.1%) and Pacific people (10.1%). The lower prevalence of mental health issues in Asians may be partly due to the differing cultural understandings of mental health. Prevalence for the MELAA or other population groups is not readily available.

Table 3 shows that in 2012-2013 the number of Asian and Pacific population referrals to Pegasus primary mental health services was 139 and 46 respectively. This has increased for Asian populations since 2011-2012 when there were 98 referrals (Bridgeford, et al., 2013). However, referrals for Pacific people have remained the same with 45 referrals in 2011-2012. The number of sessions per client has increased for both Asian and Pacific peoples since 2011-2012 when there were 2.0 and 2.3 sessions per client respectively. The referral rate is lower than would be expected to this service for Asian and Pacific peoples, given their proportion in the population.

Table 3. Referrals to Canterbury primary mental health services, 1 July 2012 to 30 June 2013

Ethnicity	Number of Clients	% share	Number of Sessions	% share	Sessions per client
Māori	330	6.9	972	6.2	2.9
Pacific	46	1.0	143	0.9	3.1
Asian	139	2.9	445	2.9	3.2
Other	4,278	89.3	14,028	90.0	3.3
Total	4,793		15,558		3.2

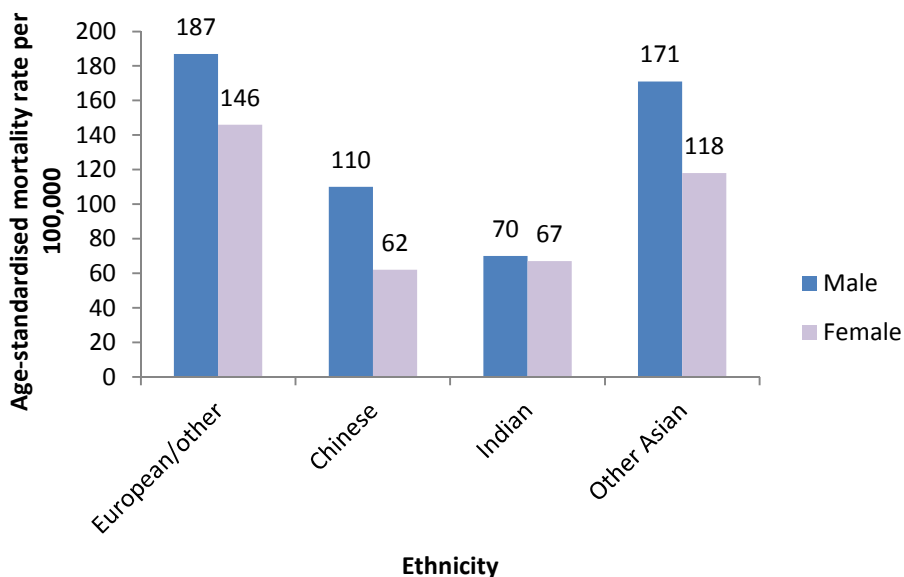
Source: Primary Mental Health Programme Manager Pegasus Health

Cancer

Cancer is one of the highest causes of mortality in New Zealand. The most common causes of cancer mortality are lung, colorectal, breast and prostate. Cancer mortality in Chinese and Indian populations was lower than European/Other whereas for other Asian it is similar. Prevalence for MELAA or other population groupings is not readily available.

Figure 3 shows that Chinese and Indian populations had lower cancer mortality than European/Other, which was statistically significant. Other Asians had slightly lower levels of cancer mortality, which was not statistically significant. The leading cause of cancer mortality in all groups was lung cancer. Chinese, Indian and other Asian groups also have lower numbers of cancer registration. The leading cause of cancer registration in males was prostate cancer and for women breast cancer.

Figure 3. Age-standardised overall mortality rate from cancer (per 100,000) among people age 15 years or older, Auckland region, 2006-2008 (Mehta, 2012)

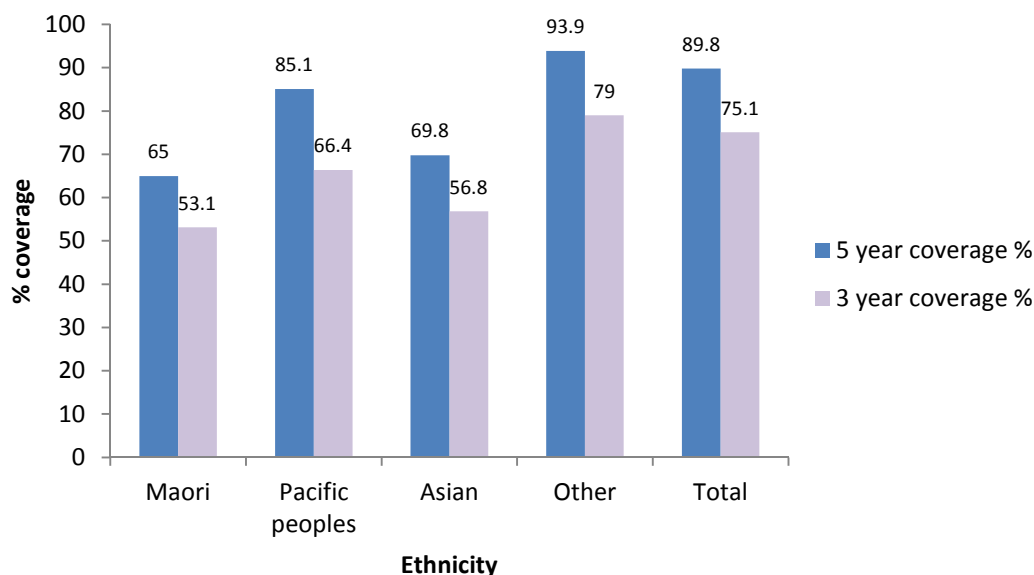


Source: National Mortality Collection

European/Other refers to all European and non-Māori/Pacific/Asian peoples

Figure 4 presents cervical screening coverage in Canterbury. Unfortunately while data for Pacific people, Asian and Other are available, these cannot be broken down into subgroups. In Auckland between 2008-2010, coverage rates for Chinese, Indian and Other Asian were all low, ranging between 25-45% (Mehta, 2012). In 2006 African (40%), Middle Eastern (34%) and Latin American (60%) people also had low levels of coverage in Auckland (Perumal, 2010).

Figure 4. National Cervical Screening programme 3 year and 5 year coverage rates for Canterbury March 2013



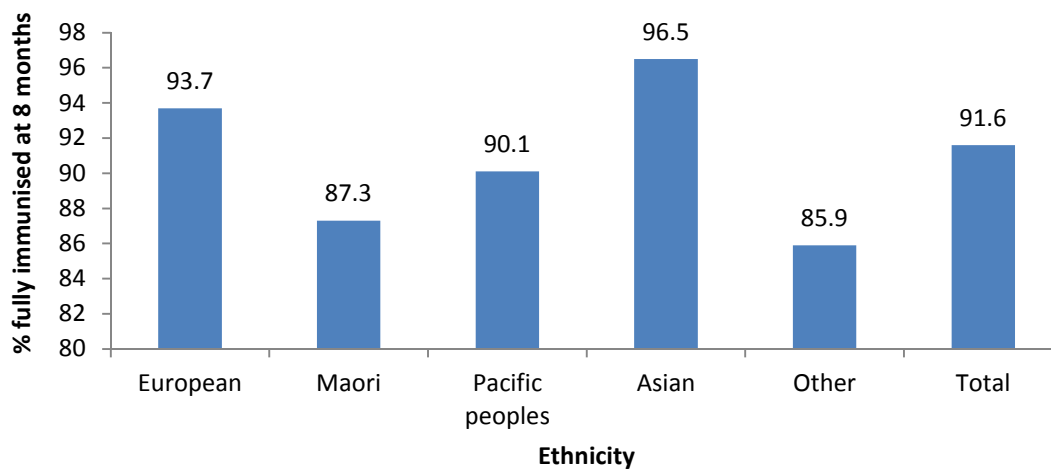
Source: National Cervical Screening Programme

Child Health

Child health is important, not only for the child but also in that it has long term consequences for health later in life. A number of risk factors for diseases, such as diabetes and cardiovascular disease, arise in childhood. Asian populations have high rates of immunisation and B4 School Checks, whereas rates for Pacific peoples tend to be lower.

Figure 5 shows that Asian populations have high levels of immunisations, whereas Pacific peoples and Other rates are lower. In Auckland, Chinese, Indian and Other Asian all had similarly high rates of immunisation compared to those with European ethnicities (Mehta, 2012). Immunisation rates in Pacific peoples were also lower than in those from European ethnicities. There is no information on MELAA or other population groupings readily available.

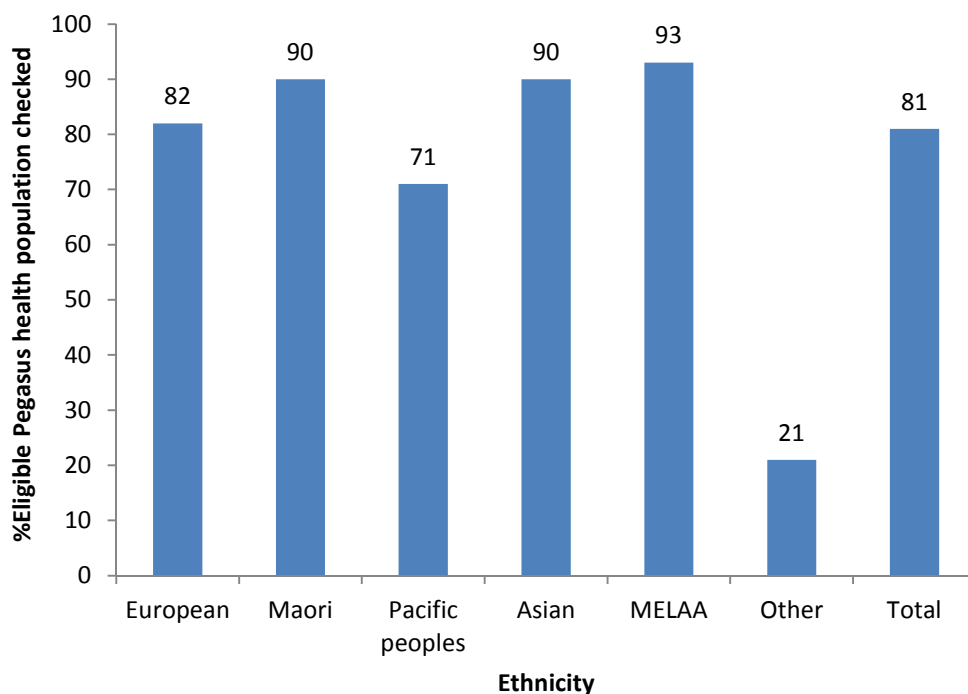
Figure 5. Percentage of 8 month olds immunised in Canterbury 2012-2013



Source: National Immunisation Register

Figure 6 shows that the percentage of B4 School Checks completed in the Canterbury population was high in both Asian and MELAA populations. However, completed B4 School Checks in Pacific people was lower.

Figure 6. B4 School Checks carried out in THE eligible Canterbury population July 2012 to June 2013



Source B4 School Check Programme Manager Pegasus Health

Access to Primary Health Care Services

Access to primary health care is the first point of contact people have with the health system. It is important for the maintenance of health and for accessing secondary and tertiary health care services.

The 2011-2012 New Zealand Health Survey (Ministry of Health, 2012a) provides information on access to primary health care services for European/Other, Māori, Pacific peoples and Asian. No information on MELAA is available.

Fewer Asian adults visited their GP in the last year compared to Māori (75%), Pacific peoples (75%) and European/Other (80%).

Fewer Asian adults (19%) and Pacific People (20%) visited a practice nurse in the last year compared to Māori (30%) and European/Other (33%).

Fewer Asian adults (8%) visited an after-hours medical centre in the last year compared to European/Other (14%), Māori (13%) and Pacific peoples (13%).

Increased numbers of Pacific peoples (31%) and Māori (39%) experienced unmet need for primary health care compared to Asian (22%) and European/Other (26%). Unmet need was defined as being:

- unable to get an appointment at their usual medical centre within 24 hours
- unmet need for GP services due to cost
- unmet need for after-hours services due to cost

- unmet need for GP services due to lack of transport
- unmet need for after-hours services due to lack of transport.

It is important to note that there are many other reasons for unmet need that are not covered by this indicator.

Barriers to Accessing Primary Health Care and Health Promotion

Both the interviews with key stakeholders and review of the literature identified recurring barriers to access of primary health care services. The factors could be seen to be due to three overarching themes, including difficulties in communication, the New Zealand health system and the wider determinants of health.

Difficulties in Communication

Interpretation services

Language was commonly identified as a huge barrier for CALD populations, both by interviewees and in the literature. Patients with limited English proficiency can experience a range of difficulties. In the UK, those with limited English proficiency may find it difficult to explain their current condition or their health to health professionals (Lakhani, 2008). In addition in New Zealand, patients may also feel that they are dismissed by health professionals who they feel do not have time to understand what they are trying to communicate (ChangeMakers Refugee Forum, 2011). Interviewees found that language problems led to misunderstanding medications or side effects, which had been dangerous in some situations. It is essential that those with limited English proficiency have access to interpreters.

The use of professional interpreters is considered best practice for those with limited English proficiency. Despite this, there is evidence from local and international research that the use of professional interpreters is low. Seers et al (2013) estimated that 0.7% of Pegasus Health general practice consultations which probably required a professional interpreter, had the services of one. This may be due to reasons associated both with the health professional and patients from CALD populations.

Children are often used as interpreters during consultations; however there are numerous problems in this. Apart from inherent ethical issues, Renzaho (2008) found that in Australia using children as interpreters may mean that information may not be accurate due to their interpreting ability. Interviewees explained that some health professionals assumed that if children were able to speak the patient's language fluently they were automatically able to explain medical terms, whereas this may not be the case. In addition not all children are able to speak the patient's language fluently but are assumed to be able to do so. Children should therefore not be used in any medical consultations.

There are many reasons that health professionals may not use interpreters. Seers et al (2013) found that health professionals are unaware of the funding for interpreting services in Canterbury (Pegasus Health currently funds access to professional interpreters through Services to Improve Access funding). Interviewees also identified that health professionals were not utilising interpreters because they felt that using an interpreter took up too much time, the patient may not ask for it, they think the patient understands them and they have previously not worked with interpreters. There is therefore a need to both inform health professionals of the funding of interpreters as well as providing training in using them.

Those with limited English proficiency are also reluctant to utilise interpreters for many reasons. In Australia, Renzaho (2008) found that those from CALD populations prefer to rely on family members for normal consultations and utilise professional interpreters in emergency situations only. This may be due to families feeling that they should be interpreting for their family members. Although Renzaho (2008) found that patients recognised that using family members could breach their confidentiality, interviewees also suggested that patients were worried about privacy when using an interpreter. It is therefore important to inform patients that a professional interpreter is bound by confidentiality and a code of ethics.

Interviewees felt that other reasons those from CALD populations were reluctant to use interpreters were that they did not want to cause providers inconvenience by requiring interpreters to be present, the loss of natural flow during the conversation and not hearing the explanation directly from the doctor's mouth. Some patients have also found that health professionals will talk to the interpreter during the consultation rather than to the patient. While these issues may be harder to resolve, training for providers on using interpreters and normalisation of the service may help increase acceptability.

Cultural differences

While being able to understand the language is important, cultural differences between health professionals and those from CALD populations can have a detrimental impact on the health professional-patient relationship. Interviewees in this report suggested that health professionals were not always culturally or religiously sensitive to those from CALD populations and did not always acknowledge their needs. Internationally, a lack of awareness of cultural differences by health professionals is thought to contribute to compromised patient-provider relationships and can make it difficult to achieve the most appropriate care (Renzaho, 2008; Stuart, 2008). In the UK, healthcare professionals have been found to feel uncertain and apprehensive in responding to the needs of those from CALD populations (Lakhani, 2008). In Australia, misunderstandings have led to non-attendance at appointments and non-compliance with treatment (Komaric, Bedford, & Driel, 2012). An awareness of cultural differences is therefore imperative in providing quality care for those from CALD populations.

Cultural differences can also be reflected in differing styles of communication. The type of questions the patient expects to be asked and the level of information they wish to be given can vary from culture to culture. Interviewees felt that in New Zealand psychiatrists ask questions in a very direct manner, especially about suicide, which those from CALD populations are unfamiliar with and may make them feel uncomfortable. Many of those from CALD populations may be more comfortable with answering indirect questions. Some of those from CALD populations do not want to bother health professionals or make a fuss and therefore tell the health professional what they think they want to hear and not what their true needs are. It is therefore important for health professionals to be aware of differing communication styles, to ask those from CALD populations as to how they wish to be treated and slowly build up a rapport and trust.

The health beliefs of those in CALD populations frequently differ to 'Western' beliefs of health. For instance, some of those from CALD populations may have fatalistic beliefs, ie believing that a higher power is in control of a person's life and therefore they do not have control over the diseases that affect them (Remennick, 2006). In the USA studies have found that Muslim women believe that their lives are ultimately controlled by God (Underwood, Shaikha, & Bakr, 1999). Interviewees identified that those from the Philippines may have superstitious beliefs about their health. As a result, those from CALD populations may not be able to relate with health messages that are given based on a 'Western' understanding of health.

Those from CALD populations may have a lack of understanding of health from a 'Western' point of view and therefore they may not realize that a particular behavior may increase their risk of disease. This can make health promotion or prevention of a disease particularly difficult to access, especially if the service was not available in their home country. Some interviewees felt that those from CALD populations only felt that their health was an issue if they were experiencing symptoms and was not a priority if they were well. The concept of screening or preventing disease from occurring may be new concepts to those from CALD populations and therefore needs to be explained well to these groups.

Although health promotion and preventing disease may be new concepts, Underwood (1999) found that those from CALD populations in the USA placed great importance on health. Similarly,

interviewees also felt that those from CALD populations were interested in health and wanted to learn more about it. However, interviewees felt that there was a lack of communication from providers informing those from CALD populations about health issues or the risks of not looking after their health. This may be due to service providers not giving enough consideration as to how to communicate health messages to those from CALD populations (ChangeMakers Refugee Forum, 2011). More emphasis therefore needs to be given to this area.

Methods of treating illness in New Zealand can be different to those many in CALD populations are used to. This does not only refer to the use of traditional medicines but also perceptions on how illnesses should be dealt with. Some of those from CALD populations often want a treatment to fix the problem straight away, regardless of the problem. Interviewees suggested that for those in CALD populations observing a symptom's progression or giving symptomatic relief, eg paracetamol, is often not an acceptable solution. In Auckland, it was found that Asian migrants make assumptions about how medical care should be provided and may feel that they were treated inadequately if their expectations were not met (Mehta, 2012). More time should be taken to ensure that those from CALD populations understand the advice or treatment they are given and the reasoning behind it.

Traditional methods are still used by those in CALD populations. Interviewees identified that many older people do not want 'Western' medicine, which may be partly due to a lack of understanding of medicines used in New Zealand. Traditional medicines are obtained from a number of different sources such as from their home country or from an 'expert' in their community. It is important that health professionals enquire about traditional medicines that those from CALD populations may be taking.

Mental health is a particular condition where there are vast cultural differences in the way it is approached. In many CALD cultures in New Zealand there is a lot of stigma attached to mental health (Mehta, 2012). In some Asian cultures mental illness such as schizophrenia or organic brain disorders may be perceived as supernatural punishments for wrong-doings and therefore entail shame (Ho, Au, Bedford, & Cooper, 2003). Interviewees stated that mental health problems were not talked about in communities and there was a belief that it should not be discussed with others. However, younger generations may have more knowledge of mental health issues and their interaction with physical health. The lack of awareness and understanding of mental health issues is a particular aspect that needs to be addressed in CALD populations.

Interviewees felt it was difficult for patients to trust mental health providers even when confidentiality was assured. This may be partly due to a patient's hesitance to talk about mental health issues and their concern about the diagnosis they will receive. Standardised Western assessment tools can also pose risks for those from CALD populations where the language, cultural norms and other concepts may be different and therefore diagnoses may be made inappropriately (Marsella, 2011; Tse, Hoque, Sobrun-Maharaj, & Kim, 2008). In addition, due to the stigma attached to mental health conditions, patients can be fearful that members of their community will find out that they are accessing mental health services. While bilingual mental health counselors have been a success in Christchurch, some patients are reluctant to attend sessions at the Christchurch Migrants Centre due to fear that other community members will see them there. It is important that mental health services are culturally sensitive and those from CALD populations are able to trust them.

The length of appointment times available in primary care is often not sufficient to meet the needs of those from CALD populations. In New Zealand, GPs not taking the time to explain the problem has led to patients being referred to hospital without knowing why (ChangeMakers Refugee Forum, 2011). In the UK, it is thought that where consultations are longer and there is a strong continuous relationship between the doctor and the patient, work on health promotion, self care and modifying health seeking behavior, is more productive (Lakhani, 2008). Interviewees also felt that it is important

for those from CALD populations to develop trust with health professionals, which is not possible given the short duration of an appointment. Appointment times need to be flexible to allow the time to be extended if necessary for those from CALD populations.

Diversity of workforce

The lack of a diverse workforce was found to be a barrier to those from CALD populations accessing health services. In Australia, Komaric (2012) felt that a low level of representation of those from CALD populations in the workforce contributed to inadequate resourcing being directed at CALD populations. Interviewees thought that those from CALD populations may perceive themselves to be a 'minority' and that this could lead to them feeling misunderstood by health professionals. More bilingual health professionals were thought to be necessary to enable CALD populations to feel better understood. There are a limited number of general practices and pharmacies that are able to offer bilingual health professionals in Canterbury and more are needed.

Health System

Health system paradigm

The New Zealand health system is based on 'Western' paradigms and around an individualist society. In contrast, many CALD populations are frequently based on a collectivist society. A collectivist society puts the goals of the collective ahead of their own (Triandis, Bontempo, & Villareal, 1998). As a result, the goals of the collective are very similar to the goals of the individual, with a strong emotional attachment to the group. Conversely, in an individualistic society there is a strong emphasis on the individual's goals.

Differing paradigms have implications on the decision making processes that individuals make about their own health. For those in CALD populations the opinions of others in the community will have a large influence on the decisions of individuals. Interviewees believed that some from CALD populations trusted the views of a community more than that of the health professional. This has implications on the extent of health messages being accepted by those from CALD populations.

Approach to CALD

How services are planned has an impact on the health of those from CALD populations. Interviewees felt that services were uncoordinated and usually reactive to a particular situation. In Australia, a similar lack of coordination and duplication of services has been found (Renzaho, 2008). Many interviewees felt that this resulted in inflexible funding systems which acted as barriers to accessing health services for those from CALD populations. They described that there was a limited funding for social supports such as outreach workers or health professionals to do home visits. Strong organisational advocacy for the CALD population is required to highlight their health needs and coordinate the approach to improve the health of this group.

Complex system

The New Zealand health care system may be unfamiliar to many of those from CALD populations, especially if they are not New Zealand born or have recently moved to New Zealand (Mehta, 2012). In the UK, Lakhani (2008) found that patients from CALD populations can have limited understandings of the services offered and how to access them. In Australia, this can occur despite generalized knowledge of health services (Komaric, et al., 2012). This may in part be due to health care services being organized differently in New Zealand to the home countries of those from CALD populations. Interviewees highlighted that deciphering the differences between primary and secondary care can often be difficult in New Zealand and people may be unsure of where to go for their health problems. Those from CALD populations were particularly uncertain of the need to be enrolled with a general practice and this may stem from few general practices in their home country. A lack of understanding of the health system, combined with previous patient experiences, can lead to patients from CALD populations having unrealistic expectations of services.

The New Zealand health system may be a source of disempowerment for many people. In their home countries, those from many CALD populations would have made their own referrals to specialists and bought their own medications from pharmacists without a prescription. Interviewees felt that in New Zealand, patients from CALD populations had to rely on health professionals to do this and as a result took away their control, making them feel unable to make their own decisions. In the UK, those from CALD populations may also feel unable to exert any real influence on health care planning (Lakhani, 2008). Enabling people to take control of their health is therefore important in encouraging those from CALD populations to access primary health care and health promotion.

Primary health care services not being able to provide a high level of continuity of care can be a barrier for those from CALD populations. In the UK, CALD populations have been found to value continuity of care but find it seldom occurs (Lakhani, 2008). In New Zealand, while continuity of care was not brought up as an issue with interviewees, having to interact with different health care professionals can be difficult for those from CALD populations (ChangeMakers Refugee Forum, 2011). It is therefore important that trying to ensure continuity of care is maintained in Canterbury.

The inflexibility of the primary care appointment system has been a source of frustration for those from CALD populations. In the UK it was found that the process of making appointments and understanding choices is particularly difficult especially when rigid booking systems are present which do not offer the flexibility to respond to the patient's need (Lakhani, 2008). Interviewees also felt that some of those from CALD populations struggled to book appointments when they needed them. In the UK, another cause of complaint can be the length of appointment time, as those from CALD populations often have complex or multiple issues or require language support (Lakhani, 2008). This was also felt to be the case by interviewees. A more flexible appointment service is therefore needed for those from CALD populations.

The receptionist plays a pivotal role in how patients from CALD populations experience health care services. As the first contact that patients have with the health system, the receptionist can determine whether the experience is positive or negative. For Pacific people in New Zealand, an unwelcoming reception and negative encounters with ancillary staff were often found to be interpreted as racial discrimination (Ludeke et al., 2012). Patients from CALD populations in the UK have found that interaction difficulties with receptionists and conflicts can arise when making appointments (Lakhani, 2008; Stuart, 2008). In addition, the receptionist can act as a gatekeeper and help to navigate patients through the health care system. It is therefore important that receptionists understand the difficulties that those from CALD populations may face and become sensitive to these.

Information and education resources

There are limited translated resources available for those from CALD populations. In Australia, Renzaho (2008) found that those from CALD populations specifically lacked non-English information about health services. Interviewees felt that information is not always translated in languages that are needed. Information in languages such as Bhutanese and Kurdish are often difficult to obtain in Canterbury. Interviewees stressed however, that translating information in respective languages was often not sufficient as some concepts did not translate well from English into other languages and therefore would not be relevant to CALD populations. It is therefore important that information resources are also culturally appropriate as well as in the required language.

Wider Determinants of Health

The wider determinants of health will have a large impact on the health of those from CALD populations. Social issues such as housing, unemployment, poverty, racism, marginalisation, education and literacy can have a substantial impact on a patient's health (Lakhani, 2008; Marsella, 2011; Tse, et al., 2008). In addition to affecting their health, it can also impair their ability to focus on

their health needs. In doing so, those from CALD populations may place less priority on their own health and therefore not access the services that they need.

Those who have limited English proficiency may face barriers to many other services in Canterbury. They therefore have a higher tendency to isolate themselves from society due to the difficulties in trying to communicate. This can have a negative effect on their physical and mental health (ChangeMakers Refugee Forum, 2011). Interviewees felt that poor access to primary care could be seen as a broader issue of exclusion for those from CALD populations. This can be especially important for health promotion as it may limit a person's ability to make healthy lifestyle choices. For example if a person is unable to speak the language or does not know where to access services, they are unlikely to go and enroll at a gym on their own. It is therefore not only important for health care services to be more accessible to CALD populations, but many other services as well.

Interviewees felt that costs involved in accessing health services were a barrier to health services. In New Zealand this can be especially problematic for refugee populations (ChangeMakers Refugee Forum, 2011). Interviewees felt that those from CALD populations were often not aware of disability allowances to help with health care costs. While some general practices offer lower rates these were still seen as prohibitive for some. As a result those from CALD populations may only access care at a late stage.

The availability of transport was often seen as a barrier for CALD populations in New Zealand (Mehta, 2012). Interviewees felt that this was the case for older, rather than younger people. However, youth and their families accessing mental health services in New Zealand did feel that transportation was an issue (Sobrun-Maharaj, Nayar, & Choummanivong, 2008). While the Red Cross and St John are able to provide transport for those meeting criteria, more services need to be aware of this issue.

Breaking down the barriers

While those from CALD populations may have variable health status and some may experience barriers to accessing primary health care and health promotion, there are strategies that have been identified in the literature as well as by the interviewees that have the potential to improve health.

Understanding needs of CALD populations

When addressing the needs of any population it is essential to first understand these needs. Renzaho (2008) found that in Victoria, needs prioritisation was not informed by a needs assessment or consultation with the stakeholders. The needs identified by those from CALD populations were therefore not met by services. In Auckland, health needs assessments on Asian and MELAA populations have been undertaken and highlighted issues for those groups (Mehta, 2012; Perumal, 2010). In Canterbury it will be important to understand the needs of all the CALD populations prior to initiating any strategies.

Improving the quality of ethnicity data is central to understanding the needs of the CALD population and has been seen as a priority internationally (Chin, 2000; Lakhani, 2008; Stuart, 2008; Tse, et al., 2008). In Canterbury there are indications that ethnicity protocols are not consistently adhered to across all general practices. In addition while data on some ethnicities is collected, it is not always reported (Cook & Appelhoff, 2013). Improved ethnicity data will allow the health status of those from CALD populations to be identified, as well as their utilisation of health care services. There is work underway in general practices to address these issues.

The CALD population needs to be acknowledged and be part of the future of Canterbury. Interviewees felt that a plan is required for those from CALD populations for the next five years that strategises how the health of those from CALD populations might be improved. For services to provide the greatest benefit they need to be embedded systematically into the sector. This should include removing financial barriers to the system and an acknowledgment that the special needs of some of those from CALD populations may need additional resources (Fortier, 2010). In addition, in the USA few providers think about biases within services that results in attempts to get patients from CALD populations to conform to the mainstream culture, rather than meeting on their cultural ground (Chin 2000). It is important that all strategies to improve the health of those from CALD populations are culturally appropriate.

In determining the approach to addressing the needs of those from CALD populations, it has become clear that providing separate services for each community is unrealistic. However, as Lakhani (2008) eloquently states *'a model of flexible, personalised care that is part of mainstream healthcare'* is required.

A culturally competent health care system approach has been advocated by many countries (Anderson, et al., 2003; J. Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003; Chin, 2000; Renzaho, 2008; Smedley, 2008). In the US, the National Standards for culturally and linguistically appropriate services in health and health care (see Appendix 3) provide a blueprint for individuals and organisations to implement culturally and linguistically appropriate services. There are currently fifteen standards covering 1) governance, leadership and workforce; 2) communication and language assistance and 3) engagement, continuous improvement and accountability (The Office of Minority Health, 2013). The National Health and Medical Research Council in Australia has also developed a Cultural Competency in Health guide to help with planning at all levels of the health system (National Health and Medical Research Council, 2005). A culturally competent health care system approach seems to be an appropriate response to improving the health care of those from CALD populations.

There are many definitions of what culturally competent health care is. Betancourt (2002) has described it as:

'A set of behaviours and attitudes and a culture within the business or operation of a system that respects and takes into account the person's cultural background, cultural beliefs, and their values and incorporates them into the way health care is delivered to that individual.'

Culturally competent health care is therefore far more than providing interpreters or producing translated information, although these are of course important. Anderson (2003) has identified that culturally competent healthcare system interventions should include an appropriate mix of the following:

- Programmes to recruit and retain staff who reflect cultural diversity
- Use of interpreter services or bilingual providers
- Cultural competency training for healthcare providers
- Use of linguistically and culturally appropriate health education materials
- Culturally specific healthcare settings

This framework has been utilised to identify strategies to break down the barriers to accessing primary health care and health promotion for those from CALD populations.

Programmes to recruit and retain staff who reflect cultural diversity

Achieving diversity at every level of the health care setting can influence the way in which the sector meets the needs of the population it serves (Anderson, et al., 2003). Betancourt (2002) identified that health care systems are influenced by the leaders that create them and by the workforce that enacts them. In Australia, a low level of CALD representation on the healthcare workforce can lead to minimal resources being directed at those from CALD populations (Komaric, et al., 2012). It is therefore important that diversity is reflected from the leadership level, all the way through to the provider level.

There are also many other advantages to creating a more diverse workforce. Interviewees believed that these included patients finding it easier to relate to CALD health professionals, language matching to allow better communication and CALD health professionals modeling behaviour for their colleagues. There is therefore the possibility that a more diverse workforce will create better patient relationships with all health professionals.

Clear career pathways for those from CALD populations are needed to increase workforce diversity in primary health care. Programmes to advance health care leadership in those from CALD populations are especially important (J. R. Betancourt, et al., 2002). Not only does the primary health care and health promotion sector need to become an attractive sector for CALD high school students, it also needs to be attractive for those who have already trained as professionals in their home country. Interviewees were aware that many from CALD populations had been professionals in their home country and could be coached into the health service. Clear career pathways will therefore encourage those in CALD populations to enter the health workforce.

Use of interpreter services or bilingual providers

It is essential that patients are able to understand the health information and advice they receive. A bilingual counselling service in Christchurch has been well received by those from CALD populations and is increasingly being used. However, where bilingual providers are unavailable, the use of professional interpreters is recommended. Pegasus Health provides funding for interpreters and the use of this service is improving; however there remains room for improvement. The use of professional interpreters needs to be normalised within health care to ensure that all those requiring the service have access to it.

In order for professional interpreting services to be normalised, interviewees identified multiple strategies that would allow this to occur. Professional interpreting services need to increase their visibility in general practice to ensure that all staff are aware of their service. Simplifying and automating booking systems for interpreters would ensure that interpreters are always booked for those who require the service. The availability of conference phones was also identified as a way to make telephone interpreting more acceptable. Training is also required for all health professionals to be able to use interpreters and ensure that the patient still feels involved in the consultation. Once general practices are utilising interpreters successfully then an increased number of professional interpreters will be needed to ensure that patients can always access them.

In addition to working with primary care, professional interpreting services also need to increase awareness of the availability and benefits of professional interpreters in CALD populations. The CALD population also has to be reassured that the professional interpreter will maintain confidentiality. Increasing advocacy for professional interpreters in other health service providers is also needed to ensure that patients remain confident in the system. Through normalising the use of professional interpreters those from CALD populations will be able to express their needs to health professionals and be able to understand the advice they are given.

Cultural competency training for healthcare providers

Cultural competence training is designed to:

- 1) enhance self awareness of attitudes towards people of different racial and ethnic groups;
- 2) improve care by increasing knowledge about the cultural health beliefs and practices;
- 3) improve skills such as communication (Anderson, et al., 2003).

Cultural competency training has been found to be effective in increasing cultural awareness and open-mindedness, improving the understanding of multi-culturalism and improving communication with minority groups as well as generally improving ethnic minority patient care (Henderson, Kendall, & See, 2011).

While some understanding of the different cultures in Canterbury is beneficial, it may be unrealistic for staff to know the details of every culture. Focusing on specific cultural knowledge can reinforce stereotypes and discriminatory practices if providers only gain a superficial grasp of the issues (Chin, 2000). Additionally differences within ethnic groups will occur and therefore care needs to be taken when applying broad assumptions to individuals. Interviewees felt it was acceptable for staff to ask patients how they would like to be treated and that staff need to know who to contact if they were having problems or had particular questions. The important aspect of cultural competency is therefore acknowledging that patients from CALD populations will have different beliefs and world views and staff in health care services should be sensitive to this.

Internationally it is felt that cultural competency training for all staff members in health care services should be provided (Stuart, 2008; Tse, et al., 2008). Receptionists were identified as being in a key role as gatekeepers and navigators, as well as being the first point of contact with patients. Therefore while cultural competency training is essential for all staff it is especially important for receptionists.

Use of linguistically and culturally appropriate health education resources

Health information messages that are developed for the majority of the population may not be accessible or relevant for those from CALD populations (Anderson, et al., 2003). Health education resources need to take into account differences in language as well as be sensitive to cultural beliefs and practices. They also need to reflect an appropriate level of health literacy for the community being targeted (J. R. Betancourt, et al., 2002). Interviewees suggested that resources should be developed

with CALD populations to ensure they are culturally appropriate and relevant. Through this process it will also ensure that the resource being developed is perceived to be needed by the community.

The range of culturally or linguistically appropriate resources in Canterbury is currently insufficient and interviewees felt that they had to look internationally to find appropriate resources. Increased mental health education resources were especially needed to increase understanding of mental health issues, services and promote help seeking behaviour (Ho, et al., 2003). In Australia, Komaric et al (2012) found those from CALD populations wanted culturally- tailored health-related information using a variety of media such as leaflets, radio, audio-visual and newspapers. Therefore there are a variety of different mediums through which health education information could be relayed.

Culturally appropriate health care

CALD population engagement

As mentioned previously, there are many aspects of a Westernised health care system that are unfamiliar to many of those from CALD populations. While there may be certain situations where ethnic specific services are required, in other situations a flexible approach as described by Lakhani (2008) may be more appropriate. In either situation involvement of those from CALD populations is essential for services to be able to meet their needs. In the UK and USA it has been suggested that communities need to be empowered to make decisions about their health and should be actively involved in the planning, implementation and evaluation of health activities (J. R. Betancourt, et al., 2002; Lakhani, 2008; Smedley, 2008). In New Zealand, an appropriate way to do this is to identify leaders from CALD populations to collaborate with health service providers (Tse, et al., 2008). Engagement of CALD populations in Canterbury will enable services to be delivered in a culturally appropriate way.

Cultural Community Workers

Those from CALD populations need further understanding of the New Zealand health system. This can be especially important in ensuring those from CALD populations enroll with a general practice. In the USA, Chin (2000) identified that case management, outreach and transportation are necessary for utilisation of services by those from CALD populations. Cultural community workers, in the role of patient navigators or cultural brokers, may be able to fulfill some of these requirements. In the USA, cultural community workers have been used to teach disease prevention, conduct assessments of health problems and help people obtain appropriate health resources (Smedley, 2008). Cultural community workers have been found to improve communication between providers and patients, increase satisfaction in the health care system, increase knowledge and awareness about health care services and health, expand cultural understanding between health care system providers and patients, increase screening rates and increase follow up care and appointment keeping (Henderson, et al., 2011).

Cultural case workers have been used in the Auckland DHB in Child Disability Services and have been found to be invaluable to the service (Black, Butler, Dunbar, & Wheeler, 2011). The benefits to families have been improved access to health and other services, decreased isolation, increased knowledge about a range of services including health, social system and financial entitlements and an improved living situation. The benefits for services have been an increased knowledge and understanding of the family's ethnic, cultural and religious background, improved relationships with the family resulting in better engagement and outcomes and streamlining of processes. Roles such as cultural community workers and cultural case workers may be beneficial in Canterbury.

Partnership Community Workers (PCWs) were established by Pegasus Health as part of the Services to Improve Access funding (see Appendix 1). Their aim is to ensure people are able to access primary health care (JHI Consultancy, 2009). They are employed by umbrella organisations and subcontracted to the PHO. They work in collaboration with a group of general practice teams and

local communities to identify at risk people and refer them to general practice as appropriate. They can also receive referrals to further assist the ongoing care of patients under the Services to Improve Access programme. Interviewees identified that PCWs assisted patients in navigating the health system, identifying and removing barriers to accessing primary care and linking patients to other supports. For example, supporting them to get to doctors' appointments, organising interpreters and ensuring that follow up occurs.

An evaluation on the Services to Improve Access programme found that GPs and nurses who had contact with PCWs felt that they had improved access for enrolled patients and had a positive relationship (JHI Consultancy, 2009). There had, however been difficulties in building relationships with general practices. Following the evaluation many changes were made to the PCW service which have improved the service. Interviewees reported there was a large variation in the effectiveness of individual PCWs. This was felt to depend on the level of understanding of the health system or whether they kept general practices informed regarding patients. As a result there may be further improvements which can be made.

Increased training and support for PCWs could be beneficial. Interviewees felt that more health promotion training, cultural competency training and counseling training for PCWs would be beneficial. A mentoring or buddy system was also suggested to allow PCWs to be exposed to different populations other than their assigned population, in order to increase their experience. While there are three PCWs from refugee backgrounds there is potential to increase the effectiveness of all PCWs for all CALD populations.

It is unclear as to whether PCWs need to be from the CALD population in order to be effective in their role. Some interviewees felt that to understand the cultural context or be able to speak the language, ideally the PCW should be from the same community. Others were less concerned with whether the PCW was of the same culture but more concerned that the PCW cared about the health of the community and was passionate in their role. In Auckland it was found that the age, gender, religious background, or ethnicity of the cultural case worker was less important than attributes such as knowledge of the New Zealand health social systems, empathy, compassion and a sense of understanding and respect for CALD families (Black, et al., 2011). Therefore it may not be necessary to recruit PCWs from CALD populations as long as the PCW is passionate and effective.

Flexible Appointments

Many of those from CALD populations need time to establish rapport and trust with the health professionals they are in contact with; however time restrictions in the health system may result in health professionals not being able to build this relationship. Interviewees felt that if issues were not fully discussed it could lead to repeat visits. When interpreters are required, longer appointment times are also often needed. Appointment times therefore need to be flexible in order to meet these needs and this should also be reflected with appropriate funding.

The times when appointments are available may not be suitable for those from CALD populations. Many from CALD populations may be unable to attend appointments during work hours due to work commitments or childcare issues. Interviewees suggested appointments in the evening or at the weekends were needed. In Auckland, catch-up immunisation or cervical screenings days held on Saturdays were successful. Mobile services or home visits by GPs were also suggested as ways to improve access. The availability of appointment times in Canterbury need to be more flexible to meet the needs of CALD populations.

Targeted Health Promotion

Health promotion for those in CALD populations needed to be targeted and delivered in a culturally appropriate way. A wide body of research demonstrates the efficacy of health promotion, disease prevention and disease support interventions that are designed with the linguistic, cultural and

educational characteristics of the target population in mind (Fortier, 2010). The most successful programmes are often aimed at specific groups in particular places.

Targeted health promotion for those from CALD populations is required. Many of those from CALD populations do not understand how their health is impacted by the decisions that they make. Interviewees identified that key role models within the communities could be utilised to spread key messages. They also suggested that health promotion is done in settings familiar for CALD populations such as churches, mosques or the Christchurch Migrants Centre, or using already planned cultural events to promote key messages.

Mental health is a specific area where increased health promotion was felt to be required. Interviewees felt that those from CALD populations needed more information regarding both mental health services and more importantly to increase awareness of mental health issues. It was suggested that leaders in the communities needed to convey this information as they are respected and trusted for their cultural knowledge. It is important that the community is empowered to be able to take ownership of mental health issues.

Conclusion

Limitations

This report provides a foundation for an approach to improving the health services for CALD populations to take. There are however, limitations to this report that need to be acknowledged. The ability of the report to analyse the health status of the CALD population was restricted due to reliance on other reports for data. It was found that reports infrequently present data on CALD populations or groupings within CALD. Ideally analyses would have been performed on Canterbury data to illustrate these outcomes. It was however, not within the scope of this report to do so.

In addition, the interviews were mainly done with health professionals or social service providers. While important information from these interviewees has been obtained, patients themselves may have other important or slightly different insights. It is important that the patients themselves are consulted if any strategies or plans are put in place.

This report intentionally has not covered any of the impacts that may have resulted from the Christchurch earthquakes. There are however important issues that are beginning to emerge and should be investigated further. These include those from CALD populations coming to Christchurch as workers for the rebuild who are on work visas shorter than two years. There is confusion within this group as to what health services they and their families are eligible for. This group in particular needs further attention.

The focus in this report is to improve access to primary health care services for those from CALD populations. To optimise the benefits, a whole health system response is needed. If those from CALD populations have negative experiences with some health care services they may extend these perceptions to other health care services. It is therefore important that other health care services in Canterbury also start planning to meet the needs of those from CALD populations.

The primary health care sector has limited influence on wider society or the wider determinants of health. As described previously, social influences such as employment, isolation, racism and low income can all affect health status and a person's ability to access health care. These are areas over which primary health care or health promotion has little control over and therefore while acknowledging that barriers may occur because of these, there may be little that primary care can do about them.

Possible Actions

There are a wide variety of possible actions that PHOs could undertake to improve access to primary health care, as well as health promotion for CALD populations. In addition there are areas that PHOs could increase their support to health service providers to enable them to improve access for CALD populations. These possible actions are suggestions and it is acknowledged that not all will be possible in a short timeframe.

PHO

Foundations of the health service

- Provide leadership on promoting the need for more culturally responsive services
- Understand the health needs of CALD populations
- Encourage systems to ensure quantity and quality of ethnicity data
- Establish a plan for improving services for CALD populations

Programmes to recruit and retain staff who reflect cultural diversity

- Employ staff from CALD populations at all levels of the organization

- Advocate for a more diverse health care workforce

Use of interpreter services or bilingual providers

- Collate a register of bilingual general practitioners
- Continue to fund professional interpreters for general practices and other primary care services
- Provide interpreter training for service providers
- Advocate for the use of professional interpreters in all service providers
- Provide education for patients on use of interpreters

Cultural competency training for health care providers

- Provide cultural competency training for all service provider staff members

Use of linguistically and culturally appropriate health education materials

- Develop and provide culturally appropriate translated information
- Use peer reviewed translation services in the development of resources

Culturally appropriate health care settings

- Utilise patient/community groups to inform services
- Investigate how the Partnership Community Workers' roles could be developed so they might act as cultural brokers within the health service
- Increase training for Partnership Community Workers, especially in cultural competency
- Undertake targeted health promotion to CALD populations

Areas that PHOs could support Health Service Providers

Foundations of health services

- Support quality ethnicity data collection and recording
- Report ethnicity at level 2 (see Appendix 2) according to the ethnicity data protocols
- Increase awareness/understanding of CALD populations enrolled within their service

Use of interpreter services or bilingual providers

- Promote the use professional interpreters
- Support systems that encourage professional interpreter use

Culturally appropriate healthcare settings

- Use computer systems to alert for complex patients or when an interpreter is required
- Undertake more targeted health promotion to CALD populations

Despite the limitations, this report has identified that the CALD population is an extremely diverse group with a huge diversity in concepts and understanding of health, trust in health care professionals and knowledge of the health system. Trying to address the needs of this group is therefore complex and may seem to be an impossible task.

The key themes that emerged to improve primary health care services and health promotion for CALD populations include understanding their health needs and taking a culturally competent health care system approach. The culturally competent health care system approach includes programmes to recruit and retain staff who reflect cultural diversity, use of interpreter services or bilingual providers, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials and providing culturally specific healthcare settings.

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Appendix 1. Definitions

Acculturation	A phenomenon which results when groups of individuals having different cultures come into continuous, first hand contact with subsequent changes in the original culture patterns of either or both groups (Redfield, Linton, & Herskovits, 1936)
Asian	A person identified as being from an ethnicity originating in Asia. Asia includes the large peninsulas of Asia Minor, India, Arabia, and Indochina and the island groups of Japan, Indonesia, the Philippines, and Ceylon (Sri Lanka); it contains the mountain ranges of the Hindu Kush, Himalayas, Pamirs, Tian Shan, Urals, and Caucasus, the great plateaus of India, Iran, and Tibet, vast plains and deserts, and the valleys of many large rivers including the Mekong, Irrawaddy, Indus, Ganges, Tigris, and Euphrates.
MELAA	Middle Eastern, Latin American and African
Services to Improve Access (SIA)	This aims to ensure people are accessing the primary health care they need. SIA funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status; Māori, Pacific people and those living in NZDep index 9-10 decile areas. The funding is for new services or improved access and is additional to the main PHO capitation funding for general practice-type care. Funds are allocated according to the number of people from these population groups enrolled in the PHO. It has three main approaches, general practice funding, practice nurse additional hours and Partnership Community Workers (JHI Consultancy, 2009).
Virtual Diabetes Registry	The Ministry of Health has established a national Virtual Diabetes Registry using five nationally collected health databases. These include hospital admissions for diabetes (excluding gestational diabetes, outpatient attendances for diabetes or diabetes retinal screening, insulin or oral hypoglycaemic agents dispensed on two or more occasions, four or more HbA1c tests and enrolment with a PHO (Mehta, 2012).

Appendix 2. Level 2 Codes for ethnicity data (Ministry of Health, 2009)

Level 2 – alphabetical order		Level 2 – code order	
Description	Code	Code	Description
African (or cultural group of African origin)	53	10	European NFD
Asian NFD	40	11	New Zealand European
Chinese	42	12	Other European
Cook Island Māori	32	21	Māori
Don't know	94	30	Pacific peoples NFD
European NFD	10	31	Samoan
Fijian	36	32	Cook Island Māori
Indian	43	33	Tongan
Latin American/Hispanic	52	34	Niuean
Māori	21	35	Tokelauan
Middle Eastern	51	36	Fijian
New Zealand European	11	37	Other Pacific peoples
Niuean	34	40	Asian NFD
Not stated	99	41	Southeast Asian
Other Asian	44	42	Chinese
Other ethnicity	61	43	Indian
Other European	12	44	Other Asian
Other Pacific peoples	37	51	Middle Eastern
Pacific peoples NFD	30	52	Latin American/Hispanic
Refused to answer	95	53	African (or cultural group of African origin)
Response unidentifiable	97	61	Other ethnicity
Samoan	31	94	Don't know
Southeast Asian	41	95	Refused to answer
Tokelauan	35	97	Response unidentifiable
Tongan	33	99	Not stated

Appendix 3. The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (The Office of Minority Health, 2013)

Principal Standard

- 1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

- 2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
- 3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
- 4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

- 5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- 6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- 7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- 8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

- 9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
- 10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
- 11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- 12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- 13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
- 14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
- 15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.