Submission to the Independent Hospital Pricing Authority (IHPA) *Draft Work Program 2014-15*

July 2014

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Introduction

The Victorian Foundation for Survivors of Torture (Foundation House) is an agency that provides services and support for people of refugee backgrounds who have fled persecution, torture and war-related trauma to find safety in Australia.

The Victorian Refugee Health Network is auspiced by Foundation House. The Network brings together health, community and settlement services to build their capacity to provide more accessible and appropriate healthcare for people of refugee backgrounds. The Reference Group includes senior representation from these sectors, peak bodies and relevant government departments. The Network is part of the Refugee Health Network of Australia.

In 2013 Foundation House published the report, *Promoting engagement of interpreters in Victorian health services* that included a literature review, extensive stakeholder consultation and advice, legal advice and survey of educational institutions providing health practitioner education in order to better understand facilitators and barriers to interpreter services provision in healthcare settings. This submission is based on the findings of that report.

Response to the IHPA Work Program 2014-15

The primary focus of this submission is *Program objective 2: Determination of the NEP and NEC for public hospital services, NEP determination – iv Consideration of an adjustment factor for Culturally and Linguistically Diverse patients.*

It also responds to:

- the Work Program objectives in calling for submissions to: *enhance focus on the equitable funding of public hospitals* and *improve efficiency, accountability and transparency across the public health care system*
- Program objective 1 relating to pricing for quality and safety.

This submission provides an overview of the evidence for an adjustment for low English proficiency (LEP) to the National Weighted Activity Units (NWAUs). It is recommended that IHPA undertake a cost analysis of services for LEP patients as part of the 2014-15 Work Program as part of the considerations of an adjustment factor for Culturally and Linguistically Diverse patients.

The rationale for an adjustment for patients with low English proficiency (LEP) is two-fold that are consistent with IHPAs objectives:

- *Unavoidable costs associated with provision of interpreting services*

  The provision of interpreting services for patients with low English proficiency (LEP) is an unavoidable cost. The costs include interpreting service delivery, health practitioner time in providing interpreter mediated services, administration and equipment costs. These costs together with length of stay and related factors would need to be taken into account to undertake an accurate cost ratio analysis for LEP patients.

- *Quality and efficiency*

  There is a growing body of evidence that effective provision of interpreting services results in better quality and cost effective care, including reduced length of stay associated with interpreter services provision for LEP patients.

These factors are explored in greater detail below (see pages 3-7). Levels of English language proficiency vary significantly across different regions of Australia and the costs of providing interpreters will vary depending on the activity type. The differential population distribution indicates the need for a cost adjustment to be activity-based rather than a cost that is borne equally across all health services.

Background

Appropriately credentialed interpreters should be an essential part of the health care team for patients with low English proficiency. The failure to use credentialed interpreters when required presents significant risks to hospitals, practitioners and patients, due to potential for misdiagnosis, patients' misunderstanding of health practitioners' advice or patients being unable to give informed consent to treatment because they do not understand the nature and associated risks of the treatment/procedure[1]. The benefits of engaging credentialed interpreters are well recognised and include improved communication, greater utilisation of services, improved clinical outcomes, and more satisfaction with care.[2]

The importance of using credentialed interpreters is recognised in the *Australian Charter of Healthcare Rights* and *the Australian Safety and Quality* (ASQ) *Framework for Health Care*. Communication is one of the charter rights and working with credentialed interpreters is a strategy identified in the guidance material to support both users and providers of health services to achieve this right. Guides that have been developed for healthcare teams, managers and other personnel to embed the *ASQ Framework for Health Care* in the healthcare system, include advice relating to the engagement of interpreters.

A recent report, *Promoting engagement of interpreters in Victorian health services* highlighted significant shortfalls in the engagement of credentialed interpreters in a range of health settings, including hospitals.[3]

Inadequate funding was identified as a significant barrier to engaging credentialed interpreters in healthcare settings and the report recommended "that the IHPA should include price loadings for the provision of interpreting services as a component of the national pricing for public hospital services".[4]

Demographics

Around 3% of Australians have low English proficiency, defined as speaking English 'not well' or 'not at all', and are therefore reasonably expected to require interpreting services in a health setting. People with low English proficiency comprise particularly vulnerable populations including new arrival humanitarian settlers[i,5] and older adults from more established migrant backgrounds.[6,7]

The distribution of people with low English proficiency varies between and within states as well as within cities. For example, 4% of Victorians have low English proficiency, which is accounted for by 5% of the population in Greater Melbourne and only 0.8% in regional Victoria.[8]

Legislative & policy context

The National Health Reform Agreement outlines IHPA's role of:

> *determining adjustments ('loadings') to the national efficient price required to take account of legitimate and unavoidable variations in the costs of service delivery, including those driven by hospital size, type and location (Clause B3 (g))*

Another section of the Agreement refers to loadings 'in respect of patient characteristics, and service location' (Clause A56).

[i] 91% of Australian humanitarian arrivals 2008 – 2013 had 'nil or 'poor' English when they arrived in Australia.

The Agreement provides that:

> *In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:*
> *a. hospital type and size;*
> *b. hospital location, including regional and remote status; and*
> *c. patient complexity, including Indigenous status (Clause B13).*[9]

Consideration of a low English proficiency adjustment is consistent with Clause B3 relating to legitimate and unavoidable variations in the costs of service delivery, Clause A56 relating to patient characteristics and Clause B13 relating to patient complexity.

IHPA review of CALD adjustment

In 2013-14, IHPA reviewed the National Hospital Cost Data Collection (NHCDC) and Admitted Patient Care activity data sets to ascertain whether an adjustment factor for culturally and linguistically diverse (CALD) patients was warranted for the *2014–15 Pricing Framework*. These data sets did not provide sufficient evidence and IHPA undertook to work with jurisdictions to examine additional data sets to further analyse CALD patient costs.[10] 'Country of birth' is available on these data sets[ii], but not 'interpreter required', 'preferred language' or 'year of arrival'.

There is more robust evidence for a more specific adjustment for low-English proficiency/requirement for an interpreter, rather than a broader CALD related adjustment. 22% of the Australian population are born in non-English speaking countries (and included in the larger CALD cohort) while only 3% have low English proficiency that indicates the need for interpreting services consistent with *Australian Charter of Healthcare Rig*hts and the *Australian Safety and Quality (ASQ) Framework for Health Care.*

Low English proficiency adjustment

The following sections explore two inter-related factors that are recommended for consideration of an adjustment for patients with low English proficiency:

- Unavoidable costs associated with provision of interpreting services
- Quality and efficiency.

Unavoidable costs associated with provision of interpreting services

Requirements for interpreting services may vary across health consultations. Those who speak English 'not well' or 'not at all' would be expected to require an interpreter for all health consultations[11], to enquire about subjective health status, explain procedures, gain consent for examinations and other invasive procedures and explain follow up care. Interpreters may also be required in certain situations for people who self-report that they speak English well, as they may struggle to understand complex health terms, and stressful or unfamiliar situations may affect patients' ability to communicate effectively.[12]

The costs associated with provision of interpreting services include:

- The remuneration of the interpreters who are engaged, which will vary significantly depending on for example whether they are contracted from a private provider or employed by the hospital
- The additional time taken by a health practitioner to undertake a consultation when working with an interpreter[13]
- The administrative costs associated with arranging interpreting services
- The infrastructure costs for equipment required for telephone/video interpreting.

[ii] National Minimum Data Set (NMDS) NHCDC Round, http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nat-hosp-cost-data-collection-round-16 accessed 7th July 2014 and National Minimum Data Set (NMDS) Admitted patient care NMDS 2013-14 available on: http://meteor.aihw.gov.au/content/index.phtml/itemId/491555 accessed 7th July 2014

Price Adjustment for the National Weighted Activity Units (NWAUs)

It is recommended that an adjustment for National Weighted Activity Units (NWAUs) similar to the approach taken for paediatric, indigenous, remote and private patients be explored. Subject to further analysis, the frequency of adjustments, based on low English proficiency population data is comparable to the rate of existing adjustments for the subacute model: paediatric adjustment applied to 0.6% of activity; indigenous adjustment to 1.5%; remoteness to 6.6% and private patient to 17.6%.[14]

Patients who attract this adjustment would be those who require an interpreter.

The 'interpreter required' data item is included in:

- the Victorian standard hospital data collection systems, the Victorian Admitted Episodes Dataset (VAED)
- the Queensland Hospital Admitted Patient Data Collection (QHAPDC)

In addition, the NSW Ministry of Health *Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016* requires reporting on the use of interpreters via the routinely collected Local Health District data sets. Other states and territories would need to be checked.

The existing data items (interpreter required) could be used to attract a low English proficiency (LEP) adjustment. There are however, significant limitations in using 'interpreter required' and 'interpreter usage' to estimate potential adjustments/price for LEP given reported shortfalls in current interpreter services provision. A realistic adjustment needs to take into account:

- Additional costs for interpreting services, additional health practitioner time, administration and equipment,
- Longer length of stay (LOS) mitigated by the provision of effective interpreter services (including phone, video or face to face), as evidenced by the Northern Hospital example in Victoria (see page 7).

The level of adjustment would need to be modelled against typical interpreter services provision across Australian Refined Diagnostic Related Grouping (AR-DRG), Australian National Subacute and Non Acute classification (AN-SNAP) or other relevant classifications, including emergency department presentations.

The starting point for calculation would be interpreter services required across average length of stay/ outpatient appointment duration and numbers of practitioners typically required (for example, medical, physiotherapy, pathology, pharmacy).

Implementation or change of the funding model for patients with low English proficiency should be supported by quality standards and accreditation processes reflecting Commonwealth and State policies regarding requirements for interpreting services if IHPA objectives relating to cost effectiveness and quality are to be realised.

Quality and efficiency

The related consideration of a price adjustment for patients with low-English profiency is that of quality and efficiency. There is a growing body of evidence that effective provision of interpreting services results in better quality and cost effective care.

Working with credentialled interpreters in health consultations improves quality of care, improves client safety, promotes access to health care, reduces unnecessary health expenditure, reduces stress on families and minimises risk of legal complications.

Good communication between a health practitioner and a client during a clinical consultation is essential to ensure the safety, quality and effectiveness of care.[15, 16, 17, 18, 19, 20, 21]

Quality of care

> 'When I did my glucose test I had no interpreter booked for that appointment. After consuming the fluid my condition was very bad I was fainting but I was not able to let the staff know about my condition. I had to wait till I was better. If I had interpreter I could have let them know about my condition.'
>
> *Research participant reported in Yelland et al, (2013), Having a baby in a new country, Murdoch Children's Research Institute, Victorian Foundation for Survivors of Torture, p.17*

When interpreting services are required, credentialled interpreters should be engaged as they are less likely to make errors and any errors made are less likely to be of clinical consequence.[22, 23, 24] Credentialled interpreters operate under a code of professional ethics to ensure their services are impartial and confidential,[25] and their level of skill is of a sufficient standard.[26]

When communication barriers exist, the quality of care for clients diminishes.[27, 28] Some consequences are: poor understanding of discharge diagnosis, poor understanding of treatment plans, late presentation of symptoms, and reduced likelihood of participating in medical decision making.[29, 30, 31] Victorian community services workers have reported that they 'are aware of multiple incidences where miscommunication within consultation rooms and hospital settings have had negative impacts on clients health outcomes'.[32]

The Australian Psychological Society noted the way in which quality of care diminishes in the therapeutic context when communication barriers exist[33].

> *It is impossible to provide a high quality psychological service without effective communication between the psychologist and the client. Inadequate communication with clients who have low English proficiency limits their ability to access services and also has a profound impact on the quality of treatment received when they do access services.*
>
> *In psychological settings communicative demands are complex. Clients are required to communicate difficult experiences and to discuss interpersonal relationships. In the case of refugees, extremely sensitive issues of torture and trauma are also likely to be raised in a psychological context. In the presence of a thought disorder, delirium, dementia, anxiety or depression, the capacity to communicate in a second language is further impaired.*
>
> *Inadequate communication will limit the capacity of the psychologist to:*
>
> - *develop a therapeutic relationship*
> - *understand the point of view of the client*
> - *understand the cultural context of the client*
> - *conduct an assessment*
> - *formulate a diagnosis*
> - *reach agreement on an appropriate treatment plan, and*
> - *monitor and evaluate the effectiveness and any adverse effects of treatment.*[34]

Conversely, working with credentialled interpreters has demonstrated more effective clinical treatment, greater client satisfaction with treatment, and increased likelihood of desired health outcomes.[35, 36]

> A WA government review recommended the utilisation of interpreter services after finding that 'Client care was compromised by communication difficulties between clinicians and clients whose primary language was not English.'
>
> *Government of Western Australia, (2008), From death we learn, p 6.*

Client safety

> A number of preventable adverse events have occurred in Australia where qualified interpreters were not engaged, including a 35-year-old Afghan refugee who died and two clients who had procedures undertaken on incorrect body parts.
>
> *Bird, S., (2010), Failure to use an interpreter, Australian Family Physician, Vol. 39 (4), p 241; Department of Human Services, (2004), Sentinel event program: annual report 2003–04, p 24.*

Communication barriers increase the risk of medication errors[37, 38] and adverse health outcomes.[39, 40, 41]

An Australian study found that some informants reported 'adverse events such as missing dialysis appointments, taking medications inappropriately, and non-compliance with renal diet and fluid restrictions' associated with language barriers among dialysis patients.[42] A study at a Queensland hospital found that that use of interpreting services was associated with a reduced likelihood of an adverse pregnancy outcome.[43] Failure to recognise this relationship 'stands as a resident pathogen within the health care system'.[44] Good communication facilitated by a credentialled interpreter is therefore considered essential to client safety.[45, 46]

Access to health care

Research demonstrates that communication barriers reduce access to health care,[47, 48, 49, 50, 51, 52, 53] including:

- fewer hours of home and community care[54]
- fewer visits to health practitioners[55, 56]
- lower attendance at antenatal classes[57, 58]
- lower likelihood of being referred for a follow-up appointment following an emergency department visit[59]
- less participation in preventive screening[60, 61]
- less utilisation of telephone support/advice lines.[62]

Credentialled interpreters have been found to improve access, with increases in clinical visits, follow-up visits, number of prescriptions written and filled, preventive screening services, and the likelihood of referral for mental health care for asylum seekers.[63, 64, 65, 66, 67, 68, 69] Parents have reported that availability of interpreters would make it easier to access health care for their children.[70]

> Concern has been expressed that many elderly clients from a non-English-speaking background are isolated in their homes and are not accessing services due to both language and service delivery barriers.
>
> *HREOC, (2005), Not for service: experiences of injustice and despair in mental health care in Australia, p 762.*

Unnecessary health expenditure

Communication barriers unnecessarily increase expenditure on health services as they are associated with:

- higher non-attendance rates at clinics[71]
- increased diagnostic investigations[72]
- higher hospital admission rates[73, 74, 75]
- increased length of stay in hospital and emergency departments[76, 77, 78, 79]
- decreased likelihood that clients will seek early treatment at the onset of cardiovascular disease[80]

- more frequent intravenous hydration.[81]

Conversely, providing credentialed interpreter services has been linked with reduced rates of people returning to emergency departments[82] and failing to attend appointments.[83] Working with credentialed interpreters has been found to increase the use of preventive or early detection services, which reduces the costs associated with late-stage disease treatment or emergency visits.[84, 85]

Recent US research suggests that working with credentialed interpreters can also significantly reduce the likelihood of patients being readmitted to hospital.[86] This research examined the cases of 3,060 low-English-proficiency patient admissions for readmission and found that the rates of readmission were significantly higher for patients who did not have an interpreter at admission or discharge. 24.3% (103/423) patient admissions who did not have an interpreter present at admission and discharge were readmitted within 30 days, compared to 16.9% (163/963) of patients with an interpreter at admission only, 17.6% (85/482) of those with an interpreter at discharge only, and 14.9% (178/1192) with an interpreter at both admission and discharge day (Chi-square = 19.5, df = 3, $P < 0.001$).

In Victoria, Northern Health has demonstrated a link between the engagement of credentialed interpreters and the length of stay in hospital. Northern Hospital data shows a decrease in bed stays for low English proficiency patients with increased interpreter services provision, but the costs associated with LEP patients maybe expected to be higher than English proficient patients due to the cost of interpreting services provision and longer Length of Stay (reduced but still higher than English proficient patients).[87]

Table 1: Northern Health language services activities and inpatient length of stay (LOS) data[iii]

Factor	2012/13	2011/12	2010/11	2009/10	2008/09	2007/08
Language services staff	15.1	15.1	12.1	10.6	8 (+2.6 casual)	5
Requests for interpreting services & growth	45,075 (-2%)	45,996 (+15%)	39,940 (+6.5%)	37,480 (36%)	27,501 (+61%)	17,000
Transcultural training sessions & #staff	78 (315)	85 (272)	92 (295)	77 (na)	60 (na)	35 (na)
Online transcultural training sessions	42	NA	NA	NA	NA	NA
# of translated documents & words	38 (98,816)	52 (89,960)	77 (70,830)	49 (50,202)	33 (33,303)	15 (55,554)
LOS of English Speaking (ES) patients	4.6	4.6	4.7	5.4	6	6.1
LOS of Low English Proficient (LEP) patients	6.3	6.2	6.4	7.7	8.4	8.8
LOS gap: ES vs LEP patients	1.7	1.6	1.7	2.3	2.4	2.7

There have been similar international findings, with one study reporting a reduction of three days length of stay in hospital (over a four-year period with interpreter interventions).[88] There is a need for further formal research in this area, particularly in the Australian context.[89, 90]

An associated question is the costs associated with failure to use interpreters in emergency departments. A study regarding access to specialist services identified 'unknown or unspecified causes of morbidity' as the most common diagnosis for those from refugee source countries presenting to emergency departments in Victoria in the period 2003–2008. In comparison, for the broader Victorian population 'unknown and unspecified causes of morbidity' was the 16th most common reason for presentations to emergency departments.[91] There may be a number of causes for this, including clinical presentations that were unable to be classified. However, it certainly indicates the need for further investigation regarding the care provided to patients with low English proficiency in emergency departments, and clinical outcomes.

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Endnotes

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