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Culturally and linguistically diverse (CALD): terminology and standards in reducing healthcare inequalities

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The World Health Organization (WHO) reports healthcare as a human right, calling to action Universal Health Coverage principles, whereby health for all population groups should be adequately provided without financial hardship.[1] On 23 December 2020, the Executive Board of the WHO proposed the Agenda on achieving better oral health as part of the universal health coverage and noncommunicable disease agenda towards 2030.[2] This Agenda is partly a consequence of oral healthcare which has been largely neglected in healthcare.[3] Subsequently, oral healthcare is inadequately provided in many countries, whereby only five countries cover the cost of dental care; Austria, Mexico, Poland, Spain and Turkey.[4] The UK along with five other countries cover a large portion of dental costs,[4] but here in Australia we are lagging behind.[5]

Globally, migrant populations experience a myriad of barriers to oral healthcare, for example, in the USA, elderly Chinese migrants reported language barriers,[6] while in the UK, African migrants affirmed English proficiency challenges, thereby hindering access to healthcare services.[7] Access and utilisation to oral healthcare by migrants is not merely afflicted by cost alone, but because migrant groups face literacy, cultural and other barriers.[3,8-10] In Australia, oral healthcare services are delivered in the private sector with concessions to low-income, children and eligible groups. Consequently, this means that migrant populations are unable to access timely oral healthcare services. Hence migrant populations are at greater risk of poor oral health, without basic universal oral healthcare in Australia, thereby hindering psychosocial aspects of self-esteem and quality of living. Nearly 30% of the population of Australia is overseas born and over 300 languages other than English are spoken.[11] This migrant group is also commonly referred to as the culturally and linguistically diverse (CALD) population. CALD groups under-utilise mainstream healthcare services,[12] however, healthcare that meets the needs of all CALD groups is fundamental in reducing healthcare inequalities. This is recently evident with the COVID-related communication gaps in health information.[13]

National definitions of CALD within research, policy and government documents differ substantially, making it difficult to collate population specific healthcare needs. Subsequently, the twenty-year-old Standard CALD definition, as defined by the Australian Bureau of Statistics requires a renewed review, with 2nd and 3rd generation CALD groups, who may be Australian born, converse in English, and yet be ethnically diverse. Thus, who is classified as CALD in research and policy, and are CALD groups represented within the current Australian context, taking into account generational differences? To help shed light on some of these aspects, in this commentary, we provide clarity around CALD terminology within an Australian context, and identify the need for nationally consistent Standards, to understand population relevant healthcare needs.

Brief background from Non-English Speaking Background (NESB) to CALD

From a historical context, migration policy changes occurred during the 1960s.[14] Increases in migrant populations were seen from non-English speaking countries. By the 1970s the Whitlam Labor Government recognised immigrant special needs which resulted in the multiculturalism policy. Key features of this policy celebrates cultural diversity, including the significance of immigrant political participation.[14] Although it wasn't until 1984, in New South Wales that "the right of equality of access to healthcare services regardless of cultural or linguistic skills"[14(p298)] shifted focus from individual responsibility, to the healthcare system. The Commonwealth government committed to health policy for Multicultural Australia by 1988.[14]

Within this multicultural policy, the term 'Non-English Speaking Background' (NESB) was widely cited within government policy documents to describe migrant population groups, however in 1996, the term culturally and linguistically diverse (CALD) replaced the former NESB. Changes in CALD standards were agreed by Commonwealth, State and Territory Ministers at a meeting of the Ministerial Council of Immigration and Multicultural Affairs in 1996.[15] CALD was introduced to be inclusive of individuals based on more than simply language, as problems arose with the term NESB.[16]

CALD definitions used in reports and policy documents vary by State and organisations. The Australian Institute of Health and Welfare describes CALD in a report as a parent who is overseas born, conversing in a language other than English.[17] Dental Health Services Victoria[18] refers to CALD as differing from the English speaking majority, embracing differences in religion, spirituality, racial backgrounds, ethnicity and language. While the Australian Government Department of Foreign Affairs and Trade goes a step further to include different cultural backgrounds, traditions, values and beliefs within the CALD definition.[19] Despite the good intentions of the CALD semantic and the lack of a universal definition in place, some challenges are presented here. CALD groups are heterogenous, so despite grouping individuals in this category, the uniqueness within cultures and societies is understated. Others argue that by using this CALD term, inequities maybe perpetuated by 'racism and othering' in social structures.[16,20] Additionally, categorising 'who' is defined as CALD, is flexible and thus complex, whereby

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overseas-born individuals from English speaking countries such as Ireland and the United States are then encapsulated in this definition. Therefore, on the one hand, CALD is inclusive of diversity, but on the other hand, this presents challenges in how effective the term is in dissolving inequity and 'othering' through exclusion.[16,20]

Alternative options to the CALD term have been suggested by Sawrikar and Katz,[16] who coined the term 'Australians Ethnically Diverse and Different from the Majority' to encompass belonging, embracing language, culture and race to decrease exclusion as 'other' from the mainstream population. The idea behind this suggested term is to change the discourse to reduce social exclusion and inequity and advocate an Australian belonging. Although the 'ethnic' label would offer a limited reduction in health disparities as previous studies link 'ethnicity' with racism.[21] Another sociologist, Dr Adusei-Asante also reported problems with the CALD term affirming that the label 'inferiorises' non-English speaking minority population groups as 'deviants' by creating divisions into 'us' and 'them'.[22] The Federation of Ethnic Communities' Councils of Australia currently recommends the term culturally, ethnically and linguistically diverse (CEALD).[23]

Implementing standards for statistics on cultural diversity

Researchers are presented with an additional challenge here; CALD groups are largely under-represented not only in leadership roles within Australian organisational structures[24] but also in research, which limits evidence in how to improve access, utilisation and policies specific to community needs.[25] In 2001, the Department of Immigration and Multicultural Affairs together with the Australian Bureau of Statistics[15] launched a guide to implementing standards for statistics on cultural diversity. Now twenty years on, a review of the standards to better understand access and equity issues in CALD groups in the contemporary Australian context is required. The ABS Standards incorporated a Minimum Core Set of four variables[15]:

- Country of birth
- Indigenous status
- Languages spoken other than English at home
- Proficiency in spoken English

Additional variables for potential inclusion are ancestry, country of birth of mother and father, religious affiliation, first language spoken, language spoken at home, main language spoken at home and year of arrival in Australia. Yet survey data and research methods often miss numerous variables listed here, as well as other factors, for example the cultural or religious background of an individual.[26] Requesting such information on surveys is not only sensitive but has the potential for 'othering' groups from Anglo-Australians, therefore, how can researchers, policymakers and government utilise CALD variables in more effective ways to reduce healthcare inequity? Scholars have utilised English proficiency, by administering surveys in the CALD native or English language and/or the number of years in the host country as proxy measures for determining CALD groups over time/generations.[27] These proxy measures aren't necessarily robust to account for cultural generational differences.[28]

Healthcare inequity arises from unequal social relations[29] and in reducing these disparities, a complex system of socio-cultural, economic and policy changes are needed. Further qualitative exploration is required[30] in understanding whether CALD or CEALD is the most appropriate term to use going forward, and equally important, how can we reduce the widening oral health and general healthcare inequities? For example, the WHO Agenda on Oral Health 2030, affirms strengthening health systems through integrated, population wide oral health prevention measures, and by including communities in the process of planning and monitoring programmes related to preventive oral healthcare.[2] Promoting population health and reducing disparities can be adopted through Sustainable Development Goals 2030, which incorporate human rights and Universal Health Coverage.[31] Goal 3 dictates good health and wellbeing, in an inclusive society that endorses wellbeing for citizens, with attention to tackle vulnerabilities and population specific needs.[32] Achieving health equity targets command global, local, collaborative efforts between different sectors, from health workforce, economic sustainability, environment, private industry and government (among others).[32,33]

More broadly, the COVID-19 pandemic underscored socioeconomic and sociocultural inequities experienced in CALD communities. In the first year of the COVID-19 pandemic in Australia there were four times the number of deaths in the lowest socioeconomic groups compared with the highest group.[34] Socioeconomic conditions exacerbate inequities whereby CALD groups are likely to be in precarious employment in sectors like aged care or low income jobs, which thereby poses the inability to 'work from home'.[35] Marmot affirms that CALD groups are disproportionately represented in high risk occupations, reside in deprived areas and experience structural inequities, including racism.[36] Therefore, these risks accumulate to impact health outcomes, as reported within the *Build Back Fairer: The Covid-19 Marmot Review* in England. Higher COVID-19 risk and mortality rates are reported in areas of more disadvantage.[36] Similarly, in Australia hard lockdowns disproportionately impacted CALD groups in NSW and Victoria. Language barriers, varied English literacy levels and a myriad of barriers in accessing healthcare services are only further complicated by confusing health messages.

Pandemic-related policies tended to neglect sociocultural factors that affected CALD communities. This was evident firstly from inaccurately translated healthcare information, and then the ongoing inadequate vaccination messages. Moreover, CALD groups are likely to live in multigenerational households, which limits social distancing ability.[37] Therefore, a positively COVID-19 tested family member could not isolate within their own residence. The pandemic deepened structural inequities within the system, with policing that targeted specific areas. In effect, areas that were more prone to health disadvantage, with a greater proportion of CALD migrants, precarious employment, varied literacy levels, overcrowded households and lack of support resources, were not given the priority proportionate to their higher risk levels.[37] These policy approaches reflect the relative lack of community inclusive consultation, local champions and CALD community leaders within policy and health planning processes.[25] Lessons from the pandemic underline the need for more effective collaboration with multicultural organisations and strengthening the ABS CALD measures in research and public policy. A nationally consistent CALD standard is long overdue and essential to inform and implement healthcare programs in culturally relevant ways that meet population needs. Collecting CALD data is just one step in a complex web of factors that are required to alleviate healthcare inequities.

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Notably, Indigenous status is included on national data collection forms, as diverse groups who experience significant oral and general healthcare disparities, compared to Australian born counterparts.[38] Although government reports and scholarly research utilise the term CALD, in reference towards migrant groups, the definition used within policy and research remains unclear.[16,17] The ABS Guide, as described above is only a general suggestion, with flexibility in government structures and organisations, in adopting and/or implementing their own standards. It's time to renew and revise this ABS to a nationally consistent standard and potentially consider CEALD, as embracing ethnic differences within differing generations in the population.[23] Consultative discussion with multicultural communities, with a renewed review of the ABS standards would improve health data information for migrant groups and the potential to address health disparities through specialised, culturally relevant interventions.

Referring to a heterogenous group, the term CALD positively evolved from NESB, but there is still insufficient clarity as to who is classified as CALD and whether second generation CALD groups should be included within this definition. With the global mobility of migrants worldwide,[39] reducing oral health inequities between and within societies is of prominence, and this CALD term should reinforce this. Despite some drawbacks, we acknowledge that firstly, the semantic CALD or CEALD is valuable for identifying population health needs in research and policy. Secondly, we endorse the need for nationally consistent CALD measures, thereby embracing ethnic groups, individuals that differ from the English speaking majority in terms of culture, language, race, religious, values or beliefs. A review of the ABS Standard definition is well overdue to identify the contemporary healthcare needs of a diverse population. Research and policy discourses should be positive, embracing and inclusive, without 'othering', and ultimately contribute to reducing health inequities and inequalities in a multicultural Australian society.

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