Towards Better CALD Health Data: **A National Opportunity.**

October 2025

Policy Brief

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Introduction

Culturally and linguistically diverse (CALD) populations in Australia remain critically underserved by existing national health data systems. Despite longstanding recognition of CALD communities as priority populations in major policy documents such as the *National Preventive Health Strategy 2021–2030* (NPHS), there is persistent inconsistency in how cultural, linguistic, and migration-related variables are collected, reported, and integrated into the policy process. The lack of quality, disaggregated data fundamentally limits visibility of CALD experiences in the healthcare system, undermining the design of equitable services and outcomes.

National datasets continue to rely on high-level or proxy indicators - such as "born overseas" or English proficiency - that fail to adequately reflect the diversity and complexity of CALD populations. Such limitations are compounded by variable data collection practices across jurisdictions, reduced participation rates due to mistrust or accessibility issues, and underutilisation of available data in program evaluation and strategic decision-making.

A strong and persistent national discourse calls for the importance of improving CALD data systems through more inclusive, standardised, and actionable methods. Key contributions come from Monash University's Health and Social Care Unit (HSCU), which has undertaken foundational work on multicultural health equity and systems design; the Royal Australian College of General Practitioners (RACGP), whose position statements emphasise improved cultural identifiers in patient records; the Refugee Health Network of Australia, which has highlighted systemic exclusions in current data regimes; and the 2020 Federation of Ethnic Communities' Councils of Australia (FECCA) report *If we don't count it, it doesn't count*, which called for national coordination and disaggregation of CALD data. These perspectives have been echoed and validated through Departmental processes, particularly the October 2024 Roundtable on Improving Multicultural Health in Australia, which reinforced the need for culturally responsive data reform as a foundation for future health equity policy.

Australia's domestic efforts align with an expanding international policy framework that recognises the need for improved refugee and migrant data systems. As a signatory to the Global Compact on

Refugees, Australia has committed to strengthening national data capabilities to better support protection, inclusion, and service planning for migrant populations. The Compact calls for improved data comparability, disaggregation, and cross-sector coordination, particularly across health, protection, and social policy domains. Australia's participation in UNHCR-led global pilot projects, including early work on linked data systems for humanitarian entrants, has demonstrated promising national practice. Building on this foundation, there is a timely opportunity to show global leadership by advancing scalable models for migrant health data integration that respond to both domestic equity goals and international obligations.

While the importance of strengthening CALD data systems has been widely recognised across community, professional, and research sectors, progress has been gradual and fragmented. Despite longstanding technical insights and consistent calls for reform, national implementation has remained uneven. This brief helps consolidate momentum and identify expert-informed, practical pathways for improving the quality, comparability, and use of CALD health data. It also seeks to clarify the enabling policy, governance, and performance mechanisms through which a more coordinated and culturally responsive data infrastructure might be effectively advanced within Australia's federated health system.

Approach

This brief explores the adequacy and coherence of current health data systems in capturing and applying information related to CALD populations. It supports efforts to improve data consistency, quality, and use by clarifying the structural and policy conditions required to achieve a more coordinated and inclusive national approach.

Consultation across the MRHP followed targeted scoping work to understand the persistent limitations affecting the collection, quality, and use of CALD health data across Australia. It responds to long-standing calls for reform and aims to ensure that CALD perspectives are meaningfully and systematically represented in national health data architecture.

The work examined technical, cultural, and operational barriers to high-quality data collection, assessed alignment and fragmentation across standards and frameworks, and surfaced practical strategies for embedding CALD data governance in national health infrastructure. A central objective was to identify policy mechanisms and accountability levers that enable culturally responsive data practice at scale. Findings were synthesised thematically to consolidate areas of consensus and to map realistic, system-level opportunities for reform.

Findings

This brief identified a series of key thematic challenges that underscore the need for structured, system-wide reform in how health data is collected, governed, and used for CALD populations.

- **Inconsistent data capture:** Cultural, linguistic, and migration-related indicators are collected inconsistently across datasets and jurisdictions. Core demographic fields - such as ethnicity, language spoken at home, or country of birth - are coded with variable definitions and levels of detail, impeding comparability and data integration across systems.
- **Barriers to Participation:** CALD community participation in data systems is often hindered by structural and practical barriers. These include language constraints, culturally inappropriate questions or collection settings, and lack of trust stemming from unclear data purposes or concerns about confidentiality. Such factors undermine participation from the very populations most affected by data invisibility.
- **Under-representation in major datasets:** Many CALD groups are missing from administrative and survey datasets due to exclusionary sampling practices or accessibility challenges - particularly affecting people with low English proficiency, recent arrivals, or those on temporary visas with limited interaction with mainstream health services. This leads to policy blind spots and inequitable planning.
- **Misaligned data variables:** A disconnect exists between the demographic data commonly collected and the information actually required to inform equitable health policy. Data coding such as “born overseas” or “language spoken at home” offer limited insight into system interaction, cultural health practices, or structural vulnerabilities.
- **Limited data use and governance:** Existing CALD data is rarely applied in performance monitoring or planning. Lack of linkage across systems and absence of feedback mechanisms mean collected data often fails to inform equity-driven decision-making or advance community accountability.

Finally, Australia lacks a nationally agreed minimum core dataset for CALD health information. While some states have progressed jurisdiction-specific models or initiatives, there is no federated coordination. This fragmentation continues to limit national comparability and accountability.

Improving CALD health data requires action on both the content and the structure of national data systems: what data is collected, how it is collected, and how it is governed. Strategic directions arising from this brief include standardising core indicators, embedding culturally safe data collection practices, improving digital and governance alignment, and ensuring regular, accessible feedback to CALD communities. These findings inform the policy recommendations that follow.

Key Insights & Recommendations

The consultation findings are structured around five intersecting themes, each concluding with strategic recommendations.

1. The Case for National Data Consistency

Achieving consistent collection of core CALD indicators across all levels of the health system - from primary to tertiary care - is critical to improving equity, continuity of care, and the effectiveness of health system responses. However, the current landscape is marked by significant variability between jurisdictions and service settings. This inconsistency limits the comparability, interoperability, and policy utility of CALD health data at both state and national levels. While some progress is occurring through inclusion of standard CALD indicators in primary care software and hospital systems, there is no national mandate requiring uniform collection.

Five key data items are considered both achievable and essential:

1. Country of birth
2. Year of arrival
3. Language spoken at home
4. Need for interpreter
5. Self-identified cultural background

The selected data items reflect both the practical feasibility of their collection and their combined ability to generate a nuanced understanding of an individual's cultural and linguistic needs, thereby informing effective policy. Country of birth alone does not adequately describe cultural identity, as diverse cultural groups may originate from the same country; self-identified cultural background offers this critical distinction. Language spoken at home and need for interpreter capture both communication needs and the degree of language support required to ensure safe care. Year of arrival provides important context for system literacy and access barriers, with recent arrivals often requiring additional support.

Incorporating these five data items as **mandatory core fields**, rather than optional inputs, would significantly enhance the quality and comparability of CALD health data. Their inclusion within routine data capture systems supports targeted public health messaging, service design, and equitable resource allocation, without imposing undue operational burden on clinical workflows.

Key Recommendation 1: Introduce a mandatory national minimum dataset for CALD health indicators, comprising five core variables, and embed this in health service accreditation standards.

Key Recommendation 2: Align CALD data collection requirements across primary care, aged care, hospital, maternity, and mental health systems, including in immunisation and disaster response datasets, so as to more effectively configure data for responsive interventions.

2. Accreditation, Standards and Governance Mechanisms

National standards and accreditation frameworks represent the most immediate and effective levers for embedding CALD data reform. Despite earlier efforts to include CALD indicators in prior standards, consistent adoption has not been achieved. The upcoming revision of the National Safety and Quality Health Service (NSQHS) Standards, scheduled for the 2025-2030 cycle, presents a critical opportunity to embed CALD data-collection requirements across health services. Linking these requirements to accreditation and compliance mechanisms would ensure sustained and system-wide implementation.

Alignment across regulatory and operational levers is essential to maximise policy impact. Priorities include:

- Mandatory CALD data fields within clinical software platforms for GPs, aged care providers, and public hospitals;
- Inclusion of CALD health data collection as part of Continuous Professional Development (CPD) requirements for frontline health practitioners;
- Coordination between federal and state regulators to prevent duplication or inconsistency in reporting obligations.

Key Recommendation 3: Secure inclusion of CALD data collection requirements in the third edition of the NSQHS Standards (2025–2030), leveraging the upcoming engagement phase as a key reform window.

Key Recommendation 4: Embed CALD data collection protocols into primary care clinical software, hospital electronic records, and aged care platforms to ensure system-level consistency and ease of compliance.

3. Cultural Responsiveness and Participation

Cultural safety and trust are essential foundations for improving CALD data quality. Evidence demonstrates that individuals are generally willing to share cultural and migration-related information when the process is respectful, the setting is appropriate, and the purpose is transparent. Interpreters play a critical role in this process - not only supporting communication but acting as cultural mediators who help explain the importance of data sharing and foster understanding.

Health workers, including both administrative and clinical staff, require practical support to collect CALD data meaningfully. This includes training on the importance of CALD data, how to approach culturally sensitive questions, and how to communicate the purpose and use of the data collected. Strengthening workforce capability in culturally safe practices will improve both data accuracy and community confidence in the health system.

Transparency and feedback are also vital to maintaining trust. Providing CALD communities with regular and accessible feedback on what data shows and how it informs service planning reinforces accountability and ensures that diverse perspectives contribute to system improvement.

Future priorities include embedding cultural responsiveness in data collection protocols, providing structured training for all health service personnel, and establishing processes to ensure CALD data findings are routinely shared with affected communities in culturally appropriate formats. Embedding data-sharing mechanisms into project and reporting cycles from the outset will ensure transparency and community benefit are core features of Australia's health data system.

4. From Collection to Use: Embedding Data in Policy and Planning

While high-quality data collection is foundational, its ultimate value lies in how the data is used. Even where CALD data is captured, it is frequently siloed, under-analysed, or excluded from core evaluation and funding mechanisms. There is an urgent need to embed CALD data within key decision-making structures - such as health equity indicators, resource allocation models, population health strategies, and performance reporting frameworks.

Perinatal and women's health remain significant areas of data deficit, with limited documentation of maternal ethnicity and related cultural factors. Mental health screening - particularly for perinatal depression - was also identified as susceptible to cultural underreporting, contributing to underdiagnosis and service access gaps.

Future policy directions include requiring the integration of CALD data into all population health monitoring, equity targets, and program evaluations; and prioritising improvements in CALD data

capture across maternal, perinatal, and mental health services, ensuring these indicators are embedded in funding and performance frameworks.

5. Inclusion Beyond Medicare Data Capture

Many CALD population groups remain underrepresented in national health datasets due to Medicare-based data dependency. Asylum seekers, temporary migrants, and humanitarian entrants are often omitted from administrative systems despite active use of the health system. This produces systemic invisibility, particularly in service planning and during periods of crisis or disruption.

Assumptions persist that non-Medicare populations are either too small or not entitled to care. However, most CALD populations of concern hold Medicare and regularly access services. Data gaps often reflect system design rather than true levels of demand. National data systems must evolve to reflect the full spectrum of health service users, including those outside conventional administrative datasets.

Future policy directions include extending national data collection strategies to capture system users not represented in Medicare datasets - such as asylum seekers and temporary visa holders - and strengthening real-time data sharing across services and jurisdictions. This is especially critical for ensuring inclusive emergency response planning and continuity of care during public health crises.

Conclusion

There is clear momentum across clinical, research, policy, and community sectors to improve the quality and strategic use of CALD health data, recognising it as essential to equitable care and effective system planning. While this agenda has been consistently raised over many years, progress has remained incremental, often constrained by uneven implementation and the absence of strong structural levers. This brief does not seek to replace existing work in the field, but to sharpen, align, and support implementation of long-recognised priorities.

Key insights confirm the need to embed CALD data reform within the core infrastructure of the health system - through national standards, software integration, workforce development, and improved governance mechanisms. The upcoming 2025–2030 revision of the National Safety and Quality Health Service (NSQHS) Standards presents a particularly timely and strategic opportunity to advance this agenda.

The four recommendations outlined in this brief provide a targeted and achievable foundation for action. Together, they support a broader national effort to ensure that Australia's health data systems reflect and serve the diversity of its population.

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