

Building on Strength

Developing Australia's Bilingual and
Bicultural Health and Care Workforce

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MIGRANT & REFUGEE
HEALTH PARTNERSHIP

About Migrant and Refugee Health Partnership

The Migrant and Refugee Health Partnership was formed in 2016 to bring the health and the community sectors together to address systemic barriers to health access for migrant and refugee communities. The Partnership is the peak multicultural health body and provides a strong focus both on the health system capability to work effectively with migrants and refugees, and on strengthening health-promoting assets in migrant and refugee communities with a view to improving community health and wellbeing. The Partnership is auspiced by the Social Policy Group.



About the Social Policy Group

The Social Policy Group (SPG) is a national body with specialist expertise in social policy and program design with a focus on population diversity, social and community cohesion, gender equality, community participation and inclusion, systems' responsiveness, and community outreach and engagement. SPG combines strong governance and a comprehensive national approach, with a powerful community focus and a commitment to access and equity.

Introduction

This policy brief describes key opportunities for Australia to nurture and develop its bilingual and bicultural health and care workforce.

There is considerable evidence supporting the important and unique roles to be played by this workforce, especially in countries with large and diverse migrant populations. The linguistic and cultural skills they offer constitute a valuable national asset. Australia is well placed to take advantage of this, raising the prospect of migrant communities gaining greater access to quality and safe culturally responsive health and care services.

However, this prospect is far from a reality. Currently, many migrant communities struggle to find culturally responsive services, leaving them vulnerable to poor health and social outcomes. This comes at a significant cost not only to individuals and families, but to Australian society more broadly. Identification and training of the bilingual and bicultural workforce is haphazard at best, often missing altogether. Data to enable better understanding of the presence and impact of this workforce is scant.

This policy brief aims to collate the evidence necessary to change this situation, providing a small number of important recommendations about how best to nurture this vital human resource.

This paper first describes the role of bilingual and bicultural workforce and places it in the context of Australia's health workforce, as well as more broadly in the care (aged and disability) sector workforce. While data is limited, it is important to try to understand the extent of the roles these workers currently play and where they work.

This brief explores the evidence to support the importance of these roles. From an academic perspective, more traditional research and evaluation has occurred in relation to the role played by this workforce within health settings, rather than in care settings. It should also be noted that much of the evidence found is derived from other countries.

A commitment to the development of an Australian program of research and evaluation into the impact of the bicultural and bilingual health and care workforce is a clear recommendation made here and congruent with similar workforce research programs recently described in Europe (Kuhlmann et al 2018).

This brief then considers some of the key policy and other issues affecting the bicultural and bilingual health and care workforce in Australia. The contribution of this workforce during the COVID-19 pandemic has been crucial (Weng, Mansouri and Vergani 2021). It has played a key role in supporting migrant and refugee communities through promoting COVID-19 awareness and information, including vaccination preparedness activities. It has been successful in reaching deep into migrant and refugee communities and ensuring the provision of accurate in-language information.

This paper contends that, building on this experience, Australia is ideally placed to develop a strong, structured and sustainable approach to the development of its bilingual and bicultural health and care workforce. This will benefit the workforce itself, as well as Australia's diverse communities across the nation.

Recommendations

This policy brief has identified four key areas in which intelligent and targeted investment will support and grow Australia's bilingual and bicultural health and care workforce:



Workforce Development



Better Data Collection and Reporting



The Development of Standards



Encouraging Excellence

Several actions are listed under each of these investment areas.

Workforce Development

Recommendation 1

Federal and State/Territory Governments should work together to develop a dedicated workforce plan to first recognise and then increase the number and proportion of bilingual and bicultural health practitioners and health workers in health and care services who facilitate health and wellbeing outcomes for people from migrant and refugee backgrounds.

Recommendation 2

Federal and State/Territory Governments should consider and establish national workforce targets, in close consultation with relevant industry bodies and the community sector, to guide investment in the next generation of bilingual and bicultural health practitioners and health workers, including workers that facilitate access to, and navigation of, health and care services.

Recommendation 3

Workforce development should be supported by enhanced data collection on the changing demographics and health and care service needs of communities. This would permit workforce planners at Federal and State/Territory levels and service providers to better tailor their work (including in relation to hiring practices and service delivery) to the cultural and linguistic characteristics of particular communities. This should take place in consideration of both the size and levels of English proficiency in those communities.

Recommendation 4

Members of the bilingual and bicultural health and care workforce should be meaningfully engaged in the development of strategies to strengthen the impact and recognition of their contributions, both at organisational and workforce planning levels.

Better Data Collection and Reporting

Recommendation 5

The Federal Government, working with the Australian Institute of Health and Welfare and the Australian Bureau of Statistics—as well as in consultation with community and health and care sectors—should improve data collection processes to ensure access to data on the number, demography and spread of the bilingual and bicultural workforce. As a minimum, this should encompass the health, aged and disability care sectors. The Government should further resource an audit of the current workforce.

The Development of Standards

Recommendation 6

To support the workforce plan, Federal Government should invest in the development of a national competency standards framework for bilingual and bicultural health practitioners and health workers.

Recommendation 7

Drawing on relevant standards already developed and adopted in Australia (Competency Standards Framework for culturally responsive clinical practice: Working with people from migrant and refugee backgrounds) and globally (WHO's Refugee and migrant health: Global Competency Standards for health workers), this framework can guide professional development of the workforce and clearly articulate the roles of bilingual and bicultural health practitioners and health workers (including the distinction between the bilingual workforce and interpreters).

Recommendation 8

To ensure the proper recognition of the role of bilingual and bicultural health practitioners and health workers, the workforce competency standards framework should be accompanied by guidance for employers in the health and care services on policies and practices in relation to job descriptions, recruitment, salary and loading arrangements, training, support and career progression.

Recommendation 9

The development of the competency standards framework for bilingual and bicultural health practitioners must engage the relevant health practitioner professional and regulatory bodies, so that the standards become part of the fabric of professional standards and development.

Recommendation 10

The Federal Government should invest in the development and delivery of national training for bilingual and bicultural health practitioners and health workers, based on the competency standards framework and accredited with relevant professional bodies.

Encouraging Excellence

Recommendation 11

Working with community and sector partners, the Federal Government should resource the establishment of a national clearing house of good practice in recruitment, retention and professional development of bilingual and bicultural health practitioners and workers. This will inform and guide the development of the workforce, and policies and practice to support it.

Recommendation 12

The Federal Government should resource the establishment of a national online community of practice for bilingual and bicultural health practitioners and workers to facilitate ongoing sharing of best practice, tools and resources to support the workforce.

Recommendation 13

Federal Government should resource a dedicated effort to support research and evaluation into the role and impact of Australia's bicultural and bilingual health and care workforce.

Who makes up the bilingual and bicultural health and care workforce?

The key characteristic of the bilingual and bicultural health and care workforce is that its members are primarily employed for their professional skills (clinical or otherwise) in health and care (aged and disability) settings.

Their language and cultural skills are available to their workplace as an additional benefit. For example, a nurse who can practise both in English and Vietnamese is a bilingual health practitioner.

Bilingual workforce

The competency standards framework for clinicians produced by the Migrant and Refugee Health Partnership (2019) and widely endorsed by the peak professional bodies for health practitioners defines a “professional with bilingual skills” as someone who, while employed in a professional capacity, is able and willing to utilise their proficiency in a language other than English as an additional skill. Some professionals are employed specifically for their proficiency in a language other than English.

Another useful definition of ‘bilingual worker’ comes from the Centre for Culture, Ethnicity and Health (2007):

A person employed to use their language skills in English and another language with a linguistic proficiency in both languages appropriate to the function of their position who also understands and shares the values of the non-English speaking background community they are employed to work with and their employing agency.

Importantly, bilingual workers are not interpreters (though they may often collaborate). Matthews et al (2000) have described seven key differences between the roles played by interpreters versus bilingual workers. As an illustration of the difference, in a health care setting interpreters work within a triadic (three-way) relationship, with the health care provider and the person receiving care. Interpreters are not focused on a relationship with the person receiving care. Bilingual workers however operate directly with the persons receiving care in a dyadic (two-way) relationship.

Bicultural workforce

The competency standards framework for clinicians by the Migrant and Refugee Health Partnership (2019) defines a “professional with bicultural skills” as having cultural skills and knowledge that they are able and willing to use to facilitate communication between the organisation and communities with whole they share experiences and understandings (so they are employed primarily as a professional, while some are employed specifically for their cultural skills).

Centre for Multicultural Youth helpfully defines bicultural workers as members of the workforce engaged to use their cultural skills and knowledge to facilitate communication between their organisation and communities with similar cultural experiences and understandings. Their focus is not foremost on execution of a professional role (such as nursing), but specifically to build good communication and relationships with cultural communities.

In the health settings, bicultural workers are key intermediaries to engage with and support diverse communities’ understanding of health information. They need to understand information to be able to explain it accurately, at the right level of language and in ways that ‘make sense’ within the cultural and social norms of their community (Centre for Culture, Ethnicity and Health 2021). The term ‘bicultural’ worker stresses the centrality of cultural skills and knowledge in this role, as opposed to language skills.

In addition to possible language concordance, bicultural workers offer several advantages (Piper 2016):

- clients feel more comfortable with someone from their own background
- workers have an understanding of the background of the clients
- workers are better able to assess clients’ needs
- it is easier to build a relationship of trust between worker and client.

For building understanding and developing policy, these definitions are useful. However, in the real world, the workforce may in fact be bilingual, bicultural or both bilingual and bicultural.

In the health sector specifically, it is also useful to distinguish between bilingual and bicultural health practitioners (engaged primarily for professional skills – their bilingual/bicultural skills are additional to those) and bilingual and bicultural health workers who, while working in health settings, are not registered health practitioners and are often engaged primarily for bilingual and/or bicultural skills. This is a distinction already usefully clarified in relation to Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP 2022). For the purposes of this brief, the roles are distinguished as follows:

	Health Practitioner	Health Worker
Bilingual	Qualified and registered. Engaged primarily for professional skills and willingness to utilise bilingual skills is an added benefit.	A worker in a health setting, often engaged primarily for application of bilingual skills (at a level appropriate to their position). <i>Note: these workers do not replace the need for engagement of interpreters.</i>
Bicultural	Qualified and registered. Engaged primarily for professional skills and willingness to utilise bicultural skills is an added benefit.	A worker in a health setting, often engaged primarily for application of bicultural skills (at a level appropriate to their position).

It is important to note that bilingual and bicultural workforce operates in an Australian multicultural society that is not static but reflects the complex, rich and tangled story of Australian immigration (Ang 2009), as well as shifting trends in politics and society.

Where do they work?

The bilingual and bicultural workforce may be employed across diverse settings in health, aged, and disability care. These settings may include primary care, hospitals, community based health and support services, and local government services. The workforce may be employed in public and private settings, including for example, at private hospitals supporting the provision of care to an estimated 13,000 foreigners who come to Australia to purchase specialised medical treatment (Deloitte 2011).

This brief will describe the general absence of agreed standards or training for bicultural and bilingual workforce. The diversity of employment settings is a complicating factor in addressing this, needing to ensure that any standards or training are fit for purpose and reflect this diversity.

How many bilingual and bicultural workers are there?

In short, this is not known. Comprehensive, high-quality data on the health and care workforce can assist in informing policy and service planning and, while sources of data in Australia are numerous, their capacity to drive better policy and planning is unclear at best (Gillam et al 2020, Gide et al 2021). Simply put, there is no clear understanding of the size, composition, or other characteristics of Australia's bilingual or bicultural workforce. From a human resource planning perspective, this is a fundamental flaw that must be remedied.

We can make some suppositions.

First it is important to locate these workers as part of a fast-changing demographic landscape in Australia. The 2016 Census of Population and Housing (Australian Bureau of Statistics 2017) showed that more than a quarter (26%) of Australia's population (6,163,667 people) were born overseas, up from 25% in 2011. Fifty years ago, in 1966, Australia's overseas-born population was only 18% of the total Australian population. The proportion of people from non-English speaking backgrounds has increased. So overall, the Australian population is rapidly becoming more diverse. Australia's capacity to meet the health and care needs associated with this diversity is being challenged. People with cultural and language skills are an important resource. With the potential pool and diversity of people needing care is growing, we need to consider the available workforce.

By 2024, it is estimated that the workforce supporting the National Disability Insurance Scheme will number 83,000 (NDIS Workforce Plan 2021). The aged care sector employs around 434,000 people, of whom just under 50,000 identify as being from a non-English speaking background (Australian Government 2020). The health sector employs approximately 586,000 people (Australian Institute of Health and Welfare 2021). Across these three sectors, this totals 1.1 million people.

The Australian Bureau of Statistics (2017) suggest that more than one quarter of all Australian households speak a language other than English at home. Presuming the Census was representative of the workforce, this would mean at least 275,000 workers in the health, aged and disability care sectors spoke a language other than English at home.

The suggestion that a quarter of this combined workforce come from non-English speaking communities accords with other data suggesting that more than 30% of Australia's 'frontline workers' were born overseas (Australian Research Council 2018). A NSW Government report on its public service workforce found 18.5% of employees across all agencies had English as a second language (NSW Government 2021). Queensland Health's Workforce Diversity and Inclusion Strategy 2017 – 2022 goes further, recording 11.14% of its employees as being from a non-English speaking background and setting a target for this to become 12.75% by the end of the plan.

In the disappointing absence of more formal or recognised data, it is reasonable to assert that at least 250,000 workers in Australia across the health, aged and disability care sectors would be proficient in a language other than English. How many of these might use their language or cultural skills as part of their work is not known of course, but this would represent the possible current 'pool' of skills. This significant number is mirrored in other countries. For example, while immigrants represent 17% of the overall U.S. civilian workforce, they are 28% of physicians, 24% of dentists and 38% of home health aides (Batalova 2020).

Australia has a large, growing and increasingly diverse population and a significant pool of bilingual and bicultural skills. How can we intelligently deploy these skills to the maximum benefit of our diverse community?

Why are they important?

As the population becomes more diverse, organisations increasingly interact with people from migrant and refugee backgrounds. Delivering quality care to people from migrant and refugee backgrounds requires workers to adopt culturally responsive practices and utilise competencies enabling them to communicate and work effectively with this cohort. This has been recognised both internationally by the World Health Organization (2021) and domestically (Migrant and Refugee Health Partnership 2019). Targeting workers in the health sector in particular, these competency standards highlight the competencies and behaviours needed to provide high-quality health services to refugees and migrants with the aim of supporting the development of competency-based curricula tailored to the local context and for health workers to achieve a minimum level of competence to ensure better health outcomes for refugees and migrants.

The desirability of developing some specific capacity to effectively address the needs of diverse communities has been understood for a long time both in Australia (Iredale and Gluck 1993) and elsewhere (Chung 1989). Some bicultural support services have been operating in Australia for more than forty years (Ethnic Children's Services Worker Program 2022).

In a multicultural country like Australia, bilingual and bicultural health workers play a crucial role in facilitating a person-centred approach to care – "an approach to the planning, delivery and evaluation of health care that focuses on developing mutually

beneficial partnerships between clinicians and persons and their carers, and is respectful of and responsive to the preferences, needs and values of persons and consumers” (Migrant and Refugee Health Partnership 2019). A person-centred approach places the person at the centre of the service they are receiving, and takes account of their life experience, age, gender, culture, heritage, language, beliefs, identity, support networks and agency in decision-making.

Bilingual and bicultural health practitioners and health workers are integral to culturally responsive practice and organisational capacity to deliver equitable services. It is critical that health service organisations and their workforces examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery (Curtis et al 2019). Further, engagement with members of the bilingual and bicultural health and care workforce themselves is essential for the development of a critical understanding of the systemic and/or organisational barriers to their effective engagement in the workplace, and the development of strategies to improve workforce diversity. Reflexivity is a challenging and powerful approach that goes beyond a checklist.

The role of bilingual and bicultural workers in health and care settings: Overview of the evidence

As practitioners in their respective professions, bilingual workers are already a valuable resource.

The utilisation of their additional language skills accentuates this value as has been demonstrated across multiple settings in health care and beyond. However, it should be noted that much of this evidence is derived from overseas, not Australia. This highlights the need for renewed research and evaluation efforts domestically.

In the health context, it is useful to differentiate between bilingual health practitioners and other health workers, with the former specifically applying their additional language skills in discharging their professional role – as doctors, nurses, allied health professionals and so on.

There is good evidence indicating that where community health workers share a similar cultural background with immigrants and refugees, they are better able to respond to the health needs of these populations (Wells et al 2011).

Ngo-Metzger et al (2007) established that language barriers are associated with less health education, worse interpersonal care, and lower patient satisfaction. They found that some of these issues could be effectively addressed by engaging interpreters. However, in terms of patients' ratings of their providers and the quality of interpersonal care, having an interpreter present does not serve as a substitute for language concordance between patient and provider.

Looking specifically at the issue of the risk of adverse medication use, Wilson et al (2005) found that limited English proficiency is a barrier to medical comprehension that increases risks, but that access to bilingual workers substantially mitigates (but does not eliminate) this risk.

Henderson and Kendall (2011) collected evidence from randomised controlled trials and controlled studies that examined strategies for promoting cultural competence in health service delivery in diverse communities. The outcomes examined included changes in consumer health behaviours, utilisation or satisfaction with the service, and the cultural competence of healthcare providers. Their review supported the use of trained bilingual health workers, who are culturally competent, as a major consideration in the development of an appropriate health service model for diverse communities.

In an Australian study into the use of bilingual workers in community mental health settings, Mitchell et al (1998) identified these workers as having at least four critical roles, including:

- direct clinical service provision to clients
- mental health promotion and community development
- cultural consultancy, and
- service development.

Willoughby et al (2018) presented a case study, from the Australian Italian community, demonstrating the positive role bilingual doctors could play in smoothing communication with patients, while at the same time noting their role should be best seen as complementing, not replacing, a health system that provides professional interpreters in medical consultations.

Sheehan and Jansen (2009) have described how New Zealand has progressed development of a national bicultural and interprofessional program in clinical teaching and supervision. They report several benefits arising from this program, including that participants expressed increased confidence in their skills, better career prospects and a more strategic view of their organisations and roles.

Oldfield et al (2019) found bilingual workers enhanced childcare experiences, especially for those families subject to vulnerabilities such as poverty or restrictive immigration policies. The Group Well Child Care model they evaluated was found to enhance the expertise of the workers, moderate parents' use of health services and improve relationships.

Engstrom and Min (2004) evaluated bilingual social workers and found them often crucial in offering services to clients who cannot communicate effectively in English. They did note the importance of providing these workers with additional language resources and workload adjustments.

Cioffi (2002) describes the important role bilingual health workers can play in improving the capacity of Australian nurses:

If one can get someone who can talk to them in their own language it's obviously a lot more anxiety relieving for the patient to know that they can communicate well with staff.

Vignato and Guinon (2019) demonstrate how similar structured support, scaffolding contextualised learning through a learning community and "The Puente Project" bicultural and bilingual outreach guidelines, resulted into the 'HealthStart' project. This project has increased rates of training and retention of nursing staff from diverse backgrounds in California.

Monto (2021) has highlighted a process of structured recognition, training and professionalisation of bilingual workers (teachers) in Oregon. This is providing a new and sustainable method of growing this workforce, to the benefit of both students and communities.

Broughtwood et al (2011) reported that bicultural workers play a significant and complex role in supporting individuals and families affected by dementia. They concluded the significance of their role should be more clearly acknowledged in the development of policy, further research and service provision within the dementia field.

There has been a series of evaluations undertaken in the United States. Enriquez et al (2008) documented enhanced health outcomes among Hispanic adults living with HIV infection because of care provided by health care workers who are bilingual and bicultural, together with the use of culturally and linguistically appropriate patient education materials. McCarthy et al (2021) document the effectiveness of bilingual and bicultural 'navegantes' in assisting low-income, Spanish-speaking population in Rhode Island. Mojica et al (2016) noted the positive impact bilingual workers had on beliefs and attitudes regarding early detection in a range of cancers, recruiting individuals for programs, educating them, and influencing cancer knowledge and screening behaviour.

A literature review regarding bicultural workers commissioned recently by cohealth confirms the importance of these workers, bringing valuable cultural knowledge useful for assisting clients to navigate complex services, empowering community members through community-led initiatives, building trust, advocacy, and provision of accessible information in relevant languages (Changaira 2022).

Goris et al (2020) point out that to address access barriers and improve health outcomes in communities, the involvement of what they call multicultural health workers, recruited from the targeted diverse communities, has gained momentum worldwide (Norris et al. 2006; Andrews et al. 2007; Brownstein et al. 2007; Gibbons and Tyus 2007; Saxena et al. 2007).

There are examples of this model of care being used in China, India, Iran, Europe, Thailand and other countries around the world (Bhat et al. 1999; Azizi et al. 2003; Rakhshani et al. 2003; Voorman 2003; Cheng et al. 2005; Gibbons 2006; Sunil et al. 2006; Wong and Leung 2008, Phanwichatkul et al 2016), though appearing 'promotoras de salud' and 'multicultural health promotion officers'. Given this momentum, they wonder why Australia has been slow to adopt such models of care.

On this basis, Goris et al undertook a worldwide systematic review of the evidence arising from evaluation of the role played by these workers. Covering the period 1 January 1995 until 1 November 2010 they found 39 studies of which 31 were randomised controlled trials. They found that bicultural workers "were associated with positive chronic disease prevention and self-management outcomes across a range of settings and populations. They do this by providing social support, health education, outreach services and enhanced case management.

As community-change agents, trusted peers and providers of social support, [they] appear to be able to motivate, facilitate and help empower CALD community members to access health care services and adopt required behaviours that contribute to improved health outcomes". They conclude by calling for the broader systemic application of bilingual workers in Australian primary health care.

Many countries, including member states of the European Union, have successfully introduced the position of cultural mediators within their health systems to address the gaps between conventional health practice and the diverse needs of multicultural communities. Cultural mediators reduce cultural and linguistic barriers, improve accessibility and increase the quality of health care for migrants and refugees (International Organization for Migration 2016). This role is defined by the EU as "a professional who facilitates the communication (including interpretation) between people speaking different languages and with different cultural backgrounds". While the role is evolving, it is not currently a registered profession in the EU, thus the role of cultural mediators yet to be clearly defined and acknowledged. There is not yet any standardised code of conduct, and the role is not exercised within a certain legal framework.

There is considerable evidence indicating the positive contribution of cultural mediators within the health sector. In Spain, there was an increased number of organ donations among migrants after cultural mediators worked with migrant communities in-language and discussed their concerns (Frutos et al 2008). In Northern Europe, refugees from the Balkan corridor who had experienced mental and physical trauma were supported by psychologists with the help of cultural mediators (Arsenijević et al 2017).

Canada has successfully demonstrated the role to be played by Multicultural Health Care Brokers in delivering community health care (Torres et al 2014) with one health profession commenting:

I'm completely convinced that every single newcomer to the country should have a health broker, I mean, I have no doubts about that ... immigrant families manage fairly well in comparison to the refugee families, but the refugee families really struggle and should, do need that kind of support, I feel quite strongly.

The successful embedding of cultural mediators within health systems overseas provides a model for how Australia could recognise, formalise and support the role of bilingual/bicultural health workers.

Key policy considerations affecting the bilingual and bicultural workforce

Invisibility in workforce planning policy

In 1998, Johnson et al commented that little attention had been paid to the composition and roles of the health workforce, particularly in relation to data indicating the extent of employment of bilingual health staff and the application of their linguistic skills and/or cultural knowledge in the workplace. Evidence indicates that not much has changed. Despite the recognition of the significant role played by bilingual and bicultural workers, they do not figure in key existing strategies and policy documents.

The National Medical Workforce Strategy 2021-2031 (Department of Health 2021) places very strong emphasis on issues of cultural safety and training, but only as they pertain to Aboriginal and Torres Strait Islander peoples. There is no mention of the importance of ensuring the next generation of health professionals is properly equipped to meet the needs of Australia's population in all its diversity, including culturally, ethnically and linguistically diverse communities.

The NDIS National Workforce Plan: 2021–2025 (NDIS 2021) does state that “there are particular challenges attracting and retaining culturally and linguistically diverse workers”. However, the Plan suggests this may be largely due to a lack of culturally appropriate communications materials about the NDIS rather than broader issues of recruitment, training or retention. The Plan states that the NDIS workforce does not currently reflect the diversity of its participants and that there is a need to recruit workers from diverse backgrounds to better match the diversity of the NDIS clients. No data is presented and few specific actions are provided. The Plan does flag a possibility of exploring ‘microcredentialling’ to enhance “culturally safe work practices” (p21).

The 2020 Aged Care Workforce Census Report includes more detail, explaining that the number of direct care workers who identify as being from a non-English speaking background in 2020 was 49,475 or 35% of the total direct care workforce. This is quite a steep increase from 26% in 2016. The Australian Government *A Matter of Care: Australia's Aged Care Workforce Strategy* states that specific consideration needs to be given to meeting the skills and competency development needs of new hires and some groups within the workforce from culturally and linguistically diverse backgrounds “who may need additional support in the workplace” (Department of Health 2018). The Strategy provides some seed funding, to be allocated to encourage projects designed to better address the needs of people who identify as Aboriginal and Torres Strait Islander; culturally and linguistically diverse; and lesbian, gay, bi-sexual, transgender and intersex.

The Strategy does not provide specific mention of bilingual or bicultural workers or suggest any relevant actions.

So, while the bicultural and bilingual workforce across the health, aged care and disability sectors is likely to number around 250,000 people, key policy and strategy documents contain practically no mention of actions, and no dedicated new resources designed to acknowledge and then strengthen their workplace contributions.

To support the sustainability and effectiveness of policy and workplace responses, it is critical that members of the bilingual and bicultural health and care workforce are engaged in the development of strategies to address these gaps.

Recommendations for Workforce Development

- 1 Federal and State/Territory Governments should work together to develop a dedicated workforce plan to first recognise and then increase the number and proportion of bilingual and bicultural health practitioners and health workers in health and care services who facilitate health and wellbeing outcomes for people from migrant and refugee backgrounds.
- 2 Federal and State/Territory Governments should consider and establish national workforce targets, in close consultation with relevant industry bodies and the community sector, to guide investment in the next generation of bilingual and bicultural health practitioners and health workers, including workers that facilitate access to, and navigation of, health and care services.
- 3 Workforce development should be supported by enhanced data collection on the changing demographics and health and care service needs of communities. This would permit workforce planners at Federal and State/Territory levels and service providers to better tailor their work (including in relation to hiring practices and service delivery) to the cultural and linguistic characteristics of particular communities. This should take place in consideration of both the size and levels of English proficiency in those communities.
- 4 Members of the bilingual and bicultural health and care workforce should be meaningfully engaged in the development of strategies to strengthen the impact and recognition of their contributions, both at organisational and workforce planning levels.

Lack of Data

As stated, there is a paucity of data in relation to this workforce – their number, demographics, skills, etc. In turn, this means the capacity for longer term human resource planning is very limited. It limits the capacity of planners to align the recruitment of members of the bilingual and bicultural health workforce to broader community demography (Johnson et al 1998). As the populations and needs of communities shift over time (for example, with an influx of new migrants or refugees from a particular region), sensible human resource planning would permit such shifts to be reflected in health and community workforce recruitment practice.

Beyond workforce data, there is also a paucity of data in relation to community needs. There have been significant recent efforts to address aspects of this deficit, for example through the regional planning being undertaken by Australia's 31 Primary Health Networks (Department of Health 2022). Bilingual and bicultural health practitioners and workers are not engaged to represent their communities and therefore do not replace the need for investment in comprehensive community engagement strategies for understanding community health needs.

Paradoxically, while specific cultural groups are often identified as priorities in government plans and strategies, efforts to address their needs are regularly hampered through failure to identify and collect necessary data on their living circumstances, health and welfare. This means we lack the data necessary to understand, monitor and report on the needs of these groups. This is an issue understood but not addressed in Australia over decades (Federation of Ethnic Communities' Councils of Australia 2020).

Recommendation for Better Data Collection and Reporting

- 5 The Federal Government, working with the Australian Institute of Health and Welfare and the Australian Bureau of Statistics—as well as in consultation with community and health and care sectors—should improve data collection processes to ensure access to data on the number, demography and spread of the bilingual and bicultural workforce. As a minimum, this should encompass the health, aged and disability care sectors. The Government should further resource an audit of the current workforce.

Lack of National Competency Standards and Training

While many agencies readily acknowledge the benefits of bilingual and bicultural workforce, there are no national competency standards, training or policies that define or contextualise these roles. This results in an inconsistency in role descriptions and functions, and a difficulty in determining appropriate remuneration for bilingual and bicultural workforce in different sectors.

Another significant challenge is the lack of competency-based training for bilingual and bicultural workforce. While there have been fragmented and largely short-term bilingual and bicultural workforce training programs delivered over time through jurisdiction-based arrangements (FECCA 2017), there are no ongoing programs implemented nationally.

The limited national initiatives in this regard include:

- National Disability Services (2016) produced a workbook designed to encourage service providers to consider employing bicultural workers to better meet client needs. This workbook includes 'practical strategies' and useful information but is an optional or supplementary activity for employers, not a set of nationally recognised competencies.

- As part of its nationally accredited community services training curriculum, the Australian Government added a new training handbook to accompany the community health services TAFE course titled Undertake Bicultural Work with Forced Migrants in Australia (Piper 2016). The handbook was designed to provide 12 sessions of 2 hours of face-to-face instruction, aiming to equip bicultural workers with necessary skills and background, in areas including:
 - legal and ethical considerations (national, state/territory, local) relevant to settlement services
 - privacy, confidentiality, mandatory reporting and disclosure
 - conflict of interest and maintaining professional boundaries
 - availability of resources and assistance within, and external to, the organisation, including relevant referral networks and how to access their services
 - strategies for worker to maintain their own wellbeing and to support wellbeing of colleagues and clients
 - time management and stress management techniques, and
 - impact and relevance of trauma and vicarious trauma.
- The National Accreditation Authority for Translators and Interpreters (NAATI 2022) delivers a Community Language Aide (CLA/bilingual worker) test designed to give businesses and government departments confidence that their multilingual staff can effectively and competently communicate to non-English speaking clients or stakeholders in a two-way conversation (the role of a CLA is different to that of an interpreter). The CLA test, available in over 50 languages, assesses a candidate's ability to communicate in a simple and direct exchange of information on familiar and routine matters. NAATI assesses each test against a marking rubric for competency across four areas: task achievement, coherence and fluency, grammar and vocabulary, and pronunciation.

Overall, Australia has no uniform articulation of the competencies for bilingual and bicultural health practitioners and health workers. Competencies, similar to those already designed for use in the health sector (Migrant and Refugee Health Partnership 2019), would benefit practitioners and workers—and organisations that employ them—by establishing recommended and optimal bilingual and bicultural practice standards, and informing the development of health practitioner and health worker education, training and professional development. A national competency framework for bilingual and bicultural health practitioners and health workers would establish a benchmark for bilingual and bicultural practice.

Recommendations for the Development of Standards

- 6 To support the workforce plan, Federal Government should invest in the development of a national competency standards framework for bilingual and bicultural health practitioners and health workers.
- 7 Drawing on relevant standards already developed and adopted in Australia (Competency Standards Framework for culturally responsive clinical practice: Working with people from migrant and refugee backgrounds) and globally (WHO's Refugee and migrant health: Global Competency Standards for health workers), this framework can guide professional development of the workforce and clearly articulate the roles of bilingual and bicultural health practitioners and health workers (including the distinction between the bilingual workforce and interpreters).
- 8 To ensure the proper recognition of the role of bilingual and bicultural health practitioners and health workers, the workforce competency standards framework should be accompanied by guidance for employers in the health and care services on policies and practices in relation to job descriptions, recruitment, salary and loading arrangements, training, support and career progression.
- 9 The development of the competency standards framework for bilingual and bicultural health practitioners must engage the relevant health practitioner professional and regulatory bodies, so that the standards become part of the fabric of professional standards and development.
- 10 The Federal Government should invest in the development and delivery of national training for bilingual and bicultural health practitioners and health workers, based on the competency standards framework and accredited with relevant professional bodies.

Examples of Good Practice: cohealth and Enliven

There are two stand-out examples of good practice implemented in Victoria, cohealth and Enliven.

cohealth is one of Australia's largest not-for-profit community health services, with 1,200 staff working at 30 sites across nine local government areas in Melbourne's central, northern and western suburbs. cohealth's bicultural program was established in 2017 and they have led the development of innovative approaches to bicultural work, developed training and professional standards to support employment of bicultural workers and community-led engagement with their communities. They have a pool of bicultural workers and have developed tailored approaches to training. cohealth offer a specific work program (<https://www.cohealth.org.au/get-involved/bi-cultural-work-program/>) where bicultural workers are trained to:

- co-design and deliver community-led projects that respond to their community's priorities and needs
- Assist organisations to identify community strengths – their interest, needs, or challenges

- Review materials, resources or service delivery to assess accessibility, relevance and cultural safety
- Develop shared language around key messages
- Recruit for programs, workshops, employment and join interview panels
- Share information with community groups in relevant language and culturally appropriate ways
- Educate community members about services and facilitate access
- Advocate for their community's needs.

cohealth has developed professional standards for bicultural workers and runs an internship program for, and a network of, multilingual bicultural workers. Cohealth developed these standards in response to the challenges faced by their workforce over time. For example, it has been difficult to establish clear roles and responsibilities for bicultural workers, possibly leading to confusion and frustration. Workers have also needed to come to terms with the complexities of living and working in one's community and culturally appropriate boundary setting. This can influence decisions about when bicultural workers should be engaged as opposed to other workers. There are also ethical considerations and cultural responsiveness guidelines, developed to make it easier and clearer for bicultural workers to fulfil their roles. cohealth's standards also provide inclusive recruitment guides and payment policies designed to influence the evolution of culturally responsive human resource practices. The standards also provide guidance with regard to self-care and supervision. The development of these standards exemplifies cohealth's commitment to the establishment of a vibrant, trained and professional bicultural workforce in Australia.

Enliven is a Primary Care Partnership in Victoria whose catchment includes the south-eastern Melbourne local government areas of Greater Dandenong, Casey and Cardinia. It has developed *Bicultural Brilliance, A Toolkit for Working with and as Bicultural Workers* (2018), among other resources. The toolkit sets out a framework to support best practice to sustain the recruitment and retention of a quality bicultural workforce, including human resource planning tools, position descriptions and other resources.

cohealth and Enliven represent exceptions to the rule, in that bilingual and bicultural work is typically remains under-recognised or, worse, invisible. This does not mean there are no regular, time and budget-limited programs undertaken across myriad community and government organisations aimed at supporting migrant communities (such as this: <https://www.nh.org.au/bicultural-workers-in-the-community-monitoring-program/>). The issue is that these are temporary, often unevaluated, and fail to spur the sustainable growth of this critical workforce.

The development of Australian standards could build on some of these existing developments, while also aligning with the World Health Organization's (2021) *Refugee and migrant health: Global Competency Standards for health workers* which specifically calls for the engagement of bilingual and bicultural workers as part of delivering 'culturally sensitive care'.

There is an urgent requirement to build new capacity to learn from examples of good practices, such as those presented here. Pockets of excellence and good practice exist across Australia and should inform broader systemic planning and design, to better meet the needs of communities.

Similarly, there is value in providing a national, ongoing capacity building and support platform for the bilingual and bicultural workforce as a space to learn from one another, share practice, and access tools and resources. An online community of practice focused on capacity building, sharing of learnings, and provision of information and resources on emerging evidence and good practice would provide such an avenue for professional collaboration and excellence.

Remuneration and Recognition

Given the added value that the bilingual and bicultural health and care workforce brings to the work of their organisations, it is appropriate that they are adequately and proportionately remunerated, in accordance with industry awards where relevant. For bilingual health practitioners and workers in particular, their language skills risk being exploited as a welcome 'free' resource for their employer.

There is little, if any, evidence where organisations have met the challenge of providing proper recognition and remuneration for bilingual workers (El Ansari et al 2009).

It is important to address this issue by developing a standard framework to manage and regulate salaries or loadings, and to develop clear career pathways for bilingual workers.

Role Creep

In the absence of clear roles and descriptors, there is a danger for bilingual and bicultural health practitioners and workers of 'role creep'. This term refers to the expansion of a person's role beyond their normal duties, including requests for support from the community, their employers and/or from colleagues seeking assistance. It can also include incorrect assumptions that members of the bilingual and bicultural health and care workforce are available to represent the views and attitudes of their communities. This can place both the health practitioners/workers and the people they provide care to at unacceptable risk and create avoidable disincentives for this kind of work. An organised approach to preventing role creep would require human resource infrastructure that is currently (generally) unavailable, such as (cohealth, 2021):

- Clear position descriptions outlining expected outcomes and scope of role/work
- Appreciation of the complexities of living and working in one's community, and how this can result in additional requests for support, cultural obligation and shared personal spaces
- Understanding of the need to limit organisational requests for workers to provide "community perspective" outside of their role
- The creation of opportunities for career progression and increased pay as BCW role becomes more complex.

Career Progression

Appropriate career pathways should be provided to all staff members, including those with bilingual and bicultural capabilities. This could be achieved through the application of standard human resource practices such as personal development and career planning, positive recognition of bicultural staff's skills, mentoring, feedback and so on.

While accredited health practitioners performing bilingual/bicultural functions are often not recognised for their bilingual/bicultural skills and contributions, they do have professional progression pathways in their respective health practitioner roles. These pathways might be enhanced by professional and regulatory bodies developing recognised education structures and levels for the bilingual/bicultural workforce which provide and reflect continuing professional and career development.

For bilingual/bicultural health workers, there is often a lack of any such recognition or pathway. Research indicates that bilingual and bicultural workers not only lack appropriate pathways for training, accreditation and professional development, they often face challenges in moving out of low-level roles within organisations (Centre for Multicultural Youth 2011). It is important that bilingual and bicultural workers do not become 'stuck' in particular roles because the organisation needs their language skills in particular areas.

From their research into the long history of health care among the Chinese community in San Francisco, Yang and Kagawa-Singer (2007) suggested the following were key steps to building and nurturing the bicultural and bilingual workforces:

- Recruitment of foreign trained professionals into health and community workforces
- Better data and understanding about where shortages/need exists
- Professional training of native-born, ethnic professionals
- Recruitment and training of native-born, ethnic minority professionals
- Incentive programs to assist with this recruitment (e.g., reduced fees, course waivers)
- Improved educational opportunities for people from diverse communities to undertake training.

The introduction of standardised and accredited pathways for professional development may go some way to addressing structural barriers to the career advancement of bilingual and bicultural health and care workers. However, it is important not to assume that improved recruitment and retention of a diverse workforce will naturally lead to more equitable outcomes for the bilingual and bicultural workforce – this also requires broadscale organisational reflexivity and commitment to cultural change.

Recommendations for Encouraging Excellence

- 11 Working with community and sector partners, the Federal Government should resource the establishment of a national clearing house of good practice in recruitment, retention and professional development of bilingual and bicultural health practitioners and workers. This will inform and guide the development of the workforce, and policies and practice to support it.
- 12 The Federal Government should resource the establishment of a national online community of practice for bilingual and bicultural health practitioners and workers to facilitate ongoing sharing of best practice, tools and resources to support the workforce.
- 13 Federal Government should resource a dedicated effort to support research and evaluation into the role and impact of Australia's bicultural and bilingual health and care workforce.

Conclusion

This paper presents the evidence to support the expansion of bilingual and bicultural health and care workforce, together with a set of practical recommendations to guide next steps.

Australia's bilingual and bicultural health and care workforce already plays a strong and critical role. Its members help eliminate language and cultural barriers, facilitating cross-cultural understanding, and bridging socio-cultural gaps. They develop trust and a therapeutic relationship between migrant and refugee communities and the health, aged and disability care system, minimising power imbalances, empowering individuals in relation to their needs, and advocating for the broader needs of communities.

Australia is in a strong position to capitalise on this strength through strategic investment in first better understanding this workforce—its size, operation, and location—and then structuring more sustainable and effective recognition and support. On this basis, Australia's natural multicultural advantage can be leveraged, with long term benefits not only for the workforce itself, but for Australia's diverse communities as well as the effectiveness of health and care systems.

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