NSQHS Standards 3rd edition – Council Consultation – Submission

Strengthening the National Safety and Quality Health Service Standards through CALD Data Consistency and Clinical Relevance

On behalf of The Social Policy Group (SPG) and the Migrant and Refugee Health Partnership (MRHP)

Submission to: NSQHSSThirdEdition@safetyandquality.gov.au
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About the submitting entity

The Social Policy Group

The Social Policy Group (SPG) is a trusted partner of government, community leaders and service providers with a proven track record of delivering impactful and responsive social policy solutions for Australia's communities. As a peak body for settlement, multicultural health, and multicultural affairs, and a recognised leader in best practice and thought leadership across areas such as gender equality, economic analysis, access to justice, and community sector capacity building, SPG plays a pivotal role in fostering equitable social policies through facilitation, evidence-based practice, and collaborative partnerships.

The Migrant Refugee Health Partnership Council

The Migrant & Refugee Health Partnership (MRHP), auspiced by SPG and funded by the Department of Health, Disability and Ageing, works to improve health outcomes for migrant and refugee communities across Australia. The purpose of the MRHP is to develop, advocate for, and promote strategies that enhance health access, experiences, and outcomes for migrant and refugee communities in Australia. As part of this role, MRHP contributed directly to the development of the Commission's NSQHS Standards User guide for health service organisations providing care for patients from migrant and refugee backgrounds (2021), providing sector expertise and practical guidance on embedding cultural responsiveness into safety and quality standards.

Our Submission

The Problem: CALD Data Heterogeneity as a Systemic Quality and Safety Risk

The absence of a consistent and comprehensive collection of cultural and linguistic data across Australian health services represents a fundamental and enduring safety and quality risk. For patients from culturally and linguistically diverse (CALD) backgrounds, who make up nearly one in three Australians, critical information that underpins safe, equitable, and person-centred care is often missing or incomplete.

At the clinical level, this heterogeneity means that providers may not know whether a patient requires an interpreter, has limited English proficiency, or has migration-related risk factors that influence their health outcomes. This gap undermines core functions of safety and quality, including informed consent, accurate diagnosis, medication safety, and continuity of care. For health systems, it creates a fragmented evidence base: without standardised data, services cannot reliably measure equity in access or outcomes, compare performance across jurisdictions, or design interventions tailored to multicultural populations.

This is not a new problem. It has been repeatedly identified in research, community advocacy, and government reviews as a persistent barrier to equitable care. The Commission's own NSQHS Standards User guide for health service organisations providing care for patients from migrant and refugee backgrounds (2021) acknowledged that routinely collecting demographic information such as country of birth, year of arrival, language spoken at home, interpreter requirement, and English proficiency is essential to understanding patient needs and tailoring care appropriately. Yet these recommendations remain inconsistently applied.

The result is a paradox: while Australia recognises cultural diversity as central to its population health profile, its health system is structurally unable to "see" CALD populations in a systematic way. As the next section outlines, this gap is not due to a lack of knowledge about what is needed - there is a longstanding consensus on the solution. It reflects a failure to embed consistent CALD data standards into the national safety and quality architecture, leaving equity and safety risks unaddressed.

A Well-Documented, Longstanding Issue with National Consensus on the Solution

For more than two decades, the need for consistent CALD data collection has been clearly recognised, yet remains largely unimplemented across Australian health services.

Persistence of key issues in data includes:

- Fragmented data practices across states and services;
- Difficulty comparing health service usage or outcomes between CALD and non-CALD patients;
- Lack of actionable data to identify and understand service gaps, underuse, vulnerability or risk in multicultural communities.

The ABS Standards for Statistics on Cultural and Language Diversity (1999) established a minimum set of four variables - country of birth, main language other than English spoken at home, proficiency in spoken English, and Indigenous status - with additional items including ancestry, religion, and year of arrival.

Despite being endorsed nationally, these standards have been applied inconsistently, with most datasets relying only on country of birth or language spoken, leaving major gaps in service planning and outcome measurement.

The consequences of this inconsistency are well documented. The FECCA report If we don't count it, it doesn't count! (2020) showed that health and human services data routinely omit key CALD variables, rendering millions of Australians effectively invisible in policy and research. A 2021 systematic review of CALD definitions in epidemiological research confirmed the heavy reliance on single proxies such as country of birth, undermining comparability and generalisability. Similarly, the 2024 Health Equity Matters review found no health datasets fully adhered to ABS standards, with selective use of variables like interpreter required and year of arrival leading to systematic underestimation of health needs.

Other jurisdictions, such as Canada and the EU, routinely collect these measures, while within Australia, the mandated Indigenous identification variable demonstrates the effectiveness of standardisation. This Commission's own NSQHS Standards User guide for health service organisations providing care for patients from migrant and refugee backgrounds (2021) directly recommends routine collection of key demographic information as essential for tailoring safe care and monitoring equity (pp. 7–8).

Consensus on the five core variables - country of birth, year of arrival, main language spoken at home, self-identified cultural background, and need for an interpreter - has been consistently reaffirmed across national reviews, state frameworks such as the Victorian Family Violence Data Collection Standards, and most recently the Department of Health and Aged Care Multicultural Health Advisory Group roundtable on improving multicultural health in Australia held on 15 October 2024, which brought together government, researchers, and community leaders. That roundtable confirmed sector-wide agreement that embedding these five items is fundamental to clinical safety, service equity, and accountability. This consensus is further reinforced in the National PHN Multicultural Health Framework (2024), which sets expectations for Primary Health Networks to embed cultural responsiveness, consistent CALD data collection, and equity considerations into commissioning and planning. Alignment of the NSQHS Standards with this framework would ensure coherence across service levels and reduce duplication or gaps.

Despite this longstanding clarity, action has been limited. Without consistent CALD data, health services cannot measure equity of access, quality, or outcomes. The NSQHS Standards (Third Edition) now present the opportunity to finally codify this consensus into practice - embedding the five variables as a core safety and quality requirement, on par with other essential demographic indicators.

The Five Agreed CALD Minimum Data Items

We strongly advocate for inclusion of the following **five minimum data items** in the revised NSQHS Standards as a baseline safety and quality requirement:

1. Country of birth
2. Year of arrival in Australia
3. Main language spoken at home
4. Self-identified cultural background
5. Need for an interpreter

These items provide actionable, clinically relevant information on communication needs, migration-related risks, and cultural context. They are aligned with ABS standards, AIHW minimum datasets, and established practices in comparable jurisdictions. They also mirror the Commission's own recommendations in the NSQHS Migrant and Refugee User Guide.

Intersectional Dimensions of Equity Data

While the five CALD core variables provide a necessary baseline, health equity in practice requires a broader intersectional approach to data capture. Cultural and linguistic background often interact with other critical determinants of vulnerability – including rural and remote location, gender and sexual identity, educational attainment, and socio-economic status - to shape patient safety risks and access to care.

Collecting these variables in a consistent, structured way enables services to identify compounding forms of disadvantage and adapt care at the point of delivery, for example by tailoring communication, improving continuity of care in remote communities, or providing gender-sensitive and trauma-informed services. At the system level, integrating intersectional data into service design and planning supports more targeted resource allocation, ensures equity considerations are built into service design, and aligns with the NHQHS commitment to person-centred, safe, and responsive care across Australia's diverse populations and expansive geography.

Health Service Relevance: A Patient Safety and Accreditation Imperative

Cultural and linguistic data are not merely an abstract equity concern; they are central to clinical safety. For example:

- Interpreter use is a proven predictor of reduced readmission rates, improved medication safety, and greater patient understanding.
- Year of arrival and English proficiency inform risk stratification, care planning, and health literacy strategies.
- These variables are relevant to all health services, from acute hospitals to aged care, maternity, and primary care.

Embedding them in NSQHS accreditation would ensure consistency and accountability across the health system. To date, uptake of CALD demographic data has been voluntary and inconsistent. The RACGP Position Statement on Healthcare for People from Refugee Backgrounds and People Seeking Asylum reinforces this concern, emphasising that without structured and consistent data collection, primary care services struggle to deliver safe, equitable, and culturally responsive care. The current consultation is therefore a crucial opportunity to codify these expectations into the Standards themselves, ensuring every service contributes to a nationally coherent, equity-informed data infrastructure.

A Proposed NSQHS Pathway for Implementation

We recommend that the NSQHS Third Edition:

1. Mandate collection of the five minimum CALD data items across all health services as a safety standard, aligned with ABS methodology.
2. Embed these items into core actions under Partnering with Consumers, Clinical Governance, and Comprehensive Care.
3. Require services to report annually on the completeness of CALD data and interpreter use.
4. Support progressive expansion into primary care accreditation, particularly through RACGP and related bodies, enabling system-wide standardisation.

Conclusion

It is no longer acceptable to omit CALD data standardisation from national safety and quality expectations.

The NSQHS Standards (Third Edition) present a critical opportunity to close a longstanding gap in Australia's health system by embedding consistent CALD data collection as a core requirement of safety and quality. Inconsistent practices have left large sections of the population effectively invisible to service planning, clinical monitoring, and equity reporting.

By mandating the five core variables - country of birth, year of arrival, main language spoken at home, self-identified cultural background, and need for an interpreter - the Standards can provide the foundation for a coherent, nationally aligned approach to multicultural health data.

This highly targeted and achievable reform would not only bring health data into line with established ABS methodology and international practice but also ensure that health services are equipped to measure and respond to the needs of Australia's diverse communities. In doing so, the Standards can help create a safer, fairer, and more accountable health system for all.