

# Towards culturally competent health care: Language use of bilingual staff

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## Abstract

*The presence of diverse language skills within health staff provides opportunities to better meet the needs of a multicultural population. A cross-sectional survey of all staff within the South Western Sydney Area Health Service was undertaken to compare language skills with population needs and examine the context of language use. Thirty-one per cent of staff (n = 964) were bilingual or multilingual, with the predominant languages spoken being Tagalog (Filipino), Cantonese, Hindi, Spanish, Vietnamese and Italian. Thirty-seven per cent of bilingual staff used their language skills at least weekly, predominantly in situations of simple conversation and giving directions. Bilingual staff are a valuable resource for the organisation and the presence of a similar overall proportion of bilingual and bicultural staff may engender tolerance and adaptability in providing care to a diverse population. However, supply does not directly match community demand. This mismatch will continue unless recruitment is focused towards identified language groups. The high proportion of staff who rarely used their language skills (37%) may be due to lack of opportunity or limited need, and suggests that further research needs to examine service models that locate bilingual workers close to client need. This study takes a crucial first step towards realising equitable and culturally appropriate care utilising the principles of productive diversity.*

## Introduction

Australia's cultural diversity presents both challenges and opportunities for health care consumers and providers (Hartley 1995). Government policy directions (at both national and State/Territory level) have described the dimensions of cultural diversity and provided a broad framework for how public authorities, such as health services, are to respond to that diversity. An important element of that framework focuses on how well an organisation's workforce is equipped to meet the needs of a culturally diverse consumer population, and how much that workforce reflects the diversity of the population it is serving (New South Wales Health 1995). The concept of productive diversity, with a focus on the benefits of a diverse workforce in meeting consumer and other organisational needs, has also emerged in Australia in recent years and is contributing to management theory and practice (Cope & Kalantzis 1997). To date, however, limited attention has been paid to the composition and roles of the health workforce, and there has been little data available that indicate the extent of employment of bilingual health staff and the application of their linguistic skills and/or cultural knowledge in the workplace.

South Western Sydney Area Health Service (SWSAHS) covers seven local government areas in south-western Sydney and is an area of extraordinary cultural diversity. In 1996, 242 553 residents (34.4%) were overseas-born, and 235 763 residents (36.5%) spoke a language other than English at home (Australian Bureau of Statistics 1996). The area has a high number of new immigrant arrivals, in particular, arrivals under the family reunion and humanitarian programs (SWSAHS 1995). Planners within the SWSAHS recognise that a number of strategies can be implemented to improve the ability of the health workforce to meet the needs of its diverse population, however, such strategies have been limited by a lack of reliable data (SWSAHS 1995). This study was undertaken to provide such data for the area health service. Objectives of the study include determining the nature of languages other than English present in health staff of SWSAHS, and describing the context within which language skills are being used.

## Literature review

In health care, language plays a major role in communication, appropriate assessment, interpretation and, subsequently, health intervention (Lipson 1996). Limited English skills have been acknowledged as a possible cause for the reduced ability, or inability, of patients from a non-English-speaking background to access medical systems (Easthope 1995). In a Melbourne study, Minas, Stuart and

Klimidis (1994) emphasised the under-utilisation of mental health services by consumers from a non-English-speaking background. They proposed that the availability of bilingual staff be a part of the solution. An increased use of health services by patients from a non-English-speaking background has been demonstrated where bilingual staff have been available (Fong & Gibbs 1995).

One of the major factors in satisfaction with health care delivery for Vietnamese consumers, a major consumer group within SWSAHS, was feeling understood by health care providers, and being able to understand the written and verbal instructions of providers (D'Avanzo 1992). Interpreters are important facilitators of communication between the patient and the health professional, although these services form part of a range of possible strategies. Specialised ethnic health services exist, but are few in number and often community-based. The review of the Ethnic Health Worker Programme in New South Wales (Davis & Garrard 1989) recommended increased employment of bilingual health professionals. The availability of bilingual health professionals and other staff, and the willingness of these staff to provide complementary services within a defined and controlled manner has largely remained unexplored within mainstream health services.

The only insights into the availability and role of bilingual staff have been obtained from mental health experiences and ethnic-specific services developed thus far. Minas, Stuart and Klimidis (1994) identified that the absolute number of staff with a language other than English and with enough skill to use this language in clinical work was less than the demand. Approximately 31% of mental health staff in Victoria could communicate at some level in another language, with 14.3% capable at a clinical level. This implies that 16.7% could also provide some level of assistance.

In addition, there was some difficulty in having the opportunity to use this language. Staff speaking a language other than English could use that language in less than 6% of their clinical contacts. From this survey of 991 professionals, the mismatch between the language spoken by the staff and the patient's language was confirmed, as well as inadequate interpreting services. The authors concluded that 'language resources already available in the system need to be put to more sensible use' (Minas, Stuart & Klimidis 1994, p 257). These authors called for 'service models and administrative arrangements' that would facilitate the close approximation of clinical language skills in clinical settings of most benefit to patients from a non-English-speaking background (Minas, Stuart & Klimidis 1994, p 257). In summary, the first step to achieving these ideals is the enumeration of bilingual staff in an area health service and the identification of how these languages are currently used within mainstream health services.

The study reported in this paper addressed the following research questions.

- What proportion of staff are bilingual or multilingual?
- What are the languages spoken by these staff and how do they compare to the equal employment opportunity database, workforce planning data, and the SWSAHS population?
- What are the characteristics of bilingual or multilingual staff (languages spoken, staff category, clinical practice area)?
- How frequently do staff use a language other than English in patient encounters and in what situations do these interactions occur?
- What proportion of the bilingual/multilingual staff prefer not to disclose their language skills and what are the reasons for this non-disclosure?

## Methods

A cross-sectional descriptive survey of language skills of SWSAHS staff was undertaken in November and December of 1996.

## Sample

Some 3186 staff responded to the survey questionnaire distributed to 5877 staff. Respondents were compared by broad language category data with the only other known source of data on language available for the SWSAHS workforce, the equal employment opportunity survey of 1996. The overall response rate was 51% (76.08%, 964/1267 for bilingual staff; 41.50%, 1903/4586 for monolingual staff (English-speaking); 213 persons did not complete the item referring to languages spoken). Although the overall response rate was moderate, this study focused on issues relating to bilingual staff. The response for bilingual staff was far more critical and was satisfactory (76%). The response rate also varied by staff category, with extremely high responses being received from nurses (97%–100%; comparisons made with NSW Health Nursing Workforce Annual Survey of 1994).

Other characteristics of all respondents include age at last birthday, gender, country of birth, type of service employed in, and length of employment. The age of staff was mainly in the 35 to 44 years category (35.8%) with 26.2% of staff being between 25 and 34 years of age. The majority of respondents were women (81.8%; 2578/3151 – 35 staff did not complete this item). For all respondents, 61.5% were born in Australia, with the next most predominant group being born in the Philippines. Seventy-five per cent of the survey

respondents worked within the hospital environment. The majority of staff (47%; 1462/3094 – 92 staff did not complete this item) were employed within SWSAHS for six or more years.

### **Survey questionnaire**

The questionnaire consisted of a three-page survey in a format that allowed for subsequent scanning. Items in the questionnaire included demographic data such as gender, age, years employed by SWSAHS, staff category, areas of clinical practice and country of birth. Items relating to the language audit included whether the staff member spoke a language other than English at home, whether they used other languages when talking with patients or their families at work, how frequently they used these language skills, in what situations, and whether they would like to participate in a focus group to discuss the use of a second language in the health service. Finally, an item was included that requested whether the staff member would be happy to have their language skills assessed. Staff wishing not to disclose their additional languages were also asked the reasons why.

Standard items such as language spoken at home were used to allow for comparison with the census data for the population in south-western Sydney. Items on the frequency of second language usage were developed throughout the pilot testing phase and closely matched the items used in the study by Minas, Stuart and Klimidis (1994). A set of specific clinical situations were devised, based on a data collection tool used by the interpreter service with minor modifications, and ranged from 'simple conversation' to 'counselling and therapy'.

Pilot testing of the questionnaire was undertaken in representative groups of the SWSAHS staff. In total, 158 staff completed a questionnaire and modifications were made to enhance the questionnaire. Particular difficulties arose from multilingual staff and it was decided that only a low level of information would be obtained for the third or subsequent language spoken.

### **Procedure**

The survey form was attached to the pay slips of all SWSAHS staff. There was no linkage between pay slip and survey form or staff identifier placed on the survey form, thus assuring confidentiality. Prior to the survey date, information about the study was sent to all general managers, requesting site support on the day of the survey. As a large proportion of staff who would be completing the survey spoke English as a second language, additional support was offered to staff at each site. All site support staff received a one-hour educational session on the

purpose of the survey and any particularly difficult items. Also, this group shared ideas on how to best provide support to staff. All surveys were returned via an envelope through the internal mail.

All data were scanned and a text file extracted. Logical checks were applied to the data to identify and correct missing or illogical responses and eliminate same language answers.

Ethical clearance for this study was provided by the SWSAHS Ethics Committee. A letter containing information about the survey was attached to each survey form outlining the aims of the study, what would be done with the information from the study, and that this was a voluntary survey and that confidentiality of staff information and anonymity would be maintained at all times. Staff were also assured that participation in the survey in no way obligated the staff member to any extended role beyond their current job description.

## Results

Survey data were analysed using the computer package Statistical Package for the Social Sciences (SPSS) for Windows 6.1, using descriptive statistics and, where applicable, cross-tabulations. The results presented in this section of the paper focus on bilingual staff only and answer the research questions posed for the study.

### Languages spoken by bilingual/multilingual staff

Table 1 demonstrates that 928 staff are bilingual or multilingual. The total percentage of bilingual or multilingual staff based on this response rate would be 30%. Reflecting upon the response rates, this would be a slight overestimate due to the poor response rate in staff speaking English only compared to staff speaking a language other than English. The likely estimate when adjusting for the differing response rate would be 27%.

The languages spoken at home are listed in Table 2. The more prevalent languages are Tagalog (Filipino), Cantonese and Spanish. Table 2 does not include those staff who speak English at home but also speak another language or those who are multilingual. These additional staff are included in Table 3. It is important to note that staff could have selected more than one response. This would suggest that they could be bilingual or multilingual.

Other characteristics that may be important in understanding the potential roles and skills of bilingual or multilingual staff include what staff category they are, and in which clinical area they are located (Table 4).

**Table 1: Staff who speak any other languages<sup>1</sup>**

	Number	Percentage
No, speak English only	2074	69.1
Yes, bilingual, I speak another language at home and English	556	18.5
Yes, bilingual, I speak English at home and another language	185	6.2
Yes, multilingual	187	6.2
Unknown <sup>2</sup>	104	–
<b>Total</b>	<b>3106</b>	<b>100.0</b>

Notes:

1. Excluding ethnic health staff/interpreters.
2. No response recorded for this item.

**Table 2: Languages, other than English, spoken at home<sup>1</sup>**

Language	Number	Percentage
No, English only	2221	73.7
Yes, Italian	45	1.5
Yes, Greek	32	1.1
Yes, Tagalog (Filipino)	113	3.7
Yes, Arabic	32	1.1
Yes, Hindi	57	1.9
Yes, Mandarin	21	0.7
Yes, Cantonese	89	3.0
Yes, Vietnamese	49	1.6
Yes, Spanish	74	2.5
Yes, Other	282	9.4
Unknown <sup>2</sup>	91	–
<b>Total</b>	<b>3106</b>	<b>100.0</b>

Notes:

1. Excluding ethnic health staff/interpreters.
2. No response recorded for this item.

**Table 3: Other languages spoken**

Language	Number of responses <sup>1</sup>	Percentage
Yes, Italian	41	11.0
Yes, Greek	10	2.7
Yes, Tagalog (Filipino)	6	1.6
Yes, Arabic	9	2.4
Yes, Hindi	10	2.7
Yes, Mandarin	32	8.6
Yes, Cantonese	23	6.1
Yes, Vietnamese	5	1.3
Yes, Spanish	26	7.0
Yes, Other	212	56.7
<b>Total</b>	<b>374</b>	<b>100.0</b>

*Note:*

1. This sample excludes ethnic health staff/interpreters and is a multiple response item (n = 315).

Many bilingual staff are nurses (40.2%), allied health staff (16.0%) and hotel and support staff (7.3%). This also highlights the small proportion of staff in the ethnic health/interpreter category who are available to provide assistance in communication throughout mainstream services.

An understanding of the area of practice of bilingual staff allows the health service to consider what type of service model may be possible. Different models may be considered that utilise large or small numbers of bilingual staff, depending on the ethnic groups that may present within these practice areas. Bilingual staff worked in a diversity of clinical areas, with the major areas being medical (11.7%), surgical (8.4%), aged care (7.3%), child and youth (6.1%), and mental health (5.7%).



**Table 4: Staffing category (bilingual staff only)**

<b>Staffing category</b>	<b>Number</b>	<b>Percentage</b>
Senior management	6	0.6
Medical staff (senior)	41	4.2
Medical staff (junior)	15	1.5
Senior nursing (NUM)	22	2.2
Registered and enrolled nurse	397	40.2
Allied health	158	16.0
Diagnostic	31	3.1
Ethnic health/interpreter	59	6.0
Health promotion	17	1.7
Clerical staff (front-line/patient contact)	59	6.0
Clerical staff (no patient contact)	56	5.7
Trades (managers, supervisors)	1	0.1
Trades (staff and apprentices)	7	0.7
Hotel and support services (managers, supervisors)	9	0.9
Hotel and support services (staff)	72	7.3
Other	37	3.7
Unknown <sup>1</sup>	6	—
<b>Total</b>	<b>993</b>	<b>100.0</b>

*Note:*

1. No response recorded for this item.

### **Comparison between languages of bilingual staff and SWSAHS population**

The comparison presented in Table 5 emphasises the similarity in proportion of many language groups in south-western Sydney to that of the bilingual/multilingual staff, although two major differences are apparent. For the Arabic language, the health staff represent 1% of all staff, whereas in the 1996 Census 5.0% of the SWSAHS population was Arabic-speaking. A similar disparity can be seen with 5.2% of the SWSAHS population speaking Vietnamese and 1.6% of the health staff speaking the same language. To a lesser extent, there appears to be an under-representation of staff speaking Italian, Greek, Croatian and Serbian compared with the 1996 Census data. Conversely, Tagalog (Filipino) and Hindi-speaking staff are present in the area health service workforce in greater proportions than for these language groups in the SWSAHS population in 1996.

At the time of writing, a detailed birthplace listing from the 1996 Census was not available, precluding analysis of some birthplace groups significant in south-western Sydney, such as those from Cambodia and Laos.

**Table 5: Comparison between the 1996 Census and the survey of language spoken at home**

	1996 Census <sup>1</sup>		Survey <sup>2</sup>	
	Number	Percentage	Number	Percentage
Speaks English only	389 743	60.3	2 221	71.5
Speaks other languages:				
Arabic, including Lebanese	32 177	5.0	32	1.0
Australian indigenous languages	79	0.0	0	0.0
Chinese languages:				
Cantonese	15 960	2.5	89	2.9
Mandarin	5 617	0.9	21	0.7
Other	5 613	0.9	8	0.3
<i>Total</i>	<i>27 190</i>	<i>4.2</i>	<i>118</i>	<i>3.8</i>
Croatian	7 287	1.1	14	0.5
French	2 181	0.3	8	0.3
German	3 534	0.5	17	0.5
Greek	11 240	1.7	32	1.0
Hungarian	1 193	0.2	5	0.2
Indonesian	888	0.1	6	0.2
Italian	21 137	3.3	45	1.4
Macedonian	5 896	0.9	15	0.5
Malay	109	0.0	3	0.1
Maltese	3 662	0.6	10	0.3
Netherlandic	828	0.1	14	0.5
Polish	4 571	0.7	19	0.6
Portuguese	1 256	0.2	5	0.2
Russian	1 515	0.2	4	0.1
Serbian	7 000	1.1	14	0.5
Spanish	16 685	2.6	74	2.4
Tagalog (Filipino)	6 107	0.9	113	3.6

*continued*

**Table 5: Comparison between the 1996 Census and the survey of language spoken at home *continued***

	1996 Census <sup>1</sup>		Survey <sup>2</sup>	
	Number	Percentage	Number	Percentage
Turkish	2 610	0.4	8	0.3
Vietnamese	33 578	5.2	49	1.6
Other <sup>3</sup>	45 043	7.0	189	6.1
<i>Total</i>	<i>235 766</i>	<i>36.5</i>	<i>794</i>	<i>25.6</i>
Not stated	18 918	2.9	91	2.9
Overseas visitor	2 119	0.3	0	0.0
<b>Total</b>	<b>646 546</b>	<b>100.0</b>	<b>3 106</b>	<b>100.0</b>

*Notes:*

1. Persons aged five years or more (Australian Bureau of Statistics, 1996 Census of Population and Housing).
2. Staff (excluding 61 ethnic health workers) who speak English at home but also speak another language would appear in the 'Speaks English only' category. This results in some omission of potential languages used by these staff in this table.
3. Includes 'inadequately described' and 'non-verbal so described'.

**Language usage patterns**

Although these languages may be present in staff, the mismatch between the available skill and the opportunity to use the language needs to be examined. Table 6 highlights that most bilingual staff do use their language other than English at work.

A closer examination of these patterns by frequency in Table 7 highlights that language use by ethnic health staff (including interpreters) is nearly twice as frequent in terms of daily use. Forty-eight per cent of the ethnic health staff (including interpreters) use their language skills more than once a day compared to 3.1% of the bilingual staff. Forty-seven ethnic health staff (including interpreters) (90.4 %) use their language skills once or more a week, compared to the 173 bilingual staff (37%) using their language skills once or more a week. Differences in the 'Rarely' category are more pronounced, with a large proportion of bilingual staff (37.4%) rarely using their language skills. These differences may be expected, as most ethnic health staff are employed to work with a particular community and interpreters work constantly in two or more languages. However, the total number of bilingual staff using their language skills on a daily basis (n = 95) exceeds the number of ethnic health staff (including interpreters) (n = 42).

**Table 6: Uses other language at work, speaks a language other than English at home<sup>1</sup>**

	Number	Percentage
No	291	37.3
Yes	489	62.7
Unknown <sup>2</sup>	2326	–
<b>Total</b>	<b>3106</b>	<b>100.0</b>

Notes:

1. Excluding ethnic health staff/interpreters.
2. No response recorded for this item, not applicable to monolingual staff.

Bilingual staff were also asked whether they preferred to tell others about their language skills. One-quarter of them did not wish to tell others. The reasons given by staff for such reluctance related to not speaking the language well enough (38%, 115/303) as well as perceiving this role not to be their job (13%, 39/303). Negative attitudes of fellow workers were also an issue, although not to a major extent (7.9%, 24/303). These staff noted 'bad' experiences. Thirty-seven per cent of bilingual staff (excluding ethnic health staff/interpreters) were willing to have their language skills assessed (345/943).

**Table 7: Frequency of language use**

Frequency	Ethnic health staff Interpreters/Interpreters only		All bilingual staff (excluding ethnic health)	
	Number	Percentage	Number	Percentage
More than once a day	25	48.1	15	3.1
About once a day	17	32.7	80	16.6
About once a week	5	9.6	78	16.2
About once a month	4	7.7	74	15.4
Rarely	1	1.9	180	37.4
Other	0	0.0	54	11.2
Unknown <sup>1</sup>	11	–	447	–
<b>Total</b>	<b>63</b>	<b>100.0</b>	<b>928</b>	<b>100.0</b>

Note:

1. No response recorded for this item.

## Situations where language skills are used

There was a mixture of situations in which staff used their skills, with giving directions and simple conversation being the predominant situations. There were, however, a considerable number of situations in which complex language skills were used such as counselling, consent and taking a medical history. Bilingual staff appear to be involved in a wide spectrum of situations in which their language skills are being utilised.

A question was also included in the survey asking all staff, bilingual or not, whether they would like to discuss aspects of second language usage. Both monolingual and bilingual staff were encouraged to participate and 792 staff wished to discuss the issue. This emphasised the importance of the issue to staff and the investigators used other research techniques, not reported here, to explore more complex issues surrounding the use of language skills by bilingual staff.

**Table 8: Situations of language use at work**

Situations	All bilingual staff (excluding ethnic health/interpreters) (n = 487)	
	Number of responses <sup>1</sup>	Percentage
Simple conversation	358	17.6
Giving directions	267	13.1
Registering/booking	81	4.0
When patients/clients are upset	186	9.1
Identification of problem and giving explanation	233	11.5
Taking medical history and assessing medical condition	176	8.7
Explanation/consent for treatment or procedure	171	8.4
Consent for release of information	40	2.0
Written consent	31	1.5
Ongoing treatment	186	9.1
Education	168	8.3
Counselling and therapy	92	4.5
Other situation	44	2.2
<b>Total</b>	<b>2033</b>	<b>100.0</b>

*Note:*

1. This is a multiple response item.

## Discussion

Language barriers remain a critical impediment to providing appropriate health care within mainstream health services. This study represents the largest reported language audit of all staff within an area health service. Survey questionnaire items have been developed and applied to SWSAHS staff. The aim of this study was to establish the proportion of bilingual or multilingual staff and compare these proportions with the population. The second major component of this study was to identify how frequently bilingual or multilingual staff use their language skills and in what context. Identification of staff who are unwilling to disclose their language skills and the reasons for such non-disclosure were also an important area of interest. The response rate to the survey questionnaire in the bilingual staff was satisfactory (76%), but a lower response rate was obtained from monolingual staff (English-speaking) (42%). This has resulted in a slightly higher estimate (31%) of bilingual staff than that likely to be present in the population. The response rate within bilingual nurses was very high.

Some 741 staff (25%) have been identified within this survey as bilingual, with a further 187 staff members being multilingual (6%). This total proportion (31%) is similar to that found by Minas, Stuart and Klimidis (1994) in a study of mental health staff in Victoria. Predominant languages spoken by staff include Tagalog (Filipino), Cantonese, Hindi, Spanish, Vietnamese and Italian. The languages spoken by staff were compared with the 1996 Census data on 'languages spoken at home' by the population within SWSAHS. There were similar proportions in many languages, but shortfalls in such groups as Arabic (including Lebanese) and Vietnamese speakers were evident. These are major ethnic groups represented in the SWSAHS population and represent a significant number of health consumers. To a lesser extent, shortfalls were evident for Italian, Greek, Croatian and Serbian speakers. The mismatch for these predominant population groups will continue unless recruitment is focused on particular language groups. This suggests the use of a focused employment policy, such as the targeted employment of an Arabic-speaking staff member in an area where there are high concentrations of Arabic-speaking patients. The presence of a similar overall proportion of bilingual and bicultural staff may engender tolerance and adaptability in the provision of care to a diverse population. High concentrations of specific language groups in staff, relative to population size, may provide an opportunity for other roles beyond communication, for example, involvement in health promotion activities.

Most bilingual or multilingual staff use their language skills at work (62.7%). The frequency with which these skills are used in patient encounters is high, with 173 (37%) bilingual staff members using their language skills weekly or more

frequently. A comparison with ethnic health staff demonstrated that 90.4% of ethnic health staff and interpreters use their language skills weekly or more frequently. However, the small number of these specialised workers emphasises the major contribution bilingual and multilingual staff make to enhancing communication with patients. This also highlights the valuable resource these staff members are to the organisation. The Minas, Stuart and Klimidis study (1994) concluded that bilingual mental health staff were only able to use their language skills in a small number of clinical encounters. These authors reinforced the importance of locating the staff member with the skill in close proximity to the patient requiring the communication skills (Minas, Stuart & Klimidis 1994). There was a high proportion of staff who rarely used their language skills (37%) in this study. This may reflect lack of opportunity for contact or limited need.

Non-disclosure of language skills was present, but at much lower levels ( $n = 303$ ) than were expected. The major reason for non-disclosure was related to the staff member being unable to speak the language well enough. In contrast, 345 bilingual staff were agreeable to having their language skills reviewed by an independent assessor. The final area of interest in the survey data was the situations in which staff used their language skills. Predominance existed in the area of simple conversation and giving directions (30%), with other major situations being identifying problems and giving explanations (12%). The high frequency of these types of language use support the perception that non-clinical forms of communication are important to consumers and staff, and are often unmentioned in contemporary research in this area. The more clinical forms of communication are often the only forms reported.

The numbers of bilingual and multilingual staff within mainstream services and the frequency of their language use suggest that a substantial resource is available for patients from a non-English-speaking background within the SWSAHS. The ability of the organisation to locate these skills in close proximity to patient need is the challenge that goes beyond this study. The development of appropriate policies and procedures that would protect and nurture these skills to the benefit of patients from a non-English-speaking background and health providers is the opportunity facing this organisation. These investigators are currently examining the role and function of bilingual staff, and the experience from monolingual staff's perspective.

Although being able to communicate with a patient in their own language is important, this is recognised as only one element in providing culturally competent care. The availability of language skills does not equate to cultural competence (information about the culture, attitude and skills such as cross-cultural communication, cultural assessment) (Lipson 1996). This study focused

on human resources within an organisation, rather than the organisational culture that would foster innovative approaches to service delivery. Fong and Gibbs (1995) propose some areas that also should be considered, such as organisational assumptions and values, staff dynamics, organisational processes, behavioural norms and the mode of dealing with culturally diverse clients. The knowledge gained from this study is the first step within this change process.

The findings of this study highlight the availability of bilingual health professionals and other staff, and the willingness of these staff to provide complementary services. The information gained from this survey, and the subsequent research in progress, should provide the foundation for policy direction related to language use within health services.

Changes in the demographics of the population – consumers and health staff – now provide us with the opportunity to better match culturally and linguistically diverse consumer needs with available resources. This opportunity can be expected to increase over time, although the diversity of the area and the high number of new arrivals (less likely to include those with recognised health qualifications) need to be recognised in any attempts to improve the ‘match’ between the staff profile and the consumer population.

This provides greater potential to operate according to a productive diversity model as described by Cope and Kalantzis (1997). Some of the processes required have been defined by this study, while others require further development. The process followed throughout this study included the identification of the demand, the enumeration of the resource, and confirmation of the willingness of the resource to provide the service. The organisational culture must be able to support this process of change. This requires the organisation to have the flexibility to locate bilingual workers where the need is, to provide the policy to protect staff in their roles, and to target recruitment towards priority language groups. The outcome may be enhanced satisfaction for health consumers and health professionals.

Further research needs to introduce or examine service delivery models that locate bilingual workers in close proximity to client need. The responses of health care consumers to these innovative models would need to be assessed. Language competence assessment of health care professionals is also a component of language use in health and requires further research. Research efforts should also be directed to developing and evaluating appropriate policy.

This study takes a crucial first step towards realising equitable and culturally appropriate health care utilising the principles of productive diversity. This preliminary step is part of a process which will naturally unfold within a



supportive environment. The ability to provide this supportive environment is the future challenge for health care services, peak professional bodies and policy-makers.

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