

Why public health practitioners and researchers must stop using the term ‘culturally and linguistically diverse (CALD)’

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ABSTRACT

The term ‘culturally and linguistically diverse’ (CALD) is used in Australia to describe some groups of migrants. Implicitly, the term defines ‘others’ who are ‘different’ to the dominant normative Australian. The use of the term as standard language in health literature and public discourse has increased dramatically over the past decade. Australians who are labelled as CALD have argued that the term affects their sense of belonging to the Australian community. As public health researchers and practitioners, we must minimise potential risks of harm, maximise health benefits and ensure the rigour of our data collection, analysis and reporting methods. We argue that we must refrain from continuing to use this concept and that there is no need for a new label to categorise some members of our diverse Australian population as ‘others’.

Keywords: diversity, equity, ethics, inclusive language, migrants, public health, refugees, social cohesion.

KEY POINTS

- The term ‘culturally and linguistically diverse’ stems from historical social categorisation, which uncritically divides the Australian population into ‘them’ and ‘us’.
- The use of the term in health literature and public discourse has increased dramatically.
- Public health researchers and practitioners should refrain from continuing to use the term to prevent harm.
- Collection, analysis and reporting of specific and detailed demographic data relevant to the topic of interest and population is essential for improving health equity.

Introduction

In Australia, individuals born overseas and descendants of migrants are from various cultural, religious and linguistic backgrounds, reflecting a wide range of socioeconomic and English proficiency statuses.¹ Many of these overseas-born individuals and their families are commonly categorised as ‘culturally and linguistically diverse’ (CALD) groups in health research and policy. The concept of CALD has no agreed-upon definition and is applied inconsistently.² Recent critiques of the term suggest that modifying and standardising the definition is needed, including adding ethnicity as a criterion.^{2–4} However, a more defined concept is unlikely to change the effects of such a term, which can be alienating and indiscriminating by constructing a population of ‘others’.^{3–9} Positioning a group within the population as ‘others’ can shape and perpetuate negative stereotypes, contributing to experiences of discrimination and racism and, thus, poorer health outcomes.^{10–12} In an era where anti-immigration sentiments are rising in Western democracies,¹³ with some veering towards fascist autocracy, it is imperative to scrutinise how previously well-intentioned classifications can undermine inclusivity and, more seriously, human rights. Adding to the recent calls by Abdi *et al.* for the CALD category to be discontinued,¹⁴ in this commentary, we discuss the history of the term, the use of the term in health literature and public discourse, its harms, and our responsibilities as

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public health researchers and practitioners. Although this paper focuses on the Australian context, a similar argument can be helpful for other countries where terms such as ‘ethnic minorities’, ‘visible minority’, ‘Black, Indigenous, and people of colour (BIPOC)’ or ‘people of colour (POC)’ simultaneously homogenise otherwise diverse peoples and define ‘others’ within society.¹⁵ It is also important to note that discontinuation of the use of the term ‘Black, Asian and minority ethnic (BAME)’ in the UK government’s communications was based on the recognised harms associated with its use.¹⁶

The history of the term

The term ‘culturally and linguistically diverse’ is linked to the Core Set of the Standards that the Ministerial Council of Immigration and Multicultural Affairs defined to replace the term ‘non-English speaking background (NESB)’. The Council report did not contain the term ‘culturally and linguistically diverse’;¹⁷ rather, over time, it has been adopted as a shorthand for describing broad groups of migrants in Australia.

The increasing use of the term

To investigate the popularity of the term, we reviewed global scientific health publications. In November 2024, we searched PubMed,¹⁸ one of the main databases for health research, using the simple search string ‘culturally and linguistically diverse’. We did not define any inclusion and exclusion criteria. We found 1051 publications, with the first two publications originating in the United States of America (USA) in 1992. Between 1992 and 1999, there were seven publications from the USA and one from South Africa. In 2000, there were two publications, both from Australia. The number of publications increased gradually and peaked in 2023 with 177 publications.

When we added ‘AND Australia*’ to the PubMed search string to capture publications from Australia, 796 publications were located, peaking in 2022 with 136 publications. After the year 2000, on average, 74% of the global publications using the term ‘culturally and linguistically diverse’ were from Australia, with a range between 33% and 100%.

The rising popularity of the term ‘culturally and linguistically diverse’ in Australia is also reflected in public discourse. To investigate the relative popularity of the term in Australian discourse over time, we used Google Trends¹⁹ data from January 2004 (availability of Google Trends) to October 2024 (the month before conducting the search). ‘Relative popularity’ is presented as a relative search volume (RSV) and ranges between 0 and 100 for each month.

The first RSV value was given to the term in March 2011 as 52, and in April 2011, the term had its third-highest RSV with a value of 97. The value fluctuated between 0 and 69 until March 2022, when it reached 76. After that, the

average value was 72.5, with 18 out of 31 months having a value above 76, with a notable peak of 100 in February 2023 and 99 in August 2022.

Together, these searches demonstrate that the use of CALD as a categorisation is growing globally and particularly in Australia. Although the increased focus on the health of migrants is generally intended to improve health equity, the use of the term as a standard language to describe an apparent group within the Australian population is creating harm.

Labelling ‘cultural difference’ throughout Australia’s history

As outlined in the recent commentary by Abdi *et al.*,¹⁴ the term ‘culturally and linguistically diverse’ has only entered Australian policy and popular discourse in the past few decades, yet it stems from a longer lineage of seeking to account for ‘cultural difference’ when the Australian population is counted. We contend that extending even further back to the colonisation of the continent provides insights into long-standing constructions of ‘citizen’ and ‘non-citizen’ that are still at play today. Australia’s 1901 constitution treated Aboriginal and Torres Strait Islander peoples differently from settlers, and they were excluded from being counted as part of the national population.²⁰ Following the Federation, the *Immigration Restriction Act 1901*, the *Pacific Island Labourers Act 1901* and the *Naturalisation Act 1903* aimed to restrict immigration to those of British origin. These laws formed what was known as the White Australia Policy.²¹ Australia’s early migration policies occurred against a global backdrop of scientific exploration and natural history scholarship influenced by discredited 18th and 19th century theories of ‘race’. From the late 1700s, the works of scholars, such as Francois Bernier and Carolus Linnaeus, involved categorisation based on skin colour, and the construction of hierarchies that devalued those classified as non-European.²² While these theories may seem antiquated now, their legacy persists in ideas of cultural diversity being something other than white Europeans.

Decades of multicultural policy in Australia have contemplated and redefined why ethnic and cultural differences are important and how they should be described and counted. As such, echoes of discredited racial hierarchies sit below the surface of broad population categories that are uncritically described in relation to an ‘Australian’ mainstream. Implicitly, the term ‘culturally and linguistically diverse’ defines ‘others’ who are ‘different’ to a dominant normative Australian ‘Self,’ presumably, the ‘white Australian’.^{7,8}

Negative effects of the term

As described above, labelling a group within a population as ‘other’ has been used throughout history as a powerful tool

to enforce real or imaginary differences. Commonly, these labels are linked to undesirable characteristics and negative stereotypes.¹¹

With the increased use of the term ‘culturally and linguistically diverse’ in public discourse, Australians who are categorised as CALD have argued that the term affects their sense of belonging to the Australian community. They have argued that the label doesn’t celebrate diversity but rather creates an invisible line, marking some groups of the Australian population as ‘not quite Australian enough’. They describe how being labelled as CALD feels ‘weird’ and ‘othering’ – as though it boxes people into a category that marks them as fundamentally different from the mainstream.^{5–9} Research has consistently shown that such othering leads to the labelled group experiencing status loss, stigma, discrimination and racism, affecting their access to resources and services, including healthcare, education and employment, as well as their health outcomes.^{11,12,23}

So, as public health researchers and practitioners, what can we do?

Myser (2003) in Mayes (2020) argues that ‘by ignoring the way dominant social and ethical theories normalise whiteness “we risk repeatedly reinscribing white privilege – white supremacy even – into the very theoretical structures and methods we create as tools”...’.²⁴ Considering the concept of CALD in light of Australia’s colonial history brings into sharp relief deep ethical and social problems.

Public health researchers and practitioners are well versed in their ethical and professional obligations to minimise potential risks of harm and to maximise health benefits. As public health research and practice evolve, we identify new risks related to our practice that we did not recognise previously. However, when we become aware of new risks, it is our responsibility to make sure that we do not use tools or language that may perpetuate harm to individuals or society. As we have reported, although the use of the term is often well-intended to highlight inequities, it can also increase division and reinforce negative stereotypes or ‘soft’ racial hierarchies.

Apart from our ethical responsibilities, we also need to ensure the rigour of our data collection, analysis and reporting methods. By using the term ‘culturally and linguistically diverse’ as a category, we erase the differences among diverse groups of the Australian population and simply assume that the population can be categorised into two large groups: (1) mainstream and (2) CALD. Categorising people as CALD oversimplifies the various health experiences of different migrant communities, shaped by factors such as social status in society, ethnicity, appearance, place of birth, religious beliefs, language, sexual orientation, gender, disability, socioeconomic status, length of stay in the destination country and citizenship. We suggest that data broken down into smaller, specific variables relevant to the

topic of interest and population is essential for improving health equity and reducing unintended negative impacts. Reporting the diversity of the population of interest with sufficient and specific demographic data can help to highlight inequities that might not be visible in aggregated data. Following the philosophies of co-design, we can work in partnership with communities to better understand how multiple demographics and social identities intersect to shape individuals’ health experiences and outcomes.²⁵ In particular, processes of co-design can assist public health to shift away from a deficit discourse to other matters of interest to migrant Australians. Based on the ethical and professional obligations of public health researchers and professionals to ‘minimise harm and maximise benefits’, we also ask health-related journals to discontinue the use of the term CALD in their publications.

Conclusion

The term ‘culturally and linguistically diverse’ in Australia stems from a history of social categorisation, that uncritically divides the population into positions of ‘us’ versus ‘them’. With the increasing use and popularity of the term and the normalising of its use in public discourse, the potential for harm to social cohesion, individuals and groups is heightened. As public health researchers and practitioners with the obligation to minimise harm and maximise benefits, we must refrain from continuing to use this term. We argue for the considered use of variables that carefully and accurately reflect the spectrum of contemporary migrant Australians. We argue that there is no need for a new term to replace ‘culturally and linguistically diverse’ and further categorise some groups of the Australian population as ‘others’.

Ethics

No ethics approval was needed for this commentary.

References

- 1 Australian Bureau of Statistics. Characteristics of recent migrants. Canberra: ABS; 2019. Available at <https://www.abs.gov.au/statistics/people/people-and-communities/characteristics-recent-migrants/latest-release> [cited 17 June 2025].
- 2 Pham TTL, Berecki-Gisolf J, Clapperton A, O’Brien KS, Liu S, Gibson K. Definitions of Culturally and Linguistically Diverse (CALD): A Literature Review of Epidemiological Research in Australia. *Int J Environ Res Public Health* 2021; 18(2): 737. doi:10.3390/ijerph18020737
- 3 Sawrikar P, Katz I. How useful is the term ‘culturally and linguistically diverse’ (CALD) in Australian research and policy discourse? Social Policy Research Centre; 2009. Available at <https://apo.gov.au/node/17673> [cited 17 June 2025].
- 4 Marcus K, Balasubramanian M, Short S, Sohn W. Culturally and linguistically diverse (CALD): terminology and standards in reducing healthcare inequalities. *Aust N Z J Public Health* 2022; 46(1): 7–9. doi:10.1111/1753-6405.13190
- 5 Adusei-Asante K, Adibi H. The ‘Culturally and Linguistically Diverse’ (CALD) label: a critique using African migrants as exemplar. *Australas Rev Afr Stud* 2018; 39(2): 74–94. doi:10.22160/22035184/ARAS-2018-39-2/74-94

- 6 Scanlon Foundation Research Institute. 'Why call me that?' Reflections on labels in a diverse nation. 2023. Available at <https://scanloninstitute.org.au/publications/essays/reflections-on-labels> [cited 8 December 2024].
- 7 Udah H, Singh P. 'It still matters': The role of skin colour in the everyday life and realities of black African migrants and refugees in Australia. *Australas Rev Afr Stud* 2018; 39(2): 19–47.
- 8 Hatoss A. Where are you from? Identity construction and experiences of 'othering' in the narratives of Sudanese refugee-background Australians. *Discourse Soc* 2012; 23(1): 47–68. doi:10.1177/0957926511419925
- 9 Udah H. Searching for a place to belong in a time of othering. *Soc Sci* 2019; 8(11): 297. doi:10.3390/socsci8110297
- 10 Bhopal R. Spectre of racism in health and health care: lessons from history and the United States. *BMJ* 1998; 316(7149): 1970–3. doi:10.1136/bmj.316.7149.1970
- 11 Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol* 2001; 27(1): 363–85. doi:10.1146/annurev.soc.27.1.363
- 12 Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. *Annu Rev Public Health* 2019; 40: 105–25. doi:10.1146/annurev-publhealth-040218-043750
- 13 Cheung-Blunden V, Dechesne M, Miodus S, Dixit S, Hyun RN. Sources of anti-immigrant sentiments in Western democracies: A contextual approach. *Curr Opin Psychol* 2022; 47: 101432. doi:10.1016/j.copsyc.2022.101432
- 14 Abdi I, Tinessia A, Mahimbo A, Sheel M, Leask J. Is it time to retire the label "CALD" in public health research and practice? *Med J Aust* 2025; 222(5): 220–2. doi:10.5694/mja2.52608
- 15 Library of the Canadian Parliament. Race and Ethnicity: Evolving Terminology. 2022. Available at <https://hillnotes.ca/2022/01/31/race-and-ethnicity-evolving-terminology/> [cited 17 June 2025].
- 16 The United Kingdom Government Office for Equality and Opportunity. Why we no longer use the term 'BAME' in government. 2022. Available at <https://equalities.blog.gov.uk/2022/04/07/why-we-no-longer-use-the-term-bame-in-government/> [cited 17 June 2025].
- 17 Australian Bureau of Statistics. Standards for statistics on Cultural and Language Diversity. A set of statistical standards used to collect all necessary information for consistent measurement of cultural and language diversity in Australia. Canberra: ABS; 2022. Available at <https://www.abs.gov.au/statistics/standards/standards-statistics-cultural-and-language-diversity/latest-release> [cited 17 June 2025].
- 18 National Library of Medicine: National Center for Biotechnology Information. PubMed. Bethesda, MD: NLM; 2025. Available at <https://pubmed.ncbi.nlm.nih.gov/> [cited 17 June 2025].
- 19 Google. Google Trends. 2025. Available at <https://trends.google.com/trends/> [cited 17 June 2025].
- 20 Australian Human Rights Commission. About Constitutional Recognition, Aboriginal and Torres Strait Islander Social Justice, Founding document of the nation. Sydney, NSW; 2024. Available at <https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/about-constitutional-recognition> [cited 17 June 2025].
- 21 National Archives of Australia. The Immigration Restriction Act 1901. 2024. Available at <https://www.naa.gov.au/explore-collection/immigration-and-citizenship/immigration-restriction-act-1901> [cited 17 June 2025].
- 22 Ford CL, Airhihenbuwa CO. Critical race theory, race equity, and public health: toward antiracism praxis. *Am J Public Health* 2010; 100(S1): S30–5. doi:10.2105/AJPH.2009.171058
- 23 Staszak J-F. Other/otherness. In: Kobayashi A, editor. International Encyclopedia of Human Geography. Vol. 1. Elsevier; 2008. pp. 1–7.
- 24 Mayes C. White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare. *J Aust Stud* 2020; 44(3): 287–302. doi:10.1080/14443058.2020.1796754
- 25 Routen A, Lekas HM, Harrison J, Khunti K. Intersectionality in health equity research. *BMJ* 2023; 383: 2953. doi:10.1136/bmj.p2953

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