PERSPECTIVES

Addressing Language Barriers: Building Response Capacity for a Changing Nation

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The absence of universally available language services is a national healthcare system failure, the burden of which is suffered by patients with limited English proficiency and their healthcare providers. Conceptualizing mandatory provision of language access as an unfair, unfunded mandate ignores massive and fundamental social changes taking place. Overcoming language barriers is essential to safe, quality health care. This paper, informed by the experience of *Hablamos Juntos*, a national demonstration project funded by the Robert Wood Johnson Foundation, argues that national and health industry investments are needed to develop population-based approaches supported by communication and information technology, and that these investments may prove useful to improving healthcare communication for English-speaking patients as well.

KEY WORDS: patient-provider communication; patient safety; quality; interpreter; LEP; language barriers.

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INTRODUCTION

Around the world, 160 million people live outside their country of origin.¹ The face of America is changing too. In 1950, there were nine White persons under age 40 for every one person of color;² by 2000, this ratio was 1.7.³ Today, one in eight Americans is foreign-born,⁴ and 45% of children under age 5 are children of color.⁵ These demographic changes signal fundamental social changes that, in health care, will translate into increased cultural and language diversity among patients. Because communication in health care is vital to safe and quality health care, language barriers are emerging as a new risk that few doctors and healthcare organizations are prepared to handle.

Conceptualizing mandatory provision of language access as an unfair, unfunded mandate ignores massive and fundamental social changes taking place in the U.S. and abroad. As healthcare leaders, we can continue to leave patients and providers to figure this out, one encounter at a time, or we can

act boldly by investing in broader strategies and policies, those that can lead to building response capacity for the healthcare industry as a whole. To do more than just say no requires that healthcare leaders accept that our nation will include LEP populations well into the future and that overcoming language barriers is essential to safe, quality care.

CREATING POPULATION-BASED MODELS

In 1896, Henry Ford built his first car in a little brick shed in his garden.⁶ Thin Lizzie, as it was called, consisted of a two-cylinder, four-cycle motor, mounted on bicycle wheels with no reverse gear or brakes. Others were also building cars at the time, and Ford's initial attempt was not a big success. Later, as we know, Ford did succeed, by systematizing the manufacture of automobiles and by tapping the efficiencies and quality-control advantages of mass production. It is fair to say that Ford accelerated the adoption of automobiles as a mode of transportation and that, largely due to his big-picture thinking, we drive cars today whose performance, safety, and reliability, for the most part, we take for granted.

The healthcare industry's current response to language barriers is essentially requiring each provider to invent his or her own car. Hospitals and doctors, on their own, are expected to readily respond to all languages spoken in their communities, a daunting challenge when we consider there are more than 300 languages spoken in the U.S. What is even more amazing is that some healthcare providers are investing significant resources to meet the language needs of their communities. They are traveling health care's highways and byways in their versions of Thin Lizzie. Henry Ford's innovative thinking has not taken hold in the field of healthcare interpreting in the U.S.

In contrast, Australia has taken a population-based approach to translation and interpreting (together referred to as language services). The Translating and Interpreting Service (TIS), established in 1973 and operated by the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs, is the oldest interpreting service in Australia.⁷ Initially, the objective of the agency was to enable communication for immigration and naturalization services and for emergencies. Soon, other government and commercial businesses pressed for routine access to these language resources. Today, TIS is the largest language agency in Australia, competing for clients and interpreters against several other government and privately run language services.

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I recently site-visited TIS's national office and was able to observe their operations firsthand. The agency is highly computerized and enables access to more than 1,500 interpreters, who can be reached through a national call center located in Melbourne using a standard, toll-free number. Daily, interpreters speaking over 120 languages and dialects report their availability to accept assignments from their home computers or telephones. Interpreters can use cell phones, land lines, or computers to provide services and can be deployed to nearby assignments when in-person interpreting is needed. By simply calling the toll-free number and providing a personal identification number, federal, state, and local government offices, hospitals, doctors, and businesses can all be connected within seconds to an interpreter who speaks the language for which they need interpretation. Healthcare callers are given priority by the technology, and fees are waived for services to government-sponsored patients.⁸

TIS call-center operators simply ask what language is needed and call up a list of interpreters currently signed on to the system. The information technology supporting the network generates miniprofiles of interpreter qualifications and their certification, training, and interpreting experience to enable operators to match interpreters to the assignment. As impressive are the proficiency exams that have been developed for 57 of the 120 languages spoken in Australia. These exams are the work of the National Accreditation Authority for Translators and Interpreters, LTD (NAATI), an Australian government-owned company established in 1977 to develop standards and accredit interpreters and translators.⁹ NAATI serves as an advisory body for the translation and interpreting industry in Australia and is the accreditation body of first resort for new emerging languages. It is charged with creating methods to train and assess the skills of interpreters of less frequently used languages.

Australia and the U.S. are significantly different. The TIS model may not be suited to our market-driven healthcare system, but applying technology and population-based strategies may offer opportunities not imaginable in today's environment. State or federal grants to develop publicly funded regional models to pace fees set by private language agencies, and establish quality standards, can lead to benefits beyond cost savings and are certainly worth exploring.

INTERPRETERS FOR HEALTH CARE

Hablamos Juntos is a national program, funded by the Robert Wood Johnson Foundation, supporting 10 demonstration projects aimed at improving language services in healthcare organizations. As Director of the National Program Office overseeing these demonstrations, I have learned that assessing for language proficiency and training interpreters can be challenging and time-consuming. Through this program, I have also learned firsthand the level of effort required to develop trained interpreters for one language and wondered, "Why must each healthcare organization do this alone?"

Foundation funding, critical to incubate practical and innovative solutions for language services, is not enough to develop the resources needed or to match the scale of demand. Nationally coordinated efforts to assure readily available,

trained interpreters and translators would be more efficient. The federal Department of Education's Office of Special Education and Rehabilitative Services offers an example of a nationally coordinated approach using competitive grants to support Regional Interpreter Education Centers charged with growing the number of sign-language interpreters in the nation.¹⁰ Located in colleges and universities, these centers receive congressional funding to teach interpretation skills to new interpreters for the deaf and hard-of-hearing.¹¹ This sustained investment, over the last 30 years, has led to numerous American Sign Language interpreter training programs. The last round of funding, for the first time, designated a coordinating center to promote and encourage collaboration among the regional centers to advance sign-language interpreter training.

A similar national investment is needed to develop the pedagogy, assessment tools, and teaching methods needed to ensure consistent development of trained interpreters and translators for healthcare environments.

DEVELOPING HEALTH COMMUNICATION RESEARCH CENTERS

When Peter Sutherland, honorary Ambassador for the United Nations Industrial Development Organization, was asked how companies can prepare for success in an age of globalization, he responded "The only point of view any of us depends on is the view from where we are standing. Stand in many places to get many points of view."¹² So it is with language barriers. We need to stand in many places to envision new ways to meet the language and communication needs of diverse communities; interpreters are but one essential element. Language and communication are decidedly different. Adjunct to a shared language is content knowledge, a mysterious mixture of health literacy, culture-bound notions related to health and illness, and potentially other influences not yet defined. Key to communication is having a common language, but clearly, when 90 million English-speaking Americans have trouble understanding and acting on health information, shared language alone does not assure effective communication.¹³

As healthcare professionals, we need to develop a deeper understanding of communication issues that come with diverse patient populations and to distinguish health literacy challenges from language and cultural barriers. In doing so, we may be able to apply what we learn to improve communication with English-speaking and non-English-speaking patients alike. We also need to test and learn the benefits and drawbacks of different ways to deploy or use interpreters effectively and ways to ensure quality and safe health care for every patient without incurring more cost than value. With scarce resources being an ever-present challenge, effectiveness research – to guide responses in communities, within organizations, and between patients and doctors – is imperative. Without evaluation, we can end up foolishly spending healthcare dollars for Cadillac services when a Volkswagen may do.

The issues that need examination are complex and require the contributions of a variety of experts. Action-oriented research centers are needed to examine language barriers in the context of health communication, bringing together disciplines from different fields (applied and social linguistics, communication, etc.), as well as healthcare practitioners and

patients, to study different aspects of interpreting and applying what is learned to model development and best practices. Our current experience-based knowledge needs to be supplemented with disciplined examination of the benefits and limitations of different styles of interpreting (e.g., dialogue, simultaneous, consecutive) and the different mediums for providing interpreter services (via Internet, telephone, in person, or through video conferencing). Language access research can also explore the viability of virtual translation centers and repositories of translated documents and promote local registries of qualified interpreters and translators.

We also need to test different ways to pay for these services (e.g., subscriptions, per-minute fees) and to explore other solutions to leverage economies of scale across the healthcare industry or within regions or communities. If we are willing to redefine language barriers as a national concern visited on healthcare providers, we can see new approaches to address language barriers to health care.

CONCLUSION

Clear communication is essential for safe, quality healthcare services. Poor communication can lead to disastrous outcomes, especially for patients with limited English ability. Through the work of *Hablamos Juntos*, it has become clear that national and health industry investments are needed to develop the field of language services and that these investments may prove useful to improving health communication for English-speaking patients as well. The absence of universally available language services is a national healthcare system failure, the burden of which is suffered by patients with LEP and their healthcare providers. Healthcare organizations borrow and replicate untested solutions and programs and struggle to grow trained interpreters. There is no valid reason that healthcare organizations should independently develop, from scratch, the resources needed to provide language access for LEP patients. Lack of coordinated efforts is wasteful and contributes to wide variations in quality of interpretation and, ultimately, in quality of care and health outcomes.

Eliminating language barriers in health care requires a calibrated and focused effort to develop response capacity across the nation. Attending to language barriers at the provider level is essential, but working only at this level leaves communication gaps that undermine the benefits of these investments. Other than *Hablamos Juntos*, there have been few national investments to address language barriers to health care. Healthcare organizations expend precious resources reinventing the wheel without assuring quality and safe health care for all patients. Sustained investments in population-based solutions that leverage the power of computers and communication technology can lead to solutions that can reach across boundaries of responsibility to enable large and small healthcare provider organizations to serve patients of many languages. Funding for action-oriented research and evaluation, and to stimulate innovations and use of technology to make language services more affordable for everyone, is

needed, as are investments in the training of interpreters and development of healthcare materials in many languages. As our nation grows ever more linguistically diverse, we need to face the needs posed by language barriers in health care and develop efficient, coordinated solutions to meet them, rather than continue to reinvent the wheel, one provider at a time.

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