



National
Center
for
Cultural
Competence

Policy Brief 2

GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT ■ UNIVERSITY CENTER FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers

Nationally, linguistic diversity creates complex challenges for health care delivery systems. During the last decade the number of people in need of health care services who have limited English proficiency has risen dramatically. (The term limited English proficiency as used in this brief includes those individuals who do not speak English). Accurate and honest communication between health care providers and patients is essential for the effective delivery of quality health care services. Significant barriers exist in the delivery of linguistically competent health care services. These include but are not limited to the following:

- Although Title VI of the Civil Rights Act of 1964 prohibits discrimination against persons with limited English proficiency, there are statutes in many states that have English only requirements. The use of state funds to provide linguistic access services is strictly prohibited by these states. There is a perception that even Federal funds can not be used for the provision of linguistic access services within English only states. This continues to be litigated at the state and Federal levels.
- Standards for linguistic access have not been issued at the Federal level. In the absence of such Federal standards, there have been varying degrees of responsiveness among states. Very few states have developed standards for linguistic access. Those which have placed emphasis on Managed Care Organizations, provider contracting, and specific health and mental health services in defined settings.
- Health care providers are not typically trained in academic and continuing education settings to work with interpreters in providing services to people with limited English proficiency.
- There are shortages in qualified personnel to provide medical translation and interpretation services especially in rural areas.
- Inadequate resources have been allocated for the provision of translation and interpretation services at the state and local levels.
- Segments of the immigrant and refugee population are unlikely to advocate for translation and interpretation services due to linguistic and cultural barriers, which include the perception of adverse political repercussions.

These barriers highlight the need for primary health care organizations to develop and execute policies, structures, practices and procedures to support the delivery of linguistically competent health care services.

Rationale for Linguistic Competence in Primary Health Care Delivery Systems

■ *Changing Demographics*

According to 1990 Census data, 32 million people in the United States, or 13.8% of the population, speak a language other than English at home. Most current Census data indicate that there are over 300 languages spoken in the United States. This trend is expected to continue.

■ *It's the Law!!*

Title VI—Prohibition Against National Origin Discrimination—has specific provisions addressing persons with limited English proficiency. This Federal law and related guidance mandate the development of policies and procedures that address the language assistance needs for effective communication between health and social service providers and persons with limited English proficiency (See text box on page 3). This statute

mandates language assistance when language barriers cause persons with limited English proficiency to be excluded from or denied equal access to programs funded by the U.S. Department of Health and Human Services. Some states have enacted legislation that require health care organizations to provide linguistic access based on predetermined population thresholds within a defined geographic area.

■ ***Improved Access and Cost of Care***

Persons with limited English proficiency are not likely to seek health care services unless the providers meet their linguistic needs. Delays in seeking health care often result in the need for costly services to treat advanced stages of diseases. This has serious ramifications for both the health care delivery system and the individual. Invasive diagnostic and treatment procedures, specialty care, lengthy hospitalization and long-term care are costly. Delayed access to health care may result in lost wages, decreased productivity and an increased risk for chronic illness, disability, undue suffering and possibly death.

Studies have documented evaluation approaches and the cost benefits of providing interpretation services. Health maintenance organizations (HMOs) are beginning to recognize the benefit in providing interpreter services. In one midwestern state, three of the largest Medicaid HMOs consider interpretation services equivalent to social services and recognize that failure to provide these services transforms simple medical problems into complicated and expensive treatment and management issues. Chang, et al., 1998.

■ ***Meeting Accreditation Standards***

Accrediting agencies that review and certify hospitals and other health care facilities play a pivotal role in setting standards. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions such as home health care and psychiatric facilities, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health managed care organizations (MCOs), have adopted standards that require language access in health care.

JCAHO standards require health care organizations to “have a way of providing for effective communication for each patient served”. JCAHO standards expect that patient and family education take into account culture and language. The NCQA requires that MCO enrollees be provided with written materials that they can understand. This standard, however, only applies when 10% or more of the MCO membership is non-English speaking.

■ ***Decrease the likelihood of liability and malpractice claims***

Failure to provide interpretation and translation services may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also in some states the failure to convey treatment instructions accurately may raise a presumption of negligence on the part of the provider.

The ability to communicate well with patients has been shown to reduce the likelihood of malpractice claims. A study appearing in the Journal of the American Medical Association indicates that the patients of physicians who are frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. The use of qualified medical interpretation and translation services enhances patient-provider communication, thereby decreasing the risk of malpractice. Other studies support this fact (Physicians Risk Management Update, 1995; American Medical News, 1996; Virshup, et al., 1996; Meryn, 1998; American Family Physician, 1997; Hospital Topics, 1997; JAMA, The Journal of the American Medical Association, 1997).

■ ***Increasing the market share***

In today’s competitive health care industry, strategies to increase the recruitment and retention of satisfied health care consumers are essential to the survival of primary health care organizations. Providing interpretation and translation services is a key strategy given the current population profiles and projected trends.

IT'S THE LAW!

Selected Federal laws and regulations that mandate linguistic competence:

■ TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

“No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” Guidance issued by the Office of Civil Rights further clarifies Title VI as it relates to persons with limited English proficiency. Specifically, providers should establish and implement policies and procedures to fulfill their Title VI equal opportunity responsibilities including reasonable steps to provide services and information in appropriate languages other than English to ensure that persons with limited English proficiency are effectively informed and can effectively participate in any benefit. Nearly every health care provider is bound by Title VI, because Federal funding of health care is almost universal.

■ THE HILL-BURTON ACT

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a “community service obligation”, one of which is a general principle of non-discrimination in the delivery of services. The Office of Civil Rights has consistently interpreted this as an obligation to provide language assistance to those in need.

■ MEDICAID

Medicaid, a Federal-state cooperative program of medical assistance, provides health insurance to adolescents, children and families who are poor, and people with disabilities and those who are indigent and elderly. Medicaid regulations require Medicaid providers and participating agencies, including long-term care facilities, to render culturally and linguistically appropriate services. The Health Care Financing Administration, the Federal agency that oversees Medicaid, requires that states communicate both orally and in writing “in a language understood by the beneficiary” and provide interpretation services at Medicaid hearings.

■ MEDICARE

Medicare is a Federal program that provides insurance to people 65 years of age or older, with certain disabilities who are under 65 years of age, and of any age with permanent kidney failure. Medicare addresses linguistic access in its reimbursement and outreach education policies. Medicare “providers are encouraged to make bilingual services available to patients wherever the services are necessary to adequately serve a multilingual population”. Medicare reimburses hospitals for the cost of the provision of bilingual services to patients.

■ EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

This Act requires hospitals with emergency departments that participate in the Medicare program to treat all patients (including women in labor) in an emergency without regard to their ability to pay. The EMTALA Act was passed to reduce the practice of “dumping” patients who lacked the financial ability to incur hospital costs. EMTALA stipulates a hospital’s responsibilities to the patient which include the diagnosis, treatment, informed consent, and notification of condition and intent to transfer to another facility. Hospitals that fail to provide language assistance to persons of limited English proficiency are potentially liable to federal authorities for civil penalties as well as relief to the extent deemed appropriate by a court.

Linguistic Competence: Policy Making Implication for Primary Health Care Organizations and Programs

Health care organizations have been slow to develop and implement policies and structures to guide the provision of interpretation and translation services. In the absence of policies, structures and fiscal resources, the burden of such services remain at the practitioner and consumer level. The following checklist is designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations

Does the primary health care organization or program have:

- a mission statement that articulates its principles, rationale and values for providing linguistically and culturally competent health care services?
- policies and procedures that support staff recruitment, hiring and retention to achieve the goal of a diverse and linguistically competent staff?
- position description and personnel/performance measures that include skill sets related to linguistic competence?
- policies and resources to support ongoing professional development and inservice training (at all levels) related to linguistic competence?
- policies, procedures and fiscal planning to ensure the provision of translation and interpretation services?
- policies and procedures regarding the translation of patient consent forms, educational materials and other information in formats that meet the literacy needs of patients?
- policies and procedures to evaluate the quality and appropriateness of interpretation and translation services?
- policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that are provided?
- policies and resources that support community outreach initiatives to persons with limited English proficiency?
- policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services needs?

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DEFINITIONS

The terms interpretation and translation are often used interchangeably. The NCCC makes a distinction between the two terms and has provided the following definitions.

Translation typically refers to the written conversion of written materials from one language to another.

Interpretation is the oral restating in one language of what has been said in another language.

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- The NCCC acknowledges the contributions of Elena Cohen in assisting with the literature review for this brief.

For More Information...

For more information on the topics covered in this policy brief, please see the listing of resources below.

TOPIC AREA Statistics and Demographic Data

Statistics about immigration patterns available at <http://www.immigration.gov/graphics/index.htm> (April 24, 2003)

National, state, and county statistic and demographic data by age, racial, ethnic and linguistic subgroups is available at

General Information www.census.gov
Population Estimates <http://eire.census.gov/popest/estimates.php> (April 24, 2003)
Population Projections www.census.gov/population/www/projections/popproj.html (April 24, 2003)

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TOPIC AREA Providing Linguistically Competent Health Care Services to People of Diverse Racial/Ethnic Backgrounds

The websites of the following organizations provide an array of information and resources on providing culturally and linguistically competent health services and medical interpreting.

Diversity RX: www.diversityrx.org (April 24, 2003)

National Multicultural Institute: www.nmci.org (April 24, 2003)

Cross Cultural Health Care Program: www.xculture.org (April 24, 2003)

**Center for Immigrant Health,
New York University School of Medicine:** www.med.nyu.edu/cih/ (April 24, 2003)

Office for Civil Rights Policy Guidance: www.hhs.gov/ocr/lep (April 24, 2003)

For additional information on medical interpretation and translation services contact:

The National Council on Interpretation in Health Care
Cross Cultural Health Care Program at PacMed Clinics
1200 12th Avenue S. Seattle, WA 98144
www.xculture.org

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About the



The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Center for Child and Human Development (GUCCHD) and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of Cooperative Agreement #U93-MC-00145-09 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services (DHHS). NCCC shares partnerships with two Federal departments, two Federal administrations, one Federal agency and nine of their respective bureaus, divisions, branches, offices, institutes, and programs. Additionally the NCCC conducts a collaborative project under the auspices of another Cooperative Agreement with the GUCCHD and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS.

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