Language Barriers in Health Care

A Changing Linguistic Demographic

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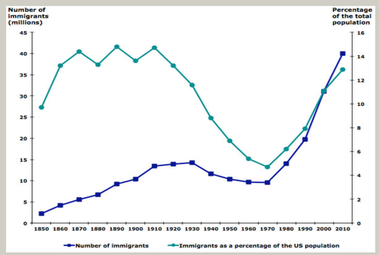
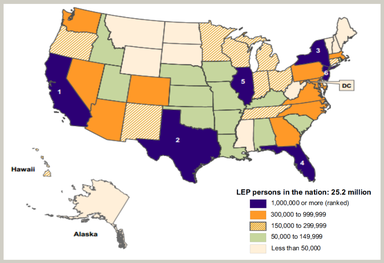
Introduction

Increases in immigration since 1970, especially from Latin America, have created a demographic need for language access.



Background

Since the 1970s, the growth rate of immigrants in the US has been higher than at any other time since the mid-19th century. Developed countries face challenges associated with globalization, and need to make necessary changes to adjust and account for the presence of racial, ethnic, and linguistic minorities integrating into society. One set of issues that has arisen from this demographic shift is related to the constraints placed on public institutions. Health and education systems in particular have needed to respond to the presence of numerous linguistic minorities.



Research Question

Our initial intention was to explore the role of language barriers in health care, and to determine if language barriers cause health disparities. Disparities in health care are grouped into two main categories, health status and access to care. Language and culture both effect the communication process and can create a barrier to access.

Initial Findings

After reviewing the literature, we concluded that disparities in health care based on language barriers are a concern of the health care system. Its response to a rapidly-growing, linguistically diverse population in the US is largely interpretive services. The disparities in question (of access and quality of care received) largely center on how the institutional structure can respond to the increasing linguistically diverse society.

The findings of our research can be grouped into three categories: the causes of language barriers in health care, the effects of language barriers in health care, and a closer examination of the linguistic and cultural aspect of the communication process between those with limited English proficiency (LEP) and health care providers.

Causes

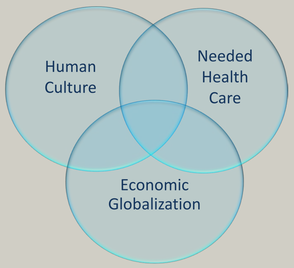
Globalization, Language, and Health Care

There are three main components creating a situation where language barriers are a concern in the health care setting:

- The anthropological component describes the human tendency to develop culture and language and communicate within a cultural and linguistic context.
- The second component is the recent phase of economic globalization that began in the 1970s. This brings individuals from a setting in which they are culturally and linguistically adapted to a new social and institutional environment to which they are not yet adapted.
- The third component is the need for health care services, shared by all humans regardless of our cultural conditioning and primary language.

Together, these three components define the contours of the situation in which English-speaking medical personnel and a Western-based model of health care must adjust to a non-English-speaking population; this including sensitivity to differing cultural frameworks and perceptions of care experienced in other parts of the world.

An Interdisciplinary Model of Causation



Local Action

Two Local Organizations

Catholic Health System of Western New York and the International Institute of Buffalo are organizations which can be viewed as a part of the LEP Population-Health Care System. These two organizations, among others, are local examples of how institutions respond to a changing demographic situation and have complied with federal mandates and standards concerning access to health care for those who are of LEP.

International Institute of Buffalo
Western New Yorkers Embracing the World

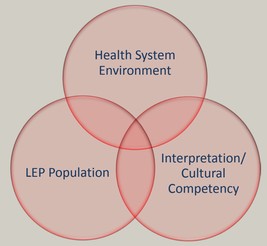
Catholic Health
Sisters of Charity Hospital
St. Joseph Campus

Effects

Under-utilization of Services and an Institutional Response

The second category of our findings indicates that the major result of having a growing LEP population in the US centers more on the ability of the health system to provide access to quality care for linguistic minorities than on the health status of LEP groups. The most significant finding related to the effect of language barriers on care received showed that LEP individuals were more likely to forego doctor visits than English proficient individuals of the same socio-economic status and ethnicity. For the populations in question, there appears to be an under-utilization of health services. However, the creation of agencies and policies such as the Office of Minority Health, Executive Order #13166, and the publication of Culturally and Linguistically Appropriate Services (CLAS) Standards indicate our society's commitment, on social and legislative levels, to making health care accessible and culturally understandable to all persons residing in the US.

An Ecological Model of Institutional Adaption



Health Care Organization Cost/Benefit Analysis

As a result of this institutional response, individual healthcare providing organizations (hospitals, clinics, etc.) must comply with federal mandates to provide accessibility for LEP patients. These organizations face the dilemma of being legally required to provide interpretive services without having received increased funding to offset the costs of complying with CLAS Standards. However, the US Office of Management and Budget estimates that the cost of providing interpretation services is only 0.5% of the total cost of receiving care. For the healthcare organization, they are faced with a cost/benefit analysis in deciding how to comply with federal laws related to language access.

Interpreters

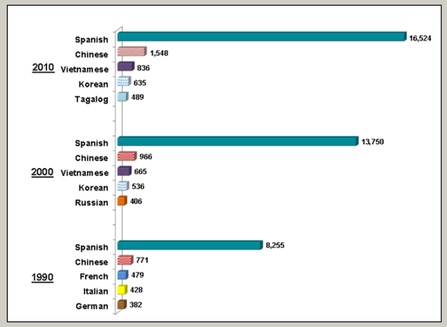
Language Science, Interpretation and Cultural Competency in Reducing Disparities

A final area of interest in exploring the role of language barriers in health care is the language science, especially the socio-linguistic aspect of communication in the health care setting. In examining this aspect of the subject, we found that interpretation services are generally considered to be the most effective method of reducing disparities associated with having LEP. Essentially when a patient receives health care, they must be able to navigate the environment that they are in, express their concerns, and exchange important information with health care providers. This necessitates a need for persons in the health care setting with cultural competence and full linguistic knowledge. Interpretation services provide this link so that necessary concerns from both the patient and the health care professional can be communicated and vital information exchanged. Our research shows that interpretation services are the most effective way to bridge cultural and linguistic barriers which create disparities in health care access and outcomes for LEP populations.

Ecology

An Explanatory Model of Change

An ecological triad consists of an entity, an environment, and the entity-environment relationship. This is a dynamic system in which the parts respond to one another. Viewed from this perspective, an LEP population is the entity, the health care system is the environment, and the presence of language barriers contributes to the entity-environment relationship. From this conceptual framework, we can see how the presence of a rapidly growing linguistic minority has catalyzed an institutional response, and how cultural competency measures and use of interpretative services function in a complex and flexible system that is able to compensate for an increasingly linguistically diverse population.



Between 1990 and 2000, the US population experienced a 42.3% increase in persons who speak English less than "very well"

Political and Health Care Institutional Response

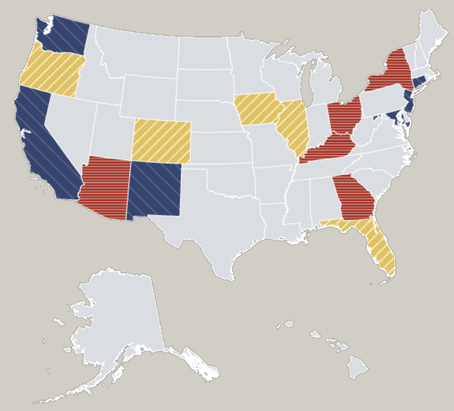
1964
Title VI of Civil Rights Act

1994
Office of Minority Health
Promotes the collection of health data, ethnic, and primary Language categories and strengthening infrastructures for data collection, reporting, and sharing

1995
Center for Linguistic and Cultural Competence in Health Care

2000
- Executive Order #13166
- CLAS Standards
- LEP Guidance from the Office for Civil Rights

2012
Enhanced CLAS Standards to be released



denotes legislation requiring (WA, CA, CT, NJ, NM) or strongly recommending (MD) cultural competence training that was signed into law.

denotes legislation that has been referred to committee and is currently under consideration.

denotes legislation that died in committee or was vetoed.

UNDERGRADUATE ACADEMIES
CIVIC ENGAGEMENT
GLOBAL PERSPECTIVES
RESEARCH EXPLORATION
A LIVING & LEARNING COMMUNITY

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