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 1990s, 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 must make necessary changes to adjust and account for the growing linguistic diversity. The presence of numerous linguistic minorities is largely interpretive services. The disparities in question (of access and quality of care received) largely center on how 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 linguistic minorities, especially those from Latin America, have created a demographic

Local Action

Catholic Health System of Western New York and the International Institute of Buffalo

Research Question

Our initial intention was to explore the role of language barriers in health care, and to determine if interpretative barriers create a health disparity. Disparities in health care are exacerbated by the increasing population of individuals with limited English proficiency (LEPs) that culture both effect the communication process and can create barriers 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 setting. There are three main components creating a situation where language barriers are a concern in the health care setting:

1. The anthropological component describes the human tendency to develop culture and language and communicate within a cultural and linguistic context.
2. The second component is the recent phase of economic globalization that began in the 1990s. This brings individuals from a setting in which they are culturally and linguistically isolated to a new social and institutional environment in which they are not yet adapted.
3. The third component is the cost for healthcare services, shared by all humans regardless of our cultural conditioning and primary language.

Archetypal Model of Causation

An Ecological Model of Institutional Adoption

Health Care Organization Cost/Benefit Analysis

As a result of this institutional response, individual healthcare providers implementing practices (gadgets, clinics, etc.) must consider the cost of resources to provide accessibility for LEP individuals. It is not unusual to find that the cost of interpreting services without having received increased funding, to offset the cost of communicating with LEP Standards. However, the Office of Management and Budget estimates that the cost of providing interpretation services is 5%-7% of the total cost of evening care. For the healthcare organization, they find a cost/benefit analysis in deciding how to comply with federal laws related to language access.

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 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

Cited Works


