LANGUAGE ACCESS IN HEALTH CARE
STATEMENT OF PRINCIPLES

To guide the way toward a world in which language barriers do not affect health outcomes, a diverse group of interested stakeholders developed these principles. The intent is to provide a broad framework to inform efforts to improve health care delivered to limited English proficient individuals.

Nearly 47 million people – 18% of the U.S. population – speak a language other than English at home.[1] The 2000 census documented that over 28% of all Spanish speakers, 22.5% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English "not well" or "not at all."[2] Estimates of the number of people with limited English proficiency (LEP) range from a low of about 11 million, or 4.2% of the U.S. population – who speak English "not well" or "not at all" – to over 21 million people, or 8.1% of the U.S. population – if one includes those who speak English less than "very well."[3]

As demographic trends continue to evolve,[4] the prevalence, composition and geographic distribution of languages spoken will continue to be fluid and necessitate the ongoing assessment of language needs. Multilingualism is spreading rapidly, in rural states and counties as well as urban environments.[5] Between 1990 and 2000, fifteen states experienced more than 100% growth in their LEP populations – Arkansas, Colorado, Georgia, Idaho, Kansas, Kentucky, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South Carolina, Tennessee, Utah and Washington.[6]

As the number of non-English speaking residents continues to increase, so does the demand for English-as-a-Second-Language (ESL) classes. This heightened demand has led to long waiting lists for ESL classes in many parts of the country.[7] For example, in New York State, one million immigrants need ESL classes, but there are seats for only 50,000 while in Massachusetts, less than half of those who applied for English classes were able to enroll.[8]

Research documents how the lack of language services creates a barrier to and diminishes the quality of health care for limited English proficient individuals.[9] Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2% of those who did not need an interpreter and those who needed and received one.[10] Language barriers also impact access to care – non-English speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than do English speaking patients.[11] Language access is one aspect of cultural competence that is essential to quality care for LEP populations.

Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to LEP individuals' access to health care and a serious threat to the quality of the care they receive.[12] The increasing diversity of the country only amplifies the challenge for health care providers,[13] who must determine which language services are most appropriate based on their setting, type and size; the frequency of contact with LEP patients; and the variety of languages encountered. But without adequate attention and resources being applied to address the problem, the health care system cannot hope to meet the challenge of affording LEP individuals appropriate access to quality health care.

Those endorsing this document view it as an inseparable whole that cannot legitimately be divided into individual parts. Each of the principles articulated here derives its vitality from its context among the others, and any effort to single out one or another would therefore undercut the structural integrity of the entire framework.[14] The principles are as follows:

1. Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans.

2. Competent health care language services are essential elements of an effective public health and health care delivery system in a pluralistic society.

3. The responsibility to fund language services for LEP individuals in health care settings is a societal one that cannot fairly be visited upon any one segment of the public health or health care community.

4. Federal, state and local governments and health care insurers should establish and fund mechanisms through which appropriate language services are available where and when they are needed.

5. Because it is important for providing all patients the environment most conducive to positive health outcomes, linguistic diversity in the health care workforce should be encouraged, especially for individuals in direct patient contact positions.

6. All members of the health care community should continue to educate their staff and constituents about LEP issues and help them identify resources to improve access to quality care for LEP patients.

7. Access to English as a Second Language instruction is an additional mechanism for eliminating the language barriers that impede access to health care and should be made available on a timely basis to meet the needs of LEP individuals, including LEP health care workers.

8. Quality improvement processes should assess the adequacy of language services provided when evaluating the care of LEP patients, particularly with respect to outcome disparities and medical errors.

9. Mechanisms should be developed to establish the competency of those providing language services, including interpreters, translators and bilingual staff/clinicians.

10. Continued efforts to improve primary language data collection are essential to enhance both services for, and research identifying the needs of, the LEP population.

11. Language services in health care settings must be available as a matter of course, and all stakeholders – including government agencies that fund, administer or oversee health care programs – must be accountable for providing or facilitating the provision of those services.

ENDORSING ORGANIZATIONS:

Aetna
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Assistants
American Association of Physicians of Indian Origin
American Civil Liberties Union
American College of Physicians
American Counseling Association
American Hospital Association
American Medical Association
American Medical Student Association
American Nurses Association
American Psychiatric Association
American Psychological Association
American Public Health Association
Asian American Justice Center
Asian Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Association of Clinicians for the Underserved
Association of Community Organizations for Reform Now
Association of Language Companies
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
California Association of Public Hospitals and Health Systems
California Health Care Safety Net Institute
California Healthcare Association
California Healthcare Interpreting Association
California Primary Care Association
Catholic Charities USA
Catholic Health Association
Center for Medicare Advocacy
Center on Budget and Policy Priorities
Center on Disability and Health
Children's Defense Fund
Cuban American National Council
District of Columbia Language Access Coalition
District of Columbia Primary Care Association
Families USA
Family Voices
Greater N.Y. Hospital Association
HIV Medicine Association
Institute for Reproductive Health Access
The Joint Commission
La Clinica del Pueblo
Latino Caucus, American Public Health Association
Latino Coalition for a Healthy California
Massachusetts Medical Interpreters Association

Medicare Rights Center
Mexican American Legal Defense and Educational Fund
Migrant Legal Action Program
Molina Healthcare, Inc.
National Asian American Pacific Islander Mental Health Association
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum
National Association of Community Health Centers
National Association of Mental Health Planning and Advisory Councils
National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Association of Vietnamese American Service Agencies
National Center for Law and Economic Justice
National Committee for Quality Assurance
National Council of La Raza
National Council on Interpreting in Health Care
National Family Planning and Reproductive Health Association
National Health Law Program
National Immigration Law Center
National Hispanic Medical Association
National Latina Institute for Reproductive Health
National Medical Association
National Mental Health Association
National Partnership for Women and Families
National Respite Coalition
National Senior Citizens Law Center
National Women's Law Center
Northern Virginia Area Health Education Center
Physicians for Human Rights
Presbyterian Church (U.S.A.) Washington Office
Service Employees International Union
Society of General Internal Medicine
Summit Health Institute for Research and Education
USAction

[1] U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), *available at* http://factfinder.census.gov. *See also* Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* at 70-71 (2002) (reporting that more than one in four Hispanic individuals in the U.S. live in language-isolated households where no person over age 14 speaks English "very well," over half of Laotian, Cambodian, and Hmong families are in language isolated households, as well as 26-42% of Thai, Chinese, Korean, and Vietnamese).

[2] *See* U.S. Bureau of Census, *Ability to Speak English: 2000* (Table QT-P17) *available at* http://factfinder.census.gov.

[3] *Id.*

[4] For example, from 1990-2000, the "top ten" countries of origin of immigrants residing in the U.S. changed significantly. In 1990, the top ten were Mexico, China, Philippines, Canada, Cuba, Germany, United Kingdom, Italy, Korea and Vietnam. In 2000, while the top three remained the same, three countries fell off the top ten; the remaining changed to India, Cuba, Vietnam, El Salvador, Korea, Dominican Republic and Canada.

[5] *See* Peter T. Kilborn and Lynette Clemetson, *Gains of 90's Did Not Lift All, Census Shows,* NEW YORK TIMES, A20 (June 5, 2002) (finding the immigrant population from 1990-2000 increased 57%, surpassing the century's great wave of immigration from 1900-1910 and moving beyond larger coastal cities into the Great Plains, the South and Appalachia).

[6] 1990 and 2000 Decennial Census. Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well."

[7] *See, e.g.,* National Center for Education Statistics, *Issue Brief: Adult Participation in English-as-a-Second Language Classes* (May 1998), *citing* Bliss 1990; Chisman 1989; Crandall 1993; U.S. Department of Education 1995; Griffith 1993.

[8] Suzanne Sataline, *Immigrants' First Stop: The Line for English Classes*, The Christian Science Monitor (Aug. 27, 2002).

[9] *See, e.g.,* Flores G, Barton Laws M, Mayo SJ, et al.., *Errors in medical interpretation and their potential clinical consequences in pediatric encounters*, Pediatrics 2003, 111(1):6-14; Ghandi TK, Burstin HR, Cook EF, et al. *Drug complications in outpatients,* Journal of General Internal Medicine 2000, 15:149-154l; Pitkin Derose K, Baker DW, *Limited English proficiency and Latinos' use of physician services,* Medical Care Research and Review 2000, 57(1):76-91. *See also*, Jacobs, et. al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), *available at* http://www.calendow.org/pub/publications/LANGUAGEBARRIERSAB9-03.pdf.

[10] *See* Dennis P. Andrulis, Nanette Goodman, and Carol Pryor, *What a Difference an Interpreter Can Make* at 7, The Access Project (Apr. 2002).

[11] *E.g.* Judith Bernstein *et al., Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up,* J. OF IMMIGRANT HEALTH, Vol. 4 No. 4 (October 2002); IS Watt et al, *The health care experience and health behavior of the Chinese: a survey based in Hull*, 15 J. PUBLIC HEALTH MED. 129 (1993); Sarah A. Fox and J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 MED. CARE 1065 (1991).

[12] Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). *See also* Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71–72 (2002) (describing recent survey finding 51% of providers believed patients did not adhere to treatment because of culture or language but 56% reported no cultural competency training).

[13] For the purposes of this document, "providers" includes health care institutions such as hospitals and nursing homes; managed care organizations; insurers; and individual clinicians and practitioners.

[14] It is anticipated that this document will be disseminated to other interested stakeholders, Congressional and Administration staff, and the media solely to raise awareness of this issue and to support policies consonant with these principles. However, endorsement of these principles by an organization should not be interpreted as indicating its support for, or opposition to, any particular legislation or administrative proposal that may emerge.