

Speaking Freely:

A Case for Professional Health Interpretation in London, Ontario

On Behalf of

The London and Middlesex Local Immigration Partnership

Health and Wellbeing Sub-council

Access to Health Interpretation (AHI) Work Group

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Executive Summary

The delivery of health care can be challenging in Canada's multicultural mosaic, since immigrants who are unable to speak one of two official languages are at a disadvantage when they need to access services in general and those in health care in particular. There is considerable evidence, both research-based and anecdotal, that this barrier has an impact on immigrants' quality of care, financial resources, equity and human rights.

Patients with limited English proficiency (LEP) face a greater frequency of medical errors, lower satisfaction with their care and a greater likelihood of using services that are inappropriate for their health concern (Diamond et al., 2008). Evidence indicates that the use of professional interpreters has a profound positive impact on clinical outcomes, reduces clinical errors, improves disparities in utilization of services and improves patient understanding of diagnosis, treatment and management of chronic disease (Health Canada, 2001; Karliner et al., 2007; Access Alliance, 2009).

In an era of significant budgetary austerity for health care organizations, there has been concern regarding the cost of offering language interpretation services. However, there is growing evidence that costs associated with interpretation services are likely to result in net savings because they lessen the use of diagnostic testing, decrease hospital admissions, reduce lengths of stay and allow health care professionals to use their time more efficiently (e.g., (Flores, 2005; Alliance of Community Health Plans Foundation, 2007; Access Alliance, 2009).

Although the principle of universal access to care under *The Canada Health Act* stipulates that all residents must be entitled to services on uniform terms and conditions, these rights are not being equally applied to those with LEP. Without adequate provider-patient communication, appropriate access to health care is virtually impossible. This disparity contradicts the principle of

universality – that all insured residents are entitled to the same level of health care – under the *Act* (Health Canada, 2001).

In London, Ontario, like many cities, there are gaps within the system in terms of access to professional interpretation. While large organizations typically have policies requiring an interpreter and some funding allocated to support these services, in actuality, the need for interpretation is often not recognized and care decisions are made regularly without the full understanding of the patients or family members (London-Middlesex Health Providers Alliance, 2014a). As a significant settlement site, with growing diversity and health-related needs (London-Middlesex Local Immigration Partnership, 2014a), the London-Middlesex region must develop a systems approach, as well as specific program and provider-level interventions to address the needs of immigrants, building on the successes of other jurisdictions, such as Toronto and Erie-St. Clair, as well as on recommended practices in the literature.

Recommendations

Based on the available evidence and highlighting the positive impact on quality of care, financial savings, and health equity, the following recommendations are offered to improve access to professional health interpretation:

Program/Provider Level:

- Conduct a needs assessment to define the scope of the issue (e.g., data collection regarding number of languages, volumes of patients in various settings, etc.).
- Establish processes to identify and respond to LEP patients throughout health care service systems using standardized protocols or practices.

- At discharge, offer LEP patients information on how/where to access local English language classes.
- Include patients in the development and evaluation of protocols through participatory research and evaluation of the impact of interpretation services.
- Develop initiatives to empower LEP patients and help them advocate for their right to interpretive services (a possible strategy could include the use of Peer Leaders to lead health promotion projects).

Organization/Systems Level:

- Enlist the support of senior leaders in health organizations to facilitate equity across the system.
- Develop mandatory provider training that promotes continuous development of cultural competence, and embed such processes in organizational philosophies of patient-centred care.
- Establish clear policies and guidelines and identify organizational representatives to liaise with interpreters and clients, to ensure patient safety, to advocate for appropriate services, etc.
- Conduct research and evaluation to develop appropriate models of interpretation and cultural competence that are tailored to the specific needs of communities and organizations, and monitor the success of these initiatives.
- Establish and integrate community partnerships and resources, including possible inter-organizational collaboration to establish a “clearinghouse” for shared multilingual health resources (CRICH Survey Research Unit, 2014).

Political/Social Level

- Develop national standards for health interpreter training, including accreditation and standards of practice.
- Create policies that recognize health interpretation as a “medically necessary” service, respecting minority language rights for residents not proficient in an official language.
- Create a “secure envelope” of funding for health interpretation services, and make access to it conditional on providing culturally competent care.
- Consider training International Medical Graduates living in Canada, but not working in their fields of study, to qualify them as medical interpreters and health educators.

Introduction

It has been said that language represents “medicine’s most essential technology” (Health Canada, 2001, p. 1). Diagnosis, informed consent, patient education and health care all revolve around the management of information. In fact, research has revealed that more than 70% of the information on which clinicians base their diagnoses is derived from patient history and physical examination (PEI French Language Health Services Network, 2007). Effective provider-patient communication that allows for mutual understanding and reciprocity is therefore more than just a “facilitator” of care, but a critical component of health care itself (Schyve, 2007). Although access to health care is the right of every Canadian, in our increasingly multicultural and multilingual society it has become apparent that certain groups are not afforded the same quality of health services. While a variety of structural (e.g., lack of transportation) and societal (e.g., poverty, racism) barriers have been shown to influence access to health care, in the case of newcomers and established immigrant groups who do not speak one of Canada’s official languages, communication challenges rather than cultural beliefs or practices are the most significant impediment to accessing health services. Language challenges faced by immigrants to Canada tend to be viewed as “newcomer issues” that simply require individual adaptation rather than changes in how services are provided. Furthermore, solutions to these challenges (such as referrals to language services) are generally provided by settlement service organizations with little health knowledge rather than by health care organizations. This arrangement results in poor integration of such services and deters recognition of their crucial impact on health care and outcomes (Health Canada, 2001). Moreover, communication barriers are associated with a range of adverse outcomes that influence all levels of health care, including underuse of both primary and preventive care, poor comprehension of and adherence to medical advice, and inefficient use of health related resources (PEI French Language Health Services Network, 2007). Although initial access is certainly an important issue, this paper will primarily

focus on challenges that occur after making preliminary contact with health services – how do patients who face language barriers navigate health encounters, and what can be done to mitigate these barriers?

Although there is consensus that optimal communication occurs where both providers and patients speak the same language, the proportion of providers in Canada who speak minority languages cannot accommodate our changing demographics (Health Canada, 2001). Because encounters between patient and provider necessitate the exchange of information, various remedial strategies are utilized, including the use of interpreters. Although in recent years there has been a move toward professionalizing health interpreters, it remains the norm for untrained, “ad hoc” interpreters (including family, friends, and other staff members) to facilitate the exchange of critically important, sensitive information (Health Canada, 2001). Generally speaking, a *professional interpreter* is defined as “any individual paid and provided by the hospital or health system to interpret”, while an *ad hoc* interpreter is “an untrained person who is called upon to interpret” (Karliner, Jacobs, Chen, & Mutha, 2007, p. 731). Although perhaps more convenient, studies have found that either “getting by” without any form of interpretation or the use of ad hoc interpreters both have a negative impact on patient safety, confidentiality, and satisfaction. For immigrants, these factors effectively inhibit access to health care and prevent equal application of the constitutional right to health care. Specifically, this disparity contradicts the principal of universality – that all insured residents are entitled to the same level of health care – under the Canada Health Act (Health Canada, 2001).

The number of residents of Canada who speak neither official language has increased substantially in the last decade, intensifying the importance of addressing communication barriers in health care (Health Canada, 2001). This is an important issue locally given that London, Ontario is one of the primary recipients of refugees per capita in the province. Although many immigrants

initially settle in larger urban centres, London has become a significant secondary settlement site (London & Middlesex Local Immigration Partnership, 2014a). With a population of 366,151 (2011 Canadian Census), approximately 21% of residents are immigrants, and almost 15% of those have arrived within the last five years (Statistics Canada, 2013). A study in London (Centre for Community Based Research, 2014) concluded that the paucity of health services available in minority languages often obstructs community members from booking appointments and seeking support in preventive health screening. Furthermore, participants in a conversation circle (an informal, non-hierarchical discussion group) conducted by the London - Middlesex Local Immigration Partnership (2012) described how they opt to go to the hospital for non-urgent problems because interpretation is more likely to be available there than in community clinics.

Barriers in communication have been shown to have negative effects on access to and quality of health care, patient safety, health outcomes, patient satisfaction and provider satisfaction (Health Canada, 2001). The use of professional interpreters has been demonstrated to positively address such issues, although policies and procedures for how and when these services are best used requires further development (Diamond, Schenker, Curry, Bradley, & Fernandez, 2008; focus group with London providers). Articulating clear guidelines and standards for linguistically and culturally competent care has been associated with improvements in quality, efficiency, and equity in services (Alliance of Community Health Plans Foundation, 2007).

The overall purpose of this position paper is to examine the need for professional health interpretation services in London, Ontario, based on a literature review and an assessment of the current state of services in the local community, and to offer recommendations for improvement at the organizational and system levels. In order to accomplish these goals, a comprehensive review of the available research literature was undertaken, and, to provide more of a London-specific context, focus groups, surveys, and a conversation circle were conducted with health care providers,

interpreters, and clients. The recommendations will address the impact of health interpretation on quality of care, efficiency, costs, equity, policy, and human rights, particularly as related to London, Ontario. Although this paper will focus on the unique context of London, the information provided can likely be generalized to many communities throughout Canada who are facing similar challenges.

Quality of Care

Quality of care can be defined in a number of ways, but for the purpose of this paper, three main aspects of care will be examined: (1) patient and provider satisfaction, (2) patient safety and informed consent, and (3) health outcomes and effectiveness. Communication challenges have been shown to adversely affect all of these factors; in fact, Roat (as cited in PEI French Language Health Services Network, 2007, p. 11) has stated that “[a]nything that compromises the quality of the communication between patients and physicians represents a threat to the quality of care provided.” Due to language barriers, patients with limited English proficiency (LEP) face a greater likelihood of medical errors, lower satisfaction, and less appropriate use of services (Diamond et al., 2008). In effect, they are prevented from receiving the same quality of health care as their English-proficient counterparts.

Patient and Provider Satisfaction

Patient satisfaction represents one of the most well documented measures of effective communication between patient and provider, and is also itself an outcome of care (Health Canada, 2001). It has been linked to better patient understanding, adherence to treatment plans, and improved self-care (Bagchi et al., 2011). Patients who speak a language that differs from that of their providers report lower satisfaction than those with language concordance, and this relationship applies to all levels and aspects of medical care (Mahmoud, Hou, Chu, Clark, & Eley, 2014; Ramirez, Engel, & Tang, 2008). Interactions with LEP patients in which a professional interpreter is not present have

been identified as less responsive in terms of timeliness of access to service delivery and are less patient-centred, which contributes negatively to patients' perceived quality of care. Patients who describe their quality of care as poor are less likely to comply with treatment plans and appointments (Access Alliance Multicultural Health and Community Services, 2009). One study found that LEP patients who needed but were not provided with an interpreter consistently rated their quality of care as lower on multiple measures, including provider friendliness, respectfulness, and whether the provider made them feel comfortable (Flores, 2005).

On the other hand, many studies have shown that the presence of a trained interpreter can help to address the gap in patient satisfaction. Access to trained interpreters is positively associated with improvements in LEP patients' satisfaction, quality of care, and health outcomes; the use of ad hoc interpreters has not been shown to have similar effects (Flores, 2005). Although one study found that the introduction of enhanced language services did not improve patient satisfaction, its findings were confounded by the presence of multiple Spanish-speaking health care providers in the control group (LEP patients in the study spoke Spanish) (Jacobs, Sadowski, & Rathouz, 2007). A higher-quality randomized trial in an emergency department in which blocks of time were assigned to professional, in-person interpretation or "regular" services (including access to a phone interpretation line or ad hoc interpreters) discovered that 96% of patients in the treatment time blocks were "very satisfied" with the quality of care they received. This finding stands in contrast to the control group, in which only 24% were satisfied (Bagchi et al., 2011). In surveys with interpreters from Across Languages in London, Ontario, respondents indicated that non-English-speakers rarely or never declined professional help when it was offered (Across Language Interpretation Services, 2014).

Provider satisfaction is also influences quality of care because it helps to minimize burnout and employee turnover and is associated with decreased medical errors (Bauer & Alegria, 2010). Dealing with language barriers in the workplace can lead to heightened stress and lower job

satisfaction, and providers may find their confidence diminished as they grapple with meeting ethical standards of care. Furthermore, for medical students facing communication challenges with patients, the quality of learning may be affected (Health Canada, 2011). The use of professional interpreters (rather than “getting by” or using ad hoc interpreters) has been shown to have positive effects on provider satisfaction as well. In Bagchi et al. (2011), it was found that 94% of providers (including physicians and nurses) were “very satisfied” with health encounters that included a professional health interpreter. Furthermore, providers were much more satisfied with their own ability to communicate when they received training on how to use interpreters appropriately (Ngo-Metzger et al., 2007). Despite these findings, professional interpretation services remain largely underutilized even when available (Ramirez et al., 2008).

Patient Safety and Informed Consent

Another key element related to quality of patient care is patient safety. Indeed, it has been noted that “failure to recognize the critical link between (...) language and patient safety unacceptably exposes patients (...) to preventable adverse events in hospital contexts (PEI French Language Health Services Network, 2007).” It is not surprising that communication challenges represent the most common cause of serious adverse events in health care (Access Alliance, 2009). Language challenges in obtaining informed consent also have a bearing on patient safety, since understanding and agreeing to procedures can have a profound impact on the safety of care that is provided. Language barriers have been identified as a major obstacle to medical comprehension, which substantially increases the risk of adverse reactions to medication (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). Indeed, pharmacists report much greater difficulties in communicating with LEP patients, and a heightened risk for non-adherence to medication (Phokeo & Hyman, 2007). Patients who encounter language barriers have a greater chance of experiencing adverse medical events in general, and an increased likelihood of clinical consequences and harm. Difficulties in

communication can prevent a physician from determining a patient's symptoms, which can lead to procedural errors or misdiagnosis and associated harmful sequelae (Access Alliance, 2009).

Informed consent scores have been found to be significantly lower for LEP patients, and it has been suggested that they may not receive the quality and content of information necessary to make informed decisions (Hunt & de Voogd, 2007). LEP participants in a conversation circle conducted by the London & Middlesex Local Immigration Partnership (2012) indicated that they sometimes agreed to tests or treatments without understanding what they entailed. All patients should be made aware of any uncertainty, risks, and choices in their treatment plans, regardless of their ability to speak one of the official languages (Access Alliance, 2009). In fact, "informed consent... is ethically required of healthcare practitioners in their relationships with all patients; [it is] not a luxury for a few" (President's commission for the study of ethical problems in medicine and biomedical and behavioural research, as cited in Schenker, Wang, Selig, Ng, & Fernandez, 2007, p. 294). Canadian common law dictates that in cases where a patient does not speak an official language, the physician must ascertain that the patient comprehends the information before beginning any form of treatment (PEI, 2007; Health Canada, 2001). It is unclear how such a determination would be possible in the absence of adequate translation and interpretation services.

It has been suggested that efforts to improve patient safety should recognize minority language speakers as a high-risk group, with extra care taken to ensure patient understanding (Wilson et al., 2005). As mentioned previously, there is a tendency in health care settings to rely on ad hoc interpreters rather than trained professionals, but studies have found that the use of ad hoc interpreters can actually result in more errors than no interpreter at all (Flores, Abreu, Barone, Bachur, & Lin, 2012). Research has also shown that when professional interpreters were used, clinically significant errors were greatly diminished (Karlner et al., 2007). Professional interpreters'

responses to the Across Languages survey indicated that medical terminology and jargon are one of their biggest challenges, and that continuous learning is important to their role (AL survey). Other studies have found that interpreters with at least 100 hours of training make the fewest errors, regardless of their years of experience (Flores et al., 2012). It has been well documented that patient safety is enhanced when professional interpreters are present, which has a positive effect on clinical care for LEP patients (Access Alliance, 2009; Karliner et al., 2007). Taken together, these findings suggest that, when an interpreter is needed, waiting for the services of a professional is typically the best option, even in situations where it is inconvenient or seems inefficient.

Health Outcomes and Effectiveness

In general, studies have shown that patients who do not speak a majority language are less likely to receive effective, evidence-based care than patients who do not face language barriers (Access Alliance, 2009). This leads to disparities in both health outcomes and effective use of services and preventive care. Patients who face language difficulties are at a greater risk for impaired health status, and are less likely to have a usual source of medical care (Flores, 2005). Lacking a regular provider, along with scarcity of interpretation services in community clinic settings, increases the likelihood that LEP patients will end up in the emergency department for problems that could be treated by a family doctor (Mahmoud et al., 2014; London & Middlesex Local Immigration Partnership, 2012). In fact, many non-English-speaking patients reported that had they developed the same condition in their home country, they would have been more likely to visit a general practitioner rather than the emergency department (Mahmoud et al., 2014).

During hospitalizations LEP patients are also less likely to receive appropriate, quality health care. Language barriers are associated with increased risk of intubation for asthmatics (language was more of a risk than smoking), more invasive tests, and differences in prescribed medications.

Research indicates that patients who feel an interpreter is needed but who are unable to access one face a greater likelihood of being discharged without a follow-up appointment (Health Canada, 2001; PEI 2007). Others have shown that families of LEP patients receiving end-of-life care are at a greater risk of receiving less information and emotional support from clinicians (Thornton, Pham, Engelberg, Jackson, & Curtis, 2009). In the London conversation circle with LEP clients, one person described a situation in which an interpreter was not called until the late stages of illness, when loved ones learned that the patient's condition was terminal (London-Middlesex Local Immigration Partnership, 2012).

Jimenez, Moreno, Leng, Buchwald, and Morales (2012) note that pain is the most common medical complaint among hospitalized patients; and the quality of pain treatment is a good indicator of overall quality of care. Hospitalized children who had non-English-speaking parents were revealed to have fewer pain assessments than children of English proficient parents, and were less likely to receive opioid analgesics for comparable levels of pain (Jimenez, Jackson, Zhou, Ayala, & Ebel, 2014). Patients in obstetric and gynaecological care face similar experiences. Poor communication due to language barriers may interfere with patient assessment and treatment, which in turn may result in suboptimal management of pain symptoms. Patients who are granted consistent access to professional interpreters report greater levels of pain management and timely treatment, and give improved ratings of perceived provider helpfulness (Jimenez et al., 2012). The use of professional interpreters is linked with improved triage, assessment, and decreased wait time for appropriate care. In sum, interpretive services can assist providers in getting a better understanding of a patient's overall needs, which correlates with improved quality of care as a whole (Bagchi et al., 2011).

In the case of psychiatric services, language barriers can have a particular impact on quality of care, as symptoms may not be directly observable and histories are dependent on patient self-

report (Bauer & Alegria, 2010). Research has demonstrated that even when patients are connected with the health care system, they may postpone seeking mental health care due to concerns about stigma and also language challenges, resulting in underuse of mental health services (PEI, 2007). Barriers in communication may impede a thorough and accurate mental status examination, as well as the process of care itself. Ad hoc interpreters have been shown to be particularly problematic in the case of psychiatric care, although even trained interpreters can find these situations a challenge. Patients are more likely to give brief replies, and to speak in the present tense when attempting to converse in English, which can suggest current, rather than past symptoms. This finding may well apply to other types of medical situations as well (Bauer & Alegria, 2010).

In recent years, a growing emphasis has been placed on the importance of preventive care in health services, and patients with language barriers are at a particular disadvantage in this area (Centre for Community Based Research, 2014; PEI, 2007). Their participation in prevention and screening programs is much lower than individuals who speak an official language, and although cultural beliefs, such as traditional modesty and embarrassment about personal tests, act as barriers to accessing these services, research has shown that the most influential factor in determining access is whether patients had previously had a discussion on the topic with their doctor (Centre for Community Based Research, 2014; Health Canada, 2001). Cancer screening programs in particular have been successful in lessening the incidence of cervical and breast cancers in the general population, but not in non-English-speaking groups. A project in London found that reducing cultural and language barriers through a comprehensive community outreach initiative led to increased participation in preventive cancer screenings and increased patients' openness to preventive care (Centre for Community Based Research, 2014).

The use of professional interpreters has been demonstrated to have a profound impact on clinical outcomes and disparities in utilization of services, in addition to improving patient understanding of diagnosis and treatment and management of chronic disease (Access Alliance, 2009; Health Canada, 2001). Communication is an important factor in patient compliance, not only because it is essential to understanding treatment instructions, but because it is also a source of support, motivation, and reassurance (Health Canada, 2001). LEP patients with Type 2 Diabetes Mellitus who have access to professional interpreters have been shown to be much more likely to meet guidelines for testing, clinic visits, and dietary consultations (Flores, 2005). Beyond observable effects on patient satisfaction and compliance, effective communication has been found to have a positive effect on actual patient health outcomes, such as anxiety, pain, recovery from symptoms, and functional status (Health Canada, 2001). In fact, it has been found that employing professional interpreters in health encounters can raise the quality of care for LEP patients to levels comparable to their English-speaking counterparts (Access Alliance, 2009; Karliner et al., 2007).

Schuyve (2007, p. 361) contends that “[p]atient rights, quality of care, and patient safety each in itself is sufficient to justify a commitment to effective communication. Together they make effective communication in health care obligatory – it is a critical component of the health care itself”. Providing high quality health care remains a major priority for many health care institutions, and it may also make sense from a business perspective. As the number of Canadian residents who do not speak an official language continues to grow, their “market share” is increasing as well. Ensuring that LEP patients are satisfied and receive safe and appropriate health services is not only a “nice thing to do;” one can also make a business case for developing culturally and linguistically competent care (Alliance of Community Health Plans Foundation, 2007).

Efficiency and Costs

While many organizations recognize the benefits of incorporating language services and other forms of culturally competent care into their practices, the perceived costs of developing and operating these services are a major barrier that has led to gaps in both quality and accessibility (Access Alliance, 2009; Alliance of Community Health Plans Foundation, 2007). Although there is consensus that many cultural competence strategies can be cost-effective over a longer period of time, a focus on short-term pay-offs can sometimes prevent organizations from seeing the value in implementing them (Access Alliance, 2009; Brach & Fraser, 2002). A cost-benefit analysis is defined as “the process of evaluating the expected costs in relation to benefits in order to determine if a program or service is worth [implementing]” (Access Alliance, 2009). Conducting a true cost-benefit analysis in this instance is very complex, since the absolute costs of failing to provide language services are poorly documented and difficult to quantify. Determining “benefits” can be particularly challenging because of a wide range of potential consequences and delayed effects (Health Canada, 2001). However, a review of the literature has revealed that the benefits of using professional interpretation tend to outweigh the costs, and that in the long run, these services can reduce overall institutional costs and improve efficiency. Indeed, a report from the Conference Board of Canada contends that developing solutions to address social determinants of health (including immigrants’ access to health services) would have a positive influence on business performance and profits, in addition to improving the overall health of Canadians. From this perspective, improving access to interpretation services not only improves the quality of health care for newcomers to Canada, but makes good business sense as well (Access Alliance, 2009).

When examining the influence of professional interpretation services on efficiency and costs, one can use a number of lenses. It is important to consider more than immediate costs, as initial

barriers to access may lower primary expenditures, but may lead to increased costs down the line when patients present with more advanced (and more costly) stages of illness (Health Canada, 2001). As mentioned, some indicators, particularly socioeconomic factors, are difficult to measure, but in some cases it is possible to examine financial indicators and outcomes, such as the impact of introducing services on overall budgets. Secondly, one can compare utilization indicators, including patient length of stay and use of tests, which act as a proxy measure of health care costs. Finally, one can consider the effects of language services on general organizational efficiency, such as more effective use of time and resources.

Financial Indicators

In terms of the overall costs of providing professional interpretation, research has been somewhat limited. While the majority of research has been conducted in the United States, key findings can be extrapolated to Canadian contexts. One study found that providing an enhanced interpreter service represented only 1.5% of the average hospital cost per patient (Jacobs et al., 2007). This cost does not represent a significant expense, particularly if its use results in improvements in other measures of efficiency. A pivotal study by Hampers et al. (as cited in Access Alliance, 2009, pg. 6) examined the difference in rates of diagnostic testing and length of stay for patients with and without language barriers. The authors concluded that the presence of a language barrier translated to a \$38 increase in costs for tests, an increased likelihood of hospital admission, and a 20 minute longer stay in the emergency department. However, with the use of professional interpreters rates were similar to those of English-speaking patients. The Young Children's Health Centre in Albuquerque, NM estimates that even after adjusting for salary increases, using trained in-house staff interpreters has saved the organization over \$50 000 in interpretation costs (Alliance of Community Health Plans Foundation, 2007).

Research has demonstrated that creating networks between health care organizations in order to share resources and to assist clients is one of the most effective ways of organizing language services (Access Alliance, 2009). This includes the development of programs that screen patients before they arrive at the emergency department, in order to triage patients and connect them with more appropriate care. Telesalud Molina Healthcare in Long Beach, CA initiated a two-tiered model with 24-hour live service to nursing advice and interpretation assistance in the patient's language of preference. Nonclinical staff answered intake calls and registered nurses received calls requiring interpretation, clinical assessment, or intervention. This project was able to assist patients with their medical issues, and in some cases, to redirect them to other services. In fact, 65% of callers who reported that they originally planned to go to the emergency department opted to utilize alternative types of care. The project generated a cost-savings of \$2448/ month during the pilot phase, which was extrapolated to an annual savings of \$29 000. The program was scaled up to include services in eight states, which resulted in a total savings of over \$750 000 (Alliance of Community Health Plans Foundation, 2007). In another example, the Contra Costa Health Services Project, also in California, established a partnership between four hospitals, which jointly developed the Health Care Interpreter Network, a remote video/voice medical interpretation project. The pilot project ran for 10 weeks and resulted in a cost-savings of \$0.80/minute. The total savings produced by the project was \$25 000 (Alliance of Community Health Plans Foundation, 2007). In Toronto, Ontario, under the sponsorship of the Toronto Central Local Health Integration Network, a collaborative of health care organizations provided similar phone-based interpretation services to achieve an efficient and effective model in improving accessibility (CRICH, 2014).

In-person interpreters have been shown to produce cost savings as well. L.A. Care in Los Angeles, CA hired one full-time employee to train approximately 250 health care providers per year as interpreters. This initiative, conducted over 2004/2005, generated an annual cost savings of \$183

500 (Alliance of Community Health Plans Foundation, 2007). Another interesting resource-and-cost-sharing initiative, The Multilingual Health Resource Exchange, established by UCare Minnesota, significantly improved access to health information for non-English speakers while saving money for individual organizations. UCare collaborated with other health care organizations to develop an easily accessible, web-based clearinghouse of health resources, available in multiple languages. Partner organizations each pay \$2500/year to support the project. Producing language-specific versions of material has been estimated to cost approximately \$300; providing over 1600 shared resources in multiple languages translates to a value of \$480 000 (Alliance of Community Health Plans Foundation, 2007). In the London study regarding cancer screening, many participants reported that take-home materials were only provided in English, which limited the effectiveness of their post-intervention learning (Centre for Community Based Research, 2014). Likewise, participants in the Access to Health Interpretation conversation circle reported similar experiences (London – Middlesex Local Immigration Partnership, 2012). Access to shared multilingual resources for commonly used patient information could prove to be very cost-effective in health promotion strategies.

Utilization Indicators

In much of the research on language barriers and health care, utilization indicators are used as indirect measures of cost, as findings are not always quantified in dollar amounts. Outcomes related to these measures (including hospital admissions and length of stay) can affect costs directly while also influencing overall efficiency in terms of waiting lists and service duplication (Access Alliance, 2009). As mentioned earlier, the evidence suggests that communication challenges are associated with more frequent and longer emergency room visits, even when the use of other services might be more appropriate (Access Alliance, 2009; Health Canada, 2001; London-Middlesex Immigration

Partnership, 2012). Studies have also shown that when clinicians experience communication difficulties with LEP patients, they tend to rely more on diagnostic tests to compensate for these challenges. In many cases, LEP patients are exposed to significantly more hazardous, expensive tests and procedures, including intravenous fluids and costly CT scans (Access Alliance, 2009; Flores, 2005). However, research has shown that the use of professional interpreters can lessen inappropriate testing for these individuals (Access Alliance, 2009; Karliner et al., 2007).

Many studies have found that language barriers are associated with more frequent hospital admissions (in some findings, up to a 70% greater likelihood), perhaps as a precautionary measure. But when professional interpreters are used, hospitalization rates for LEP patients are comparable to those who speak English (Access Alliance, 2009; Flores, 2005; Health Canada, 2001). Patients with communication difficulties and children with non-English speaking parents also face longer stays in hospital once admitted (Access Alliance, 2009). One study by Jean-Baptiste et al. (as cited in Access Alliance, 2009) found that patients with language barriers stayed in the hospital for 6% longer compared to patients who spoke an official language, even after adjusting for comorbidity and socioeconomic status. Similarly, Lindholm, Hargraves, Ferguson, and Reed (2012) found that non-English-speaking patients who did not receive professional language interpretation had an increase in their length of stay of between 0.75-1.47 days, as opposed to patients who had access to an interpreter at both admission and discharge. When interpreters were used, studies found rates of hospital admissions and visit lengths were equivalent to English-speaking patients (Karliner et al., 2007).

General Efficiency

Using professional interpretation services has also been shown to improve general efficiency, and to make financial sense in this regard. When staff members are not struggling to communicate,

they can use their time more efficiently, and bilingual employees are not pulled from their regular duties to serve as ad hoc interpreters. Research has revealed that lack of access to interpretation is associated with delays in treatment, management, and discharge processes. The use of ad hoc rather than trained interpreters has been found to increase the likelihood of missing information, repeated interviews, and lack of confidence in diagnoses (Flores, 2005). Professional interpretation services can mitigate these findings. The Contra Costa project mentioned above was able to improve overall efficiency for interpretation services, serving 25-30 patients each day compared to the 10-15 served by the previous system (Alliance of Community Health Plans Foundation, 2007). An example of a creative and prudent use of professional interpretation services took place at Holy Cross Hospital in Silver Spring, MD. Group discharge classes were established for Spanish-speaking mothers who had not experienced complications giving birth. This innovative approach reduced wait-times for interpreters, and expedited the discharge process while cutting costs (Alliance of Community Health Plans Foundation, 2007).

As discussed previously in the section on patient safety, the risk of adverse events is lessened when professional interpreters are used, which reduces the risk of liability for damages. In effect, the risk of costly medical malpractice is diminished when professional interpreters are used. Adverse events themselves can increase costs, regardless of legal implications, simply because of the use of additional services and resources (Access Alliance, 2009). Similarly, the effective use of preventive screenings and other health promotion programs have been shown to offset costs by addressing health issues while they are more manageable and responsive to self-care (Flores, 2005). When health promotion programs are presented in patients' own language or interpreters are used, significantly more patients report increased knowledge and increased likelihood of attending cancer-screening clinics (Centre for Community Based Research, 2014; Flores, 2005). While there appears to be some debate about the effects of professional interpreters on visit duration, the positive impacts

(including reduced medical errors, improved patient compliance, and more appropriate use of services and resources) appear to compensate even if extra time is spent (Flores, 2005). Interestingly, while some studies show that physicians actually spend less time with LEP patients, most clinicians incorrectly *perceive* that they spend more time with such patients than with English-speaking individuals (Flores, 2005; Thornton et al., 2009).

Overall, the literature has demonstrated that although professional interpretation services may require some initial investments, providing these services results in important benefits to the health care system (Access Alliance, 2009). In other words, financially responsible spending on language services results in subsequent savings. London's role as a significant location for immigrant settlement, as well as its leadership in health care innovation, suggests unique opportunities for developing culturally competent care. Indeed, creative thinking has been noted as a critical element in maintaining effectiveness and containing costs (Alliance of Community Health Plans Foundation, 2007). Since “[c]ulturally *incompetent* care is inefficient and not cost-effective long-term” (Alliance of Community Health Plans Foundation, 2007, p. 24), providing professional interpretation services as a broader strategy of culturally competent care makes financial sense.

Equity, Policy, and Human Rights

Health Disparities Among Immigrant/Minority Populations

Although health care is recognized as a universal right of all Canadians, it is clear that not all residents enjoy equal access and quality. Language challenges act as a barrier to providing excellent, equitable health care to all citizens, which effectively results in an unequal application of human rights (Health Canada, 2001). In recent years, studies have begun to view equity in health care as an indicator of good quality; “[e]quity is achieved by providing care that does not vary in quality by personal characteristics, such as linguistic proficiency, ethnicity, gender, geographic location, and

socioeconomic status” (Access Alliance, 2009, p. 4). Despite this recognition, the research clearly reveals that glaring health disparities exist for ethnic minority and immigrant populations. Interestingly, however, many immigrants arrive in Canada with a better health status than longer-term residents, although their health often subsequently deteriorates (the “healthy immigrant effect”) (Centre for Community Based Research, 2014; Health Canada, 2001). A possible explanation for this finding is that immigrants face systematic ignorance of the need for interpretation of language and barriers to health care once they arrive in Canada, which consequently influences their health status. Language barriers have been shown to have a significantly negative effect on health and health care; studies have documented that proficiency in an official language is itself a social determinant of health, which may in turn interact with socioeconomic status and ethnicity (Flores, 2005; Health Canada, 2001). Ethnic minority groups experience greater morbidity, mortality, and shorter survival rates for cancer, and are more likely to report experiencing feelings of disrespect when seeking health care. Recognizing that power imbalances in medical encounters can be particularly pronounced in language discordant situations is critical in developing strategies for patient and family oriented care (Health Canada, 2001).

Philosophy of Patient and Family-Centred Care

In recent years, there has been increasing emphasis on developing health services that promote a philosophy of patient and family-centred care. Patient-centred care includes “respect for patients’ values, preferences and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support; and involvement of family and friends” (Access Alliance, 2009, p. 4). Unfortunately, however, LEP patients often experience feelings of frustration and insecurity, particularly in situations where interpretation and patient-provider relationships are less than optimal (Wiking, Sundquist & Saleh-Stattin, 2013). Too often,

providers may regard communication primarily as a means of obtaining clinical data, instead of an opportunity to attend to patient concerns; this can negatively impact rapport. These findings can be particularly pronounced for patients with language barriers (Diamond et al., 2008). The use of professional interpreters, combined with an emphasis on patient-focused approaches and adequate consultation time, has been shown to alleviate some of these negative feelings (Wiking et al., 2013). Indeed, as Schyve (2007, p. 360) notes, “[t]he more the care is patient- and family-centred, the more frequent the communication with the patient and the patient’s family to understand the patient’s perspective and to involve the patient in the treatment team itself.” In the absence of adequate communication, patients and their families are unable to participate equally in the treatment process. Without some form of interpretation to ensure dialogue, client-centred care for LEP patients cannot exist. Indeed, “a health care organization cannot be culturally competent if it cannot assure that providers and patients can communicate and understand one another” (Alliance of Community Health Plans Foundation, 2007, p. 13).

Cultural competence goes beyond language to include behaviours, attitudes, and policies that interact within a system to enable effective engagement in cross-cultural encounters. Strategies can include using interpreter services, developing culturally competent health education, and increasing knowledge of patients’ cultural behaviours and environments. The goal is to develop more appropriate services for minority group populations in an effort to reduce health disparities (Brach & Fraser, 2002). For example, in the London cancer-screening intervention, the two-pronged project targeted health providers and immigrant communities by developing cultural competence workshops for providers and using peer leaders to improve health education for community members (Centre for Community Based Research, 2014). This type of culturally appropriate health education can promote increased openness to preventive screenings and adoption of healthy lifestyle practices, resulting in prevention, earlier detection, and a reduced use of services in the future (Brach & Fraser, 2002).

Providing access to health interpreters therefore represents only a piece of a broader strategy of culturally competent care. “Relying solely on interpreters to provide a communication bridge to services that may be culturally uninformed or unresponsive will not provide true access”; however, without improving language access, addressing a larger agenda of developing culturally competent care would prove impossible (Health Canada, 2001, p. 96).

Program and Organizational Policies and Culture

In a survey of Montreal family doctors, 77% reported that communication represents the greatest obstacle to patient management (Parsons, Baker, Smith-Gorvie, & -Hudak, 2014), and yet, a major barrier to improving care for patients who lack official language proficiency is the general acceptance of communication difficulties as “the norm.” Underuse of interpretation services (even when available) is common, policies for communicating with LEP patients are often vague, and other aspects of care are often seen as more valuable (Diamond et al., 2008). In a focus group with London providers, many reported that no formal policies were in place outlining how and when to use interpretation services (provider focus group). Similarly, physicians in a study by Diamond et al. (2008) reported that they often rely on their own guidelines to decide if and when to use an interpreter, weighing the perceived benefits against the perceived “inconvenience” of seeking a professional interpreter. Determining whether to “get by” or “get help” therefore tends to be a fluid process in which providers may struggle to balance real vs. ideal practice, professional responsibility, and the ethics of informed consent. One respondent in a local AHI conversation circle reported that by their third visit, a physician suggested using the client’s daughter instead of a professional interpreter, as the daughter spoke some English (London-Middlesex Local Immigration Partnership, 2012). A study by Parsons et al. discovered that physicians tend to depict communication as a shared responsibility between themselves and patients, although they portrayed the decision of whether to

get help as solely their own. “[T]hey spoke at length about the information *they* deemed important, but said relatively little about what information *patients* might see as important” (2014, p. 6, ff). This power imbalance does not reflect the tenets of patient-centred care championed by many organizations. While some respondents in the study by Diamond et al. (2008) indicated having some training on how to access interpretation services, most stated they did not receive direction regarding *when* professional interpreters should be used. Studies have shown, however, that underuse of interpreters is only one part of a much “bigger picture” of challenges in providing care in an increasingly multicultural context. Merely adding supplemental communication resources may not be enough to transform provider behaviours or institutional culture (Michalec, Maiden, Ortiz, Bell, & Ehrental, 2014). To address this social norm of unfounded acceptance and achieve broader organizational goals of cultural competence, interventions targeting providers as well as the practice environment must be jointly implemented (Diamond et al., 2008). Research has shown that multiple exposures to cultural competency education are more effective than one-time training; therefore, a model that integrates continuous education may be the most successful (Chen, Youdelman, & Brooks, 2007).

Language services should not be seen as a disconnected feature to be “tacked on” to existing programs, but as a vital core element of a strategy to improve quality of care for all patients (Access Alliance, 2009). Schyve (2007, p. 361) agrees, noting that “[a]daptation does not adequately represent the challenge of implementation.” Instead, cultural competence strategies must be incorporated into an overall redesign of the system in which it is to be a part. Unfortunately, another major structural barrier to improving cultural competence is a lack of political will and recognition of immigrant rights in health care. Health care providers who participated in a study by Diamond et al. (2008) reported that they sometimes encountered situations where LEP patients were seen as an inconvenience, and in some cases, undeserving of care (e.g. “If you come to our country, you should

speak our language.”) (Michalec, et al., 2014). In developing strategies of cultural competence, providers must “continually engage in self-reflection and self-critique [that reflects a recognition of] cultural humility” (Centre for Community Based Research, 2014, p. 8). Training in patients’ right to interpretation has been associated with better outcomes, including a reduction in the use of children as ad hoc interpreters and an increased likelihood of using professional services (Zheng, Patel, Hryniewicz, Katz, 2006). Although all Canadian citizens are granted the right to access health care that is free from barriers, until the rights of immigrant and minority populations are explicitly addressed through legislation, they may continue to face health disparities due to obstacles in executing this right.

Legislation and Human rights

While most Canadians view the right to universal health care as a matter of national pride, in Canada these rights may not be created equal. There are few legal mandates for language rights in health care, although as discussed, communication represents a vital element of health care. This section will discuss opportunities for recognizing language access rights in health care as related to Canadian law, while comparing examples from the United States.

The Canada Health Act represents the most relevant legislation in regard to language rights, as it provides universal medical coverage to all Canadian citizens. It states that “[t]he primary objective of Canadian health care policy is to protect, promote, and restore the physical and mental well-being of Canada, and to facilitate reasonable access to health services without financial or other barriers” (Canada Health Act, 1984). The principle of universality stipulates that all residents must be entitled to services on uniform terms and conditions; as this paper has shown, this is not always the case for individuals who do not speak an official language. All services that are “medically necessary” are to be accessible, and at present, health interpretation services have not been included

under that umbrella (Health Canada, 2001). However, as research presented in this paper has demonstrated, without adequate communication, quality health care is virtually impossible. Denying health interpretation recognition as a medically necessary service therefore interferes with the fundamental elements of health care itself.

The Canadian Charter of Rights and Freedoms also includes provisions that may apply to the issue of language barriers in health care. Section 15 states that:

“Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical ability.”

This section requires that all Canadians be treated equally, and while the right to language access is not specified, challenges could perhaps be made based on discrimination against national or ethnic origin (Health Canada, 2001). In the United States, The Supreme Court has viewed discrimination based on language as comparable to discrimination based on national origin. In 2000, the US Department of Health and Human Services Office for Civil Rights declared that denial of adequate interpretation services to LEP patients constitutes a form of discrimination (Zheng et al., 2006).

Although the US has legislation recognizing language rights at both state and federal levels, in practice this does not necessarily mean that non-English speakers always have access to language services, and there are no national standards recognizing certification of health care interpreters. A major barrier is a lack of reimbursement for services, as each state determines whether and how payment is provided (Chen et al., 2007). This could be an impediment in Canada as well, even if health interpretation was recognized as medically necessary. Because health care in Canada is mandated federally but implemented provincially, designated funding for interpretation services in

health care could be “patchy.” However, in the US, legislation links funding for programs with meeting regulations for language access; failure to do so could result in a denial of funding. This is not currently the case in Canada (Health Canada, 2001).

The legal foundation for language accessibility in the United States is upheld in Title IV of the 1964 Civil Rights Act, which states that:

“No person in the United States shall, on the 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.” (Chen et al., 2007)

Canadian law requires interpretation or other language allowances in both judicial and educational settings, but this requirement has not been extended to health care venues. This is surprising, given the magnitude of the issues at stake in many health care encounters. In Canada, human rights legislation offers a framework within which rights can be challenged, and a seminal ruling by the Supreme Court of Canada in 1997 declared that hospitals must provide interpreters for Deaf patients. This ruling suggests an opportunity for championing the rights of other minority language speakers. Few health jurisdictions or institutions in Canada have policies that require language access services to be offered to all patients and, often, services within different communities have been implemented independently of one another (Health Canada, 2001). In 2000, the US Office of Minority Health published the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*, which represent clear guidelines for implementing culturally competent policies and procedures and which serve as a guide for health care organizations (Chen et al., 2007). Similar guidelines would need to be developed specifically for our Canadian context.

In Canada, national standards outlining language access must be developed, along with a comprehensive strategy for addressing language barriers more broadly. Professional interpretation services therefore represent a necessary but insufficient step towards promoting equitable, inclusive health care based on a foundation of cultural competence (Health Canada, 2001). Broader structural inequalities within the health care system and Canadian society as a whole must be challenged if health disparities for minority groups are to be addressed. It has been said that “every health system is an expression of ‘the political culture, the social and moral values, and economic imperatives’ of the society it serves” (Canadian Bar Association Task Force on Health Care, as cited in Health Canada, 2001, p. 13). If this is the case, we must reconsider whether our current policies reflect the principles of multiculturalism that Canada publicly espouses.

Discussion

The goal of this paper was to outline evidence for providing access to professional health interpretation in London, Ontario. The research reviewed here clearly indicates that current standards and services are inadequate to meet the increasingly multicultural and multilingual population of London, and indeed, of Canada as a whole. While most of the large health organizations in London do offer professional interpretation services at no cost (London-Middlesex Local Immigration Partnership, 2014b), it appears that most health organizations lack formal policies for when and how to utilize these types of services. Furthermore, smaller agencies and many primary care providers do not provide professional interpreters, which leads to variations in access and quality of care. Health providers have indicated a need for more education in cultural competence and for improved integration of services (provider focus group), whereas LEP clients report feeling frustrated and overwhelmed due to communication barriers and lack of culturally appropriate care (London-Middlesex Local Immigration Partnership, 2012; 2014c).

As discussed previously, the use of professional interpretation services has been clearly demonstrated to have significant positive effects on quality of care, patient satisfaction and safety, and to improve appropriate use of various health services and resources. While implementing programs may require some initial investment, the available data also demonstrate that developing culturally and linguistically competent strategies in health care – including at a minimum the use of professional interpretation services – makes good business sense as well. However, it remains clear that truly improving access to equitable, socially responsible health care for all Canadians requires the official recognition of language rights for residents who lack official language proficiency. As Bowen (Health Canada, 2001, p. VII) noted, there is currently “sufficient evidence on the negative effects of language barriers on health access and care; attention should now (...) be directed to the practical issues of developing standards of practice and appropriate models of service.” Above all, however, the need for professional interpretation services must be recognized not as a “special request,” but as a fundamental right (Goggins, 2008).

Recommendations:

It is clear that recommendations must be examined at three levels - the program/provider level, organization/systems level, and political/social level - to achieve sustainable change.

1. Program/Provider Level

The following recommendations apply to health care providers and the programs in which they offer services.

- Develop systematic ways to collect language data from patients during health care visits to build awareness of community and organizational needs.
- Programs/providers should have a standardized protocol or practice to identify LEP patients. For example, patients with some degree of English proficiency should be asked

at intake to identify the primary language spoken at home, and to rate their proficiency in official languages (if they rate their proficiency as less than “very good,” an interpreter should automatically be called. When limited English is obvious, an interpreter should automatically be called).

- At discharge, provide LEP patients with information on how/where to access local English language classes.
- Wherever possible, providers should schedule extra time for patients who require interpreters, perhaps through system-supported incentive plans.
- Include patients in the development and evaluation of policies and procedures through participatory research and evaluation of the impact of interpretation services.
- Develop initiatives to empower LEP patients and help them advocate for their right to interpretive services (a possible strategy could include the use of Peer Leaders to lead health promotion projects).
- Develop straightforward methods for LEP patients to identify themselves and to request access to a professional interpreter (some examples could include a card to present stating the patient’s name and spoken language along with a request for an interpreter, or the display of multilingual posters that allow patients to point to their language).

2. Organization/Systems Level

The following recommendations are for the organization/systems level and target operational structures and processes, including policies, procedures, and professional development.

- Develop mandatory provider training that promotes continuous development of cultural competence, and embed such processes in organizational philosophies of patient-centred care.
- Designate a staff person to liaise with clients and to be involved in advocacy efforts.
- Implement training initiatives to highlight the importance of effective communication in health care and how to work with professional interpreters.
- Encourage the support of senior leadership in health organizations.
- Conduct research to develop appropriate models of interpretation and cultural competence that are tailored to the specific needs of communities and organizations.
- Ensure clear guidelines are outlined for how and when professional interpreters should be used.
- Implement evaluation strategies to monitor success of initiatives, and include cultural competence in measures of overall quality of care.
- Recognize the link between language barriers and patient safety in developing patient safety recommendations and processes.
- Establish and integrate community partnerships and resources.
- Through collaboration with multiple organizations, establish a “clearinghouse” for shared multilingual health resources.

3. Political/Social Level

Recommendations for the political/social level address a broader range of issues and initiatives that transcend health care.

- Develop national standards for health interpreter training, including accreditation and standards of practice.
- Develop policies that recognize minority language rights for residents not proficient in an official language.
- Recognize health interpretation as a “medically necessary” service.
- Create a “secure envelope” of funding for health interpretation services, and make access conditional on providing culturally competent care.
- Consider training International Medical Graduates living in Canada but unable to work in their fields of study, to qualify them as medical interpreters and health educators.

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