Winnipeg Regional Health Authority

Office régional de la santé de Winnipeg

LANGUAGE BARRIERS WITHIN THE WINNIPEG REGIONAL HEALTH AUTHORITY

Evidence and Implications

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About the author: Sarah Bowen, Ph.D., has extensive experience in the area of access and quality of care for underserved populations, and the specific issues of language access services and organizational diversification. She is the author of several related reports and articles, including *Language Barriers in Access to Health Care* (Health Canada, 2001)*, Access to Health Services for Underserved Populations in Canada* (Health Canada, 2000), *Cultural Competency in Paediatric Health Care: Issues and Best Practices* (National Network for Cultural Competency in Paediatric Health Care, 2002); and *Assessing the 'costs' of health interpreter programs: the risk and the promise* (In Brunette et al., Selected Papers from the Third International Conference on Interpreting in Legal, Health and Social Service Settings, 2003).

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EVIDENCE AND IMPLICATIONS

KEY POINTS

- The proportion of Manitobans facing language barriers to health care is projected to increase in the coming years – not decrease as is commonly assumed.

- Language barriers have perverse effects on health service utilization – they decrease utilization of primary care and preventive services, and increase utilization of higher intensity services (such as diagnostic testing), and both hospital admission and length of stay.

- The international literature provides consistent evidence that language barriers are associated with increased instances of misdiagnosis, poorer health outcomes, poorer patient adherence, and lower satisfaction.

- Failure to address the risks to informed consent and confidentiality presented by language barriers presents increased risks to organizational liability.

- While there are costs associated with establishing language access programs, failing to address language barriers also has important cost implications. The cost implications of language barriers have been identified.

- Appropriate language access services are a critical element in organizational strategies to address health disparities, improve quality, and manage risk.

- Provision of trained interpreters provides important benefits to individual providers and the health system, as well as to clients.

- Language access services appear to be most efficient and cost effective when organized at a regional, rather than facility, level.

LANGUAGE BARRIERS WITHIN THE WINNIPEG REGIONAL HEALTH AUTHORITY: EVIDENCE AND IMPLICATIONS

EXECUTIVE SUMMARY

Background

Those who do not speak the same language as their health care provider are recognized as a population underserved by the health system. Four constituencies in Canada may face barriers to health care due to lack of official language proficiency: First Nations and Inuit communities; newcomers to Canada (immigrants and refugees), Deaf and Deaf-Blind persons, and minority official language speakers (e.g. Francophones living in Manitoba). There are two basic strategies for addressing language barriers – increasing the number of same-language encounters, and providing interpretation services. It is difficult to get an estimate of the number of individuals who may require an interpreter in some circumstances – in Manitoba the proportion may be as high as one in 12. The number of health encounters requiring interpretation depends on a number of factors, including health status and age structure of the minority language population, and availability of other resources in the community. The proportion of the Manitoba population requiring language access services is anticipated to increase, as the Manitoba government has instituted a strategy to dramatically increase the number of immigrants accepted into the province.

With the exception of Deaf patients using ASL and official language minority patients in one or two provinces, the rights to language access in minority languages have not been established in Canada. However, there is specific legislation to protect patients from procedures for which they have not provided informed consent, and to ensure that the confidentiality of health information is protected. The codes of ethics of health professions, and the mission, goals, and values of health organizations also state a commitment to providing equitable and quality care.

Evidence on Impacts of Language Barriers

There is overwhelming international consensus on the impacts of language barriers, in spite of differences in health system organization and the populations of concern. Although there has been limited Canadian research undertaken on the impact of language barriers, the research that has been conducted is consistent with international findings. There is mounting evidence that language barriers have a larger negative effect on quality of care than does race or ethnicity.

Lack of language access services presents barriers to first contact for most health services. Language barriers have been demonstrated to decrease participation in health promotion and prevention programs – programs that have important implications for the long term health of the population – and delay presentation for care. They result in lower participation in cancer screening programs. Access to almost every type of health program and service appears affected; prenatal education, first aid courses, pharmacy education services, and support services for caregivers of the elderly, for example. Evidence on use of emergency services is conflicting – with higher use reported for use of emergency departments and

lower use of telephone services (such as 911). There are additional barriers to mental health and reproductive health services. Language minority communities in Canada, as in other parts of the world, identify lack of language access as the greatest barrier to health services.

Language barriers are also associated with greater risks of misdiagnosis, poorer patient understanding of their condition and adherence to prescribed treatment, lower satisfaction and confidence, and differences in prescribed treatment. There is less likelihood of appropriate pain management. Both clinical and psycho-social care may be negatively affected. Greater risks are found in health areas, such as mental health, that rely more on interpersonal aspects of care. Concerns about confidentiality due to unavailability of trained interpreters may result in patients concealing or omitting relevant information. This presents additional challenges in areas such as mental health or reproductive health.

The research indicates that language barriers are also associated with differences in health outcomes. Some of these differences may be related to delayed presentation for care; others to delayed treatment because of misdiagnosis or poor patient understanding of recommended treatment. Language barriers are associated with less effective management of chronic diseases such as diabetes and asthma. Patients with unaddressed communication barriers are less satisfied with care, and less confident in their providers.

Patients are often prevented from providing informed consent; and language barriers often result in the organization failing to protect the privacy and confidentiality of patient information. Inappropriate use of family members – particularly children – as interpreters risks the health and well-being of not only the patient, but the whole family.

Language barriers have been demonstrated to have perverse effects on health service utilization: they decrease utilization of preventive and screening services, and can increase use of more costly services (such as diagnostic testing, hospital admission, and length of hospital stay). This contributes to decreased health system efficiency, including longer waiting lists. Two factors within the health encounter account for increased service utilization. First, the provider may exercise greater caution in the face of language barriers. This "uptriaging" results in greater likelihood of increased diagnostic testing, specialist referral, hospital admission, or repeat visits. If greater caution is not exercised, language barriers increase the risks of misdiagnosis due to incomplete or inaccurate assessment, and of complications resulting from less appropriate treatment and poorer patient comprehension.

Provider awareness of the risks of using untrained interpreters (the most common response in Winnipeg) appears low. The research indicates that use of untrained interpreters may be more dangerous than no interpreter at all, because there is the illusion that communication is taking place. Transcript analysis research reveals the type and frequency of errors made by untrained interpreters. Many of these errors have potential clinical consequences, and may be an unrecognized source of medical errors. Winnipeg case studies provide illustration of the results of using ad hoc interpreters.

Research on the barriers faced by those lacking official language proficiency is consistent with the generic literature on medical communication. This literature indicates that satisfaction, adherence, pain, anxiety, functional status and physiologic measures of blood

pressure and blood glucose are affected by quality of communication. The relationship between literacy and health has also been well-established. Individuals who lack official language proficiency also lack health literacy in English or French. An estimated 29% of foreign-born Canadians who are university-educated may be functionally illiterate in an official language.

Language barriers also have broader impacts on the health system. Those not proficient in an official language are often excluded from evaluation and research activities, with the result that the experience of an important sector of the population may not be included in planning. Language barriers also have a negative effect on provider learning and satisfaction, and increase the risks of malpractice liability.

The "Business Case" for Addressing Language Barriers

The costs associated with patterns of utilization that result from failing to address language barriers are often hidden from decision-makers. In addition, the number and variety of consequences of language barriers makes comprehensive economic evaluation infeasible. Decisions on whether to provide language access services are often made on the basis of the proposed "cost" of providing these services, while overlooking the "costs" of the consequences of failing to do so. However, recent research provides empirical evidence to support the conceptual model explaining the proposed pathways that result in increased costs. This model is summarized on page 28.

As useful as cost effectiveness analysis is, it is only one criterion for decision making, and does not exempt an organization from making ethical decisions, meeting legal obligations, or providing quality care. There is good evidence from local case studies that patients of the WRHA who lack English language fluency are being denied their rights to informed consent and that confidentiality of their information is often not protected. These factors, along with the increased risk of misdiagnosis associated with language barriers, increases the risk of liability for providers and the regional health authority.

Provision of language access services should be viewed not as a separate "add-on" program, but as an essential component of a strategy to meet organizational goals – to manage risk, improve quality, reduce health disparities, and establish partnership with vulnerable communities. Addressing language barriers is the one strategy for improving organizational cultural responsiveness that has the greatest evidence of effectiveness. Challenges to addressing these barriers include: low provider awareness of the risks of using inappropriate interpretaters; marginalization of minority language communities from organizational planning; and the invisibility of the effects of language barriers to decision-makers in a climate where other issues appear more urgent. An additional barrier is the common view that interpretation services are too costly – and failure to consider the costs of failing to provide adequate language access.

Recommended Next Steps for the WRHA

There is strong international consensus on best practice standards for providing language access services. These standards stress the need for coordinated organizational policy and procedures, use of only trained interpreters for key health encounters, availability of information on interpretation services in the languages of the community, and systems for record keeping and evaluation.

A high-level analysis of current practice within the WRHA indicates that the health authority is failing to meet minimum best practice standards. Ad hoc solutions have been developed for different language communities and for different service/program areas. While many individuals may take steps to ensure appropriate interpretation, this is not reflected in organizational policy. The services available – and therefore the standards of service provision – vary by language constituency, service or program area, and time of day. This system is both inefficient and poses risks to patients and providers.

A number of different models can provide services that meet best practice standards – each of these has advantages and disadvantages. The best model must be determined through assessment of local needs and currently available resources. However, any model developed should be coordinated at the regional level, and address the language access needs of all language constituencies. It is likely that a "combination" model (incorporating a limited number of staff interpreters, sessional community interpreters, use of telephone interpreting services in well-defined circumstances, bilingual providers, and community-based education initiatives in minority languages) will be most feasible for a health authority such as the WRHA, which serves many smaller language communities.

Recommendations for initiating development of language access services incorporate best practice recommendations from the research on organizational cultural responsiveness:

1. To create a responsibility centre for language access services that has responsibility for all constituencies and reports to senior management;
2. To undertake an environmental scan and organizational assessment to determine the strengths and weaknesses of current responses, and resources currently available to support development of language access programs;
3. To consolidate support for addressing language barriers at the senior levels of the organization;
4. To develop, in conjunction with stakeholder groups, a strategic plan for communicating and integrating the recommended model into organizational policy, planning and processes; and
5. To develop a recommended model to provide language access services for the Winnipeg Health Region. This model should be based on current and projected needs for the Winnipeg region, maximize use of community resources, and incorporate creative, lower-cost alternatives to respond to language barriers. The model should respond to the needs of all language constituencies, and address the needs for language minority communities to access both clinical services and community-based health promotion resources.

The benefits of addressing language barriers are many: increased health system efficiency; improved capability to manage risk and improve quality; improved health outcomes; and enhanced relationships with minority language communities. The projected increase in the number of Manitobans facing language barriers, combined with national initiatives to establish standards for health interpretation, creates a context where development of appropriate responses will be an issue of increasing concern.

INTRODUCTION

Purpose of this report

This report was prepared as a background paper for the Winnipeg Regional Health Authority (WRHA). Its objectives are to: a) summarize the current evidence related to the impact of language barriers; b) review current WRHA practice in the light of accepted best practice in the area of language access; and c) provide an evidence base to facilitate further assessment and planning.

Scope and limitations of the report

The importance of effective communication in provision of health care services cannot be overstated. There is a significant body of work that focuses on health communication and its impact on service utilization and health outcomes. This report, however, focuses more narrowly on one aspect of health communication – the impact of barriers faced by those who do not share the same language as their providers.

Language can never be fully understood apart from "culture" – language and culture are inextricably intertwined. Language barriers – and the strategies developed to address them – must be understood within the larger context of cultural responsiveness (or competence) of health organizations. The focus of this report, however, is limited to *linguistic* barriers to health care. It is also important to recognize that the impact of language barriers will have different effects based on a number of client, provider or system factors. These include such factors as client education, health status, and previous experience with the health system; provider attitudes (including prejudices), knowledge of, and experience with, specific ethnic/racial/language communities; and the presence or absence of other responses within the health care system to promote culturally responsive care.

In addition, strategies to address language barriers are developed within a broad historical, cultural, and legal context, where many other language issues (e.g., the rights of official language speakers, and the desirability of protecting and promoting Aboriginal languages) must be considered. However, this report does not attempt to address these important issues; rather it focuses specifically on evidence of the impact of language barriers in accessing quality health care.

Although the report references current WRHA practice in addressing language barriers, this is a high-level analysis based on information provided by the Language Barriers Advisory Committee (Appendix A) and is not intended to provide an assessment of language access services and current practice.

How this report is organized

This report is organized into four sections. Following the introduction, **Section 1: Background** defines the constituencies in Manitoba who face language barriers; describes the two basic approaches to addressing language barriers; provides an overview of rights to language access to health care in Canada; and discusses issues related to determining the number of residents who require language assistance services. **Section 2: Evidence** provides a summary of the research on the impacts of language barriers, and explores the pathways that are proposed to lead to the observed outcomes. **Section 3: Implications** explores the "business case" for addressing language barriers and examines the implications of this

evidence for regional health authorities, specifically as they relate to risk management, quality improvement, and achieving population health objectives. **Section 4: Response** summarizes accepted best practices in ensuring language access, provides an overview of responses to language barriers, and proposes "next steps" for the WRHA.

A note about case studies
All case examples used in the report took place in Winnipeg. Identifying information has been removed to protect confidentiality.

Glossary
The glossary beginning on the next page defines key vocabulary used in the report.

GLOSSARY

Language access is an umbrella term that describes the ability of clients to communicate effectively with those in the health care system, and for providers to communicate effectively with them. Language access can be provided in many different ways: interpretation (in person or remote), availability of health information in a variety of formats and languages, signage, or direct service by bilingual service providers**.**

Interpretation. For the purposes of this report, interpretation refers to the process by which a spoken or signed message in one language is relayed, *with the same meaning*, into another language. This definition recognizes the complexity of the task of interpretation. Interpretation may be categorized as ***proximate***, meaning the interpreter is present in the encounter, or ***remote*** (e.g. by using telecommunications technology). ***Health interpretation*** or ***medical interpretation*** refers to interpretation for health issues or within the health system. ***Trained health interpreters*** are those who have appropriate training in the profession of health interpreting, including knowledge of health system organization, medical vocabulary in both languages, and ethical standards and codes of conduct related to health care. ***Community interpreters*** may be either paid or volunteer, and often work on behalf of a community agency or organization. They may or may not have received any training in interpreting. ***Ad hoc or volunteer interpreters*** are family members, friends or others who act as interpreters for the client.

Translation refers to the written conversion of one language into another.

Language concordant encounters are health care interactions where both provider and client are fluent in the same language. In ***language discordant encounters***, provider and client do not speak the same language.

Mother tongue: First language learned in childhood that is still understood (Statistics Canada). A more useful measure of those who may face language barriers is those who ***speak a non-official language most often at home.***

Aboriginal: All indigenous persons of Canada of North American Indian, Inuit or Metis ancestry, including those in the Indian Register. ***Registered, status or treaty*** Indians are those who are registered under the terms of the "Indian Act", and whose names appear on the Indian register. ***First Nations*** are those who report being a member of a First Nation of Canada.

Deaf, deaf. The word deaf, when the 'd' is capitalized, as in Deaf, refers to those who belong to the cultural community of Deaf people. Many of these persons are pre-lingually deaf, and while they may learn to read and write English or French, they learn these as second languages. In contrast, the words *deaf* or *deafened* (with a lower case d) refer to lack of hearing. Not all those who are deaf are members of the Deaf community, or use sign language.

ASL. (American Sign Language) is the signed language most commonly used by Deaf persons in Canada. There are, however, many other signed languages.

Immigrants: People who are, or who have been at one time, landed immigrants to Canada (Statistics Canada). A landed immigrant has been granted the right to live in Canada permanently. ***Refugees*** who are accepted into Canada are one class of landed immigrants. Refugees have the same rights as other immigrants; however, they often have additional health needs. ***Refugee claimants*** (or asylum seekers) do not have landed immigrant status; they arrive in Canada requesting to be accepted as refugees.

Minority official language speakers in Canada are French or English speakers who are a numerical minority in the province or area in which they live (e.g. Francophones in Manitoba).

Culture is defined as aspects of individual and group identities that include language, religion, ethnicity, gender, experience of migration, social class, political affiliation, family influences, age, sexual orientation, geographic origin, and other life experiences. An **ethnic group** shares a common language, "race", religion, or national group. **"Race",** once defined as a biological category, is now recognized as a social category.

Ethnic coding, or **ethnic identifiers** refer to data included in health information that provides information on one or more factors related to Aboriginal status, immigration status, visible minority status, ethnicity, language preference, or official language proficiency. Ethnic coding remains controversial in Canada, and there is no national consensus on its use. As a result, with the exception of coding related to Registered First Nations persons, there is no consistency of coding in health data, placing constraints on the ability of researchers to determine differences in health status, utilization or health outcomes by these measures.

SECTION 1: BACKGROUND

Four "constituencies" in Canada may face language barriers to health care.
There is increasing evidence that a number of populations are underserved by the healthcare system in Canada. Those who do not speak the same language as their health care provider are recognized as one of those underserved groups[1].

There are four constituencies in Canada who may face barriers to health care due to having a non-official language: First Nations and Inuit communities; newcomers to Canada (immigrants and refugees), Deaf and Deaf-Blind persons, and minority official language speakers (e.g. Francophones living in Manitoba). In spite of significant differences between these communities in population, health status, legislated rights to language access, primary government department responsible for service delivery, and preferred strategies for addressing language barriers, the international research on the effects of language barriers indicates that the impact of language barriers is similar across these groups.

There are two fundamental approaches to addressing language barriers.
The best communication is achieved when providers and patients speak the first language. The ideal solution therefore is to *increase the proportion of same-language (language concordant) encounters*. Strategies in this category include increasing the number of residents proficient in English (by provision of English as a second language classes for example), or by increasing the number of health professionals who speak minority languages (e.g. designated bilingual positions). However, there are important limitations to this approach. First, it is not feasible (particularly in a province such as Manitoba, which hosts many small language communities) to ensure linguistic matching between providers and patients for every encounter. Nor is it realistic to assume that encouraging English language use will eliminate all language barriers. There will always be a need for language interpretation services for some patients, and for some services. The second response to addressing language barriers is, therefore, the *provision of interpretation and translation services* to bridge the communication gap present in language-discordant encounters.

Right to language access services varies between constituencies.
While the Canada Health Act guarantees "reasonable access" to health care on uniform terms and conditions, reasonable access has not been defined, and historically has been defined simply as the absence of explicit financial barriers[2]. Rights to linguistically appropriate service are addressed by the Official Languages Act, interpretation of the Canadian Charter of Rights and Freedoms, and federal and provincial human rights legislation. The Official Languages Act entrenched in law the rights of English and French speakers to a range of services in their own language. At the federal level (and in Manitoba) there is no legislated protection for Aboriginal or immigrant languages.

Provision of language access services is not an "insured service" under the Canada Health Act. A challenge under the provisions of the Canadian Charter of Rights and Freedoms (the "Eldridge case" of 1997), however, confirmed the rights of Deaf patients to medical interpretation. This challenge was pursued under the disability provisions of the charter and it was specifically noted that the decision was not setting a precedent for other language groups. However, as the arguments on which the decision was based are also applicable to other minority speakers, it is unclear what the decision would be if such a challenge were

pursed under the "national or ethnic origin" provisions of the charter. For example, the ruling states:

> *Interpretation services should not be conceived of as "ancillary services" which, like other non-medical services such as transportation to a doctor's office or hospital are not publicly funded. Effective communication is quite obviously an integral part of the provision of medical services. (Eldridge v. British Columbia (Attorney General), 1997.* [3]

Since the Eldridge decision, the government of Manitoba has funded provision of sign language interpretation for insured health services.

In addition to general rights legislation, there are specific legal and ethical provisions guaranteeing client rights in medical decision making. There is specific legislation to protect patients from procedures for which they have not provided informed consent, and to have the confidentiality of health information protected. Health organizations have a duty to require, through policy, evidence of informed consent in the medical record. "Failure by the health care provider to remove any communication barriers that may result in misunderstandings by the patient, therefore providing invalid consent to treatment, could result in hospital liability"[4].

Common law in Canada has recognized that where a patient does not speak an official language, it is incumbent on the physician to ensure that the patient understands the information that is communicated before administering treatment. This includes the obligation to be attentive to the language ability of the interpreter, and a positive duty to ensure the patient actually understands the information given.[5]

In addition to a requirement to comply with external regulations defined in law, the code of ethics of health and social service professions require providers to obtain informed consent, provide explanations, ensure confidentiality, and refrain from practicing their professions under conditions that may impair service quality. This has important implications for professional-client interactions where a language barrier is present.

It is also a fundamental assumption of Canadian society that publicly funded health services provide equitable services to *all* Canadians – in other words, equitable service is viewed as a "right" by Canadians. This commitment is often reflected in the mission and vision statements of health care organizations. This report, therefore, is based on the assumption that equivalent access and quality of health care should be provided to all Canadians.

A significant minority of the Manitoba population requires language access services. It is difficult to get an estimate of proportion of the population that requires language access services. As of the 2001 census, only 1.5% of the Canadian population reports no official language capability[1]. This figure, however, is a significant underestimate of the need for language interpretation. Many people with rudimentary knowledge of French or English lack the level of language proficiency required to access services and effectively communicate in a medical encounter. Nor is the use of mother tongue other than French or English (1 in 6 Canadians, and 1 in 5 Manitobans, as of the 2001 Census) an appropriate estimate, as this

[1] Unless otherwise noted, all statistics in this section are taken from publicly available 2001 Census data, Statistics Canada.

proportion vastly overstates the numbers of those who lack official language fluency. It is often believed that the best estimate may be the percentage of the population that speaks a non-official language most often at home – this is approximately 10% of the Canadian population, and just under 8% of the Manitoba population.

In Manitoba, just over 12% of the population was born outside of Canada (compared to 18.4% of the overall Canadian population, and over 26% of the populations of British Columbia and Ontario). In 2002, 46% of immigrants could speak neither English nor French on arrival in Canada. This figure, which has been rising over recent years, is higher for many refugee populations. In 2001, 61% of the immigrants who came to Canada in the 1990s used a non-official language as their primary home language, and 10% continue to report no knowledge of either official language. In comparison, only 56% of the immigrants who arrived in the 1980s spoke a non-official language at home in 1991. These figures do not include international students.

Approximately 14% of the population of Manitoba, and 8% of the city of Winnipeg identifies as Aboriginal. While the percentage of the Canadian population reporting Aboriginal ancestry is on the rise, the percentage reporting an Aboriginal language as a mother tongue is decreasing, down 3.5% since the last census. Twenty-five percent, compared to 29% in 1996, report knowledge of an Aboriginal language: one in ten of these reports using it most often at home. Sixty-five percent of Aboriginal people in Manitoba report English as a mother tongue (4% report French). However, 76% speak English most frequently at home[6]. Unlike immigrant populations, the majority of those speaking only an Aboriginal language are in the older age groups, and fewer children are learning Aboriginal languages. The WRHA also provides service to approximately 3,300 Inuit patients from Nunavut each year, with a total of over 9,500 outpatient appointments, and approximately 7,800 hospital days. Sixty-five percent of Inuit speak Inuktitut at least regularly in their home, and staff of Kivalliq Inuit Services estimate that approximately half of the patients seen in Winnipeg need interpreting assistance.

In 2001, of the 4.2% of Manitobans who report French as a mother tongue, 45% speak French most often at home. It is generally accepted that 1/1000 is the closest estimate of deaf persons who use sign language, but that the figure is higher among Aboriginal populations[7]. An estimated 1,000 culturally Deaf Manitobans (the vast majority of whom live in Winnipeg) use sign language, and approximately 50 Deaf-Blind individuals require intervenors to communicate.

It is, however, not only important to look at the proportion of the population that may need language access services for some or all of their encounters with the medical system – what is more important is ***the number of language-discordant health encounters.*** This is affected by a number of factors:

- *Health status* of the minority language population. In Manitoba, for example, Aboriginal peoples are recognized as having lower health status. As a result, Aboriginal persons experience a greater average number of health encounters than the general population. Refugee populations often suffer from serious health conditions and diseases. These same characteristics make many communities a priority for health promotion/prevention programs.

- *Age structure of minority language populations*. A higher proportion of both immigrants and Aboriginal peoples are in their child-bearing years (e.g. 46% of recent immigrants, compared to 31% of the general population are in the 25-44 year age range. The median age of Aboriginal population in Manitoba is 22.8 years, compared to 37.7 for the non-Aboriginal population.) Not only is this a period of high health care use for women (and a critical period for health promotion), but many pediatric encounters with Canadian children rely on communication with parents who are not proficient in English.
- *Area of health or type of program*. For example, in Manitoba, one third of seniors have a non-official language as a mother tongue. As many older people often revert to their first language with stress and age, providers of seniors' health services may face a larger proportion of language discordant encounters.
- *Institutional completeness* of the minority language community. Institutionally complete communities can provide a range of health, social, educational, economic and cultural services through providers of the same language and cultural background. Smaller centres such as Winnipeg pose additional challenge to minority language speakers as there are likely to be fewer professionals speaking minority languages and fewer sources of language concordant information and care. New immigrant communities are less institutionally complete than older ones, and hence, needs for language access services are likely to be greater.

The number of Manitobans requiring language access is projected to increase
Of importance to planning for Manitoba is the projected increase in the numbers of individuals likely to require language interpretation as the result of provincial initiatives to increase immigration. Manitoba, in conjunction with the federal government, has instituted a plan to increase the number of immigrants to 10,000 annually by 2006 [8]. This approach is described by the Manitoba minister for immigration – who states that the government intends to make Manitoba the "number one choice for international immigrants" – as "*a comprehensive response to demographic challenges such as declining birth rates, an aging workforce and the impending retirement of the baby boomer*s".[9] The Société franco-manitobaine is also actively recruiting French-speaking immigrants. In 2003, Manitoba received 6,474 immigrants, (of whom 5,115 settled in Winnipeg) – an increase of 40% from the previous year. This increase in immigration is offsetting the loss of older minority languages speakers.

These recent immigrants, from Asia, Africa, and the Middle East, face additional barriers as health beliefs and practices are less similar to Canadian practice than those of earlier immigrants. As visible minority persons they may also be at higher risk of stereotypical attitudes on the part of providers. In addition, an increasing number of unilingual French speaking patients requiring language interpretation are immigrants (from African countries of the Francophonie for example), who require cultural as well as linguistic interpretation, and may have additional health needs. The limited availability of services more readily available in larger cities has contributed to the difficulty that Manitoba has had retaining many immigrants in the past. Appropriate access to health services provided through, for example, provision of trained interpreters is considered a priority for many newcomer families.

SECTION 2: EVIDENCE OF IMPACT OF LANGUAGE BARRIERS

INTERNATIONAL OVERVIEW

Given the extensive literature and practical experience related to the impact of communication distortions between patients with limited English proficiency and monolingual English providers, it seems clear that not providing linguistic access services would increase the incidence of miscommunication, misdiagnosis, inappropriate treatment, reduced patient comprehension and compliance, clinical inefficiency, decreased provider and patient satisfaction, malpractice injury, and death. (Office of Minority Health, 1999)[14].

There is strong international consensus on the impacts of language barriers within the healthcare system.
There is overwhelming international consensus on the impacts of language barriers, in spite of differences in health system organization and the populations of concern [10-11]. Research from Australia and New Zealand has focused both on Aboriginal and immigrant populations [12-13], whereas the countries of Europe have emphasized immigrant and refugee populations.

Much of the research on language barriers has been undertaken in the United States. Two factors have contributed to this. The first is the presence of specific legislation (Title VI of the Civil Rights Act, and the Americans with Disabilities Act), requiring health organizations to provide linguistic access for "minority" groups. The second is the growth of managed care organizations, and the interest of such organizations both in marketing to minority populations, and in controlling costs. The combination of specific directives regarding provision of language interpretation services within federally funded health services, and the "business case" orientation of a private health care system, has resulted in national attention being focused on language barriers.

A high profile, multi-year national initiative intended to develop national consensus on standards for culturally and linguistically appropriate care, sponsored by the Office of Minority Health, resulted in the 2001 report *National Standards for Culturally and Linguistically Appropriate Services in Health Care.*[15] The 2002 Institute of Medicine Report, *Unequal Treatment*[16], and a previous report *Racial and Ethnic Differences in Access to Health Care* [17] analyzed differences in treatment received within the health care system by racial/ethnic groups, and galvanized many within the health professions. These reports highlighted the contribution of language barriers to these disparities. Language access has emerged as an important quality issue, and in 2003 the Centres for Medicare and Medicaid Services identified the provision of culturally and linguistically appropriate services as one of two topics for national quality assessment and performance improvement.[18]

There has been limited Canadian research undertaken on the impact of language barriers, although the research that has been conducted is consistent with international findings. Much Canadian research has focused on immigrant populations. A 2001 review of the research literature related to language access analyzed research evidence from a Canadian perspective, and assessed implications for the provision of health care in Canada. There was strong evidence that Canadian patients who did not speak an official language often did not receive the same standard of ethical health care as other Canadians, and that much (though

not all) of the international research could be appropriately generalized to the Canadian context [10].

There is growing evidence that language barriers have a greater impact than "culture" on utilization patterns and quality of care.
Recent research has attempted to "disentangle" the effects of culture and language and their effects on health care utilization and health outcomes. There is mounting evidence that language barriers have a larger negative effect on quality of care than does race or ethnicity [10, 19-25]. Several U.S. studies have found greater disparities between Hispanics and Whites, than between Blacks and Whites, in access and treatment received – even when other potentially confounding variables are accounted for. However, when language is included as a variable, English-speaking Hispanics have outcomes similar to Whites, while Spanish-speaking Hispanics continue to have the poorest outcomes [21, 23]. This research has contributed to greater attention to the importance of language barriers in contributing to health disparities.

INITIAL ACCESS TO HEALTH CARE SERVICES

Language barriers have been associated with both higher and lower rates of service utilization. There is inconclusive evidence that language barriers affect the rate at which patients present for acute or emergency care. There is, however, convincing international evidence that language barriers result in lower use of non-acute – particularly preventive and screening – services. While administrators and providers often focus on the problems presented by language barriers in urgent or emergent situations, long term health of the population is affected by participation in preventive and health promotion programs.

For those not fluent in an official language, the process of determining what services are available, making an appointment, and even finding the service can require the services of an interpreter. Information is often received via "word of mouth", as those requiring an interpreter may not be able to access telephone, print, or internet resources (often only available in English).[26] Language barriers can also result in decreased awareness of the range of health-related services and their appropriate utilization. For example, those not fluent in an official language may be unaware of services such as Health Links – Info Santé, and so underutilize some appropriate resources. One of the results of these barriers is that non-urgent care, as well as preventive care, is often not accessed. In Winnipeg, the "Health Advocates" program, which linked medical students with refugee settlement services, found a low level of awareness among settlement staff of the range of health care services and guidelines for appropriate utilization. As these individuals are often the sole source of health orientation for newly arrived (often unilingual) refugees, it can be predicted that appropriate use of services by their clients would be negatively affected.

Winnipeg: *Medical students volunteering to screen refugees newly arrived in Winnipeg were surprised to discover that several of them had been told in the refugee camps that they were lucky they had tested negative for HIV and syphilis. They were told that they would never have to worry about these diseases again – as Canada was a 'clean' country and those diseases were not found here. This was of particular concern as settlement staff reported that sex trade workers were actively soliciting in the housing unit where the new arrivals lived, and it was also reported that some of these new arrivals were testing positive for HIV after they arrived in Canada.*

Language barriers are associated with less use of health promotion and health education resources [26-28] **and HIV/AIDS education and counseling services**.[26,29] Access to health promotion/prevention services includes exposure to health campaigns and both patient-initiated and provider-initiated activities. There is solid evidence that language barriers result in lower participation in almost every form of preventive care. In a large American survey fewer patients lacking English language fluency report receiving screening for colon cancer, counseling for smoking cessation, or – if suffering from hypertension, diabetes or heart disease – having their blood pressure checked regularly.[30]

Language barriers prevent access to ambient health information (information that most of us "pick up" through everyday activities such as reading the newspaper, viewing a bus advertisement, or listening to the radio). Much preventive information is conveyed in this form – from information on preventing exposure to the West Nile virus, to alerts on the new cases of syphilis in the core area. However, in most cases information is only available in English (and sometimes French). Those who lack official language proficiency, including Deaf and Deaf-Blind persons, often do not have access to this information.

Language barriers are associated with lower rates of access to non-urgent care. The research provides consistent evidence that a language barrier is associated with lower frequency of general checkups,[31] fewer visits for non-urgent medical problems,[32] less likelihood of a regular provider,[23] less likelihood of a physician visit, flu shot or mammogram,[25] and fewer paediatric visits.[33]

Language barriers result in lower participation in cancer screening programs. The best Canadian evidence of barriers to preventive programs is found in the area of cancer screening programs. Aboriginal women and some groups of immigrant women are less likely to have mammography or cervical screening.[34-38] French-speaking women have also been reported to have lower participation of some services.[39]

Winnipeg: *A 50 year old Chinese woman arrived at a special cervical cancer screening clinic with her husband. He informed staff that she had never had a PAP test before – that she was unaware of the importance of cervical screening until she read an article about it in her own language in the local Chinese paper.*

This is consistent with findings in the international research. While it is often believed that "cultural differences" are the major factor in lower participation in these programs, this is not confirmed by either the Canadian[40] or international research.[41-42] This research indicates that language barriers are a greater barrier than cultural beliefs, and that many more women would participate in such programs if they were given information or if their doctor had recommended the program to them.[42] Language barriers are identified as one of the greatest barriers to such discussion.[43]

There is inconsistent evidence on use of emergency services. There is less evidence that language barriers impact access for urgent/emergent conditions, and the evidence available is not consistent. There is some evidence that barriers to physician and preventive care may lead to greater use of hospital emergency departments,[44] however, language barriers may also present barriers to some emergency services, particularly telephone emergency services.[45] One example of how language barriers may affect access to

emergency care is demonstrated in the July 2004 case, where a contributing factor in the drowning death of a child in Toronto was that the caregiver's inability to speak English – and the fact that she was not aware that the 911 service could provide interpretation – prevented her from making a 911 call.[46] Access to poison control centres is also reported to be lower for those not proficient in English.[47-48]

Access to almost every form of supplementary or alternate health service is affected by language barriers.
The international research points to less use of out-of-hours service,[49] pharmacy services,[50] support services for caregivers of the elderly,[51] access to programs for children with special needs,[22] childbirth education programs,[52] and participation in first aid or CPR courses.[53] There is also reported lower use of telephone information or health lines.

Language barriers are identified as the greatest barrier to health care by language minority communities themselves.
Qualitative work with immigrant communities indicates that many newcomers identify the lack of trained interpreters as the greatest barrier to health care in Canada[26, 54]– similar to results found in other countries. Canadian research indicates that while providers place the greatest importance on understanding the cultural beliefs and practices of various communities, members of these communities themselves emphasize the importance of language barriers.[26, 55-58] Even in the United States, where many non-English speaking clients lack health insurance, language barriers are often cited as the greatest barrier preventing access to care.[59-60]

EFFECTS ON THE HEALTH ENCOUNTER

There is a growing body of evidence that language barriers compromise quality of care, even once the client does present for care. The case study literature provides a comprehensive source of information on the range of problems that may result from language barriers, as well as the mechanisms through which care is impaired. Numerous examples of delayed diagnosis, inappropriate referral, failure to explain the patient's condition or recommended care, and failure to obtain informed consent or ensure confidentiality have been documented.[26, 61-63] These case studies also provide insights on the impact of language barriers on other family members.[64] However, the limitation of the case study literature is that it does not give an indication of the extent of the problems experienced, or the number of similar incidents which may have occurred. This next section summarizes the evidence related to quality of care resulting from more recent studies.

Patients facing language barriers receive different treatment than other patients.
Many non-English speaking patients feel that they are treated unfairly because of their lack of English language fluency, and that providers treat them differently, often resulting in lower quality care.[16] In the United States, there is increasing attention directed to the role that ethnicity and "race" play in health disparities. Important differences are found not only in health status, but in quality and intensity of healthcare and diagnostic services across a wide range of procedures and disease areas. Furthermore, a few well designed prospective studies have been able to link these disparities in care with poorer clinical outcomes.[16] Many of these studies, however, do not address the question of language, and were only able to determine

differences by "race". Given the different context of race in the U.S., caution should be observed in generalizing these studies to Canada.

Some recent research, however, suggests that in many cases language may be an explanatory factor for differences in treatment. A survey of medical residents by Chalabian & Dunnington in 1997 found that 97% of residents believed that language barriers affected quality of care. Respondents also reported that they shifted their focus of care to bedside encounters not requiring patient participation[65]. In another study, 80% of residents surveyed admitted avoiding communication with families when a language barrier was present, and more than half felt that the family didn't understand the diagnosis.[66]

Language barriers appear to affect provider prescribing behaviour.
Other studies have found differences in other prescribing patterns by ethnicity: some of these suggest that language may be a factor, but there are no consistent patterns of difference. For example lower rates of prescription of hormone replacement therapy [70] and of warfarin for stroke [71] were associated with language barriers, but another study found higher rates of general prescribing.[72] Flores et al., (1998) found that 5% of parents reported that their children had received inappropriate prescriptions as a result of language barriers.[59]

Language barriers affect both physician-directed utilization, and patient-initiated appointments.
Because language barriers present difficulties in history-taking and assessment, it is proposed that they may result in a greater number of physician-initiated return appointments and specialist referrals. On the other hand, one study found that both patients who used an interpreter, and those who did not use one but felt that one was needed, were significantly more likely to be discharged without a follow-up appointment.[73]

If there is misunderstanding leading to misdiagnosis, if the diagnosis and treatment instructions are not understood, or if the patient's questions have not been addressed, even a simple condition may result in many patient-initiated return appointments.

One area of special concern is the impact of language barriers on pain management.
Two U.S. studies found poorer pain control in Hispanic than African-American patients. Cleeland et al. (1997) found that only 35% of minority patients with cancer, compared to 50% of non-minority patients, received guideline-recommended analgesic prescriptions – more Hispanic than African-American patients (69% compared to 54%) were inadequately medicated, suggesting that English-language fluency may have been an important factor.[67] Hispanic ethnicity was also a strong predictor of analgesic administration for long bone fracture in the emergency department, with Hispanics twice as likely to receive no pain medication.[68]

In a study of patients with advanced malignancies, control of symptoms was poorer for non-English speaking patients, and 92% of those who were unaware of their diagnosis were non-English speaking.[69]

Some health areas, such as mental and reproductive health, present additional concerns.

The research indicates that greater barriers are found with health services that rely more on interpersonal aspects of care. Access to mental health and counseling services are of particular concern – there is perhaps no other health area where diagnosis and treatment is as dependent on language and culture. There is strong evidence of delayed care due to language barriers[74-76] and many Deaf persons may not be aware of mental health services.[77] Similar barriers are found for resources for domestic violence and sexual assault,[8-80] and addictions[81-82]. Often counseling-related programs do not even attempt to provide service – and may refer clients to generic helping agencies (such as settlement agencies). These organizations often do not have the expertise required to provide these specialized services, resulting in two-tier service delivery.[26, 74, 82]

Winnipeg: *A refugee woman is released from hospital after having a therapeutic abortion. When she arrives home she finds that the woman who had been asked to "interpret" for her had told everyone in her community why she was in the hospital.*

Language has been identified as the most ubiquitous barrier to mental health and counseling services, and the area where providers have the most concerns about using interpreters.[74] It has been observed that patients give different responses to questions depending on the language of interview. [83-84] Encounters where language barriers have been partially or inadequately addressed are associated with lower reporting of past traumatic events and severe psychological symptoms, and result in fewer referrals to psychological care.[85]

Use of untrained interpreters may lead to clinically significant distortions, as indicated by this classic exchange documented through transcript analysis:

> Patient: *I know…I know that God is with me. I'm not afraid, they cannot get me. (Pause). I'm wearing these new pants and I feel protected. I feel good, I don't get headaches anymore.*
> Interpreter: *He says that he is not afraid, he feels good, he doesn't have headaches anymore.*[83]

Concerns about confidentiality because of use of untrained interpreters may also result in the patient withholding crucial information. Providers may be less likely to initiate or continue treatment as they may feel that therapy is of little use to those with limited official language proficiency.

Additional challenges are presented by language barriers in the area of sexuality and reproductive health (including testing and counseling for STIs/HIV). Fear of loss of confidentiality is a particular concern in sharing concerns that may be embarrassing or stigmatizing.[26, 86] Reproductive health issues, which are of concern to high percentage of the healthy population, account for a large number of health encounters and have important implications for long term and intergenerational health.

Another area of particular challenge is that of rehabilitation services and services for persons with disabilities. Difficulties in appropriate assessment and therapy due to language barriers may result in additional delays in treatment. Language barriers may present almost insurmountable problems for assessment of speech or developmental delay.[27]

HEALTH OUTCOMES

Less research has measured the effects of language barriers on health outcomes. One of the best ways to measure differences in health outcomes is through analysis of large data bases using language proficiency codes – data that is generally not available in Canada. However, as indicated above, several studies have measured intermediate effects, such as delays in seeking care, misdiagnosis, inappropriate treatment, and reduced comprehension and adherence to treatment. In addition, the generic literature on health communication has linked good patient provider communication with improved health outcomes.[93-96]

These research results are consistent with the proposed pathways identified through the case study literature. Language barriers will decrease non-urgent access as the "cost" to the patient (inconvenience, embarrassment, loss of confidentiality) outweighs perceived benefits. This dynamic may result in decreased participation in preventive programs, and delays in seeking care – one route to poorer health outcomes. In addition, poor communication in the medical encounter can result in an incomplete or inaccurate history, misdiagnosis, a treatment plan based on misinformation, and poor understanding on the part of the patient of his condition and the prescribed treatment. This dynamic is more likely to result in both delays to appropriate treatment, and potential complications (e.g., drug complications or poor management of chronic diseases).

A recent U.S. study of outpatient drug complications demonstrated that having a primary language other than English or Spanish was significantly correlated to reported drug complications, although no significant differences were found by race, gender or education. The failure of providers to adequately explain side effects was associated with increased reporting of complications.[97] U.S. studies have confirmed that many minority cancer patients are diagnosed with later stages of disease; delay in seeking care is one reason proposed for the poorer health outcomes of these patients.[16, 99] A 1997 Ontario study using the Cancer Knowledge Survey for Elders found that the proportion of non-English language respondents with incorrect answers was higher in than for English language respondents on all items, suggesting one reason why non-English speakers may delay seeking care for cancer symptoms.[100]

Surveys of patients can provide some useful insights into patient perceptions of health outcomes. Flores et al. (1998) found that 8% of Spanish-speaking parents reported that language barriers had resulted in poor medical care, 6% in misdiagnosis, 5% in inappropriate medications, and 1% in inappropriate hospitalization.[59]

Language barriers can contribute to poorer management of chronic diseases.
Management of lifelong chronic conditions, such as diabetes and asthma, are of interest as in these diseases appropriate self-management has important effects on both outcomes and health service utilization.

Asthma: One of the most striking indications of possible health outcomes of language barriers was described in a study by LeSon and Gershwin (1996) of young adults with asthma.[101] The purpose of the study was to determine risk factors for intubation (intubation was used as a marker for predicting death). This retrospective cohort study of hospitalized young adults included all asthmatics admitted to a university medical centre over a 10 year

period. A large number of potential risk factors were investigated, including socioeconomic variables and a variety of factors related to psychosocial functioning. Patients with language barriers (defined as an inability to speak English) were 17 times more likely to be intubated than patients with the same characteristics who were fluent in English. In contrast, patients with low formal education were only 5.7 times more likely, and active smokers 7.1 times more likely, to be intubated. Manson (1988), in a population of unilingual Spanish speakers with asthma, found that those with a language-discordant physician were less likely to have therapeutic blood levels of bronchodilator medication and were more likely both to miss office appointments and make an emergency room visit.[102] This study suggests a pathway through which language barriers may affect health outcomes: poorer patient understanding may result in less compliance with medication regimes; resulting in poorer symptom control and higher risk of acute episodes – some of which may result in intubation or even death.

Diabetes: A key predictor of complications in diabetes is self-monitoring of blood glucose [103] – ethnic minorities are one group with lower self monitoring behavior. Limited English language fluency has been associated with less knowledge of diabetes management, less likelihood of receiving diabetes education, and less likelihood of performing self-monitoring of blood glucose.[91, 104] Karter et al. (2000) found that lack of English-language proficiency was a significant predictor of less than optimal testing.[91] In contrast, Tocher & Larson (1998) found that more non-English speaking than English-speaking patients were receiving care that met guidelines.[105] In this study, however, professional interpreters were available for all patients, indicating that trained interpretation is an important strategy for improving diabetes management. In the United States, patients with diabetes who are African-American or White report more frequent eye exams, examination for sores, and blood pressure monitoring than do Hispanics or Asian-Americans,[30] again suggesting that language, rather than ethnicity, is a key factor.

There is strong and consistent evidence that patients facing language barriers are less satisfied with their care.

Client satisfaction is the most recognized and widely-used measure of effectiveness of provider-patient communication. It is also an outcome of care, and it has been suggested that it is highly correlated with quality of care. One would expect that individuals who do not share a common language with their providers would be less satisfied with their care. A large number of studies have been conducted in this area: the consistent finding is that those facing a language barrier are significantly less satisfied, and more likely to report problems with their care.[31,87,106-108]

Language barriers may prevent patient understanding, and result in lower adherence to prescribed treatment.

A review of the literature reveals consistent and significant differences in understanding and compliance when a language barrier is present. This is likely one explanation for differences in health outcomes. A study by David and Rhee (1998) found that only 53% of those with a language barrier, compared to 84% of controls, felt that side effects of medications were explained.[87] Another study tested patients' ability to recall their diagnosis, follow-up instructions, and proper use of prescribed medicines. Spanish-speaking patients provided an average of only 46% correct responses, compared to 65% for English-speaking patients [88]. In an Australian study, 35% of patients lacking English language fluency were found to lack knowledge of drug dosage, frequency, or function.[89] In another study, 27% of patients who

felt they needed an interpreter but didn't get one did not understand instruction for taking their medication, compared to 2% of those who got an interpreter or didn't need one.[90] Karter et al. (2000) explored patterns of self-monitoring of blood glucose by diabetic patients in a managed care population. Having difficulties with English was a significant predictor of less than optimal frequency of testing. The authors proposed that those with language barriers had difficulty benefiting from English-language diabetes education.[91]

A review of North American burn units found that 41% of facilities reported language and sociocultural barriers to patient education [92]. Given the complexities of care for burn patients this lack of patient information may well be associated with poorer outcomes.

ETHICAL STANDARDS OF CARE

Obtaining informed consent and maintaining patient confidentiality are critical standards in delivery of ethical care.

When patient and provider do not share the same language, there is an immediate barrier to informing the patient of his condition and the choices available.[110] This barrier is in addition to the challenges to informed consent found in all provider-patient interactions.

Winnipeg:

A woman presented at a hospital outpatient clinic requesting a therapeutic abortion. Staff were concerned when they realized she had a previous abortion at the same facility only a year earlier. The woman did not speak English even though she had lived in Canada for many years. Her husband, who acted as an interpreter, spoke some English, although clinic staff described his language ability as "limited".

A chart review indicated that the patient was given contraceptive counselling at the time of the first abortion, and made a decision to be sterilized. Until this procedure could be scheduled, she decided to use Depo-Provera, an injectable contraceptive method she was familiar with from her country of origin. The woman returned regularly for Depo-Provera injections. During one of her regular visits, abnormal cervical cells were discovered through routine screening and the woman was scheduled for a colposcopy. Following this procedure, the woman did not return for her next scheduled visit for Depo-Provera. She subsequently became pregnant.

Why did she not return? A follow-up interview (using a trained health interpreter) revealed that the woman had understood that the cervical procedure she had undergone was the sterilization she had requested. She assumed that no further contraceptive methods were needed, and did not return for further injections.

There is disturbing evidence from analysis of local case studies that members of all four language constituencies are often not giving informed consent to procedures – and in some cases are not even aware of what procedures they are scheduled for. "Consent" also has different meaning in different cultures,[111] requiring additional caution in communication. Unpublished research within the Health Sciences Centre identified several different incidents where patients were known not to have been informed of their condition; and where informed consent was not obtained.[112] Consent is also an issue for research participation: language minorities are at greater risk of either being excluded from clinical trials or of not understanding the implications

of trials they enroll for.[113] One of the greatest risks of using untrained, ad hoc interpreters is the risk to confidentiality. This is particular concern in sensitive areas such as mental health or reproductive health.[26, 114] Use of untrained interpreters provides no protection to either the family or to the institutions that the expected standards of confidentiality will be met.

Language barriers affect the health and well-being of other family members.
Relatives or friends may be forced to miss work (and often lose pay) to provide interpreter services. They often report stress related to the responsibilities of interpretation when they know their English language ability is limited.[115] Mistranslation (as demonstrated by the case study on the previous page) may result in tension between family members. Winnipeg school administrators report ongoing problems with children missing school to provide interpretation for their parents.

Winnipeg: *A woman went into labour at 30 weeks resulting in the stillbirth of twins. The circumstances of the birth were traumatic, as one of the twins started to emerge while the mother was at home using the toilet. The family had been in Canada less than a year, and the woman spoke no English. An 18 year old relative was used for most interpretation. However, at the time of discharge, the social worker attempted to use the woman's 8 year old son as an interpreter, until it became apparent that not only was he not capable of interpreting, but that he was also in distress, and needed support and comfort.*

Of particular concern is the risk to healthy family functioning created by using children as interpreters. Children may be exposed to inappropriate information, and the normal authority and privacy of parents may be disrupted. They may be resentful of being forced to miss school and other activities. The effects may be more profound if the topic is sensitive or traumatic.[61] For example, it is reported that Winnipeg children are used as interpreters for birth control counseling, surgical sterilization and pregnancy termination appointments.[26] In one case, a child was used as an interpreter in preparing his parent to be transported to Ontario for transplant surgery. Children also report embarrassment at being exposed to the private body functions of their parents. Ill children may be asked to interpret the nature of their illness or condition to their parents. In extreme cases, the stress of interpreting in distressing family circumstances can lead to the need for psychiatric care.[64]

Winnipeg: *A middle-aged woman, in Canada for less than two years and unable to speak English, found a lump in her breast. As no one else was available, she used her 18 year old son to interpret for her, although he speaks only limited English. At the consultation with the surgeon, she was asked to remove her clothes and expose her breast, which caused both her and her son great embarrassment. As a result of his intense embarrassment, the son refused to go with his mother for the next appointment. The visit also increased the mother's anxiety unnecessarily, as – because the son lacked the appropriate medical vocabulary – he translated the word "cyst" as "something*

Language barriers result in lower standards of care for some communities.
Most organizations make a commitment to providing equitable care to all citizens: one of the principles of health care provision – and one in which Canadians take pride – is that all are treated equitably by the health system. There is, however, good Canadian evidence, including evidence from Winnipeg case studies – that those who are not proficient in an official language do not obtain the same quality of care as other residents. In the case example on page 17 – for example, it is unlikely that an English-speaking client who was recognized by providers to be "compliant" would be prescribed Depo-Provera, as there are other methods with lower risk of complications and side effects. Such methods are,

however, more likely to be prescribed in the presence of a language barrier, as they require less explanation. The evidence that language barriers may result in poorer health outcomes is another indication that equitable care is often not received.

Winnipeg: *A child in the emergency room was asked to provide explanations on his condition to his parents, even though he was experiencing violent vomiting at the time.*

SERVICE UTILIZATION AND COST

An important question for health services is what effect language barriers have on service utilization and cost. Unfortunately, most health data collection systems across Canada collect little in the way of "ethnic" identifiers, with the exception of data related to registered First Nations persons. As a result, there is little data on Canadian utilization by measures of ethnicity, forcing us to analyze the international research for applicability in the Canadian context.

The logic model predicting impacts on service utilization is well developed.
This model proposes that language barriers will result in an underutilization of preventive and non-acute services due to the difficulties in making initial contact (the cost/benefit to the patient results in non-action). It is theorized that such avoidance or delayed care will result in greater use of acute or emergency services, as well as delayed diagnosis for some conditions. Once presenting for care, there are two scenarios which impact utilization. One is that the provider fails to compensate for the language barrier, with the result that the initial service utilization is equivalent to that for other patients. This scenario, however, increases the likelihood of misdiagnosis and poor patient adherence, with the result of increased future utilization. This includes return physician visits for unresolved problems; more intensive treatment for more advanced disease; and treatment of complications from prescribing errors or the patient's failure to understand treatment instructions. Consequently, although immediate utilization is similar, long term utilization is predicted to be higher.

Winnipeg: *An untrained interpreter accompanying a woman to a community clinic for treatment of a sinus infection, mistakenly used the word "constipation" rather than "congestion". The error was not discovered until after the woman had her prescription filled and she questioned why she would need to administer the medication by rectal suppository. Another appointment was necessary.*

In the second scenario the provider, in recognition of the language barrier, takes additional precautions to compensate for poor communication (e.g., ordering tests rather than relying on patient history, making a specialist referral, admitting to hospital, or prolonging hospital stay).

Language barriers may result in increased use of diagnostic testing.
It is suggested that a language barrier may increase the use of diagnostic testing and other interventions. This "up triaging" is proposed to result from physicians being more cautious when faced with language barriers. Hampers et al. (1999) in a study of 2,467 patients in a paediatric Emergency Department determined that in cases where a language barrier existed (8.5% of cases) patients were more likely to be given intravenous fluids and admitted to hospital. The overall mean charge for tests was also significantly higher ($145 vs. $104).

Employing an analysis of variance model, the presence of a language barrier accounted for a $38 increase in charges for testing. This study included in the language barriers group both those who used an interpreter and those who didn't. This led the authors to suggest that, as a result, the study likely understated the results of language barriers as in many cases the interpreters would have facilitated understanding.[116]

In a later study, Hampers and McNaulty (2002), using a prospective cohort design, compared incidence and costs of diagnostic testing, admission rates, use of IV fluids, and length of Emergency Department visits of four groups of children – those who were English-speaking, those who had a language barrier but were treated by a bilingual physician, those who used a professional interpreter and those who had a language barrier but for whom a professional interpreter was not available.[117] They found that management of non-English speaking cases by bilingual physicians was similar to that of the English-speaking cohort. However, when a language barrier was present and a professional interpreter was not, physicians performed more frequent and expensive testing, treated children more conservatively (i.e., more intravenous hydration and more frequent hospital admissions). When a professional interpreter was used, no difference in incidence or cost of testing was detected, although admission rates remained slightly higher. Length of visit was the same for both the language barrier and the interpreter groups.

In another U.S. study, non-English speaking patients with abdominal pain had significantly more tests ordered (specifically CBC counts, serum electrolyte determinations, urinalysis, ECGs and abdominal CT scans). No significant differences were found, however, in tests ordered for patients presenting with chest pain.[118.]

Similar results were found in a Quebec study, although the research compared "ethnic groups" with native-born Canadians (rather than attempting to measure language ability). This study used Quebec administrative data, along with data from the 1987 Quebec health survey. Ethnic groups were found to make a significantly higher number of visits to specialists, and used more diagnostic radiology.[119] The authors suggested that one explanation might be that those defined as "ethnic groups" in the study were more likely to face language barriers, with the result that providers exercised greater caution.

Language barriers are associated with increased rates of hospital admission and increased length of stay.

A number of studies have found that language barriers increase the risk of hospital admission. A U.S. study by Lee et al. (1998) found that patients with a language barrier had a 70% greater chance of being admitted to hospital than those who dealt with a provider who spoke the same language; however when an interpreter was used the risk of admission decreased.[120] This study, however, did not control for potentially confounding variables such as socioeconomic status. Hampers et al. (1999) also found that children were more likely to be admitted to hospital if a language barrier was present, even after controlling for other explanatory factors. [116]

A recent Canadian study undertook a retrospective study of inpatient admissions in Toronto, to investigate differences in length of stay and mortality, based on limited English-language proficiency. It was found that patients who lacked English-language proficiency had a longer hospital stay for 7 of 23 conditions, with differences in length of stay ranging from

0.7-4.3 days. However, they did not find a significant increased rate of in-hospital death. The average length of stay for *all* limited-English patients was an additional .5 days per patient – a figure which suggests the potential of significant additional costs.[121]

Barriers to mental health services predict overall increased utilization.
Barriers to appropriate mental health services have particular implications for physician and hospital utilization, as unresolved mental health issues are often expressed in physical complaints. Recent research has determined that, in Manitoba, those with a diagnosed mental health condition are estimated to use twice the number of physician visits (for all causes), twice the number of short stay hospital days, and four times the number of long stay hospital days than those without such conditions.[122] Failure to address mental health concerns, therefore, has important implications for overall health status and future health service utilization.

RESEARCH ON USE OF UNTRAINED INTERPRETERS

The error rate of untrained 'interpreters' (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all. This is because it lends a false sense of security to both provider and client that accurate communication is actually taking place. (U.S. Office of Minority Health, 1999).

An ad hoc interpreter may be more dangerous than no interpreter at all.
While providers are often most concerned about encounters where the patient speaks no English, and situations where no interpreters is available, the research suggests that there is greater risk in situations where the patient speaks limited English, or where interpretation is provided by ad hoc "interpreters". This is because in these situations, there is an illusion of communication, whereas when there is no ability to communicate, the provider recognizes that there is a problem and takes additional precautions.

The kinds of errors made by untrained interpreters have been extensively documented. One of the most effective ways to demonstrate the potential impact of such errors is by transcript analysis of actual interpretation sessions. The results indicate the actual pathways through which errors occur and the ways these errors can impact health outcomes. A number of studies have undertaken such an analysis.[123-127] Several different types of errors have been identified:

- Omitting information provided by the client or health provider
- Adding information to what the client or provider has said
- Substituting words, concepts or ideas
- Using inaccurate words for anatomy, symptoms or treatment
- Failing to interpret a message
- False fluency
- Editorializing
- Role exchange (e.g. taking over the interviewing role).

Often dozens of errors are made in the space of one short encounter. Many of these errors have potential clinical consequences. In a study of interpreting in a paediatric setting, Flores et al. (2003), found that an average of 29 interpretation errors were found per encounter, and that 63% of these errors had potential clinical consequences.[123] For example, in one instance the interpreter mistranslated instructions for administration of oral antibiotics, instructing the mother to place it in the child's ears. Similarly, Laws et al (2004) found that in over 66% of communication segments, information was interpreted either with substantial errors or not at all.[126]

It is also important to note that such errors are not necessarily avoided by using bilingual staff, (even if trained as health professionals) as interpreters if they have not also had training in interpreting skills and ethics.[125] This is because more is required to provide accurate interpretation than just knowledge of medical terminology in both languages, and a professional may be more likely to edit the patient's message to steer the provider towards a diagnosis or treatment that is line with the professional's thinking. The quality of non-professional staff (e.g. maintenance or cleaning) is on average of no higher quality than that of other community volunteers.

Winnipeg: *An Inuit patient, in hospital for a number of tests, was told his results (a terminal diagnosis) using a family friend, and while other community members were in the room. One of those present (known as a gossip within the community) immediately phoned this information back to the patient's home community. This was in spite of the fact that the family friend present had specifically requested that she not be the one to interpret any bad news and Inuit Services had scheduled an appointment with a trained interpreter later that day in order to ensure that the information was shared appropriately.*

Another serious concern about using ad hoc interpreters is that this "solution" provides no way of ensuring that a patient's confidentially is protected.

Some interpretation errors are not mistakes, but deliberate distortions or omissions. Family members may refuse to interpret embarrassing information. Ad hoc community volunteers may choose not to interpret information that they feel may reflect badly on their community. An ad hoc interpreter may also deliberately change the information given by the provider to fit with his or her personal views. For example, a Winnipeg provider reported one case where an interpreter for a pregnancy counseling appointment attempted to persuade the client to make a choice consistent with the interpreter's personal views.

Winnipeg: *I could speak some Spanish, but not enough to explain all the alternatives. At one point I stated that a certain method was 98% effective. I was surprised to hear the interpreter state "70%". I interrupted, saying that I was going to repeat the information, and that it was important to translate my message exactly as I said it. After the appointment I asked the interpreter to stay behind, and asked him what had happened. He stated that he had not translated what I had said, because he "didn't believe it was true".*

Use of ad hoc interpreters may decrease patient safety and prevent access to needed care.

In some cases the direct or indirect perpetrators of resulting health problems may be called on to interpret – not only resulting in the patient withholding information, but potentially risking the patients psychological or physical safety. Spouses responsible for injuries and symptoms related to domestic violence may omit important information, effectively preventing access to the services and treatment needed.[128] Patients from refugee- producing countries may have individuals belonging to groups responsible for deaths or torture of family members assigned to interpret for them.[26] One has only to consider the current violence in countries of Africa (e.g., Burundi, Rwanda, Sudan), the Middle East (e.g., Iraq, Afghanistan), or areas of eastern Europe (e.g., the former Yugoslavia) to appreciate that a shared language may mask ethnic hatred. Ad hoc interpretation risks such inappropriate placements, with the result that patients may avoid care, or withhold and/or distort relevant information in the medical encounter.

Winnipeg: *A family service organization, which had made a special effort to train homecare workers who spoke the language of a number of high-needs refugees, was surprised to find that many of these clients were refusing service. They discovered that the staff they had recruited were from a different region, and were perceived as on the opposite side politically to the families needing care. Given the history of killings, rapes, and torture many of the families had experienced they felt unsafe having these workers in their homes.*

THE BROADER LITERATURE ON MEDICAL COMMUNICATION

The generic literature on medical communication is consistent with the findings related to language barriers.

A broader perspective on the potential impact of language barriers is obtained by reviewing the research related to provider-patient communication. Communication is an essential diagnostic tool;[11] health care's most essential technology.[27] Reviews of the medical communication literature indicate there is a relationship between the quality of patient-provider communication and patient health outcomes.[93-96] In addition to the more obvious effects on adherence and satisfaction, quality of communication has been found to have a generally positive effect on outcomes such as pain, recovery from symptoms, anxiety, functional status, and physiologic measures of blood pressure and and blood glucose. Kaplan et al. (1989) describe three basic communication processes associated with improved health outcomes: a) amount of information exchanged; b) patient's control of the dialogue; and c) rapport established.[93] All of these processes are jeopardized in language-discordant encounters.

While the research suggests the ways in which language barriers may affect health outcomes, satisfaction and adherence, patients who lack English language fluency are generally excluded from research on patient-provider communication.[129]

Language barriers result in lower health literacy.

Health literacy (or literacy in health) is an issue receiving increasing attention in recent years. Health literacy is correlated with lower health status and poorer health outcomes, [130-131] increased rates of hospitalization,[133-134] poorer understanding of health conditions and diseases,[135] less ability to understand discharge instructions, and higher frequency of mediation errors,[134] and less use of preventive services.[136]

There are, within the "low health literacy" group, two distinct groups of individuals: a) those who are fluent in the dominant language, but have low education (or learning disabilities); and b) those who do not speak the dominant language – and may in many cases have good education and be literate in one or more minority languages. It is estimated that 29% of those who are foreign-born and claim some university education test as functionally illiterate in an official language, compared to 6% of the Canadian-born population with the same level of education.[137] These figures suggest that the official language literacy deficits of many immigrants may continue long after they obtain spoken fluency. Deaf persons are also likely to have significantly lower literacy rates in official languages.[138] While different solutions are indicated for addressing these different root causes of low health literacy, it appears that many of the impacts may be the same.

OTHER IMPACTS

Language minorities are systematically excluded from research.
Those not proficient in an official language are often systematically excluded from both clinical and health services research.[129, 139-140] Sometimes ethnic minorities are deliberately excluded; in other cases protocols fail to include them.[129,141-142] This exclusion limits the generalizabiltiy of research – and may affect both efficacy and effectiveness of treatment.[143] In addition, members of minority communities may be excluded from cutting edge treatment for diseases such as cancer.[142,144]

Research using data from the 1990 Ontario Health Survey found that 2.5% of households were excluded from the study as no one in the household spoke English or French. As a result, differences in health utilization, health status and health outcomes of these studies may be underestimated.[39] Recent local assessment within the WRHA determined that there was no provision for language minorities in program evaluation activities, with the result that the perspectives of these groups were not available to planners.[112]

Language barriers decrease provider learning and satisfaction and increase risks of liability.
Communication barriers result in both increased stress and lower job satisfaction on the part of providers. Working with an interpreter – particularly an untrained interpreter – can be frustrating. It also takes more time – time for which fee-for-service providers are not reimbursed. Providers may have less confidence that the work they are doing is useful, and express discomfort in seeing patients when a language barrier is present. They may also experience stress in attempting to meet ethical standards (in the areas of medical decision making, equity among patients, confidentiality, patient vulnerability and cultural representation) when a language barrier is present.[145]

Language barriers also present challenges to learning for medical students and residents. The focus of care may shift to encounters not requiring patient participation, and many skills that are taught by role-modeling cannot be demonstrated.[65]

Linguistic barriers to accurate diagnosis and informed consent may also place a provider at greater risk of liability as indicated in the examples on page 29. The generic research on patient satisfaction/dissatisfaction indicates that complaints about doctors are usually due to

communication problems and not technical competency issues. The Canadian Medical Protective Association has identified communication as the major source of lawsuits against its members.[146] Other issues related to malpractice claims are delays and diagnostic errors, which are also more likely when a language barrier is present.

SECTION 3: IMPLICATIONS – THE "BUSINESS CASE" FOR ADDRESSING LANGUAGE BARRIERS

ECONOMIC EVALUATION OF LANGUAGE ACCESS SERVICES

Language barriers have perverse effects on health service utilization.
As the previous section suggests, there is strong evidence that language barriers can have important effects on health care costs. First, they negatively impact use of the preventive and low intensity services – exactly the type of service use promoted by health authorities. This "underutilization" of health education and preventive services (primary prevention), combined with avoidance and delayed presentation for primary care is predicted to reduce the likelihood that disease will be identified in the early stages (secondary prevention), resulting in higher use of acute and higher intensity services in the future.

Second, language barriers within the health care encounter may negatively impact costs in two separate ways: a) "uptriaging" – more cautious practice in recognition of the risks of language barriers; or b) failing to address the miscommunication in the encounter, resulting in an increased risk of misdiagnosis. Communication barriers will also decrease the likelihood that patients will understand their condition and treatment, and follow medical advice. All of these factors affect the efficiency of the system by contributing to waiting lists through increased testing, possible service duplication, additional physician visits, less efficient use of staff time, and higher rates of hospitalization. There is also strong evidence that language barriers decrease patient satisfaction and confidence in providers – this too has been demonstrated to have impacts on adherence and future patterns of utilization.

The costs associated with these patterns of utilization, however, – unlike the "upfront" and visible costs of providing language access services – are often hidden from decision-makers. There is a paucity of data documenting the full costs and benefits of providing language access services.[44, 147]

Economic evaluation must include the costs and consequences of both providing language access services, AND of failing to do so.
Many health services do not attempt to provide language access because they believe it is too expensive to do so. Much of the decision making around "costs" of language access programs, however, is not true economic evaluation, as many assessments address only the "costs" of the intervention (e.g. the costs of providing health interpreters), rather than comparing those expenditures with the "costs" of **not** providing such services. Simply adding up the costs of providing language access services (and assuming that relying on ad hoc interpretation costs nothing) is greatly misleading.

Economic evaluation is a comparative analysis of alternate courses of action in terms of both their *costs* (inputs) and *consequences* (outputs). An evaluation may be conducted from the perspective of an individual stakeholder (e.g. a hospital), the health system in general, or society at large.[148] The perspective of most direct relevance to health authority planning is the level of the entire health system. The purpose of economic evaluation is to determine whether a program or service is worth doing compared with other things that could be done with the same resources.

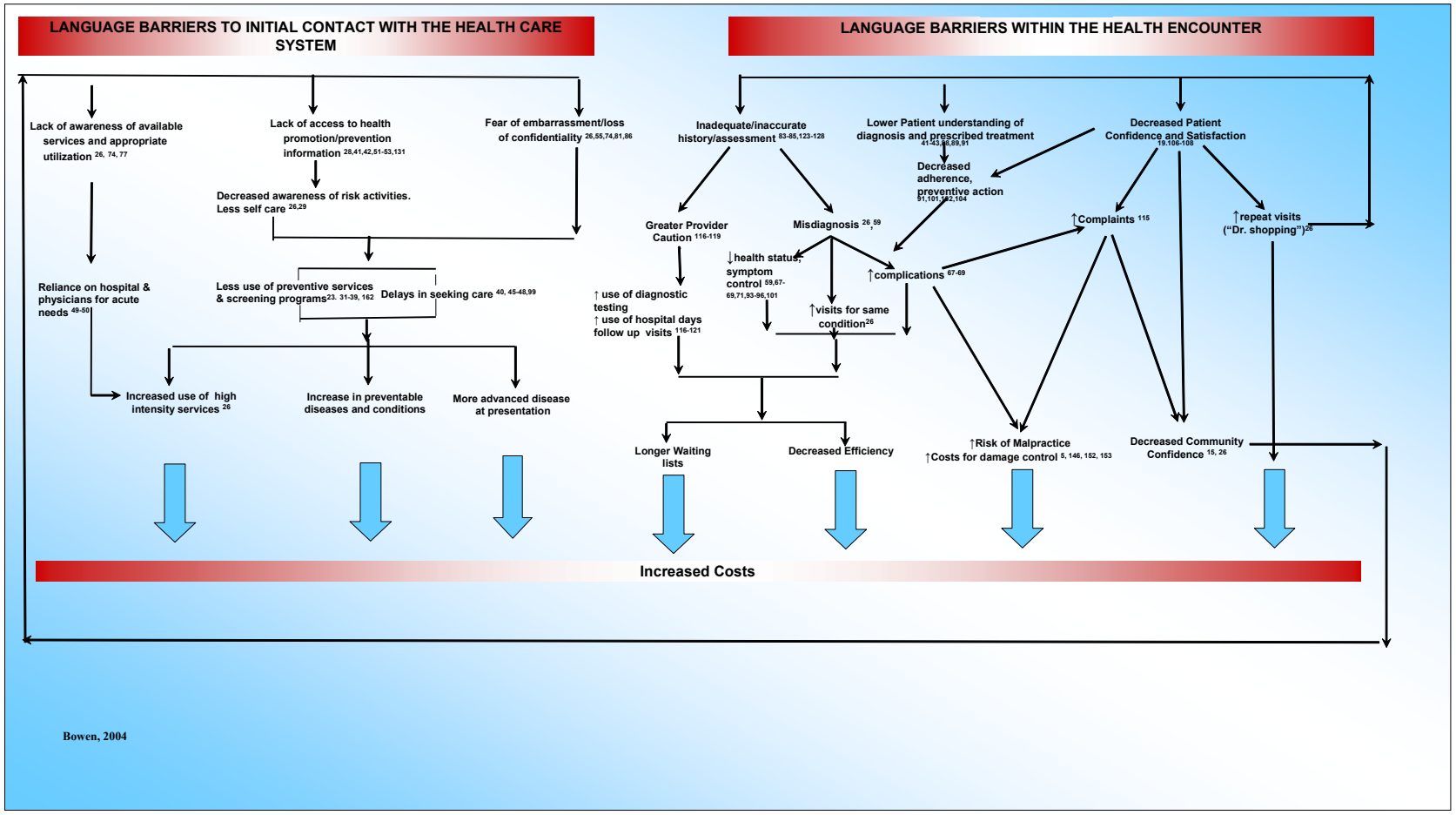
There are a number of challenges to undertaking a comprehensive economic evaluation of language access services. Information on language proficiency is not systematically recorded in patient database information. In addition, in order to measure the real cost of language barriers, it is necessary to identify *all* of the possible consequences of failing to address them, the frequency of such occurrences and the cost of each. Because of the number and variety of potential effects, it is not feasible for one study to capture them all.

Further exploration of the case study on page 17 demonstrates some of the challenges in determining the costs of language barriers. In this case, we may be able to calculate the costs of the additional pregnancy termination, any resulting complications, follow up visits, etc. from the perspective of the hospital. We may even be able to calculate the costs of staff time needed to investigate and address this issue. What we cannot readily determine, however, is whether this incident affects future patterns of utilization, whether there were other health problems (e.g. emotional distress) that were addressed by other parts of the health care system, or any costs associated with failure to communicate prevention information (we can probably assume that if the woman did not understand the purpose of the colposcopy, she may also not be able to benefit from other gynecological prevention information – such as appropriate follow-up after the procedure or breast health information). Any non-immediate effects on her health will also not be captured. Nor will any costs to the patient and her family – such as costs due to time lost from work, or physical pain and emotional distress.

Some partial economic evaluations have been undertaken. For example, Rader (1988) determined that in one hospital, 50% of the interpretation was being provided by doctors and nurses. She then calculated the total number of hours of staff interpretation provided per month and multiplied this figure by the average nurse's salary. Even though this study did not attempt to measure consequences, it did demonstrate the cost-effectiveness of hiring additional interpreters.[149] The studies by Hampers and colleagues, quoted earlier, measured only immediate consequences of language barriers from the perspective of one institution. Significantly higher charges were incurred for patients who encountered language barriers, but the costs of providing interpreters were not part of the analysis.[116-117]

Jacobs et al. (2004) compared the costs of utilization of primary care and emergency department services in a Health Maintenance Organization before and after introduction of professional interpreter services.[44] A specific objective was to increase participation in preventive and primary care services. There was a net increase in service utilization of $45 per patient for those using professional interpreters (+$56 in costs of preventive/primary care, and - $11 in emergency department costs). Limitations of the study include small sample size and the small number of costs and benefits captured. Costs were compared for only one year following introduction of interpreter services, potentially reflecting a "catch-up effect" that would be higher than in subsequent years. Furthermore, the costs of interpretation ($234 per language barrier patient per year) were considered "excessive" by study authors. As a result of overestimating the number of interpreting services needed, too many full-time staff interpreters were hired. In spite of the inflated costs, the authors concluded that the additional $279 per year for patients using interpreters was financially viable.

THE "BUSINESS CASE" FOR ADDRESSING LANGUAGE BARRIERS IN HEALTH CARE
A CONCEPTUAL MODEL



The conceptual model on the preceding page summarizes the evidence, identified in the literature, related to the potential impacts of language barriers on health care costs. This model outlines the pathways through which language barriers are proposed to affect costs, and references the research literature on which the model is based. It illustrates both the number and complexity of effects language barriers may have, and the challenges involved in developing a firm estimate of the total costs of failing to address these barriers.

RISK MANAGEMENT AND QUALITY IMPROVEMENT

As useful as "cost effectiveness" analysis is, however, it is only one criterion for decision making. It does not exempt an organization from making ethical decisions, meeting legal obligations, or providing quality care. For example, we would consider it inappropriate to ask "*Can we afford to have patients give informed consent?*".

Language barriers are an important source of medical errors.
As indicated by the model on the preceding page, there is evidence that language barriers are linked to medical errors, and in fact may be an important unrecognized source of medical errors.[123] This should not be surprising – it has been observed that without language, the work of a physician and a veterinarian are almost identical.[150] A key issue in risk management, however, is not whether errors occur, but whether the organization has done all that can be reasonably expected to prevent predictable errors from occurring. It is expected that health organizations base decision making on available evidence: the risks of relying on ad hoc interpretation are now sufficiently clear that it would be considered unethical to conduct language access research where one group was assigned to family or ad hoc interpreting.[151]

Linguistic barriers to accurate diagnosis and informed consent place health service providers at greater risk of liability.[5]
While less common than in the United States, Canadian malpractice cases have linked negative outcomes to providers' failure to remove language barriers. In Chattu vs. Pankratz, the B.C. Supreme Court found a doctor negligent in his examination and diagnosis of a man whose leg was amputated as a consequence of the resulting misdiagnosis. The ruling stated that the patient's language difficulty should have made the doctor especially careful in conducting his physical examination (an ad hoc interpreter had been used). The patient was awarded $1.3 million.[152] In another case, language barriers were identified as a contributing factor in the death of a pregnant Vietnamese woman.[153] The issue of the interpreter's role in obtaining consent was also raised in the recent inquiry into pediatric cardiac deaths in Manitoba.[154.]

Language barriers result in some populations receiving lower quality of care.
As indicated in the conceptual model on page 28, quality of care is jeopardized by language barriers through a number of mechanisms: failure to adequately assess a patient, increased risk of misdiagnosis, less likelihood that the prescribed treatment will be accepted and followed by the patient, and an increased risk of complications. There is good evidence that patients who do not have official language proficiency often do not receive the same quality of care as other patients.

Patients of the WRHA who lack English language proficiency are being denied their rights to informed consent and confidentiality of patient information.
There is compelling evidence that without trained interpreters, minority language patients do not have the opportunity to provide informed consent, and that the current practice of using ad hoc, untrained interpretation fails to protect patient confidentiality. These are two standards that health organizations have an obligation to uphold. Preliminary evidence from Winnipeg, however, indicates that these risks are also experienced by patients receiving services within the WRHA.

Language barriers present obstacles to achieving population health objectives and reducing health disparities.
Those who face language barriers are among the most vulnerable in the population. If language barriers are not addressed, they risk contributing to – and reinforcing – current and future health disparities. Language barriers were described in the Institute of Medicine report *Unequal Access* as "fertile soil for racial and ethnic disparities in health care".[16]

While linguistic barriers are more often identified as a concern by providers in emergency settings (reflecting both the need for speedy decision making and the greater likelihood that patients do not have time to arrange for their own "interpretation"), language barriers in the areas of health promotion/prevention, mental health, chronic disease management, and reproductive health have the greatest long term impact on the health of the population.

The evidence that some of the greatest impacts resulting from language barriers are in the areas of health promotion and prevention is troubling. Not only do such barriers present obstacles to the health goals of preventing avoidable disease and injury and increasing the health status of the population, they also limit the ability of a significant portion of the population to take responsibility for their own health.

Failing to address language barriers negatively affects relations with minority language communities.
Language barriers are perceived as the greatest barrier to equitable access and quality of care by many minority language communities. Survey research indicates that patients link language barriers to lower quality of care, and those experiencing language barriers express less trust in the health system. Those who get interpreters when needed are significantly more likely to judge a facility positively, than those who do not receive interpreting assistance.[90]

Standards for organizational cultural competence stress the importance of partnership with the community – this partnership is considered essential for needs assessment, and planning and evaluating the effectiveness of health promotion initiatives and health services.[15, 155] The WRHA statement of mission, vision and values specifically identifies the importance of building partnerships with the community, and including and respecting those from diverse populations. Failing to address language barriers not only presents barriers to partnership and collaboration with some vulnerable communities, it may also indicate disinterest in an issue that is a priority for many communities.

Winnipeg: "*I went with her to interpret for a number of appointments. I didn't want to do it because I didn't feel I could do a good job. But there was no one else to ask. She had a complicated pregnancy as she had diabetes, but I didn't understand a lot of what the doctor was saying – I'm an engineer not a medical person, and at that time, my English was pretty poor. .And I felt stressed – I was afraid I would make a mistake, and I don't know anything about women's business".*

BARRIERS TO ADDRESSING LANGUAGE BARRIERS

Low awareness of the impacts of language barriers presents a challenge to development of language access services.
Many decision-makers remain unaware of the impacts of language barriers on patient satisfaction, health outcomes, resource utilization and risk management.

There has been poor dissemination of the research on language access. While spokespersons for language minorities have long stressed the importance of language barriers in preventing access and contributing to health problems, until the last decade much research has utilized descriptive methods such as case studies – methods that while effective in illuminating a problem, are often not helpful in assisting decision-makers quantify the extent of the problem. It has only been in the last decade that other methods have been used to research the impacts of language barriers. This research, however, has not been effectively transmitted to decision makers, and is not utilized in planning.

There has been limited Canadian research conducted in this area. This appears to be due to a number of factors. Canadian health data does not generally incorporate "ethnic identifiers" (including preferred language), with the result that some methods (e.g. use of administrative data to investigate differences in utilization or health outcomes) cannot readily be used. The importance of this coding cannot be overstated: because coding related to First Nations status is available in administrative data, it is possible to document not only the differences in health status between Registered First Nations and the general Manitoba population, but also to provide an indication of the differences in utilization and health outcomes.[156]

Winnipeg: *French Language Services received a call from Paging that a patient in ENT was requesting a French Interpreter. The interpreter got in touch with ENT and was informed that a physician was currently seeing a French-speaking patient who was having difficulty understanding. The interpreter immediately went to the unit, where she found that the physician was chatting in the hallway with a colleague. He informed the interpreter that the client had left, and that he had managed to communicate with him using "single words". The physician, who sees the patient every 3 months, commented that the patient's English was "getting better".*

Providers are often unaware of the risks of using untrained interpreters, and the miscommunication that occurs in their interactions with patients.
Most providers will realize that there is a problem and call for an interpreter if there is no ability to communicate with a patient. They often think, however, that if someone is found to interpret, they have found an "interpreter" – even if this is a family member or hospital visitor. Because – when an interpreter is used – the provider can't speak the "other" language, he or she is unaware what is actually being communicated, and will not realize the inaccuracies or distortions that often result. In addition, if patients have basic English language skills, providers commonly overestimate their language proficiency. It is these situations that create the greatest risk, as the provider is under the impression that communication is taking place.

Many professionals are very aware of the risks of poor communication, and may make extraordinary efforts to find appropriate interpretation. However, responses such as the ones

illustrated in the accompanying case studies, are all too common. Even aware individuals are hindered in their attempts to provide good service by the absence of an organizational level response.[157]

There may be negative attitudes to those with limited English proficiency.
There is commonly an attitude that language barriers are a time limited problem – that they will "go away" over time. This attitude, combined with the attitude that language barriers are a responsibility of the patient, have often resulted in little attention being paid to the negative impacts of impaired communication. These attitudes are most pronounced towards speakers of immigrant languages as, in Canada, language barriers are often perceived to be "newcomer" issues, and it is assumed that it is the responsibility of the patient to learn English. It is estimated, however, that an average of seven years of on-going language training is needed to become proficient in a second language. This is training many do not receive, as ESL (English as a second language training) courses are limited, and new arrivals are required to work to support themselves and their families. Lack of formal education, age, and experience of trauma can present additional difficulties in language learning, with the result that the greatest barriers are often experienced by the most vulnerable.[55] Even when proficiency is attained, stress or age can result in a compromised ability to speak and understand a second language in some situations. This approach also does not recognize that the economy needs immigrants, and the Manitoba government is making efforts to increase international immigration. In addition, it has been documented that immigrants contribute more to the economy than they use in health and social services.

Winnipeg: *A community health interpreter was called to interpret for a Spanish-speaking family at Children's Hospital. When the interpreter arrived, the child had gone into surgery, and the mother had signed the consent form. The staff informed the interpreter that she was not needed, that they had found someone else. The interpreter followed up with the mother to ask if she understood everything and had her questions answered. The mother replied that she didn't understand anything – that the interpreter they provided spoke only Portuguese. When questioned by the interpreter, the response of staff was that "Portuguese is close enough" to Spanish. Similar situations are reported for other languages – e.g. failing to understand that Cree and Ojibway are different languages.*

Similar attitudes are often voiced towards other constituencies: it is believed that Aboriginal languages are "dying out", or that cochlear implants will solve the "problem" of deafness. There is even resistance among some citizens to providing French language services.

Historical, cultural and legislative factors also present challenges.
In Canada, unlike many other countries, responses to the language access needs of the four constituencies are often addressed in isolation from each other. Different legislation addresses the rights of each constituency, different government departments often have lead responsibility, and the language communities themselves often have little contact. In the past, this has presented barriers to a coordinated response. Canada also does not recognize language access as a "minority rights" issue, as it does the United States, and no challenges (under the national and ethnic origins provisions) have yet been launched under the Canadian Charter of Rights and Freedoms.

Because interpretation services have not been defined as "medically necessary" under the Canada Health Act, they suffer from the same funding challenges as many other programs and services.

Decision makers may fear the costs of providing language access services.
Many decision makers are reluctant to address the issue of language barriers because they are afraid to take on the costs of providing interpreter programs. The immediate and long term costs of failing to address language barriers (page 28), are often hidden from view, compared to the more "visible" costs of responding to the needs for language access services. The reality is, however, that language barriers "cost" the organization in one way or another.

Fears about costs are often based on a number of false assumptions – for example that solutions always require a salaried interpreter for each of the language groups identified, or that providing service will generate huge – and perhaps inappropriate – demands. In reality, however, most of those facing a language barrier would prefer to handle a health care encounter without another person present if this were possible. Many patients will continue to choose to "cope" with limited English or use family members for routine communication.

The key issue in improving access and service quality for those who do not speak the majority language is provision of *trained* interpreters where they are needed. It is possible to have paid interpreters that are not trained in health interpretation, and trained interpreters that are not "on salary". Creative and cost effective alternatives can be found that maximize use of community services and volunteers for low risk communication.

Language access services are often viewed as an additional program and cost, rather than as a strategy for achieving quality and managing risk. Many health organizations view interpreting services as an additional, stand alone program that is competing with other organizational priorities, rather than as a strategy which enables the organization to meet its goals and objectives. Language is essential to diagnosis, therefore it is important to view interpreter services as a diagnostic tool, and evaluate cost effectiveness in the same way as one would evaluate any other diagnostic aid.

While there is strong evidence that meeting the needs for language access is critical to quality and risk management, these issues are not as visible – and often appear to be less urgent – than other pressing demands on the health system (e.g. waiting lists). However, as indicated in the review of evidence, language barriers often indirectly contribute to some of these pressures on the system.

Marginalization of minority language communities from decision-making contributes to failure to prioritize language access services.
While – as indicated through analysis of the research literature – the costs and risks of failing to address language barriers are *important*, they are not readily apparent to decision makers. As the clients who are most affected by these barriers are also often excluded from planning and evaluation activities, their experiences are often not included in organizational decision-making. Because other issues present as *urgent,* addressing language barriers is often not perceived as a priority.

SUMMARY

Although the economic costs of language barriers to health organizations are not readily visible, the pathways leading to decreased system efficiency and increased costs have been clearly identified. Of even greater importance, however, are the risk management and quality of care issues that have been demonstrated to result from failure to adequately address language barriers.

SECTION 4: THE RESPONSE – ADDRESSING LANGUAGE BARRIERS

BEST PRACTICES IN MEETING LANGUAGE ACCESS NEEDS

There is strong international consensus on best practice standards for service provision in the area of language access.
Many jurisdictions have comprehensive standards related to interpreter services.[15, 157-160] A simple summary of minimum standards is listed on the following page.

There is strong consensus on practices that are unacceptable or ill-advised. Several common responses to meeting language access needs are considered unacceptable. While the most common response is to rely on ad hoc interpretation, this is unacceptable because of the risks to both patients and providers. There are often greater risks in using untrained interpreters than no interpreter at all. The least acceptable practice is to use methods such as overhead paging, as neither the providing institution nor the patient has any knowledge of the individual – in addition to the risks of inaccurate interpretation, there is no protection of patient confidentiality. However, using untrained staff members – while perhaps providing better controls over issues of confidentiality – poses many of the same risks as any other untrained person. This solution may also place additional stress on both staff acting as interpreters (and their colleagues) often leading to resentment.[10, 160]

Canadian initiatives to address language barriers are now underway.
The Primary Health Care Transition Initiative has recently funded a large national project designed to examine language access services at three sites (Vancouver, Montreal, Toronto) and to develop national standards for service provision. It is exploring and developing recommendations for models most appropriate to the Canadian context. The results of this project will be available in November 2004. A related initiative, under the direction of AMSSA (Affiliation of Multicultural Societies and Service Agencies, British Columbia), is looking at equal access in remote areas.

Most jurisdictions that have developed effective language interpreter services are moving towards regional responses to needs for health interpreting services (e.g. the Vancouver Coastal and Fraser Health Authorities, the Calgary Regional Health Authority, and the Régie régionale de la santé et des services sociaux in Montreal). In British Columbia, a Director of Language Services, based with the Provincial Regional Health Authority, now has the responsibility to link and further develop services across the province. It is recognized that larger systems can provide services with greater efficiency, and promote greater consistency across services.

In some provinces there has also been a transition from separate language services for each constituency, to a coordinated response for all communities facing language barriers (Aboriginal, immigrant, minority official language, and ASL). In British Columbia, for example, the provincial language service has a mandate for all interpreter services – while it does not provide direct service for all these languages, it is responsible for identifying gaps and ensuring linkage, referral, and coordination.

Best Practice Summary

1. There is a clear policy, and associated standards on language access for the organization
    a. Interpreter services are provided free of charge to the patient
    b. Interpreter services are provided at all key points of contact
    c. Interpreter services are available at all hours of operation
    d. Training is required for interpreters used
2. Providers are required to obtain interpreter in cases where there is evidence of language barriers
    a. Clear instructions for determining need are provided, along with procedures for contacting approved interpretation services
3. Providers are provided with training in working with interpreters
4. There are written guidelines for communicating via an interpreter
5. Only trained interpreters are used
    a. Family members or friends are used only at request of patient
    b. Use of overhead paging is forbidden or strongly discouraged
    c. Bilingual staff members (other than interpreters employed by the institution) are used for interpretation only
        i. If they have received training in interpretation
        ii. In clearly identified situations, or emergencies
6. Training for interpreters includes
    a. Orientation to facilities and programs
    b. Ethics (confidentiality and privacy of health information, informed consent, appropriate role of the interpreter)
    c. Medical terminology and concepts
    d. Interpreting skills
7. Training for interpreters is a minimum of 40 hours
8. Patients are provided with information on their rights to interpretation assistance
    a. There is signage in languages of the community
    b. Information on rights and services is available in languages of the community
9. Language access services report directly to senior management
10. There are coordinated records kept on
    a. Language of patients
    b. # of interactions where an interpreter is needed
    c. # of interactions where an interpreter is used
    d. Type of interpreter used (e.g. hospital employed, family member, community worker)
    e. Name of interpreter
    f. Cases where problems occurred due to language barriers
    g. Cases where interpreter not available
11. Position descriptions for interpreters are in place
    a. The position description recognizes the complexity of the interpreters role
12. An evaluation process for interpreters is in place.

There are many benefits to providing appropriate language access services.
There has been more research on the impact of language barriers than on the impacts of trained health interpreters, although provision of trained interpreters has been demonstrated to increase use of preventive services and patient satisfaction. A study by McKinney et al. (1995) demonstrated that enrolling Deaf patients in a primary care program that provided American Sign Language interpreters improved preventive care, compliance, and physician-patient communication.[162] Those in the primary care program were significantly more likely to report receiving preventive testing, counseling for psychiatric and substance abuse problems, and higher satisfaction. This research does have some limitations as there were differences in characteristics between cases and controls. A Canadian study of clients, health professionals, and interpreters working with the Inter-regional Interpreters Bank in Montreal found significant differences in satisfaction between use of professional vs. ad hoc interpreters.[76] A study by Jacobs et al. (2001), in the United States found that instituting professional interpreters increased the use of recommended preventive services and decreased use of hospital emergency services.[163] Patients consistently prefer to use professional interpreters.[76, 163]

Winnipeg: *An immigrant, who was being treated in the emergency department, was accompanied by an untrained community interpreter. As this volunteer had other commitments, s/he was forced to leave. A program coordinator from the hospital (who did not have responsibility to provide interpretation services but was fluently bilingual) volunteered to interpret. At this time, in addition to the complaint for which the client was being treated, two additional issues were brought to the attention of the interpreter. Hospital records indicated that the patient had an appointment for a pregnancy termination; however, she claimed to have no knowledge of what procedure she had been scheduled for. Secondly, the patient complained several times to the attending staff that she believed she had malaria, and wanted to be tested for it. After assertive attempts to bring this to staff attention, the attending physician finally responded that the test could not be done at the hospital. The staff person who was providing the interpretation followed up with a phone call to Infectious Diseases, and was informed that not only could the test be done there, but that it should be. The physician was subsequently contacted to clarify hospital services and policy.*

The case study above indicates some of the benefits of trained interpretation. Several benefits to the patient and the institution were obtained through the intervention of a trained interpreter in this case – benefits that were not achieved with the untrained interpreter:

- *Explanations to the patient of her condition and proposed treatment were provided.* Investigation by the interpreter determined the reason she had been scheduled for a hospital procedure and provided this information to the patient.
- *Informed consent was facilitated.* As a result of the information provided, the patient was able to provide informed consent to the scheduled procedure.
- *Additional, and potentially serious, health concerns and symptoms were appropriately communicated.* The interpreter had the skills to appropriately continue to raise unanswered questions on the patient's behalf – they were not ignored as they had been with the volunteer interpreter.
- *Early intervention may have prevented symptom exacerbation and potential hospitalization.* As a result of the interpreter's action the patient was able to get tested for a potentially serious disease, and receive treatment for it before symptoms became worse.
- *The interpreter was able to bring system errors to the attention of appropriate hospital authorities.* Because the interpreter had a reporting relationship with the hospital, she was able to

clarify misinformation passed on by staff. This provided the hospital with an opportunity to increase efficiency and prevent further errors affecting other patients.

- *It is likely that patient stress was reduced, and her confidence in health services increased.* The provision of skilled interpretation services can reduce the tension and stress associated with trying to communicate health information accurately, and increase the level of comfort experienced by the patient in the health interaction. We may also assume that the satisfactory resolution of this case would promote confidence in the medical care received – which, in theory, would improve adherence and confidence in future interactions.

We cannot assume that any of these positive outcomes would have occurred had – as is more often the case – the entire interaction been handled by an ad hoc interpreter. Similar benefits can be achieved in assisting clients to access health promotion/prevention resources.

Winnipeg: *A Deaf woman is currently employed as a Baby First/Early Start Home Visitor. Her involvement with community members assists Deaf families in becoming familiar with community-based education opportunities such as the Feeding Babies Workshop at the West Kildonana library by the WRHA community nutritionist.*

There are a number of models for meeting best practice standards.
A variety of different models for addressing language barriers have been identified, along with the strengths and weaknesses of each.[10, 161] Developing appropriate models is a particular challenge in health regions such as Winnipeg, where there are relatively small populations of many different language groups. It is also important to recognize – and integrate into planning – the reality that each of the language constituencies may have different expectations of the interpreters role,[10, 111] or a preferred service delivery model.

Models for addressing language barriers may incorporate one or more of the following:

a) facility-based health interpreters
b) community-based health interpreters
c) regional coordination of services
d) "generic" professional interpreters located in the community
e) telephone interpretation (e.g. contract with CanTallk)
f) use of bilingual staff
g) combined roles, where interpretation services for some communities are provided as one aspect of a larger education, orientation, or case management role
h) translation of written material
i) outreach and orientation strategies.

Examples of different models can be found across Canada. For example, the Calgary Health Region has trained and coordinates its own health interpreters. The Régie régionale de la santé et des services sociaux in Montreal utilizes a large pool of generic trained interpreters who speak many different languages. These interpreters provide both health and social service interpreting. In addition to some regionalized responses (e.g. Fraser, Vancouver

Coastal), the British Columbia Provincial Health Authority has a mandate to ensure centrally managed and coordinated language interpretation and translation services.

Each of the potential models for providing trained health interpreters has advantages and disadvantages, and the best model for a specific health region must be determined through regional assessment. Selection of the most appropriate and cost-effective model will depend on services already available in the community, the number and size of populations requiring interpretation services within the service area; health status and specific health problems experienced by the communities affected; and availability and feasibility of bilingual providers. Choosing the most effective model will also depend on whether the predicted need will require full-time, part-time, or occasional coverage for specific languages.

It is likely that a health region such as Winnipeg will be most appropriately served by a comprehensive and flexible "combination" model [165-166], where paid interpreters, volunteers, bilingual staff and telephone interpreters are all used to provide health interpretation, and where there are creative community-based initiatives to address the language barriers to health promotion/prevention and community knowledge of health resources (and their appropriate utilization).

For example, obtaining informed consent and ensuring confidentiality are priorities, as is ensuring that the patient understands the diagnosis and prescribed treatment. These encounters would require use of trained interpreters. Trained interpretation could be provided by a number of sources – community-based agencies, contractual relationships or through WRHA staff. For in-hospital stays, interpretation for many daily care tasks may appropriately be provided by volunteers or family. Training and evaluation could be provided for staff who wished to assist with occasional interpreting. Appropriate translated material can reduce the need for interpreters in some settings. Telephone interpretation may be the only good alternative in communities where there are small numbers of newly arrived immigrants, and no trained bilingual interpreters are available. In other small communities, availability of trained volunteers, paid an honorarium on a per-session basis may be more cost-effective, and would provide greater continuity and local accountability. This model may also be appropriate for special initiatives (e.g. cervical screening outreach clinics). Partnering with community agencies provides the opportunity to provide much health information through use of trained educators in clients' first language, and in a culturally appropriate format.

Any model adopted, however, must meet minimum best practice standards, be coordinated and comprehensive, and address the needs of all constituencies. The model chosen should also reflect other quality initiatives of the organization – e.g. some models have a greater potential to promote continuity of care. Whatever the model chosen, it is imperative that use of trained interpreters is directed by comprehensive organizational policy, and integrated into both planning activities and practice guidelines.[157] In addition, a combination model requires specific guidelines that provide clear direction for provider response based on the type of health problem, the skill needed in the interaction, and the availability of resources.

CURRENT RESPONSE TO LANGUAGE BARRIERS WITHIN THE WRHA

The current response to language barriers at the WRHA is fragmented:

a) there are different responses for different language communities,
b) there are different strategies used by different programs and institutions, and
c) there appears, from this preliminary scan, to be lack of consistency within institutions, programs and services in actual practice.

Winnipeg: *One of resource persons for the third year medical students got a phone call from a student placed at HSC. His question was "Where do you find an interpreter when you can't communicate with a patient? I've asked everyone here and no-one seems to know".*

There are several designated French-language, or bilingual English/French facilities in Winnipeg, and well-developed French Language Services policy. French-language policy does not address interpretation, as the approach to date is to address needs of French-speaking clients through designation of bilingual or francophone facilities, and within some institutions, of bilingual positions. However, this response is not meeting all needs. The regional French Language Services Manager reports an increasing number of requests for French-language interpretation, and many cases where language assistance should have been obtained but was either not offered or not made available.

A number of institutions keep lists of staff or volunteers who speak other languages, who may be called on to provide interpretation when needed. For example, the Saint Boniface General Hospital keeps lists of both staff and volunteers who have offered to provide this service. These volunteers, however, are not trained. Requests for interpretation are directed to Volunteer Services during business hours, and to the Information Desk out of hours. Some interpretation is also done by volunteers at Health Sciences Centre in low risk situation, but not for medical encounters.

There is a regionalized program for Aboriginal languages, which is part of Aboriginal Health Services, that provides interpretation services to most facilities. There is, however, no regional level policy on their use. This centralized service provides services in Ojibway, Cree, and Oji-Cree, is available 8:30 a.m. – 4:30 p.m. Monday to Friday. South East Referral Service provides out of hours interpreting services to their clients, but what services are available is unclear. There is no formal relationship between Aboriginal Health Services and South East Referral, and anecdotal evidence indicates that many providers are not aware of their availability or what services they provide; and no written procedures are in place.

Interpretation for Inuit patients is provided by Kivalliq Inuit Services, funded by the government of Nunavut. There are no formal policy or guidelines regarding this relationship. Three full time interpreters are on staff, but they are not able to meet all demands for interpreting, with the result that staff prioritize based on need. Many WRHA managers and staff appear unaware of the service provided by this agency, and there is great variability in whether hospital staff call when an interpreter is needed. Staff of Kivalliq Inuit Services, because they are responsible for coordinating travel and accommodation, know who is arriving in the city, and are, therefore, able to follow up and monitor appointments and patient understanding – a situation not found in other language communities.
The Independent Interpreter Referral Service is available to provide trained ASL-English interpreters for clients requiring physician or hospital services at no cost, but does charge for

community interpreting. The availability of these services within facilities is not well known, however, and some managers and staff state that they do not call the service because the hospital cannot afford it. It appears that a variety of other services (e.g. Centre of the Deaf) are used by different programs, or by staff within the same program.

Many immigrant clients arrive with their own interpreters – these may be family members or friends, staff of a settlement or immigrant serving agency, or the Immigrant/Refugee Health Program of the Sexuality Education Resource Centre (SERC). With the exception of staff and volunteers provided through SERC, these interpreters are not trained. If no interpreter is present, the Language Bank may be called – this service, operated by the International Centre of Winnipeg, provides minimal screening and training; therefore service quality varies.

At some sites, the solution for all languages is to use overhead paging (this may occur even for French, Aboriginal and Inuit languages). Staff, visitors, or others who happen to be in the building may volunteer.

Health Links - Info Santé provides English/French bilingual service on a 24 hour/7 day a week basis. It has a contract with CanTalk to provide telephone interpretation for other languages – between November 2003 and June 2004, a total of 30 interpreted sessions were provided, one third of these in French. These numbers likely reflect the low awareness of the service within language minority communities.

Information received from several other programs suggests that there is no policy in place at the program level within most programs and services, and that a variety of different "solutions" are instituted by each service area. Some programs have staff who speak other languages. For example, it is reported that there is a Deaf staff person available to Public Health, there are several languages spoken by midwives in the Midwifery Program, and some community agencies funded by the WRHA also provide language specific services (e.g. SERC, Youville, Aboriginal Health and Wellness Centre). However, the availability of these staff to other program areas, and the scope of their work remains unclear.

Some programs and services provide translated information on specific topics. Key program information is usually also available in French.

The best practice "gap"

According to identified best practice standards, summarized on page 36, it appears that the WRHA is not meeting basic standards in provision of language access services for many clients.

1. ***Policy***: There is a lack of overall policy on language access at the regional level .It also appears that most programs lack policy or procedures for provision of interpreting services. Existing policy is not consistent with best practice standards. There is no evidence that policy includes adequate safeguards for patients with limited English language proficiency in the area of informed consent.
2. ***Requirement to use interpreters***: There is no requirement for providers to use interpreters, and in fact there appears to be low awareness of the policy and procedures already in place. There is also evidence that staff have low awareness of

the risks of not using interpreters, as even the services that are available are not used as they should be.

3. ***Availability of trained interpreters***: Availability of trained interpreters varies by language, program area, time of day, and staff initiative. There is reliance on ad hoc interpreting in many or most cases.
4. ***Training:*** Of designated "interpreters", many are not trained. All the ASL-English interpreters provided through the Independent Interpreter Referral Service have received extensive training, but other sign language interpreters and family members also appear to be used. Some of the interpreters of Aboriginal Services have completed training offered through Red River College. There is an attempt to hire Inuit interpreters who are trained through Artic College, and on the job training is also provided. Staff and volunteers at SERC have received in-house training. There is lack of knowledge within the WRHA of the qualifications of interpreters used from outside agencies. Case study analysis suggests that providers often do not know who is doing the "interpreting", their ability, or what language they speak. There is no training provided for professionals on how to work with an interpreter.
5. ***Information or rights to interpretation:*** Information on interpreting services is not provided to patients in their language.
6. ***Reporting and Coordination:*** There is no responsibility centre for overall language access services within the WRHA, although there is assigned responsibility for Aboriginal Services and French Language Services.
7. ***Records:*** Some programs keep records of services provided. These are not coordinated, and vary in the information provided. There is no coordinated data base of interpreters, their availability, training or number of encounters/service requests.
8. ***Position descriptions:*** Position descriptions are available for only Aboriginal Services staff who provide interpretation.
9. ***Service Standards and Evaluation:*** There is no system in place to evaluate the services provided by interpreters. There appears to have been no assessment of the community interpretation services commonly used by WRHA programs and staff.

While use of WRHA staff may provide greater protection to patient confidentiality than using ad hoc interpreters; because these individuals are untrained, they pose many of the same risks to patients as ad hoc interpreters, and do not decrease hospital liability in cases of error. In addition, these arrangements may place additional burdens on staff (as interpretation tasks take them away from their assigned duties).

Because of the pressures by the need to provide language access for patients, many different ad hoc solutions have been developed for different language communities and in different parts of the system. While many individuals may understand the need for good interpretation, and take steps to ensure it, this commitment is not reflected at the organizational level in organizational policy. The services available, and hence standards of service provision, vary between constituency, service, and time of day. This system is both inefficient and poses risks to patients and providers.

NEXT STEPS FOR THE WRHA

Based on an analysis of the research literature on both language access and organizational cultural responsiveness, and the high-level scan undertaken for this report, the following actions are recommended.

1. Create a responsibility centre for language access

The first step in addressing language barriers within the WRHA is to create a responsibility centre for assessment and development of language access services. In order to avoid duplication, this position should have a mandate for all language constituencies. This position should report directly to senior management.

Rationale: It is necessary both to ensure appropriate resource use, and to ensure that the same standards are put in place for all communities. To be effective, the position must have the authority to make decisions within the mandate of the initiative and ensure integration into overall planning. At the same time, it is recognized that some elements of a comprehensive response are in place, and that the service preferences of different language communities may differ. Overall coordination does not imply that strategies adopted for each of the language constituencies would be the same. It is assumed that there will be strong linkages between this initiative and the Director of Aboriginal Services and the French Language Services Associate to the CEO. This coordination will, however:

a. help ensure that equivalent standards of care are achieved for each language community;
b. facilitate planning and communication within the WRHA; and
c. contribute to efficient use of resources by avoiding duplication. A number of functions related to providing language access services for the different communities can be centralized (e.g. data collection, strategic planning, staff education, interpreter training).

2. Undertake an environmental scan and organizational assessment

It is recommended that the WRHA assess current practice across program areas, identifying strengths and weaknesses**.**

a. Identify and assess, according to best practice standards, available WRHA language access programs and resources;
b. Identify and assess community language access services and resources;
c. Determine WRHA provider/administrator/governance awareness of the risks of language barriers;
d. Determine specific languages for which services are needed and the projected number of annual encounters for these languages;
e. Assess the characteristics of preferred service of various language communities;
f. Explore the feasibility and desirability of possible liaison/coordination with Provincial initiatives and other regional health authorities;
g. Assess training options and resources.

Rationale: This scan would not be focused on whether there is a need to provide language access services, but would gather information to facilitate decision making regarding the most appropriate and cost-effective way to meet best-practice standards. Each regional health authority has specific needs and population makeup and density. There are many

different stakeholders in the issue of language access, including minority language communities, and community-based organizations, and institutionally-based providers. It is essential that their experience and expertise is included in the planning process. The scope of such assessment should include community-baased, as well as facility-based, programs and services.

3. **Consolidate support for addressing language barriers at the senior levels of the organization**
   a.

a. Provide orientation for key decision-makers on the evidence related to language access and its importance to organizational quality and risk management initiatives; and
b. Develop a vision and commitment statement from the highest level of the organization regarding the importance of addressing language barriers and the intent to develop an effective plan for doing so.

Rationale: For language access programs to be effective, it is essential that they not be viewed as an optional additional program, but as an integral component of a strategy to address risk, and improve quality. Initiatives must be integrated into organizational planning and perceived as having the support of the Board and senior management.

4. **Develop, in conjunction with stakeholder groups, a strategic plan for communicating and integrating the recommended model into organizational policy, planning and processes**
   a. Develop a communication plan to inform all levels and service areas of the organization about the initiative;
   b. Develop specific strategies to ensure that language access issues are incorporated into strategic and business planning, and quality and risk management initiatives;
   c. Develop a clearly articulated plan for developing organization wide policy and procedures, including mechanisms for monitoring and updating these procedures as services develop;
   d. Draft a high level policy which addresses minimum best practice standards for ensuring language access;
   e. Review key organizational policy, procedures, and guidelines to ensure that they are upgraded to support appropriate language access processes (e.g. policies related to informed consent);
   f. Develop a phased plan for instituting training and evaluation activities.

Rationale: The literature on cultural and linguistic responsiveness highlights the importance of institutionalizing diversity initiatives into the structure and processes of the organization. The research also suggests that unless these steps are taken, there may be inefficient use of resources. Whatever "model" for service provision is selected, it is essential that there by structures and processes in place to guide and monitor its implementation.

5. **Develop a recommended model for addressing language access services for the Winnipeg region.**

This plan should reflect the criteria outlined on pages 36. It should be based on the current and projected needs for the Winnipeg area, maximize use of community resources and participation, and incorporate creative, low cost alternatives to respond to language barriers. This model should address the needs of all language constituencies.

This model should consider the recommendations arising from the Primary Health Care Initiative. As discussed on page 39, it is likely that some "combination" model will be most feasible for the Winnipeg health region. Evidence on the impact of language barriers on health promotion, prevention and screening programs indicates that plans for interpreter services should be coordinated with community education/outreach strategies which maximize the expertise of community partners. Once the identified model is approved, a phased-in implementation plan should be developed.

SUMMARY

Addressing language barriers is the one strategy for improving organizational cultural competence that has both theoretical and empirical evidence linking it to improved health outcomes.[167] Communication is an essential diagnostic tool; it is critical that language access services are recognized as an integral component of a strategy to address health disparities, manage risk and ensure quality care.

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APPENDIX A

MEMBERSHIP OF WRHA LANGUAGE BARRIERS ADVISORY COMMITTEE

Lenore Good, Health Sciences Centre Volunteer Services

Jeanette Edwards, WRHA Community Development

Jeannine Roy, WRHA French Language Services

Bonnie Dubienski, Independent Interpreter Referral Service

Lori Johnson, SERC (Sexuality Education Resource Centre) and Klinic

Anna Ling, SERC (Sexuality Education Resource Centre)

Catherine Cook, WRHA Aboriginal Health Services

Paul Nyhof, Health Links - Info Santé

Gary Tessier, St. Boniface General Hospital, Volunteer Services