Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities

by Jane Perkins, Harry Simon, Francis Cheng, Kristi Olson, and Yolanda Vera
National Health Law Program
January 1998

Executive Summary

Overcoming language barriers to health care is critical to the well- being of millions of immigrants in the United States today. Immigrants with limited English proficiency (LEP) often face substantial communication problems at almost every level of the health care delivery system. At the administrative level, simply scheduling an appointment can be an ordeal for LEP patients.

At the clinical level, when communication barriers prevent health care providers from understanding their patients' symptoms, proper medical care can be a near impossibility. The absence of a trained interpreter not only may lead to improper diagnoses and care, but also may call into question the doctor's ability to obtain a patient's informed consent.

In most cases, providers have the means to overcome language barriers. Providers that serve large numbers of LEP patients can hire bilingual providers and staff interpreters. Local language banks and community- based organizations can provide contract interpreters who are fluent in various languages. When necessary, telephone translation services can furnish interpreter services in over 140 different languages.

Yet in communities throughout the country, providers continue to muddle through their contacts with LEP patients, relying upon their own rudimentary skills, patients' family members, hospital service employees, and other untrained interpreters. In some cases, these practices may reflect an assumption that providers have no obligation to bridge language barriers with limited-English speaking patients. In most instances, this assumption is wrong as a matter of law.

The Need for Linguistically Appropriate Healthcare Services

About thirty-two million people in the United States, 13.8 percent of the population, speak a language other than English at home. However, despite this large constituency, and laws that require recipients of government funds to provide appropriate language access to health care services, the current state of linguistic access to health care leaves much to be desired. The National Health Law Program has identified three factors that contribute to this problem.

First, the number of different languages spoken in the United States has increased dramatically over the last thirty years. The current health care system is not equipped to operate in an environment where numerous languages are spoken.

Second, current levels of funding often are inadequate to meet the rising demand for interpretive services. While the exact costs of these services are difficult to quantify, a recent survey of eight Seattle-area institutions shows that the added expense of working with LEP patients does impact a health care provider's budget. Unfortunately, the current situation is exacerbated by the federal cutbacks on public benefits for

immigrants.

And, third, while both federal and state laws require access to linguisti cally appropriate health care, these laws are little known and rarely enforced.

The Current State of Affairs
These factors have resulted in an unhealthy reliance on untrained interpreters. Most encounters with limited-English speakers are handled by employees untrained as interpreters or by friends or family of the patient. Researchers have found that untrained interpreters are prone to errors that can seriously impair the health care delivery process.

A less commonly used method that involves volunteer interpreters from community agencies holds some promise in that the agencies often take a leadership role in advocating for linguistic access to health care. Unfortu nately, because volunteers may not be trained in medical interpreting, many of the concerns about untrained interpreters may apply.

Trained interpreters are used much less frequently. A small number of providers employ staff interpreters. Other providers have turned to contract interpreters and language banks that employ contract interpreters to assist in communicating with patients. Yet other providers use telephone interpretation services to meet the needs of patients.

Language Access Responsibilities under Federal Laws
In the 1960s, with the passage of federal civil rights laws and the Medicaid Act, the federal government launched a major effort to protect the civil rights of minorities and safeguard the health of millions of indigent people. As both enforcer of civil rights laws and as a major purchaser of health care services, the federal government continues to have a pivotal role in making health services more available to linguistic minorities. A number of federal laws address requirements for language access in health care.

Title VI of the Civil Rights Act of 1964. Title VI of the Civil Rights Act of 1964 states "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Because federal funding of health care is pervasive, nearly every health care provider is bound by Title VI. The U.S. Department of Health and Human Services (HHS) has long recognized that Title VI requires linguistic accessibility to health care. In addition, the Office for Civil Rights (OCR) within HHS has consistently interpreted Title VI to require the provision of qualified interpreter services and translated materials at no cost to patients.

The Hill-Burton Act. Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a "community service obliga tion" that lasts in perpetuity. OCR has consistently taken the position that this obligation requires Hill-Burton fund recipients to address the needs of LEP patients.

Medicaid. Medicaid is a cooperative federal-state medical assistance program that provides health insurance coverage to indigent aged, blind, and disabled people; poor families with children; and poor children and adolescents. Medicaid regulations explicitly require state programs to operate consistent with Title VI of the Civil Rights Act. The Health Care Financing Administration (HCFA), the agency in charge of Medicaid at the federal level, requires states to communicate with beneficiaries both orally and in writing in a language understood by the beneficiary and to provide

interpreters at Medicaid hearings. Medicaid regulations also provide heightened protections for people who reside in long term care facilities and to children and adolescents who are part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Medicare. Medicare is the federal health insurance program that covers people aged 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medicare provides reimbursement to Medicare-participating hospitals for bilingual services to inpatients and has initiated pilot programs employing the use of bilingual forms and educational materials.

Federal Categorical Grant Programs. Community health centers and migrant health centers that receive federal funding must agree to provide services in the language and cultural context most appropriate to their patients.

Emergency Medical Treatment and Active Labor Act. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals that participate in the Medicare program and have an emergency department to treat patients in an emergency (including women in labor) without regard to their ability to pay. EMTALA sets forth diagnosis and treatment responsibilities that may be difficult or impossible to meet for hospitals that fail to overcome language barriers with their patients.

Language Access Responsibilities Under State Law
In recent years, state legislatures and administrative agencies have begun to recognize the growing need for linguistically appropriate health care and to adopt measures that require or encourage health care providers to take steps to overcome language barriers.

Language Access Laws. A few states have passed comprehensive language access laws that set forth a general responsibility for health care facilities to ensure communication with LEP patients. Some of these laws, such as those passed in California, Massachusetts, and New York, detail specific guidance to providers on what they must do. In other states, such as Illinois, the legislation notes the importance of translation services, but leaves it largely to the health care provider to decide on the services it will offer. Many more states have tied language access laws to specific categories of health services. Not surprisingly, states have reserved some of the most stringent requirements for mental health and long term care facilities.

Many states also have enacted provisions that encourage or require both state agencies and social service agencies with whom they contract to provide language appropriate services to LEP patients. Model legislation in California, called the Dymally-Alatorre Bilingual Services Act, imposes direct obligations on state and local agencies to provide appropriate translation services. The Act requires, for example, that agencies translate materials explaining their services into languages spoken by five percent or more of the populations that they serve and employ sufficient numbers of bilingual persons to ensure access for non-English speaking persons.

State Civil Rights Laws. State civil rights laws provide another source of authority for the imposition of language access requirements on health care providers. For example, California's civil rights statute prohibits recipients of state funds from discriminating on the basis of ethnic identification, religion, age, sex, color, or physical or mental disability.

Malpractice Laws. State statutes and common law rules governing professional malpractice are yet another important source of language access obligations. Inadequate communication with patients may result in liability under tort principles in three ways. First, providers may discover that they are liable for damages resulting from

treatment in the absence of informed consent. Second, providers face potential claims that their failure to bridge communication gaps breaches professional standards of care. Third, a provider's violation of language access laws may raise a presumption of negligence in some states.

English-only Laws. At least eighteen states have enacted laws that make English the official state language. While many of these laws are purely symbolic, some require public officials to speak English—and no other language—when conducting state business. Even the most strict of these laws, however, includes exceptions for law enforcement and public health activities. The effect on language access of a public health exception contained in such laws is hard to measure. Some state agencies may interpret the exception broadly, while other agencies may choose to invoke the exception only in very specific public health activities involving, for example, infectious diseases.

Language Access Responsibilities in the Private Sector
The provision of publicly-financed health care services is rapidly being delegated to the private sector, with significant effect on the provision of language services. Two developments are particularly noteworthy -- the increased reliance on for-profit managed care plans and the growing influence of private accreditation organizations.

Managed Care. Some innovative HMOs are employing novel programs to provide linguistically appropriate services to LEP patients. Harvard Community Health Plan, for example, has adopted interpreting policies that encourage pre-scheduling of appointments and use of on-staff interpreters.

State governments also can play an important role by adopting base-line standards that managed care companies doing business in the state must meet. While there has been little legislative activity to date in this area, about half of the 80 or so Medicaid managed care contracts reviewed for this manual addressed the need for culturally sensitive services. California, for example, has not only passed legislation that encourages assessment of the linguistic accessibility of managed care plans, but also has inserted noteworthy linguistic accessibility provisions in its Medicaid managed care contracts, including provisions that require health plans to assess the language capability of their service areas and to develop plans explaining how they will serve LEP populations within those service areas.

Accrediting Agencies. State and federal agencies increasingly relying on private accreditation entities to set standards and monitor compliance with those standards. Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions (e.g. psychiatric facilities, home health agencies), and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health MCOs, have adopted standards that require language access in health care.

JCAHO standards require hospitals to employ policies that provide effective communication means for each patient served. For example, on admission, patients must be informed of their rights. If these rights are listed on written notices and postings that the patient cannot understand, then the patient should be informed of his or her rights in a manner that he or she can understand. The NCQA accreditation process calls for MCOs to be able to provide materials in languages understood by LEP enrollees if they serve major non-English speaking populations (at least 10 percent of membership). NCQA's Health Plan Employer Data and Information Set (HEDIS) 3.0 presents a set of performance measures for commercial, Medicare, and Medicaid managed care plans. It includes questions regarding bilingual doctors and staff, availability of trained interpreters, and whether materials are printed in languages other than English.

Recommendations
Based on the research conducted for this manual, the National Health Law Program has identified the following key provisions as critical to the delivery of health care to LEP populations.

1. Health care providers and purchasers need education on the federal and state laws governing linguistic access, particularly Title VI of the Civil Rights Act.
2. Government agencies and citizens need to enforce the civil rights laws.
3. Efforts to collect data on LEP health status and utilization need to be increased.
4. Hospitals and managed care organizations need to hire and contract with bilingual providers/interpreters who can meet the needs of their patients.
5. The linguistic measures in HEDIS 3.0 should be strengthened. In the meantime, existing provisions need to be taken seriously by insurance purchasers and MCOs—and the results need to be made accessible to the public.
6. State Medicaid agencies should review their Medicaid provider manuals and guidelines and contracts with managed care organizations to assure that, at a minimum, they comply with the requirements for linguistic access that have been announced in OCR decisions.
7. State laws and contract provisions should be monitored and enforced by the state, and offending providers should be sanctioned.
8. States and health plans need to assure that affected LEP consumers' views are understood and incorporated.
9. Advocacy organizations that work on behalf of limited English speaking populations and that work to improve health care access should continue to be involved in efforts to improve linguistic access.
10. Principles of interpreter services need to be established and followed to assure the availability of qualified interpreter services.

Conclusion
Immigrants are coming to the United States in increasing numbers, and they will continue to come here to stay. This influx represents new challenges to health care providers and purchasers, and it opens up new health care markets.

Unfortunately, the health care system is not adequately equipped to serve limited English speaking populations, and it has only begun to recognize the marketing opportunities that these populations present. Yet, the problems are not going unaddressed. Innovative approaches to serving limited English speaking persons are being developed across the United States.

In addition to a growing awareness that population shifts are creating a greater need for translation services, there are laws that require linguistic access. Numerous federal and state civil rights laws protect limited English speakers against discrimination in the delivery of health care. Unfortunately, states, health care providers, and managed care organizations are largely unfamiliar with these legal requirements—even though most of those who are participating in Medicare and Medicaid have signed contracts that explicitly require them to adhere to the civil rights laws, particularly Title VI of the Civil Rights Act. Consumers and consumer organizations also are not fully informed. Clearly, there is much that needs to occur in the areas of development, education, and enforcement.

Funding for this manual was provided by the Henry J. Kaiser Family Foundation. The views expressed are those of the authors and not necessarily those of the foundation. This publication will be available from the Henry J. Kaiser Family Foundation. For more information on ordering a copy, please call Brendan McTaggart in NHeLP's Los Angeles office at (310) 204-6010.

800 656-4533
Pub 1362