Advancing health equity through language access – a global imperative

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Abstract

In this article, the authors outline the universal right to health, healthcare, and language access in healthcare, with a focus on policies and practices in the European Union and the United States. The authors spotlight contrasting views on whether language access should be considered a social determinant of health or an independent factor and assert that health equity is not achievable if language barriers are not systematically addressed in healthcare organisations and in the context of the individual care plan. Drawing from personal and professional experiences, and from a well-established body of medical research, the authors underscore what happens when language access infrastructure is not present in healthcare - with impacts to access and adherence, quality of care, and patient outcomes. The authors propose a language access framework to move healthcare organisations and the communities they serve towards health equity.

Introduction

he universal right to health is clearly articulated in the 1946 Constitution of the World Health Organization, which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and posits that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."¹

This universal right carries freedoms and entitlements. Its freedoms include the right to be free from non-consensual medical treatment, such as experiments and research or forced sterilisation. The entitlements include the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health, which includes the equitable provision of health-related information and the participation of the population in health-related decision-making.²

While all member states have recognised the aspirational right to health written into the foundational document establishing the United Nations in 1948, just 38 percent constitutionally guarantee their citizens the right to healthcare services and 14 percent guarantee the right to public health.³ Some countries have stated before human rights bodies or in national legislation that they cannot or do not wish to provide the same level of protection to migrants as to their own citizens. Many have defined their health obligations towards non-citizens in terms of "essential care" or "emergency care". Because these concepts mean different things in different countries, and sometimes in different regions of a country, their interpretation is often left to healthcare organisations or to individual healthcare practitioners.2

Addressing this variability in recognising and upholding the right to health and healthcare, a 2022 report by the British Medical Association asserts, "Health is such a fundamental human good that it is meaningful both to talk of it as a universal right, and to ensure that all governments are held accountable to their obligations to protect, respect, and fulfil it. Whatever the underlying economic system, where a state has ratified relevant human rights treaties, it has accepted a set of standards against which its progress in realising those rights – and any violation of them – can be called to account."⁴

The EU places a strong emphasis on an individual's right to healthcare, both within a member state's borders and in the context of cross-border migration. The legal framework and directives seek to ensure that individuals can receive healthcare services and are protected against discrimination based on nationality.⁵⁻⁷ However, EU directives on the provision of healthcare do not affect laws and regulations in member states on the use of languages, effectively leaving it up to each country to decide whether to deliver information in languages other than those which are its official languages.⁸⁻¹⁰

The US has no formally codified right to health,11 and while federal law guarantees a patient's right to language access in healthcare,12 not all states have implemented or enforced these provisions equally.13 States with strong public support for immigrant and minority rights may be more likely to implement and enforce language access provisions, while those with more restrictive immigration policies may be less inclined to do so. For example, the Florida Patient Bill of Rights reads, "A patient in a health care facility who does not speak English has the right to be provided with an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient", ostensibly leaving it up to healthcare facilities to decide whether to build language access infrastructure.14 Florida is also the only US state to mandate that hospitals ask patients about their citizenship status.15

It's important to note that individuals on both sides of the pond have the right to seek redress at the national level if they believe their language rights have been violated.^{16,17} However, in practice, the extent to which these overarching protections are realised may vary depending on the state in which the individual resides and the prevailing state-level policies.^{10,13,18} Regardless of whether language rights are locally protected, language access and a person's experience of health and healthcare are inextricably linked. For all of us, the only way to meaningfully access



healthcare is through clear bidirectional communication with healthcare professionals and receipt of health information in a preferred language.19

Social determinants of health, language barriers, and health equity

In individualistic societies, free choice and personal autonomy are widely valued. Personal autonomy also appears to play a role in achieving health. In simple terms, we can make personal choices to achieve better health outcomes. Yet the idea that health equity can be attained through personal choice discounts a wide variety of social, physical, economic, and linguistic factors that

contribute to achieving or failing to achieve this goal.²⁰ In public health, non-medical factors that influence health outcomes are called social determinants of health (SDOH), and it is broadly accepted that they directly impact a person's quality of life, their access to healthcare, their access to social services, and their risk for disease.

The US Department of Health and Human Services, in its Healthy People 2030 initiative, categorises SDOH into economic stability, education access and quality, healthcare access and quality, and neighbourhood and built

environment.²¹ SDOH are directly linked to lack of health equity, which the American Public Health Association defines as "everyone having the opportunity to attain their highest level of health". The US and the EU have proposed strategies to combat health inequities, and at the core of that fight are SDOH.

Language barriers have not traditionally been classified as SDOH, although some proponents suggest they should be. A De-

linked.

cember 2019 American Academy of Applied Linguistics public affairs engagement brief calls for attention to language in healthcare "not merely as a demographic marker, but arguably as one of the most significant (and yet underexplored) social determinants of health in underserved linguistic minority communities." The authors make the case that applied

linguists can play an impactful role in advancing the cause for reducing such disparities.²²

Analyses of SDOH and patient safety in

healthcare reveal that linguistic minorities are more likely to experience worse health outcomes

Linguistic minorities are more likely to experience worse health outcomes overall because of language barriers.

barriers.^{23,24} Facing unattended language barriers in healthcare, minority language speakers are unable to engage in meaningful informed consent processes and their autonomous decision-making is compromised if they cannot fully grasp the nuances of the local majority language; overall, they are less satisfied patients and

overall because of language

they experience greater emotional distress due to lack of control over their health. In other words, if social determinants undermine a patient's autonomy, so do language barriers.

While maintaining that language is an "independent determinant of health outcomes", in an article published in the AMA Journal of Ethics, Dr Jason Espinoza and Dr Sabrina Derrington argue for linguistic redress, highlighting that limited proficiency in the majority language is an "unchosen disadvantage" and urging healthcare providers and organisations to take responsibility for overcoming language barriers at the individual and institutional levels.²⁵

Whether language should be considered a SDOH or whether it is an independent factor, the

Language access and a person's experience of health and healthcare are inextricably

consensus is that language barriers place minority language speakers at a significant disadvantage compared to majority language speakers in any life context. Health equity, therefore, is not achievable if language barriers are not considered at the outset of caring for a patient. Moreover, it

can be argued that building robust language access infrastructure in healthcare organisations and in linguistically diverse communities is foundational to any sustainable progress on the health equity front.

Inadequate language access and a lack of culturally appropriate healthcare services have profound and far-reaching consequences for patients, healthcare providers, institutions, and the healthcare system. These issues, well-docu-

mented in the medical research literature, adversely impact quality of care and ultimately health equity. For the purpose of this article, we will bundle the impact in three groups: access and adherence, quality of care, and patient outcomes. For each, we will share a small vignette from our frontline experience as language access administrators in US hospitals.

Access and adherence

Language barriers result in decreased access to care^{26,27} and reduced adherence to treatment plans.²⁸ Patients who cannot effectively communicate their symptoms or understand medical instructions may not receive the appropriate care they need, and this, in turn, can lead to higher mortality rates (Patient story 1).²⁹

Quality of care

One of the pillars of a therapeutic relationship is effective communication. Where language access infrastructure is weak or non-existent, the overall quality of healthcare delivery is negatively impacted (Patient story 2). The resulting patient dissatisfaction³⁰ leads to a lower

Health equity, therefore, is not achievable if language barriers are not considered at the outset of caring for a patient. likelihood of returning or recommending a healthcare facility. Clinician satisfaction is also at stake. The inability to communicate with their patients, in the absence of language concordance or language services, contributes to moral distress and burnout, as clinicians feel unable to fulfil their commitment and vocation to provide the best possible care. How can a provider "do no harm"

and establish effective communication with their patient when unattended language barriers are in the way?

Patient outcomes

Numerous studies have demonstrated that patients who are unable to communicate in the majority language are at a greater risk of experiencing suboptimal healthcare outcomes. For instance, language barriers have been associated with an increased risk of patient harm,^{31–34} longer hospital stays,^{34–36} a higher likelihood of hospital readmissions,³⁶ compromised patient well-being, and higher healthcare costs.^{30,37,38} These consequences undermine the fundamental Hippocratic principle of "First, do no harm."

It is essential for the healthcare workforce, institutions, and policymakers to recognise the



Patient story 1: Follow-up

Patient treated for breast cancer in community hospital with no language assistance services. Patient achieves cancerfree status, and is subsequently lost in the system, receiving no follow-up care. Patient presents two years later at a major cancer centre with symptoms; cancer has metastasised and is untreatable. Patient reports that, due to language barriers and lack of language assistance, she never understood that there was a five-year treatment plan that needed to be followed.

critical importance of building language access infrastructure, regardless of what the current local legislative landscape may be. By doing so, we not only enhance the quality of care provided to minority language populations but also make strides in the pursuit of health equity (Patient story 3).

Addressing the language access imperative in healthcare

To provide equitable, safe, and effective care for all patients, it is essential to address language access. In language concordant environments, where patients and providers share a common language, patients receive more information and are asked more questions,23 which aids in achieving an accurate diagnosis sooner. In the highly litigious US healthcare system, physicians treating patients with whom they share a language fear malpractice much less²³ and report higher professional satisfaction than when confronted with language barriers. Language concordance, undoubtedly, is a first-line health equity strategy. Yet language concordance is not always possible, and the engagement of qualified healthcare interpreters and translators becomes the next best just strategy in linguistically diverse populations.

Successful language equity interventions are multipronged. To build a culture of language justice in a healthcare system requires infrastructure, sustained effort and commitment from institution leaders, consistent messaging and education, as well as expectation-setting through policy and enforcement. This work is reminiscent of the revolutionary focus required to instil a culture of hand hygiene in hospitals.³⁹

An observational study published in JAMA

Pediatrics reported on mortality rates among Latino children in a US paediatric intensive care unit (PICU) before and after linguistic and cultural intervention.²⁹ Before intervention, Latino children's mortality rate was 3.7 x higher than the mortality rate for White and African American children, when adjusted by severity of illness. After implementing a multilevel linguistic and cultural intervention, this inequity was eliminated. Interventions included cultural sensitivity training for clinicians, hiring additional bilingual staff, expanding the availability of trained interpreters in the



Patient story 2: "I like my doctor"

Patient note, written in Portuguese on post-visit hospital survey: "I like my doctor. He thinks he speaks Portuguese. Sometimes I understand him."

emergency department and PICU, making consent forms and educational materials available in multiple languages, and expanding outreach to Latino communities.²⁹ While it may be tempting to oversimplify the solution to the language access challenge by establishing a contract and outsourcing language services entirely, the hospital rejected a quick-fix fallacy, opting instead to address several nuanced variables. In the 3-year post intervention period, PICU mortality for Latino children dropped to a level comparable to the levels of White and African American children.²⁹

The health equity imperative inspires us to propose a language access infrastructure model grounded in the global legal framework, existing medical literature on language access and health equity, and lessons from the field (Figure 1). As advocates, we seek to present building blocks that can be integrated in the structure of any organisation, if not already there, and to offer concrete action steps at all levels of a health system.

The foundation of the proposed model is anchored on the global legal framework that health equity and language access are a human right, and the Hippocratic Oath to, "first, do no harm". Building on best practice guidelines,⁴⁰ and expanding with lessons from the field, we put forward for consideration four pillars: language services, people, processes, and technology, to eliminate linguistic and cultural barriers in healthcare and enable health equity through language access. The requirements for this "Language Justice Framework" are set out below (Figure 1).

Language services

All healthcare language access models include oral interpretation. For quality and practical purposes, it is recommended that the institution maintains qualified healthcare interpreter staff – nationally certified where applicable – in the largest minority languages, supplemented by vendor services. Staffed in this way, service is delivered in a combination of modalities (inperson, video, and telephonic) to meet communication needs at all touchpoints. For fastpaced environments such as emergency wards, intensive care units, surgical centres and birth centres, deployment of area-assigned staff interpreters or unit-based interpreters⁴¹ serving the largest minority languages may help mitigate any absence of language services due to time pressures associated with the provision of critical care in an already fast-paced environment. Many healthcare systems deploy video remote interpreting (VRI) devices in patient care areas to facilitate on-demand language access in multiple languages. Some healthcare systems build interpreter call centres, with the goal of handling most telehealth, video, and telephonic interpretation requests internally for the largest minority languages. All healthcare systems should procure high-quality contracted services as a backup to internal systems and a fail-safe for handling emergent or unanticipated language needs.

Critical written communication is translated by qualified professionals. As part of the language needs assessment, each institution identifies specific business-critical communications and vital documents. Some vital document examples are patient history forms, consent forms, aftervisit summaries, patient instructions, questionnaires, and leaflets providing information about services. Alternate media to written communication are made available to those who are unable to read, who speak languages without a written form, or who prefer to consume information via audio, video, social media, or health apps.

People

If serving a large organisation, professional interpreters enjoy career advancement within the institution and remain in the profession while achieving new levels of competency, continuously developing through milestones (professional certification, advanced academic degrees, etc.), and contributing to process improvements, education, and the community. Interpreters are valued as team members, enriching the en-

Patient story 3: Eye injection

Deaf patient who uses American Sign Language (ASL) to communicate is seen in eye clinic without an ASL interpreter. Provider applies eye injection. Mother reports patient distress. A few days later, patient is hospitalised to address comorbidities. Same eye injection treatment is required prior to discharge, but this time an ASL interpreter was present. History-informed provider states plan to perform eye treatment with patient sedated to improve compliance. ASL interpreter provides a communication consultation and recommends that the provider explains the procedure, including risks and benefits. After interpretation, the patient consents to undergo the eye injection without sedation. Patient is collaborative during the procedure and is complimented for outstanding compliance. Institution and family save costs associated with a longer hospital stay, anaesthesia, additional clinicians, and operating room time.

Health Equity Language Access Infrastructure

Eliminating language and cultural barriers in healthcare

Improving healthcare access and outcomes for linguistically diverse communities

Providing comprehensive language services and culturally appropriate care

LANGUAGE SERVICES

• Oral interpreting in all modalities

- Qualified interpreter staff
- Unit-based interpreters
- Appropriate modalities at all points of contact (in-person, video, telephonic)

• Translation of written materials

- Business-critical communications
- Vital documents
- Patient Rights
- Health App messaging
- Wayfinding signage
- Alternate media
- Qualified Bilingual Speakers (QBS) - clinical and nonclinical staff

PEOPLE

- Institutional language services standards council governance
- Professional recognition: Medical Interpreter/ Translator Certification
- Elevating medical interpreter/translator: Career progression rewards specialisation, education and contributions
- Language professionals partner with physicians in research and publication
- Engagement of internal and external stakeholder communities
- Staff onboarding education
- Structured cycles of inservice training throughout organisation

PROCESSES

- Linguistic needs
 assessment: Identifying
 language minorities,
 frequency of occurrence and
 touch-points
- Language services policies and procedures
- Annual goals aligned with health system goals
- Internal and external marketing, communication of language services
- Data-driven decision-making
- Continuous process improvement
- User-friendly interpreter/ translation request and dispatch functions
- QBS Competency Evaluation

TECHNOLOGY

- Integrated phone, video and telehealth technology solution supports staff interpreters and expands to partner for global language reach
- Multilingual electronic health education library
- Translation Management System
- EMR supports documentation of
 - Preferred language: patient & caregiver/ support person
 - Language of care (oral & written)
 - Other communication needs/assistive devices
- Request management and Dispatching system
- Multilingual website, health apps, appointment management
- Interpreters' communication device within institution

Hippocratic Oath: First, do no harm

Global Legal Framework: Health Equity and Language Access as a Human Right

Figure 1. Language Justice Framework

The Language Justice Framework provides a comprehensive language access framework to support building a new, or improve an existing, comprehensive language access programme.

Abbreviations: EMR, electronic medical record; QBS, qualified bilingual speaker.



counter by providing cultural consultation to help bridge patient and provider perspectives. Ideally, clinicians receive early education in intercultural communication, starting in medical school. Healthcare institutions implement onboarding and in-service training for faculty and staff to learn to engage language assistance services efficiently and effectively. Providers and language professionals partner with faculty to conduct research, learn from each other, share governance, and bring about improvements that authentically meet the needs of all stakeholders. At the highest level, interpreter scientists advance practice within an institution and contribute to the broader medical language access literature.

Processes

Conducting a language needs assessment is the cornerstone for establishing the scope of a language access programme.42 It is necessary to understand the demographic ecosystem in which the healthcare organisation exists, and how, in turn, this organically determines the minority language mix: How many languages need to be served? Where and how often do the minority language populations come in contact with the organisation? From the reception desk to the operating theatre, consider implementing language access infrastructure that seamlessly supports communication at all points of contact. Whatever the reach of the organisation, it is essential to right-size language services, people, processes, and technologies to the needs of the community when creating your language access plan.40

Established processes provide precise guidance for accessing language services appropriately and in a timely manner. Institutions make sure that patients and visitors are informed of free language assistance services through obvious signage and clear instructions.

Standard and objective verification of language competency is required for bilingual clinicians to provide safe and effective language concordant care. A guiding rule of thumb may be to mirror availability of linguistically competent bilingual providers and staff – such as physicians, nurses, and clinical and non-clinical support staff – proportionate to the size of the community's minority language groups. Finding and developing local talent, hiring clinicians and staff from the community, can help build trust and strengthen the healthcare organisation's connection to the diverse population it serves.

Technology

When used appropriately and implemented correctly, technology streamlines access to qualified interpreters and helps support a seamless and consistent patient experience. Its utilisation should be focused on ensuring quality and the best care experience possible.43 Electronic medical records (EMR) support language preference and "interpreter needed" fields for patient and caregiver/support person. Interpreter request and dispatch systems are integrated with the EMR and are user-friendly and intuitive. This is an efficient mechanism to track utilisation and share common information, as well as a source of data to verify compliance, support research, and inform resource advocacy. Tracking metrics allows for quick identification of successful initiatives as well as opportunities for data-driven improvements.

Conclusion

Health equity is a holy grail of modern healthcare. No one has built a perfect system, nor do we presume to believe that this model would. It is our aspirational goal that healthcare institutions everywhere engage in building cultures of language justice and take meaningful steps to advance the practice of health equity for the communities they serve.

Disclaimers

The opinions expressed in this article are the authors' own and not necessarily shared by their employers, former employers, professional associations, or EMWA.

Disclosures and conflicts of interest

The authors declare no conflicts of interest.

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