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# A comparison of the use of interpreters in New Zealand and the US

Ben Gray, Eric J Hardt

## ABSTRACT

Cultural competency in medicine is not possible unless language differences are addressed effectively. Many disparities that appear to be based on cultural, socioeconomic, demographic and other differences can be reduced or eliminated with the use of qualified medical interpretation and translation in multilingual situations. The development of this precious resource varies from country to country around the world as most developed countries face increasingly diverse groups of immigrants and refugees as well as inclusion of more indigenous groups of patients. The US has been one of the leaders in this area since the 1980s. Countries like New Zealand are in different stages of development and on different pathways. Increased international collaboration may facilitate evolution of cost-effective inclusion of professional medical interpreters as part of multidisciplinary health care teams.

Whitehead defined health outcome inequities as *differences which are unnecessary and avoidable...unfair and unjust*.<sup>1</sup> Language-based disparities are among the easiest to resolve, as solutions are already available. Pressure to increase interpreter use is driven by three areas of concern:

1. **Respect for patients' human rights:** Historically, language differences were treated as acceptable reasons for disparities in quality, satisfaction, access and utilisation of health care resources. Charts included comments like, "history unobtainable secondary to language barriers". A veterinary standard of care seemed unavoidable and normal. *Ad hoc* interpreters were used; family, friends, other patients, hospital secretaries and janitors. All were presumed to be bilingual but had no medical training. Confidentiality was a low priority. Limited English Proficient patients [LEPs] were inappropriately regarded as "problem patients." This is unacceptable.
2. **Patient safety and quality of care:** Research has demonstrated disparities based on language differences and their resolution or reduction with the

appropriate use of qualified interpreters. Serious adverse events with negative impact on LEPs are more common than for other patients, and that the events are more likely due to poor communication.<sup>2</sup> Patient safety has attained higher priority in the US and New Zealand.

3. **Cost:** The evolution of interpreter services has been delayed by concerns over high cost. Questions have been raised, and perhaps answered, about the cost of providing professional medical interpretation as compared to the money wasted when an interpreter is not used. The cost per minute of new technology, including telephone and video, has been falling with higher volume, better devices and more training.

We will describe the progress made to date in New Zealand and the US to draw out the lessons on how to increase the role of the medical interpreter.

## Defining Limited English Proficiency [LEP]

Every 10 years, the US Census asks what language is primarily spoken in the home. Those who speak other than English [NES] are asked how well they also speak English:

**Table 1:** Comparative demographic and language data.

	New Zealand <sup>3</sup>	US <sup>4</sup>
Total population	4,242,051	318,900,000
Proportion born overseas	25%	13%
Source of migrants 2013(NZ) 2014(US)	England (21%) China (9%) India (6%) Australia (6%)	Mexico (28%) India (5%) China (5%) Phillipines (5%)
Proportion born overseas of most diverse city	39% (Auckland)	39% (Los Angeles)
Speak only English at home	81%	79% (primarily)
Common languages (% of foreign language speak- ers)	Able to hold a conversation Māori (16%) Chinese (15%) Samoan (9%) Hindi (7%)	Spoken in the home Spanish (62%) Chinese (5%) Tagalog (3%)
% Speakers of other languages	18.6%	17.9%
Number of LEP patients	2.2% no English (unknown LEP)	9%

very well, well, not well or not at all. The 1980 census data raised issues of the validity of the categories. In 1982, the Census Bureau administered the English Language Proficiency Study, a validated instrument, which showed that only those NES subjects who spoke English “very well” were proficient. After this correction, the incidence of LEPs in the 1990 Census was much higher.

New Zealand does not have useful data on the number of LEPs. The census asks “*In which language(s) could you have a conversation about a lot of everyday things?*”. This identifies the numbers who speak no English, and the numbers who speak English and another language for social conversation but not the number who might be LEP and need an interpreter. As a result, it is difficult to study language-based disparities. We know that Samoan people, many of whom are LEP, have significant health outcome disparities.<sup>5</sup> Even without good data, it has been shown that interpreter use is inadequate.<sup>6</sup> One study found that in only 0.7% of consultations was a professional interpreter used for patients who spoke no English.<sup>7</sup>

In both countries, evaluation of language disparities is difficult if the definitions used in the census differ from those used at medical care sites.

Better understanding of LEP prevalence in the US has led to a number of changes:

### Organisation of interpreters

In the US, state-wide organisations for interpreters emerged. One in particular, the Massachusetts Medical Interpreter Association, ultimately evolved into an international organisation working with several other countries, the International Medical Interpreters Association. New Zealand has a society of interpreters and translators, but no organisations dedicated to medical interpreting.

### Research and LEP patients

Previously, LEPs had been excluded from research.<sup>8</sup> Research in the US on language-based disparities has increased on issues like cancer screening,<sup>9</sup> access to primary care,<sup>10</sup> patient satisfaction,<sup>11</sup> specific clinical outcomes<sup>12</sup> and many other areas. Studies have been done on elimination of disparities with appropriate interventions.<sup>13</sup> Other studies compared telephone interpreting with use of family and other *ad hoc* interpreters.<sup>14</sup> A literature review found that the use of professional interpreters is “*associated with improved clinical care more than is use of ad hoc interpreters and that professional interpreters appear to raise the quality of clinical care for LEPs to approach or equal that for patients without language barriers.*”<sup>15</sup> Such research has supported advocacy for professionalisation of medical interpretation in the US. Because of poor census data, research in New Zealand on

LEPs is difficult and limited. Research from the US and Australia may be relevant but health system differences could limit this.

### Politics

Attention to the use of interpreters is influenced by politics. In the US, President Clinton delivered Executive Order 13166 in 2000, which directed that *“Each federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services, consistent with, and without unduly burdening, the fundamental mission of the agency.”* The US Department of Justice reasoned that LEP status was a marker for foreign-born status, and thus LEPs are protected from discrimination under Title VI of the Civil Rights Act of 1964. Some states responded with specific state laws. Professional groups supported new policies and procedures. Civil rights actions were taken in cases where LEPs suffered injury attributed to lack of interpretation.

A few famous medical malpractice cases were made public, but development was limited until a specific standard of care was established by the Joint Commission, the independent organisation that accredits most medical facilities in the US. Supportive data included a study documenting that LEPs were more likely to suffer adverse events with physical harm, and that these were more likely to result from communication errors.<sup>2</sup> With established standards now in effect, medical malpractice cases are likely to proliferate.

The New Zealand political response to this issue has been more muted. The New Zealand Code of Consumer Rights<sup>16</sup> establishes the rights consumers have when receiving health care in New Zealand. Right #5 says *“Every consumer has the right to effective communication in a form, language and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.”* All rights are qualified by section 3 that says that a provider is not in breach if they have taken reasonable actions considering clinical circumstances and resource constraints. The Code is widely used as the basis for compliance and accreditation documents for hospitals and other health sites. Any patient can complain to

the commissioner if they feel a right has been breached. In the 2014/15 year, 1,880 complaints were received; only 70 were found to have breached the rights.<sup>17</sup> Since 1997, there has been only one breach opinion that mentioned the failure to use an interpreter. Thus there is a process, but it functions more by describing standards than enforcing them, with little acknowledgement that without an interpreter many other rights are not available.

The right for New Zealanders to sue doctors for alleged medical treatment injury was removed with the Accident Compensation Corporation Act,<sup>18</sup> which provides no fault insurance for all accidents, including medical treatment injury. This has many benefits as a scheme, but it does remove the fear of litigation; removing one of the pressures to provide an interpreter.

The New Zealand Health Quality and Safety Commission is the body responsible for developing programmes to improve patient safety. As yet they have not focussed on quality and safety issues relating to LEP patients.

The political climate in New Zealand towards LEPs has been muted, although the recent Syrian crisis has led to popular public pressure for New Zealand to take more refugees, increasing the focus on providing supports when they arrive in New Zealand.

### Costs

There are many ways to improve health care with higher expenditure. Studies with major impact on policy and procedures looked at costs incurred in the US. Theoretical excess costs might result from inadequate health maintenance, late presentation of disease, recurrent illness, poor compliance and other situations hard to quantify. Early studies demonstrated that care of LEPs can cost extra time and money.<sup>19</sup> Others showed that use of professional interpreters can eliminate these excess costs in various situations.<sup>20</sup> Lindholm<sup>21</sup> showed that use of professional interpreters can reduce length of inpatient stay and readmission rates, areas of very high cost savings, suggesting that money saved overall is more than the overall cost of a well-organised interpreter services budget.

New Zealand does not have useful data on the cost benefit of using an interpreter.

Because of health funding differences between New Zealand and US, there is a limit to which US experience can be generalised to New Zealand. As in the US,<sup>22</sup> it is very common in New Zealand<sup>23</sup> for family members to be used to interpret. Research has suggested that this is satisfactory at least some of the time.<sup>23</sup> Designing a study to compare cost benefit of current practice versus increased use of professional interpreter is difficult as highlighted in a recent USA study.<sup>24</sup> This study showed no significant difference in length of stay or readmission between LEP inpatients with or without use of professional interpreters. Although these unexpected findings could result from methodological problems,<sup>25</sup> it is plausible that clinicians were doing well using professional interpreters for more serious cases where the outcome on length of stay and readmission was significantly affected and not using them in less serious cases where length of stay and readmission rate was not affected. Alternate factors might be the use of the clinician's second language or of family members being particularly good at interpreting.

### Current provision of interpreter services

In the US there is widespread availability and uptake of interpreter services, with a high use of video and telephonic interpreting meaning that in theory there is access to an interpreter anywhere in the country. Two thirds of LEPs speak Spanish. Actual usage is far from comprehensive.<sup>26</sup> Progress has been made towards documented accredited training and certification by organisations led by their peers. The US has yet to achieve licencing of all interpreters as happens for other members of the health team. Because of the geography, density and relatively small numbers of LEPs, New Zealand will never be able to provide comprehensive face-to-face interpreting services. There are many languages needed with no one language dominating. Video interpreting is currently barely used. Telephone interpreting services are available during business hours and Saturday morning through the government run Language Line. Auckland, the region with the highest number and density of

LEPs, provides its own 24/7 interpreting service to all health sites. New Zealand is considering the issue of professionalisation<sup>27</sup> but little formal progress has been made. It is time that the Health and Disability Commissioner's code of patient rights were amended to require a "professional" (rather than just competent) interpreter. It is impossible at the very least to gain valid informed consent without a professional interpreter. Without assurance of the interpreter's competence, any challenge to the validity of informed consent would not hold up in court.<sup>28</sup>

### The future: lessons from the US to New Zealand

In New Zealand, a census question that measures LEP is essential. Medical interpreters are professional members of our teams and need a professional framework like any other health professional. Provider training must convey skills to work with interpreters of all types. Remote interpretation is optimal in certain situations but should be seen as an adjunct rather than a substitute for our team members. Providers who wish to practice in a second language must pass proficiency testing.

### The future: lessons from New Zealand to the US

New Zealand is much more conscious of cost effectiveness than the US when providing health care. As interpreter services grow, they will compete for budget from other health services and be prioritised according to cost benefit. The cost and availability of interpreter services vary considerably from face-to-face interpreter, video interpreter, telephone interpreter, bilingual clinician or "free" *ad hoc* interpreter. We need the clinical skills to make decisions about which tools are adequate and cost-effective for the clinical situations we face.<sup>29</sup> Insisting on always using a face-to-face interpreter, or banning bilingual clinicians from using their language skills unless certified, may be essential for the most complex consultations, but if clinicians hone the clinical skill of judging the quality of communication, the benefits of using family members and speaking directly to patients may be available without the risks.

**Competing interests:**

Nil.

**Author information:**

Ben Gray, Senior Lecturer, Department of Primary Health Care & General Practice, University of Otago, Wellington; Eric J Hardt, Geriatrics Section, Boston Medical Center, Associate Professor of Medicine, Boston University School of Medicine, Boston, USA.

**Corresponding author:**

Dr Ben Gray, Senior Lecturer, Department of Primary Health Care & General Practice, Te Tari Hauora Tūmatanui me te Mātauranga Rata Whānau, University of Otago, 23a Mein Street, PO Box 7343, Wellington.

ben.gray@otago.ac.nz

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