The Medical Tongue: U.S. Laws And Policies On Language Access

Twenty-three million people remain at risk for receiving substandard care merely because they are not fluent in English.

by Mara K. Youdelman

ABSTRACT: For twenty-three million Americans who speak English less than "very well," language barriers lead to lower quality of and worse access to health care. Although the breadth of existing federal and state language access laws might seem sufficient, the lack of comprehensive implementation and enforcement leaves millions of patients with limited English proficiency forced to accept a lower quality of care than English speakers receive. This paper reviews existing laws and offers solutions focusing on five themes: access, funding, education, quality improvement, and accountability. Improving language access is essential to ensure that the language one speaks does not affect one's health or mortality.

[Health Affairs 27, no. 2 (2008): 424-433; 10.1377/hlthaff.27.2.424]

SHOULD THE LANGUAGE YOU SPEAK determine how long you live? Unfortunately, for one in twelve Americans, it often does. In the health care system, where complex medical terminology and legalistic documents leave many English speakers confused or misinformed, language barriers only exacerbate the problem. More than twenty-three million Americans (including 10.5 million native-born and naturalized citizens and up to 4.2 million documented immigrants) speak English less than “very well” and thus have limited English proficiency (LEP).¹ Many of these people also likely suffer from inadequate health literacy. The Institute of Medicine (IOM) defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”² If a person encounters language barriers in attempting to use the health care system, she or he would also likely be unable to obtain, process, and understand basic health information. Inadequate health literacy is not only associated with worse self-management skills, lower use of preventive services, and less knowledge among patients with chronic diseases, it is also directly linked to higher mortality.³ For people with LEP, the lack of language facility creates a barrier to and threatens the quality

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of health care. For example, non-English-speaking patients are less likely than English speakers to use primary and preventive care and public health services and are more likely to use emergency rooms (ERs). Once at an ER, such people receive far fewer services than do English-speaking patients.

So how should the health care system meet the needs of LEP patients? It can do so in part by recognizing that competent language services are essential. To ensure that all patients receive the same quality of care, the system must demand, as a matter of professional ethics as much as of law, that health care providers comply with existing federal and state requirements to ensure language access.

**Federal Laws**

Virtually all health care providers must comply with Title VI of the Civil Rights Act of 1964, which ensures that federal money does not support providers who discriminate on the basis of race, color, or national origin. The U.S. Department of Health and Human Services (HHS) and the courts—including the U.S. Supreme Court—have interpreted Title VI to protect national-origin minorities who do not speak English well. Thus, health care providers receiving federal funding must ensure that they offer meaningful access to LEP patients.

In 2000, President William J. Clinton issued Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, which brought renewed attention to Title VI. Reaffirmed by President George W. Bush in October 2001, it required each federal agency to draft guidance tailored to its federal fund recipients. HHS recipients include all health care providers that receive federal funds (for example, Medicare, Medicaid, and the State Children's Health Insurance Program, or SCHIP), including hospitals, physicians' offices, managed care plans, community clinics, nursing homes, pharmacies, and state agencies. HHS issued its final Guidance in August 2003. In addition, the HHS Office of Minority Health promulgated standards for Culturally and Linguistically Appropriate Services (CLAS) in health care, which include the following: “Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.”

Other federal laws explicitly or implicitly require language services. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), a hospital's requirement to screen and treat emergency medical conditions would be difficult to complete without effective communication with LEP patients. Since hospitals may not unilaterally transfer patients, interpreters would likely be needed to obtain patients' consent. Further, hospitals that received Hill-Burton funding have an ongoing “community service” obligation that includes nondiscrimination. According to the HHS Office for Civil Rights, facilities must post notices of this obligation in English, Spanish, and other languages spoken by 10 percent or more of
the households in their service area. Unfortunately, despite these federal laws, lack of knowledge and enforcement leaves millions of people with LEP unable to obtain the same quality of care received by English speakers.

State Laws

All states have enacted statutes or regulations that clarify or broaden the federal requirements. Every state has at least two such laws, while twenty-two have more than twenty, including seven states with more than fifty laws and four states with more than seventy-five (Exhibit 1). State laws vary from being comprehensive to addressing specific health care providers or patient groups.

Although Title VI and many state laws have been in effect for years, lack of knowledge among providers about them and how to provide language services remain major obstacles to improving the quality of health care for LEP patients.

- Comprehensive laws. The comprehensive laws address all health care providers or all state agencies. With more than 150 laws, California represents the most comprehensive state approach and includes a state Title VI look-alike that prohibits national origin discrimination in any program or activity “conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state.” In addition, the Dymally-Alatorre Bilingual Services Act requires state agencies directly involved in furnishing services to a “substantial number” of people with LEP (5 percent or more of the service population) to provide services in languages other than English. In 2003, California enacted a requirement that all private managed care plans and insurers, not just those receiving federal funds, provide language services. Compliance is mandated by

<table>
<thead>
<tr>
<th>Number of laws</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–10</td>
<td>WY, SC, MT, WV, DE, GA, ID, KS, KY, MS, NV, ND, UT, VT, WI, MI, HI, SD</td>
</tr>
<tr>
<td>11–20</td>
<td>ME, WI, NH, NC, MO, TN, TX, VA, CT, LA, CO, IN, MD</td>
</tr>
<tr>
<td>21–30</td>
<td>AK, AL, AR, DC, AZ, FL, OK</td>
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<tr>
<td>31–40</td>
<td>PA, RI, IA, MN, OR</td>
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<tr>
<td>41–50</td>
<td>NE, OH</td>
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<tr>
<td>51–60</td>
<td>MA, NM</td>
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<td>61–70</td>
<td>NY</td>
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<td>71–80</td>
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<tr>
<td>91–100</td>
<td>IL</td>
</tr>
<tr>
<td>&gt;100</td>
<td>CA</td>
</tr>
</tbody>
</table>


NOTES: States are listed in ascending order for each category, so states with the fewest number of laws in their category are listed first, and those with the greatest number of laws in their category are listed last. California has 152 laws on language access.
2009. If this requirement is fully implemented and enforced, all privately insured people will have a right to language assistance.

Other states have broad laws that focus on state agencies but not private providers. Maryland's Equal Access to Public Services for Individuals with Limited English Proficiency Act requires equal access to public services for people with LEP, based on a finding that the inability to speak, understand, or read English prevents access to public services. Washington, D.C., followed Maryland's lead; its law applies to all city agencies and may be extended via contract to agency subcontractors. Thirty-three other states impose some requirements on certain state agencies or state programs.

- **Training for health professionals.** States have begun to emphasize educating health professionals about language access. Recent laws focus on how cultural and language barriers can affect the quality of care, with the goal of increasing clinicians' support for and use of language services. New Jersey, California, and Washington have enacted requirements for physicians or other health professionals.

  In 2004, New Jersey was first to adopt such a law. Each medical school must educate students on cultural competency—of which language access is a core component. And cultural competency education is required for physician relicensure. California and Washington adopted laws in 2005 and 2006. California requires all clinically oriented continuing medical education (CME) programs for physicians and surgeons to include cultural and linguistic competency curricula. Washington State has the broadest law, requiring all health professional training programs to integrate multicultural health into the curriculum. Further, professional licensing agencies are authorized to incorporate multicultural health issues into CME programs. In 2007, eight additional states introduced bills on this topic.

- **Facility licensure.** A number of states mandate language services as a condition of facility licensure. For example, Rhode Island hospitals must provide a qualified interpreter (if an appropriate bilingual clinician is unavailable) for all services provided to non-English speakers. This requirement prohibits using children under age sixteen as interpreters. Hospitals must post notices of interpreter availability in English and, minimally, the three most frequently encountered languages. Colorado requires long-term care facilities to arrange for someone who speaks the resident's language to facilitate daily communications and attend assessment and care-planning conferences.

- **Particular populations.** Every state has laws addressing specific populations—women, children, people with mental illnesses, or older Americans (Exhibit 2). Forty-six states have laws addressing mental health, including in- and outpatient services. These range from translating patients' rights notices to mandating interpreters for commitment proceedings. For example, Illinois requires state mental health facilities to provide interpreters during admission, intake, and evaluations. Its Mental Health Hispanic Interpreter Act requires that state-operated mental health and developmental disability facilities—when at least 1 percent of annual ad-
## EXHIBIT 2
States With Specific Laws On Language Access In Health Care Facilities, By Topic Area, 2007

<table>
<thead>
<tr>
<th>Type of law</th>
<th>Number of states</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>State agency</td>
<td>35</td>
<td>All states except AL, DE, GA, ID, IN, KS, KY, LA, MO, MT, ND, SC, SD, WV, WY</td>
</tr>
<tr>
<td>Medicaid</td>
<td>35</td>
<td>All states except AL, AZ, GA, IN, KS, ME, MI, MO, NV, ND, OK, SD, VT, WV, WY</td>
</tr>
<tr>
<td>Hospitals</td>
<td>23</td>
<td>CA, CO, CT, DC, FL, IL, MA, MI, MS, NV, NH, NJ, NM, NY, NC, OH, OK, PA, RI, TN, TX, VT, WA</td>
</tr>
<tr>
<td>Abortion/sterilization</td>
<td>29</td>
<td>AL, AK, CO, CT, DE, GA, ID, IA, KS, MA, ME, MI, MN, MT, NE, NH, NJ, NM, NV, NY, NC, ND, OH, OK, PA, RI, TX, WI, WV</td>
</tr>
<tr>
<td>Women’s Right to Know acts</td>
<td>11</td>
<td>AR, GA, KS, LA, MI, MN, ND, OK, RI, WV, WI</td>
</tr>
<tr>
<td>Consent to sterilization required for Medicaid payment</td>
<td>17</td>
<td>AK, AR, CA, CO, DE, ID, IA, MA, MT, NE, NJ, NM, NY, OH, PA, RI, WI</td>
</tr>
<tr>
<td>Mental health</td>
<td>46</td>
<td>All states except CT, MT, ND, SD, WY</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment Services in Medicaid Early intervention services*</td>
<td>12</td>
<td>AL, CO, DE, HI, IA, MN, NE, OH, OK, RI, TN, TX</td>
</tr>
<tr>
<td>Mental health</td>
<td>23</td>
<td>AL, CT, DC, FL, IL, IN, KS, KY, LA, MA, MO, MS, NC, NE, NH, NJ, NM, NV, NY, OH, PA, TN, WA, WY</td>
</tr>
<tr>
<td>Older Americans Act*</td>
<td>16</td>
<td>AL, CA, CO, CT, IL, IA, KS, LA, ME, MS, NE, OK, PA, SD, WV, WI</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>14</td>
<td>AK, CA, CO, CT, HI, IL, IN, IA, LA, NM, ND, OK, VA, WA</td>
</tr>
</tbody>
</table>


**NOTE:** States are listed alphabetically in each topic area.

*These state provisions implement federal requirements.

missions for inpatient or outpatient care consist of Hispanic patients—provide qualified interpreters as necessary, including whenever a recipient is admitted or receives care or treatment.²⁶

Thirty-five states have laws concerning women’s health, including twenty-nine that focus on abortion or sterilization and fourteen that address other issues such as prenatal care.²⁷ Eleven states have “Women’s Right to Know” acts, which mandate a heightened recognition of the need for language services, likely reflecting the polarized nature of the abortion debate rather than a more generalized concern for informed consent. Information about adoption, fetal pain associated with abortion, the possible detrimental psychological effects of abortion, and fetal development must be published in English and languages spoken by 2 percent or more of the state’s population. Seventeen states require interpreters to obtain LEP patients’ consent for sterilization, as a precondition of Medicaid payment.

States have also adopted provisions addressing children (twenty-nine states) and the elderly (twenty-seven). The provisions affecting children generally govern
notices about Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (twelve states) or about mental illness (eighteen).

Some state laws are based on federal requirements. The Individuals with Disabilities Education Improvement Act requires states providing early-intervention services for children to ensure that written notices to initiate or change services are in the parents' native language. Twenty-three states have explicitly enacted these federal requirements. The Older Americans Act requires consideration of cultural and linguistic issues in prioritizing services to those with the "greatest social need." Sixteen states have adopted these federal requirements.

■ Interpreter competency. Interpretation of information by "ad hoc" interpreters—including family members and friends—is much more likely to contain errors that can have negative clinical consequences than interpretation provided by trained health care interpreters. Ad hoc interpreters might not have sufficient knowledge of both languages and medical terminology, are likely unfamiliar with the appropriate role of an interpreter, and may compromise patient confidentiality or violate the Health Insurance Portability and Accountability Act (HIPAA). Additional problems arise when the interpreter is a minor. Children who interpret for their LEP parents often informally mediate rather than interpret information. Thus, some states limit the use of family members and friends as interpreters. For example, Massachusetts and Rhode Island prohibit hospitals from using children as interpreters.

Although no federal standards for health care interpreters exist, four states require or are initiating state certification. This is due, in part, to recognition that identifying oneself as being bilingual is insufficient for being a competent interpreter. Washington has the oldest certification program. More recently, Iowa, Indiana, and Oregon have required development of interpreter standards; Oklahoma initiated certification without legislation. Other states (New Jersey, North Dakota, and South Dakota) mandate the use of certified or competent interpreters but do not specify standards; California, Massachusetts, and North Carolina are developing standards without legislation.

■ English-only laws. Although there are more than 1,000 laws requiring language services, thirty states have enacted English-only laws that declare English to be the official or common language of the state and require all state activities to take place in English. However, since federal law preempts conflicting state law, states' English-only laws cannot override Title VI. Indeed, eight of the state laws have explicit exceptions to allow compliance with federal law. Even in the states without an explicit exception, any health care provider or state agency receiving federal funds must still comply with Title VI.

Policy Implications

High-quality health care presupposes effective communication between provider and patient. Communication failures can and do result in inaccurate health
histories, uninformed diagnoses, misunderstandings of prescription drug or other treatment instructions, the inability to provide informed consent, unnecessary tests, and medical errors. These can lead to higher costs, lower satisfaction, preventable complications, and higher mortality rates. Thus, any discussion about improving quality must recognize and incorporate effective communication as a key component. For people with LEP, effective communication requires certain augmentative services, for without overcoming language barriers, high-quality care will remain unattainable for twenty-three million people. Although the breadth of existing federal and state language access laws might seem sufficient, inconsistent implementation and enforcement force millions of LEP patients to accept a lower quality of health care than English speakers receive.

■ Implementation and enforcement. So what is needed from policymakers? First is greater implementation and enforcement of existing laws and potential enactment of new laws. Many providers remain unaware of how to comply with Title VI, and their lack of knowledge of state laws is even greater. Thus, it falls to both federal and state regulators to educate health care providers and provide technical assistance and resources for implementation. If these efforts fail to secure compliance, enforcement activities should be undertaken. Some state laws offer aggrieved patients legal remedies regardless of state action, but more laws should offer this so that patients do not have to await action by federal or state regulators or suffer medical harm, allowing for malpractice or negligence claims. For example, California allows civil claims against those who violate the state's Title VI law. In addition, new laws and policies can raise the public's and providers' awareness of LEP patients' needs and provide new funding and resources.

■ Funding. Recognizing that additional education and resources are essential to improving the provision of language services, a coalition of national organizations has developed a consensus-driven agenda to improve access to care for people with LEP. The coalition includes more than 100 health care provider associations, health and immigrant advocacy organizations, language companies, interpreter associations, and health organization accrediting bodies. The coalition's Statement of Principles offers a conceptual guide for achieving high-quality care for LEP patients by addressing issues of language access at the national, state, and local levels. The principles encompass five primary themes: access, funding, education, quality improvement, and accountability.

The principles recognize not only that competent language services are essential for effective public health care and health care access, but also that resources are lacking. A paramount issue has been funding. Very few private insurers defray the costs of language services for their providers. Medicare does not pay for interpreters, and only twelve states and the District of Columbia offer limited funding for interpreters in Medicaid and SCHIP. If language services are necessary to ensure that LEP Americans receive high-quality care on the same footing as English-speaking Americans, and if we believe that disparities in health care and health
outcomes based on extraneous factors are unacceptable when we pride ourselves on equality of opportunity, then funding for language services is a societal responsibility that applies to all stakeholders in the health care system, including insurers and governments. We must achieve a system in which a provider decides to use an interpreter not based on cost but based on the need for communication assistance to ensure high-quality care.

Education. But new laws and policies need to move beyond funding to education and accountability. Providers need information on available resources and how to provide language services effectively. Greater provider and consumer education is essential to broadening knowledge about existing laws and the link between effective communication and high-quality care. This can include health professionals' training and continuing education. Materials must be available in non-English languages to ensure that people with LEP can obtain health education information, respond to medical documents, and actively participate in their treatment decisions. Additional funding is also needed for English as a Second Language (ESL) instruction to improve English acquisition.

Interpreters and translators. Although encouraging more bilingual people to enter the health professions is laudable, a dearth of bilingual health professionals will continue for the foreseeable future. It is thus unrealistic to think that the health system can function without interpreters and translators. Because effective communication depends on the competency of those providing language services, quality improvement strategies should be applied to language services to ensure the competency of interpreters, translators, and bilingual staff, who may provide health care services directly in languages other than English.

Interpreters certainly need to demonstrate sufficient language skills in at least two languages but also must be knowledgeable about medical terminology, confidentiality, ethics, HIPAA, and the role of an interpreter. Development of national standards can help ensure competency and offer professional status to a marginalized segment of the health care workforce.

Quality improvement strategies should be applied broadly to eliminate disparities between English and non-English speakers. These can focus on the timeliness and appropriate use of language services; the problems of using untrained family members, children, and staff as interpreters; or ensuring that screening and discharge procedures use competent interpreters or bilingual staff. The same quality strategies used to improve clinical outcomes can apply to language services.

Accountability. Accountability focuses on ensuring effective implementation and goes beyond enforcement of Title VI. For example, as a condition of additional funding, competency requirements and reporting would offer accountability to ensure the effective use of funds.
Twenty-three million Americans remain at risk of receiving sub-standard health care merely because they are not fluent in English. The interplay of language access laws and policies should promote a system in which high-quality care is available to all. It is possible to eliminate health care disparities based on language barriers, so it is imperative that we do so. The language one speaks should not affect one's health or mortality.

This work was made possible by the generous support of the California Endowment. The author gratefully acknowledges Steve Hitov for his thoughtful comments on earlier drafts of the paper and Kristina Devilla, Sarah Dobra, Dennis Hsieh, Jane Perkins, Sarah Pfau, and Doreena Wong for their research assistance.

NOTES
1. U.S. Census Bureau, “Selected Characteristics of the Native and Foreign-Born Populations” (Table no. S0602), 2005 American Community Survey (ACS). According to the ACS, 10,422,037 native and naturalized citizens speak English less than “very well.” Additionally, 35,352,033 are “foreign-born,” not naturalized, but not delineated between documented and undocumented. To determine the percentage of documented foreign-born people, two estimates were considered: (1) 26 percent of the foreign-born are undocumented [J. Passel, R. Capps, and M. Fix, “Undocumented Immigrants: Facts and Figures,” http://www.urban.org/url.cfm?id=1000587 (accessed 28 December 2007)]; and (2) 11.5 million are undocumented [R. Paral, “The Growth and Reach of Immigration: New Census Bureau Data Underscore Importance of Immigrants in the U.S. Labor Force,” Immigration Policy Brief, August 2006, http://www.allf.org/ipc/ipc/policybrief/policybrief_2006_81606.shtml (accessed 28 December 2007)]. This results in a range of 8,950,591–11,259,062 foreign-born documented immigrants. To determine how many have LEP, these numbers were multiplied by 38.7 percent—the percentage of LEP foreign-born naturalized citizens. While a greater percentage of documented immigrants are likely to have LEP than naturalized immigrants are (in part because naturalization requires English competency), this percentage offers a reasonable, if somewhat underinclusive, estimate. The number of LEP foreign-born documented immigrants thus ranges from 3,463,879 to 4,357,257.


9. 45 CFR, sec. 80, app. A (lists examples of federal funding, including Medicare and Medicaid).


13. 42 U.S. Code, sec. 291c(e); and 42 CFR, sec. 124.603.
17. Ibid., secs. 7290–7299.8.
21. New Jersey Revised Statutes C.45:9-7.2–7.4; California Business and Professional Code, sec. 2190.1; and Revised Code of Washington, 43.70.615.
26. Illinois Compiled Statutes, chap. 405, sec. 75/0.01–75/1.
27. Some states have both types; five have general provisions but none on abortion or sterilization.
29. 42 U.S. Code, sec. 3002(24).
32. State of Rhode Island General Laws, sec. 231754; and Code of Massachusetts Regulations, title 105, sec. 130.1105(D).
39. For example, the Speaking Together National Language Services Network program focuses on quality improvement strategies for hospitals' language services. See http://www.speakingtogether.org.