Healthcare Interpreter Policy: Policy determinants and current issues in the Australian context

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Abstract. Healthcare interpreter policy comprises both the written and the unwritten actions that affect the interpreter service, its structure, funding and service provision arrangements. A model of interpreter service policy is proposed which identifies the interactive policy determinants as being: interpreter provider factors, non-English-speaking (NES) patient factors, managerial factors. health system factors, stakeholder factors, factors associated with non-health sectors and evidence and research. Interpreter policy is viewed as being nested within multicultural and mainstream healthcare policy. Using this model, the article canvasses the range of factors currently influencing healthcare interpreter policy, discusses the evidence and research related to the effectiveness of current policy, and makes suggestions for future policy directions. Key policy directions suggested include: clarification of interpreter roles and responsibilities; taking action to maximise the service reach, scope and effectiveness; developing the cultural competency of healthcare providers; and improving the health literacy of patients with limited English proficiency. It is argued that these changes must be made with an overall healthcare interpreter policy context that defines the central concern as patient safety.

Keywords: interpreting; health care; health policy; immigration; welfare.

Interpreter Policy and the Policy Process

Policy and the policy process are highly contested terms. In the health context, Buse et al (2005) see policy as embracing

> 'courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system…. including policies made in the public and private sector.....and the actions external to the health system which have an impact on health.' (Buse et al 2005 p6)

Dye argues that policy is anything that governments choose to do or not do (Dye 2001), that is, that policy may be explicit or implicit (Folz 1995), written or unwritten.

Health policy also includes actions outside of the healthcare system that impact on health or health status (Palmer & Short 2000). For instance immigration policy changes supporting the immigration of people from sub-Saharan Africa, or small village communities from south-east Asia, has significant implications for the organisation, delivery and budgets of healthcare interpreter services, as the range and demand for cross-linguistic encounters increases and diversifies.

Policy can be seen as one of the key dimensions of the health system; others are resources, organisational structure, management and support systems, and service delivery (Janovsky & Cassels 1995 p12). Fundamental to policy analysis is the way power and influence are exercised and the way

societies and governments function (Buse et al 2005; Walt 1994). Thus, this model of interpreter policy highlights the important role of key stakeholders.
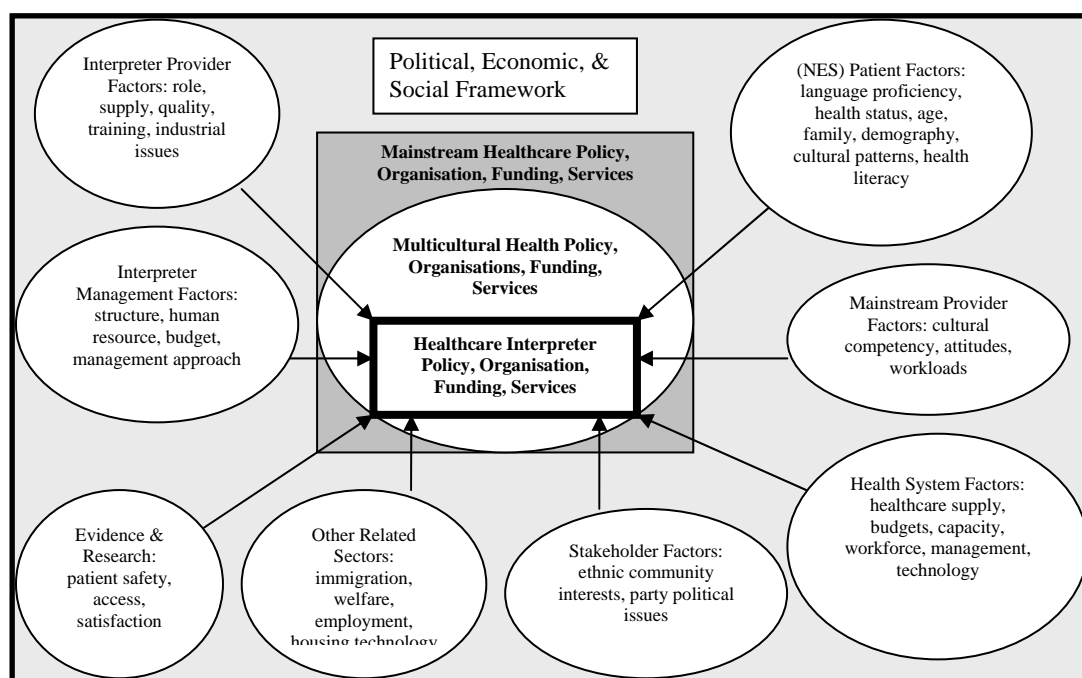

Figure 1: Model of Interpreter Policy in Healthcare

The Model of Interpreter Policy within Healthcare

The complex and dynamic nature of the interpreter health policy process is modelled in Figure 1. Interpreter policy operates within a context that is both defined and influenced by the broader political and social context. Thus attitudes towards immigration, immigrants, health and welfare social provision all (explicitly or implicitly) frame, mediate and influence interpreter service policy and provision. Healthcare interpreter policy is intertwined and nested within multicultural and mainstream healthcare policy. The interpreter service is a key multicultural service which promotes access to health services for people with limited English proficiency.

Many more direct factors may interactively influence or determine interpreter policy and service delivery. These include factors associated with the patients with limited English (including their language proficiency, beliefs, socio-cultural background, age, health status, family relationships), factors associated with interpreters (including their personal and socio-cultural background, interpreter supply, quality, accreditation and training), factors associated with the interpreter service management (budget, structure, management culture), factors associated with healthcare providers (such as their cultural competency, attitudes and workloads), healthcare system factors (such as budgetary constraint, service capacity, workforce supply, institutional culture), the advocacy and interests of key stakeholder groups (including ethnic community groups and party political groups), and the available evidence and research.

At the operational level, interpreting in healthcare is a complex communicative interaction between provider, interpreter and patients; parties which have unequal power relations and each of which has their own socially and institutionally mediated values, demands, beliefs, expectations and goals.

These factors consciously and unconsciously shape each encounter. Thus, as Angelelli notes:

> '..interlocutors bring their own set of beliefs, attitudes and deeply held views on interpersonal factors, such as gender, race, ethnicity, and socio-economic status, all of these get enacted. The interpreter…. also brings her own set of beliefs, attitudes and deeply held views that are constructed, co-constructed and re-enacted within the interaction.' (Angelelli 2008, p 149)

Contextual Policy Determinants in the Australian context

Mainstream Healthcare Policy, Budgets and Systemic Factors

In the period since the 1970s when multicultural policy was proclaimed by the Australian federal government, the mainstream healthcare context has undergone a series of shifts which in turn have impacted upon multicultural health and interpreter policy.

The early seventies was a time when policy was concerned with distributional goals seeking to redress social disadvantage, extend the rights of minority groups and improve participatory democracy. Migrant rights groups and community lobby groups advocated for mainstream health service changes to improve equity and access (Garrett & Lin 1990). The introduction of universal health insurance and the development of the community health program were arguably the two most significant health care changes. It was during this period of mainstream healthcare upheaval, that multicultural and interpreter policies and services were conceived and developed (Garrett & Lin 1990). In many respects they developed in response to advocacy rather than evidence (Kelaher & Manderson 2000). Policy was generally enshrined in service guidelines and protocols rather than regulation or legislation.

In the 1980s the mainstream policy focus shifted to a concern with equity and efficiency (Eagar et al 2001). Policy focused on de-institutionalisation and on means of improving coordination and integration.

By the 1990s the accelerated efficiency drive led to a concern about the quality and effectiveness of health interventions (Eagar et al 2001). Fiscal availability in health services had tightened, in response to the rising costs associated with increased demand, population ageing, wage increases and increasing costs of technology (Sax 1990). As health care budgets tightened, so too did the budgets of interpreter services, affecting the reach, scope, flexibility and effectiveness of the service. Some interpreter services responded by introducing operational policies such as fee charging for selected services or facilities or capping of particular service types. Others limited their service provision to the public hospital sector and carefully prioritised interpreter calls in terms of their perceived urgency or complexity. The relative priority of interpreter provision in community health or outpatient settings versus acute hospital care was debated with priority inevitably being given to Emergency Department requests for interpreters. Distance technologies such as telephone and tel- and video- conferencing were sometimes employed to improve efficiency and reach. However, the supply of interpreters remains outstripped by the demand (Garrett et al 2008b).

In this most recent decade, health care policy has promoted effectiveness, health outcomes, performance monitoring, quality and patient safety (Lazarus

1998; Lapsley 2000). Patient safety has been the most prominent policy concern and evidence has been required as the basis for investment.

However, in the healthcare interpreter and multicultural health field, evidence has been limited and uneven (NHMRC 2005). The important relationship between language services and patient safety remains unstudied in the Australian context. The impact of interpreter services in preventing disparity based on race or ethnicity has not been examined. Thus, in the last decade, a disjuncture has arguably emerged between the driving policy ideals of the mainstream (patient safety) and the goals and ideals of interpreter policy (access and equity).

Stakeholder Policy Determinants in the Australian context

The NES Patient Factors Influencing Interpreter Policy

Over half a million people in Australia (561,413) or 2.8% of the total population speak English not well or not at all, according to the most recent population census (ABS 2006). Being unable to proficiently speak English is associated with a range of social factors which may be critical in a highly structured hospital environment. Aside from being unable to negotiate complex institutions such as hospitals alone, the non-English-speaking patient is likely to have a lower income and to experience poorer health status (Kliewer & Jones 1997). It has also been suggested that non-English-speaking patients have poorer health outcomes (Smedley et al 2003), although this has not been tested in the Australian context.

The Australian non-English-speaking population is highly diverse in terms of their countries of origin, languages spoken, proficiency in English, religions, length of residence, and education levels. The health status of immigrants can vary as a function of age, socioeconomic status, language proficiency, and settlement issues (Kliewer & Jones 1997). For example, poor English proficiency has been associated with poorer health and greater use of medical services (Kliewer & Jones 1997).

Many studies report that language barriers decrease equity in healthcare by reducing access to healthcare services including primary care and emergency department care. Further language barriers have been reported as reducing patient understanding and involvement in decision-making, and decreasing adherence to treatment, including medications (Derose & Baker 2000; Ferguson & Candib 2002; Fiscella et al. 2002).

A fundamental policy concern must be improving the health literacy (within the Australian context) of patients with limited English proficiency. Improving health literacy needs to be carefully targeted, ongoing and employ a large variety of educational and information methods.

Mainstream Provider Factors

Mainstream providers in 'western' healthcare services undoubtedly operate within a paradigm which has been termed 'biomedicine'. Good argues that 'clinical narratives' or 'therapeutic plots for patients' are created and shaped through assumptions about the role, obligations and conceptions and responses of both patient and provider (Good 1995, p. 464). Clinicians learn to 'read the unfolding medical plot determined by disease and patient response' (Good 1995, p. 464). That is, that mainstream providers construct and then represent the patient's condition and this is then enacted within the patient-provider-interpreter interaction.

Where an encounter is inter-cultural, encounters are inherently more complex. Much has been written about the great potential for miscommunication with patients with limited English proficiency, derived from diverse beliefs and behaviours, language barriers and cultural differences (Parsons 1990; Stuart et al 1996), problems in understanding medical language (Bourhis et al 1989), differences in gender, class and power (Kaufert & Putsch 1997), racism, bias and stereotyping (Ferguson & Candib 2002; Johnstone & Kanitsaki 2008), and divergent consumer and provider roles, preferences and expectations (Cortis 2000). Language barriers and the approach to facilitating communication are arguably the most fundamental of these issues in the case of the non-English-speaking patient (Flores 2005; Karliner et al 2007). The negative consequences of poor inter-cultural communication may include inappropriate use of health services, incorrect diagnosis, non-compliance, dissatisfaction, poor rapport, and the patient feeling fearful and desperate (Ferguson & Candib 2002; Meeuwesen et al 2006).

A literature review on intercultural doctor-patient communication found that doctors showed lower levels of positive affect when interacting with ethnic minority patients and that ethnic minority patients were less verbal, assertive and affective in intercultural communication (Schouten & Meeuwesen 2006). A study in the Netherlands, found that the interview time spent with Dutch patients was longer compared with immigrant patients, that immigrant patients showed greater compliance and agreeability with their General Practitioner, that doctors gave more medical advice to immigrants, yet were more empathic towards Dutch patients, and that doctors were less affective towards immigrants (Meeuwesen et al 2006). In another study, minority patients were found to be less likely to engender empathy, establish rapport, receive adequate information, or participate in decision-making (Ferguson & Candib 2002). Intercultural medical consultations resulted in more misunderstanding, less compliance, less participation and less satisfaction than in intra-cultural consultations, although most reviewed studies did not directly assess the relationship between communication and outcomes (Schouten & Meeuwesen 2006). Studies of this type have not been conducted in the Australian setting so the degree of transferability of these findings is uncertain.

Cultural similarities between provider and patient, particularly in terms of language and physical appearance have often been cited as facilitating the clinical relationship and improving agreement, accessibility and outcomes (Powe 2004; Chen et al 2005). The importance of bilingual professionals has been cited in studies (Johnson et al 1998). However, the poor match between the languages represented in the bilingual workforce and the languages of patients has also been a consistent finding.

The factor that can significantly affect the patient-provider relationship is the cultural competency of the provider, service and organisation (Garrett et al 2008a). Culturally competent care relates to behaviours, attitudes and policies that support a negotiated process of appropriately caring for people across languages and cultures (Cross et al. 1989). The cultural competency of providers must be a formative element in any healthcare interpreter policy.

Interpreter Provider Factors Influencing Interpreter Policy

Language facilitators, whether they be professional interpreters, family or bilingual staff, provide a necessary and empowering communication bridge for the patient with limited English. However, healthcare language service

provision is fraught with vexing issues such as the accuracy of interpretation or of cultural interpretation, issues associated with confidentiality and trust, the potential for bias related to cultural, political or familial affiliation, queries about the appropriate roles and responsibilities of interpreters and concerns regarding both the healthcare provider's and the interpreter's legal and ethical duty of care (Vasquez & Javier 1991; Ozolins 1993; Angelelli 2008).

The diverse and increasingly complex roles of professional interpreters in the health care setting has been noted. This complexity is in part derived from the range of interpretation modes, including face-to-face, remote, telephone and tele- or video-conference linkage; further, interpretation may be simultaneous or consecutive. A large literature exists on possible interpreter roles, ranging from a neutral conveyor or renderer of the spoken word, cultural and linguistic broker, gatekeeper or powerful mediator between the parties, advocate for the healthcare provider, and advocate for the powerless non-English-speaking patient (Martin & Valero- Garcés 2008; Hale 2008). Such roles are inevitably mediated by individual interpreter preferences and professional standards, and, as outlined in the model of interpreter policy, by the social and institutional factors influencing other aspects of interpreter policy.

The roles and responsibilities of interpreters may be referred to in policy documents, for example, the NSW Standard Procedures for the Use of Health Care Interpreters (NSWHealth 2006). This policy defines interpreters as responsible for 'the oral transmission of speech from one language to another'. However, this conception of the interpreter role as a 'communication conduit', what Davidson terms 'neutral machines of semantic conversion' (Davidson 2002, p379) and Angelelli terms 'language converter' (Angelelli 2004) has been vigorously contested in the recent literature (Valero Garcés & Martin 2008). Several studies have demonstrated through methods such as sociolinguistic and discourse analysis that interpreters, both consciously and unconsciously, exercise considerable agency and influence in the process of constructing and facilitating communication between provider and patient (Davidson 2000; Davidson 2002; Angelelli 2008). Thus, interpreters have the capacity to influence, or at least shape, the outcome of interpreted interactions in the medical setting. Clearly, interpreters, as the mediator in the interaction, comprehend the interactive discourse through their own perceptual and cognitive lenses, thus resulting in a representation, which is influenced by a complex myriad of personal, professional, contextual and socio-cultural factors. Values, attitudes, experiences and expectations may all, for example influence the perception, construction and representation of communication.

Both professional and non-professional interpreters have been found to participate in keeping interviews moving and in constructing an outcome, which matches their own understanding of the institutional goals and expectations (Wadensjo 1998). One study found that interpreters had an overall tendency to reduce what is being said, by omitting, revising or reducing the content in the interaction. Further it has been found that there was very little social talk or small talk when an interpreter was involved (Aranguri et al 2005). Some US studies have questioned the correctness of interpretation in the medical setting (Baker et al 1996; Karliner et al 2007).

Yet, distinctions must surely be made between the professional interpreter, in Angelelli's terms, 'bringing the self' to the encounter (Angelelli 2004), interpreters working to professional norms and expectations, interpreters

facilitating information provision and, on the other hand, interpretation that is clearly inaccurate or widely divergent from the patient or provider's communicative intent or where the interpreter even takes over the provider's role. While recognising that all communication is subjectively constructed, it is important that relativistic perspectives do not prevail to such an extent as to render the professional interpreter's role as irrelevant.

Addressing this complexity of issues requires self-aware, professionally accredited, highly trained and accountable healthcare interpreters who transparently and purposefully discuss and agree upon the interpreting approach with both provider and client. At the institutional and professional level, the expectations need to be clarified in interpreter policy. Leading commentators in the translating and interpreting field have noted this gap between such research findings and the policy documents in respect of the role of interpreters (Angelelli 2008).

Effectiveness of Interpreter Services – The Evidence and Research

There have been very few published Australian studies discussing interpreter services or the usage of healthcare interpreters. In general the sample sizes in such studies are very small, and in two studies the usage of interpreters is assessed by surveying staff (Heaney & Moreham 2002; Giacomelli 1997), a method which may not elicit reliable results as it relies on staff identifying the need for an interpreter. Kazzi and Cooper (2003) in a cross-sectional study of interpreter usage in paediatric emergency cases mailed translated questionnaires to non-English-speaking parents, with non-respondents being followed up by a telephone survey undertaken by an interpreter. They found that of 131 respondents who identified themselves as requiring an interpreter, 47 (36%) received a trained interpreter and 55 (42%) an 'adhoc' interpreter (family or friends). Less than half of these respondents were identified by Emergency Department (ED) staff as needing an interpreter.

Garrett et al (2008b) in a study using a patient survey and medical record review, with 258 respondents, similarly found that only about a third of patients with limited English had actually used an interpreter in hospital and that only about half of those who spoke limited English reported that they were offered an interpreter in hospital. They found that usage of interpreters was particularly limited in the ED, with only 13% of ED patients using a professional interpreter. The study found that about 60% of those patients who were admitted to the hospital had used an interpreter. Most patients, whether they were admitted or emergency department patients, saw an interpreter only once during their hospital stay. However, the likelihood of receiving an interpreter increased significantly with the increased clinical complexity of patients. For many patients, interpreters sorted out problems at some point in their hospital stay (Garrett et al 2008c).

The high rate of usage of family and friends as interpreters has been a consistent finding in research studies (Garrett et al 2008a; Kazzi & Cooper 2003; CEH 2006). Forty eight percent of the patients in one study advised that they would prefer to use family and friends to interpret (Garrett et al 2008b).

An unpublished literature review undertaken by the Centre for Multicultural Health, UNSW, reports a number of operational and managerial challenges in providing interpreter services. Inefficient booking systems, inadequate interpreter availability, provider perceptions that interpreters are difficult to attain, the patient's inability to directly book an interpreter, patient preferences for family or friends as their interpreter, and the lack of flexibility of the interpreter service were factors cited as potentially

mitigating against optimal usage or monitoring of interpreter services (Centre for Multicultural Health 2003). Such systemic issues need to be addressed in operational policies.

Although quality Australian studies in interpreter effectiveness are sparse, a number of recent seminal international studies have associated professional interpreter usage with increased patient satisfaction, improved patient understanding, greater patient participation in decision-making, high levels of compliance by patients with recommended treatments, improved access by patients to services, and fewer medical errors (Karliner et al 2007; Timmins 2002; Jacobs et al 2001; Flores 2003). Thus, the overall significance and effectiveness of the professional interpreter service is not at issue.

Rather, a key question in relation to interpreter service effectiveness in the Australian context is the service reach and availability and the extent to which policy is meeting the basic requirements of key stakeholders.

Conclusion

Understanding the diverse perspectives of each of the major stakeholders is clearly fundamental for effective healthcare interpreter policy. For the patient, policy needs to broach issues associated with health literacy, the role of the family in brokering language barriers, service access and their healthcare safety. For the provider, cultural competency, particularly enhancing skills in inter-cultural communication, is fundamental. For the interpreter, clarification of role expectations is essential.

The review of evidence related to interpreter service effectiveness indicates that systemic changes may be needed at an operational level to maximise the reach and availability of the service. This might include extended usage of technology, selectively changing the mode of communication (e.g. less face-to-face interpreting and more telephone interpreting) or improving interpreter budgets.

The further development of interpreter services may be hampered by a lack of substantiating research and evidence. Improving the (Australian) evidential base for interpreting services would place interpreter policy on a firmer footing within mainstream healthcare. Further, effective interpreter policy might wisely base its discourse and purpose firmly within the mainstream discourse on patient safety. This would improve the opportunities for interpreter service developments within the current tight fiscal environment.

In summary, there is a complex array of determinants in the interpreter policy arena. The Model of Interpreter Policy (Figure 1) provides a useful means of conceptualising these policy determinants. The model highlights the interactive impact of diverse stakeholders, including the non-English-speaking patient, the provider and the interpreter, interwoven with healthcare institutional and broader social factors.

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