

Reducing Language and Cultural Barriers

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A prerequisite for quality medical care is effective communication between patient and caregiver. Nearly half (48.6%) of all U.S. physicians in 2008 reported that difficulty communicating with patients because of language or cultural barriers was at least a minor problem affecting their ability to provide quality care, though less than 5 percent viewed it as a major problem. The failure of physicians to address communication barriers, coupled with the potential ineffectiveness of measures taken, may contribute to disparities in the quality of care across racial and ethnic groups.

Interpreter services: An ever-increasing number of people in the United States speak a language other than English at home (56 million people aged 5 and older in 2008, 44% of whom reported they speak English less than “very well”). These facts highlight the need for interpreter services to improve the quality of care for patients with limited-English proficiency.

Moreover, providers have legal obligations to provide needed interpreter services, at least for patients with public insurance. While nearly 97 percent of physicians have at least some non-English speaking patients, only slightly more than half of physicians (56%) were in practices that provided interpreter services in 2008. Of physicians in practices that provided interpreter services, 44 percent were in practices that offered interpretation in only one language, 16 percent were in practices offering two languages, with the rest in practices providing interpretation in three or more languages, including telephonic translation services.

Interestingly, among physicians with patients who speak different languages, those in practices providing interpreter services were more likely to report communication difficulties than those without access to interpreter services, even after adjusting for the percentage of minority patients treated. While this may reflect greater demand for interpreter services among practices experiencing language barrier problems, it also may indicate that interpreter services are not always readily available or are inadequate. Nearly one in five physicians (18.8%) reported being unable to obtain interpreter services in the past 12 months that they believed were medically necessary. Moreover, of physicians reporting that their practices provided interpreter services, it is unclear how many provide professional interpretation services, as opposed to using staff members who may be less than fluent in the language, unfamiliar with medical terminology or unaware of cultural nuances.

Non-English, written patient-education materials: Low health literacy—defined as limited capacity to obtain, process and understand health information and services needed to make appropriate decisions—is associated with less use of preventive services, more frequent hospital and emergency department visits, and poorer health. Minorities, particularly those not proficient in English, are disproportionately represented among individuals with low health literacy.

Although other care management practices have been found to be more effective than written materials in educating and engaging patients in their own self-care, physicians can help promote health literacy by providing patients with written information about their conditions and self-care instructions.

Offering patient-education materials in appropriate languages for patients with limited-English proficiency also can promote health literacy. Among physicians in practices treating patients with any of four prevalent chronic conditions—asthma, diabetes, congestive heart failure and depression—72 percent in 2008 reported their practice provides patient-education materials for at least one of the four conditions. Yet, only 40 percent of physicians in these practices reported providing patient-education materials in languages other than English for at least one of the conditions.

Physician training in minority health: Culturally competent care emphasizes comprehension of cultural differences and the interaction with individuals' health expectations and behaviors, disease incidence and prevalence, and treatment outcomes. The goal of minority health education is to develop practitioner skills to tailor care to patients' culturally unique needs. Roughly four in 10 physicians in 2008 reported they received some training in minority health, such as cultural competency training, through professional meetings, workshops or continuing medical education courses. However, the survey question did not assess the nature of the training, its comprehensiveness or how recently it was received. Although more likely to have received training in minority health than other physicians, only half of physicians in high-minority practices (defined as 50% or more minority patients) had received such training.

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