Children's Hospital of Philadelphia
PolicyLab

Healthcare Equity for Children and Families with Limited English Proficiency

Health Equity

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Image

This blog is adapted from a Children's Hospital of Philadelphia (CHOP) Grand Rounds talk given by PolicyLab's Katherine Yun, MD.

Thanks to Medicaid and the Children's Health Insurance Program (CHIP) – two types of public health insurance – and community health centers, most parents, even those with limited means, are able to call their primary care office to get advice or schedule an appointment. But what about parents who don't speak English? Are they able to get health care for their children when they need it? Do their children receive high-quality care? If not, what should be done?

Nearly one in four U.S. children has at least one immigrant parent, and one in six (16%) has at least one parent who has difficulty speaking English. Parental language barriers are particularly common for children of Latino (48%) and Asian heritage (40%), as well as children living in poverty (27%). Of the approximately 14 million people in the U.S. who speak very little or no English, the majority speak Spanish (10 million people). The remaining 4 million speak hundreds of different languages from all corners of the world.

Impacts on Patient Care and Research

Children and families who speak little to no English receive worse patient care as a result of communication barriers. Although professional interpreters are easy to contact via the phone or Internet, providers and staff often receive little or no training in the efficient use of interpreter services. Some facilities continue to turn children away if they are unable to bring a family member or friend who can interpret for them. In primary care settings, parents who speak little English are less likely to receive appropriate anticipatory guidance (information about keeping children healthy).

Families who don't speak English well are also more likely to be excluded from research studies. This is often because researchers haven't been trained in including these families. Sometimes there are concerns about the added cost of interpreters or the validity of results with "different" populations. This is ironic since many of these same studies are aimed at improving care and services for vulnerable or marginalized children and families. It also challenges us to reflect on ethical questions related to justice, which calls for both the burdens *and benefits* of research to be equally distributed across the population. Excluding these families from research also affects the quality of the science. In a survey of researchers studying patient-doctor communication, the majority of researchers excluded patients with limited English proficiency (LEP). Of the researchers who included LEP patients, one third said their study results would have been different had they not included these patients.

What should be done?

Our first step should be to reframe our thinking. There isn't a "right number" or "acceptable number" of children who can receive poor care or be excluded from the benefits of research. Instead, we need to embrace a new way of thinking. If there is a "right number" it should be zero. And responsibility should lie with the health system to achieve this goal. Patient safety, which includes language access, should be inherent to health systems, not considered an "add on." This can be done by thinking about the hospital as an ecosystem and not just focusing on one piece. It is a system in which every single aspect is important.

What does this mean in practice?

Training in language access should extend to all members of the health care team, including secretaries, telephone operators, and other frontline staff. This kind of training emphasizes direct, clear, plain language communication, which helps make English-language communication better as well. Hospitals should also invest in visual wayfinding (e.g., universal signage) as part of facility design. These investments make the hospital more welcoming for all patients, not only those with communication barriers.

We also need to look at the regulatory system for health care research with a fresh eye. Rules that are intended to protect patients from exploitation are critically important, but we must be careful to make sure that they don't end up being exclusionary. One example of this is the "witness requirement" for short-form consent (a type of informed consent for research that uses a shorter written form). When adults who don't speak English complete a short-form consent with assistance from a telephonic interpreter, an *additional* bilingual adult who is not affiliated with the research study is typically required to serve as a witness. This places an additional and often unsurmountable burden on the potential research participant even if the individual would like to enroll in a low-risk study with potential for direct benefit. It also disproportionately impacts individuals who speak less common languages for which in-person interpreters are less readily available (often individuals of African or Asian origin).

These suggested changes to the health care system and regulatory system for health care research are just a few changes that could have a significant impact on achieving health equity for all.

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