

In March 2010, a law called Patient Protection and Affordable Care Act (also known as Obamacare) reformed certain aspects of the private insurance industry and public health programs, including access to Medicaid insurance to over 30 million Americans. However, a majority of the States, in addition to numerous organizations and individual persons, have filed suit in federal court challenging the constitutionality of this Act. The Supreme Court is scheduled to review the matter in March 2012.

The largest public systems are Medicare and Medicaid. Medicare is a social insurance program for the elderly, some of the disabled under 65, and those with end-stage renal failure. It is administered by the federal government and financed through a combination of payroll taxes, general federal revenues and premiums. It covers 13 percent of the population. Medicaid is an entitlement program for the poor, administered by the States within broad federal guidelines. It covers 12 percent of the population. Additionally, it is estimated that 40 million citizens have no health insurance coverage. Most of these would become Medicaid eligible if the Supreme Court upholds the constitutionality of Obamacare.

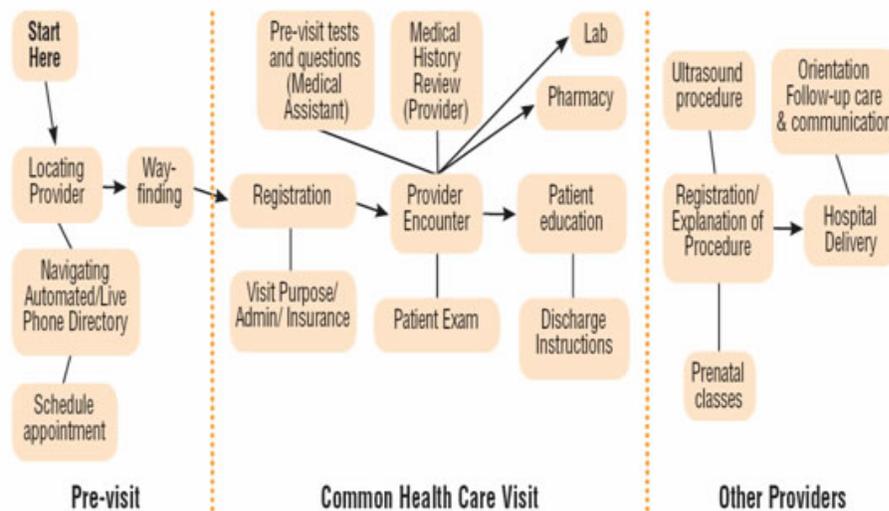
 **Table 2. Sources of Health Insurance Coverage, 2008**

	Age Group			
	Under 19	Under 65	65+	All Ages
Population (millions)	78.7	263.7	37.8	301.5
Type of Insurance				
Employment-based	60.0%	63.3%	35.5%	59.8%
Private Nongroup	5.1%	6.3%	26.7%	8.9%
Medicare	0.8%	2.9%	93.4%	14.3%
Medicaid or Other Public	29.7%	14.9%	9.1%	14.1%
Military or Veterans' Coverage	3.0%	3.3%	7.5%	3.8%
Uninsured (percent)	10.3%	17.3%	1.7%	15.4%
Uninsured (millions)	8.1	45.7	0.6	46.3

Lets talk for a moment about emergency rooms, which in America are legally obliged to see all patients who enter their doors, regardless of their ability to pay. The number of patients coming to emergency departments has been steadily increasing, not only because the number of uninsured has been growing and using the emergency room every time more frequently, but also because insured patients who have no quick access to regular doctors are also showing up. This includes older people, who represent the fastest growing population of emergency room visitors. It has recently been said that up to 120 million people visit emergency rooms every year. Not only are emergency rooms overburdened but also, additionally, almost 20 million of these patients will be individuals who do not speak English as their primary language. This is the case throughout the entire system of healthcare.

According to the US Census Bureau, over 20% of the population, about 50 million, speak a language other than English at home. These figures may be as high as 40% in some States. Insurance companies and hospitals try to provide medical information in various languages, especially Spanish and Chinese, but also in 150 other languages.

The barriers that non-English speaking patients encounter in healthcare are not limited to linguistic difficulties. Patients lack experience with health care terms, concepts and procedures, specially the bureaucracy attached to many medical encounters. They are afraid of or don't understand diagnosis, don't understand the concept of the pain scale, are ignorant about the legal aspects of informed consents, cannot read with proficiency, even in their mother language, to name but a few. There are also many cultural barriers related to participation in a healthcare encounter, aggravated by systemic barriers that prevent easy access to the services they need.



Website for this image: hablamosjuntos.org - junctures.jpg

These barriers in communication result in difficulties to establish an adequate relationship between the healthcare provider and the patient, which may directly impact diagnosis, misunderstanding of needs, incorrect assessment of medical history, plan of care, prescription of medications, and follow up recommendations, and a myriad of other non-desirable results. Many times these will result in repeat ER episodes, especially with children.

Title VI of the Civil Rights Act of 1964 states that, “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” Federal guidelines are in place to ensure that recipients of Federal financial assistance avoid violation of Title VI's prohibition against national origin discrimination by making accessible to limited English proficiency individuals all those programs and activities normally provided in English. Entities covered include any and all that directly or indirectly receive grants, training, use of equipment, donations of surplus property, and other assistance from the Federal government (most hospitals, for example, and most state and local agencies, nonprofits and other organizations).

Executive Order 13166 was signed in the year 2000 by president Clinton to improve access to services for persons with Limited English Proficiency, known as LEP individuals, and defined to be those persons whose primary language is not English and whose ability to read, speak, or write English is limited. This Executive Order was meant to clarify the requirements under Title VI, ensuring that recipients of Federal financial assistance provide meaningful access to their LEP applicants and beneficiaries.



Federal Register

Wednesday,
August 16, 2000

Part V

The President

Executive Order 13166—Improving Access to Services for Persons With Limited English Proficiency

Department of Justice

Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons With Limited English Proficiency; Notice

The goal of all language access planning and implementation is to ensure that there is an effective communication with Limited English Proficient (LEP) individuals, which requires ensuring effective communication at all points of contact between an LEP and the provider

To assist Federal agencies in carrying out these responsibilities, the U.S. Department of Justice issued a Policy Guidance Document, *"Enforcement of Title VI of the Civil Rights Act of 1964 - National Origin Discrimination Against Persons With Limited English Proficiency"* (LEP Guidance). In May 2011 it also issued the Planning Tool for Language Access Assessment for all Programs that receive Federal Assistance.

Additionally, all 50 states now have laws that address the issue of language access in health care settings and many individual localities also have provisions requiring language services for LEP individuals. Seventeen states have language access laws addressing insurance providers and/or managed care organizations. Many private providers of healthcare and medical services have already implemented – or are in the process of doing so - Policies and Procedures on Language Access for Limited English Proficient (LEP) Patients and Families.

Language Competency

Past President of IMIA, Izabel Arocha, summed the need for language competency as follows: “Language permeates all areas of the hospital. It serves all departments and is not a separate service. Everything is affected by language access. Language services need to be accurate for patient safety. There is liability for hospitals that do not have interpreters. Health outcomes are related to communication errors.”

In the U.S., language competency in the medical setting is not an option but a requirement. The U.S. regulates that any patient that walks into any hospital in the U.S. who does not speak English must receive language assistance. That is the law. “A patient should be able to walk into any hospital in the U.S., and if he doesn't speak English, he must receive language assistance.” (Marty Conroy, Manager, Public Health Initiatives, Language Line Services.) However, although a lot has been accomplished in the last two decades, there is still a long road ahead. Quoting Alvaro DeCola in *Making Language Access to Healthcare Meaningful*: “As the non-English speaking population of the United States has increased, the gap in communication between linguistic minorities and health care providers has become more evident. Current regulations ensuring interpreter access for language minorities are unenforceable and have become a burden to health providers as well as LEP patients. Compounding the problem, the lack of national standards for health care language interpreters increases the likelihood of misdiagnosis and miscommunication.” This is where we are, and moving forward in many fronts.

One of the best resources to understand all the above is the website “LEP.gov” as it “promotes a positive and cooperative understanding of the importance of language access to federally conducted and federally assisted programs.” I recommend you visit that site.

