Editorials

Addressing language as a barrier to healthcare access and quality

INTERNATIONAL MIGRATION, LINGUISTIC DIVERSITY, AND COVID-19

International migration has increased rapidly over the past 20 years, with an estimated 281 million people living outside their country of birth.[1] Similarly, migration to the UK has continued to rise over this period; current annual migration is estimated to be >700 000 per year (net migration of >300 000).[2] With migration comes linguistic diversity, and in health care this often translates into linguistic discordance between patients and healthcare professionals. This can result in communication difficulties that lead to lower quality of care and poor outcomes.[3] COVID-19 has heightened inequalities in relation to language: communication barriers, defined as barriers in understanding or accessing key information on health care and challenges in reporting on health conditions, are known to have compounded risks for migrants in the context of COVID-19.[4] Digitalisation of health care has further amplified inequalities in primary care for migrant groups.[5]

LANGUAGE CHALLENGES IN PRIMARY CARE

There have been substantial reductions in funding for English language course provision over the past decade, and associated challenges in meeting demand for English language learning.[6] This has put increased pressure on public service providers to ensure that all patients receive the same level of access and care to avoid perpetuating inequalities. The UK's Equality Act 2010 places a legal duty on the NHS to reduce inequalities between patients with respect to their ability to access health services. Guidance for primary care states that *'patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others.'*[7]

This is also reflected in guidance from the General Medical Council that *'Doctors have a duty to make all possible efforts to ensure effective communication with their patients.'*[8] This includes eliciting patient preferences for communication and ensuring the patient understands what is involved from booking an appointment, having the consultation, and any follow-up appointments or investigations.

Existing evidence in the UK shows that there are several ways in which access to primary care may be challenging for people with limited spoken English language proficiency. People who do not speak English well report greater barriers to accessing primary care than those who do,[9] have a poorer patient experience,[10] and are more likely to be in poor health.[11] Interpreting services (including in-person, telephone, and video interpreting) are currently provided under the Interpretation and Translation Services framework agreement, as one of the possible ways to mitigate language barriers and to ensure patients, carers, and clinicians understand each other. Yet, despite a wealth of evidence that the use of professional interpreters is beneficial for patient experience and outcomes,[12-13] our understanding of interpreting services, in terms of how they are implemented and how they are experienced by patients, is limited.

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This means that although principles for how primary care should commission services have been proposed (for example, provide access free at the point of delivery with options for online systems and longer consultations, and responsibility for booking interpreters),[7] they are not always based on scientific evidence on how interpreting services are currently used or implemented, and are targeted at commissioners rather than people using these services.

EVIDENCE ABOUT INTERPRETING SERVICES

Worryingly, we know that interpreting services in primary care are underused in relation to the need for them,[14] despite primary care being the first point of access when people are unwell or experience symptoms. A more detailed understanding of the use and experience of interpreting services in this context is a crucial step to address limited language proficiency as a barrier to healthcare access, which will reduce inequalities in health.[15]

As a response to the limited empirical evidence/literature on this topic, we have recently conducted pilot work with people with limited English proficiency in South Asian communities across the UK. This revealed that difficulty requesting language support, worry about putting strain on the healthcare service, and lack of confidence in discussing health concerns with an interpreter are common barriers to accessing primary care. We also found evidence that the practice of informal interpreting, such as relying on a patient's children or other family members to mediate the communication, prevails, although it has long been shown to be associated with a greater number of errors than professional interpreting, and lower physician and patient satisfaction, as well as raising confidentiality and ethical concerns.[16] Our finding that patients prefer to rely on family and friends despite investment in professional interpreting services has ethical, financial, and clinical implications, which require further understanding.

Evidence also demonstrates that there is significant variation in how clinical commissioning groups (CCGs) in England and Wales implement interpreting services.[17] We suggest that there needs to be up-to-date guidance, based on systematically collected and appraised evidence, for decision makers and professionals involved in the provision of language support in health care, such as commissioners of language services, healthcare professionals, and professional interpreters. We also need these professional groups to be supported to act in more inclusive, linguistically and culturally sensitive ways while harnessing the benefits of the digital transformation in the NHS to enable them to make decisions based on the best available evidence. This could include technology-based training in (mediated) clinical communication alongside upskilling in intercultural competency, for example, by following guidance on the health needs of migrant patients[18] or specific guides for professionals that demonstrate good practice.[19-20]

This editorial focuses on limited spoken English proficiency as a barrier to accessing primary care especially for migrant populations, but similar points could be made about removing barriers to accessing written documents and about the importance of understanding and meeting the needs of other groups such as people who are D/deaf, blind, or deafblind, for whom COVID-19 has introduced additional challenges. For example, mask mandates, alongside the lack of availability of transparent masks, has led to unacceptable communication challenges for patients and healthcare professionals, as well as leaving communities feeling isolated and overlooked.[21] We would therefore like to take this opportunity to highlight the Accessible Information (DCB1605) standard, which aims to make sure that people who have a disability, impairment, or sensory loss get appropriate information and communication support from healthcare services.[22]

While there are many stages through the patient life cycle where inequalities exist, improving our understanding of interpreting provision, as well as driving change at policy, practice, and education levels, will be crucial in facilitating access to health care for linguistic minorities in the UK. Ultimately, language-based and other inequalities need to be considered in a consistent approach. As a step towards this, the focus on language support through interpreting provision for migrant populations can inform, as well as be informed by, approaches adopted for other groups where communication difficulties exist.

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