Improving the Health and Health Care of Non-English-Speaking Patients

We know very little about the health status and health care of the 14 million people in the United States who do not speak English well. We do know that Latinos and Asians constitute the largest portion of non-English-speaking patients, and they usually are in good health when compared with their English-speaking counterparts. By classifying patients in broad ethnic categories, however, we may overlook significant health issues for subgroups defined by country of origin, English proficiency, culture, length of time in the United States, educational level, employment status, or income level. For instance, Hayes-Bautista and colleagues found that Latinos in California had higher death rates than Anglos from motor vehicle accidents, cirrhosis, and diabetes.[1] Arcia found that Latino parents were much more likely to report that their children were in poor health than non-Latino parents.[2] Asians have higher rates of potentially preventable diseases, such as tuberculosis, hepatitis B, liver cancer, and lung cancer, than other ethnic groups in the United States.[3–5] Moreover, from 1992 to 1993, the incidence of AIDS was increasing more rapidly among Asians than among other ethnic groups in the United States.[6] Non-English-speaking Latinos and Asians are least likely to have been included in existing health statistics and most likely to have health problems requiring attention. Almost no information is available concerning the health status of other non-English-speaking populations.

Non-English-speaking patients receive fewer preventive services and have less access to care than English-speaking patients. Reviewing the literature, Flores and Vega found that lack of health insurance and lack of a regular source of care were the main barriers preventing access to care for Latino children.[7] Perez-Stable and colleagues, however, found that fewer Latinos than Anglos had cancer screening tests, even in a prepaid health plan in which financial considerations were presumably not an issue.[8] The use of ethnic media,[9] as well as intensive community outreach, can increase the use of preventive services among non-English-speaking patients.

Aside from the delivery of preventive services, little is known about the quality of care for non-English-speaking patients in the physician's office. The article by Tocher and Larson in this issue begins to fill that void.[10] Tocher and Larson found that the length of an office visit did not differ between non-English-speaking and English-speaking patients. Of particular interest is the fact that physician perception of the length of the visit did differ, with physicians reporting longer visits with non-English-speaking patients. The strength of this study lies in its careful and detailed assessment of visit length and the inclusion of the physician perspective. The study, however, only begins to examine important issues related to the health care of non-English-speaking patients. In particular, no attempt was made to measure the quality of patient care. This information is necessary to assess whether the length of the visit *should* differ for non-English-speaking patients.

It is difficult to believe that equal time translates into equal care for non-English-speaking patients. In fact, over 90% of physicians in the Tocher and Larson study perceived that they needed more time with non-English-speaking patients. In a previous study, however, Tocher and Larson found no relation between the quality of care for diabetic patients and their ability to speak English,[11] and this result might occur when there are extensive interpreter services. Similar studies need to be conducted in other settings involving patients with varied conditions.

To improve the health of non-English-speaking patients, we need to understand more about them. One report found that 40% of studies concerning patient-physician interactions excluded non English-speaking patients, limiting the generalizability of their results.[12] Many patient-satisfaction surveys sponsored by health insurance plans exclude non-English-speaking patients. Specific studies focused on non-English-speaking patients are needed to understand better the impact of cultural norms and expectations on the patient-physician interaction and to identify factors affecting the outcomes of care, including functional outcomes, biological health status, patient satisfaction, and health care costs. Even if the *efficacy* of a treatment is not related to a patient's ability to speak English, the *effectiveness* of treatment may suffer when patients do not understand follow-up instructions.

Because Hispanics and Asians are the fastest growing segments of the U.S. population, the number of non-English-speaking patients in the United States can be expected to increase. In fact, by the year 2015, 40% of the population of California is projected to be of Hispanic origin and 17% of Asian origin. At the same time, there is growing dissatisfaction with the quality of patient-clinician interactions and increased pressure on physicians to see more patients per hour. If, as Tocher and Larson have found, physicians perceive that non-English-speaking patients take more time, they may feel that caring for non-English-speaking patients exacerbates the time pressures. To prevent this, support needs to be provided through interpreter services, improved educational materials, and possibly the allotment of longer visit times in managed care organizations.

Approaches should be tailored to the setting. At the county hospital where Tocher and Larson conducted their study, 22 different languages were spoken. Given the diversity of the non-English-speaking population, we need to use innovative ways to facilitate communication, such as simultaneous translation provided by an interpreter at a remote site linked to headsets worn by the patient and clinician.[13] We also need to distribute educational materials in different languages over the Internet.

To improve the health of non-English-speaking patients, we need to remove the barriers that prevent their access to care, enhance communication between them and health care workers, and involve more non-English-speaking patients as subjects in health services research. The cost of the investment required to accomplish these goals would be offset by future reductions in the cost of health care for non-English-speaking patients.—**DEBORAH A. TAIRA, SCD,** *Beth Israel Deaconess Medical Center, Boston, Mass.*

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