

**Introduction: Health and Human Service
Delivery to Limited English Proficient and
Immigrant Communities: Policy, Management,
and Educational Issues**

Janice Frates^{1,*} and Michelle Saint-Germain^{2,*}

¹Health Care Administration Program and

²Graduate Center for Public Policy and Administration, California
State University Long Beach, Long Beach, California, USA

ABSTRACT

Immigration increased and the immigrant population became much more widely dispersed during the last decades of the 20th century. Many of these new immigrants are Limited English Proficient (LEP) individuals. These demographic shifts, and federal policy initiatives that expanded civil rights legislation of the 1960s, have created new

*Correspondence: Janice Frates, Health Care Administration Program, California State University Long Beach, 1250 Bellflower Boulevard, Long Beach, CA 90840, USA; Fax: 562-985-5536; E-mail: jfrates@csulb.edu. Michelle Saint-Germain, Graduate Center for Public Policy and Administration, California State University Long Beach, 1250 Bellflower Boulevard, Long Beach, CA 90840, USA; Fax: 562-985-4672; E-mail: msaintg@csulb.edu.

service demands for both public and private agencies that participate in publicly funded health and human services programs to accommodate both language and cultural differences of their client populations. The introduction to this special symposium issue of the *International Journal of Public Administration* includes: (1) Overview of demographic trends and service needs; (2) Major federal policy initiatives, stakeholder responses and suggested future policy options; and (3) Key policy, management, and educational issues inherent in delivering health and human services to LEP and immigrant populations and how the authors address them.

OVERVIEW

The 2000 census confirmed that immigration greatly increased both in scope and scale in the last decade of the 20th century, thus impacting more communities and garnering increased attention as a national policy issue. The demographic imperative of a growing and more broadly dispersed immigrant population places new service demands on both public agencies and private organizations that participate in publicly funded health and human service programs. Meeting these challenges, and revamping their services to accommodate limited English proficient (LEP) and immigrant populations, raises a series of interrelated policy, management, and educational issues that the papers in this special symposium issue address. This introduction presents: (1) an overview of the key demographic and service issues facing public managers today; (2) a discussion of key stakeholders' responses to government policy initiatives for improving service delivery to LEP and immigrant populations as well as suggestions for future policy options; and (3) how the authors in this symposium address these issues.

Demographics

The number and proportion of LEP persons across the United States have increased since the 1970s, primarily as a result of legal immigration. Immigration policy changes that expanded the admission ceilings in 1965, 1970, and 1990 and eased the acceptance requirements for political refugees fueled this growth. Undocumented immigration has also grown since the 1970s, to a far greater extent than previously recognized. New analyses of the 2000 census data and the March 2000 Current Population Survey by the Urban Institute and the Immigration and Naturalization



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Service produced revised, higher, consensus estimates of the foreign-born population from 28.4 million to more than 30 million; and of the undocumented immigration population from about six million to about 8.5 million, with 500,000 people added each year.^[1]

Michael Fix, Director of the Immigration Studies Program at the Urban Institute, cited some key statistics on current trends that have particular relevance for healthcare organizations:

- One in nine US residents is an immigrant.
- One in five children in the United States is the child of an immigrant.
- One in four poor children in the United States is the child of an immigrant.
- One in four low-wage workers in the United States is foreign-born.^[2]

The 2000 census revealed not only great growth in the number of immigrants but also some surprising trends about their dispersion. Up until the early 1990s, the majority, almost 75%, of newly arriving immigrants settled in six states: California alone received one third, with the remainder going to New York, Texas, Florida, New Jersey, and Illinois. Starting in the mid 1990s, more immigrants began moving into other states, generally through the middle of the country.

During the 1990s, the foreign-born population in these “new growth states” grew twice as fast (61% vs. 31%) as the foreign-born population in the traditional “big six” immigrant-receiving states. Both documented and undocumented immigrants have also become more geographically dispersed.^[1]

Service Needs

Foreign-born immigrants and their dependents (children and elderly relatives) comprise a substantial proportion of the limited English proficient population. LEP individuals face the highest barriers to accessing and using health and human services. Higher poverty rates and lower educational achievements among some segments of the foreign-born population further impede their ability to understand the United States health and human service systems and to access benefits to which they are legally entitled. However, the biggest barrier by far is language. The US health care system is especially fragmented and confusing, with a plethora of programs and payment systems, and LEP persons frequently find it incomprehensible.



According to the 2000 census, only 67% of the foreign-born population had health insurance coverage for all or part of the prior year, vs. 86% of native-born respondents.^[3] One ironic obstacle may be immigrants' higher rates of participation in the labor force, which disqualifies them for some means-based health programs: 80% of foreign-born men 16 years and older were working in 2000 vs. 74% of native-born men.^[4] Just 45% of foreign-born workers in 1999 had employer-based health insurance vs. 55% of native-born workers, and a higher proportion (19%) of households headed by foreign-born individuals received Medicaid coverage vs. 12% of households with a native-born head. A great many Medicaid beneficiaries are native-born dependents, primarily children, of foreign-born parents. However, these differences appear to decline over time: Naturalized citizens and foreign-born individuals with more than 20 years residency had rates of employer-based coverage similar to that of native-born residents.^[3]

Language barriers also can negatively impact the quality of medical care. A study was conducted of 4200 patients who used urban hospitals in 2000, including more than 600 uninsured LEP and/or Spanish-speaking individuals. Fewer than half (46%) of the LEP respondents received interpreter services; 54% said interpreter services were not available. Of those who felt they needed an interpreter, 25% reported leaving the hospital without understanding how to take their prescribed medications and 74% said they were never asked if they needed assistance paying for their medications.^[5] Earlier studies on language barriers have found that LEP patients are more likely to use hospital emergency rooms and consume more medical resources than other patients, and less likely to use primary and preventive care services, keep scheduled appointments, or take prescribed medications.^[6] A small but intense study of LEP pediatric encounters found that errors in medical interpretation are common and often have potentially adverse consequences, and that ad hoc interpreters make more errors, as well as more errors with more potentially adverse consequences, than trained interpreters.^[7]

FEDERAL POLICY INITIATIVES AND STAKEHOLDER RESPONSES

The anti-discrimination language contained in Title VI of the Civil Rights Act of 1964 prohibits organizations receiving federal financial assistance from discrimination on the basis of race, creed, color, or national origin. The federal Office of Civil Rights and the courts have interpreted Title VI to require recipient entities to provide oral and



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written language assistance at no cost to LEP patients where language differences inhibit meaningful access to medical care and social services.^[8]

The US Department of Health and Human Services Office of Minority Health was created in 1985 to address minority health concerns and support work toward the elimination of racial and ethnic health disparities. In the late 1990s, OMH turned its attention to developing policies to support promote culturally competent health care. In 1997, OMH convened a project advisory committee and commissioned a large scale project to: (1) review and compare extant cultural and linguistic standards in use by federal and state agencies and other national organizations; and (2) develop a set of national Cultural and Linguistic Appropriate Services (CLAS) standards with recommendations for implementation and oversight.^[9] The final regulations were published in the Federal Register on December 22, 2000. Standards four through seven cover LEP patients, requiring health care organizations to:

- Offer and provide language assistance services at no cost to LEP patients at all points of contact in a timely manner during all hours of operation.
- Provide LEP patients both verbal offers and written notices of their right to receive language assistance services in their preferred language.
- Assure the competence of language assistance services provided to LEP patients by interpreters and bilingual staff, using family and friends only at the request of the patient.
- Make available easily understood patient-related materials, and post signage in the languages of the commonly encountered group(s) in the service area.

The federal Office of Minority Health (OMH) received many public comments expressing a wide range of stakeholder opinions on the draft Cultural and Linguistic Appropriate Services (CLAS) standards. A number of health care providers and provider organizations expressed strong objections to what they considered an unreasonable administrative and financial burden, and noted the absence of cost-effectiveness data on cultural and linguistic service interventions. The CLAS standards project team and advisory committee, while acknowledging the validity of cost burdens, found the clinical, ethical, and social justice arguments for cultural and linguistic competence more compelling. They attempted to mollify providers by suggesting a flexible implementation approach and recommending additional resources for healthcare organizations to



implement the standards. To further address provider concerns, OMH is funding the development of guidelines by an outside agency with expertise in cultural and linguistic competence, and posting each section of the first draft of the guide for a 30-day period to invite provider feedback (these guidelines may be retrieved from Ref. [10]).

At about the same time that the CLAS standards were undergoing final review, President Clinton issued Executive Order 13166 reaffirming provisions of Title VI of the Civil Rights Act of 1964 and requiring each Federal agency to “ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries.”^[11] The Department of Justice (DOJ) then issued a general guidance document with compliance standards for federal funding recipients. The DOJ document called for each federal agency to publish a specific guidance for its programs’ covered entities, and to prepare a plan to improve access to its programs by eligible LEP persons. The Department of Health and Human Services (DHHS) was the first federal agency to publish the required guidance, just three weeks after the issuance of the Executive Order.^[8] The DHHS guidance applies to physicians, hospitals, Health Maintenance Organizations, and all other providers who receive payments directly or as subcontractors from Medicare, Medicaid, the State Children’s Health Insurance Program, or any other federally funded health program.

Stakeholder responses to the Executive Order and ensuing guidances varied considerably. The American Medical Association (AMA) issued a statement opposing the Order to the DHHS Secretary, joined by all 50 state medical and dental associations, arguing that the cost of complying with the new federal guidelines for providing language assistance to LEP patients would be prohibitive and could reduce physician participation in federal programs serving them.^[2] A bill introduced by Republican representative Bob Stump to repeal Executive Order 13166 garnered 69 co-sponsors and is still under consideration by the Government Reform Committee of the House (as of early February 2003, the subcommittee on government efficiency, financial management, and intergovernmental relations had taken no action on the bill its current status may be reviewed at Ref. [13]). ProEnglish, an organization dedicated to protecting English as the official language of the United States, sued the Bush administration over Executive Order 13166 on the grounds that the rules violate the First Amendment to the Constitution, were not authorized by Congress, and are inconsistent with prior federal court decisions. This case was dismissed as premature in August 2002 by the federal district court but ProEnglish is appealing it.^[14] On the other hand, the National Alliance for Hispanic Health organized a coalition of health



organizations to support full implementation of the LEP policy guidance.^[15]

In February 2002, DHHS reissued its policy guidance with additional requests for public comment. In communications to the Secretary of DHHS and the Office of Management and Budget (OMB), the AMA presented the results of a multi-state survey it conducted documenting that the hourly cost of professional agency interpreter services exceeds the payment for a Medicaid visit.^[16] Researchers at the University of California Davis Medical Center in Sacramento found that physicians spent 15–25% longer with Spanish and Russian-speaking patients than they did with English-speaking patients whether or not they used interpreters, and estimated this additional physician time increased the cost per visit by \$10–\$11.^[17] The OMB published a report assessing the costs and benefits of implementing the federal guidance that included case studies of healthcare programs. The OMB analysts developed aggregate estimates of the annual cost of all types of healthcare services and of the possible costs to all types of healthcare providers of providing interpretation services to LEP patients. They concluded that the average cost of providing interpreter services would be about \$4 per visit or 4.5% of the average annual premium, estimated at \$856 per visit. The OMB report identified, but did not quantify, the following as major benefits of language assistance services to LEP patients: potential reduction of medical errors and costs; assurance of truly informed consent; and increased patient satisfaction.^[18]

The Department of Justice published final guidance on June 18, 2002, noting that the policy guidance is “not a regulation, but a guide—an analytical framework that recipients may use to determine how best to comply with statutory and regulatory obligations to provide meaningful access to the benefits, services, information, and other important portions of their programs and services for individuals who are limited English proficient.^[19] It allows recipients of federal financial assistance considerable flexibility to comply with the Executive Order, based on an individualized self-assessment that balances four principal factors:

- (1) The number or proportion of LEP eligible persons who are actual or potential clients.
- (2) Frequency of contact by LEP individuals.
- (3) Importance of the service provided to people’s lives.
- (4) Resources available and costs.

The final guidance emphasizes two basic principles behind the balance it seeks: first, to ensure that LEP individuals are not left out of



federally assisted programs; and second, to reduce the costs of compliance with LEP requirements for small organizations including businesses, local governments, and nonprofit agencies. The guidance further stresses that the type of LEP service will vary according to the type of program (e.g., oral interpretation or written document translation) and the service mix needs to be based on findings from the four-factor analysis to determine what is both necessary and reasonable. The guidance strongly recommends, but does not require, recipients to prepare and periodically update a written implementation plan for meeting the needs of the LEP populations they serve.

At present, compliance enforcement of Executive Order 13166 appears to be quite timid, reflecting the declared federal goal to achieve voluntary compliance. The Department of Justice investigates when it receives a complaint or other report indicating noncompliance with its regulations; uses voluntary mediation to resolve most complaints; attempts to secure voluntary compliance through informal means; and offers technical assistance to recipients of federal financial assistance at all stages of an investigation. A finding of noncompliance that cannot be resolved informally may result in an administrative hearing and other enforcement proceedings and ultimately may be cause for termination of federal assistance. The guidance acknowledges that compliance will take time, and encourages recipients to document their intermediate steps and efforts to achieve compliance.^[20] The tone of the guidance document is extremely conciliatory and cooperative, designed to encourage rather than force compliance.

At the state level, the approach is similarly nonconfrontational. In 2002, the California legislature passed, but the governor vetoed legislation requiring Medicaid and State Child Health Insurance Program (SCHIP) managed care plans to implement programs for provision of culturally and linguistically appropriate services, including provision of 24-h access to interpretation services for all LEP patients. The governor's veto message indicated that he considered these provisions unnecessary since Medicaid and SCHIP plans were already subject to federal contractual requirements to demonstrate cultural and linguistic competence.^[20] Currently under consideration is a bill to prohibit the use of children as interpreters in state funded medical, legal, or social services programs. The California Medical Association, the only organization to publicly oppose the bill, seeks an amendment allowing Medi-Cal (Medicaid) patients to choose the interpreter they consider most appropriate, including a family member.^[21] The federal guidance allows states a wide range of options to provide language assistance services, while stressing that providers should only use family members or friends at the



patients' request and when no trained, professional interpreters are available.

The AMA and other provider organizations have raised a legitimate objection to the federal government's requirement that they provide language assistance services to LEP patients, since most providers will incur additional costs to provide these services without receiving additional revenues. Federal matching funds are available for states to include interpreter services as an optionally covered benefit in their Medicaid and SCHIP programs, although only five states have set up systems to either make available or pay providers for interpreter services. Hawaii, Washington, and Utah contract with language interpretation agencies and pay these agencies directly for services provided. Minnesota and Maine reimburse providers for arranging or providing interpreter services.^[22]

POTENTIAL POLICY SOLUTIONS

One policy solution would be to require all states to establish systems to include LEP language assistance as a covered benefit and reimbursable service in Medicaid, SCHIP and other health programs receiving federal funds. Provider organizations have a good business case to press for additional reimbursement or resources from both state and federal payers, as well as from commercial payers, to provide language assistance services to LEP patients.

Another, and ultimately more effective, longer-range policy solution would be to reduce the need for interpreters—encouraging and providing financial support for more bilingual and bicultural individuals to become healthcare professionals. In 1999, the UCLA Center for the Study of Latino Health found that just 4.8% of licensed California physicians were Hispanics while the total state population was more than 30% Hispanic. This translated to a ratio of one Hispanic physician per 2893 Hispanics in the state, compared with one non-Hispanic doctor per 335 non-Hispanic residents.^[23] A recent study of the California health professional workforce found that just 4% of Golden State nurses were Hispanic and 9% were Asian/Pacific Islander in 1996.^[24] However, diversifying the health professional workforce, though commonly acknowledged as a worthy objective, is, and will continue to be, a contentious issue, and is therefore unlikely to become a viable, short-term policy option.

A private or educational sector solution could emanate from health professional educational institutions encouraging aspiring practitioners to acquire additional linguistic and cultural knowledge to effectively serve an increasingly diverse patient population. Increasing linguistic and cultural



competence can also involve providers learning to speak languages other than English and becoming informed about other cultures than their own.

PAPERS IN THIS SYMPOSIUM

The foregoing discussion identified a number of policy, management, and educational issues inherent in delivering health and human services to limited English proficient (LEP) and immigrant populations. The most salient are:

- (1) The number of limited English proficient individuals is increasing, more widely dispersed, and more varied than ever before.
- (2) Health and human service programs are increasingly finding LEP individuals within their service areas.
- (3) Federal policy on the provision of service to LEP persons addresses both access and quality issues.
- (4) Providers of health and human services face a number of challenges to implementing federal guidelines.
- (5) It will remain to be seen how well these initiatives address the wide political, economic, and social disparities in both access to and outcomes from health and human services for persons with limited English proficiency.

Most of the papers address the first and second points in the background section, providing additional information on specific immigrant and LEP groups. Gabrielle Lessard's opening paper addresses the third and fourth points. Although it has been demonstrated that enhanced language access to services can improve both quality of care and patient satisfaction, organizations receiving federal funds subject to the guidance remain concerned—justifiably—about the financial impact of yet another government service delivery mandate, without an explicit or consistent funding mechanism, in an era of shrinking federal funds. Advocates for LEP and immigrant communities are attempting to deal with both active and passive resistance from agencies and organizations impacted by these mandates. Lessard's paper discusses the most salient provisions of Title VI and Executive Order 13166, and offers practical suggestions for its implementation by both public agencies and community organizations.

The fourth point, challenges facing providers of health and human services implementing the federal guidelines, is addressed by the next two papers. Janice Frates and Kevin Torres show in their case study of a large



urban hospital how bilingual and bicultural college students studying health care administration were used to serve as medical interpreters. The paper by Konane Martinez, Carola Green and Fernando Sanudo explores the challenges that a community health center experienced while implementing a model training program, especially with regard to organizational systems change, in attempting to comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

The next two papers describe the experiences of two programs designed to provide culturally appropriate services to LEP and immigrant populations that have traditionally been considered extremely difficult to reach and serve. Michelle Saint-Germain and Ruby Ogawa focus on the Korean-speaking element of a project designed to help LEP Asian leukemia patients seeking bone marrow transplants. Jean Schroedel and Brooke Herndon assess the efforts of a large urban public health department to promote cervical cancer screening to among low-income, immigrant, Hispanic, and Asian women.

The last two papers address the final point, concerning broader social policy and equity issues. Kathleen Staudt and Nuria Homedes question the value of community collaborative organizations that decentralize programs and demand considerable local leverage and in-kind contributions from the community. These authors argue that such collaboratives create a pernicious tax on poor communities in the name of building community capacity, and squander social capital by eroding relationships of trust among members of the collaborating organizations. They compare two collaborative efforts, one focused on health and the other on economic development, in order to highlight challenges for sustaining a health care system that serves the poor, including immigrants.

In the concluding paper, Thad Hall proposes that many provisions of the 1965 Voting Rights Act have not been fully implemented, so that language minority voters' rights are still often ignored or not respected. The paper also presents suggestions for election officials and community organizations to effect service improvements for language minority voters.

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