HOW DOES LANGUAGE AFFECT PEOPLE'S ACCESS TO HEALTHCARE?

This policy brief is written for Malaysia's policy makers, in particular Ministry of Higher Education (MOHE), Public Service Department (PSD) and Ministry of Health (MOH), law makers, politicians, academicians, and community leaders. This brief examines the quality of healthcare in the direction of: How does language affect people's access to healthcare?

Patient's language proficiency influences their accessibility to healthcare and to improve their quality of life. This is because language is a major tool of communication. This relationship is of less concern in most research and policy making process in Malaysia. Nevertheless, Malaysia as an Upper Middle-Income Country (UMIC) and a medical tourism hub should investigate various means of overcoming language barrier to ensure accessibility to healthcare.

Language Barrier & Health Care Quality

6.6% elderly which can speak in either Malay or English in Malaysia (Selangor state) have unmet healthcare needs. This is lower than a few other countries most probably due to the selection of study population which have good proficiency in both languages. (1) Although there are not much data on the language proficiency of Malaysians, Asian American who have limited English language proficiency (LEP), report high level of dissatisfaction with healthcare.(2) Language barrier in healthcare is found to cause healthcare provider and patient's miscommunication, reduction of satisfaction and reduction of the quality of healthcare delivery and patient safety. (3)

Good healthcare quality means "providing patients with appropriate services in a technically competent manner, with good communication, shared decision making and cultural sensitivity"(4) Quality healthcare includes characteristics such as accessibility, affordability, acceptability, appropriateness, competency, timeliness, privacy, confidentiality, attentiveness, caring, responsiveness, accountability, accuracy, reliability, comprehensiveness, equity and etc. (5)

Malaysian nurses deal with language barriers frequently. They deal with it in a few ways such as non-verbal communication, verbal communication, interpretation, simple language, proactiveness to learn patient's culture and language with teamwork as the backbone. All these are done progressively depending on situational need. (6)

History of Malaysian's Language

Malaysia is a country of multiethnicity which comprises of Malays and indigenous groups (69.8%), Chinese (22.4%), Indians (6.8%) and others (1.0%). (7) Most of the elderly Chinese females have low educational level and poor literacy in Malay language and English. This is mainly due to the education accessibility during early days of *Tanah Melayu* right before independence.

According to the census in 1980's, the illiteracy rate of females are slightly higher than the number of literates. (8) This translates into the illiteracy rate of females aged around 70-90 years old in year 2021.

A local study among urban elderly also shown non-Malays (22.03%) have a slightly higher percentage of limited health literacy compared to Malays (18.64%). Besides, elderly aged more than 70 years old and have lower educational level were more likely to have limited health literacy.(9)

Cultural Competence and its Sociocultural Barriers

Due to various health disparities observed, there is an emergence of "cultural competence" which is defined as one that acknowledges and incorporates -- at all levels -- the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs especially from the "social context". Joseph et al. identified sociocultural barriers to health care and classified it into organizational, structural, and clinical barriers.

The structural barriers are:
i) lack of interpreter services or culturally/linguistically appropriate health education materials is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care.
ii) Bureaucratic intake process and long waiting time for appointments
iii) Barriers regarding referral to specialists and continuity of care. (10)

This shows that the use of interpreter system is very important to a culturally competent health system

Use of Interpreters and Language Concordant Health Care Workers

Although the health care quality for outpatient visits for LEP Asian immigrants who use interpreters and those whose clinicians speak their language are similar, certain aspects of communication may be compromised. (11) In Malaysia, interpreter system is only available in some private health institutions such as Sime Darby Healthcare group but not nationally. (12)

In U.S., it is found that interpreter services contribute indirectly to increased cost and the length of treatment visits. (3) Therefore, there is a dire need to have a health care workforce of language diversity who are language concordant to provide quality care to diverse patient populations. (10, 11)

Recommended Actions

#1: Professional medical interpreter services

With the growing cultural and linguistic diversity in Malaysia, health care system would be required to implement effective and efficient strategies to provide high-quality, professional interpreter services for those who need them. Through a systematic review, Leah et al. found that professional interpreters are associated with positive benefits in communication (errors and comprehension), utilization, clinical outcomes, and satisfaction with care. (14)

#1.1 Patient's are entitled to interpreters

Enactment of law that "patient receiving care are legally entitled to interpreters when language concordant clinicians are unavailable" under The Federal Constitution of Malaysia. For example, Title VI of the U.S. Civil Rights Act of 1964 specify that LEP patients receiving federally funded services are legally entitled to interpreters when language concordant clinicians are unavailable. (13)

#1.2 Interpreter as standard of accreditation and KPI

Incorporate professional interpreter services and number of language concordant health care workers into the list of standard service list of **Malaysia Society for Quality in Health** (MSQH) accreditation criteria and make it a mandatory key performance index (KPI) for all public health facilities such as primary healthcare clinics (*klinik kesihatan)*, district hospital and state hospital. This means that the Ministry of Health should create vacancies for professional medical interpreter in each healthcare facility based on needs.

#1.3 Professional medical interpreter course

Professional medical interpreter course of undergraduate and post-graduate should be introduced by faculty of arts in higher educational institutions for non-medical background personnel. Besides, short interpreter courses can be provided for health care providers to equip them skills

to speak in other languages and with more cultural sensitivity. Certain balance of cross-cultural knowledge and communication skills seems to be the best approach to cultural competence education and training.(10) Scholarships with paid leave should be provided to public health servant to encourage continuous professional development. These courses are uncommon in Malaysia but widely available in other countries.(15-17)

#2: Language diversity in the health care workforce

It has been found that this is well correlated with the delivery of quality care to diverse patient populations. Spanish-speaking patients, for example, report more satisfaction with care from Spanish-speaking providers than from non-Spanish speaking providers.(18)

#2.1 "Diversity" and "minority recruitment"

Initiatives to recruit health care workers with diverse language profile should be done with the collaborative effort of Public Services Department and Human Resource department of Ministry of Health, academic health centers, hospitals, and medical schools. For example, in 1970 the Physician-Population Parity Model of the Association of American Medical Colleges (AAMC) was established to increase the representation of minority in medicine. Malaysia as a country with great diversity, has the obligation to ensure a balance of supply and demand in language needs of our population.

#2.2 Data Collection & Measurement

Implementation of racial/ethnic data collection and develop specific quality measures for diverse patient population. (10) Firstly, addition of ethnicity/ language spoken by geographical distribution into the Human Resources for Health Country Profile. (19) Secondly: Addition of language spoken by geographical distribution into Malaysia Census. This can help Public Health Services Division and Ministry of Health to match the distribution of need of language with the supply of health care workers. Besides, it can be included as a parameter in the human resources of health country profile.

#3 Enrollment of Health Care Students

Enrollment of medical, pharmaceutical, dentistry and allied health students based on language, besides academic result, psychometric assessment result, social inclusitivity and socioeconomic strata.(20)

PSD should provide all local universities with the data of how many HCW who is able to speak which language is needed 5 years later to guide the intake of healthcare students based on the language needs.

#4: Online Translation Tools

MOH should promote the use of online translation tools such as Google Translate and MediBabble in hospitals, which is found to increase the satisfaction of both healthcare workers and patients and thus translate into the improvement