



California's Limited English Proficient Population (LEP) and Strategies to Promote Health Care Access

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Approximately 6 to 7 million Californians--one in five--have limited English proficiency (LEP), meaning these individuals cannot speak English well or cannot speak English at all. In San Francisco, Los Angeles, Monterey, and Imperial counties one-quarter to one-third of the population has limited English proficiency.

Language barriers often result in health care barriers. Research shows that language barriers contribute to inadequate patient evaluation and diagnosis, lack of appropriate and/or timely treatment, and other medical errors that compromise the safety of LEP patients and result in increased medical costs.

The current national reform effort to expand insurance coverage and reduce health disparities provides an opportunity to address communication barriers for LEP persons.

Although Federal and California law requires provision of language services, these services are not always used effectively. In California, all state-funded entities--SCHIP, Medicaid, and Medicare public and private providers, and all general acute care hospitals--are required to provide language services for LEP groups that equal 5% or more of the population served. Additionally, all private health plans in California are required to ensure language access when a language is spoken by 15,000 enrollees (0.75%) within large health plans, or by 3,000 enrollees (5%) within small health plans.

Our study seeks to inform efforts to improve the use of language resources in meeting the needs of California's LEP populations. We examine California's LEP population by language and country of birth and assess the types of communication barriers. We also evaluate the LEP population's health care utilization across a range of characteristics and offer recommendations for using language resources most effectively.

Methods

Using the 2007 California Health Interview Survey (CHIS), we selected adults, aged 18-64, and identified California's various LEP groups as defined by respondents' self-report of speaking English "not well" or "not at all." We categorized LEP groups by language spoken at home, and country of birth. Next, we estimated variables related to health care use and communication needs. To simulate the California population, we weighted data according to instructions in the CHIS technical manual. Then we calculated descriptive statistics (N, %, chi-square, mean, t-test) with English speakers as the reference group. We also searched the academic and medical literature, as well as the Internet, for reports by foundations, government agencies, and various non-profit groups, to evaluate which types of language access strategies are most suitable and cost-effective for various types of information exchanges.

Findings

Analyzing the 2007 CHIS, we identified the following LEP groups by language spoken and country of birth:

- Spanish speakers from Mexico (n=2,342,000)
- Spanish speakers from El Salvador (n=202,000)
- Mandarin or Cantonese speakers from China (n=187,000)
- Vietnamese speakers from Vietnam (n=114,000)
- Spanish speakers from Guatemala (n=107,000)
- Korean speakers from Korea (n=103,000)
- Spanish speakers from Other Central American countries (n=51,000)
- Spanish speakers from South America (n=36,000)
- Speakers of "Another Asian Language" from South Asia/Cambodia (n=35,000)
- Speakers of "A European Language" from Europe (n=18,000)
- Speakers of "Other Languages" from Other Countries (n=79,000)

Several CHIS questions asked specifically about language barriers, including difficulty understanding the doctor because the doctor spoke a different language; difficulty reading instructions on a prescription bottle; and difficulty understanding written information at the doctor's office.

When examining language barriers, our study showed that all LEP groups, except the European LEP group, had a significantly greater portion reporting difficulty on all three measures compared to the English-speaking group. Specifically, we found that:

- Difficulty with spoken language was highest among Other Central Americans (16%), Vietnamese (16%), Chinese (10%), and Guatemalans (9%); only 1% of English speakers reported difficulty with spoken language.
- Difficulty reading prescriptions was highest among Chinese (39%), SouthAsian/Cambodians (31%), Salvadorans (31%), and Guatemalans (31%); only 5% of English speakers reported difficulty reading prescriptions.
- Difficulty reading information at the doctor's office was highest among Salvadorans (58%), Chinese (57%), Guatemalans (45%) and, Mexicans (39%); only 11% of English speakers reported difficulty reading written information.

When examining chronic diseases and health risks, our study showed high portions of LEP groups having diabetes, obesity, and food insecurity. Specifically, our study showed that:

- Diabetes was highest among Mexicans, Salvadorans, and South Asian/Cambodians (12%-18%). In contrast, 6% of English speakers reported diabetes.
- Obesity was highest among Mexicans, Salvadorans, other Central Americans (72%-82%) and among Vietnamese (59%) compared to English speakers (56%). A significantly smaller portion of LEP persons from the Chinese (28%) and Korean (36%) groups were obese.
- Food Insecurity or the lack of consistent availability of nutritionally adequate and safe foods was especially high among Mexicans, Salvadorans, Guatemalans, Vietnamese, and South Asians/Cambodians (36%-41%) compared to English speakers (7%).

When examining health care access, LEP groups showed low levels of doctor's visits and use of preventive care (except for cervical screening among Spanish-speaking women). Specifically, our study showed the following:

- Access to a doctor: Among the Spanish-speaking LEP groups, 33%-40% reported no doctor visit. However, South Americans' access was similar to that of English-speakers (18%). Among Asian LEP groups, 34% of Chinese and 37% Koreans said they hadn't been to the doctor in the past 12 months.

- Cervical cancer screening: The portion of Korean and Vietnamese women current with screening guidelines was significantly lower (63%-65%) than Spanish-speaking women (97%- 85%) and English-speaking women (84%). The high portion of Spanish-speaking women current with cervical cancer screening may reflect public health efforts within Spanish-speaking communities to increase screening or perhaps the availability of Spanish-speaking clinics where screening can be performed conveniently and affordably.
- Breast cancer screening: The portion of Mexicans, Guatemalans, Chinese, Koreans, and Vietnamese current with screening guidelines was significantly smaller (approximately 50%) compared to English speakers (62%).
- Colorectal cancer screening: Relatively small portions of all groups were current with colorectal screening guidelines. Approximately 25%-37% of Mexicans, Koreans, and Vietnamese were current compared to 38% of English speakers.

Policy Recommendations

Our study shows LEP groups suffer from certain chronic diseases and health risks in greater portions than do English speakers. However, LEP groups have less access to doctors and lower use of preventive care than English speakers. Effective use of language resources can be instrumental in improving health access and health care for LEP groups. Moreover, research shows that the cost of providing effective language services may be recouped through reduced testing, shorter visits, and improved patient compliance. Therefore, we make the following recommendations:

- **The State should work to increase the supply of bilingual medical professionals.** Emphasis should be placed on recruiting and training bilingual persons in the medical field. Medical professionals should be trained in language and interpretation skills.
- **The State should invest in new technologies, such as call centers and video interpretation pools.** These technologies can maximize the use of trained medical interpreters and bilingual providers across the state, making bilingual medical personnel available in remote locations. For example, a LEP patient could be seen using a remote interpreter or bilingual clinician over video.
- **The State should encourage doctors and pharmacists to improve their written materials.** Simple changes in written materials may improve

patient understanding and compliance. For example, typed, as opposed to hand-written, instructions are easier for LEP persons whose native language does not use a Roman alphabet. Patient understanding and compliance is improved by having a bilingual nurse, ad-hoc staff, or family member review pharmacy and doctor instructions with the patient before leaving a doctor's office. Written materials must be compatible with the very low educational level of some LEP groups.

- **The State should encourage outreach to the LEP communities to tap available language resources.** Religious groups and community-based organizations can provide many valuable types of support services, other than direct medical interpretation, including appointment and transportation arrangements, health facility navigation, patient registration, and assistance with follow-up instructions and prescriptions. Outreach efforts must also inform LEP communities about where and when language services are available, and the appropriate use of family and friends to help access services.
- **The State should support health education efforts that meet the medical, technological, and informational needs of each target population.** For example, programs targeting diabetes control among the Spanish-speaking population could adopt the use of evening "one-stop shop" mobile clinics that allow patients to conveniently see a number of bilingual/ bicultural specialists at regular intervals. Previous successful outreach models, such as the cervical cancer screening program for the Spanish-speaking population, should be emulated. Community education programs, whether targeting weight control among the Spanish-speaking population or targeting compliance with cancer screening guidelines among the Asian-language population, must be tailored to the LEP group's culture-specific understanding of the medical problem and employ the preferred media and format for receiving information (phone, radio, video or TV, brochures or local newspapers). Most LEP groups do not have access to the Internet.

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