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Addressing language barriers to health care, a survey of medical services in Switzerland

Summary

Two descriptive, quantitative cross-sectional surveys including all services of internal medicine and psychiatric services examined how Swiss medical services address the problem of language barriers in health care and how they respond to the high number of allophone patients. Of all the medical services (MS), 244 responded to the questionnaire (Internal medicine: 166; Psychiatry: 78; overall response rate 86.6%). Half of them (51%) estimated the proportion of allophone to the total number of patients at 1–5%. Only 4% of the MS collected statistics on the number of allophone patients (2 internal medicine, 8 psychiatric services). A third of the MS perceive communication with allophone patients as significantly difficult. Only 14% often use qualified interpreters, while 79% often use relatives, 75% often health staff, 43% often employees. Qualified interpreters are less frequently used in internal medicine than in psychiatry. There is an expressed need for qualified interpreters speaking Albanian, Bosnian/Serbo-croat, Tamil and Kurdish. Only 11% of the studied MS have a budget for interpreters, and 17% have access to an interpreter service. 48% express the need to have access to interpreter services. There is a need to raise the awareness of health professionals on the advantages of having access to trained interpreters and on the limits of using relatives as translators. This calls for coordination at national level, policy development and training, in order to ensure adequate communication and quality care for migrants.

Health has become a important issue of migration policy development, as it reveals sensitive areas such as accessibility and equity. Sketching out health policies for Europe, the World Health Organization stated as a primary target that by the year 2000 the differences in health status between countries, as well as between population groups within countries, should be reduced by 25% through the health status improvement of the underprivileged populations and ethnic groups[1]. Consequently the responses of the medical services to the needs of ethnically and culturally different people have to be improved[2]. Existing medical services should be adapted to migrants' needs in three ways: by increasing awareness of specific cultural and ethnic characteristics, by providing adequate information on administrative procedures of the medical services available in migrants' mother tongues, and by making interpreter services available[3].

Among the seven million residents in Switzerland, 63.6% speak German, 19.2% French, 7.6% Italian and 0.6% Romanch, the fourth official language in Switzerland. The remaining 8.9% speak other languages, the most important of which are Spanish (spoken by 1.7%), South Slavic (Serbian, Croatian and Bosnian, 1.6%), Portuguese (1.4%), Turkish (0.9%), English (0.9%) and Albanian (0.5%)[4]. Foreigners account for more than 21% of the total population[5]; 155'000 of them are refugees and asylum seekers (equalling 2% of the total population) coming from countries including Kosovo, Albania, Iraq, Sri Lanka, Bosnia, Turkey, Georgia, Somalia and Congo[6].

Good quality of care requires good communication between patient and health professional. This is a key issue in migrant health care because of the rising number of allophone (foreign-language speak-

ing) patients. While a few cross-sectional surveys give an overall picture of the language barriers present in other countries (see for example in the USA[7], in Austria[8], or in the UK[9]), there is so far no such baseline data available in Switzerland.
The survey presented in this paper attempts to provide a first national overview on how Swiss medical services address the problem of language barriers and assess the consequent need for, and use of, interpreters.

Methods

The research consists of two identical cross-sectional questionnaire surveys, using a descriptive quantitative approach. The sample included all services of internal medicine and psychiatric services (outpatient departments, emergency units and inpatient departments), in all three linguistic regions: German, French and Italian-speaking Switzerland. A covering letter explaining the purpose of the survey and a self-administered questionnaire (in French and in German) was mailed to the head doctors of these services. They could answer themselves or transmit it to head nurses, administrators or social workers. Reminders were sent twice to those which did not reply. All questionnaires, including the incomplete ones, were included in the data analysis. Different categories were introduced concerning the type of the services (out or inpatient). From the five university hospitals with more than one service (of internal medicine or psychiatry) several questionnaires were included. The data analysis was done using the public health software Epi-Info 6.02.
The items included questions on estimates of the proportion of allophone patients to the total number of patients in the medical services, the perceived communication with allophone patients, the use of different types of interpreters, the access to interpreter services and, finally, a request for suggestions on the above issues. In this study an interpreter was defined as a person who translates and facilitates communication between persons who are unable to communicate in a common spoken language.
Among the different types of interpreters we consider:

- Informal interpreters:
  - Relatives (family members, children, friends)
  - Health staff (nurses, doctors, and other health professionals),
  - Hospital employees (cleaners, clerks, guardians, carriers, aides, kitchen staff, etc.),
  - Volunteers (welfare, church and non-governmental organisations, embassy staff)
- Qualified interpreters (trained, paid).

Results

Characteristics of the medical services and their allophone patients

Answers were received from 152 out of the 173 services of internal medicine and 42 out of the total 51 psychiatric services. This equals an overall response rate of 86.6%. Hospitals with more than one service of internal medicine or psychiatry sent back a corresponding number of questionnaires; thus 166 from the medical services and 78 from psychiatric services, totalling 244 (Table 1). Out of these, 68% (167) came from German-speaking Switzerland, 26% (63) from French-speaking and 6% (14) from Italian-speaking Switzerland. Most of them came from inpatient departments (81%), the remaining 19% from outpatient departments. The questionnaires were filled out mostly by the head doctors of the respective medical service (85%), but also by head nurses (7%), administrators (5%) and social assistants (4%).
Only 4% of the studied medical services collected information (statistics) on the number of allophone patients treated in their services (2 medical services and 8 psychiatric services). Rough estimates on the allophone proportion according to the respondents varied greatly: half of the respondents (51%) estimated the allophone proportion at 1 – 5%; 13% estimated the proportion as less than 1% and 32% as higher than 5%.
Communication with allophone patients was perceived differently by Swiss medical services. Only 9% of them think that there is no difficulty when communicating with allophone patients, while 57% find it slightly difficult. One third of all the respondents say communication is difficult (25%) or very difficult (9%). This latter group perceives allophone communication as a real problem. Interestingly, the communication problem is perceived more clearly in psychiatric services, with comparatively far more services rating communication with allophones as difficult or very difficult (see Table 1 for details).

Medical services' use of interpreters

In order to communicate with allophone patients, 64% (154) of the medical services said they "often" used someone interpreting between patient and provider (any type of interpreter, informal or qualified), while the other services admitted using someone to interpret "rarely" (31%, 75), or "never" (3%, 8). There is a significant difference between the two types of medical services: 71% (115) of the services of internal medicine "often" use someone as an interpreter, compared to 51% (39) of the psychiatric services saying the same.

	Internal Medicine (n = 166)	Psychiatric Services (n = 78)	Total (n = 244)
Medical services			
German-speaking Switzerland	68% (114)	68% (53)	68% (167)
French-speaking Switzerland	26% (42)	27% (21)	26% (63)
Italian-speaking Switzerland	6% (10)	5% (4)	6% (14)
Respondents			
Physicians	87% (145)	81% (63)	85% (208)
Nurses	7% (11)	7% (5)	7% (16)
Administrators	5% (8)	6% (5)	5% (13)
Social assistants	1% (2)	7% (5)	4% (7)
Services collecting data on allophone patients	1% (2)	10% (8)	4% (10)
Estimation of allophone patient proportion			
Proportion lower than 1%	14% (22)	12% (9)	13% (31)
Proportion ranging from 1% – 5%	53% (86)	45% (35)	51% (121)
Proportion ranging from 5% – 10%	17% (27)	22% (17)	18% (44)
Proportion ranging from 10% – 15%	11% (17)	9% (7)	10% (24)
Proportion higher than 15%	2% (3)	9% (7)	4% (10)
Proportion unknown	4% (6)	4% (3)	4% (9)
Perceived difficulty in communicating with allophone patients			
Communication not difficult*	11% (18)	5% (4)	9% (22)
Communication slightly difficult*	62% (103)	45% (35)	57% (138)
Communication difficult*	19% (32)	36% (28)	25% (60)
Communication very difficult*	7% (12)	13% (10)	9% (22)

* Significant differences between internal medicine and psychiatric services (Pearson's Chi-Square): $p < 0.05$.

Table 1. *Characteristics of medical services (internal medicine and psychiatric services in Switzerland, 1996/1997).*

Table 2 details the frequency of use of different types of interpreters. Most medical services (79%) heavily rely on relatives and friends, saying that they use them "often"; 75% "often" use health staff speaking other foreign languages; 43% often use hospital employees (i.e. non-health staff), and 12% often use volunteers (embassy staff, refugee organisations, etc.). Only 14% "often" use qualified interpreters. It is striking that a majority of medical services "never" (60%) or only "rarely" (26%) use qualified paid interpreters. Answers to the frequency of use of different interpreter types vary considerably between psychiatric and medical services. Hospital employees are more frequently used to interpret within internal medicine than in psychiatric services, and only 4% (5) of the services of internal medicine "often" use qualified interpreters, as compared to the 36% (23) of psychiatric services.

Strategies of medical services dealing with patients speaking a given language.

Figure 1 displays the proportion of the different interpreter types used in the most prevalent languages appearing in the study. The management of Albanian, Kurdish, Arab, Tamil und Turkish was similar: high proportions (up to 50%) of relatives serving as interpreters, followed by hospital employees (up to 20%) and by health staff (around 10%). Qualified interpreters represented small proportions between 10 and 15%. The language management of South-Slavic patients looked slightly different, showing higher numbers of health professionals (and hospital employees) serving as interpreters. There was a comparable situation among Portuguese-speaking and Spanish-speaking patients: equally high proportions of relatives, health professionals and employees (about 30% each), but no qualified interpreters were called upon; often (5–10%) no interpreter at all is called. The patterns of

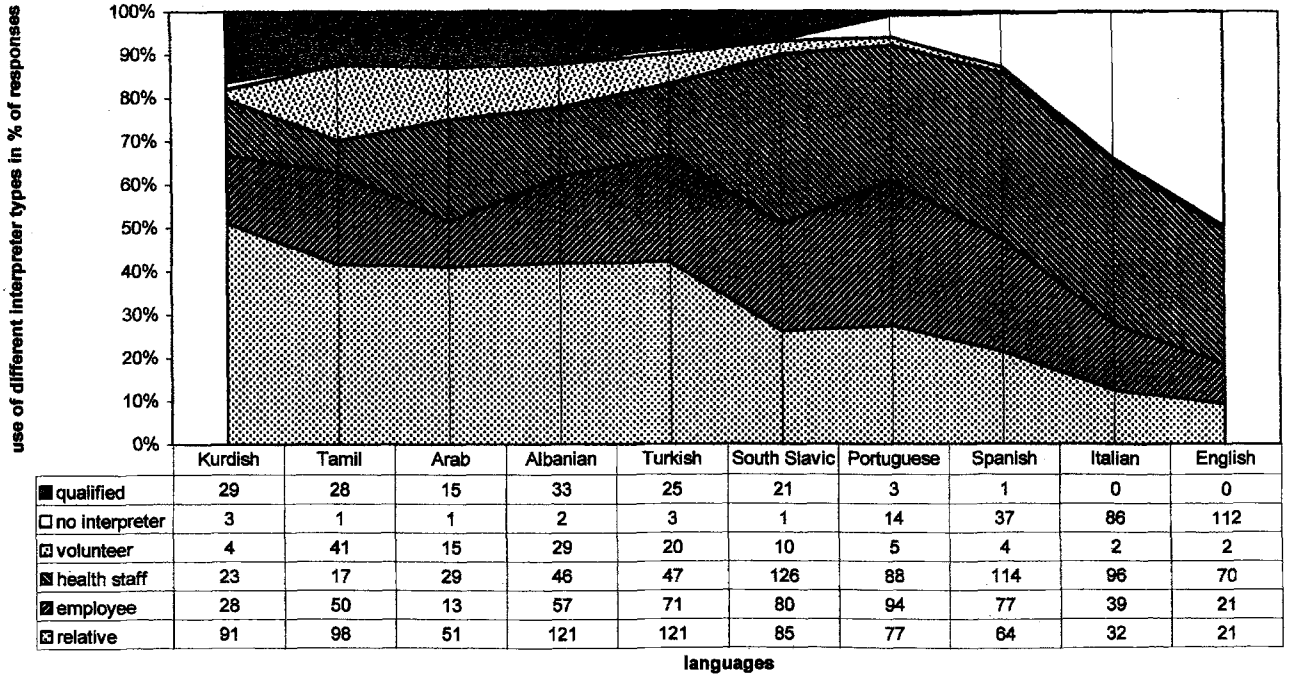
	Internal medicine services (n = 166)			Psychiatric services (n = 78)			Total (n = 244)		
	often	rarely	never	**often**	rarely	never	**often**	rarely	never
Use of relatives **	**85 % (133)**	14 % (22)	1 % (2)	**67 % (45)**	30 % (20)	3 % (2)	**79 % (178)**	19 % (42)	2 % (4)
Use of health staff ***	**78 % (118)**	21 % (32)	1 % (2)	**68 % (45)**	29 % (19)	3 % (2)	**75 % (163)**	23 % (51)	2 % (4)
Use of hospital employees *	**50 % (75)**	45 % (67)	5 % (7)	**25 % (16)**	61 % (39)	14 % (9)	**43 % (91)**	50 % (106)	7 % (16)
Use of volunteers ***	**9 % (11)**	58 % (74)	33 % (42)	**20 % (11)**	46 % (25)	34 % (18)	**12 % (22)**	55 % (99)	33 % (60)
Use of qualified interpreters *	**4 % (5)**	21 % (28)	75 % (98)	**36 % (23)**	35 % (22)	29 % (18)	**14 % (28)**	26 % (50)	60 % (116)

Significant differences between internal medicine and psychiatric services (Pearson's Chi-Square): * $p < 0.001$. ** $p < 0.05$. *** p not significant.

Table 2. *Frequency of use of different interpreter types (internal medicine and psychiatric services in Switzerland, 1996/1997).*

Portuguese and Spanish, both languages of communities established in Switzerland for decades, suggest the following trend: the longer an allophone community is living in Switzerland, the less relatives are used in medical services for interpretation. After an even longer period, less interpreters and more health staff are used, and eventually no interpreter at all is needed. Finally, for most (2/3) English-speaking patients no interpreters at all were used, evidently because most health professionals speak English.

To the question "For which languages would you want to have



	Kurdish	Tamil	Arab	Albanian	Turkish	South Slavic	Portuguese	Spanish	Italian	English
qualified	29	28	15	33	25	21	3	1	0	0
no interpreter	3	1	1	2	3	1	14	37	86	112
volunteer	4	41	15	29	20	10	5	4	2	2
health staff	23	17	29	46	47	126	88	114	96	70
employee	28	50	13	57	71	80	94	77	39	21
relative	91	98	51	121	121	85	77	64	32	21

Figure 1. *Language management of allophone patients.*

	Times mentioned by medical services		
	Internal Medicine (n = 166)	Psychiatric services (n = 78)	Total (n = 244)
Albanian	48	34	82
South-Slavic*	45	30	75
Turkish	49	23	72
Tamil	27	16	42
Kurdish	13	7	20
Arabic	12	2	14
Russian	4	9	13
Spanish	5	3	8
Portuguese	3	4	7
German	0	4	4
French	2	2	4
English	0	2	2
Other languages	8	4	12

* Including Bosnian, Croatian, Serbian.

Table 3. *Requirements for trained interpreters, according to specific languages (internal medicine and psychiatric services in Switzerland, 1996/1997).*

interpreters available?", the languages most often mentioned were Albanian, Serbo-Croat, Turkish, Tamil and Kurdish, i.e. languages spoken by communities with a high proportion of recently arrived refugees (see Table 3).

Interpreter networks

Only 11% of the medical services have a budget for interpreters (18 psychiatric services and 9 internal medicine) (Table 4). A third of the services responded by saying they had access to an interpreter network. Most often this simply means having either a list of available hospital staff who speak foreign languages or a list of volunteers who could be called if necessary. Nonetheless, 17% (42) have access to a service with qualified and paid interpreters. Finally, 48% (111) of all services express the need to

	Internal medicine (n = 166)	Psychiatric services (n = 78)	Total (n = 244)
Medical services having budgets for interpreters*	6% (9)	24% (18)	11% (27)
Medical services having access to an interpreter network**	30% (50)	43% (33)	34% (83)
Medical services having lists of bilingual staff ***	27% (44)	31% (24)	28% (68)
Medical services having lists of volunteers**	8% (14)	23% (18)	13% (32)
Medical services having access to qualified interpreter networks*	8% (14)	36% (28)	17% (42)
Medical services feeling the need to have access to interpreters networks*	37% (60)	73% (51)	48% (111)
Medical services intending to set up qualified interpreter networks***	5% (8)	15% (10)	8% (18)

Significant differences between internal medicine and psychiatric services (Pearson's Chi-Square): * $p < 0.001$. ** $p < 0.05$. *** p not significant.

Table 4. *Interpreter services, networks and budgets (internal medicine and psychiatric services in Switzerland, 1996/1997).*

have access to an interpreter network, but only 8 % (18) plan to set one up. Comparing the two types of services, proportionally more psychiatric services have budgets and access to interpreter services; and far more psychiatric services express the need to use interpreter services in the future.

Discussion

Even in a multilingual country such as Switzerland, language barriers remain a significant problem which must be addressed. Because most Swiss people speak several languages and succeed fairly well in communicating minimally in other Swiss languages and with the migrants' languages having been essentially roman languages (Italian, Spanish, Portuguese), there has been little awareness of language barriers in the past. In the last 20 years however, with the arrival of different migrant groups, this mode has proven unsuccessful, as the many new languages, most of them not related to Western European languages, have made communication difficult. Findings in this nationwide survey suggest that Swiss medical services roughly use two main strategies to address the problem of language barriers: the use of informal interpreters and, second, to some extent, the use of qualified interpreters. In addition, in spite of a variety of different interpreter services, there is an expressed need for networking and the setting up of agencies offering interpreters for medical services.

Using informal interpreters

In general, medical services rely on the internal language resources: health professionals often speak foreign languages and can find a common language to communicate with their allophone patients. The problem with this approach is that they rely on their own linguistic skills which they can hardly evaluate themselves. Neither can they ensure that patient and provider have understood each other, especially when culturally sensitive issues are addressed which would need cross-cultural mediation[10].

A number of medical services have regularly updated language lists of the available bilingual staff who can be called upon if necessary. These are usually not trained interpreters, but help establish minimal communication. The frequency of the use of bilingual staff directly reflects the degree of integration of a migrant community into the local society. It is, for instance, easy to find medical staff speaking languages of some of the Mediterranean countries, such as Italian, Spanish, Portuguese and, to some extent, Bosnian/Serbo-croat communities which have been present in Switzerland for decades[4].

Using family relatives as informal interpreters is the most frequently used solution in addressing the problem of language barriers. It does not cost anything to the health care services, there is no incumbent responsibility, whereas the patient with his language difficulty feels it his duty to bring someone who makes communication possible. The use of relatives is particularly prominent for Kurdish, Albanian, Tamil and Turkish patients. Migrants, especially refugees from war-torn countries, who are likely to show post-traumatic disorders feel ill at ease when speaking about trauma and its consequences with their relatives or friends as interpreters. Often, sensitive and personal issues cannot be discussed. Potentially problematic situations arise in which the use of relatives is highly questionable, for the patients themselves (as regards intimacy) and for the person interpreting (as regards confidence). Although it is important to integrate the family in the therapy of a patient, trained interpreters are then definitely needed. This goes along with the priority languages for interpreters, pointed out by the medical services (Table 3). They feel awkward about using relatives or friends as interpreters and wish above all to have qualified interpreters for the languages of countries where conflicts are the reason for forced migration (Turkey, Sri Lanka, former Yugoslavia and Albania).

Using informal interpreters may lead to serious communication problems[11], and to a subsequently inadequate quality of care. Relatives may be proficient in two languages, but may not know how to interpret; deficient translation leads to misunderstandings[12], wrong diagnosis and low compliance[13]. Lacking a critical understanding attitude towards both cultures, relatives are not able to provide the necessary cultural mediation. Relatives, especially children[14], are at a high risk of stress disorder, when they have to translate in emotionally charged interviews[15] (e.g. history of violence or forced migration). Despite the obvious pitfalls informal interpreters are widely used. Surveys in Vienna[8] (where the use of children was specifically assessed) and among Swiss private practitioners[16] confirm our findings. While two thirds of the physicians found that language was a most important barrier in communication problems with refugees, 75% thought that friends and family members would do well as interpreters, only half of them found it problematic that children were used as interpreters, and for almost half of them the interpreter problem is normally solved by the migrants themselves[17].

Using qualified interpreters

The present research has revealed that communication with allophone patients is perceived as a major problem, more clearly in psychiatric services than in internal medi-

cal services. They estimate the number of allophone patients as being quite high, although very few of them have statistics on their allophone patients. Having access to qualified interpreters for several languages, is one of the needs most often felt. However, on the whole, qualified interpreters are rarely used. Figure 1 shows drastically that qualified interpreters make up only a very small proportion of all types of interpreters. The underuse of qualified interpreters and over-use of informal interpreters was also reported in studies conducted in the US[18] and Austria[8], whereas countries with a tradition of providing access to health care for allophone populations (such as Australia[19], and to a lesser degree Canada and Scandinavian countries) reveal systematic use of qualified interpreters in health settings.

While in general psychiatric services use interpreters of any type (informal and qualified) less often, they use trained interpreters comparatively more often. This reflects the importance of verbal communication in psychiatric services and, on the other hand, the reliance of "somatic" medical services on nonverbal communication and medical exams and interventions. Our data suggest that the more recently a migrant group have arrived in Switzerland, the more likely medical services will be to opt for trained interpreters. This is the case for the recently arrived migrant groups, where in about a tenth of all cases of allophone patients, a qualified interpreter was used.

Using interpreters is becoming an issue of quality assurance in migrant health care. It has been shown that the use of qualified interpreters leads to better understanding of diagnosis and treatment of patients[20], higher professional and patient satisfaction[21], better compliance[22] and quality of care[23]. Therefore, utilisation of qualified interpreters has to be encouraged, by making interpreter services routinely available, as a short-term strategy at least, in areas with a high percentage of allophone population.

Policy implications

The availability of interpreters networks in Switzerland is scanty. A few interpreter services do exist, nearly all of them provided by organisations in urban settings with high migrant proportions. Nearly half of the medical services answered that they wanted to have access to interpreter services. There is thus a clearly felt need for setting up interpreter services. Apart from the well established interpreter services in Switzerland's main cities (described and compared elsewhere[24]), there is a variety of heterogeneous services, in small or large hospitals, with different financing schemes and approaches. These different services will need co-ordination and support, if they want to survive. The Federal Office of Public Health commissioned a team of experts involved in interpreter issues to prepare a baseline report of interpreting in Switzerland, comprising an overview of the main institutions providing interpreter services in Switzerland, compared with a range of models in Europe, a discussion of the different interpreter roles and concepts and the respective legal considerations[24]. The issues raised in this baseline report were discussed in a conference held last year and led to founding the association for the promotion of interpreting and cultural mediation in health, social and education services[25]. The next stepping stone in the provision of qualified interpreter services will include financial planning, human resource development and the evaluation of the quality of interpreter-aided care.

Access to health care for migrants is a key issue in migration policy development. Misunderstandings and lack of language proficiency renders allophone patients often unable to have access to health care. Linguistic and cultural barriers make migrants a vulnerable group who risk suffering from inadequate diagnosis and treatment. Ensuring communication with allophone patients means essentially addressing the language barriers. Working with an interpreter as a linguistic and cultural mediator appears to be the most promising strategy to overcome the language barrier. The systematic introduction of qualified interpreters will considerably improve provider and patient satisfaction, and, above all, the quality of care for allophone migrants.

Zusammenfassung

Sprachbarrieren im Gesundheitswesen, Umfragen in den medizinischen und psychiatrischen Kliniken der Schweiz

Die zwei vorliegenden Querschnittstudien untersuchen mittels Umfragen in den medizinischen und psychiatrischen Kliniken der Schweiz, wie diese mit den Sprachbarrieren umgehen, die sich durch die grosse Zahl fremdsprachiger Patienten ergeben. 166 medizinische und 78 psychiatrische Kliniken (K) beantworteten den Fragebogen (insgesamt 244; Rücklaufquote 86,6%).Der Anteil fremdsprachiger Patienten wird von mehr als der Hälfte (51%) der K auf 1–5% geschätzt, von einem Drittel der K auf mehr 5%. Lediglich 4% der K führen Statistiken über fremdsprachige Patienten. Kommunikation mit Fremdsprachigen stellt für 34% der K eine beträchtliche Schwierigkeit dar. Nur 14% ziehen häufig qualifizierte Übersetzer bei. 79% der K geben an, häufig Angehörige beizuziehen, 75% häufig Pflegepersonal, 43% häufig Spitalpersonal. Qualifizierte Übersetzer werden in den medizinischen K seltener eingesetzt als in den psychiatrischen. Am dringendsten wären laut den befragten K qualifizierte Übersetzer in den Sprachen Albanisch, Serbokroatisch/Bosnisch, Türkisch und Tamilisch. Nur 11% der 244 K verfügen über ein Budget zur Entlöhnung von Übersetzern. Es besteht dringender Bedarf, Behandelnde und Pflegende zum Thema Übersetzung zu sensibilisieren, sowohl was die Vorteile der Zusammenarbeit mit Übersetzern, als auch was die Grenzen übersetzender Familienangehöriger betrifft. Koordination und Planung auf nationaler Ebene werden nötig sein, sowie Ausbildungsprogramme, die adäquate Kommunikation und Pflegequalität sicherstellen.

Résumé

Barrières linguistiques et soins: résultats d'enquêtes dans les services médicaux en Suisse

Avec l'augmentation des mouvements migratoires, la langue constitue une barrière potentielle dans l'accès aux soins. Afin de préciser comment la Suisse se situe face à cet enjeu, nous avons mené une enquête auprès des services de médecine et de psychiatrie du pays. Un questionnaire portant sur l'utilisation d'interprètes a été adressé aux directions médicales de tous les services concernés. Le taux de réponse a été de 86,6%, soit un total de 244 questionnaires retournés (166 pour la médecine et 78 pour la psychiatrie). Trente-quatre pourcent des répondants perçoivent la communication avec les patients de langue étrangère comme significativement difficile. Dans 14% seulement des services (5 de médecine et 23 de psychiatrie) on fait régulièrement appel à des interprètes qualifiés. Les professionnels de la santé ont plus souvent recours aux proches du patient (79%), au personnel technique et administratif (75%) ainsi qu'au personnel soignant (43%) pour traduire. Un besoin en interprètes qualifiés s'exprime en priorité pour les langues suivantes: Albanais, Serbo-Croate (et Bosniaque), Turc, Tamoul et Kurde. Ces résultats indiquent que les problèmes liés à l'utilisation d'interprètes informels et les avantages de travailler avec des interprètes qualifiés ne sont pas encore suffisamment connus. Une prise de conscience devrait s'opérer par l'intermédiaire d'une coordination nationale et de programmes de formation dans le domaine de l'interprétariat médical.

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