

## Guest editorial

# Are translation and interpretation services a necessity or a luxury?

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In December 2006, the BBC reported that '... more than £100m of public money is spent on translation services in the UK' (BBC News, 2006). Local authorities, it was stated, spent £25 million, NHS trusts £55 million, and legal services, including the courts, a total of £31 million in translating and interpreting services for users who did not speak English. The rather predictable response seen on the BBC and national newspaper message boards reflected considerable indignation from sections of the general public, the argument proceeding along the lines of, 'If *they* can't be bothered to learn English, *they* shouldn't have access to *our* public services'.

Also somewhat predictably perhaps, upon hearing of the BBC report, Ruth Kelly, Secretary of State for Communities and Local Government, asked the Social Cohesion Unit for a review of language services across government. The government's intervention is seen by some segments of society as a 'victory for common sense' (Taxpayers' Alliance, 2006). Anticipated to report in the middle of 2007, it however remains to be seen whether this review will add anything original to the ongoing heated debate as to how best to encourage social cohesion and integration between Britain's 4.6 million black and minority ethnic (BME) groups and wider society.

The main bones of contention among critics have been the monetary cost of translation and interpretation services and the belief that, through allowing the perpetuation of parallel communities, such services hinder integration. Although important concerns, little consideration has, however, thus far been given to the likely detrimental effects on health and social care provision of restricting access to the *already inadequate* availability of translation and interpretation services for these marginalised communities.

It is salutary to reflect on some of the key factors that have driven the recent (welcome) investment from the NHS, charities and other public bodies to make translation and interpretation services more widely available. These include the growing recognition that most BME groups experience disproportionate morbidity and mortality for a range of disorders, but despite longstanding NHS commitments to tackling these inequalities, very little progress has been made (Nazroo, 1997). Related to this has been a deepening understanding of the multifaceted environmental factors that have contributed to these inequalities, and awareness that tackling the issue of language support is important to improving access to equitable care. Surveys conducted in the mid-1990s assessing adult language capacity and literacy in Britain, for example, found that there was, especially among older people and women of certain BME groups, often only a limited ability to understand spoken English (Rudat, 1994). Subsequent work by Modood *et al* (1997) and others showed that the linguistic abilities of many minority ethnic groups were not even at the 'survival level', such that they would be unable to complete even the most simple tasks in English, thereby underscoring the need for widespread availability of translation and interpretation services. But perhaps most important of all was the introduction of the Race Relations (Amendments) Act 2000. Introduced following the Macpherson Report (1999), this focused attention on the concept of 'institutional racism', and in so doing placed on public bodies the unprecedented duty to promote race equality. A consequence of this legal development was the interpretation by many public bodies, including the NHS, of the need to provide appropriate language provision as part of their efforts to promote equality of opportunity (Thorlby and Curry, 2006).

The linguistic challenges facing public sector organisations such as the NHS are, however, immense, as evidenced by studies which have found that there are approximately 300 different regional and national languages being used in London alone (Szczepura *et al*, 2005). It is thus unsurprising that, as anyone who has ever tried to access them knows only too well, availability of interpreters, and especially those who are professionally trained, is problematic. Gerrish *et al* (2004) have suggested that one reason for the lack of professional interpreter input into many consultations where they are needed may be the lack of awareness among patients of the availability of such interpreting services and, added to this, a general inability in knowing how to make their needs known. Service providers, in contrast, report lack of ready access to suitable culturally and linguistically qualified interpreters when they are most needed: in general practitioner (GP) surgeries, outpatient clinics and on hospital ward rounds, for example.

As a result, in order to avoid having to reschedule appointments or delay ward rounds, frontline staff will frequently make use of family members as a convenient alternative to accredited interpreters. Using family members in this way can, however, result in additional problems such as breaching confidentiality, censoring of information, especially 'bad news' scenarios, with knock-on implications for consent issues and hampering the provision of patient-centred care (Howard, 2006). What causes more concern still is the persistence in using children for interpreting in medical settings (Webb, 2005). Although the use of children as interpreters is considered unacceptable, it is nevertheless still common practice, especially when interpreters are in short supply. Apart from being ethically questionable, children lack the vocabulary and the emotional maturity to serve as effective interpreters. The use of children as interpreters has led to such concern that the state of California has taken the first step to draft regulations that would prevent children from interpreting at private hospitals, physicians' offices or clinics (Burke, 2005). Thus, although the practice has long been discouraged, 70% of the public sector services still use family and friends as interpreters (McPake and Johnston, 2002); restricting access to professional interpretation services will only exacerbate this problem.

It has been argued that the money spent on translation and interpretation would be better spent on promoting access to English language teaching for these marginalised individuals. This suggestion about the need to participate in society and become more British by learning English may have been credible if funding for English for Speakers of Other Languages (ESOL) courses was not at the same time being squeezed. A shortage of teachers has meant inadequate provision and courses being overwhelmed in trying to

meet increasing demand from adult migrants and refugees (National Institute of Adult Continuing Education (NIACE), 2006). The criteria for getting on one of these courses also provide a major hurdle, with eligibility for free tuition available only to refugees or those who have been legally resident in the UK or the European Union for three years (or 12 months if married to a British citizen). Added to this the government is at the same time also planning to axe free English language lessons for adult asylum seekers from August 2007, which will essentially undermine efforts to encourage some of the most vulnerable new arrivals to Britain to integrate.

Rather than pour cold water on the recent welcome progress that is being made in improving access to services through greater language support, the government must recognise that in globalised societies such as ours there will always be a need for high-quality translation and interpretation services. Meeting the language support needs of such marginalised people is essential if we aim to build an equitable, just and integrated society, but that in itself is insufficient as it should go hand in hand with greater access to learning English. It is our experience that few people deliberately choose not to have the tools to communicate effectively; rather, as most British people who have tried to learn French or any other foreign language know only too well, learning a language is a slow and challenging process, particularly in an environment that is perceived to be critical and unsupportive.

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#### CONFLICT OF INTERESTS

The authors are working on a Chief Scientist Office project grant: 'Developing services to meet end of life care needs of South Asian Sikh and Muslim patients and their families in Scotland' (reference: CZH/4/242).

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