Subcommittee on Rights of Ethnic Minorities
Use of Healthcare Services by Ethnic Minorities

Submission from the Equal Opportunities Commission

Purpose of the Paper

This paper sets out to provide the Equal Opportunities Commission's (EOC's) views to the Subcommittee on Rights of Ethnic Minorities regarding access to and use of healthcare services by ethnic minorities (EMs).

Protection under the Race Discrimination Ordinance

2. Access to good healthcare is an important determinant of quality of life in any place. It is a necessity and a right. Given that "provision of goods, facilities and services" is covered by the Race Discrimination Ordinance (RDO), any discrimination in accessing healthcare services on the ground of one's race would be treated as unlawful race discrimination.

3. Under the RDO, it is unlawful for service providers (whether for payment or not) to discriminate against any person on the ground of his/her race by refusing to provide the services, or provide the services to him/her in the like manner, terms and quality.

4. Given that language used by people is often associated with their race, unfair treatment based on language without justifiable reason(s) may constitute indirect discrimination against EMs. However, more as a best practice recommendation, we advise the provision of both Chinese and English information at the least, and EM

languages preferably, wherever essential and possible in order to aid access to services for EMs. Additionally, the option of asking for interpretation should be made available and the procedure for doing so clearly communicated.

On Hospital Authority

EMs' Concerns

5. Being able to communicate one's health problem and understand the doctor's diagnosis and recommendations is critical in healthcare. While interpretation services are available for hospitals and out-patient clinics, awareness about the service and the procedure involved in asking for it is still not widespread.

6. In addition, reports of patient experience point to several areas of concern:
   a. Relatives, children and strangers are often called upon to interpret for EM patients in the absence of a qualified interpreter.
   b. Requests for interpretation service are not always acceded to by frontline staff; lack of information about the service by the staff has been pointed out as one reason, another being the additional procedures that it may involve.
   c. EM patients are always at a loss especially for the first appointment. As there appears to be no procedure of proactively asking if the patient requires it, the burden falls on the patient to be aware of the service and request the doctor or nurse for it.
   d. The problem is further compounded in the case of Accident and Emergency (A&E) where the patient arrives without an appointment and the medical staff are working under time pressure.
   e. It is learnt that telephone interpretation services are not commonly used though they would be a quicker option, especially in A&E or other

situations where there is no time to wait for an interpreter or it is a first-time visit to the doctor.

f. Use of interpreters in in-patient treatment is not common. Members of the EM community reflected that hospitalized EM patients were not always aware of their diagnosis and the procedure they went through or the treatment they were receiving.

EOC's Recommendations

7. The use of **professional interpretation services** should be improved by:

a. Ensuring clear, strict instructions and enforcement on not using ad-hoc interpreters such as relatives, friends, children or other patients in place of professional interpreters as the consequences of miscommunication could be serious;

b. Having a designated office, such as the Patient Resource Centre, at an easily accessible and identifiable location in every hospital to be responsible for registering all requests for interpreters so that the booking procedure can be standardised and simplified;

c. Drawing up clear guidelines and protocol on when and how to offer and arrange interpretation services for EM patients and widely disseminating the information to all medical staff;

d. Encouraging the use of telephone interpretation in A&E and in-patient treatment;

e. Including the provision of interpretation services as an essential service indicator and not an optional activity; and

f. Displaying posters in major EM languages at prominent locations, such as next to the registration counters, to inform EM patients of their rights to request for interpretation services.

8. **Staff training** should be strengthened by:

a. Organising more training for all staff, particularly frontline staff, on interpretation services, as against the current practice of once-a-year training session;
b. Making "Cultural Sensitivity" part of medical school and nursing school curriculum; and
c. Training staff to be able to identify patients, especially first-timers, who may need interpretation service and also proactively offer the service as part of the procedure.

9. EM Patients are not clear on how to ask for an interpreter, especially for the initial or one-off visit to General Outpatient Clinic (GOC). There is currently no option for interpretation service in the Phone Booking System. Even worse, EM patients are basically unable to book for an interpreter since the time required for sourcing an interpreter is 2-3 days while the clinic appointment has to be made only 24 hours ahead. Therefore an overhaul of the **Phone Booking System** for GOC to include an interpreter booking option is recommended.

10. **Demand assessment** for interpretation service should be conducted by actively sourcing data that can help estimate demand by area, language, gender and nature of health care sought. The service should not simply be measured by the number of cases where interpretation was provided. Rather, it should be assessed in terms of percentage of non-Chinese patients visiting the hospital who were provided with interpretation service. This data is also advised to be made accessible to the public for service enhancement.

11. The following alternative/additional interpretation service provision should also be actively considered:

a. On top of the existing outsourced interpretation services provided by NGOs, **in-house interpreters** in high demand languages, e.g. Urdu, Hindi, etc., can be stationed in those hospitals with high EM visit rate particularly for emergent services such as A&E and on-site interpretation for in-patient treatment. Their role can also be expanded to be the in-house trainer and adviser for the provision of interpretation services;

b. There is an increasing pool of local EM youth who are proficient in spoken Cantonese and written Chinese to a limited extent. The Hospital Authority is recommended to revisit the Chinese language requirements requisite for its job positions in different levels and give due weight to additional language and cultural competence in its staff recruitment, so as to hire more **non-Chinese employees** who can speak other languages and can be called upon to interpret when needed.

On Department of Health

12. Most of the recommendations listed above on interpretation services and staff training are equally applicable to the services provided by clinics under the Department of Health (DoH). In addition, the EOC is concerned about the dissemination of information on general health, seasonal epidemics, vaccinations, DOH special programs such as subsidised colorectal screening for those aged 60-70 years etc., among the EM population. Efforts should be made to ensure that the elderly and vulnerable among the EMs are brought within the net of all public schemes as they may have less access to information and therefore a lesser likelihood of availing of the scheme. This will require the training of frontline staff to inform patients and help them with the process as well as targeted publicity for EM communities.

13. For screening of children with suspected special needs, the diagnostic assessment process must take into account the language circumstances of the child. As assessments are at present carried out in Chinese or English, an EM child who is largely only proficient in his/her mother tongue, may have difficulty being diagnosed accurately. Care must also be taken while using an interpreter for the assessment, though it may be the only option, as it could affect the results and the resultant support services and intervention prescribed. The DoH may consider allowing assessments carried out in the home country or by specialists in the mother tongue language to be given due weight in the overall diagnosis and follow-up services.

Conclusion

14. In conclusion, recognising that healthcare is a basic and critical need, the EOC urges the Government to make this as convenient and easy to access for EMs as possible. While some measures are in place, implementation may need to be enforced and monitored. Also, the Government is urged to critically study the systems themselves and either revamp or replace them where inefficient or ineffective, with the ultimate objective of delivering quality service for all.

Equal Opportunities Commission
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