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in cross-border healthcare

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Study on Public Service Translation in Cross-border Healthcare

***Final Report for the European Commission
Directorate-General for Translation
Reference: DGT/2014/TPS***

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ABSTRACT

Linguistic diversity permeates every thread of the European Union fabric. Cross-border healthcare is increasing among EU citizens and residents who seek care under Directive 2011/24/EU or Regulation (EC) N° 883/2004. In a multilingual and intercultural society like the EU, patients and providers may not share a language. If patients cannot access healthcare services in a language they fully understand, equal access to safe and high-quality healthcare is not guaranteed. Through the use of both quantitative and qualitative methods, this exploratory study examines language policies as well as responses provided (or lack thereof) to linguistically diverse patients in areas of Germany, Greece, Italy, Spain and the United Kingdom. The cost of language provision as well as good practices are also studied. Results show that a variety of responses, ranging from professional translation and interpreting support to informal and unprofessional ad-hoc solutions, are used to address the language needs of patients. In the absence of formal language guidance in EU legislation, in most observed cases appropriate language services are not provided for patients who do not speak the language of the Member State in which they seek healthcare. This study has implications for policy makers, healthcare providers, educators, translators and interpreters serving the needs of linguistically and culturally diverse patients.

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EXECUTIVE SUMMARY

1. Introduction

In the European Union both the mobility of citizens and their access to healthcare are rights guaranteed in the EU Charter of Fundamental Rights. Mobility of citizens is a right exercised with increasing frequency as the distinction between nation states is becoming less significant. When citizens are mobile and travel to, or reside in, another Member State than the MS of affiliation they may at times need access to healthcare services.

In multilingual and multicultural societies such as the EU, patients who are not proficient in the language of the Member State in which they seek care may need different types of language support such as: 1) information in their own language; 2) translation of specific documents (e.g. medical records or documents for reimbursement); or interpreting and/or cultural mediation in order to access safe and high-quality healthcare. This is both the case of patients who reside in a MS and do not speak the societal language yet, as well as patients who cross borders to seek care in a Member State the language of which they cannot access. Neither Directive 2011/24/EU¹, nor any other EU document (except for Directive 2010/64/EU on the right to interpreting and translation in the framework of criminal proceedings) contemplates how EU patients may access information or communicate with healthcare staff and providers in a language that is not their own. In the absence of formal legislation and policy guidance, organizations and patients are left to their own devices to meet communicative needs; this, at times, results in unequal access to the highest level of protection that all EU citizens are guaranteed.

2. Context of the Report

This report examines the language needs of the EU multilingual and intercultural societies as well as the responses provided (or lack thereof) to meet these needs. The European Commission's Directorate-General for Translation (DGT) established the following specific objectives for this report:

- To review the language policies in place that facilitate access to cross-border healthcare from the perspective of language;
- To examine the interplay of language and access to study if language is a right or an enabling factor; if linguistic access is respected, enforced and/or sanctioned;
- To study the cost of language support, and in its absence, the total social cost of failed social and economic integration;
- To review the types of language services, how they are organised, and who provides the services; and
- To examine good practices in language services and make recommendations for language provision in public services.

In addition, the DGT established the following two conditions which impact the feasibility, research questions and methodology of this study: 1) a timeline of nine months and 2) a maximum budget of € 55,000. In response to the DGT Call for Tenders, an exploratory study was conducted in areas of Germany, Greece, Italy, Spain and the United Kingdom. The study uses quantitative and qualitative methods to answer five research questions. It applies questionnaires, documentary analysis, interviews and non-participant observations. Two hundred and nine informants -

¹ 2011/24/EU acknowledges the patient's right to information and the obligations of the Member States of treatment and of affiliation (see Article 4).

among them patients and family members, policy makers, city council members, NGO staff, non-profit organization staff, community centre leaders, healthcare administrators and providers, language service providers such as translators, interpreters and language/cultural mediators (both freelance and members of staff), agency owners, presidents of T&I professional associations, cultural mediation cooperatives and software developers participated in the study. In addition, we conducted observations and obtained translation and interpreting samples from 128 sites representing rural and urban, public and private healthcare centres, clinics, general and specialized hospitals, accident and emergency departments, ministries of health and NGO offices. Three hundred and thirty-one respondents took part in two questionnaires.

3. Key Findings

3.a. Legislation and Policy

None of the documents constituting the EU framework (i.e. the Directive, the Charter of Fundamental Rights of the European Union, the Treaty on the Functioning of the European Union or the Regulation 833/2004) explicitly refer to language provision for EU citizens or legal residents pursuing healthcare in Member States in which they cannot access the information. In the absence of a clear EU legislative guidance, the pertinent legislation of each MSs that participated in this study varies considerably. In most cases there is not any legislation that guarantees comprehensive language services to patients. Legislation that guarantees professional language services (e.g. United Kingdom) was found to be a good practice. Findings highlight the following:

- There is not any legislation in place at the EU level that defines the responsibility for who is to provide language services in the healthcare setting.
- In Germany, the only reference to language in legislation is in regard to obtaining consent from patients in a language that patients understand.
- Neither in Germany nor in Greece is there evidence of legislation that contemplates the provision of language services to patients who cannot access the national language.
- In the United Kingdom Equality legislation compels institutions to provide language services so that patients can access healthcare services. Not providing language services is considered discriminatory and institutions must provide professional services.
- In both Italy and Spain regional languages are protected by law. Therefore, information must be offered in these languages.

3.b. Language Services

Across the participating Member States of this study language support for cross-border healthcare patients is not provided in an even and consistent manner. In most cases professional language support is not provided at all. This calls into question the right to access safe and high-quality healthcare. Cross-border patients in most cases are responsible for the translation of documents and medical records. Language provision is perceived as costly and not always essential. Findings highlight the following:

- With alarming frequency, healthcare institutions do not provide any formal language services and ad-hoc language brokers are called upon to perform translation, interpreting and language/cultural mediation without compensation.
- Family members or friends of the patient, as well as bilingual staff or volunteers translate and interpret since professional services are not offered.

- The responsibility of translating documents to seek reimbursement under the Directive in most cases falls on the patient.
- When provided, professional interpreting services are offered across a range of modalities. Face-to-face, telephone and videoconference interpreting have all been documented.
- In both Germany and Greece professional language services are limited and were only observed in relation to consent forms and videoconference interpreting in private clinics, respectively.
- In Italy institutions frequently call upon intercultural mediators to provide language services.
- In Spain bilingual medical service is offered in regional languages. This includes the provision of bilingual forms and documents as well as the employment of bilingual staff and providers. Thus, no translation or interpreting is needed between the national and regional language.
- In the United Kingdom public healthcare institutions routinely offer professional language services to patients who do not understand written or spoken English. These institutions have Equality and Diversity departments in charge of guaranteeing equal access.

3.c. Cost

In the participating Member States language provision in healthcare is not included as a line item in any national budget. When professional services are available individual healthcare institutions, regional healthcare trusts or the patients themselves pay these costs. In many cases the alleged cost of service was cited to be a deterrent for the provision of professional language services. In other cases, healthcare administrators reported that the cost for providing professional language services is recouped in the medium to long-term and that not providing such services prohibits social integration and actually costs healthcare institutions more in the long-term.

4. Key Recommendations

In light of the observed and reported practices across the Member States of this study the report makes the following recommendations:

- Since language support is needed to allow equal access, professional language support should be accounted for in legislation. Improvised practices, ad hoc bilinguals performing language brokering *in lieu of* professional services do not constitute a responsible way to address the language needs of a diverse population in the EU.
- Information provided by National Contact Points should be available at least in all the official languages of the EU (including sign-languages). This would ensure effective access to information and observe non-discriminatory practices.
- Bilingual staff whose degree of proficiency in both languages and translation/interpreting skills cannot be verified should not be required to perform the duties of translators, interpreters or cultural mediators. They should first be afforded appropriate professional development opportunities.

This report should be of interest to all EU citizens and residents pursuing healthcare in a MS other than their own, as well as policy makers, healthcare organizations and providers, language providers (individuals and companies) and NGOs working with linguistically and culturally diverse patients.

RAPPORT EXÉCUTIF RÉSUMÉ

1. Introduction

Dans l'Union européenne, la mobilité des citoyens et leur accès aux soins de santé sont des droits garantis par la Charte européenne des droits fondamentaux. La mobilité des citoyens est un droit qui est exercé avec une fréquence croissante au fur et à mesure que les distinctions entre les Etats-nations deviennent de moins en moins importantes. Lorsque les citoyens sont mobiles et voyagent ou résident dans un autre État membre, ils ont parfois besoin d'un accès aux services de soins de santé. Dans les sociétés multilingues et multiculturelles telles que l'UE, les patients qui ne maîtrisent pas la langue de l'État membre dans lequel ils cherchent à obtenir des soins peuvent avoir besoin de différents types de soutien linguistique comme 1) de l'information dans leur propre langue; 2) la traduction de documents spécifiques (par exemple, des dossiers médicaux ou des documents de remboursement); ou de l'interprétation et/ou de la médiation culturelle afin d'accéder à des soins de santé sûrs et de haute qualité. Ceci est le cas à la fois des patients qui résident dans un État membre et qui ne parlent pas encore la langue de la société, et des patients qui traversent les frontières pour se faire soigner dans un Etat membre dont ils ne parlent pas la langue. La directive 2011/24/UE², pas plus qu'aucune autre législation de l'UE (à l'exception de la directive 2010/64/EU relative au droit à l'interprétation et à la traduction dans les procédures pénales), n'établit comment ces patients peuvent accéder à des informations dans une autre langue que la leur ou communiquer avec les prestataires de soins de santé s'ils ne parlent pas la langue de l'établissement. En l'absence de législation formelle et d'orientation politique, les organisations et les patients se débrouillent seuls en termes de communication ce qui, à certains moments, occasionne une inégalité d'accès au niveau élevé de protection garanti à tous les citoyens de l'UE.

2. Contexte du Rapport

Ce rapport examine les besoins linguistiques des sociétés multilingues et interculturelles de l'UE ainsi que les réponses fournies (ou non) pour satisfaire à ces besoins. Les objectifs spécifiques fixés pour ce Rapport par la Direction générale pour la traduction (DGT) de la Commission européenne sont les suivants :

- Analyser les politiques linguistiques en place pour faciliter l'accès aux soins de santé transfrontaliers du point de vue de la langue ;
- Examiner l'interaction de la langue et de l'accès afin d'étudier si la langue est un droit ou un facteur favorable ; si l'accès linguistique est respecté, appliqué et/ou sanctionné ;
- Estimer le coût du soutien linguistique et, en son absence, le coût social total de l'échec de l'intégration sociale et économique ;
- Passer en revue les types de services linguistiques, la façon dont ils sont organisés, et les prestataires de ces services ; et
- Examiner les bonnes pratiques en matière de prestation de services linguistiques et faire des recommandations pour la prestation desdits services dans les services publics.

En outre, la DGT a fixé les deux conditions suivantes pour cette étude, qui ont un impact sur sa faisabilité, les questions de recherche et la méthodologie : 1) un calendrier de neuf mois ; et 2) un budget maximum de € 55 000. En réponse à l'appel

² 2011/24/EU reconnaît le droit des patients à l'information et les obligations des Etats membres de traitement et d'affiliation (voir Article 4)

d'offres de la DGT, une étude exploratoire a été menée dans plusieurs régions en Allemagne, en Grèce, en Italie, en Espagne et au Royaume-Uni. Cette étude utilise des méthodes quantitatives et qualitatives pour répondre à cinq questions de recherche. Elle se sert de questionnaires, de l'analyse de documents, d'entrevues et d'observations de non participants. Deux cent neuf informateurs ont participé à cette étude – dont des patients et leurs familles, des décideurs politiques, des conseillers municipaux, des membres du personnel d'ONG, des membres du personnel d'organisations à but non lucratif, des dirigeants de centres communautaires, des administrateurs et prestataires de soins de santé, des prestataires de services linguistiques tels que traducteurs, interprètes et médiateurs linguistiques et culturels [externes et permanents], des directeurs d'agences, des présidents d'associations professionnelles de traducteurs et interprètes, des coopératives de médiation culturelle et des développeurs de logiciels. En outre, nous avons observé et obtenu des échantillons de traduction et d'interprétation de 128 sites représentant des cliniques et centres de soins de santé en milieu rural et urbain, publics et privés, des hôpitaux généraux et spécialisés, des ministères de la santé et des ONG. Trois cent trente et une personnes ont répondu à deux questionnaires.

3. Principales constatations

3.a. Législation et politique

Aucun des documents constituant le cadre législatif de l'UE (à savoir la Directive, la Charte des droits fondamentaux de l'Union européenne, le Traité sur le fonctionnement de l'Union européenne ou le règlement 833/2004, qui ensemble constituent le cadre de l'UE, ne se réfèrent explicitement à l'offre de services linguistiques pour les citoyens de l'UE ou les résidents réguliers à la recherche de soins de santé dans des Etats membres où ils n'ont pas accès à l'information. En l'absence d'orientation législative claire de l'UE, la législation pertinente en vigueur dans chacun des Etats membres qui ont participé à cette étude varie considérablement. Dans la plupart des cas, il n'y a aucune législation qui garantit des services linguistiques complets pour les patients. La législation qui garantit des services linguistiques professionnels, comme au Royaume-Uni, s'est révélée être une bonne pratique. Les principaux résultats sont les suivants :

- Il n'y a aucune législation en place au niveau de l'UE qui définit qui est responsable d'offrir des services linguistiques dans le cadre des soins de santé.
- En Allemagne, la seule référence à la langue dans la législation se réfère à l'obtention du consentement des patients dans une langue qu'ils comprennent.
- Ni en Allemagne, ni en Grèce n'a-t-on pu établir l'existence d'une loi qui prévoit la fourniture de services linguistiques aux patients qui ne comprennent pas la langue nationale.
- Au Royaume-Uni, la législation sur l'égalité (*Equality Act*) oblige les institutions à fournir des services linguistiques afin que les patients puissent accéder aux services de soins de santé. Ne pas fournir ces services linguistiques est considéré comme discriminatoire ; en outre, les institutions doivent fournir des services professionnels.
- En Italie et en Espagne, les langues régionales sont protégées par la loi et donc toute information doit être obligatoirement disponible dans ces langues.

3.b. Services linguistiques

Dans aucun des Etats membres participants de cette étude, il n'est offert de soutien linguistique uniforme et cohérent pour les patients dans le cadre des soins de santé transfrontaliers. Dans la plupart des cas, aucun soutien linguistique professionnel n'est

fourni, ce qui remet en question le droit d'accéder à des soins de santé sûrs et de haute qualité. Très souvent, les patients transfrontaliers sont eux-mêmes responsables de la traduction des documents et des dossiers médicaux. L'offre de services linguistiques est perçue comme coûteuse et pas toujours indispensable. Les principaux résultats sont les suivants :

- Avec une fréquence alarmante, les établissements de santé ne fournissent pas de services linguistiques dignes de ce nom; la traduction, l'interprétation, la médiation linguistique/culturelle sont assurées par des non professionnels qui ne reçoivent aucune compensation.
- Les membres de la famille, les amis du patient, ainsi que le personnel bilingue ou les bénévoles assurent la traduction et l'interprétation faute de service professionnel.
- La responsabilité pour la traduction de documents de demande de remboursement en vertu de la directive revient au patient dans la plupart des cas.
- Lorsqu'ils sont fournis, les services d'interprétation professionnelle sont offerts selon des modalités qui ont toutes été décrites: interprétation face-à-face, par téléphone et vidéoconférence.
- En Allemagne et en Grèce, les services linguistiques professionnels sont limités et ne sont offerts que pour les formulaires de consentement et l'interprétation par télé- et vidéo-conférence dans les cliniques privées, respectivement.
- En Italie, les institutions font souvent appel à des médiateurs interculturels pour fournir des services linguistiques.
- En Espagne, un service médical bilingue est offert dans les langues régionales. Cela comprend la mise à disposition de formulaires et documents bilingues ainsi que le recours à du personnel bilingue. De la sorte, il n'est pas nécessaire de traduire ou d'interpréter entre les langues nationale et régionale.
- Au Royaume-Uni, les établissements de santé publique offrent régulièrement des services linguistiques professionnels à des patients qui ne comprennent pas l'anglais écrit ou parlé. Ces institutions ont des services dits d'égalité et de diversité (*Equality & Diversity Departments*) chargés de garantir l'égalité d'accès.

3.c. Coût

Dans les États membres participants, l'offre de services linguistiques dans les établissements de soins de santé n'est pas reprise comme un poste dans le budget national. Lorsque des services professionnels sont disponibles, ce sont les établissements de santé individuels, les centres hospitaliers régionaux publics ou les patients eux-mêmes qui en assument les coûts. Dans de nombreux cas, le coût présumé de services linguistiques professionnels est présenté comme dissuasif. Dans d'autres cas, les administrateurs de la santé ont indiqué que le coût de services linguistiques professionnels est amorti à moyen et à long terme et que leur absence interdit l'intégration sociale et coûte en fait plus aux institutions de soins de santé sur le long terme.

4. Principales recommandations

À la lumière des pratiques observées et rapportées dans les États membres objets de cette étude, le rapport fait les recommandations suivantes :

- Etant donné que le soutien linguistique est nécessaire pour permettre un accès égal, la législation doit prévoir que ce soutien soit fourni par des professionnels. Le recours à des pratiques improvisées, à des bilingues ad hoc

ou à des non-professionnels en remplacement de services professionnels ne constitue pas une façon responsable de répondre aux besoins linguistiques de la population diversifiée de l'UE.

- Les informations fournies par les Points de contact nationaux devraient être disponibles au moins dans toutes les langues officielles de l'UE (y compris les langues des signes). Cela permettrait d'assurer un accès efficace à l'information et d'observer des pratiques non discriminatoires.
- Le personnel bilingue dont le niveau d'éducation dans les deux langues et les aptitudes à traduire/interpréter ne peut être établi ne doit pas exercer les fonctions de traducteurs, d'interprètes ou de médiateurs culturels. Ces personnes doivent d'abord recevoir un perfectionnement professionnel approprié.

Ce rapport devrait être d'intérêt pour les citoyens et résidents de l'UE qui souhaitent obtenir des soins de santé transfrontaliers, pour les décideurs politiques, les organisations et les prestataires de soins de santé, les prestataires de services linguistiques (particuliers et entreprises) ainsi que pour les ONG/Organisations à but non lucratif travaillant avec des patients linguistiquement et culturellement divers.

INTRODUCTION

Linguistic diversity permeates every thread of the European Union fabric. In the EU, the interplay between linguistic diversity and geographic mobility and its consequent impact on access to and provision of healthcare remains understudied. Questions regarding the interpretation and implementation of EU directives, specifically as they refer to language access in a multilingual environment, have not been sufficiently researched. In addition, the interplay between the interpretation and implementation of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 ("the Directive") and the reality of the field as well as the observed behaviours in practice of all stakeholders need to be considered. This exploratory research will contribute to evidence-based policy-making. It will enhance our understanding of the degree to which policy and practice converge or diverge when it comes to respecting the right of EU citizens to access high levels of social protection and healthcare, thus contributing to social cohesion and social justice. Therefore, this study is both necessary and timely as an initial insight into the plethora of issues related to healthcare provision in a linguistically diverse Union.

This introductory section contains three sub-sections. Sub-section 0.1 introduces the issue of cross-border healthcare and presents background information about the study. It explains to the reader the rationale behind the study design. Sub-section 0.2 presents a brief review of the relevant literature on cross-cultural/linguistic communication in the healthcare setting, the context in which this study is situated. Sub-section 0.3 offers an overview of the following sections of this report.

0.1 STUDY BACKGROUND INFORMATION

The European Union is a common project between different countries of diverse peoples. To the common project peoples bring with them their race, ethnicity, language, and gender orientation, along with other social factors. The essence of the project resides in the balance between the EU's intrinsic diversity and its capacity to protect that diversity while supporting integration. Diversity includes not only the combination of states and nationalities, but goes beyond these administrative divisions and incorporates the blending of cultures, traditions, habits, lifestyles and principles. The EU is proud of this diversity and keeps working to ensure its policies respect its heterogeneous nature while supporting the mobility of its citizens to create a parallel European identity, under which all cultures are included and feel at home.

In the midst of all these differences, languages play a key role in protecting the balance between the diversity of the EU and the desire for better communication to pursue the Union's common goals. Languages are one of the richest expressions of identity and empower speakers when it comes to expressing their truest convictions, desires or needs (Fishman 1999, Kockel 1999, Nic Craith 2006 & 2007, Phillipson 2000).

Language support in a multicultural environment is a major priority that enables communication between citizens of different Member States (MSs) who do not share a language. This guarantees freedom of expression. Paying attention to this support will protect the right of all citizens to have a voice and adequately communicate with others, thus avoiding unintended discrimination on the basis of language.

The interplay of language and access, specifically as it relates to equality in accessing healthcare services and securing human health protection, is present in the fundamental texts of the EU such as the Charter of Fundamental Rights of the European Union ("the Charter"). The Charter establishes the guiding values of the Union. Access to healthcare and freedom of movement are included in the Charter, as well as non-discrimination and cultural, religious and linguistic diversity. Language access and translation and interpreting (for spoken or sign languages) services have an important role at the point where these rights intersect. Essentially, language provision through translation and interpreting becomes necessary when mobility, healthcare, non-discrimination and linguistic diversity are guaranteed. These rights cannot be effectively ensured or put into practice without language access. The Directive expands the rights of citizens to seek and be reimbursed for cross-border healthcare. The Directive clarifies the reimbursement and procedural process and also defines the competencies of MSs. Furthermore, it specifically mentions (section 3) the role of health systems as central components of the Union's high levels of social protection, and their contribution to social cohesion and social justice as well as to sustainable development. Implicit in all statements above is the notion of linguistic access, yet neither the Directive nor any other EU legislation defines how language services are to be provided to cross-border healthcare patients. The high levels of social protection, their contribution to social cohesion and social justice can only be realized in a multilingual environment where language access (written, spoken or sign) is recognised and provided.

In multilingual Europe, as in many other multilingual societies in the world (e.g. Canada, India, South Africa, United States), cross-linguistic communication is increasingly frequent, especially when it relates to accessing services. In regard to healthcare, when monolingual EU citizens seek healthcare outside their home MS, they frequently resort to language brokering to accomplish their communicative needs. Such brokering is needed in order to access information and services from speakers of the societal language of the MS in which healthcare is sought. As European citizens become more mobile, and as the European Union continues to grow as a community in which borders and barriers are easily overcome or simply eliminated, EU citizens increasingly resort to such language brokering. Whether performed entirely by professional humans (translators, interpreters, language-service providers) or ad-hoc parties, or by appropriate software (e.g. machine translation with post-editing), or hybrid models (humans utilising CA Tools), translation and interpreting (spoken or sign) have always been central to cross-linguistic communication between speakers who do not share a language. In addition, in some countries the existence of many regional languages (e.g. Catalan, Galician, Valencian and Basque in Spain, or Welsh, Gaelic and Scots in the United Kingdom), coupled with the development of effective public services such as cross-border healthcare has contributed to the need for public service translation and interpreting as a means to access healthcare services.

As stated in the report from the Special Interest Group on Translation and Interpreting for Public Services (SIGTIPS, 2011), the European Union is an entity where internal mobility and migration are factors that have made MSs increasingly multilingual and multinational. For persons who lack adequate command of the societal language, whether they are mobile EU citizens, migrants, or asylum seekers, translation and interpreting services play an important role in providing access to public services. Translation and interpreting make service provision possible and are not limited to just foreigners or foreign residents since any EU citizen who is outside his/her own MS may require language provision if unable to access the language of the MS where healthcare is sought. Directive patients would fit into this category. The SIGTIPS also points out that national legislation on translation and interpreting services is limited to specific settings or recommendations. Despite the real need for these services a broad

national legal framework that specifically recognises the right to access them in the public sector is, for the most part, missing. In contrast to this lack of specific national legislation guaranteeing translation and interpreting services the Charter explicitly supports language diversity and prohibits discrimination on the basis of language.

This study addresses the issues raised in the General and Specific Objectives of the DGT Call for Tenders DGT/2014/TPS aimed at fostering evidence-based policy-making. The DGT General Objectives are: 1) to review language needs in our multilingual and intercultural societies; and 2) to review the responses that are provided, or not provided, to meet these needs. A pilot study (as exploratory research) - adapted to meet feasibility criteria given the constraints imposed by two conditions³ established by DGT - was designed to meet the general and specific objectives set by DGT for their commissioned study on Public Service Translation on Cross-border healthcare. To contextualize this study, in the next section we present a brief review of previous work done on translation and interpreting in healthcare settings within and outside Europe. In many multilingual areas (e.g. Australia, Canada, and the United States) the phenomenon is well recognised and has been sufficiently researched as discussed in the next section.

0.2 BRIEF REVIEW OF THE RELEVANT LITERATURE ON CROSS-CULTURAL/LINGUISTIC HEALTHCARE COMMUNICATION

When patients and providers/administrators do not share a language, translation, interpreting and other less formal practices of language support (e.g. intercultural mediation) including language brokering performed by non-professional translators and interpreters are used to enable access to information and services⁴. Translation (by humans or machines) allows patients to access important resources. Consent forms are an important example of documents that are translated, as well as prescriptions and medical records. Translation of other documents such as test procedures and instructions, educational brochures, pamphlets and institutional health reports also ensure greater access on the part of linguistically diverse patients. Lastly, it should not be overlooked that translated materials are used to inform patients of how to access translation or interpreting services and understand the implications of the healthcare received.

Besides the importance of language support in a context of diversity, the need for quality language access is essential when EU citizens access basic services such as healthcare, justice, education, information on their rights, etc. in a MS which is not their own. Sharing a common space and common rights requires facilitating the means that enable cross-border cooperation. Language support is one of them. In the EU, the importance of language support has already been addressed by a series of EU-funded projects, such as *Aequitas* (Hertog, 2001), the *Aequalitas* project (Hertog, 2003), the *Building Mutual Trust I* project (Building Mutual Trust, 2011), the *TRAFUT* project (EULITA, 2011a), the *ImPLI* project (EULITA, 2011b), the *QUALETRA* project (EULITA, 2012) or the *Co-Minor-IN/QUEST* project (CO-MINOR, 2012), the *Speak Out for Support (SOS-VICS)* project (Del Pozo *et al.*, 2014), among others.

All these projects consider language access both as a fundamental right and an enabling condition for citizens benefiting from public services of EU MSs. Furthermore these projects have widely documented the need for quality-guaranteeing measures in

³ The DGT set the following two conditions for this study which impact its feasibility, scope, research questions and methodology: 1) a maximum timeline of nine months; and 2) a maximum budget of € 55,000.

⁴ In this report the terms "language provision" and "language access" refer to all languages, whether sign or spoken.

language support. Specifically in healthcare, quality measures in language support are essential to avoid unintended violations of patients' rights due to low quality language provision. There are reported cases of issues observed in communication in healthcare settings such as mistakes, delay in treatment, wrong diagnosis, repeated visits, deterioration of patients' health and unnecessary escalation to emergency cases due to lack of/substandard language provision, errors and inaccurate communication within the EU and beyond (Zborowski, 1952; Greenwald, 1991; Rollman, 1998; Ramer *et al.*, 1999; Callister, 2003; Flores *et al.*, 2003; Meyer, 2011; Angelelli, 2012; Baraldi & Gavioli, 2012; Jiménez *et al.*, 2012; Mason, 2012; Angelelli, 2014).

Managing language diversity and giving language support in the context of health protection is of great importance because communication in such an environment brings together a series of factors that make the healthcare setting especially sensitive (Cambridge, 1999; Angelelli, 2000, 2004 a&b, 2008 a&b, 2011 & 2012; Bolden, 2000; Davidson, 2001; CHIA, 2002; Flores, 2005; Moreno *et al.*, 2009; Michalec *et al.*, 2014). Those factors can be summarized as: 1) uneven levels of health literacy and power differentials among participants: more vulnerable participants in communication (patients) vs. expert participants (healthcare providers); 2) management of sensitive and confidential information (e.g. patient's medical records, treatment alternatives and their side effects); and 3) decision-making and responsibility on sensitive issues that may impact directly on a patient's health and well being (e.g. provider requesting and patient giving informed consent to a treatment/procedure).

While interacting with healthcare providers or administrators, patients may be considered as "vulnerable" participants in communication (Wynia & Matiasek, 2006; Sewell, 2009) because they rely on the information provided from expert sources or expert speakers to make a decision concerning their health. Their own knowledge or expertise is not sufficient. Patients make informed decisions about their health only through the information they can access and through their communication with experts. Besides, when patients do not share the same language with the healthcare organization/providers, they become even more vulnerable or dependent on either technology (for machine translation) or another party (the translator/interpreter) who bridges the communication gap with the expert speaker (the healthcare provider or hospital administrator). In other words, patients' autonomy relies on their full access to information, regardless of the language in which information is provided.

While accessing information on healthcare across languages the three parties that participate, i.e. patients seeking care, providers supplying it, and healthcare translators/interpreters enabling communication, belong to different speech communities (Angelelli 2000 & 2004). Members of these diverse cultural groups often understand healthcare systems and practices differently (Angelelli & Geist Martin 2007). In addition, in some medical settings (e.g. mental health) it is often the case that linguistic minorities are vulnerable groups and, therefore, power differentials between providers and patients become salient. In many areas of the world, research studies in bilingual health literacy and intercultural communication (e.g. Kuhajda, Thorn, Gaskins, Day and Cabbil 2011 and Arora, Bedros, Bhole, Eastwood, and Moody 2012) have shown that providers of language services in healthcare perceive their roles along a continuum of more or less powerful agents who broker power differentials (Angelelli 2003 & 2004).

It is also necessary to acknowledge that healthcare communication—in the context of accessing information to make a decision (e.g. obtaining, understanding or discussing information from National Contact Points or their webpages in cross-border healthcare)—, is not one-way (e.g. healthcare organisation or providers delivering information to patients). Rather it is a cross-cultural/linguistic communicative event, in

which healthcare organisations/providers and patients engage in informative interaction with the objective of protecting all patients' rights of proper access to adequate and complete information (Coiera, 2006). Therefore communication and language support, (e.g. translation, interpreting) in cross-border healthcare are essential to ensure patients' rights to quality services when they do not share a language with healthcare organisations or providers.

In addition, language access is not only considered essential for making informed choices, i.e. at the information stage. Rather, quality language access (e.g. through translation and interpreting) is needed throughout the whole healthcare process, ensuring the continuity of healthcare provision once the patient has made an informed decision. Accordingly, any language policy implemented in the field of healthcare may not only be protective of patients' rights but address healthcare professionals' needs (Karliner *et al.*, 2007; Anderson *et al.*, 2003) as well. The provision of quality healthcare is also rooted in an efficient healthcare cooperation system, in which cross-border professionals work hand-in-hand to ensure health protection and continuity of treatment (Wismar, 2011; EPF, 2015). Working hand-in hand to provide quality healthcare means that providers in MS of treatment need access to the relevant information for patients (e.g. insurance policy, medical records or previous prescriptions) in their own language. At the same time they produce content to be shared with professionals of other MSs (e.g. patients' MS of affiliation or other where patient access follow-up treatment) who may need to perform follow-ups or health checks (e.g. medical result reports). These professionals in other MSs, in turn, need access to the content in their own language.

Since, as stated above, the EU is a union where plurality and diversity of cultures is celebrated and because language is essential in the expression and materialization of culture, languages play a key role in peoples' identity (Fishman, 1999). In addition, language is intrinsically connected to identity (Fishman, 1999). Thus, language diversity should not be perceived or considered as a problem, a barrier or an obstacle. It would be as absurd as saying that diversity in social factors (like age, gender, age, race to name just a few) are barriers. Language diversity in the EU is a fact, not a problem, and needs to be regarded as a shared heritage that needs to be protected and respected.

The EU has taken measures to protect citizens who do not speak the societal language regarding access and communication in legal matters, specifically concerning criminal proceedings. The Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the Right to Interpretation and Translation in Criminal Proceedings was commissioned by the Directorate-General for Justice. Directive 2010/64/EU defines minimum protections in this field and states that "the right to interpretation and translation for those who do not speak or understand the language of the proceedings is enshrined in Article 6 of the ECHR, as interpreted in the case-law of the European Court of Human Rights" (OJEU, 2010).

Directive 2010/64/EU also ensures that those in need have access to adequate language services and that these services be provided in a timely manner and free of charge. Furthermore, "Interpretation and translation ... should be provided in the native language of the suspected or accused persons or in any other language that they speak or understand in order to allow them fully to exercise their right of defence, and in order to safeguard the fairness of the proceedings (22)." This Directive further acknowledges that the power differential of the persons who do not speak/understand the language of the court can place these persons at a disadvantage and in a position of weakness.

The required provision of language services under Directive 2010/64/EU is of relevance when considering the healthcare setting and Directive 2011/24/EU. As discussed above, power differentials also exist in healthcare communication and users of healthcare services are in a position of weakness when communicating with healthcare providers. Patients cannot fully access information and services without language services; this is similar to suspected or accused persons who cannot fully exercise their judicial rights in criminal proceedings. Despite these similarities Directive 2011/24/EU did not specifically mandate translation and interpreting services in the way that Directive 2010/64/EU did. The lack of clarity on the issue of language in the Directive 2011/24/EU raises questions about the plausibility of access on the part of patients who may not share a language with providers and, thus, may not truly access information (Cohen, 2005).

The European Union is in a similar position to many other linguistically diverse areas of the world (e.g. Australia, Canada, India, South Africa, or the USA) that are characterized by language diversity and celebrate it. Language diversity has played a major role in the integration and balanced coexistence of such heterogeneous societies and groups. These countries have also developed different language policies which aim to provide equal rights for users of different languages who share common spaces and public services, such as education, healthcare or justice (Lo Bianco, 1990, 2003; Crawford, 1992; Burnaby, 1996; Council of Higher Education, 2001; Lilama, 2011). Individual MSs in the EU have also taken similar measures to protect linguistic diversity and access. The protection that Spain offers to regional languages (e.g. Catalan, Galician, Valencian) is an example of this.

The European Union has begun to address the issue of language access in selected areas of public services (justice in criminal proceedings) as evident by Directive 2010/64/EU. Nevertheless, the healthcare sector is without a specific EU legislative framework for the provision of language services. This study describes how, in the absence of such guidance, language needs are met (or not met) in the healthcare setting in selected sites of Germany, Greece, Italy, Spain, and the United Kingdom. It includes an examination of legislation, policy, provision of language services (or lack thereof), costs and best practices in each of the five participating MSs.

0.3 REPORT CONTENT AND ORGANISATION

This report is organized into six sections followed by a bibliography and annexes. Section 1 presents the research questions (RQs) and the methods to address them. Section 2 addresses RQs 1 and 2 by considering the legislation and policy for cross-border healthcare of the participating MSs and how these impact the rights of cross-border healthcare patients in regard to language. Section 3 addresses RQ3 by describing how language services are provided across the five MSs participating in this study. Through documentary evidence, findings from interviews and observations, the variety of responses of MSs to the language needs of patients are presented. Section 4 addresses RQ4 by providing information on both the cost of language provision as well as on the social cost of not providing language services. Section 5 addresses RQ 5 by reporting on the best practices observed in the participating MSs. Section 6 presents the conclusions of the study followed by its implications and empirically-based recommendations.

SECTION 1: METHODOLOGY

Language diversity and communicative needs are inherent characteristics of the multilingual and multicultural EU. EU citizens and residents have communicative needs and this is the reality in which healthcare provision is immersed. This phenomenon⁵ is complex and multi-layered, especially when considering the implications of cross-border healthcare under the Directive 2011/24/EU. To embrace this phenomenon, we have to account for various levels of legislation, policy and practices, as well as decision-making by stakeholders. Stakeholders include policy makers, healthcare providers and administrators, healthcare insurance companies, language service providers (freelancers, [e.g. translators and interpreters], language service professional associations, private companies, institutional employees and software designers), as well as patients - including family members.

To study language diversity as well as communicative needs and review the multiple responses (or lack thereof) provided to meet these needs, we need various lenses and approaches that provide enough flexibility to account for all possibilities. This section discusses the methodology used to answer each of the five research questions that guide the study. These questions are stated in sub-section 1.1 below.

1.1 RESEARCH QUESTIONS

To achieve the general and specific objectives (SO) commissioned by DGT, the study proposed five research questions⁶ (RQs). These are:

RQ1: What are the language policies in place at the local and national level in the five Member States (MSs) participating in this study to support the implementation of EU law⁷ related to patients' rights to access cross-border healthcare⁸? (SO 1)

RQ2: Are patients' rights to access cross-border healthcare respected in principle or in effect and are they legally enforceable and sanctioned? (SO 2)

RQ3: How is language support provided? Who is providing it? And what are the standards of practice and ethical considerations observed? (SO3)

RQ4 [comprises two questions] (SO4):

RQ4.1: If language support to assure patient's rights to access cross-border healthcare is available, what is an estimate of the cost of providing it?

RQ4.2 If language support to assure patient's rights to access cross-border healthcare is not available, what is an estimate of the social cost of a failed social and economic integration?

RQ5: What good practices exist and what are the minimum criteria for providing good public service language support? (SO5)

Given the limitations of time and funding (see Introduction, footnote 1), the above stated research questions were deemed feasible only for an exploratory study limited in scope.

⁵ The phenomenon of language diversity and its effect on communicative needs affect access to healthcare (and public services) in general, beyond the scope of the Directive.

⁶ Our research questions' alignment with the specific objectives (DGT Call for Tenders p.6) were discussed and approved in our Technical Offer (pp.2-3).

⁷ Communication of the European Commission, *A New Strategic Framework for Multilingualism* (COM(2005)596, 22.11. 2005), points III.5 & 6.

⁸ Provisions on the application of patients' rights in cross border healthcare (Directive 2011/24/EU) and on the coordination of social security systems (Regulations (EC) N° 883/2004 and 987/2009).

1.2 RESEARCH METHODOLOGY

The complex nature of the study, as well as its required wide scope, calls for a multi-pronged methodology that allows for the triangulation and validation of findings. By using a mixed-paradigm approach the study brings together qualitative and quantitative methodology to answer the five research questions stated above. Table 1 below indicates the methods and data sources used from each of the paradigms to answer the five research questions (RQs) that shaped this study:

Table 1: Research questions, methods and data

Research questions	Qualitative methods	Quantitative methods
1. National/local language policies to support implementation of EU legislation	<ul style="list-style-type: none"> i. Interviews with policy makers and officials (insight into policy, relevant documents, etc.). ii. Document analysis (legislation, policy guidance and documents, consultation processes, policy review) 	Questionnaire 1
2. Patients' right to access respected/enforceable, sanctioned	<ul style="list-style-type: none"> i. Document analysis (consent forms, instructions for tests, brochures, posters, signs, announcements) ii. Interviews (with policy makers, healthcare administrators, healthcare providers, social workers, NGOs, language service providers, patients and patients' family members). iii. Non-participant observations of healthcare settings (reception area, waiting rooms, provider-patient consultations, treatment and examination areas) 	Questionnaires 1 and 2
3. Language support provided (how, by whom)	<ul style="list-style-type: none"> i. Non-participant observations ii. Interviews with agency owners, freelancers, translation & interpreting professionals, NGO representatives, legal representatives, and healthcare administrators, providers, practitioners, patients and family members. iii. Document analysis 	Questionnaire 2
4.1. Language support estimated cost (if provided) 4.2. Lack of language support (if not provided) and estimated cost of social failed integration	<ul style="list-style-type: none"> i. Non-participant observations ii. Interviews with hospital administrators, legal representatives, lawyers, and language service providers iii. Document analysis 	Questionnaires 1 and 2
5. Good practices and minimum criteria	i. Document analysis (translations, brochures, exams, recruitment and administrative systems, course descriptions)	Questionnaire 2

	ii. Interviews with hospital administrators, healthcare providers, language-service providers and patients iii. Non-participant observations	
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1.3 RESEARCH DESIGN

A complex problem calls for a complex design. The design of this study combines documentary evidence with self-reported data (collected by questionnaires), recall (interviews) with naturalistic data (direct empirical observations) gathered during fieldwork. At least four factors contribute to the current complex situation of language and access to healthcare in the EU. Those are: 1) the communicative needs within the multilingual and mobile EU; 2) popular beliefs and assumptions on minimum requirements to communicate appropriately; 3) settling for ad-hoc, low quality and inconsistent responses *in lieu* of professional solutions to meet language needs and to provide access to services; 4) the perception of an allegedly disproportionate cost of quality language provision. These factors are exacerbated by a monolithic and almost unchallenged view that current ad-hoc language provision in healthcare settings is not an issue and does not need coordinated planning (i.e. “language is irrelevant; we manage”). This study addresses these factors and the overall question of language needs and access at two different levels. Firstly, it explores the attitudes and perceptions of all stakeholders in order to understand their beliefs on the role that language plays in patients' access to healthcare. Secondly, it deals with the actual manifestations of language diversity and access to healthcare during actual instances of information exchange in bilingual healthcare oral and written communicative events.

Sampling – Decision-making process

In regard to participating MSs, the following information should be helpful in understanding the rationale behind selection criteria. This study called for a stratified sampling of MSs that was not feasible given the limited timeline and budgetary constraints. The next best option was to choose MSs on the basis of criteria that are meaningful and relevant to the goals of this study. Thus, MSs were chosen based on: 1) size as determined by number of seats in the European Parliament (www.europarl.europa.eu/meps/en/crosstable.html); 2) migration patterns in the last 20 years (Eurostat webpage, online data code: migr_imm1ctz and migr_imm5prv, Eurostat statistic Books (2011)); 3) linguistic consequences of migration (as reported in Kerswill (2006)); 4) team access to networks and language combinations within the timeframe to respond to the DGT call for tenders. As a result, five MSs have been chosen for this exploratory study. They are: Germany, Greece, Italy, Spain, and the United Kingdom. The data collection in Greece had to occur in two phases. Given the volatile political climate, as well as a country facing severe economic and financial difficulties, many of the interviews and observations were cancelled and/or changed several times. In addition, seeking permission from sites and consent from participants took longer than for other regions.

Participants

Within each of these MSs, we targeted informants who represented all of the categories of stakeholders needed to answer our research questions - i.e. policy makers working at the national/regional level in healthcare policy; healthcare administrators and providers working in public and private hospitals and clinics in urban and rural areas; lawyers specializing in issues of access and language; medical-

insurance companies; consumer-protection agencies; NGOs; language-service providers (companies, agency owners, institutional employees and free-lancers); translation and interpreting professional associations, language/T&I software developers, patients and their family members. In each of the five MSs countless efforts were made to reach and persuade all levels of stakeholders to participate (left-hand column in Table 2 below). A total of 235 informants were contacted. Of the 235, 209 informants participated in interviews and observations and a total of 331 responded to our surveys. Table 2 below provides a summary of informants interviewed per MS. To observe confidentiality and preserve the identity of participants, names of informants and sites are coded providing only MS and number.

Table 2: Informants interviewed per Member State

Informants	Germany	Greece	Italy	Spain	United Kingdom
National Contact Point	1	1	8	2	5
Policy makers	6	2	2	2	2
Lawyers	3	1	1	1	2
NGO's officers	1	4	1	3	3
Healthcare providers	9	10	8	1	6
Healthcare Administrators	1	4	2	11	6
Researchers in Healthcare communication	2	2	4	1	2
Insurance companies	1	N/A	N/A	N/A	N/A
T&I Association Presidents	1	1	1	0	0
Medical Association Representatives	1	1	1	1	2
Social Worker	1	1	1	1	1
T&I Agency Owners/Managers	2	2	1	3	1
Institutional T&I Management	1	0	0	0	6
Free-lance translators	3	3	3	2	2
Free-lance interpreters	3	2	3	3	2
In-house interpreter	0	0	0	3	2
Software developers	0	0	0	1	0
Cultural mediators	1	3	3	1	0
Patients and family members	0	2	2	2	3
T&I students	2	1	2	2	2
TOTAL	39	40	43	40	47

Sites

To collect information and documentary evidence, and to conduct interviews and observations we contacted the following site types (per MS) to request their participation in our study: National Contact Point offices, National and regional Ministries of Health, policy-makers offices, law offices (specializing in health and access), rural and urban clinics, healthcare centres and hospitals, NGOs, community centres, translation and interpreting agencies, T&I professional associations, medical professional associations, cultural mediators associations, T&I list-serves, universities that teach T&I. We also made direct contact with T&I professionals, ad hoc translators and interpreters and university students through business networks and social media.

In the five MSs a total of 128 sites were contacted to take part in the study. A total of 112 sites agreed to be observed and participated in the study. Table 3 provides a summary of site visits per MS.

Table 3: Types of sites visited per Member State

Sites	Germany	Greece	Italy	Spain	United Kingdom
National Contact Point	1	1	1	1	2
National Ministry of Health	1	1	1	1	1
Regional Ministry of Health / Regional Health Authorities	4	0	2	2	2
University – T&I Programmes	1		3	1	1
Policy-maker offices	2	1	2	2	3
Lawyer offices	2	2			1
Consumer right office/NGOs	1	2	0	3	2
Community centre	1	2	1	0	1
Hospital (urban)	2	5	2	3	6
Hospital (rural)	3	3	1	2	0
Healthcare centre	2	3	1	3	1
T&I Professional Associations	1	2	2	0	0
Software Developer	0	0	0	1	0
T&I agencies	1	2	1	3	3
Cultural mediation agencies	1	0	3	0	0
TOTAL	23	24	20	22	23

Figure 1: Cities and towns per Member State



Materials

Two types of materials were developed for data collection: 1) questionnaires and 2) interview protocols.

1) Questionnaires

Based on EU DGT request, two exploratory questionnaires⁹ were designed to obtain information from the various participating stakeholders on the transposition of the Directive and the role of language in healthcare communication. Questionnaire 1 (see Annex 1) targeted policy makers, hospital administrators, insurance companies, lawyers and healthcare providers. It was designed to answer questions on participants' information and awareness on the interplay between the Directive and language provision, the role of National Contact Points and the type and cost of language provision (if applicable). Questionnaire 2 (see Annex 2) targeted language service providers (translators, interpreters, [professionals and ad hoc practitioners] agency owners, software developers). It was designed to answer questions on cost, language provision and good practices.

Tables 4 and 5 below show the number of questionnaires sent and received per Member State.

Table 4: Totals for Questionnaire 1

Member State	Total Q1 Sent*	Total Q1 Received	Response rate
Germany	15	8	53.3%
Greece	18	11	61.1%
Italy	15	7	39%
Spain	19	10	52.6%
United Kingdom	6	5	83.3%
TOTALS	73	41	56.2%

* Refers to actual numbers sent after numerous (min 3 - max 8) inquiries via e-mail and phone calls to identify the exact person who should receive the questionnaire. Confirmation with exact recipient was obtained before sending the questionnaire out.

Table 5: Totals for Questionnaire 2

Member State	Total Q2 Sent	Total Q2 Received	Response rate
Germany	239	23	9.6%
Greece	190	34	17.89%
Italy	475	36	7.5%
Spain	399	68	17%
United Kingdom	1,277	121	9.5%
TOTALS	2580	290	11.2%

2) Interviews: Semi-structured protocols for interviews were designed to obtain information from different stakeholders during the face-to-face and remote interviews (either via Skype or telephone). Table 6 below shows an example of interview protocol designed for National Contact Points.

⁹ Note: these were designed for exploratory purposes only. Unlike valid and reliable measurement instruments that measure a construct and allow generalisation of results based on stratified sampling, no results should be generalized on the basis of these questionnaires alone.

Table 6: Example of protocol for topics/questions

<p>- <u>General responsibilities of the NCP</u></p> <ul style="list-style-type: none"> • Work at the NCP and work the NCP performs in country/regions • General responsibilities of the NCP. Interaction of the NCP within a country/area • Collaboration of NCP with other institutions (e.g. Department of Health) • Implementation of the Directive in territory (from the perspective of the NCP) • NCP plan for cross-border care, specifically in relation to regional languages (discuss if significant issue) <p><u>Communication</u></p> <ul style="list-style-type: none"> • Collaboration between NCPs from different MSs • Difficulties arisen for either incoming or outgoing patients who seek cross-border care and do not speak MS language • Translation of documents (medical records, receipts, etc.) handled for incoming and outgoing cross-border patients • Interpreting services for cross-border patients • Future of cross-border healthcare over the coming years • Role of communication in different languages in cross-border healthcare • Need for language services such as translation or interpreting <p><u>Patients, providers and administrators</u></p> <ul style="list-style-type: none"> • Written and oral communication re: cross-border healthcare • Needs/costs of translation/interpreting
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Data

Four types of evidence were collected in this study: 1) questionnaire data; 2) documentary evidence; 3) interview data and 4) non-participant observation data.

1- Questionnaire 1 data was gathered from the questionnaires sent to policy makers, legal offices, healthcare organisations, administrators and providers. It targeted respondents' awareness and knowledge about the transposition and implementation of the Directive as well as their perceptions of language (needs, cost and provision) while accessing healthcare under the Directive. Questionnaire 2 data was gathered from translators, interpreters, and ad-hoc language and intercultural mediators. It targeted their perceptions of language provision under the Directive. Additionally Questionnaire 2 looked at the experience and training of professionals, how translation and interpreting services are provided and the costs of these services, the institutional structures in place that provide language services, and the professionals' perspective on the quality of service provided.

2- Documentary evidence was gathered for three purposes: 1) to document and analyse the transpositions of the Directive as well as any resulting national legislation that evidences the transposition. Additional legal documents were also studied to explore the transposition of the Directive into regional/local legislation and to determine if language was a consideration during such transposition; 2) to study written healthcare documents (e.g. consent forms, admission forms, instructions prior to performing a test) provided by hospitals/clinics to patients either in the language of the organisation or in other languages and to determine access on the part of patients, taking into account the language and the accuracy of information provided; 3) to analyse policy documents of institutions or other organisations that indicate how (if) translation and interpreting services are planned for and provided. This includes

policy guidance, equality schemes, as well documents that compile data on service provision.

3- Interview data was gathered from face-to-face and remote interviews conducted with all levels of stakeholders willing to be interviewed. They included: policy makers (e.g. advisors to EU Commission, regional representatives, ministers, deputy ministers), NCP representatives, lawyers, healthcare administrators and providers, government representatives, NGOs, translators, interpreters, T&I professional association leaders, patients and family members.

4- Non-participant observation data was gathered during visits to healthcare organisations and direct observations of administrative systems and procedures, communication between staff, between patients and providers, observations of hospital staff, observations of facilities including signage, observations of procedures for remote communication, as well as observations of technology used in the provision of T&I service (e.g. automatic system for booking interpreters, use of software applications such as Universal Doctor or Google Translate).

In Sections 2, 3, 4 and 5 we present an overview of results. They are discussed and analysed in detail to respond to each of the five research questions that guide the study. RQ 1 and 2 are discussed in Section 2. Section 3 presents results and discussion for RQ3, Sections 4 and 5 deal with RQ4 and RQ5 respectively.

SECTION 2: ANALYSIS OF THE LEGISLATION RELATED TO ACCESS TO CROSS-BORDER HEALTHCARE.

This section contains 3 sub-sections and answers Research Questions 1 and 2. Sub-section 2.1 responds to RQ1: what are the language policies supporting EU law (Directive + Regulations) at the local and national level? Here we present the EU legal framework for cross-border healthcare, which is the conceptual framework for the study. This sub-section explains the relevant legal documents that make possible cross-border healthcare. Sub-section 2.2 also responds to RQ1 and country reports are presented from the perspective of language. For each participating MS there is a discussion of the transposition of the Directive as well as the national, regional and local laws and policies for cross-border healthcare. Additionally, the findings pertaining to the NCPs of each of the participating MS are presented. Lastly, sub-section 2.3 responds to RQ2: are patients' rights to access cross-border healthcare respected in principle or in effect and are they legally enforceable and sanctioned? This sub-section discusses the relationship between patients' rights to cross-border healthcare and language access. The discussion on language access centres on the concepts of language as an inherent right and as an enabling condition.

2.1 THE EU LEGAL FRAMEWORK FOR CROSS-BORDER HEALTHCARE

The legal framework for cross-border healthcare in the European Union can be found in four principal documents. First, the Charter of Fundamental Rights of the European Union ("the Charter") establishes the rights for citizens of the Union. Second, the Treaty on the Functioning of the European Union ("the Treaty") was established from the agreements of the Lisbon Treaty and defines the mechanisms for the governance of the Union. Third, the Regulation (EC) 883/2004 ("the Regulation") establishes norms and competencies for the provision of healthcare to certain classes of cross-border patients. Fourth, the Directive 2011/24/EU ("the Directive") intends to clarify the legal relationship between patients' rights and cross-border care. Table 7 contains a brief description of each of the core EU documents.

Table 7: EU cross-border healthcare legislation at a glance

EU Legislation	Description
i. Charter of Fundamental Rights of the European Union	Broad rights and guarantees for citizens of the Union (freedom of movement, non-discrimination, etc.)
ii. Treaty on the Functioning of the European Union	Mechanisms for the functioning of the Union, how the spirit of the Charter is implemented
iii. Regulation (EC) 883/2004	Establishes norms and competencies for the provision of healthcare to certain classes of cross-border patients
iv. Directive 2011/24/EU	Expands on Regulation 883/2004 by clarifying the recent jurisprudence of the European Court of Justice and allowing patients to seek care without systematic prior-authorisation as well as seek care in private facilities

Together these legal documents lay the foundations for both the rights of citizens of the European Union and the competencies of the Union and MSs pertaining to cross-border healthcare.

i. Charter of Fundamental Rights of the European Union

The Charter of Fundamental Rights of the European Union establishes broad and inclusive guarantees for the preservation of the rights of the citizens of the European Union. The Charter speaks of “common values,” namely, “indivisible, universal values of human dignity, freedom, equality and solidarity” (OJEU, 2012a). When considering the legal framework for cross-border healthcare the Charter provides the ideals from which the right to healthcare access is derived. There are several ideals of the Charter that make cross-border healthcare a reality that has to be addressed in the Union.

First, the mobility of citizens within the Union is established in Article 45 (Freedom of movement). Article 45 of the Charter explicitly ensures the freedom of movement and residence. When citizens travel to, and reside in, another MS they will, at times, require access to healthcare. Cross-border healthcare can be seen as a consequence of the free movement of persons within the Union itself.

Secondly, the right to access healthcare is established in Article 35 (healthcare). Essentially, the theme of cross-border healthcare is a result of the mobility of citizens who have the right to access healthcare. Under Article 35 a bipartite division is made. Right to access high levels of medical care is ensured while at the same time “national laws and practices” are given recognition as the mechanisms by which these are defined. Here a division is made where there is a broad guarantee at the EU level with freedom to implement policy at the level of the MSs.

Thirdly, other rights frame how healthcare is to be provided in cross-border scenarios. Articles 21 (non-discrimination) and 22 (cultural, religious and linguistic diversity) prohibit discriminatory practices and establish a position of respect toward the many diverse peoples of the Union. When considering the role of language in cross-border healthcare scenarios Articles 21 and 22 are important to keep in mind. Articles 21 on Non-discrimination and 22 on Cultural, religious and linguistic diversity have the purpose of protecting diverse and vulnerable populations from discrimination and unfair treatment. The Union takes a position of respect toward diversity and prohibits discrimination, including discrimination based on gender, race, language and religion, among others. Within the context of cross-border healthcare, we can infer that the spirit of the Charter ensures that when citizens receive medical treatment in another MS they cannot be provided inferior treatment because of their religion, MS of affiliation or other distinctive features, such as their language.

Lastly, Article 38 (on consumer protection) and its relation to cross-border healthcare must not be overlooked. Patients who seek healthcare are consumers of this service. A high level of consumer protection is guaranteed in Article 38 of the Charter and this is particularly relevant to cross-border scenarios. Due to the risks and potential consequences of poor care, which may be exacerbated when seeking treatment in an unfamiliar medical system and through a language that is not one’s own, a patient who seeks treatment in another MS may be in need of protection. Under the rights of the Charter, such patients should be protected from faulty practices and services.

Together these Articles contain the concepts that establish the underlying principles of the Union’s policy toward cross-border healthcare. This ideal exists at the intersection of these rights. The rights that these articles guarantee underscore the importance of access for cross-border patients. When seeking healthcare in a MS that is not one’s

own, access to safe, high quality healthcare will often rely on language provision. Appropriate language services can make possible the delivery of non-discriminatory, high quality healthcare to mobile patients within the ideals of the Charter.

ii. The Treaty on the Functioning of the European Union

The Treaty on the Functioning of the European Union is derived from the amendments agreed upon in the Treaty of Lisbon. It provides the legal framework and mechanisms for defining the competences of the European Union. In regard to the theme of cross-border healthcare, this document must be analysed when considering the responsibilities of the European Union.

Part Two of The Treaty on the Functioning of the European Union concerns itself with non-discrimination and citizenship of the Union. Article 19 gives the Union powers to combat various forms of discrimination and to take measures to coordinate the laws of MSs in order to achieve this end. Prohibiting discrimination is given considerable importance since European law is binding for the individual Member States.

Articles 168 and 169 concern themselves with public health within the Union. The first point of Article 168 declares that all of the policies of the Union must ensure a high level of human health. Additionally, the second point gives the Union responsibility for encouraging cooperation between MSs and supporting the actions of these states when needed. Lastly, the Commission has the authority to coordinate, monitor and evaluate the cooperation of MSs.

As in the Charter, consumer protection is recognized in the Treaty on the Functioning of the European Union. The Union can take measures to ensure consumer protection and this includes promotion of citizens' right to information. The theme of right to information provides a window to start exploring language access since consumers cannot truly access information unless it is rendered in a language that is intelligible to them. In the context of cross-border healthcare the question of how consumers' right to information is protected should be considered.

The Treaty on the Functioning of the European Union has the same spirit as the Charter of Fundamental Rights of the European Union. This Treaty can be judged as the document that details how the broad rights of the Charter are to be implemented. The Treaty does not specifically legislate on how language provision plays a role in the implementation of rights¹⁰. No specific Article or mechanism is dedicated to defining the responsibilities of the Union or of MSs to provide, for example, translation and interpreting services. The Treaty either presupposes *a priori* that these services will be provided in some manner or leaves the provision of such services to the discretion of the MSs.

A legal framework specific to the logistics of cross-border healthcare derives from a comparative analysis between Regulation (EC) 833/2004 and Directive 2011/24/EU.

Throughout the European Union access to healthcare for EU citizens is regulated mainly through two legal instruments: the Regulation and the Directive. The Charter of Fundamental Rights of the European Union guarantees freedom of movement and residence (Article 45) and healthcare (Article 35) (OJEU, 2012a). The Regulation and

¹⁰ Language rights are defined in relation with EU institutions (Articles 20d, 24-4 TFEU, 55 TEU), or in general terms as regards discrimination and linguistic diversity (see Articles 18, 19, 3.3 TFEU, Preamble TEU, and language specifically in Article 21 Charter). In the latter case, implementation is left to the Members States.

the Directive are needed to make possible these two fundamental rights. Citizens may need to access healthcare in a MS that is not their own for a variety of reasons. Workers who reside in another MS or pensioners who retire to another MS are examples. Likewise, those who travel for holiday or for business may need unexpected emergency care. Lastly, some citizens may travel outside their MS with the sole intent of receiving medical care in the MS of destination. The Regulation was first enacted to provide healthcare coverage, while the Directive complements and expands the coverage of the Regulation. Together they provide access to care in a variety of situations.

iii. The Regulation

The Regulation enacted in 2004 was designed to cover a broad range of scenarios for the provision of healthcare. Articles 17, 19, 20 and 22 are important as they cover cases where patients would seek healthcare in a MS that is not their own. Article 17 legislates for residence in another MS. Article 19 legislates for the short-term stays where emergency care may become necessary, Article 20 for citizens who travel specifically to receive healthcare in another MS, and Article 22 for pensioners who reside in another MS (OJEU, 2004).

Under the Regulation healthcare is provided through three avenues: the European Health Insurance Card (EHIC), a permanent arrangement for pensioners and a system of prior authorisation for those who seek planned cross-border healthcare. The EHIC is to be used in cases of emergency care during short visits to another MS. This is the type of unforeseen care that arises during holiday and business travel, for example. The EHIC guarantees that the holder of the card can seek care in the public healthcare facilities of other MSs and the card provides benefits to its holder (Department of Health, 2013). Pensioners are covered under the regulation through a permanent agreement of state-to-state transfer where they can continually seek care in the MS of retirement. In this way, pensioners who are covered by the social security system in the MS where they worked can receive care in the MS where they retire. Lastly, there is a prior authorisation system for citizens who seek to travel to another MS specifically to receive care. Through this system, citizens seek prior authorisation and are then able to travel to receive care in public healthcare facilities. Prior authorisation coordinates payment between MSs; patients are not responsible for paying for treatment, other than co-payments where applicable.

iv. The Directive

The Directive was enacted in 2011. It was designed to clarify the recent jurisprudence of the European Court of Justice and to a certain extent, to complement and expand on the Regulation. The Directive does so in two important areas: it includes private healthcare facilities and makes it possible to seek healthcare without prior authorisation. Under the Directive patients can seek cross-border healthcare at both public and private facilities. This includes short-term unplanned emergency care, as well as planned healthcare. The Directive gives citizens more options and more freedom at the moment of seeking care. Patients are not required to systematically seek prior authorisation under the Directive, with the exception of specific treatments that are defined under the parameters of Article 8 of the Directive (OJEU, 2011).

The Directive differs from the Regulation in its mechanism of payment. Under the Directive patients are responsible for upfront payment of the cost of their own care. They then seek reimbursement when they return to their home MS. This excludes certain special treatments that will require prior authorisation. These special treatments are defined under the parameters of Article 8. In each MS patients should

be able to access a list of treatments that require prior authorization. Setting aside these exceptions, patients take on the responsibility of payment and seeking reimbursement. The Directive and the Regulation overlap in that patients who wish to receive cross-border healthcare can seek to do so under either legislative framework. However, these patients have to take into account the options of prior authorisation, pre-payment and payment-reimbursement when they make their decision.

The Directive fills gaps in coverage by supplementing the pre-existing Regulation in some instances and by giving patients two important rights. First, the right to seek treatment at private healthcare facilities; second, the right to seek care without prior authorisation. The main beneficiaries of the Directive are EU citizens who now have more freedom because of these rights. It can also be said that private healthcare providers benefit in that they can now treat patients from other MSs who will pay up front and seek reimbursement at home. Although the Directive expands on the Regulation, there is also an overlap in some areas. This can be the case with prior authorisation where care could be sought through either instrument. In these cases of overlap, care should be provided through the Regulation unless the patient requests to use the Directive route (European Commission, 2015).

The Directive gives obligations both to patients who seek cross-border healthcare, as well as to the MSs. First, the patients have the obligation to arrange their own treatment and pay for their treatment up front. This is a considerable responsibility since they must seek information on care abroad, coordinate their care and travel, and understand the possible consequences of care abroad. They must also understand what the reimbursement scheme is as well as the reimbursement amount limit since the home MS will only reimburse up to the cost of treatment at home. Second, the MSs have broader obligations under the Directive. These obligations are concerned with providing an administrative structure that facilitates, but does not necessarily promote, cross-border healthcare. This administrative structure includes a system for reimbursement for patients as well as providing National Contact Points (NCPs) that will coordinate information on cross-border healthcare for both incoming and outgoing patients.

Tables 8 & 9 are presented to illustrate the beneficiaries of the Regulation and the Directive, as well as the logistics for providing care under each instrument.

Table 8: Beneficiaries of legislation

	REGULATION 883/2004	(EC)	DIRECTIVE 2011/24/EU
BENEFICIARIES			
Pensioners	Article 22		Article 7(2)(b)
Patients who seek emergency care (care during short term business or holiday stay)	Article 19: For public providers (This is achieved through the European Health Insurance Card)		For private providers and when European Health Insurance Card is not used
Patients who seek planned cross-border care	Article 20: Only public providers are included		Through the Directive all public and private providers are included

Table 9: Logistics of care

	REGULATION (EC) 883/2004	DIRECTIVE 2011/24/EU
LOGISTICS OF CARE		
Mechanism for payment	State-to-state transfer, patients do not pay (except co-pays if applicable)	Patients pay costs up front. They can then seek reimbursement. (In cases where prior authorisation is needed, patients should seek care through the Regulation, unless they insist on using the Directive and paying up front)
Prior authorisation	Prior authorisation is required (Except for emergency care which is covered through European Health Insurance Card)	Prior authorisation is not needed except for specific treatments as defined under Article 8
Undue delay (if treatment cannot be provided in reasonable time frame in MS of residence)	Patients can seek care in another MS through the Regulation	Patients can seek care in another MS through the Directive

2.1.1 CURRENT CONSTRUCTIONS OF LANGUAGE FROM A LEGAL PERSPECTIVE

The aim of this section is to assess how, at both European and European Union level, language is construed from a legal perspective. The ultimate purpose of this analysis then is to highlight the way in which language is currently legislated, particularly within the EU. Although the discussion will mainly consider European sources (the European Convention of Human Rights; the European Union; the national legislation of some EU countries), a brief juxtaposition with frameworks existing at international level gives the analysis a more comprehensive edge.

2.1.2 International, European and European Union Sources

United Nations

The Universal Declaration of Human Rights, at art. 2, sets forth the following fundamental principle:

“Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.”

Therefore, a legal document of international standing and signed by most countries of the world community has incorporated a scope of protected characteristics sufficiently wide to decree that people should be liberated from any discriminatory act induced as a result of language.

European Sources: European Convention of Human Rights

The European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention) is a framework that, after being initially drafted in 1950 by the Council of Europe,¹¹ came into force in 1953. The European Convention confers on the citizens of MSs noteworthy entitlements, amongst which are: the right to respect for private and family life (art 8); the freedom of thought, conscience and religion (art 9).¹²

Indeed, articles 5 and 6 are provisions on language rights in arrests and for fair trials and art 14 of the European Convention deals with the prohibition of discrimination on language grounds also. To this end, the provision ensures that the enjoyment of the rights¹³ and freedoms¹⁴ under the same European Convention 'shall be secured without discrimination on any ground'. However, in subsequently listing these grounds which will be protected from discrimination, reference is solely confined to those of 'sex, race, colour, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status'. The omission of language from the relevant grounds can only lead to the conclusion that, as things currently stand, this characteristic cannot be regarded as one which may give rise to discrimination, and thus merit protection, according to this specific legal framework.

European Union: Charter of Fundamental Rights of the European Union

At EU level, the characteristic of language is contemplated in the Charter of Fundamental Rights of the European Union (CFREU),¹⁵ proclaimed on 7 December 2000. Subsequent to the Lisbon Treaty coming into effect in 2009, the CFREU acquired the status of a legally enforceable piece of legislation, theoretically of equal standing to the EU Treaties. However, its applicability across the EU was frustrated by the insertion of an opt-out clause exercised by two EU MSs (although for very different reasons)¹⁶, at the time of its signing. The legal apparatus employed to engineer the opt-out came in the form of a specific Protocol¹⁷ added to the CFREU, under which both the British and Polish Governments made it clear that the Charter would not empower the EU courts, nor the national courts of Poland or of the United Kingdom, to invalidate 'the laws, regulations or administrative provisions, practices or actions of Poland or of the United Kingdom' found to be inconsistent with 'the fundamental rights, freedoms and principles that it affirms.'¹⁸

¹¹ Rome, 4 November 1950.

¹² In the vast law literature dealing with law and human rights, see M Amos, *Human Rights Law* (2nd edition, Oxford: Hart Publishing, 2014); J Wouters and H Meuwissen, *National Human Rights Institutions in Europe: Comparative European and International Perspectives* (Intersentia 2013).

¹³ *Eg* right to respect for private and family life (art 8).

¹⁴ *Eg* freedom of thought, conscience and religion (art 9); freedom of expression (art 10); freedom of assembly and association (art 11).

¹⁵ OJ C 326/02, 26 October 2012.

¹⁶ The British Government was opposed to the enforceability of the Charter over concerns of a procedural nature, worried that it may precipitate an influx of cases brought before the ECJ as British nationals sought to enforce their rights under the Charter in the UK. The Polish Government, on the other hand, stood diametrically opposed to the substance of the Charter, believing it to confer too liberal a range of social rights.

¹⁷ Inserted under Article 1 (1).

¹⁸ The literal interpretation of the Protocol is that it *de facto* excludes the application of the Charter to Britain and Poland. However, a different approach is that the Protocol will not have 'significant effect in practice', for the reason that the EU Court of Justice was already empowered to overturn the decisions of both the UK and the Polish courts, Therefore, the 'Charter is largely declaratory of what the ECJ had been doing for years under the language of the "general principles of law"'. P Craig and G De Burca, *EU Law: Texts, Cases and Materials* (5th edn, OUP 2011) 395.

The document under discussion, in keeping with the aforementioned Universal Declaration of Human Rights, expressly refers to language, as one of many protected characteristics in stating under art 21 (1) that:

‘Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.’

The following art 22, under the heading ‘Cultural, religious and linguistic diversity’, delves a little deeper into the list of protected characteristics to clarify that:

‘The Union shall respect cultural, religious and linguistic diversity.’

European Union: Treaty for the Functioning of the European Union

By extending the analysis beyond the CFREU and its rocky passage into force, the fundamental piece of legislation to take into account is the Treaty for the Functioning of the European Union.¹⁹ The TFEU, at Art 19(1),²⁰ does recognize and prohibit discrimination. As a result of this, the Council is empowered to ‘take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation’. However, the list of protected characteristics on this occasion does not include language within its number.

European Union. Equality Framework Directive and domestic implementation

Two pieces of EU legislation have been adopted on the back of art 19(1) of the TFEU, namely Directive 2000/43 on race and ethnic origin, and Directive 2000/78 on sexual orientation, religion and belief, age and disability.²¹ Together these Directives fall under the umbrella of an Equality Framework on Discrimination and have been implemented across the EU in the domestic legislation of each individual MS. For instance, in Britain, the applicable domestic statute is the Equality Act 2010 (EA 2010).

The main purpose of the Equality Framework is to lay the foundations for a level-playing field of rights in the terms and conditions of work across the Union. Ultimately, this should allow workers to avail of access to work and career opportunities based on merit, rather than such access and opportunities materializing subject to the protected characteristics which workers may, or may not, share.

Both the legal provisions under the TFEU and those under the Equality Framework Directives fail to list ‘language’ amongst their number, with other relevant factors (eg sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation) deemed to be the protected characteristics.

A national legislature, in implementing the EU legislation, may go beyond the ‘mandate’ received from Brussels and, therefore, broaden the spectrum of protected characteristics to cover further elements to be safeguarded from discrimination. An example of this can be seen in the case of Britain where the EA 2010 refers, under the subcategory of race, also to national identity and colour.²² However, whilst the UK has demonstrated an enlargement of the aforementioned subcategory, it has not gone as far as to include a further subcategory of ‘language’.

Although the concept of language is not particularly ‘cultivated’ at EU level, at judicial level the European Union Court of Justice has dealt with some cases relevant to language and the possibility of discrimination arising from it. A remarkable case is

¹⁹ OJ 326/01, 26 October 2012.

²⁰ This provision was introduced by the Treaty of Amsterdam as Art 13. See S Deakin and GS Morris, *Labour Law* (6th edn, Hart Publishing 2012)650.

²¹ Among Scholars, see C Barnard, *EU Employment Law* (4th edn, OUP 2012) 337-400.

²² More precisely, according to the EA 2010, s 9(1), ‘race’ includes ‘colour’, ‘nationality’, ‘ethnic or national origin’.

*Wilson v Ordre des avocats du barreau de Luxembourg*²³, where a British lawyer, seeking to register and thus work as such in Luxembourg, was refused membership of the local bar unless he consented to take a test in French, German and Luxembourgish. In the ensuing controversy, the Court held that the language requirement contravened the principle of free movement. Therefore, according to this *dictum*, any national legislation shall preclude a national law which makes registration of a European lawyer with the Bar of the host MS subject to a language test.

2.1.3 EU legislation and languages: piecemeal legal provisions

Language and education: TFEU, art 165(1)

Within the TFEU, the term 'language' does appear in further legal provisions. An example of this is art. 165(2), where it is stipulated that the EU will proactively contribute to 'developing the European dimension in education, particularly through the teaching and dissemination of the languages of the MSs.

Nevertheless, it is not plausible that the meaning to be inferred from the use of the word 'languages' in art 165(2) would equate to a right to the language. It is more of an obligation for citizens, with the support of public policies; policies based on, or connected with, the language.

Language and action in courts: Directive 2010/64.

Finally, the European Union has implemented a body of work where language is the principal driver. Directive 2010/64 is a perfect illustration of this, where the right to translation and interpretation in criminal proceedings is expressly legislated. Pursuant to art 2 of Directive 2010/64, a right to interpretation in court hearings and police questioning must be implemented in each MS, while art 3 of the aforementioned Directive confers the right to translation of relevant documents. Should any of the above additions to proceedings be required, the onus will lie with the host MS to meet the costs of interpreting and translation in accordance with art 4 of the Directive. Remarkably, this piece of EU legislation has been adopted in light of the principles enshrined in art 82(2) of the TFEU. In light of this, it would appear a particularly onerous exercise to confirm that this directive expressly recognizes linguistic rights as inherent rights. Rather, in facilitating a right to justice in each MS, it ensures that the relevant barriers, including those of a linguistic nature, can be removed.

Language: an inherent right or an enabling condition?

In light of the aforementioned discussions, it can be said that, within the realm of EU legislation, the characteristic of language does not confer an entitlement to protection against discrimination. It appears, thus, that the question of patients' protection to access cross-border healthcare may neither be enforced nor sanctioned since within the EU language does not appear to be an absolute right. This finding is the only logical outcome arising from a legal interpretation of the EU body of work, particularly the TFEU, where language is not contemplated as such.²⁴ Although the Charter for the Fundamental Rights of the European Union clearly stipulates that it is prohibited to discriminate against a person on the grounds of language, the controversial standing of the 'Charter' in the hierarchy of EU sources²⁵ has thrown a proverbial spanner in the works of any move to render this right fully enforceable and, politically speaking, entirely persuasive.

²³ (Case C-506/04) [2006] All ER (D) 89 (Sep).

²⁴ If the language had been a Treaty right, any citizen would have been able to call upon it vis-à-vis a national court, given the principle of direct applicability.

²⁵ Given the opt-out exercised by two important members, the UK and Poland. See above Section 2.2.

Due to this state of affairs, the EU directives have, as things currently stand, reached an impasse, with a right to protection from discrimination on account of language not translated into practice despite having been considered with that end in mind. Most notably, the Equality Framework (Directive 2000/43 and Directive/78) failed to codify language as a protected characteristic. However, *Language and Translation in International and EU Law* (DGT Study 6/2012 Chapter 4 "Language rights in the internal market", part 3 on health) shows that, where health and safety are at stake, EU legislation includes special provisions on language, labelling and translation arrangements.

Furthermore, the EU framework would appear to be at odds with the international frameworks, such as the Universal Declaration of Human Rights, where language is regarded as an absolute right. The reason why the right to one's own language, envisaged at international level, has not been incorporated into the EU legislation in an enforceable manner is quite obscure. The current multitude of 24 official languages, when augmented by the unavoidable barriers entailed in them and coupled with a central principle of the EU (the principle of free movement of individuals), should warrant a different outcome.

Given the preceding arguments, the manner in which language is construed by the EU, particularly as regards the legislative sources below the Treaties (Directives and Regulations), would appear to evoke a legal scenario where language is merely an enabling or instrumental factor: *ergo*, in connection with specific rights conferred on EU citizens,²⁶ measures shall be put in place by the MSs to ensure that the barrier (language) can be removed.²⁷

Ultimately, in the legal literature, there exists a dearth of discussion on the issue of linguistic discrimination, whereas debate pertaining to the officially recognised 'protected characteristics' (race, sexual orientation, *etcetera*) has been flourishing for quite some time. Academics have previously clamoured for an enlargement of the list of protected characteristics so as to encompass further features.²⁸ Although language remains on the side lines of these discussions, the EU should certainly represent a pertinent and fertile terrain on which to conduct further analysis and, possibly, a frontier for a future, prospective Equality Framework. Practically speaking, in considering the fate of this right, the prevailing dilemma of how this right should be ideally shaped by the EU and the national legislations of each MS remains a bone of contention.

²⁶ Such as the right to a fair trial, already explained above under Section 3.

²⁷ Or, in legal terms, a relative right. See T schilling, 'Language Rights in the European Union' (2008)9 German Law Journal (2008)9 1219-1242.

²⁸ The look, most notably. See C Walhurst, D van den Broek. R Hall and D Niclson, 'Lookism: The New Frontier of Employment Discrimination' (2009)51 Journal of Industrial Relations 131-136.

2.2 MEMBER STATE LEGAL FRAMEWORK AND NATIONAL CONTACT POINTS

2.2.1 Germany

In-country Legal Framework

In 2004, the case law of the European Court of Justice on the cross-border receipt of medical benefits was already transposed into national law in Germany, particularly in section 13 subsections (4)-(6) of Book V of the Social Code (Sozialgesetzbuch V). The national contact point was established on 25 October 2013 on the basis of the implementation of Directive 2011/24/EU. The legal basis in national law can be found in section 219d of Book V of the Social Code (EU-PATIENTEN.DE).

Comparing the pre- and post-Directive situation in Germany, it becomes clear that many provisions in this legal act were already included in German national law. It is important to note that translation and interpreting services for patients are not encoded in legislation and the German healthcare system is not legally obligated to provide language services for speakers of languages other than German. Regarding Articles 4, 5, 6, 7, 8 and 11 of the Directive (containing the provisions that are binding and to be transposed by each MS), it should be pointed out that the key provisions were already transposed into German law before the Directive. These Articles are selected for analysis since they contain the provisions that should be transposed in each MS (Goscinska, 2014):

Table 10: Pre- and Post-Directive Status

Directive 2011/24/EU ⁹	Germany	National Law
Art. 4 (2)	(b) DIR (c) BD (+DIR) (d) BD (+DIR) (e) BD (f) DIR	(b) PRG (c) PRG (d) PRG (e) StGB (§ 203) (f) PRG
Art. 4	(3) BD (4) BD	(3) implicit law (4) implicit law (in GoÄ)
Art. 5	(b) DIR	PRG
Art. 6	DIR	PRG
Art. 7	BD	GMG (§ 13 Para. 4 SGB V)
Art. 8	BD	GMG (§ 13 Para. 5 SGB V)
Art. 11 (1)	DIR	AMVV (§ 2 Para. 1a & 1b)

- Art 4 Responsibilities of the MS of Treatment
- Art 5 Responsibilities of the MS of Affiliation
- Art 6 National Contact points for cross-border healthcare
- Art 7 General principles for reimbursement of costs
- Art 8 Healthcare that may be subject to prior authorisation
- Art 11 Recognition of prescriptions issued in another MS

BD = before directive

DIR = transposed due to directive

BD (+DIR) = partly before directive

An analysis of interviews with more than ten experienced specialists in relevant fields indicate that in Germany, the majority of informants in the fields of healthcare services have no knowledge of the Directive's transposition. This was the case among medical practitioners and other healthcare providers at various hierarchic levels who

have direct contact with cross-border healthcare patients. These professionals were not aware of the EU Directive. Medical lawyers stated that they have a little knowledge on the implementation of the Directive (DE Inf 1, DE Inf 4). Lawmakers at the federal level as well as regional ministries who are responsible for the transposition of the Directive were highly informed on the legal implications of the Directive (DE Inf 9, DE Inf 10). During our interviews they stressed that it is too soon to discuss the effects of the Directive. None of the informants reported any issues with language for patients seeking care under the Directive. The following summarizes the point of view of all informants interviewed "Germans travelling speak English. And we do not have the obligation to provide language services to patients who do not speak German" (DE Site 7, DE Site 8).

National Contact Point

As a result of the Patients Mobility Directive, Germany established a National Contact Point on 25 October 2013. EU-PATIENTEN.DE is the website of the National Contact Point for cross-border healthcare. The German National Contact Point is an organisational unit within the German Liaison Agency Health Insurance-International (DVKA). It is part of the National Association of Statutory Health Insurance Funds (GKV-Spitzenverband). The German National Contact Point is funded by the National Association of Statutory Health Insurance Funds, the German Hospital Federation, the National Association of Statutory Health Insurance Physicians, and by the National Association of Statutory Health Insurance Dentists, as well as by the private health insurance funds.

The German National Contact Point states that its work "is based on the directives of the European Commission and on German laws to improve the quality of information provided to patients when taking up cross-border healthcare services" (EU-PATIENTEN.DE). EU-PATIENTEN.DE provides information to patients and healthcare providers on cross-border healthcare, particularly on claims related to cross-border healthcare, appeals, procedures, patients' right, the cost assumption procedure, quality and safety regulations. While the NCP has to provide information it should not engage in case management.

While the main target group is defined by the NCP as patients from Germany and other MSs who would like to claim cross-border healthcare services, the NCP also provides information for health insurers and healthcare providers (e.g. physicians and hospitals).

Patients seeking information on cross-border healthcare in Germany are provided with information on healthcare providers in Germany.

EU-PATIENTEN.DE offers various search engines for finding healthcare providers:

- For finding hospitals, the search engine of the German Hospital Federation is offered. The search engine includes a separate section for international patients.
- For finding doctors, the search engine of the National Association of Statutory Health Insurance Physicians (only in German) is offered.
- For finding dentists, the search engine of the National Association of Statutory Health Insurance Dentists (only in German) is offered.

There are also search engines offered for finding midwives, chemists, physiotherapists and oxygen stations. For diagnosing and treating rare diseases, the NCP offers a link to the reference portal Orphanet.

Information is also useful for providers. While interviewing lawyers we asked questions about where doctors or hospitals get information to answer patients' questions. The lawyers mentioned the National Contact "Points" as sources for information. They refer to "them" and elaborate that "National Contact Points are points where people (German speakers) can get information, both doctors and patients, where they can access answers to all their questions." While lawyers used the plural form, this study only identified one NCP in Germany, which was observed as part of fieldwork (see Section 1) (DE Inf 4). For those considering care in Germany and who would like to receive information on cross-border healthcare the NCP can be reached via telephone (+49 (0) 228 9530 – 800) or via an online contact form (<http://www.eu-patienten.de/en/kontakt/kontakt>). The website is available in German and English. Information and advice are offered in these two languages as well.

2.2.2 Greece

In-country Legal Framework

Greece adopted and implemented Directive 2011/24/EU through domestic Law 4213/2013 that was published in the Government's Gazette bearing the No. 261. The date that this Greek legislation came into effect was the day of its publication in the Government's Gazette on 9 December 2013, however it was not fully implemented into domestic law with pending procedures until October 2014. The legislation covers the entire country. With four chapters and thirty articles overall, the Greek Law 4213/2013 reflects the provisions and the guidelines of the Directive. Greece has opted for an overarching national legislation for the Directive and does not have a regional approach to Directive legislation. It should also be noted that this legislation does not include a framework for the provision of translation and interpreting services for cross-border healthcare patients.

At the Greek Ministry of Health, the director of the Department of International Affairs and Policy is in charge of monitoring and implementing the Directive. This position does not include responsibility for the content of implementation policy, but only for monitoring and supervising implementation and coordination (EL Inf 3). The Ministry of Health views the transposition of the Directive proactively and is "interested in promoting medical tourism and attracting medical patients from abroad. Administrative steps have been taken to draft health policy for cross-border patients" (EL Inf 3).

In the informant's words: "we are working hard. We have established (in October 2014) a unit for the formulation of health policy and medical tourism and a new regulation was issued at the end of October 2014... It became apparent in our 2012-2013 discussions that we needed a policy on medical tourism. The goal is to attract mainly private patients to specialized clusters for IVF treatment, medical spa" (EL Inf 3).

Greek Law 4213/2013 presents the general scope of the legislation and the terminology used, which is a reflection of the terminology used in the Directive. Terms like 'cross-border healthcare', 'patient' and 'medical record', are defined so that Greek authorities have a clear understanding of them. Specific and detailed information is also given concerning the responsibilities of Greek healthcare institutions in regard to cross-border care. This includes information on the processes and procedures to be

followed for cross-border healthcare, as well as on rights of EU citizens in Greece or of Greek citizens in other MSs. This information is in agreement with the 2011/24/EU Directive.

Greece's healthcare system is universal. It covers every person who has an electronic European Health Insurance Card (EHIC), an IKA Health book (issued for short term travellers or visitors), or any person who has an AMKA number (a unified national number for any person living in Greece, which is also available for long term foreign residents). They can go to an IKA / *EOPYY* registered GP (the initials *EOPYY* in Greek stand for 'National organization for healthcare services, provision, division of international affairs') or specialist free of charge, and get IKA prescriptions from them (EL Inf 3).

Even in a universal system there are exclusions. It is true that illegal/undocumented immigrants can go to public hospitals since the Ministry of Health will take care of people without documents. These immigrants mostly come from Syria, India, and Pakistan and to a lesser extent Africa (EL Inf 5).

However, recently, "the economic crisis has left about 30% of people uninsured: unemployed people for more than one year, poor people who cannot afford an insurance, self-employed people who in time of crisis decide whether to keep contributing to their health care or use the money for more urgent needs. As a result, some 60-70 clinics/pharmacies developed spontaneously as NGOs over the last 5 years offering primary care services... Doctors, nurses and pharmacists volunteer their time and resources to help the uninsured" (EL Site 8).

The role of the National Contact Point (NCP) is also established in Greek Law 4213/2013. The Ministry of Health was involved in the preparatory stage of the transposition of the Directive but it does not serve as a NCP since that responsibility is left to *EOPYY* (the NCP). Decision 264 of *EOPYY*'s Board of Directors defined the role and the function of the Hellenic National Contact Point. The Administrative procedures have been completed according to Article 9 (Ministerial Decision: Y9a/76908/11.09.2014). Healthcare cases that may be subject to prior authorization have been defined according to Article 8 (Ministerial Decision: Y9a/79323/16.09.2014).

Greek Law 4213/2013 also has several other purposes. First, it clarifies the procedures and criteria for prior authorisations for cross-border health care. It also deals with the logistics of the cooperation between the MS on cross-border healthcare issues as well as e-health issues, new technologies and the advancement of medicine through new methods such as e-health governance and the Hellenic eHealth Network (*ΕΣΔΗΥ*).

National Contact Point

EOPYY is the National Contact Point for Greece and can be contacted via email. When scheduling an interview, we used e-mail first and then made a phone call. When we arrived at the offices multilingual staff members, who were very enthusiastic about the meeting, greeted us. We did not need the services of our interpreter to communicate with the NCP.

The development of a fully functioning NCP is an on-going project. The NCP is understaffed and has a considerable workload given that it serves 57 regions in Greece, 7 of which are in Athens. Furthermore, medical committees are needed to examine claims for prior authorisations. These committees should be formed by the end of August 2015. On the topic of prior authorisations, the NCP has dealt with confusion over the difference between the Regulation and the Directive. Reimbursement for Greek patients who travelled for healthcare has been rejected because patients had not received prior authorisation when they were required for certain treatments. The NCP has experienced problems like these because there has been insufficient time since the implementation of the Directive and the opening of the NCP office.

The website for the NCP is still being developed. The website is in Greek and some information is in English. It does not provide phone/fax contact but prefers internet (www.eopyy.gov.gr), e-mail (ncp_gr@eopyy.gov.gr), personal consultation at the interactive front desk at the national office or consultations at regional healthcare divisions of *EOPYY*.

Under the Directive, all MSs can choose to exercise prior authorisation of treatment for healthcare that involves (a) an overnight hospital stay, and/or (b) highly specialised and cost-intensive healthcare services. The National Contact Point of Greece, *EOPYY*, is able to inform a patient if they are eligible to pursue cross-border healthcare and which treatments require prior-authorisation. While the NCP provides information it does not engage in case management. Thus, potential patients can reach out to the NCP and ask about the eligibility of the care they would like to receive in Greece. A generic form (see Annex 3) to request specific information can be accessed by both healthcare providers and patients either on the website or at *EOPYY*'s offices. Hospitals also can provide these forms.

Through the same form, patients and healthcare providers can request information concerning cross-border healthcare and request examination of an application concerning cross-border healthcare. Informants stated that requests to *EOPYY* are usually answered within ten working days.

Informants working in rural health centres (EL Sites 8 and 10) were aware of the Greek law for the Directive but they were unaware of its specific content. They concurred that cross-border healthcare information came to their hospital systems through *EOPYY* or the National Ministry of Health, but they were not familiar with the Directive. Some (EL Sites 4 and 9) did know that *EOPYY* is the contact point for Greece and that it can give them more information on the topic if needed but others did not think it was important for them (EL Sites 6 and 1). Even though hospitals in Greece are specialized and are not (in theory) primary health care providers, they do in fact provide primary health care free of charge to patients who need it (regardless of citizenship).

Informants working in hospitals (EL Site 1) also indicated that the process for opening a file for a cross-border patient, or the process for obtaining reimbursement seems very bureaucratic. Despite the difficulties Greek hospitals are welcoming cross-border patients. It appears that in Greece, healthcare providers value cross-border patients because the services they provide are paid in full by the patients' MS, thus securing income for the institution. It was explained to us that this income is important. Since the start of the financial crisis in 2010 there have been various budget cuts to healthcare and insurance funds are financially struggling. Thus, hospitals and institutions see cross-border healthcare and Directive patients as an opportunity and

the healthcare policy makers are working to draft health policy to promote cross-border services (EL Inf 3).

2.2.3 Italy

In-country Legal Framework

The Directive has been implemented through the Italian Legislative Decree n.38 (*Decreto Legislativo*, 2014), which was enforced on the 5th of April 2014, approximately 6 months after the set deadline²⁹. In accordance with the legislation the Ministry of Health has been established as the National Contact Point in Rome (*Ministero della Salute*, 2015). This Ministry together with the Ministry of Foreign Affairs has set up a working group in which all the regions are participating. This working group has a priority to set up a regional contact point in each region. Much autonomy is given to the regions for planning and the Veneto region has received considerable state funding for the Directive and all cross-border healthcare-related activities. Thus far institutions in Italy have organized conferences and focus groups in order to facilitate Directive transposition (IT Inf 5).

Despite these efforts, the transposition of the Directive is not uniform across all regions. Based on research performed all of the Italian Regions have acknowledged the Directive and the Legislative Decree. Nevertheless, official regional legislation, provisions or policy regarding its implementation and transposition are rarely found. Thus, the Directive is recognized but not, for the most part, specifically legislated for at the regional level. In addition to the lack of specific regional legislation to implement the Directive, there is also a lack of legislation concerning translation and interpreting services in healthcare.

Despite the lack of comprehensive policy guidance, respondents reported that healthcare providers are aware of the national implementation of the law. Likewise, respondents reported that there is a norm in place to ensure compliance and to sanction non-compliance with the implementation of the Directive. This norm is the Legislative Decree n. 38. It was also reported that compliance is ensured by individual hospitals/healthcare services through their own mechanisms that were in place before the Directive took effect. Lastly, regional guidelines specific to the Directive to improve awareness and compliance are under development.

There is no evidence that a National Department of Health or National Health Institution is working on the implementation of the Directive (see paragraphs 1 and 2 above), or planning actions to undertake implementation. There is, however, a committee in charge of "mobility", including members who are supposed to work on the implementation of the Directive. A regional representative from Umbria coordinates this committee. The committee is composed of representatives of all the Regional Administrations and of three members of the Ministry of Health.

Evidence of current work from the Regional Administrations on policies concerning access to cross-border healthcare was found for the following three regions: Emilia Romagna, Veneto and Abruzzo. The Regional Administration of Emilia Romagna has established two working groups. First, a committee was formed. Secondly, a group of professionals in the healthcare field has taken shape. These are two different groups

²⁹ *Decreto legislativo* 4 marzo 2014, n. 38 (GU n.67 del 21-3-2014).
<http://www.gazzettaufficiale.it/eli/id/2014/03/21/14G00050/sg>

that work on the strategic and technical levels of cross-border healthcare respectively (*Determinazione*, 2014).

Veneto is potentially a very important region because it is a major tourist area, so EU citizens may be likely to seek care in this area. Here the Regional Administration created two contact points: a Regional Contact Point (Bur, 2015) at the *Azienda Ospedaliera di Padova* (Padova General Hospital) and one at the *Istituto Oncologico del Veneto* (Veneto Oncological Institute). Likewise, in Abruzzo the Regional Administration created a Regional Contact Point and drew up guidelines for costs and reimbursements (*Legge Regionale*, 2014). These are examples of regions that have been at the forefront, at least in Italy, of planning for cross-border healthcare and the Directive. During our meeting with the NCP in Rome (IT Site 7; IT Inf 14 to 18) the representatives of the regions stated that the regional contact points were being established and not functioning yet.

In addition to regional planning, Veneto has also cooperated with other MSs through a cooperative cross-border project (Hospital Network for Cross-border Healthcare, 2015). This project involves four hospitals in Italy and collaboration with Austria, Belgium, France, Germany, Greece, and Hungary. It is mainly aimed at obtaining a better understanding of the financial and organisational requirements related to the new EU rules on cross-border healthcare. Additionally, it provides guidelines for hospitals and promotes information sharing between the MSs. A telephone discussion with one of the researchers involved in this European project and a follow-up interview with other members of the team in Verona revealed that the project is still in progress and the results will be ready in January 2016. However, the first results (anticipated by this informant- IT Inf 5) confirm that the number of institutions using the Directive is very small, and that the Directive is not fully applied. The project includes healthcare services, not only in Veneto, but also in 4 more regions, namely: Friuli Venezia Giulia, Lombardia, Piemonte, and the Autonomous Province of Bolzano.

At a more general level, there is supporting activity from a project led by the Italian regions Toscana and Veneto (*Mattone Internazionale*, 2015). Its goal is to organise training, events, workshops, meetings and internal projects in order to further the integration between the European Union and the Italian regions in terms of services and policies related to cross-border healthcare and the Union. In particular, the project has organised four events in Rome, Naples, Florence and Venice where training about the Directive was given.

Interviews were performed with informants from Rome, Naples, Verona and the regions of Lombardia, Basilicata and Emilia Romagna (IT Inf 1 to IT Inf 11). Through these interviews we were able to gather information on the transposition of the Directive at local level. One important finding is that the law contains a series of points that practically limit the ability of patients to receive care abroad. This ability is limited because of the procedure for prior -authorisation and the way in which such authorisation is required. For example, according to the law, if a procedure requires hospitalization of at least one night and expensive instruments, then it will require previous authorisation. Moreover, if healthcare can be provided "reasonably well" in the patient's region, no authorisation for cross-border assistance is possible. Thus, patients' ability to receive care under the Directive is limited by its very requirements and this interpretation of the law in Italy.

Beyond the process of prior-authorisation, it was also found that local health institutions (IT Site 5) are establishing temporary norms to address the issue of cross-border healthcare. These temporary norms are established by local hospitals and healthcare sites (IT Sites 5 and 6) and they can be organized in a way that they

believe is best for their institution, as long as they guarantee the protection of the rights of EU citizens. Local institutions have had to adapt in this manner because Italy has been late in implementing the Directive. Italy has chosen an arduous process by transposing the Directive into a National Decree, which in turn will be transposed into regional legislation (Spain also employed a similar strategy to transpose the Directive). While transposition into national decree has now been more or less accomplished, implementation of regional regulations is only beginning and just three regions have actually started organising this process. It was also reported that Italy is preparing national guidelines for regional implementation and that many regions are waiting for these to be published. Thus, the temporary norms, which emphasize the rights of all EU citizens, are in place until these general guidelines are implemented.

One member of the regional committee in Emilia Romagna explained that the regional contact points presently used are the same as those used under previous legislation. The regional contact points are located in specialised healthcare services that are spread across the regional territory. The same is true for Veneto. Therefore, the strategy of regional governments, which has been confirmed by new contacts in Veneto, is to identify individual hospitals and institutions as contact points at the regional level. Information from a physician (IT Inf 10) from the General Hospital in Modena confirms that there are offices in local hospitals that are monitoring the phenomenon of indirect assistance.

National Contact Point

The National Contact Point of the Ministry of Health provides patients with information that facilitates access to cross-border services, for example information about conditions and eventual reimbursement or complaints. However, there are accessibility issues for the public wanting to reach this NCP since it is reachable only via e-mail and responds to queries in approximately ten days. The National Contact Point can only be contacted through an online format and there is no personal contact or possibility to speak with a person. Information was sought through the online form and the reply by email was very limited in scope and did not provide any detailed information on the Directive or on the process of reimbursement. The response essentially repeated the information that was already available on the website. Even though the NCP is difficult to reach it is still, according to questionnaire respondents, known to healthcare providers. During our interview with the NCP (IT Site 7) we mentioned this communication difficulty. Informants explained that they prefer to keep records of communication and that is why they do not reply to phone calls/inquiries.

Out of the seven informants present at the Ministry meeting with the NCP, five were in agreement that there are problems with the provision of information by the NCP. The information provided is said to be superficial or not helpful, but efforts are in place to change this. It seems clear that there is some confusion about the function of the NCP, directly observed through our attempts to contact the office. Other informants from hospitals and clinics (IT Inf 10, IT Sites 5 and 6) confirm this lack of effectiveness. Only two respondents (IT Site 7) state that the NCP provides information on the quality of care. One informant explained that there is no international quality standard in place, but the NCP is preparing a list of institutions that are certified and authorised according to the Italian national quality standards. This list has yet to be released. Some respondents did affirm that the NCP provides information to both outgoing and incoming patients but this response was not universal (IT Inf 5, IT Inf 9). In addition, as we have seen, there are issues with access to and quality of information. In regard to language access, the information

provided by the NCP is currently in English and Italian. The NCP officers required interpreting from English into Italian during our meeting.

Communicating with regional contact points proved to be just as difficult as communicating with the NCP. The contact points at regional level are not call centres and are definitely not ready to speak to potential patients. Reaching the person who is in charge of the Directive was also very difficult since information from both the website and from those who answered the phone is very scarce.

After numerous and repeated calls to administer questionnaires 1 and 2 (by e-mail or by telephone) to all regions, only 7 of 15 and 36 of 475 questionnaire responses respectively have been received.

In addition, one of the regional contact points that is in the process of being established, chose not to respond to the questionnaire because of lack of knowledge. In this case it was claimed that the Ministry does not provide any guidelines and that regional administrations work autonomously. Lack of knowledge is also evident in the number of missing answers to the questionnaire and shows how difficult the situation is in terms of the implementation of the Directive.

2.2.4 Spain

In-country Legal Framework

The Directive was not fully transposed in Spain until the final passing of *Royal Decree No. 81/2014 establishing the standards to guarantee cross-border healthcare* on 7th February 2014 after the deadline of 25th October 2013. This is the legal instrument for Directive transposition and it has taken effect over the entire Spanish territory.

Prior to the passing of *Royal Decree No. 81/2014* the Inter-territorial Board of the National Health System (*Consejo Interterritorial del Sistema Nacional de Salud*) created in March 2012 a Work Group for the transposition of the Directive (*Consejo Interterritorial, 2012a*). This Inter-territorial Board has responsibility for guaranteeing the cohesion of the Spanish Health System. It also coordinates the differences that may exist in the organisation of Health Services in the different Autonomous Regions (ARs).

With this in mind, the Inter-territorial Board partnered with other stakeholder groups in 2013 to prepare for the transposition of the Directive. During a consultation process the Autonomous Regions and Cities, as well as other national health bodies and organisations, participated in deciding the content of the legislative instrument in charge of transposing the Directive into Spanish legislation (*Consejo Interterritorial, 2012b*). The result of this process was the *Draft Royal Decree No. 81/2014 establishing the standards to guarantee cross-border healthcare (Boletín Oficial del Estado, 2014)*³⁰. According to the information we gathered during our interview at the Ministry (ES Inf 18, ES Inf 14) with representatives from all 17 autonomous regions on the Inter-territorial Board, Spain has experience of dealing with different languages (for example, in Galicia, the official languages are Galician and Spanish; in the Levante region they are Valencian and Spanish). The use of regional languages is recognized and protected in the national Constitution (as in Switzerland and Belgium). Therefore, the linguistic adaptation that Spain has made internally to meet the

³⁰ <http://www.boe.es/boe/dias/2014/02/08/pdfs/BOE-A-2014-1331.pdf>
<http://www.msssi.gob.es/en/pnc/normativa/rd812014.htm>

linguistic needs of its autonomous regions is apparent in the bilingual documents collected during observations (see examples listed in the Bibliography, under Other references consulted), in the bilingual signage within healthcare centres and in the fact that most healthcare providers speak the local language as well as Spanish (ES Site 12, ES Site1).

The content and spirit of Royal Decree No. 81/2014 are very similar to the content and spirit of Directive 2011/24/EU. This Royal Decree states the principles of patients' freedom of choice, access to high quality healthcare and of non-discrimination based on place of origin.

In addition to the Directive there is a pre-existing legislative instrument that is part of the national legal framework for cross-border healthcare in Spain. The Royal Decree No. 1030/2006, of 15th September, establishes the catalogue of common services of the National Health System and the procedure for updating it (Boletín Oficial del Estado, 2006). This Royal Decree describes what services are available in the country's Health system by defining the set of techniques, technologies, methods, activities, resources and procedures that allow the provision of basic healthcare in Spain, and the entitlement of other EU citizens when applying for cross-border healthcare in this country.

Health Services in Spain are a responsibility of the regional governments of the autonomous regions (ARs) and are organized and managed independently in each of them, except in the cases of the Autonomous Cities of Ceuta and Melilla, which depend directly on the National Institute of Social Security. Royal Decree No. 81/2014 has effect over the whole of the Spanish territory but, since ARs also have legislative power, there is also regional legislation that is relevant for the implementation of Directive 2011/24/EU.

This regional legislation is limited since it only exists in some ARs. In other ARs the regional legislation identified as relevant for the implementation of Directive 2011/24/EU has not necessarily been passed after its transposition. In other cases relevant legislation may already have existed or may have been adapted to comply with the requirements of the Directive. Regardless, in some ARs the NCPs are unaware of the relevant legislation. Even in ARs that have legislation specific to the Directive and cross-border care, language support and services are not included in such legislation.

In Castile and Leon, the Directive is transposed regionally through the Order SAN/1008/2014 of 18th November. This legislation regulates the procedures for reimbursement and prior-authorization for cross-border healthcare. Likewise, in Galicia there is the Instrument 5/2014 that also regulates cross-border healthcare in that region. These are examples of ARs that have legislation specific to the implementation of the Directive.

For most ARs that took part in the questionnaire, this is not the case. The ARs that gave this response stated regional legislation specific to the Directive was lacking and they may or may not have other legislation pertinent to cross-border healthcare. The NCPs in each region have been found to have limited information in this respect and may not have any knowledge of regional legislation in their AR. Examples that demonstrate the variety of possibilities are as follows.

First, there are several (6) contacts at the NCPs of ARs that replied to the questionnaire by stating that there is no relevant regional legislation that transposes the Directive. This is the case in Canary Islands, Cantabria, Castile and La Mancha,

Extremadura, Navarre, and Valencia. Nine out of ten NCPs of ARs said they are aware of the existence of the national transposition. Secondly, there is an example of legislation relevant to cross-border healthcare but this instrument does not specifically transpose the Directive and is limited to certain specific areas of cross-border healthcare. This is the case with the instrument 18/13 in the Canary Islands that ensures the rights of cross-border patients in this region. Lastly, in many instances the existence of regional legislation for the transposition is unknown or undeterminable. In these cases, NCPs were contacted but were unable to provide legislative information on the Directive. Additionally, the websites had either no information or only very rudimentary information. The unclear organizational structure is combined with general problems with the availability of information on websites, a lack of contact phone numbers, or emails being re-routed to other agencies. The overall panorama is that the regional legal framework is not clearly defined.

Despite a lack of comprehensive regional legislation institutions in Spain have adjusted to the Directive. One example is the process for writing and obtaining prescriptions. On the prescription itself the active ingredients are listed instead of the commercial name of the medicine. Additionally, the information of the healthcare provider, including his/her telephone number and health centre is codified on the prescription. Lastly, Spain is at the forefront of electronic prescriptions and this is an important advance (ES Inf 18). During our interviews at the Ministry we were given a PPT on the linguistic project that Spain is leading for the terminology database to support multilingual medical records (ES Inf 14).

There are also reported problems with implementation that require policy solutions. Invoicing is a problem because the invoice system for healthcare differs between MSs. This complicates the reimbursement process. Likewise, the Directive creates some paradoxical situations; for example, a Spaniard who receives cataract surgery abroad will be reimbursed (assuming he had received a prior authorization) but he will not be covered in the same way if he goes to a private healthcare centre in Spain (ES Inf 1).

It was also reported (ES Sites 6 and 7) that the Spanish private sector would “definitely be interested in exploring the potential offered by the Directive and by medical tourism” (ES Inf 9) They would combine medical care and good weather in an attractive formula especially if communication is not perceived as a deterrent (ES Site 11). Interestingly, in private clinics observed there were bilingual staff and professional interpreters as they recognise the importance of communicating with patients in their own language. Their interest in marketing services though is not limited to other MSs, as they also receive many patients from the Middle East and China and they are planning to be more aggressive in attracting patients from those regions.

National Contact Point

The Ministry of Health, Social Health and Equality (*Ministerio de Sanidad, Servicios sociales e Igualdad*) in Madrid houses the National Contact Point for the Directive (ES Inf 18, ES Inf 19). There are an additional 17 regional NCPs responsible for information, prior authorization, and reimbursement. The purpose of the NCPs is to give citizens adequate information on cross-border healthcare as a means of ensuring this right. Additionally the activity of the NCP will be complemented by other units responsible for cross-border healthcare from the different ARs, from the National Institute for the Management of Health (*Instituto Nacional de Gestión Sanitaria*) and from civil servants’ mutual societies. The NCP in Spain is part of the Administrative

Unit responsible for Citizen Information at the Ministry of Health, Social Services and Equality in Madrid.

The website of the Spanish NCP is hosted on the main website of the Ministry of Health, Social Services and Equality. This website contains general information on cross-border healthcare, on the relevant EU and Spanish legislation, on the rights of patients, on the NCPs of other MSs and on the contact information and websites (when available) of the rest of the regional information units. All information is available in Spanish and only certain information is provided in English and in other co-official languages in Spain.

It was reported that language is not an issue for the NCP in Spain. There are very few examples of Spaniards going abroad, approximately 10 per year, and language has not been a major concern or problem thus far. Likewise, for incoming Directive patients travelling to Spain there is very little information. These patients mainly go to private providers and detailed information about them is not compiled by Spanish institutions (ES Inf 18). However, the NCP had to report to the EU and thus requested information from all autonomous regions in 2005. And to this day there are very few cases.

The NCP is difficult to access since virtually the only method of doing so is by email. Although a phone number exists, a recorded message directs callers to send an email. Contact by email is also unreliable since repeated requests on behalf of this project team received a delayed response. Thus, as in Italy, information about cross-border healthcare is only obtained through the website and through queries to an email address that can be unresponsive.

The legal framework at regional level does not establish clearly functioning Regional Contact Points in each region. In Catalonia and the Basque Country there was no functioning contact point. In other cases the contact person was unaware that they were listed as a NCP. This was the case with Castile and Leon, Ceuta, Canary Islands, and Melilla. Lastly, the NCPs in Andalusia, Aragon, Asturias, Catalonia, Balearic Islands, La Rioja, and Murcia were unresponsive to inquiries.

A very common issue throughout regions was that the NCPs were housed under the umbrella of different agencies and were not clearly defined. This was discovered through telephone inquiries to the listed contacts. Depending on the region, the NCPs could be found as a part of different agencies such as General Information Services, Customer Service Departments, Benefits Departments, Citizen Services, or Insurance Services. Without a clearly defined NCP the result was that inquiries were passed on and routed to other agencies that were not listed as NCPs. This was a common practice and occurred in Aragon, Asturias, Cantabria, Castile and Leon, Catalonia, Madrid, Galicia, Balearic Islands, Canary Islands, and Melilla.

The Spanish Ministry of Health is working to solve other procedural and administrative problems such as the "interoperability of the different healthcare systems" of the different ARs. This same issue is judged to be of relevance for the Directive and cross-border patients across the EU. Healthcare systems across the EU are not sufficiently interconnected and "No logistical solution has been put in place. We are lacking the necessary tools to connect the MSs." The effort of the Ministry to develop technology and procedures that facilitate interoperability and the circulation of patients and the exchange of medical records could also be of use at the European level. "The EU needs to invest in (developing) computer tools to establish similar protocols" (ES Inf 18).

2.2.5 United Kingdom

In-country Legal Framework

In the UK the Department of Health took the lead in negotiating, on behalf of England, Wales, Scotland and Northern Ireland, the terms of Directive 2011/24/EU with the European Union (UK Inf 1). The UK has a regional implementation of the Directive administered by authorities in England, Wales, Scotland and Northern Ireland yet this negotiation process allowed for an implementation that also has national consistency. The Department of Health performed an impact assessment, a public consultation and also drafted policy guidance for Directive implementation (Department of Health, 2012, 2013).

The impact assessment suggested a policy choice for transposition of the Directive through "intelligent copy out." This type of transposition copies directly from the text of the Directive, where appropriate, for transposition into UK law. However, it is not strict "copy out" since adaptations are made so that the specific context of the UK is taken into account. This type of transposition allows for the obligations of the Directive to be fulfilled in an appropriate way. The impact assessment estimated the costs for the transposition of the Directive and, despite insufficient data, considered the implications of the demand for cross-border healthcare. The impact assessment also categorized the obligations of the Directive into three categories: establishing a NCP, ensuring fair procedures for reimbursement and prior authorisation, and making arrangements for incoming patients. The impact assessment did recognize that potential Directive patients would consider language as a factor that could influence their decision to seek cross-border healthcare, but that it is less of a factor for patients who have strong ties with other EU countries. Additionally, the NCP was estimated to be an institution that could save on the costs of the translation of foreign receipts through centralised administration.

The purpose of the Department of Health policy guidance is to provide information that will assist with the implementation of the Directive so that relevant healthcare institutions understand the obligations and impact of the Directive. The procedural actions for reimbursement and prior authorisation are covered in detail and, like the impact assessment, translation of receipts is mentioned and the National Contact Points are recognised as institutions that can assist with this process. It is even suggested that the UK NCPs can collaborate with NCPs from other MSs to do so. The policy guidance also states that "there are a range of other issues that patients will need to be aware of when seeking treatment in another European country – for example, there may not be the same standards of care, there may not be the same styles of treatment or of aftercare and there may be language barriers to negotiate" (Department of Health, 2013). These language barriers are mentioned as an important factor to be considered for patients, however language issues are not dealt with in a comprehensive matter in the policy guidance.

Regional authorities then followed suit with a similar process based on the Department of Health policy. Regional impact assessments and policy guidance are similar to those of the Department of Health but specifically address regional issues (Department of Health Social Services and Public Safety, 2013a; The Scottish Government, 2013; Welsh Government, 2013). A good example of regional adaptation of policy is Northern Ireland since, unlike other regions in the UK, Northern Ireland shares a land border with a EU MS, the Republic of Ireland (Department of Health Social Services and Public Safety, 2013a, 2013b, 2014). Travel between Northern Ireland and the Republic of Ireland is easier than travel between the UK and other MSs and healthcare administrators increasingly see both countries on the island as a single healthcare

market. Additionally, the Republic of Ireland does not have a healthcare system that is fully funded publically while Northern Ireland does (Department of Health Social Services and Public Safety, 2014; UK Inf 16). This has obvious implications when considering cross-border healthcare. Consequently, Directive implementation in Northern Ireland considered these geographical and social factors.

The Directive was transposed through statutory instruments by the deadline of 25 October 2013 in England, Wales and Scotland (National Health Service, 2013; National Health Service England and Wales, 2013). It was transposed after the deadline through statutory rules in Northern Ireland on 27 December 2013 (Health and Personal Social Services, 2013). England and Wales share the same statutory instrument while Scotland and Northern Ireland have their own statutory instruments and statutory rules respectively. A closer look at the regional implementation of these statutory instruments through impact assessments and policy guidance shows further recognition of language issues.

Taking the case of Northern Ireland, the impact assessment included collaboration with pertinent organisations including political parties, Health and Social Care representatives, the British Medical Association and other associations of medical professionals, community organisations, business organisations, and a host of governmental organisations ranging from the Chamber of Trade to the Equality Commission (Department of Health Social Services and Public Safety, 2013b). During the consultation process the following language issues were raised as important points to be considered for Directive implementation. The Health and Social Care Board responded to the consultation by stressing the importance of informed consent and that for patients whose first language is not English "appropriate interpreting services must be available" (Department of Health Social Services and Public Safety, 2014). Here it is worth noting the importance of interpreting in obtaining informed consent for patients who, although they may speak English, do not have English as a first language. This seems to imply that nearly all Directive patients from continental Europe would need a (sight) translation to obtain informed consent, even if they have proficiency in English. The Health and Social Care Board also responded to the consultation by commenting on the need for translated leaflets to advise patients on receiving treatment in Northern Ireland so they can make an informed decision. Lastly, Disability Action (a registered charity and volunteer organization) commented on the importance of the availability of information concerning interpreting services.

Despite these concerns, language provision was not a central issue in either the regional legislation or policy guidance for the transposition of the Directive. In fact, regional policy guidance only mentions the issue of language in two contexts: first, when discussing potential language barriers for patients who travel; and second, when discussing the translation of receipts and prescriptions from other MSs. Regional policy guidance focuses mostly on the process for reimbursement. Here the guidance on the translation of receipts and documents is that the cost of translation can be deducted from the reimbursement. There is no further guidance for addressing communication issues in cross-border healthcare and specific policy for the provision of translation and interpreting services is not given.

The implementation of policy has taken shape through these processes of legislation, impact assessment and policy guidance. Practical experience has shown that implementation is an on-going process since the Directive is relatively new and institutions are still adapting to the policy. Directive patients are rare and institutions have yet to fully streamline administrative procedures. For example, in Scotland "there have been since the inception of the Directive only roughly fifty outgoing patients and zero incoming patients" (UK Inf 13). With the low number of Directive

patients each reimbursement case is a new experience and adventure. In the UK institutions themselves have prepared for the Directive by creating specific administrative positions. An example of this is NHS Lothian, which has two administrators in charge of inbound and outbound patients. This institutional policy assists with the coordination of cross-border healthcare, provides case management and offers another layer of assistance to patients (UK Inf 18, UK Inf 19).

Regional Directive legislation does not include guidance on translation and interpreting, yet in the UK healthcare institutions must provide translation and interpreting services under Equality Legislation. In England the Equality Act of 2010 protects the public from workplace discrimination and discrimination in society (Equality Act, 2010). Regional authorities in Wales and Scotland have adapted the Equality Act and statutory instruments enforce these adaptations (Scottish Statutory Instruments, 2012; Welsh Statutory Instruments, 2011). The relevant legal instruments in Northern Ireland are the Race Relations Order 1997 and the Northern Ireland Act 1998 (Northern Ireland, 1998; Northern Ireland Statutory Instruments, 1997). Healthcare institutions in the UK comply with Equality legislation by planning equality schemes, carrying out public consultations and measuring impact on policy.

This regional Equality legislation requires that public healthcare institutions do not discriminate based on race and that they provide equal services to members of diverse communities. It is essential to note that in the United Kingdom race is a concept/construct that is understood to include language. Discrimination based on language is considered to be discrimination based on race and is a violation of the Equality Act. Thus, public healthcare institutions are required to provide language services and failure to do so would be discriminatory practice. Equality and Diversity departments, or their equivalent, ensure compliance.

National Contact Point

In the UK there are four NCPs, one in each of England, Wales, Scotland and Northern Ireland. As noted above each regional NCP is involved, with other health institutions, in Directive policy. These NCPs make information available to the public through websites. The information provided is mostly concerned with quality, safety, reimbursement and procedural matters of cross-border healthcare. The information provided varies slightly between regions and the design of the webpage of each NCP is different. Information was available in English only and in no cases were translations of information concerning the Directive and cross-border healthcare made available to potential patients. It is important to note that British NCPs can track enquiries for treatment but there can be difficulty in assessing how many patients actually come to receive treatment. The NCP in Northern Ireland has seen a threefold increase in the volume of enquiries but they are unable to tell how many patients actually come since these patients come without prior authorisation and seek reimbursement in their home country (UK Inf 16). British NCPs have been found to be accessible to the public and willing to assist with queries. The NCPs can be reached by email and telephone and this study has found the NCPs to be responsive to email and phone queries. Additionally, the NCPs have named public representatives who can also be contacted.

It has also been reported that the NCP plays the role of fraud investigator during the reimbursement process (UK Inf 16). Since the NCP has the responsibility of coordinating reimbursement they must also ensure that the treatment has in fact been given. The UK NCPs are aware of potential fraud schemes and plan policy accordingly. By actively looking for fraudulent claims under the Directive, as well as looking for

schemes promoted by unscrupulous private providers to attract patients, NCPs are protecting the integrity and resources of the healthcare system in the UK (UK Inf 1).

Processing reimbursement claims and detecting fraud is a complex task given the nature of cross-border healthcare and language is an issue in this process. First, the receipts and bills for service must be translated and decoded in order to find the equivalent treatment in the UK. This is a necessary task in order to process reimbursement. The receipts must be decoded to see if such treatment is eligible for reimbursement under the Directive and to determine the cost of such treatment in the UK. Lastly, the NCPs often verify if such treatment has actually taken place by calling the provider in the MS of treatment. Here language barriers can be an issue and representatives from the NCP seek an English speaker in the clinic of treatment to verify that a given patient has in fact received treatment (UK Inf 16).

Despite the communication problems that Directive patients could potentially face, as well as the difficulty in understanding receipts and communicating across borders, language has not been a central consideration while planning for the work of the NCPs. This includes both planning for language access for patients as well as planning for administrative language services. The Northern Ireland NCP has reported that thus far there have been no major issues with oral communication and the trend is that patients go where they have the language skills (UK Inf 16). Other NCPs and healthcare institutions have also confirmed this trend (UK Inf 13; UK Inf 18, UK Inf 19). In the UK, outgoing Directive patients are often UK residents who are originally from another MS. To illustrate this we present an example collected from Polish residents in the UK who return to Poland for treatment. They often return home for treatment since they better understand the healthcare system in Poland, are more familiar with the language and culture, and also often find family support in their MS of birth. Additionally, healthcare administrators recognise that it is likely that some Directive patients who leave the UK are seeking care in facilities that offer English language services (UK Inf 16). Even with these reported trends in patient mobility, language is not a major concern for medical professionals in the UK. The British Medical Association and the General Medical Council, two healthcare sector associations, have confirmed that language access for cross-border patients has yet to surface as an issue. These organisations prepared for the Directive but now report that it is a non-issue. They do not receive substantial feedback or enquiries about the Directive from their membership of medical professionals (UK Inf 22, UK Inf 27).

In Northern Ireland patients are responsible for the cost of translation and interpreting services. This is the case for both outbound and incoming patients. For returning patients seeking reimbursement, the NCP asks patients to translate receipts and documents prior to seeking reimbursement. It has been observed that the quality of translation can be an issue since some patients do their own translations. Patients travelling under the Directive, who arrive in Northern Ireland and need language services to receive treatment, are billed for these language services as if it were any other healthcare service. Language provision is included in the cost of service and the patients could seek reimbursement for this cost in their home MS (UK Inf 16).

The translation of receipts and documents is handled differently in other parts of the UK. In Scotland documents have been translated and paid for by healthcare institutions. This is the case for Directive patients returning home to the UK after seeking care abroad. In such cases sometimes the patients have the documents translated themselves prior to seeking reimbursement, at other times the Scottish healthcare institutions perform this task without charge (UK Inf 18, UK Inf 19). No information was provided as to the profile of the parties performing the translation. We were told translations were performed through contracted professionals. Even for

patients from other MSs translations of health documents can be provided and paid for by the institution under the principle of best practice and continuity of care. We discussed the example of a foreign patient on vacation who needs emergency treatment. This patient would receive translations of their documents prior to returning home (UK Inf 20).

In order to communicate with both healthcare institutions and NCPs in other MSs the UK NCPs rely on English as a language for communication. When reaching out to such institutions they are able to locate an English-speaking colleague and work with them (UK Inf 13; UK Inf 1; UK Inf 16; UK Inf 18, UK Inf 19). The NCPs of the UK are in an advantageous position. Since English is often used as a lingua franca in international communication, British NCPs are able to rely on English as a means of communication with healthcare institutions of other MSs.

Table 11: Summary of linguistic characteristics of NCPs' websites

Linguistic characteristics	Germany	Greece	Italy	Spain	UK
Monolingual	No	No	No	No	Yes (with a link to Google Translate)
Bilingual	DE/EN	EL/EN	IT/EN	No	No
Multilingual	No	No	No	ES/EN + menu titles only available in regional languages and French	No

Table 12: Summary of contact information about NCP

GERMANY	GREECE	ITALY	SPAIN	UNITED KINGDOM
<i>Deutsche Verbindungsstelle Krankenversicherung - Ausland (DVKA)</i>	EOPYY– National organization for health care services, provision, division of international affairs, National Contact Points GR Department	Ministry of Health, Directorate-General for health planning	Ministry of Health, Social Services and Equity	NHS
www.eu-patienten.de Email: info@eu-patienten.de	www.eopyy.gov.gr Email: ncp_gr@eopyy.gov.gr	Website: http://www.salute.gov.it/portale/temi/p2_4.jsp?lingua=english&area=healthcareUE Email: http://www.salute.gov.it/portale/temi/p_sendMailNCP_ENG.jsp	Website: http://www.msssi.gob.es/pnc/home.htm Email: oiac@msssi.es	Website: www.nhs.uk/nationalcontactpoint

Source: http://ec.europa.eu/health/cross_border_care/docs/cbhc_ncp_en.pdf - updated 10/12/2014.

2.2.6 Results from Questionnaire 1

The goal of Questionnaire 1 was to gather information on respondents' knowledge/awareness of the Directive, its implementation and its interplay with language provision. Thirty-one questions targeted four main areas: 1) knowledge and awareness of the role of National Contact Points in each MS (7 questions); 2) cooperation among MSs and languages in which information is provided to patients (10 questions); 3) information on budget allocation for language support to non-nationals seeking cross-border healthcare (4 questions); and 4) information on language support available to non-nationals seeking cross-border healthcare (10 questions).

Questionnaire 1 (see Annex 1) was sent to policy makers, hospital administrators, providers and social workers in the 5 MSs. Collaborators in the five MSs were asked to identify networks, directories and sites to start recruitment of participants. Collaborators reported encountering numerous challenges to securing participation (no response to e-mail or phone calls, obtaining one umbrella response on behalf of the organization instead of forwarding the questionnaire to organization members, refusal to participate, no interest, etc.) Research assistant time was assigned to the five MSs to recruit participants, identify the key stakeholders who needed to be targeted, follow-up and increase penetration. In spite of efforts on the part of the core team and collaborators, results were uneven across MSs. In most MSs, penetration was low and therefore participation and responses are low even when the response rate appears to be high.

By the cut-off date, questionnaires (cases for analysis) received were not all complete. As it is customary when dealing with incomplete cases (Angelelli 2004b) a decision was made to discard questionnaires that had over 20% of responses blank and to insert the mean item value for questionnaires that had 10% of blank responses. Of a total of 41 cases (i.e. questionnaires received), 22 were discarded and 19 were used for analysis. For the reasons stated above, the descriptive analysis performed should not be considered definite. Results should be interpreted as useful in revealing a pattern that merits further investigation.

The first seven questions focused on the Directive and its transposition. Policy makers who returned Questionnaire 1, as well as those we interviewed during fieldwork, know that the Directive had been transposed into national legislation (for example Royal Decree 81/2014 in Spain or L4213/2013 in Greece). All policy makers except one also know of the existence of the National Contact Point. These policy makers are also aware of how the National Contact Points provide information on how to claim reimbursement and on the quality of care in another country. This includes the dual role of providing information to EU citizens travelling from other MS to their country and vice versa.

The second set of ten questions concentrated on the implementation of the Directive. Eighteen per cent of respondents in Greece and 11% in Spain knew that their country was cooperating or assisting other MS with the implementation of the Directive. Thirty-six per cent in Greece and 30% in Spain had awareness of specific projects between their country and other MSs to implement the Directive. Only 9% in Greece

and 20% in Spain had heard about mutual assistance programs. In regard to specific questions, for example, whether patients in cross-border healthcare could access their medical records in their own language, the answer was clear in all countries: 90% in Spain and 81% in Greece said they could not. The opposite response was also clear in the UK where 60% said patients do have access to their records in their own language. A majority (90% in Greece, 70% in Spain, 60% in UK) of the patients receive adequate information on high quality healthcare provision (Questions 2.5); a vast majority of healthcare providers know about the implementation of the Directive (81% in Greece, 70% in Spain); and foreign nationals are informed of their rights to cross-border healthcare (90% in Greece, 90% in Spain, and 80% in the UK). That information is provided mostly by the NCP but also in a minor way by the network of healthcare providers. While 73% in Greece, 80% in Spain and 80% in the UK know there is a mechanism to ensure compliance with the implementation of the Directive, fewer know what the mechanism (if any) is for sanctioning failed implementation.

The third set of four questions focused on cost of language support for non-nationals seeking cross border healthcare. Sixty per cent of the UK policy makers report that there is language support available to non-nationals while 73% of policy makers from Greece indicate there is not. Only in the UK do policymakers report a budget for language support/provision to patients who do not speak English. In the remaining countries respondents believe there is no budget.

The fourth and final set of ten questions targeted more concrete information about how the language support occurs. All Greek respondents (100%) and 80% from Spain stated there was no support evident through the translation of documents and 100% of Greeks and 40% of Spaniards said there was no evidence of language interpreting. The responses from the UK were diametrically opposite with 100% stating there is evidence of language support through both translation of documents and interpreting services provided for non-nationals, and that such support is the responsibility mainly of public authorities but also of private companies. None of the respondents in the countries participating had any information as to the cost of such services. On the questions related to type of providers of language support, 90% from Greece stated it is only provided by patients' relatives/friends, 73% also stated by bilingual staff, while 10% replied by unspecified others. In the UK, 40% stated professional interpreters are used for clinical assessments and non-clinical assessment is interpreted by patients' relatives/friends and by bilingual staff.

SECTION 3: LANGUAGE SUPPORT

This section responds to research question 3: How is language support provided? Who is providing it? And what are the standards of practice and ethical considerations observed? It is divided into 5 sub-sections. Sub-section 3.1 presents an introduction to the need of language support in multilingual healthcare settings. Sub-section 3.2 briefly discusses types of language support found across the sites examined. Sub-section 3.3 explains who is providing the language support in the sites examined. In sub-section 3.4 detailed results of the empirical study for language provision are presented for each of the five Member States. Lastly, sub-section 3.5 summarizes the discussions.

3.1 INTRODUCTION

In the context of healthcare language support is needed whenever individuals who do not share a common language need to share and exchange information. Language

(sign, spoken or written) is the code through which messages are conveyed (Jakobson, 1960). Hence, if the code is not shared among the potential participants of a communicative event (Hymes 1974), language support becomes essential to convey messages across languages. Language support (also referred to in this report as language provision) allows users of different languages (written, spoken or sign) to access information and services as well as to communicate under the same conditions as users who share a language. Language support can meet the communicative needs (written, oral, visual, etc.) of users through both the use of technology and support performed by humans. Without language support communication is jeopardized. When communication about healthcare is jeopardized, access to safe, high quality healthcare cannot be guaranteed.

3.2 TYPES OF LANGUAGE SUPPORT AND HOW IT IS PROVIDED

In this sub-section we present findings on types of language support across participating MSs gathered from Questionnaire 2 (see Annex 2) and fieldwork. Specific findings within each MS are discussed in the country-by-country section (Section 3.4).

In Questionnaire 2, respondents provided the following information regarding both language support and their background: of the 100% ($n=290$) 36% of respondents hold a university degree in translation and interpreting, 20% hold a university degree in a related field (such as languages, linguistics or communication). While 31% report being certified in T&I, 13% report no specific education/training in T/I. When asked about education in public service T&I specifically, 23% report university education, 35% professional development or continuing education through professional associations; 35% have received in-house training & development from the companies where they work and 7% receive training in the hospitals.

In regard to work experience 23% report less than two years of experience, 19% from 3 to 5 years, 23% 5 to 10 years and 35% over 10 years of experience. With respect to specialization in healthcare 19% of respondents only worked in healthcare up to 5% of their time, 32% of respondents worked up to 25%, 23% up to 50% per cent and only 26% worked more than 50% in healthcare. Except in the UK, language services are not frequent in healthcare organizations as evident by the following responses: when asked when language support services are used 70% of Germans, 75% of Greeks, 41% of Italians, 57% of Spanish and 22% of British stated that T&I services are called upon only as a last resort, when all other attempts at cross-language communication have failed.

Figure 2 below shows the percentage of face-to-face versus remote language brokering and Figure 3 shows the percentage of interpreters asked to perform translations. The results for both Figures 2 and 3 reflect the types of interpreting used in the respondents' workplaces.

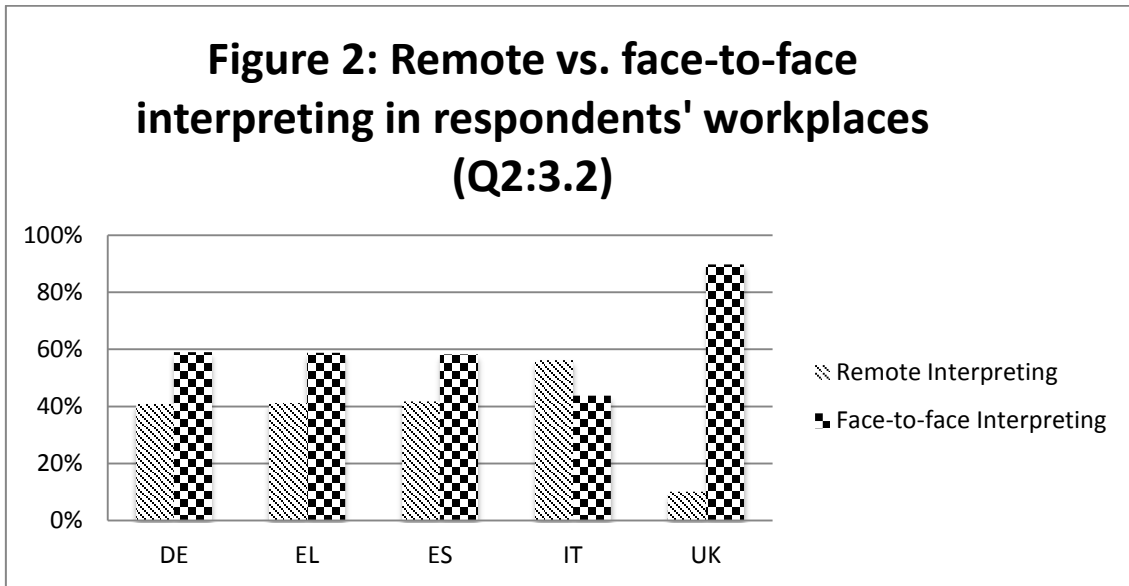


Figure 2: Remote vs. face-to-face interpreting in respondents' workplaces

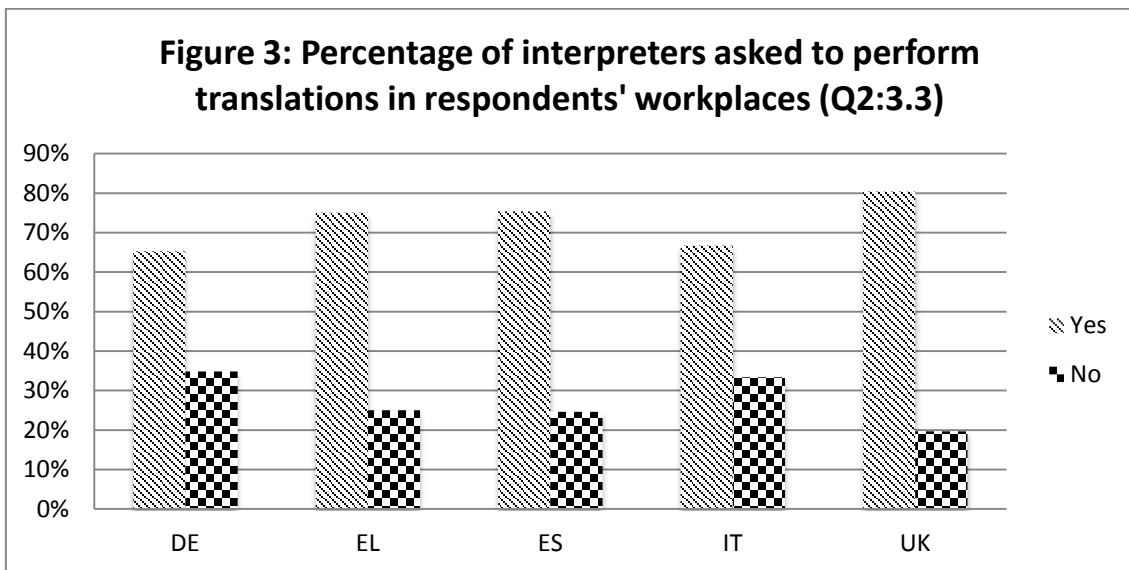




Figure 3: Percentage of interpreters asked to perform translations in respondents' workplaces

During the course of our interviews and observations, the following delivery models to provide language services were reported by healthcare institutions (See 3). Through these models, providers and patients who do not share a language are able to communicate and patients are able to access information and services. These models of language provision are necessary to guarantee access to safe, high quality healthcare for linguistically diverse individuals.

Table 13: Reported delivery models of language provision

Delivery Models	GERMANY	GREECE	ITALY	SPAIN	UK
Translation					
Human					
Machine-assisted					
Interpreting/mediation					
Face-to-face					
Telephone					
Videoconference					

*Note:  =yes, they are reported as being used;  =no, they are not reported as being used.

3.2.1 Translation

In the public and private healthcare sites visited in this project there were not many examples of professional in-house translation services that fulfil the requests of patients, providers or staff. The reported professional in-house services functioned in tandem with interpreting services and in-house interpreters with translation qualifications would also translate documents. This is a practice in the UK. The general lack of in-house translation services across the MS of this study does not mean that hospitals and clinics do not have translation needs. Based on data from interviews with healthcare providers, administrators and patients, translation needs are most often judged to be the responsibility of the patient.

Human translation (written and sight)

It was reported that translation professionals and ad hoc translators (bilingual employees, interpreters) perform written translations. In the case of professional translation, institutions often have a contracted service with a translation agency. Some institutions in the UK have such a contract in conjunction with other public services, such as the police. In other cases, institutions would rely on their own in-house translation-qualified interpreters to perform written translations of documents. This was reported to be a cost saving technique.

Professional translation service is not the norm in the MSs of this study. Ad-hoc translation of documents is the most common solution for the public and private health centres and hospitals observed in Spain, Italy and the UK. Bilingual staff members translate documents and patients are also asked to perform this task for themselves. When asked which documents are the most frequently translated, informants mentioned the following: informed consent forms, check-in forms and informative materials (e.g. information brochures/posters and/or websites). These translations are usually done only for the most common language combinations in a particular country. The most common language combinations vary between the institutions of this study and depend on the demographic profile of the population that each institution serves.

Another common reported practice is the sight translation of documents. In this case interpreters, both professional and ad hoc, perform sight translations of documents that are needed in the course of treatment. These interpreters reported that a wide variety of information needs to be sight translated and it includes consent forms, information pamphlets, patients' records and files, as well as prescriptions.

Among the issues related to translations, the following were mentioned: First, translations are not always provided for all the necessary language combinations. Secondly, translations are only provided for certain types of documents and patients do not have access to all the information available to make informed decisions. Thirdly, documents are translated only if they have been considered to be relevant or standard. Staff members decide on the relevancy of the document and if it is to be translated. Lastly, as mentioned above, since no permanent translation service is offered to patients who do not speak the institutional language, the responsibility of translating relevant documents is often placed on them.

Machine-assisted translation (CAT tools)

Across the 5 MSs the study has observed that many health centres rely on machine-assisted translations. The technology used includes specialised CAT tools, such as The Universal Doctor Speaker (Spain), specifically designed for the healthcare setting. This tool provides translation of common phrases (e.g., explanations, questions and answers) into over 30 languages (Universal Doctor, 2015). Google Translate was also reported to be an option that institutions use to a certain extent. Use of Google Translate was reported by healthcare organizations and providers in Spain (in Galicia and outside Alicante), Italy (Modena, Rome, Forli, Verona, Naples), Greece (Trikala, Athens, Chania, Vamos) and Germany (Mainz, Germersheim). No informant from the UK reported using any CAT tools.

3.2.2 Interpreting

Three types of interpreting provision were observed in the cross-border healthcare setting studied. Those are: face-to-face (also called on-site interpreting), videoconference interpreting and telephone interpreting.

Face-to-face or on-site interpreting

It was observed that some healthcare institutions provide professional face-to-face interpreting services in which a trained, professional interpreter brokers patient-provider communication in-person. This is frequently the case in the United Kingdom where the right to language service is embedded in the law (see below the section on the United Kingdom for further discussion of this). In the other MSs (Germany, Greece, Italy and Spain), professional interpreters are less frequently used and they are mostly found in private clinics. Professional face-to-face interpreting is usually reserved for situations in which the patient needs to communicate with the doctor or healthcare professional directly about medical assistance or treatment. It is not provided, for example, when informing patients about their rights and conditions related to cross-border healthcare. In all MSs of the study it was reported that non-professional ad hoc interpreters also perform face-to-face interpreting. This is increasingly recognised as bad practice in the UK as well as in many other countries in the world. In other MSs it is the norm for face-to-face interpreting. In Germany, Italy and Spain we noticed a preference for intercultural mediators over interpreters. When we inquired about this preference the explanation received was the following:

“Interpreters deal with language and mediators know about culture, medicine and language and they can also help patients get familiar with the national healthcare system/practices because they are locals” (IT Inf 12).

In Italy (see discussion below for more details) there is an abundance of companies offering mediation services and there are current discussions about integrating the figure of the language mediator into the law.

Informants in the UK repeatedly discussed the advantages of professional face-to-face interpreting. They reported that:

- 1) it fosters the necessary climate of confidentiality, trust and understanding;
- 2) it is preferred for more complex interactions;
- 3) it avoids recurrent visits due to partial comprehension of treatment;
- 4) it allows for continuity of care; and
- 5) it helps to prevent misunderstandings.

The disadvantages of professional face-to-face interpreting discussed by informants interviewed in Germany, Greece, Italy and Spain were that:

- 1) it cannot always be guaranteed for all language combinations;
- 2) it is costly;
- 3) it requires administrative coordination and may require waiting time;
- 4) it takes more time than a monolingual consultation; and
- 5) providers are not always sure about the professionalism of interpreters, especially in less commonly spoken languages.

Face-to-face interpreting provided by non-professional, ad hoc interpreters was also reported to have advantages and disadvantages. A reported advantage was the savings on cost. An often-cited disadvantage was that providers are apprehensive about trusting the quality of information received and that a lack of accurate information could have potentially negative implications for health outcomes.

Videoconference interpreting

Of all sites visited, videoconference interpreting was more the exception than the norm. It was found in few private clinics (e.g. UK Site 5, EL Site 1, ES Site 7) and in public ones (UK Inf 9 and UK Site 11).

In the private clinics we observed (EL Site 7) videoconference interpreting is used as a preferred way to respond to detailed inquiries, to describe services, and mostly for introductory consultations involving paperwork, etc. It is also used during pre-treatment or follow-ups when patients have not yet arrived or when they have already returned to their home MS/country.

An example of a public institution in the UK that has implemented videoconference interpreting is NHS Grampian. This institution provides service over vast rural regions in Northern Scotland and in-person interpreters are not always able to travel to meet with patients on-site, this being especially the case in extreme winter weather conditions. To solve this logistical problem NHS Grampian has invested in videoconference interpreting and currently has 100 Conference Call Units available for use (UK Inf 9).

A type of videoconference interpreting was also used in UK Site 11, but this was set up for use only with a specific radiology treatment. Due to the nature of the

treatment, neither the provider nor the interpreter can be present during the treatment session. In order to communicate with patients the department has videoconference technology that allows for remote interpreting. In this manner a professional on-site interpreter is present with the provider and together they communicate remotely with the patient who is undergoing treatment. The same technology is used for remote, monolingual communication (UK Site 11).

Informants acknowledge the advantages of videoconference technology, however their most frequent objection is that it requires a minimum technical infrastructure that many health centres and hospitals are unable or unwilling to put in place. Although videoconference interpreting is a cost-effective solution in terms of language support, the initial investment for the required infrastructure is not feasible yet for many public health institutions visited in all 5 MSs.

Telephone interpreting

Telephone interpreting has been found to be a popular language support solution in Germany, Spain and the UK. This type of language support is barely used in Greece and Italy. Telephone interpreting is a very common option for providing language services to patients who speak less frequently used languages. It was reported that the advantages of telephone interpreting are that it can provide greater access to a large range of language combinations with less sophisticated technology (even if it means passing the headset between patient and provider) and that patients feel less uncomfortable having certain exams and procedures performed, since telephone interpreting is less obtrusive than face-to-face interpreting. When speaking with emergency operators (Spain – see details below), they all echoed the need to have a direct connection with a phone-interpreting agency to avoid losing critical time.

Informants also discussed several disadvantages. First, it requires a minimum training of the healthcare staff and a greater effort for all speakers. It limits the conversation to two speakers, because conversations with more than two speakers are quite difficult to manage for the interpreter. Secondly, the telephone interpreter also loses a great deal of contextual and non-verbal information.

3.3 WHO PROVIDES LANGUAGE SUPPORT?

In this sub-section, we present findings on the parties providing language support across participating MSs. Detailed findings for each MS are discussed in the country-by-country section (Section 3.4). Healthcare organizations observed in this study rely on different language solutions in order to provide language access. However, language provision is not always offered with the same degree of quality. Professional services may be available but institutions also turn to non-professional and untrained translators and interpreters for the provision of language services. This can impact quality. When quality is in question ethical considerations become relevant. In the absence of language services patients are prone to receive inferior or inadequate care and their health may be placed at risk. Thus it is imperative that health institutions consider who provides language support in order to maintain acceptable levels of quality.

In the MSs of this study there is a continuum that ranges from professional translators, interpreters, cross-linguistic communicators, and cultural mediators to non-professional ad-hoc bilinguals (or alleged bilinguals) who are brought in to broker

communication on the basis of their language skills and their affiliation with the healthcare organisation (e.g. hospital employees such as receptionist, nurse, cook, technician, janitor) or familiarity with patient (e.g. patients' relatives [including children] or friends). When we inquired about qualifications, none of the 5 MSs who stated that they used ad-hoc translators or interpreters knew of these ad-hoc language brokers having any formal education or training in either translation or interpreting.

In this study we have identified four categories of individuals who deliver language services. They are:

- Hired/in-house professional translators/interpreters
- Freelance/independent contractor translators/interpreters/mediators
- Translation/interpreting agencies and mediation cooperatives
- Ad hoc translators/interpreters (can also be hired and "in-house" but they are non-professional and untrained)

Hired/in-house professional translators/interpreters

Hired, professional in-house interpreters and translators are the exception rather than the norm in the majority of healthcare sites visited, although this category is common in the UK. In some MSs, Spain for example, there are examples of in-house bilingual staff that consistently provide T&I services but they are non-professional and constitute an ad hoc solution. Very few professional ones were observed. When considering language services for Directive patients, in-house interpreters and translators are even less common due to language combinations that are not frequently sought within the healthcare setting. In all cases, hired interpreters/translators worked with language combinations that were usually demanded in their health centre because of the profile of its patients (demographics and trends of migration (UK, Italy, Spain), tourism (Spain), bilateral agreements between countries (Germany, Spain), border proximity (Germany/France), etc.³¹). Since these translators/interpreters count with a permanent position and their work is mainly carried out in a health centre or hospital, they are usually specialised in health interpreting/translation.

Freelance/independent contractor translators/interpreters/mediators

As for freelance translators/interpreters/mediators, results have shown that in Germany, Italy and Spain they are often called on to work for the private healthcare sector. They are usually part of a list of freelance translators/interpreters/mediators that health institutions contact occasionally when they have the need to communicate with a patient who does not speak the language concerned. This language support solution has proven to be more flexible than the "hired/in-house staff" formula, since it offers the possibility to contact a greater number of professionals from a wide variety of language combinations. This is especially the case of interpreters working over the phone (Germany and Spain). However, education in Translation and Interpreting is never a pre-selection criterion when calling for a freelancer. Once again, selection is based on language proficiency, which is taken at face value. This may influence the quality of the linguistic services provided and may have a resulting impact on patients' rights and on professionals' work.

³¹ See indicators of volume at http://ec.europa.eu/health/cross_border_care/indicators/index_fr.htm

Translation/interpreting agencies and mediation cooperatives

In regard to translation and interpreting agencies and mediation cooperatives, the situation is similar to the selection of freelance translators/interpreters, with the difference that in most cases these agencies have signed contracts with public health administrations or even with particular health centres or hospitals to provide translation/interpreting services for a fixed time period. During our interviews with several agency owners in Greece, Italy and Spain they referred to the economic crisis and explained how contracts were first renewed for two years, then for one year and recently not renewed. Hospital administrators confirmed this (in all three countries) when we asked about tenders and budget line items for T&I services. For healthcare organisations, working with agencies has also proven to be more flexible than working with hired/in-house staff, since agencies usually offer a large variety of language combinations and an alleged greater flexibility to cope with “complex” assignments (tight deadlines, large translation assignments, etc.) due to their ability to hire more than one professional at a time.

Ad hoc translators/interpreters

Focusing now on the last group of people delivering language support, the use of ad hoc translators and interpreters, such as relatives, friends, NGO volunteers or “bilingual” healthcare staff (for which bilingualism is taken at face value rather than measured), is the most common practice. This kind of solution is used for all language combinations and patient profiles (those receiving care under the Directive, the Regulation, immigrants from non-EU countries or political refugees). In one private clinic (ES Site 7), translation and interpreting are performed only by dedicated bilingual staff members. They may or may not have a background in translation or interpreting. They are often hired on the basis of language ability, which is not measured following a standard accreditation system that certifies language ability, translation and/or interpreting skill, or knowledge of the topics addressed. Instead, the Human Resources Department of the health centre applies other types of criteria that focus more on proving the versatility of candidates to make them more cost-effective (e.g. having more than one language combination, willingness to act as both translators and interpreters, etc.). As evidenced by the empirical data gathered during the observations, with the exception of two out of 108 healthcare organizations observed, the hired or contracted interpreters/translators do not hold a degree in translation and interpreting. Many of the individuals hired have completed certificate programs, in-house training and professional development. Interestingly, this evidence contradicts the findings from (self-reported) Questionnaire 2, thus emphasizing the importance of empirical observations.

Overall, the most common ad-hoc solutions implemented by the five MSs studied were the following:

- Asking the patient to translate all relevant documents
- Asking the patient to bring someone “who can read or speak the language”, usually a relative or a friend
- Asking a member of the medical staff who allegedly speaks the language of the patient or a commonly spoken language to act as an “interpreter/mediator”
- Hiring untrained bilingual staff to perform T&I duties
- Contacting an NGO to solicit translation/interpreting services from volunteers
- Trying to communicate directly with the patient in a commonly spoken language (e.g. English), often helped by CAT tools like Google Translate.

3.4 FINDINGS ON LANGUAGE PROVISION PER COUNTRY

One of the specific objectives of this study is to identify the language services that are provided in the five participating MSs, their quality, and who provides them. Because of the nature of naturalistic data (see Section 1) and the inclusion of unsolicited data/information, the reader will find that the information reported across MS varies. The following sub-sections provide the findings in each of the five MSs studied. For all MSs an effort was made to study not only their responses to language provision but also their views on minimum requirements to provide service, quality of provision and verification of qualifications.

3.4.1 Germany

Data collection in Germany included meetings with the following organisations: health ministries, ministries of social affairs, law firms, consumer centres; hospitals and clinics (university, border, urban and rural), medical centres, healthcare centres, community centres, professional associations of translators and interpreters, T&I agencies, community interpreting services, and the NCP office. Professionals with expertise in healthcare such as lawyers, doctors, nurses, laboratory technicians, board members of professional T&I associations, university professors, and students were included. Additionally, experts from the NCP, policy makers and language professionals with knowledge of the national panorama for language services and cross-border care informed the study.

Language provision is not embedded in German health legislation. Consequently, the German healthcare system does not provide language services for speakers of languages other than German. During our meetings at the Ministry of Health (DE Site 7) informants stated that providers are not responsible for successful communication with patients. Rather, patients themselves have to find a way to communicate with healthcare providers by presenting their own documents (already translated) or by bringing their own interpreters (be they paid or unpaid, ad-hoc or professional, trained or untrained) (DE Sites 8, 9 and 10). There are two areas of communication of information that are an exception to this general rule of non-accountability on the part of the German healthcare system: the use of sign language for patients who are deaf or hard of hearing, and communication in the context of informed consent (DE Sites 1 and 4).

To obtain informed consent from the patient, healthcare providers have to inform patients by providing an information sheet in which the medical procedure is explained in detail, including risks and possible complications. Subsequently, the healthcare provider has to talk with the patient about the procedure and possible risks it might entail. German law requires that patients be informed in a language they understand. This refers not only to the use of languages other than German, but also to technical jargon or the level of education of the patient: the physician must in every case use a language that is comprehensible to the patient. This means that the information sheets are written in a simple and direct style, without the use of medicalese, and that the oral explanations are given in a way that is understandable for individuals with different social and educational backgrounds (DE Sites 7, 8, 9 and 10).

German healthcare providers provide information sheets for all standard medical procedures in different languages. Commercial publishers produce these sheets. The publishers are responsible for the correct German and foreign language versions of

their texts, which (presumably) have been translated by professional translators. It is standard practice that hospitals have German and foreign language versions of such information sheets available for patients with limited proficiency in German. Patients have the right to read the information first, and then talk to the doctor about the procedure (DE Inf 11). The information sheets, however, have a cost. And the cost is perceived as a problem. The relationship between language provision, healthcare and cost was clearly described by an expert in gerontology (DE Inf 3) through examples of Alzheimer patients and care provided for the elderly (a population that is increasing exponentially and has become a priority for all Europe [Scottishinsight.ac.uk] and becoming a priority in the EU). In his words:

"For example, there are 34,000 beds in Germany. A Social Work unit in University of Hamburg has done a project called Easy Care. It was a social work assessment of elderly care outpatients. It used St. Joseph software. It included all written documents procedures for injections, informed consent, surgery, etc. All these forms were created for printing on demand in different languages. The use of this system has a cost. Besides German, documents most frequently used were in Turkish, Spanish, French and English. There is another system to print informed consent forms as part of a project THIEME (an e-content product). It is a ready-to-print system and all the documents, all the procedures were translated by professional translators into various languages as they were described by surgeons, etc. But, again this has a cost, it has a cost for the service, a cost for paper and printing and a cost for time. And, who pays for this? NO ONE (his emphasis). Hospitals are responsible for all expenses. The system is so costly that it is only used in serious cases, like when there is a minor involved." (DE Inf 3). The same informant goes on to state that: "over 700,000 patients undergo medical procedures every year in Germany. The figure for non-German speakers is increasing."

When discussing feedback on language provision received from the German patients who travel abroad for treatment, or elderly Germans who live abroad, providers did not recall language differences ever being discussed as an issue in their appointments, probably, in their view, because Germans who travel can speak some English. Groups of elderly and retirees who live abroad for long periods of time are depicted as groups of upper class Germans that leave for a better climate. Examples given were a CEO from the Cologne area who had arthritis and went to Mallorca, or others who go to Seville. In general, they are insured for long-term care. When they are abroad, a German assessor visits them just once to verify the quality of care and the legal requirements (DE Inf 3).

For oral briefings on informed consent with patients who do not speak German, healthcare providers may rely on ad hoc interpreters, such as nurses or relatives of the patients, or they may consider the limited proficiency of patients as sufficient for the purposes of the particular conversation (DE Inf 11). Such practice is illegal if the language barrier really hinders the patient's understanding of the information provided by the physician (DE Inf 4). However, no figures are available to indicate how often ad hoc interpreting is needed in briefings for informed consent in German hospitals. Furthermore, no legal cases are known in which communicative practices and language policies of German hospitals have been involved (DE Inf 4).

Besides explaining the content of consent forms there are many other reasons that point to a need for written or oral language provision. During interviews with healthcare providers in rural and urban hospitals (DE Sites 3, 5, 11, 12, 13, 14, and 16) we discussed their ways of coping with patients who do not speak German. Coping instead of communicating is the result of the lack of formal language provision due to costs. While discussing pain medicine a gerontologist (DE Inf 3) from a small hospital in Lower Saxony that receives many patients seeking hip-replacement surgery from other MS, predominantly the Netherlands, explained the following:

“Thirty per cent of the patients are non-speakers of German. In the pain sector doctors get impressions by looking at patients when they enter the room, they have a holistic look at the patient.”

The example discussed was of an 80-year old Turkish woman and 80% of communication was via family members. The German doctor was working in a rural hospital in a small town. Another example came from Cologne where 60% of patients are non-Germans:

“Some of the doctors use cards, little booklets with lists of words. This was reported in a project entitled Quality improvement Wave, conducted 10 years ago.” (DE Inf 3).

To illustrate resources for oral communication providers referred to an intranet site where bilingual persons are listed but they also explained that using it is not simple. For example, some of the nurses listed work 3 shifts. So bilingual personnel cannot be available all of the time when they are needed. In a small clinic in Lower Saxony specialized procedures are scheduled with bilingual staff but this does not always work. Outside language services are sometimes hired but it is rare. The finances of clinics have decreased over the years. There have been several budget cuts; for example, in the informants' service there is no secretary at all. Nurses cannot order translations or hire interpreters when they cost 50 euros an hour (DE Site 3).

Local language providers, funded by religious social welfare institutions, together with national and regional governments provide interpreting and translation services on the basis of fee-for-service regulations, or by using trained volunteers. In some hospitals (e.g. DE Inf 28), special language projects are available which organise and train bilingual employees to act as interpreters or translators (DE Sites 15 and 18). However, such initiatives are bound to local or regional contexts and are used more in the context of social welfare and counselling, rather than in health contexts. Nevertheless, during our interviews we noticed that health providers (DE Informants 3, 5, 11, 12, 13, 14, 16, 25, 26) praise such initiatives because of the obvious need for communication in languages other than German, and because of the lack of other resources and systematic approaches to translation and interpreting in the German healthcare system. During conversations, reference was made to the need for communication in languages other than German because of the big demographic changes that have taken place in the last twenty years or so. According to DE Inf 3:

“In 1995 there were 3 patients from other countries. Today, the number is a lot higher and it depends on the size of the hospital. For example currently in Hamburg there are a lot of Romanians and Bulgarians because of poverty in their own countries. So doctors in Hamburg are asking these questions: can I treat a Roma patient from Bulgaria? Am I allowed to treat this patient? This has an impact and an economic consideration. Everything has changed in real time due to poverty and inequalities among Members States.”

To sum up the findings on language provision and the Directive, it is fair to state that most healthcare providers interviewed are neither very familiar nor concerned with the Directive. The majority of providers have no interaction with Directive patients and the provision of language support for this relatively small number of patients is not a priority for them. Except for those who perceive the Directive as an enabling factor to increase the number of patients by facilitating mobility, understanding that Germany is a high-cost MS and therefore their expansion in clientele is happening mostly with private patients from the Middle East and China. In addition, most providers see language provision as a social-political area and what counts is money and economics (DE Inf 11). To put it in one of our informants' words, when asked about language provision in Germany, he stated the following:

"Let me sum up what happens to non-German speakers, migrants/foreigners from poorer nations:
1- they get less information;
2- they are considered parasites of the social system;
3- the real treatment given to these patients varies according to: a) if they have spouses that advocate for them; b) if they are assigned social workers;
4- if they have family members who can help and put pressure, like the case of a Turkish elderly woman who had 16 family members visiting while the German grandmother on the other bed had no visitors."

Directive patients in need of language services in Germany would likely find themselves in a difficult situation. With the exception of informed consent and basic translated information on procedures, cross-border patients who do not speak German have to find their own translator, interpreter or mediator, or communicate as they best see fit. With a lack of legislation that mandates language provision in healthcare, institutions and providers are not obligated to provide a means to communicate with patients who do not speak German, whether they travel under the Directive or not.

3.4.2 Greece

During these two data-collection phases team members met with representatives from ministries of health, policy makers, officers of NGOs, healthcare administrators and providers, officers of T&I professional organizations, T&I agency owners, bilingual volunteer groups (community groups) giving language assistance, translators and interpreters. They also visited the NCP office. Site visits and interviews took place in urban and rural locations on mainland peninsula and one island.

Patients seeking information on cross-border healthcare can communicate with the NCP in either Greek or English. When we inquired how the Greek NCP communicates with other NCPs, the answer was: "between NCPs it is done in English which has been chosen as the *de facto lingua franca* for communication" (EL Inf 5).

For written translation, exchanges at the NCP level are done through the IMI platform (Internal Market Information³²), a machine-based translation system developed jointly by the Commission and national administrations that can provide information on cross-border prescriptions, qualification of doctors and clinics. No single database exists (so far) at the MS level. "Apart from prescriptions, nothing else has been

³² Internal Market Information system, available at http://ec.europa.eu/internal_market/imi-net/about/index_en.htm

discussed. We thought of having a common format for reimbursement and receipts but this did not go ahead. We did not have enough time" (EL Inf 5). It appears that the NCP is well informed about language solutions available to MS from the network of the NCPs. During the conversation we asked about the translation of documents and it was confirmed that the NCP, by law, is not authorized to translate any documents for patients going abroad as it is the patients' responsibility. Some documents such as informed consent have been translated in English. As to translation into other languages, for example Polish, "language is not by law a priority... we have other urgent problems and we can manage in English". The documentation presented by patients needs to be an officially translated document (from the list of approved translators from the Ministry of Foreign Affairs).

When we asked about the qualifications of the translators on the list, their degrees, specialities, etc. the answer received from the NCP (as well from the policy makers and providers who were also interviewed) is that these translators are lawyers. Thus, a degree in law is considered a qualification to do translations. In terms of qualifications and requisites to become a NCP, we learnt that "the staff of the NCP/International Affairs Department is recruited also because they speak English (all of us), German, Italian..." (EL Inf 5). Further interviews demonstrated that not every Greek policy maker or healthcare provider is proficient in English (see reference to healthcare providers' English proficiency and need for interpreting in Section 3). This is also the reality of the Social clinics and NGOs that we observed. However, even when informants needed the help of our interpreters to communicate with us, they continued to state that they could all speak English.

Verbal communication between health service providers and patients was not reported to be an issue "because in Greece the majority of people speak English... health professionals, doctors speak English." This position overlooks the complex nature of communication in healthcare and the level of proficiency needed to be able to communicate effectively. Furthermore, as EL Inf 3 stated:

"patients always come with people, family or friends to help with language. The hospital staff is also available and the consulate or embassies can be contacted... sometimes communication is hard as it happened in 2009 in a public hospital in Athens when a patient of Pakistani origin could not communicate..."

From the interviews with healthcare providers, administrators, translators and interpreters, it was clear that in Greece no distinction is made between EU and non-EU patients. So, when discussing language needs and provisions, most of the conversations were about languages that are non-EU languages. For example, at various NGOs (EL Sites 4, 6, and 8) and social clinics in Crete, informants discussed the problem of migrants from the Middle East and Africa as follows:

"Over the last few months, big boats have arrived, each with some 300 people each. They have spent many days at sea... we give them medicine. They are people from Syria or Somalia. It is hard sometimes to find someone who can speak Arabic. At 11pm when we need an interpreter for Arabic, we call friends... there is no structure." Most of the informants in Greece made it clear that when dealing with a medical and humanitarian crisis, translation of consent forms or medical records does not seem that important. "What is important is to help people".

In rural areas of Crete (e.g. EL Site 9) there are (mainly) British retirees living for long periods of time, and there is no linguistic help for them. However, as stated by EL Inf 19:

"But ... we always manage. They come with someone from the community who can interpret for them and they bring papers written in Greek by members of our community who help them."

In another rural area close to Chania we learned that:

"for other languages like Spanish, Bulgarian either the patients know some Greek or they come with someone from the community. We always manage. Sometimes there are difficulties with language and culture... then we put a lot of question marks on the medical records. Sometime as in the case of a Turkish patient, we use Google Translate, but just for some terms." (EL Site 8)

Except for two private clinics (EL Sites 12 and 7), none of the sites visited provide translation or interpreting services to their patients. Informants claimed that since all physicians in Greece should be competent in one foreign language, the languages spoken by the physicians cover the linguistic needs of foreign patients. Based on the limited observations of the sites in each hospital visited we found some physicians and healthcare providers who could communicate in English, German, French, Italian and Spanish and their levels of proficiency varied. Informants could not recall a case where they could not communicate with a patient due to language. When patients do not speak Greek, then they usually either speak one of the European languages spoken on-site or patients bring someone with them, either a member of their family or a friend who can speak and read Greek. If everything else fails, they use Google Translate for phrases or terms and observe body language. Thus, organizations resort to ad hoc practices to meet patients' needs.

One site (EL Site 35) organized (unpaid) volunteers to provide language service. Their language provision was based on the volunteers at hand. The volunteers observed during our visit were not professionals. During our observation we captured this remark "in the past this site had secured European funding. At the time we provided training to ad hoc translators and interpreters working for us" (EL Site 35). When we inquired about the contents of the training we learned that it focussed on cultural awareness, body language and issues other than translation/interpreting skills or measuring language competence. Program directors or managers gave training sessions. No professional translators or interpreters were invited and language proficiency of participants during training sessions was taken at face value.

From data collected from professional translators, interpreters and the Professional Association of Translators in Greece, translation/interpreting professionals do not work directly with health-care providers. T&I services are provided in healthcare settings only when a patient/client directly hires and pays for them. It is therefore unusual for a professional translator or interpreter to work in healthcare settings. Most patients can get help from a relative or friend or from the healthcare professionals (doctors, nurses etc.). In the two private clinics (EL Sites 5 and 7) that provided language services we were introduced to the language service providers who were hired on the basis of their bilingual ability. They do not have formal education in T&I and here is no formal mechanism in place to measure language proficiency.

From the information gathered during observation and interviews it appears that, due to a lack of formal policy on language provision, social emergencies occurring in a volatile political climate, as well as a country facing economic and financial difficulties, the issues of communication and language services are not a priority. In fact, they are at the bottom of the priority list. In this context, even when there are professional language services that could meet communicative needs, ad-hoc solutions and use of volunteers are the norm rather than the exception because professional services carry a cost that cannot be met.

3.4.3 Italy

Data collection in Italy included regions in the north and south of the country as well as the capital city. Our team was able to secure meetings with members of ministries of health, NCPs, healthcare providers working in major healthcare institutions as well as small town health centres and GP offices in both urban and rural areas. We conducted interviews and observation in ministries, regional, urban and rural hospitals, clinics and health centres, community centres, NGOs, intercultural mediation cooperatives and universities in the following cities: Bologna, Reggio Emilia, Forli, Modena (all in Emilia Romagna), Milan (Lombardia), Naples (Campania), Rome (Lazio), San Chirico Rapparo (Basilicata), and Verona (Veneto).

Informants state that even when translations are needed they mostly resort to in-house (non-professional) help (IT Sites 5, 6 and 8). They do not send documents out to translation agencies or freelancers and they do not share a database of translated forms or documents. None of the informants from any of the sites visited (rural or urban) reported the use of Google Translate or any other CAT tool to perform translations in-house.

When budget permits, large hospitals (IT Sites 5 and 6) cover the costs of translations, interpreters and/or linguistic and cultural mediators. From all the MSs visited, Italy stands out as the one site that places the most importance on intercultural mediators and is the MS where these services are more frequently found. As stated earlier, there is a shared perception among intercultural mediators, healthcare providers and policy makers that cultural mediators convey culture whereas interpreters convey "only" language (IT Inf 12, IT Sites 4, 5, 6, 7 and 9). There is also a general perception that communication happens even through simple gestures as the patients are mainly concerned with their health and they trust the providers, even though they do not fully understand the treatment or procedure being discussed.

Physicians and nurses (Sites 5 and 6) have specifically expressed a preference for intercultural mediators as they communicate culturally sensitive information and want to be sensitive to the patients' concerns. Some of the examples discussed during a meeting with administrators and healthcare providers illustrate this preference (IT Inf 10): a North African female patient did not accept to be treated by a male nurse; muslim patients have special nutrition needs during Ramadan; a Nigerian pregnant woman advised to abort due to a blood issue refused to do so due to religious beliefs. During our visit, as we walked through different departments and wards (IT Sites 5 and 6), providers also mentioned that they prefer in-person intercultural mediators (even if they have to wait for them) to interpreters working remotely over the phone. Administrators (IT Sites 5 and 6) indicated that they have replaced intercultural mediators (although informants stated patients were not happy as they seemed to

prefer mediators from their community) with over-the-phone interpreters for reasons of efficiency and cost.

There is no formal education or career path for intercultural mediation. There are talks about professionalization by means of including the requirements, responsibilities and legal definition of this job in legislation. From time to time courses to train intercultural mediators are organized by regional authorities. At the end of those courses a certificate is issued, which has a regional validity (IT Inf 12). However, the courses are not part of an accredited curriculum and the frequency of offerings is unknown. There are only two university courses (in Forli and Modena/Reggio Emilia, the longest experience being probably that at the University of Modena and Reggio Emilia in collaboration with Reggio Emilia healthcare unit) which provide formal educational opportunities for mediators, as part of their curriculum in interpreting. There are, however, a number of university BA courses in *Mediazione Linguistica* (Language Mediation). It is not clear which of these actually provide formal training for mediators in the public services. The level of preparation of intercultural mediators can not be easily established since, in the majority of cases, except for university graduates, their main qualifications are that they came from the same ethnic group/community as the patients (which can lead to some confidentiality issues), and that they have been living in Italy for a considerable period and speak Italian. From the data gathered it appears that language skills are a central consideration for their employment.

Mediator organizations or cooperatives respond to calls for tenders from the hospitals directly, as do interpreting agencies and language service providers. These organizations contract language mediators. In their lists of freelancers, some mediator cooperatives (IT Sites 2 and 9) have individuals holding university degrees in translation and interpreting or social work, others do not hold any degree beyond secondary school. The cooperatives visited hire full-time mediators based on the demand of language combinations. The combinations most frequently needed for patients seeking care under the Directive include: English, Spanish and French, which are not the most frequent languages needed in Italy. Based on interviews informants reported that the languages most frequently needed in the North are Chinese and languages of the Middle East (especially Syrian). Mediators work face-to-face in the majority of cases. Part-time or freelance mediators are the solution for less frequently used languages such as Mandarin, for example, or, when very few mediators are found in certain language combinations, interpreting can occur over the phone.

During a meeting, providers (5 participants at IT Site 5) mentioned that they generally use in-house, non-professional solutions for language provision and, if necessary, waiters from the hospital cafeteria are used to interpret. This is the case for Polish. During the interviews they also mention that rather than having a stranger, they prefer to talk to a family member of the patient with whom they need to communicate. In their views, there is usually more trust in working with a family member than with strangers. Minors under 12 are not allowed to interpret since they need to be protected.

An important finding about the provision of language services in Italy is thus the figure of the intercultural mediator. This person links the institution with the community and brokers communication between providers, staff, patients and family members. It is essential to note that translation and interpreting are core tasks expected from and performed by the intercultural mediator yet there are no regulations or standards in place to require that they demonstrate ability in such competencies. Ethnic community affiliation and bilingual ability are highly valued by institutions, even if they are not

tested. The lack of formal training in T&I has ethical implications since quality is not ensured and thus the actual service provision or access to it may be endangered.

3.4.4 Spain

Three Autonomous Regions of Spain were chosen, due to the linguistic, demographic, geographic and social characteristics of sites. First, Valencia because it has a regional language, it is home to an expatriate community and because it is a potential destination for medical travellers. Second, Madrid because it is home to the National Contact Point, the nation's main health institutions, it has a demographically diverse urban population, and because Spanish is dominant. Lastly, Galicia because it has a regional language, has rural regions, is the destination for all the Camino routes, and it shares a border with another MS. Data collected in Spain resulted from observations of a variety of healthcare institutions including urban, rural, and border hospitals (private and public), clinics, healthcare centres as well as health ministries, NGOs, and universities. Interviews included policy makers, healthcare providers, social workers, language service providers, company owners, officers of T&I professional associations, translators, interpreters, and patients.

Language provision was discussed at various levels and ranged from what politicians, administrators and healthcare providers find they need when they work with colleagues from other MS at EU level meetings to what happens in healthcare facilities in the country. For example, while conducting interviews with different informants at the Ministry of Health, Social Services and Equality we learned that for them the lack of "Spanish simultaneous interpreting at EU-level conferences means that we lose some of the edge of being able to express ourselves in one language as an expert... One misses on the nuances... but that is because it is now assumed that English is the *de facto lingua franca* for expert meetings... We can't clone ourselves, we can't clone those who are experts in the field and also speak English well...and we have lost some EU co-presidencies due to this issue of language. And sometimes the translations made for us are not quite accurate. For example, when the Directive talks about long-term care, we can understand this in Spanish as '*cuidados de larga duración*' which does not necessarily refer to chronic illnesses "*enfermedades crónicas*" as it was translated for us (ES Inf 18).

In the field of translation, the Ministry (ES Site 10) is very active in promoting a common European platform for the translation of texts. This initiative is called Connecting Europe Facility (CEF)³³. It was briefly presented to us using during our site visit. As part of the Joint Action and Health Government Initiative, the Ministry is working towards a normalization of the clinical structure in order to achieve the interoperability of contents at the technical, syntactic, semantic, and cognitive levels. The goal is to be able to exchange information without human intervention. Another initiative in which Spain takes part is SNOMED CT, a common European terminology initiative.

Language support solutions for cross-border healthcare patients are not foreseen in the legislation transposing Directive 2011/24/EU in Spain (Royal Decree No. 81/2014 establishing the standards to guarantee cross-border healthcare). Thus solutions are not consistent across regions. Regions with two official languages (i.e. Catalonia, Basque Country, Galicia, Valencian Community) have legal instruments that ensure most official documents, signs, announcements in all public settings are issued in both languages (Spanish and the other regional language). The right to language access in

³³ CEF is available at <https://ec.europa.eu/digital-agenda/en/connecting-europe-facility>

both official languages in bilingual territories is enshrined in the Spanish Constitution (Art. 3.3 of the Spanish Constitution of 1978). Language support for the foreign population has not been developed by any legal instrument in any of the regions other than the recently passed Organic Law 5/2015 that transposes Directive 2010/64/EU on the right of interpreting and translation in criminal proceedings. Different mechanisms that were put in place in the course of an immigration peak some 15 years ago, such as face-to-face interpreters or telephone interpreting in hospitals and the social services, have now been terminated or severely cut down in most regions because of cuts in public expenditure. The main language support solutions identified in the course of our fieldwork were translations (including those done with CAT tools), telephone interpreting to a much lesser extent, and barely any face-to-face interpreting. In regions with a large expatriate British or German population, such as the Valencian Community, there are groups of native volunteers who speak Spanish and interpret in hospitals. Regional governments from the sites we visited plan for language support based on 1) their cross-cultural communicative needs and 2) their experience with a foreign population.

The responsibility for translating documents (e.g. medical records) is placed on patients (ES Sites 5, 6 and 8), who are responsible for seeking and paying for the translations of any documents requested by healthcare providers. In general, translation of standard documents, such as informed consents, prescriptions or instructions for tests were not available in languages other than the language of the country or region. However, in some public hospitals (e.g. ES Sites 5 and 15) and private clinics (ES Sites 6 and 7) healthcare providers did mention that there were translations into English of informed consents related to ordinary surgery procedures. Providers could not confirm whether professional translators had produced these translations or not. In one of the private clinics visited, one hospital administrator stated:

“doctors and nurses are recruited also because they understand and speak two or three languages. For less common languages, we contact foreign consulates... who sometimes refuse to help. In most cases, communication is not a major problem... We manage in English. We always manage. English is like a wild card (*comodín*). For consent forms for example, we simplify the language to make it more accessible, especially when the “translator” is a child who then needs to explain it to the family member.” (ES Inf 7).

There is no budget assigned for the translation of documents in any of the sites visited and the accuracy of the translation task/resulting information is not verified.

When asked about machine-assisted translation, several informants (ES Informants 8, 9 and 22, ES Sites, 1, 3, 4, 5, 8, 12, 14 and 15) perceived CAT tools as a useful means of communication with linguistically diverse patients. However a few participants mentioned they use specialised CAT tools such as The Universal Doctor Speaker. Most of them confirmed that they relied on Google Translate to help in their interactions with patients when they communicate in English. When asked about this kind of communication informants agreed that it was effective, had to be used with care and that it worked better with short phrases and decontextualized terms.

In terms of oral interaction, informants reported the use of telephone interpreting, limited face-to-face-interpreting and “*azafatas*” (hostesses/ambassadors acting as language mediators in a hospital). The frequency of telephone interpreting was, however, uneven. In public healthcare sites in the Levante area, we were told: “most

primary care physicians read English and speak enough to be able to communicate with the patient." In some regions of Valencia or Galicia, for example, health information is provided in both languages, Valencian and Spanish or Galician and Spanish (respectively). Volunteers working for NGOs perform translations. Volunteers are also providing interpreting services. When we inquired about qualifications or criteria for volunteers the following was explained to us:

"the selection and education of the volunteers are based on minimal criteria: if you speak the language and you want to volunteer, you can come. Some are retirees... nothing professional. In some cases we look at their résumé and profile. Some centres used the so-called "*azafatas*" (hostesses), who are like language mediators and would accompany the patients in cases of emergency. They would talk to the patients and inform them of their rights. The patients prefer them to the call centres (that some hospitals are using) because it is more direct and they can help better as they are physically next to the patient. The problem is that the *azafatas* had a specific schedule and were thus not always available... which is not the case of the call centres. In many places, the *azafatas* have disappeared, victims of budget cuts. Sometimes, we use a cook who speaks Polish... and we used to have a Polish doctor and an Italian anaesthesiologist." (ES Inf 5).

In general, doctors complain that interpreting increases the time of the average consultation due to the physical or virtual presence of the interpreter. Interpreters on the other hand report that a "bilingual" consultation that would have taken 30 minutes if the doctors had tried to get by with their or the patient's limited English can be done in 10-15 minutes thanks to an interpreter.

After volunteers, the next option for providing interpreting is the use of a telephone service. The few hospitals that have access to face-to-face interpreters use over-the-phone interpreting in "exceptional" circumstances. There are 3 main service providers of telephone interpreting in Spain. Their recruiting systems vary greatly from hiring untrained bilinguals to hiring graduates from interpreting programs at universities. Two of the three companies were interviewed (ES Informants 17 and 20). In these interviews they explained the criteria they use for hiring telephone interpreters. They do not require a degree or education in Translation and Interpreting. Language proficiency is the main criterion for hiring, since the companies themselves provide telephone interpreting training specific to their technical system and corporate culture.

In the private sector of the Levante area (ES Sites 3, 7, 5, and 8), some private hospitals have up to 12 different languages spoken. They hire some interpreters on a full-time basis for the languages most in demand; for the others, they manage with bilingual or trilingual receptionists and telephone operators. When asked about the qualifications of the interpreters they hire, they said they would prefer someone with a university degree and education in interpreting but if that is not the case the person needs to show that she is a native speaker.

"When the interpreter is not available (for example at night), then we use a tablet or our mobile phone with some bilingual dictionary or Google Translate. We prefer to use face-to-face interpreters. We use them even more than our stethoscopes but the cost of interpreters is very high (ES Site 7). With a staff of 480 people at the hospital, there is always someone to help us" (ES Inf 7).

In public healthcare centres, while recognizing that “a good healthcare support implies a good communication with the patients” (ES Site 7), “the patients are told to come to the consultations with their own translator.” (ES Inf 1). Thus patients come with a friend or a family member. “Some get upset because of miscommunication issues when we talk to them in Spanish and there is no one to help... they have been living in English-speaking colonies here in Valencia and do not speak any Spanish.” (ES Inf 5). And in public clinics, the doctors are civil servants... often they speak some English” (ES Inf 3).

Some private hospitals and health centres had an in-house, non-professional language service with on-site interpreters/translators who worked in different language combinations (ES Sites 3, 6, 7 and 8). Most of these private centres have a well-defined profile of foreign patients to whom they cater. So language combinations are set according to marketing efforts and needs. However, in the case of interpreting the most common practice in the sites observed is to communicate through ad-hoc interpreters, whether relatives, friends, NGO volunteers or bilingual healthcare staff who help broker communication. Neither the language proficiency nor the interpreting skills of these ad-hoc interpreters were tested. Rather, they were taken at face value.

In any case, no registers exist at present for qualified translators/interpreters in the field of healthcare or medicine. Neither are there any national professional associations in the field of healthcare, only the international organisations TREMÉDICA (Asociación Internacional de Traductores y Redactores de Medicina y Ciencias Afines) and the International Medical Interpreters Association (originally an American association founded in Massachusetts and now with a presence in various countries).

3.4.5 United Kingdom

For the United Kingdom data was collected from the four regions of England, Wales, Scotland and Northern Ireland. In England major health institutions and professional associations in London were consulted. Urban hospitals were also observed. In Wales documentary evidence was collected from urban health institutions and professionals with expertise in healthcare service to Welsh speakers were consulted. Data collection in Scotland included both urban and rural regions and professionals in translation and interpreting as well as cross-border care were surveyed. Lastly, Northern Ireland also included data collection in urban and rural regions. Organization managers and translation and interpreting professionals informed the study of how language service and cross-border care is provided.

As discussed in detail in Section 2, regional Equality legislation obligates healthcare institutions to provide language services, yet there is no regional legislation, for the Directive or otherwise, that specifies how such service is to be provided. The provision of translation and interpreting services is left to the institutions themselves and they are given the responsibility of meeting the language needs of patients and complying with the Equality legislation. With this flexibility there are a variety of models of provision in the UK and institutional responses are not uniform. Northern Ireland has opted for a regional strategy for provision by creating the Northern Ireland Health and Social Care Interpreting Service (NIHSCIS) that is responsible for administering the service for all Health and Social Care trusts within the territory. This regional service employs, trains and allocates face-to-face interpreters while also relying on a private company for telephone interpreting service. No other region in the UK has established

a regional service for language provision. Institutions in the UK essentially choose between two options for provision models.

Some institutions elect a model where they set up and manage an in-house, professional translation and interpreting service. This model combines hiring professional face-to-face interpreters for the most frequently sought languages while also awarding contracts to private agencies to provide telephone interpreting for less frequently sought languages. Translation services are managed in a similar manner. They can be performed either by the in-house interpreters who also hold translation certification or by agencies that hold a contract for translation services. Individual institutions rely on both in-house professionals and agencies for translations and choose between these depending on the size and cost of a particular translation job. There is collaboration with other public institutions. Firstly, healthcare institutions have reported combined contracts with other public institutions such as the police. Secondly, there is participation among the NHS institutions in planning for the translation of documents. However, a nation-wide database for translated documents was not reported to exist. These in-house translation and interpreting services are similar to the provisional model of Northern Ireland but smaller in scope since they do not cover an entire region and do not include multiple healthcare trusts or boards. Other institutions elect a second model and contract out all translation and interpreting (both face-to-face and telephone) services to private agencies. For some institutions this is a more feasible model since the administrative investment in creating and managing an in-house service that employs T&I professionals is considerable. In these cases, it can be more cost-effective and practical to contract agencies to provide all services. When electing the service provision model institutions consider the population they serve as well as quality and cost of service (UK Informants 7, 8, 20, 23 and 26). Professionals who work in the NGO sector (UK Inf 24) and in management of private T&I services (UK Inf 17) reported that the overriding factor for awarding contracts is cost. This was reported to be the case not just in healthcare but with the contracts for other public services such as the police. These professionals were concerned that cost considerations impact the quality of service provided.

The specifics of how service is provided are decided through institutional policy guidance, intended to ensure the broader goal of equality as specified by equality legislation. Each institution has a governance structure that includes an Equality and Diversity team or its equivalent in charge of enacting individual policy guidance. This is an institutional responsibility but there are similarities across institutions. In the case of Northern Ireland, there are individual institutional Equality and Diversity teams, but there is an overarching translation and interpreting policy drafted by NIHSCIS. Equality and Diversity professionals at the national level as well as at the institutional level stress the ethical obligations public institutions have to provide translation and interpreting services in healthcare. They view the provision of these services as best practice and as an obligation that they are working to meet (UK Informants 8, 9, 23, 25, 26 and 28). NGO managers are even more vociferous about this ethical obligation and see language provision as a core service and a necessity for diverse communities and for any patient who does not speak English (UK Informants 10 and 24).

The responsibilities of these Equality and Diversity teams are broad in scope and translation and interpreting is a part of their larger mission of promoting equal access to healthcare services. This mission is defined and ensured through equality schemes, policy guidance and outcome reports. These teams are very accessible to anyone with queries on translation and interpreting services. Accessibility to the public is considered a central equality duty. The policy documents are also accessible on the

internet. Virtually every institution has published guidance available. To understand how language service is provided in the UK we will consider a sample of policy guidance documents as well as data collected based on our interactions with healthcare institutions. The institutions were chosen based on criteria that give a better understanding of policy and service provision in the different settings (urban/rural) in the four regions of the UK.

Urban settings in the UK are home to diverse communities that require translation and interpreting services to communicate with healthcare providers. These services are a necessity, considering the trends in migration and the demographic predictions for Britain. Minority ethnic groups are responsible for 80% of the population growth in Britain over the past decade and the largest ethnic communities are Indian, Pakistani, Black African, Black Caribbean, and Bangladeshi. By around 2050 ethnic communities will represent between 20 to 30 per cent of the population (Sunak & Rajeswaran, 2014). Barts Health NHS in London serves a minority-majority population where ethnic minorities outnumber white residents and this institution monitors census data so as to better plan for translation and interpreting services into the future (NHS Barts Health, 2013). Urban healthcare institutions meet the needs of these communities through policy guidance that often underscores the need for translation and face-to-face interpreters for sizeable communities.

Sunak and Rajeswaran (2014) also report that 98% of ethnic community members live in urban regions. It may thus be erroneously assumed that language access is not a necessity in rural regions of the UK. However, healthcare institutions from rural regions also report that they consistently have to provide translation and interpreting services to both diverse communities and speakers of indigenous languages of the UK. NHS Grampian is an institution that serves the city of Aberdeen as well as vast rural regions in northern Scotland. This institution is an example of how complex the provision of service can be. Aberdeen is an important city for oil and gas companies who often recruit foreign workers. While these workers speak English, their family members who come with them may not and NHS Grampian has had to recruit interpreters for less common languages such as Kazakh. In Aberdeen face-to-face interpreting is the preferred service model, however this institution has to provide service to a vast rural region where travel can be extremely difficult in winter. For rural service locations telephone or videoconference interpreting is the model for service provision (UK Inf 9). NHS Grampian has made increasing effort, especially in rural regions, to promote telephone interpreting through Access Points, which include fixed line, mobile and conference call units. The usage of telephone interpreting at Grampian grew from 851 calls in 2006 to 5,747 calls in 2013 and fell to 5,349 calls in 2014 (UK Inf 9).

The diversity in the provision of language services in rural regions is also illustrated by examples from Northern Ireland and Wales. In Northern Ireland, health institutions in Dungannon increasingly serve diverse populations as different industries have attracted migrant workers from overseas. As these industries have grown so has the immigrant population that does not speak English. Thus, rural services have had to adapt (UK Inf 10). As evidence from Wales shows, language services also have to be provided to speakers of languages indigenous to the UK, such as Welsh. Welsh language speakers live predominantly in rural areas and in such areas there is an overall shortage of doctors. One strategy in place to encourage the use of Welsh is to educate, train, employ and retain Welsh speaking medical professionals (UK Inf 15). Lastly, Welsh language access is not limited to just rural regions in Wales as even urban institutions provide Welsh language interpreters if staff do not speak Welsh (Cardiff and Vale University Health Board, 2014).

In the UK it is common for healthcare institutions to have comprehensive policy guidance for translation and interpreting services. Two illustrative examples are the policy guidance documents of East London NHS and the NIHCIS. These establish a protocol for health professionals to aid them in better understanding and utilizing translation and interpreting services. The documents aim to be comprehensive by discussing roles and responsibilities in communication, how to decide when an interpreter is needed, the difference between face-to-face and telephone interpreting, as well as the risks associated with using friends, family members or staff to interpret. This policy specifies how to make appropriate decisions for requesting language services (Annex 4) as well as the administrative process for doing so (NHS East London, 2014). The Code of Practice of NIHCIS also emphasizes the ethical, legal and financial implications of not providing interpreters (Northern Ireland Health & Social Care Interpreting Service, 2011). The policy guidance of NHS East London and NIHCIS is not an isolated phenomenon as other NHS trusts have drafted similar policy guidance.

It is important to note that policy guidance is seen as an ideal that institutions strive to meet. Awareness needs to be raised so that staff better understand the implications of the guidance. Practical experience with healthcare interpreting shows that policy guidance can sometimes just exist in the books and it is broken by using untrained interpreters (UK Inf 17). This is even the case at UK Site 2, an NHS trust with considerable policy guidance. Here it was reported that staff and relatives interpret (UK Inf 3).

Hospital staff may also be misinformed about the nature of translation and interpreting services. An example of this is misinformation concerning the funding source for interpreting services. Staff at one NHS department had erroneously thought that they would be responsible for paying for interpreting services and were not aware of a central budget. This discouraged them from using the service and they encouraged patients to bring family members or friends to interpret (UK Inf 20).

Thus, raising awareness as well as understanding of the importance of language services, how they are provided and paid for are the practical necessity of putting guidance into practice.

These language access policies were not drafted for cross-border healthcare patients and do not explicitly mention such patients. Nevertheless, it is important to note that Directive patients would be offered translation and interpreting service under policy guidance. This is also the case with patients who had planned care in the UK thinking that they had sufficient English proficiency. If they had difficulty communicating, interpreting service could be sought (UK Inf 20). The type of interpreting that such patients would receive may vary between face-to-face and telephone interpreting. For Directive patients who speak a language that has a sizable resident community in the UK, like Polish or Portuguese for example, face-to-face interpreting would mostly likely be the service model, whereas for a language like German, which does not have a large resident population in the UK, telephone interpreting would most likely be the model of service. Lastly, it should be noted that telephone interpreting is consistently available across the UK and is used for languages that are not commonly sought at the institution as well as a back up for face-to-face interpreting for off-peak hours. Thus, it can be said that for Directive patients at the very least telephone interpreting is available. A similar arrangement is the case for translation services for Directive patients. Some institutions and hospitals have published information translated into

languages that are common in the community they serve. So Directive patients from a MS that has a sizeable resident community in the UK would have access to these translated materials. For these patients in-person interpreters could also perform sight translations. For Directive patients from a MS that does not have a large migrant population in the UK the translation services available are less clear. Translations in less-commonly used languages are not available and misunderstandings about written information most likely would be brokered through communication between the patient, the provider and a telephone interpreter. It should be noted that some institutions translate the medical records and prescriptions of patients from other MSs into the language of the patient before they return to their MS. This is seen as an ethical consideration and best practice for safety and continuity of care. The UK institution covers this cost (UK Inf 20).

Data from NHS and HSC trusts on the provision of service shows that translation and interpreting services are commonly and increasingly sought. With growing awareness and formality under equality legislation, language services, although still not provided in all situations, are being offered to patients. To give an example of the increase in interpreting sessions consider the case of Northern Ireland. In 2004 there were 823 interpreting requests for that year while in 2014 there were 95,894 interpreting requests (See Figure 4). Over the ten-year period in which the NIHSCIS was established and developed there was an enormous increase in interpreting requests and such requests are projected to continue to grow (UK Inf 7). Even in trusts that have an institutional translation and interpreting service the amount of requests is notable. Data from NHS Glasgow and Clyde shows that this institution will cover anywhere between 6,000 to roughly 8,000 interpreting requests per month. These requests are across a broad range of languages and covered through a mix of face-to-face interpreting, which can be performed either in-house or through agency interpreters, and telephone interpreting (UK Inf 8).

Data from Barts Health NHS for 2012 shows that their interpreting service must provide language access across a wide variety of languages and that they primarily serve certain communities. For Punjabi/Hindi/Urdu there were 4601 interpreting sessions, for Bengali/Sylheti, 3941 sessions, for Polish 1835 sessions and for Tamil, 1510 sessions. In addition to having to provide service to identifiable, larger communities, they must also be able to provide services to languages that are not commonly sought. For example, there were 3 interpreting sessions for German, 1 for Italian, 1 for Nepalese, 1 for Luganda, 1 for Fulani, as well as a host of other languages. What this illustrates is that healthcare institutions must be prepared to meet the needs of large resident communities as well as the needs of patients who may request interpreting for a language that is almost never sought (National Health Service Barts Health, 2013). The data also illustrate that for Directive patients, healthcare institutions like NHS Barts Health are able to meet their language needs if it is necessary.

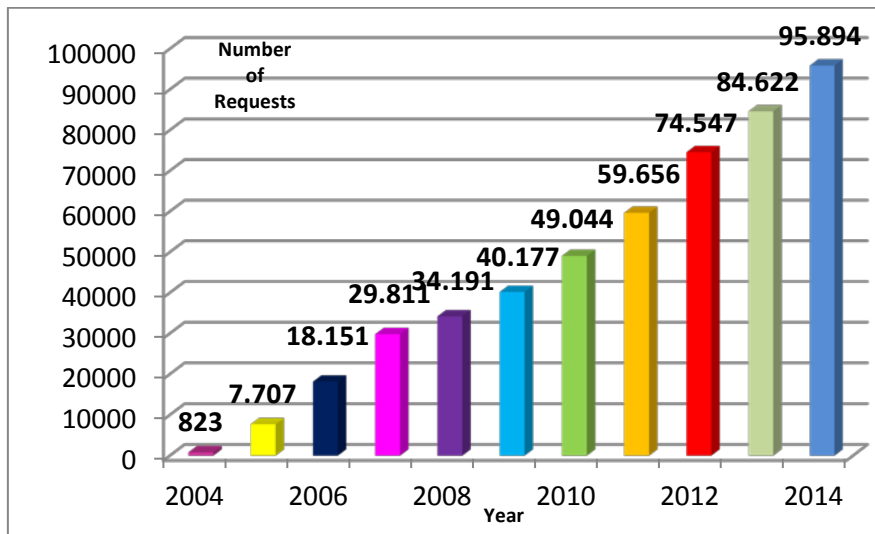


Figure 4: Northern Ireland Health and Social Care Interpreting Service Requests (Source: UK Inf 7)

Like Barts Health NHS, NHS institutions across the UK have to provide service to both large ethnic communities and speakers of less common languages. NIHSCIS and NHS Lothian are examples of this. Data from NIHSCIS shows that this institution needs to cover a broad range of languages to serve an extremely diverse community (Annex 5). NHS Lothian also provides language service to an ethnically diverse community and its data illustrate that institutions should take a localised approach since the needs of individual hospitals and clinics vary according to the communities they serve (Annex 6). UK Inf 20 stressed the need for accountability and data analysis so as to better understand how service is provided. Translation and interpreting data show that language services are not distributed evenly across hospitals and clinics. A given hospital will have a different proportion of patients from varying ethnic communities. For example, while Spanish language services will be in demand at a certain hospital, they will rarely ever be sought in another hospital. This has implications for translation services. In the past there was an example of a hospital that ordered a translation of information into Greek that was unnecessary. When data on language services was later compiled it showed that this hospital did not serve any Greek patients. Accountable record keeping can prevent errors like this and make service more efficient (UK Inf 20).

3.5 SUMMARY OF FINDINGS

Except for the UK where the law requires that professional language services be made available, patients in the other MSs are responsible for paying for and bringing the translations of their medical records and any other related document. Even with language services patients in the UK have also been reported to translate their own documents. Informants in the other MSs do not consider this request as form of potential discrimination for patients, since cross-border healthcare is perceived as a choice, not a right. Most public authorities and healthcare managers believe that public healthcare systems are not responsible for providing language support to patients who do not speak the language of the MS. This is the case for both residents and cross-border patients. When discussing cross-border healthcare, informants state "that this type of care is optional for the patient and that, when deciding whether or

not to apply for healthcare outside their MS of affiliation, they should take language barriers into account" (ES Site 5). This belief coupled with the assumption that English can be used as a lingua franca because "it can be understood by many patients" (ES Inf 23)- when in reality many patients do not speak English at all- and the scarcity of funding leads to a situation in which the public healthcare organisations' language provision (written or oral) is mostly in the hands of *ad hoc* interpreters and translators, despite the availability of freelance professional translators, interpreters and/or translation/interpreting agencies in the MS. It is clear that when language provision is not in place, organizations resort to *ad hoc* volunteers (patients' relatives and friends, NGO volunteers or bilingual staff who may or may not have sufficient qualifications) or software (such as Google Translate) to perform translation or interpreting tasks. Inevitably, this practice that may be perceived as a saving, may also have costly consequences. Most importantly, it may have costs to which one cannot assign pecuniary amount, like a human life. And, in any case, this practice has ethical consequences when discussing equal access to quality healthcare, and raises the ethical issue of minimum quality standards.

SECTION 4: COST OF LANGUAGE PROVISION

Providing language services for healthcare has a cost, as do healthcare administration, or healthcare itself. This is a fact. Budgets are always limited, they reflect priorities of Member States (MSs), and responsible budget officers always look for more efficient and cost-saving solutions. This is another fact. MSs vary in how they deal with these facts. As a consequence, cost of language provision is not a consideration in all MSs. In addition, cost is perceived and managed differently by all MSs. As we have seen in Section 2, some MSs have included language services in their legislation and have a budget for it. Others consider language provision as the problem of the patient who does not speak the language of the MS. Yet in a multilingual society like the EU, language support is central to delivering any services. Healthcare is no exception. However, the provision of language services is still not considered an integral part of healthcare services. It is not a priority. Rather it is perceived as a costly problem or a barrier. In many MSs language provision is still not budgeted for in the same way as healthcare or administrative services are.

This section examines the costs of various options for language provision observed in public and private sectors of the five participating MSs. Results from the analysis of legislation, qualitative interviews, non-participant observations and questionnaires suggest that the five MSs differ considerably in how they conceptualize, legislate, offer and pay for language services, and thus, not surprisingly in how they assign funding for them and discuss their cost. Consequently, results are discussed at varying levels across the five participating MSs (e.g. language provision is a legal requirement only in the UK). This section is divided into two sub-sections. In Sub-section 1 we discuss the reported costs of language provision. We present perspectives of hospital administrators, service managers, T&I agency owners, free-lancers, which illustrate the (perceived and real) cost of language provision. In sub-section 2, we engage in a discussion of the social cost of a failed social and economic integration of some members of society.

4.1 COST

Germany

As discussed in section 2, law in Germany does not require language provision in healthcare. Thus, hospitals are not mandated to provide language services. Unlike legal matters, for which there are requirements for language provision (translation and interpreting) and federal law states how much a court interpreter can be paid, hospitals have different practices when it comes to language provision. Some hospitals (DE Site 14) rely on unpaid or very modestly paid services (DE Inf 1). Some succeed in finding funds from insurance companies or their doctors agree to pay for interpreting services while others do not. When inquiring about job opportunities for public service translators and interpreters in Germany, based on her knowledge of the T&I industry an informant stated that “if insurances are not forced by law to cover interpreting and translation, nothing will happen. If law forced them the crux of the problem will be solved. Hospitals do not have a problem in working with translators and interpreters... but they do not have the money and they do not get it from anywhere. The exception is sign language interpreting” (DE Inf 17).

From interviews with members of the Federal association (DE Informants 12 and 13) we learned that for consecutive interpreting the rate paid to PSI working in court is 70

euros per hour, for simultaneous 75 per hour. In some areas they apply this rate to services for the police department, but not everywhere. In general, police interpreting pays from 20 to 70 euros per hour. The tacit agreement (based on information gathered at the Federal association) is that the Police Department should not work with agencies rather they should hire professionals directly. But this rule is not always observed. There are no rules for medical interpreters. But there is a distinction between non-qualified and qualified providers. For the Federal Association “qualified” applies to those who have studied or are accredited. Ad hoc providers offer services voluntarily and may not have evidence of education or qualifications (e.g. accreditation exams).

Additional information collected from the responses to Questionnaire 1 shows that the rate for a translated word is €0.07; for a translated line of 55 characters (target text) it varies from €1.40 to €2.05 and from €10 to €75 per page (no mention of how many words/lines per page). For medical interpreting, the rate varies according to language combination: German-English is €70 per hour; German-Hungarian €70 per hour. Generally it varies from €15 to €70 per hour (most around €35 per hour).

Greece

From the interviews and observations conducted in Athens, Chania, Corfu, Farkadona, Katerini, Larisa, Litihero, Marusi, Trikala, Vamos, we observed that language provision is not a priority in Greece and it is not contemplated in budgets. The situation varies from public to private healthcare organisations. From all the sites interviewed only one private clinic (GR Site 7) specializing in In-Vitro fertilization discussed their policy and budget for translation and interpreting services. This private clinic sees patients travelling under the Directive of cross-border healthcare as an addition to the number of EU and international patients they already have. The administrator interviewed explained that they invest in their business. Therefore they only use professional translators/ interpreters. The interviewee could not explain hiring requirements. When we checked with the professional interpreters who worked for us (EL Inf 29) we learned that ad hoc T&I providers work in that clinic.

During interviews, when we asked the question of cost and funding for language provision in public hospitals, clinics and healthcare centres (EL Sites 1, 8, 9, 31, 32, 33, 35, and 37) the answer was always “no, we do not have any”. Overall, volunteers, patients’ friends and family members provide translation and interpreting mostly, if not exclusively. As a result of the economic crisis the country is going through, social clinics and solidarity centres were created spontaneously and, in them, there is no funding to pay for any language professionals. Healthcare providers donate their time and so do T&I professionals. Two of the language service providers interviewed (EL Inf 29 and 30) work frequently for NGOs as volunteers.

One informant interviewed at the National Contact Point (EL Inf 5) mentioned that “there is a budget line for translation and interpreting services, for the translation of medical files and interpreting for hospitals...the hospitals are aware they can ask for money... have not done so at all.” As a result, EOPYY’s budget for cross-border healthcare was reduced. The informant added “we are trying to have approximately one million euros for 2015 but with treatments for serious surgeries and/or difficult hospitalizations... we will run out quickly... in the past, we used to have funds we could

use for translation ... but sometime it was taking three or four months to get a translation from freelance translators" (EL Inf 5).

When asked about translation of documents in the healthcare sites visited, none of them were aware of any help they could receive from the NCP. In terms of budgets and translation costs, during an interview (EL Inf 10) at an NGO, informants volunteered a story about a long translation of medical records that they could not afford. They needed a translation of a 100-page document into Greek from an insurance company in Germany, so that one of their Greek patients could pursue reimbursement for expenses incurred in Germany during treatment. They explained the records had not been translated in Germany. When they (NGO) received them they communicated with the Greek professional association. They asked for a quote from a professional translation agency. It was over €1,200. Neither the patient nor the NGO could pay for it. The Greek authorities agreed to accept a 3-page summary of the document.

When we asked providers and administrators about language provision, it became apparent that in the midst of an economic crisis, interpreting and translation are perceived as expenses and are not a priority. A frequent answer we received is "we all speak English here" (EL Informants 6 and 13). Implied in this answer is that they understand the written and oral information presented to them in English. However, during our interviews, when we started interviewing in English, we quickly had to ask our interpreter, who was working from Greek into English for us, to help the interviewees too by interpreting what we said in English into Greek for them.

Additional information collected from the responses to the Questionnaire on Translation and Interpreting shows that for translation the rate for a translated word varies from €0.04 to €0.12 (majority around €0.08) and from €14 to €20 per page (no mention of how many words per page). For interpreting, the rate varies from €20 per hour to €50 per hour for medical interpreters. One interpreter stated €280-300 per day but offers were not frequent. One project manager (who coordinates public service interpreters, medical interpreters and conference interpreters) stated the fee goes from €100 to €600-700 per day according to the language combination. During interviews with freelancers (EL Informants 29 and 30), they explained the going rate for interpreting ranges from €12 to 20 per hour.

Italy

In Italy, hospitals have to pay for the costs of using interpreters and cultural mediators. Mediator organisations (mostly called cooperatives) respond to calls for tenders from the hospitals that contract language services. The cooperatives visited hire full-time mediators for main European languages (English, Spanish, French) who work face-to-face in the majority of cases and part-time or freelance mediators for languages such as German. They have full time in-house mediators for language pairs that meet the needs of their residing population such as Chinese (IT Site 2). In this case, they work mostly over the phone. The rate for an intercultural mediator varies. The hospitals and health centres visited (IT Site 5) report the following range: from €14.62 for the first two hours, and then €8.65 for each subsequent hour up to between €13 and €20 per hour. The waiting period for payment is approximately 12 months (IT Site 2). The level of language proficiency and translation/interpreting skills of mediators could not be ascertained.

Hospital administrators contract the services of interpreters and/or intercultural mediators. The mediator cooperatives respond to calls for tenders issued by hospitals to provide language support in order to facilitate communication for non-Italian speaking patients. The cost of services provided by one cooperative (IT Site 9) for one year is €200,000 and another hospital signed a contract for €160,000 per year. This figure covers all languages.

In general, the cultural mediators are usually paid by the hour, especially for rare languages (e.g. Urdu). The fee charged is perceived as problematically low by mediators (IT Sites 2 and 9). As stated above, interpreters working in healthcare are paid €14.62 for the first 2 hours of work and €8.65 euros for the following hour. Even where the pay goes up to €19.45 per hour (IT Inf 3) and when cultural mediators charge sometimes €25-30 such fees do not compare with the fees demanded by professional interpreters (either holding degrees or certification in the field) who will, thus, not be attracted by the healthcare interpreting setting.

Additional information collected from the responses to Questionnaire 2 shows that the rate for translated word varies from €0.05 to €0.12 and from €18 to €28 per page (no information on how many words per page, except for one respondent who stated 1500 characters per page). For interpreting, the reported rate varies from €15 per hour to €30 per hour in medical interpreting. For interpreting in "public entities", during our interviews we learned that interpreters may charge €90 per day working for a mediator cooperative (IT Site 2) and €128 per day working for a pharmaceutical company.

Spain

Bi-/multilingual telephone operators working in SUMMA (the emergency service for the Madrid Community) earn between €800 and €1000 euros per month and receive a bonus for their bilingualism. In this centre, a €100 bonus per month paid to a bilingual worker is perceived as a saving on language provision. However, at the time of the interview with one of the emergency telephone operators who also interprets (ES Inf 15), this bonus had been eliminated because of the economic crisis.

Some private healthcare centres and clinics also have bi/multilingual operators. One informant (ES Inf 15) stated that in the Madrid area bi/multilingual operators received an extra €30 euros per month if they have received training as health technicians. The training may last one month and focus on one specific healthcare topic. This training helps operators to get some "basic information from the patient before delivering them to a nurse or a doctor. Training and bonus are no longer offered due to budget cuts. Moreover, nowadays the new operators hired have to be trilingual, instead of bilingual" (ES Inf 15).

While discussing ad hoc interpreting in Spain another informant who holds a university degree in T&I (ES Inf 20) stated "the cost of one night of hospitalization in the Levante area (which is about €2500 euros) can be saved with a good interpreter... because the doctor can establish a diagnostic earlier. Otherwise the patient would have been kept longer in observation." According to this view, using the service of a professional translates into a cost saving (ES Inf 20).

The over-the-phone interpreting companies sign contracts with healthcare organisations to offer translation and interpreting services. Some (ES Inf20) offer the first month free of charge, so that potential clients can try the service. Another informant offering telephone interpreting (ES Inf 17) referred to the contracts they have had with one specific healthcare centre. That hospital had signed a contract with the company for €35,000 euros for the first year, then increased it to €45,000 euros for the second year (with unlimited use of interpreters). This company paid their own interpreters €2 euros per minute with a minimum of 10-minutes for night calls. They also pay a retainer, which varies between €50 and €100, to some of their interpreters.

Another option discussed by providers (ES Sites 6 and 7) is to hire full-time interpreters, so that they can be on staff. However, this practice is not frequent. As part of our observations we shadowed these interpreters for a day in a private clinic. The interpreter worked non-stop in five languages. The interpreter earns €1200 euros per month for an 8-hour day. Occasionally the interpreter is asked to perform translations. When this happens the interpreter is paid an additional amount (not equivalent to the going-rate for translations in the area). In one private clinic that has five staff interpreters, we interviewed the supervisor (ES Informants 9 and 10). Based on our observations, we asked about workload, breaks, pressure, fatigue etc. Even when the administrators were aware of the overload of some of their interpreters, they explained "to be able to hire staff interpreters, the clinic must have sufficient demands."

When we discussed costs with translation agencies, it was said that the minimum fee they pay per translated word is 5 cents. The agencies that can justify hiring a full-time translator (given their work volume) reported paying salaries of €1200 to €1300 per month. (ES Inf 17, ES Inf 29) At the national level, the translation initiative "Connecting European Facility" (CEF) has a budget for 2015 of 1.4 million euros.

Additional information collected from the responses to Questionnaire shows that the rate for a translated word varies from €0.05 to €0.24 (the mean value is €0.10) and from €15 to €35 per page (no information gathered on how many words per page). For medical interpreting, the rate varies according to language combination. For example, Spanish to Russian is €40 per hour and Russian to Spanish €50 per hour. The rate for Spanish to Chinese is €85 per hour and for Chinese to Spanish €80 per hour. One respondent stated there is a €20 rate for the Emergency Service over the phone. Other respondents report the following fees:

- 1) "20 € / hour in public services; € 280 / half-day consecutive and simultaneous; and € 500 / full-time consecutive and simultaneous."
- 2) €20 for the first hour and then €15. Only one respondent working in a medical setting stated "face-to-face rates of 45 € / hour, and over-the-phone of € 0.60 / per min."

United Kingdom

In the United Kingdom healthcare institutions are required to provide language support under Equality legislation. For patients who do not speak English well enough to communicate in a complex healthcare situation translation and interpreting services are provided free of charge to the patient. There is a cost to the healthcare institution when fulfilling the requirement to provide language support. Gan (2012), through

Freedom of Information Act requests to NHS trusts, reported that in 2011 health trusts in the United Kingdom spent £23.3 million pounds on language services. Her report also noted that the costs of language services at the national level were rising when compared to costs in previous years.

Next we consider regional costs, institutional costs and telephone interpreting costs through NIHCIS, NHS Glasgow and Clyde, and NHS Grampian, respectively. Translation costs are also considered. The NIHCIS has a central budget of roughly £3million per year for face-to-face interpreting and the administration of the service. This is the yearly budget for face-to-face interpreting for all of Northern Ireland (UK Inf 7). NHS Glasgow and Clyde has similar budget figures and this institution spends £2.9 million per year on spoken language interpreting and £250,000 on British Sign Language Interpreting. NHS Glasgow and Clyde also uses a mix of agency and in-house professionals for translation services. This translation contract is through an agency and is coordinated in conjunction with the metropolitan police. The charge is £35 per page. However, for shorter documents and letters it is more cost effective for this institution to rely on in-house interpreters who also hold translation qualifications. When these in-house interpreters translate they bill at £20 per hour. On translation projects there is collaboration with other institutions to pool resources, but there is not a completely centralised department that handles and coordinates translation at the regional or national level (UK Inf 8). For telephone interpreting NHS Grampian spent £55,084, on this service in 2014. This was billed at 70 pence per minute but this rate is now 68 pence per minute for 2015. In 2014 the average length of a telephone interpreting call was 14.7 minutes. For NHS Grampian, telephone interpreting is not meant to replace face-to-face interpreting but is rather a cost effective supplement (UK Inf 9).

It must be noted that foreign patients are seen by some hospitals as a source of income. For example, the agenda of an upcoming event sponsored by Policy-UK and European Hospital and Healthcare Federation titled "Health tourism – the challenges for European cross-border access, data handling and the NHS" (Central London- Thursday 29th October 2015) mentions that the Great Ormond Street hospital alone generates £20 million from foreign patients. "The delegates at this conference will also have time to discuss the opportunities for the NHS to take advantage of the global mobility of patients from the EU and beyond to generate additional revenue streams as well as examining the potential impact of funding overseas treatments to efficiency and costs" (http://www.policy-uk.com/event/1767/Patients_’rights_and_fair_access_The_way_ahead_for_cross-border_EU_healthcare).

4.2 SOCIAL COST (COST OF FAILED SOCIAL AND ECONOMIC INTEGRATION)³⁴

Before discussing social cost, it is important to remind the reader that results presented in this section (as well as in the rest of the report) refer to language provision in general, i.e. beyond the cases observed in the context of the Directive. Specifically, when we inquired about cost of language provision in the five MSs, the

³⁴ As per footnote 1 on page 1, It should be noted that the cost of social integration is discussed through examples of consequences to patients, healthcare institutions and providers resulting from omission/provision of (un)necessary care, treatments or mistakes. These examples are relevant because of the associated cost to patients' suffering, and in more extreme cases, death. Additionally, there is both a real and legal cost to the healthcare institution. These are important to consider even though it is not the intention of this research team to put a monetary value on such events.

responses received repeatedly stressed that: 1) when discussing language provision, neither informants nor sites in any of the five MSs distinguish between EU and non-EU patients. They care for all their patients and, if/when they provide language services they, once again, do not discriminate between EU and non-EU languages; and 2) the number of cases of patients seeking healthcare under the Directive is too limited to allow for any meaningful discussion or conclusion.

When EU migrants go to another Member State for different reasons and periods of time, (temporary work, study, medical treatment), they integrate within the new MS with various degrees of success. During that transition, they may request some help. When they go to a healthcare centre, such help takes the form of language support.

The social costs of integration are high, not only for the hosting MS, but, most importantly for the EU migrant. Moving implies leaving behind family members, the learning of other language(s) and culture. These are reported (Directorate-General for Employment and Social Affairs, 2010 Special Eurobarometer) as the main discouraging factors. Moving to another MS is not easy, and, with the exception of currency exchange, it involves the same difficulties as moving outside the EU. Planning to leave requires a lot of preparation and time (searching for and getting a job is time consuming and challenging, and so is making the necessary plan to move the family and looking for schools plus breaking with friends and family). Healthcare is a service new residents use and therefore healthcare institutions are involved in the integration process. Language services can link the institution with the community and foster integration, yet many institutions ignore integration and prioritize saving on cost. For cross-border patients in the EU, the “human” cost is, perhaps, not always so tragic, as their stay is limited and they are not focused on integration into the MS of treatment. Nevertheless, even for these cross-border patients the theme of EU integration is relevant.

Adapting to a new culture and learning a new language is reported as something especially difficult for older people and for those with low levels of education. While 52% of Europeans expect that a lack of language skills will be a difficulty they encounter, for 19% learning a new language is a real disincentive (Directorate-General for Employment and Social Affairs, 2010 Special Eurobarometer 337:111), 26% of those who intend to move abroad have learned a new language and 18% say they want to improve their skills in the language of that country (Directorate-General for Employment and Social Affairs Special Eurobarometer 337:8).

Examples of social cost due to non-provision resulting from case law, published study results and our fieldwork.

In the absence of case law that links the Directive to language provision we discuss specific, contextual examples of cases reported by informants. These examples are relevant to cross-border healthcare and language provision (or lack thereof). Additionally, there are examples of complications that occur when language support is not provided. We have collected these through interviews and studies from other regions of the world.

Difficulties in communicating with healthcare providers, or mistakes resulting from lack of language provision or provision of dubious quality could have unforeseen consequences over human lives. While it is beyond the scope of this work to assign a numerical value to human life, human tragedies have been reported (within and outside the EU) that highlight the importance of quality language provision and show the impact of substandard translation and/or interpreting services. One example

comes from France, a MS that is not part of our study. It is discussed here because it illustrates both social (human) and financial cost incurred as a result of poor decision-making.

Based on a statement of the IGAS (General Inspectorate of Social Affairs- *Inspection générale des affaires sociales*), twenty-three patients treated with radiotherapy for prostate cancer at the hospital Jean Monnet, Epinal between 6 May 2004 and 1 August 2005, received an overdose of therapy. As a result, four died. Ten, at the time of the statement had "a severe complication" and nine underwent a "moderate improvement". Antoine Perrin, Director of the Regional Agency of hospitalization (ARH) of Lorraine, explained at a press conference that the error occurred due to an incorrect interpretation of software instructions written in English (Toviraaj, 2007).

Another example (from a non-EU area) is what happened as a consequence of a mistake by a "Spanish-speaking interpreter".

According to the suit filed in Multnomah County Circuit Court (in Portland, Oregon, United States of America) "a \$3 million wrongful death lawsuit accuses a 9-1-1 (Emergency Toll-Free number) Spanish-language interpreter of botching the translation of an address and sending an ambulance to the wrong location as a 25-year-old woman was gasping for air (The correct address given in Spanish: "2601 111th Avenue" was relayed by the interpreter to the dispatcher as "2600 101st Avenue.)." A total of 26 minutes ticked by as medics raced around searching for the woman in distress, received the correct address and arrived to find Elidiana Valdez-Lemus unconscious from cardiac arrest. She had not taken a breath in the previous 14 minutes, and doctors declared her brain dead. Three days later, she died after her family made the decision to take her off of life support." (Green, 2014).

In contrast and going back to the EU, during our fieldwork we found one example of timely successful problem solving in a similar emergency call centre. This case did not turn into an emergency thanks to a language provider being present at the call centre when the call was received.

A Romanian-Spanish interpreter working in the Madrid centre (ES Inf 15) recalled the following during our interview: " One person called 061 (toll free number for ambulance in Spain at the time, now 112) asking urgently for an ambulance for a pregnant woman on the verge of giving birth. The ambulance got the wrong address and could not find the place where the woman was located. When the ambulance arrived at the right place, it was a Roma camp... they reported nobody spoke Spanish there, only Romanian. And, right then and there the operator at the emergency call centre was connected to a Romanian interpreter (our informant), who was on duty and could help find the Roma pregnant woman just in time for delivery (ES Inf 15).

The following examples collected from Valencia and La Costa Blanca also illustrate the real or potential social cost of misunderstanding due to language and culture that could have had serious consequences. The first comes from an interview conducted in a private hospital in Spain (ES Site 5).

A German-speaking patient who was about to be released from hospital wanted to get a newspaper before leaving. He was told that in order to leave the floor and unit he was in, he had to dress in his clothes (rather than the hospital gown). He did so. He went downstairs and could not find the newspaper stall. He went to the information desk and asked in German where the newspaper stand was located. At that precise moment, the desk was expecting (another) German-speaking patient who was coming to check in for surgery. The receptionists in the area did not speak German or English and there was no provision for language services (e.g. remote, telephone, etc.) in place. At the reception area it was assumed that the person looking for a newspaper was the patient who was going in for surgery and they sent him to the pre-surgical office. Not knowing what was going on, the to-be-released German patient became anxious and increasingly scared as he realized he could not explain that he was not to be operated on... he finally fainted (ES Inf 11). Fortunately he recovered with no consequences.

When discussing issues or cases that involved language (due for example to lack of language provision) with physicians in Germany, one senior chief of staff (DE Inf3) referred to cases involving informed consent. He pointed to a specific case from many years ago involving an informed consent that was not properly handled because the patient did not speak German. In Germany, the interviewee explained, it is the obligation of the physician and the lawyer to provide informed consent to the patient in a language that is understandable to the patient. Fortunately, this case did not have major consequences. This was verified in our interviews with a senior member of a law firm specialising in healthcare. In his 30 years of practicing law, the interviewee (DE Inf 4) was not aware of any case law of medical mala praxis or issues related to language provision or lack thereof.

In one NGO in Santiago de Compostela, we interviewed a patient, a pregnant German woman who had lived in Spain for over a year. She was with her (Chilean) partner. In English she explained to us that for over six months, before she had met her partner, she had been without care because she could not access information. Here is her story:

She was born to German parents in the United States and she was considered a tourist in Spain. She came from Germany to live in Vigo and had cancelled her health insurance in Germany. She never registered in a Municipal office in Vigo. She did not know that, in Spain, registering is the first step to being able to request the card and access healthcare. She further explained that she fell between two categories: EU citizen and tourist in Spain. She needed to show cancellation of insurance from Germany and to do so she had to translate a German document into Spanish with the help of her partner. She then became pregnant and the couple, wanting to access pre-natal care, started going to the hospital and the clinic together so that the Chilean partner could interpret and advocate for her. She was told she would receive care because she was pregnant (not because she was an EU citizen) and as a pregnant woman she fell into a vulnerable category and would not be refused care. To receive care she had to go with her partner to every appointment because she wanted to ask questions and understand the procedures and the providers did not speak German or English. Her partner had to miss work to accompany her. One day a social worker who spoke little English directed her to an NGO. The NGO met with her and her partner. At the NGO a volunteer who spoke some English helped her through the registration process and the paperwork. She has now almost completed the paperwork for the Spanish health card. It took over 6 months and three people's time. Her partner still has to come to appointments with her because there are no interpreters.

Another example of the loss of time and resources that occurs when professional language services (core services) are not provided comes from the manager of one of the main telephone interpreting services in Spain.

The interviewee (ES Inf 20) discussed an error in the translation of a term made by an operator of 061 Emergency Service (SUMA) who took a call in English about a woman who had passed **out** (“desmayada”) and interpreted this as passed **away** (“muerta”). This report of a death triggered the arrival of the police and the forensic doctor at the hotel lobby from which the call was made. Upon arrival they realized their services were not needed because the person had recovered (ES Inf 20).

Although there has not been any case law, language access or other, concerning the Directive in the UK, the National Health Service (NHS) is already aware of possible lawsuits stemming from the Directive that will challenge how healthcare is delivered in the UK. This scenario results from a contradiction arising from the Directive. In the UK citizens cannot seek private care and expect to be reimbursed by the publically funded NHS. Yet under the Directive patients can seek private care overseas and return home to be reimbursed by the publically funded NHS. NHS institutions are anticipating that this discrepancy will be challenged in court and that patients will want to seek reimbursed private care at home in the UK (UK Inf 18 and UK Inf 19).

During interviews, NGO managers expressed surprise at the fact that language access in healthcare has yet to result in significant case law since there are many instances where patients have received inferior care because of the lack of an ability to communicate (UK Inf 10). Interviewees addressed the issue of social cost by saying there is a social cost for failing to provide language services since residents will not equally be able to access healthcare. Furthermore, there is an increased cost in overall service since patients who are unable to communicate do not understand their diagnosis and treatments and are more likely to need to return to seek care more frequently (UK Inf 7). Although there is no case law that links inferior treatment and poor healthcare outcomes to the lack of language services yet³⁵, healthcare professionals who work in this field are able to share their experiences of patients who received grossly inferior care due to lack of translation and interpreting services and an inability to communicate.

One professional interviewed in the UK (UK Inf 10) cited an example that illustrates the consequences when T&I services are not made available.

³⁵ There is case law in other areas of the world (e.g. US) and there is evidence in research from Canada, Australia and US that show the connection between poor outcomes or sub-standard quality of treatment and lack of professional language provision. In addition, we should bear in mind that, when confronting human loss or tragic outcomes, patients and/or family members are in a vulnerable position. Concerned with pressing issues and assessing alternatives or working through their grief may take priority to pursuing legal actions against healthcare providers. They sometimes chose resignation to action. Their choices and responses may change over time.

In this case the patient who could not speak English was diagnosed with tuberculosis. Language services were not available and the patient became very angry during the appointment. It was later found out that he became angry because he was trying to convey to doctors that he had received a prior diagnosis for lung cancer in his country of origin. This patient did not receive the necessary care and died.

The council took control of the body, performed an autopsy, cremated the body, and informed his family. The autopsy showed that this person died from untreated lung cancer. The family of the patient did not pursue legal action.

Another example of problems arising from a lack of language support is the case of a patient who was going to receive treatment for pancreatic cancer.

This patient underwent a pre-assessment with language support where he learned that he had had his gall bladder removed. This gall bladder operation was performed previously and at that time no translation or interpreting service was available to him. At that time he signed a consent form for this procedure, had his gall bladder removed and never understood that it had happened (UK Inf 12).

Cases like these illustrate the fact that there are serious health implications for patients who are unable to access language services. Professionals who work in healthcare interpreting or translating underscore that incidents like these are relatively frequent and are not isolated cases (UK Informants 10, 11 and 12). What becomes clear from these examples is that there is a real cost in terms of health outcomes. Additionally, there is the potential cost of litigation. This is an important consideration when providing translation and interpreting services. In one of our informants' words: "One settlement for inferior care due to the lack of language services has a greater potential cost than the yearly budget for providing such services" (UK Inf 10).

Language services are often viewed with scepticism because of the real and alleged costs that are associated with providing them. Gan (2012) reports on the budgetary concerns that come when translation and interpreting services are increasingly sought by patients. However, one must look at the size of such costs and budgets without being overwhelmed by increases in service requests. An analysis of the cost of service should not be limited to seeing only the growth in service requests, but rather should consider cost in relation to its true size in the health budget and the contributions such a service makes to social integration. In the case of NIHSCIS it is important to consider that interpreted health appointments still only represent roughly 1% of all healthcare appointments in the region (UK Inf 7). Thus, while this institution reports exponential growth in the requests for interpreters (see Figure 2 in section 3), such appointments are still only a small fraction of all health appointments. Additionally, the £3 million annual budget for NIHSCIS is equal to the estimated cost of running one health trust in Northern Ireland, Belfast HSC, for one day (Belfast Health and Social Care Trust, 2015). This £3 million budget for professional interpreting services can also be seen as an important investment when it is compared to the potential costs of settling lawsuits that could arise in the event of not providing language services. An informed perspective also sees this budget as an investment in greater efficiency and better health outcomes. Importantly, it was reported that initial costs are recouped in the medium to long term (UK Inf 7). Likewise, this perspective recognises that offering professional language services is in alignment with Equality legislation and promotes the broader goals of equality and social inclusion.

Other issues to consider when considering costs

It is appropriate to mention a related issue that may be considered part of either the economic or the social cost (depending on the consequences) or of both. It is the cost that results from the risk and inefficiency in communication when English becomes the *de facto* lingua franca (Seidelhofer 2009). Although several interviewees consider that "language is never central", "it is not so important", or that "it is more difficult to follow a patient through an interpreter", "we always manage with English" and "we all read English", in essence, interviewees from public or private healthcare providers, to policy makers attending EU-level conferences or talking to other MSs NCPs, NGO representatives, doctors and nurses, when asked about language proficiency and not speaking their own language, have all stated that one cannot express oneself in the same way in another language, that one is never certain of what one is saying or understanding and that one loses a lot of nuances when using English as a second/third language.

Not paying attention to language, pretending language is not important, or reducing communication to some improvised and not-shared set of gestures and drawings, or an unedited output of machine translation at the cost of running an unnecessary risk is not efficient. And, it is certainly neither responsible nor ethical, especially if a human life could be endangered. This risk can have economic consequences, for example, from the cost of inefficiency incurred when using ad-hoc volunteers or unreliable software instead of professionals to translate documents-only to find out that they are not comprehensible and have to be re-done- to the unrecoverable loss of human lives as we have seen in Epinal.

Another inefficiency observed (ES Site 6) is when doctors use ad-hoc interpreters as their "peers" to ask questions they, themselves should ask from the patients (e.g. while observing a Russian patient undergoing an EKG, the interpreter was asked to observe body language in case she could perceive fatigue). This issue has been repeatedly reported in research (See Section 0.2 p.4). In addition, the other side of the coin of this inefficient way of working with language service providers is when doctors treat interpreters as bilingual machines to which they give instructions: "just translate" ... "the interpreter is not a doctor... just translate". Inefficiency when working with interpreters has cost implications, as does inefficiency when working with CA Tools or machine translation.

Consequently, when considering the cost of language provision in healthcare, the economic and social cost of not providing it should also be considered. The use of professional translators and interpreters in healthcare requires institutions to budget for these services. These services, like all other services related to healthcare, can be cost-effective. As our previous section on language provision illustrates, in most of the sites visited during this study a choice was made not to offer professional language service. In these cases, the economic costs of non-provision, in terms of inefficiency, misdiagnosis, potential litigation, return visits and subsequent treatments due to misunderstandings are overlooked. The potential social and human costs of poor health outcomes, unequal access to services and postponed or failed integration are also overlooked. These are examples of questionable risk-management strategies. They also reflect questionable ethics and social responsibility. In many cases current practices are in direct contradiction with the EU project of social integration and equal access and could potentially put the implementation of the Directive at risk, unless language provision is dealt with appropriately.

There are examples of institutions that provide professional language services (including translation, interpreting, appropriate use of software and language mediation) and these institutions consider that the long-term cost of not providing language services is higher than the cost of providing them. In the next section on good practices we discuss how institutions provide language services, what strategies they use to offer them while, at the same time, minimizing costs. We also report on other examples of best practices we encountered in our study.

SECTION 5: GOOD PRACTICES IN BILINGUAL SERVICES AND THE PROVISION OF LANGUAGE SUPPORT

This section presents the different practices reported in Questionnaire 2 (Q2) and observed during fieldwork. The scope, quality and provision of service vary across the Member States (MSs) of the study. There are three sub-sections. Sub-section 5.1 discusses good practices reported and observed for the provision of translation and interpreting services. This includes a discussion on perceptions of efficient service models as reported in Q2 as well as on the ones observed during fieldwork. Sub-section 5.2 discusses good practices for the administration of service by showing efficient procedures used to respond to the needs of linguistically diverse communities. Lastly, sub-section 5.3 concludes with a discussion on legislation and its relevance to language services in healthcare. Legislation that requires language services in healthcare compels institutions to respond with formal solutions.

5.1. GOOD PRACTICES FOR THE PROVISION OF TRANSLATION AND INTERPRETING SERVICES

Various items in Questionnaire 2 (see Annex 2) targeted information regarding good practices. The majority of respondents (51%) do not know who provides language support. Of the remaining 49%, 20% report that hospitals only use private sector agencies, 14% a combination of volunteer services as well as private sector and 15% paid-full-time staff as well as private sector agencies. Figure 5 below shows the breakdown of who provides language services per MS.

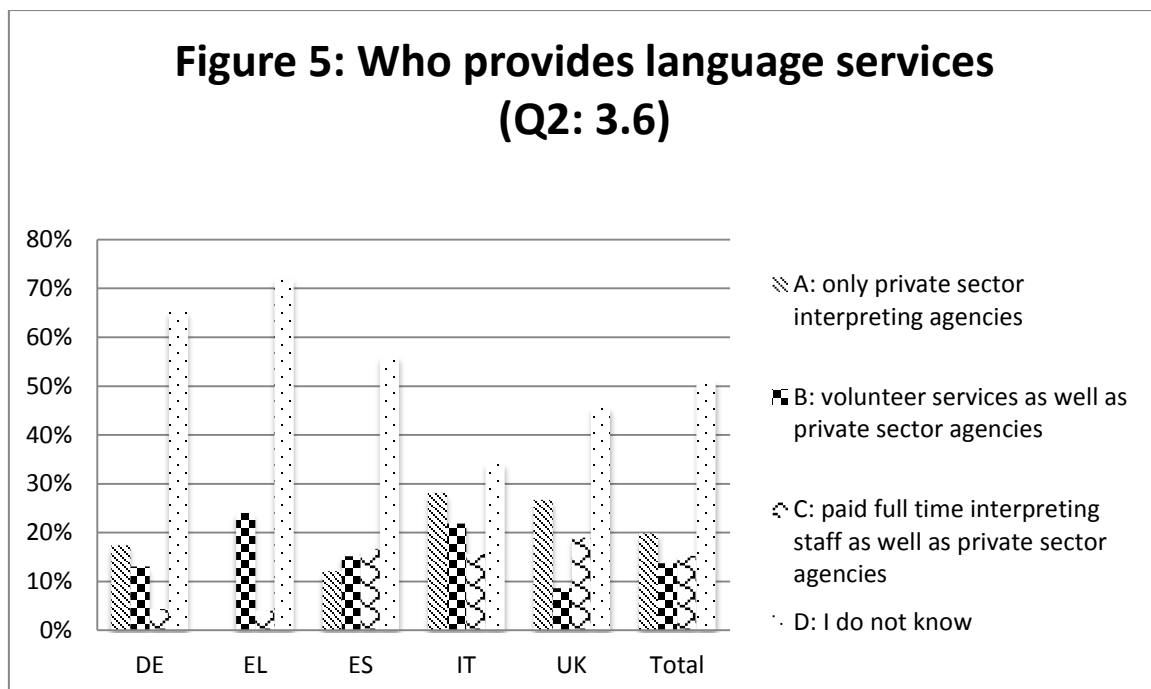


Figure 5: Who provides language services (Q2: 3.6)

Twenty-eight per cent of respondents from all MSs report no instances in which healthcare organizations with whom they work have used ad-hoc parties (family members including children and staff not hired to perform T/I). While this percentage,

though small, is worth noting in a report of good practices, 72% of respondents report the contrary. The breakdown per MS can be seen in Figure 6 below.

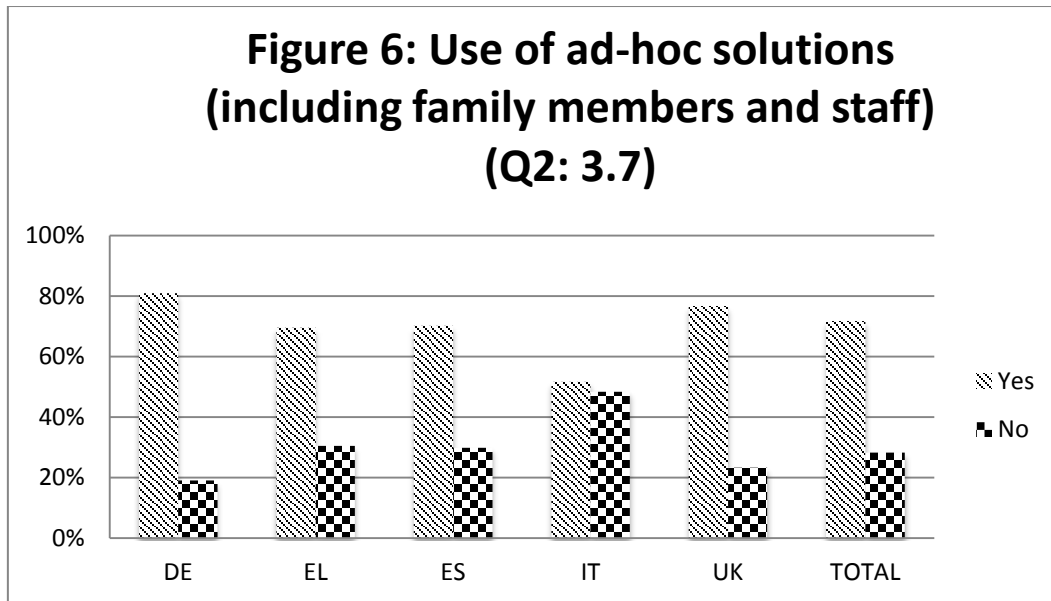


Figure 6: Use of ad-hoc solutions (including family members and staff) (Q2: 3.7)

Respondents were asked to rate the system used in their area to provide language services to linguistically diverse patients. Fifty-seven per cent rate them between highly effective and adequate. Figure 7 below shows the breakdown per MS.

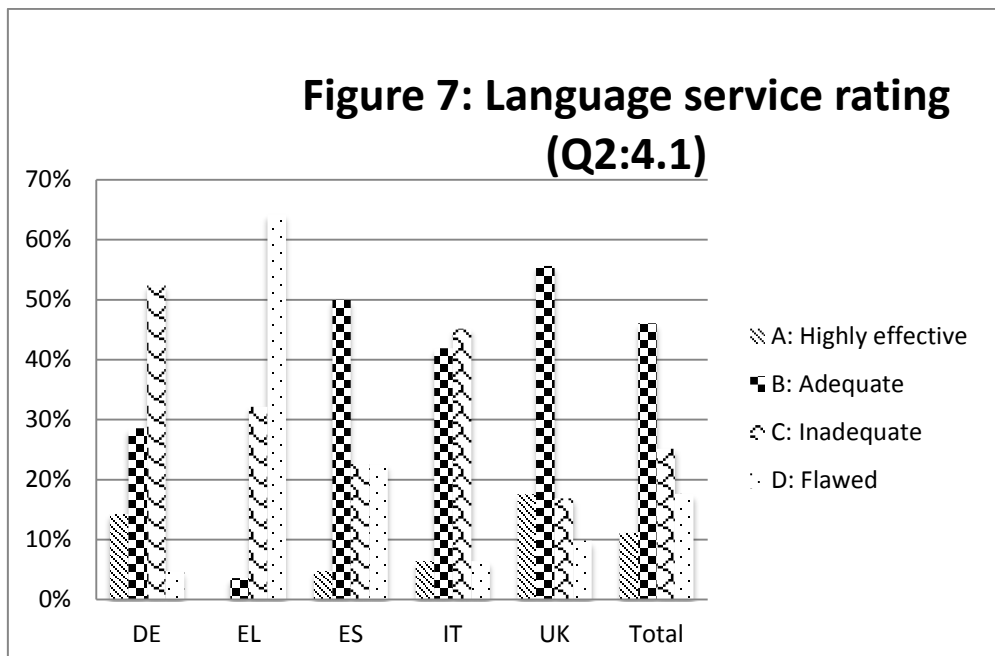


Figure 7: Language service rating (Q2: 4.1)

In addition, 23% of respondents consider there are sufficient translated resources to inform patients in their workplace and 13% stated there is no need for clearer standards/practices to ensure that hospitals seek language provision.

5.1.1 Translation

There are several examples of efficient delivery of professional translation services observed in the course of conducting fieldwork. One good practice for translation that is in place at the EU level is the availability of information across languages. During the course of the investigation documents from EUR-Lex and online EU bookshop were consulted (EUR-Lex, 2015; EU Bookshop, 2015). These two websites provide information on EU legislation and policy, and the information is made available in the different languages of the EU. The Directive³⁶ itself is translated into the languages of the Member States, as is important information on citizens' rights. This good practice has important implications for the NCPs and the provision of information for cross-border healthcare. Although the NCPs may offer information in different languages, and many times in English, there is not a shared list of cross-border healthcare publications and translations between the MSs.³⁷

The translation of consent forms and information sheets in Germany is another example of a good practice. The delivery of these translations occurs through a formal process. Providers can access both consent forms and information sheets through a centralised database that stores these in a multitude of languages. The translation of these documents was performed by a professional agency. Through the database providers can access and print these forms on demand. This is efficient because such forms are available upon request and do not need to be pre-ordered. This database is also a good example of how institutions can efficiently share resources. It eliminates repetitious work on the part of individual institutions and reduces cost since they only have to pay for each use of the translation plus printing costs. Each institution does not have to pay for the translation to be performed each time, only for the right to use it. It is through these forms that German providers can obtain consent in a language that the patients understand, as required by German legislation. These translations allow providers to obtain informed consent and comply with the law.

In Spain, an observed good practice is the availability of bilingual consent forms and information sheets for some regional languages. This was observed in hospitals and clinics in Galicia and Valencia where regional languages are spoken. These forms and information sheets are evidence of sound practices of language policy and planning on the part of institutions. As a result, translations are available in national and regional languages. Through these, speakers of regional languages can equally access all national services. It is a formal recognition by the institution of the importance of language access.

In the UK NHS Lothian provides translation of medical records and documents for foreign patients who receive emergency treatment (UK Inf 20). For example, if a tourist needed emergency treatment for a broken leg, this patient would receive a translation of the medical record of their treatment and subsequent documents. The institution pays for the cost of these translations, considering this practice as necessary for patient safety and continuity of care. This is a good practice because it ensures health protection for patients. This was not reported to be the case across the UK and there is no standard policy for all institutions throughout the UK.

NGOs also play an important role in providing translated information to patients. In all the NGOs visited (EL Sites 6 and 36, ES Sites 4 and 14, DE Site 6) we have observed

³⁶ See Article 14 of the Directive and online services: <https://ec.europa.eu/digital-agenda/en/eu-policy-ehealth> <https://ec.europa.eu/digital-agenda/en/news/eu-takes-major-step-improve-cross-border-care>

³⁷ See Article 10(1) of Directive 2011/24/EU. It calls on Member States to cooperate, especially between their NCPs in accordance with article 6, including mutual assistance to clarify the content of invoices.

health guides, information sheets, brochures about preventive care in the languages most frequently used in the area. When we inquired about the cost of the translation and printing, the interviewees (DE Inf 6, EL Informants 10 and 11, ES Informants 4, 26 and 27) discussed their collaboration with universities providing the translations (via service-learning courses and internships) and raising funds for other costs (such as printing, etc.) This good practice allows for access to information.

Lastly, the Internal Market Information System (known as IMI, at the NCP level) is an EU platform that allows for exchange of information using pre-translated questions and answers (See Section 3³⁸). It has proved to be extremely useful to some of the participating NCPs. It facilitates information exchanges on topics such as prescriptions, doctors, clinics, etc. NCP users can ask questions in their own language and receive the information requested from the platform in their own language. It is multilingual and works with all EU languages. In addition, one can use a free text box to immediately obtain a machine-translated version of the source text entered. It has no IT cost for MSs.

5.1.2 Interpreting and bilingual service

In Italy healthcare institutions are working to better accommodate linguistically diverse patients. These institutions have recognised that there is a need to help linguistically and culturally diverse people who are not familiar with the Italian healthcare system. They have responded to this need with the figure of intercultural mediators. These mediators are often hired on the basis of their bilingualism and familiarity with the culture of origin of the patient, rather than on their formal education on cross-cultural communication or related field or certification in translation and interpreting. Institutions turn to intercultural mediators in order to link the institution to the linguistically diverse community and the bilingual ability of intercultural mediators is perceived as a solution. It is often the case that the nature of their work is to broker communication, i.e. to perform translation and interpreting tasks. Further professionalization and accreditation are needed so that the proper role of intercultural mediators is understood. It should not be assumed that they are competent in translation and interpreting. The creation of this figure, while important and helpful, is not the only solution to the language needs of patients. They can speak the same language as the patients and they have knowledge of the local healthcare system. Sometimes they have some T&I education, but not always. Thus their knowledge of translation/interpreting skills has not always been measured. The practice of cultural/language mediation is highlighted because it shows that institutions are putting forth effort and responding in order to better familiarize patients with how care is provided. The mediator position is important because it allows for culturally sensitive care and builds trust between the community and the institution. The screening for their credentials and quality control of their work are not yet in place. The intercultural mediator is a step in the right direction toward acquainting the patient with the procedural aspects of healthcare in a MS that is not their own. This is essential when one considers the anxiety and fear that a patient who does not speak Italian, for example, may face when they seek care in a system that they do not understand.

There are examples of good practices in both telephone and videoconference interpreting in various MSs. In the UK the cost of providing language service is an important consideration for institutions and telephone interpreting is seen as a viable option. When considering the use of telephone interpreting, managers for Equality and

³⁸ http://ec.europa.eu/internal_market/imi-net/about/index_en.htm

Diversity or translation and interpreting services have reported savings on the cost of service. They have also reported that this push for telephone interpreting must be within the framework of equal access. In other words, guaranteeing access and patient protection does not depend on savings and cutting costs. Patient access and protection have priority. Administrators and managers also report that face-to-face interpreting has a fundamental role in healthcare communication and that telephone interpreting is a best option for certain types of encounters which are administrative or simple in nature (UK Informants 7, 9 and 20). Telephone interpreting clearly has an important role: it is a cost effective option for less commonly used languages, and can be used during off-peak hours, but it cannot completely replace face-to-face interpreting. Neither can it be provided without the appropriate quality control mechanisms including, and not limited to, the hiring of professional interpreters, the training of providers to communicate through the telephone and compensate for the lack of visual cues available to the remote interpreter.

In both Greece and the UK there are good practices involving videoconference interpreting. In Greece an observed/reported good practice was the availability of videoconference interpreting in private clinics (EL Inf 7). These private clinics that serve patients who do not speak Greek respond to the needs of patients by providing videoconference interpreting. For these clinics it is a necessary investment to ensure patient communication and safety. This is also a service meant to indicate quality and attracts foreign patients. In the UK both private and public institutions provide service using videoconference interpreting. Unlike Greece, videoconference interpreting in the UK is designed to meet the needs of the local population. This option is particularly useful for providing service to rural regions where face-to-face interpreters cannot travel easily. It allows for a balance between considerations of quality and cost. UK institutions such as NHS Grampian have invested in videoconference technology to provide this service.

For face-to-face interpreting the use of an in-house professional language service is a good practice. Numerous institutions in the UK have opted to create and manage their own in-house professional language service. In these cases, the institution itself becomes its own provider for the majority of its language needs and less frequent language combinations are still outsourced to an agency service through contract. The institution takes the responsibility for hiring and employing interpreters that meet minimum qualification standards as defined in policy. These interpreters often also hold translation qualifications and the institution can also remunerate them for performing professional translations. Institutions with in-house professional models offer training and professional development for healthcare interpreting to ensure quality. This type of in-house service allows the institution to meet its own language needs through the use of face-to-face interpreters. The institution is also able to monitor quality and cost directly. This strategy is a formal recognition by the institution of the importance of language services in healthcare.

Lastly, the availability of bilingual service in Spain should be noted. In Galicia and Valencia providers are able to attend to patients in both Spanish and the regional language to ensure effective communication. Through the use of bilingual professionals these institutions are able to provide service to speakers of regional languages and ensure equal access. The use of regional languages in healthcare institutions is linked to legislation. The protection for regional languages in legislation promotes its use in the formal context of healthcare institutions. This is a practice worth mentioning as it highlights the importance of having language rights embedded in legislation. There is, however, no norm for the entire country and bilingual providers in the different regional languages are not available throughout the whole country either. Therefore, if these speakers left their region their accessibility to cross-

linguistic healthcare would be less clear. The regional model of availability could be applied to the country as a whole where bilingualism would be valued among medical professionals and institutions would strive to offer services in the different regional languages of Spain.

5.2 ADMINISTRATION

In the UK professional language services are readily available in the healthcare setting. Healthcare organizations have implemented various good practices to provide these services. These practices eliminate inefficiencies and streamline services.

One example of good practice is the use of video screens at the reception desk that have greetings and check-in instructions available in many different languages. To serve an extremely diverse population, institutions in the UK such as (UK Sites 5 and 15) have introduced video screens with the flags of different countries on them. Patients can identify their language upon arrival, check in with their language and request an interpreter to communicate. This administrative solution eliminates inefficiency and miscommunication between reception and the linguistically diverse patients they serve.

A second administrative good practice is the existence of an automated booking system used by NIHCIS. The use of an automated booking system for interpreters was observed to have considerable potential for savings on the cost of administering the service. Such a system is in the final development phases at NIHCIS. This automated online booking system eliminates unnecessary paperwork and labour through the use of computer technology. The programme in development will eliminate manual data entry for the processing of interpreter requests and for payroll tracking and processing. In both cases, onerous paperwork and emails will be eliminated. Administrators will no longer have to manually schedule and confirm appointments and payment for interpreters since the system will automatically do this. Additionally, the system has also been designed for health professionals to book either face-to-face interpreters or telephone interpreters in accordance with the criteria from the code of practice. Before making their selection they consult the criteria that can guide their choice. Thus, health professionals will be able to better elect what type of interpreting to use depending on the type of appointment they have scheduled. This has potential cost-saving and quality implications. Health professionals can balance cost with quality and make an appropriate choice of the type of interpreting service that is needed. Additionally, the programme has been designed to select interpreters according to specified criteria so that the most appropriate interpreter for a given appointment will be scheduled. This allows for culturally sensitive care that promotes trust.

Another good practice currently in use in the United Kingdom is the existence, at the institutional or regional level, of a centralised budget for translation and interpreting services. This budget is specifically earmarked for language services. It was reported that individual departments within a health institution are less likely to seek professional T&I services if the cost of such services is deducted directly from their departmental budget. Conversely, when there is a centralised budget specifically for such services, individual departments are more likely to seek professional services instead of relying on ad hoc interpreting (UK Inf 7 and 20). Currently Equality and Diversity teams are building awareness of the budget structure within institutions so as to promote the use of professional T&I service and ensure equal access. These

budgets for language services are also seen as an investment that is recouped in the medium to long-term through greater efficiency and improved service.

Lastly another example of good practice in administration is the national directory of the Chartered Institute of Linguists which provides “users of language services and employers with access to a comprehensive, verified and up-to-date source of qualified, practising and experienced professional linguists with a demonstrated commitment to Continuing Professional Development (CPD)” (ciol.org.uk). It guarantees quality of service and it is available nationally.

5.3 LEGISLATION

The most salient *best practice* for the provision of language services (e.g. translation and interpreting) to linguistically diverse patients of healthcare (cross-border or otherwise) is their inclusion into legislation so that they become mandatory. In Germany legislation requires that providers obtain consent from patients in a language they understand. A formal solution (discussed above) is in place and translations of consent forms and information sheets are available for providers to print on demand.

In both Italy and Spain there is legislation that protects the use of regional languages. Speakers of regional languages enjoy recognition of their language and can access services in their language. The use of regional languages is considered a recognised right and patients can access information in these languages and use it to access services. In the United Kingdom Equality legislation is linked to race and ethnicity. Thus, legislation protects speakers of non-societal languages from discrimination. In the UK language is considered to be an essential component of race and ethnicity. Not providing language services is considered to be a form of racial discrimination that impedes the person's right to fully access public services to which he/she is entitled. This is discriminatory practice that can be sanctioned under law. This Equality legislation compels UK institutions to respond with equality schemes, policy guidance and provide language services.

All of these examples of legislation can be considered *best practices*. In each case the legislation in place requires a response. These responses are formal and professional in nature so that the healthcare institutions are in compliance with the law. Legislation is an example of a *practice* because it requires formal solutions rendering ad hoc ones non-compliant.

SECTION 6: CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

This study has examined language provision in cross-border healthcare communication. It has problematized the nature, cost, provision and legal status of language services such as translation and interpreting. In so doing, we have studied legislation and observed and interviewed various levels of stakeholders, such as policy makers, NGOs, language-service providers (freelancers and companies), language company directors and administrators, healthcare providers and administrators working in the public and private sector, patients and family members. As a multi-level study of the role that language provision plays in cross-border healthcare this research is framed with the understanding that 1) in the provision and administration of healthcare services, human communication (which includes paralinguistic elements such as language nuances, gestures, gaze, body language, tone, to name just a few) is essential and 2) human beings communicate through the use of language (written, spoken or sign).

Language diversity and the need to access information accurately and reliably are facts among patients, providers and administrators. Thus, in the absence of a common language, professional language provision is central not only to cross-border healthcare, but to communication in healthcare in general (as well as in all other areas of public services) in every MS of the EU. Language is not a problem or a barrier, in the same way that ethnicity, race, gender variation, religion or age is not considered as a problem or a barrier. Language diversity is a fact in all MSs. Professional language providers can facilitate communication across languages. This is also a fact. Although professional language provision is not consistently used across the MSs of this study, it is key to meeting the communicative needs of patients, providers and administrators in cross-border healthcare in the EU. Its use enables confidential, complete and reliable communication which, in turn, ensures equal access to safe, high quality cross-border healthcare, thereby guaranteeing a high level of human health protection as stated in the Directive.

Using a variety of data sources and conducting multiple analyses, this research traced language provision as perceived by stakeholders, as enacted *in situ* and as described by stakeholders in their own words. To explore the role of language provision in cross-border healthcare, the study resorted to two research paradigms (quantitative by collecting self-reported data in the form of questionnaires and qualitative by collecting documentary evidence as well as naturalistic data in the form of direct observations and interviews with observed informants to triangulate and interpret results) and combined analytic tools. These two paradigms strengthened and supported each other in such a way that the combination of both produced results that can portray how language provision occurs in the sites and can be contextualized appropriately.

Section 6 is divided into three sub-sections. Sub-section 1 discusses the conclusions that can be derived from the data collected in the study. It also addresses the study limitations. In 6.2 we discuss the implications of the results and in 6.3 we make empirically-based recommendations at different levels.

6.1 CONCLUSIONS OF THE STUDY

In the previous sections of this report we have discussed results emerging from the study of language provision from several perspectives and in detail. In Section 2 we presented its standing in EU, National and Regional legislation and problematized

languages to understand if they are an inherent right and/or an enabling condition. In Section 3 we discussed who provides language services, how and when that provision occurs. In Section 4 we provided information on the cost of language provision and in Section 5 we highlighted good practices found. When combined, results suggest the following:

- 1) European legislation in general, and Directive 2011/24/EU and Regulations specifically do not mandate language support for patients of cross-border healthcare. The Directive describes a series of patients' rights (the right to access clear information, to make a complaint, to sufficient and permanent access to a balanced range of high-quality treatment, to reimbursement of the costs of healthcare provided in another MS) but it does not explicitly mention the right of patients to access communication in a language they understand or cross-linguistically (via, for example, translation and/or interpreting). Nevertheless, the right to access communication appears to be a pre-requisite to exercise the rest of these rights. When the parties involved do not share a language, language support is needed to fulfil the requirements of the Directive (such as access to information and to safe and high quality cross-border healthcare in the Union).
- 2) Language support/provision for cross-border healthcare patients is neither guaranteed nor provided in an even manner across the MSs and sites observed in this study. This inconsistency could potentially endanger the spirit and objectives of Directive 2011/24/EU. It also calls into question the rights and protection of all EU citizens who may, in the course of their work, studies or travels, require medical assistance in a MS in which they do not understand the language well enough to communicate about a medical treatment/ emergency. It is worth noting that the lack of language support for the patients who receive care through the EHIC card is a more serious problem, since they do not go to another MS for pre-planned healthcare in the way that Directive patients do.
- 3) Except for the UK, language support/provision is not embedded in national legislation (exceptions being the protection of specific regional languages in Italy and Spain, and consent forms in Germany).

Among sites and participants there is an overwhelmingly generalized (95%) perception of English as a *lingua franca*. Participants voluntarily commented on this issue.

- 4) With the exception of UK informants, all others in this study (77.3%) share an assumption that patients, healthcare providers and administrators have enough English proficiency to understand technical written and verbal information. In their views communication equals managing or coping if one possesses some English language ability. It has also been noted that many stakeholders (at all levels) do not understand, read or speak English at all.
- 5) There is no consistent provision of translation for documents needed for cross-border healthcare (medical records, reimbursement, etc.). In almost all cases, in practice³⁹ the responsibility for the translation of all documents is placed on patients.
- 6) Except for the UK, language provision in the context of healthcare is not recognized as a core service and it is not a line item in the budget. With the

³⁹ See article 10(1) of Directive 2011/24/EU

exception of 4% of the sites visited in the remaining four MSs (public and private), the participating organizations simply do not offer language provision. They either resort to bilingual staff, volunteers or they expect patients to take care of their own language needs (by either bringing their documents translated or by bringing family members or friends to sight-translate and interpret for them).

- 7) Language provision is perceived as costly and not always essential (especially when compared to other medical needs such as supplies).
- 8) Healthcare providers' perceptions of confidentiality and privacy differ from those of T&I professionals and from those found in codes of ethics discussing language provision. Several healthcare providers (26.5%) prefer to have family members as language brokers because they are perceived as having more background information about the patient and, thus, knowing the patient better.
- 9) In three of the five MSs studied we identified two prevalent assumptions regarding language and culture: 1) that language and culture are not intertwined and can thus be separated; and 2) that translators and interpreters deal only with language ("the words"), not culture. Informants in some of these MSs advocate for intercultural mediators to fill this gap.
- 10) In the absence of formal language services, the health and safety of patients is put at risk. Informants reported cases from their personal experience and many such cases are also documented. This results in inefficiencies for the institution such as missed appointments, misdiagnosis, return visits, etc., and consequently in an increased cost over the medium and long term.

6.2 IMPLICATIONS

This section discusses the implications of the findings and conclusions of this study. Implications are both at the level of the EU and the MSs as well as in different areas (e.g. policy, budget, equality and access, non-discrimination and education). These different areas are discussed separately in this sub-section.

First and foremost, this project has implications for **policy and policy makers**. Legislation is one of the key elements that conditions the provision (or lack thereof) of quality language support in cross-border healthcare specifically and healthcare in multilingual Europe in general. At the EU level, while legislation has acknowledged a series of rights of EU patients, it has not taken into consideration the need for language support to exercise those rights. For example, Directive 2011/24/EU only mentions languages when specifying that the Directive "shall not affect laws and regulations in Member States on the use of languages" and that "Member States may choose to deliver information in other languages than those which are official languages in the Member State concerned" (article 4, section 5). It also makes a similar reference to language access in recital 48, where it states that "information should be provided by national contact points to patients in any of the official languages of the Member State in which the contact points are situated" and that "information may be provided in any other language", giving the NCPs of Member States the option, but not the obligation, to provide language support to cross-border patients. As data has shown, language service is not consistently provided across all

MSs and the Directive does not define responsibilities for the MSs. In the absence of formal policy there is the risk of **discrimination and unequal access**. Since not all EU patients/providers share a language (especially in cross-border situations), not taking into consideration language access calls into question if/how the rights of equal access to information or healthcare are to be effectively respected and implemented. Policy makers can address this potential or real discrimination by issuing policy and pushing for legislation that provides language support for linguistically diverse patients.

In regard to **budgets**, results from this project have implications for budget allocations and budget planning. Except for the UK, most budgets of observed public administrative bodies managing healthcare neither plan nor allocate funding for language support. In all the private clinics observed and in discussions with lawyers specializing in healthcare there is an increasing interest on the part of physician groups to attract patients from bordering Members States as well as from foreign countries (e.g. some areas of China and the Middle East). In addition, there is an increase in inquiries for cross-border healthcare as the Directive is opening new opportunities. Doctors and hospitals are eager to explore possibilities but language provision as a line item is only included in some (not all) private sites. These private sites recognize the importance of language services for patients and plan accordingly to provide them. While the initiative that private healthcare providers take to offer language services is important, they do not have criteria for hiring or monitoring its quality. This disregard for who provides the language service and for its quality has implications for the access, safety and quality of care. Healthcare organizations offering services to a linguistically diverse population should account for professional language provision. Budget allocations for language services would result in healthcare organizations being more efficient and effective in the delivery of healthcare to a multilingual population.

Results of our study have several implications for current conceptualizations of **language support** and the provision thereof. Improvised practices by ad hoc bilinguals or volunteers are neither an appropriate nor a reliable form of language support. In a multilingual mobile EU, allowing for the implementation of ad-hoc communicative solutions that may put at serious risk the life, health and rights of EU patients needs to be re-considered.

Thus, this work also has implications for the **education** of language-service providers. Volunteers, ad hoc translators or bilinguals acting as language providers in the field of cross-border healthcare (and Public Service Interpreting in general) may have neither education in translation and interpreting nor any specialised training in healthcare settings. When minimum quality standards cannot be guaranteed there may be implications for the protection of patients as well as serious consequences for their health and choices. In addition, ad hoc translators/interpreters may not have the same perception about their role and their work and responsibilities as professional language providers. Some believe they are part of the medical team. Others feel their work is not fully respected or acknowledged by healthcare staff. These differences in beliefs and behaviours may have undesirable implications for the patient-professional relationship and trust.

Additionally, results have implications for **healthcare providers (HCP), administrators and patients**. HCPs and administrators who assist linguistically and culturally diverse patients sometimes perceive a different language or a different culture as a barrier or a problem. Patients coming from a different cultural/linguistic background do not automatically pose a problem. There are differences in belief systems and cultural norms that affect the way in which both health and care are

perceived. These differences need to be known and addressed by HCPs and administrators when assisting linguistically diverse patients.

Additionally, the findings of the project have implications for **conceptualizations of equality, access and non-discrimination**. The main sources of information or contact for cross-border healthcare are websites and/or email addresses where patients can send their queries. This way of accessing information or contacting people could be problematic for the elderly, a sector of the population susceptible to apply for cross-border healthcare who may not have the digital skills to look for information or communicate with NCPs electronically. Besides, (translated) information on cross-border healthcare can only be accessed electronically. This mode of information delivery has at least three implications: 1) it creates a false expectation of computer literacy across sectors of the population; 2) using NCPs websites (in their current state) as a main (or only) channel of information delivery can be identified as problematic when/if these websites are not adequately adapted for disabled patients (e.g. sight impaired or blind patients) and when there is not the same amount of information given orally on an answering recorded device; and 3) across MSs, NCPs' websites do not present the same type and amount of information in the MS language and in their English translation.

6.3 RECOMMENDATIONS

This section provides several recommendations based on the findings and conclusions of the project. These recommendations aim to contribute to the enhancement of cross-border healthcare. They also align with guaranteeing EU citizens their right to access public services (beyond cross-border healthcare) in a multilingual and diverse environment such as the EU. They are categorized as follows:

Recommendations related to legislation on language provision and quality.

- Language support is essential to enable equal access to quality public services in general for EU citizens or public service providers (see, for example, Directive 2010/64). Therefore the EU should consider the inclusion of professional language provision in the legislation related to cross-border and mobile healthcare (i.e. regardless if care is sought under the Directive or the Regulations). The spirit of Directive 2011/24 EU is that all EU patients enjoy equal access to healthcare. This includes the right to make informed decisions based on information provided by healthcare authorities and professionals. It often implies, for example, the signing of an informed consent form or the ability to continue treatment in their country of affiliation. This means that information needs to be provided in a language that can be understood by the patients and professionals in both the MS of affiliation and the MS of treatment. Thus, the inclusion of professional language support/provision in EU legislation would ensure the viability and effectiveness of cross-border healthcare and would protect patients' rights to access healthcare (and information).
- Professional language support should be redefined and accounted for in legislation. Improvised practices, ad hoc bilinguals or non-professional language brokering *in lieu of* professional services do not constitute a responsible way to address the language needs of a diverse population in the EU. Language support that adheres to minimum criteria of professionalism (see Section 5) should be provided to ensure quality and effective cross-border healthcare (as well as healthcare in general).

- Patients are vulnerable *per se*. When they cannot access information on their own health, or make informed decisions about it, they become even more vulnerable. Quality control mechanisms should be in place to monitor the quality of language services patients receive in order to guarantee equal access to highest levels of services. A more comprehensive legislation should outline conditions for the allocation of funds for professional language service provision.
- Patients and providers should have the opportunity to challenge the quality of language provision if not satisfied with the service. Public authorities should establish adequate channels that allow patients and providers to question the quality of language provision and preventive measures (see, for example, Directive 2010/64) such as recording and storage of documentation [e.g. translations or interpreted renditions] should be in place to ensure expert review, if needed.
- Because some EU citizens (patients and healthcare providers) only communicate using local and regional languages, it is also advisable that language policy actions be considered at a national and regional level (where healthcare is a responsibility of regional/local authorities) to account for the communicative needs of these language users. These actions should, at the very least, include the translation of basic documents (e.g. consent forms, disclosures) and the provision of interpreting.

Recommendations related to information provided by National Contact Points

- Information provided by National Contact Points should be available at least in all the official languages of the EU (including sign-languages), although it is acknowledged that this would go beyond the provisions of Directive 2011/24/EU. This would ensure effective access to information and observe non-discriminatory practices.
- Patients' right to access quality information does not only imply their right to professional language support. Quality information also refers to appropriately adapted materials in different formats that can be properly understood by all EU patients, regardless of their age or special circumstances. For instance, elderly patients who may not be computer literate or disabled patients (including sight-impaired, blind, hearing-impaired and deaf patients) should receive the same quality information by channels that guarantee it.
- A central place where MSs could look up information directly would certainly avoid research time. NCPs could share information with MSs through a database. This would save the time of communicating directly (even via e-mail) with a NCP about information that could be readily available to providers. All MSs could benefit from having a centralized place to look for costs. As noted by one informant "A major problem reported in our MS meetings is the different tariffs. This create[s] problems at the moment of reimbursement (to the point that) ... we are not interested in getting foreign patients... Obviously, if they come, we need to take care of them..." (ES Inf 32).

Recommendations related to extent of professional language provision

- The provision of professional language services for cross-border patients should not only be available at the beginning of the process (the information -seeking or pre-authorization stage), but until the cross-border healthcare assistance process ends. This may include the exchange of documents that affect patients' health (e.g. medical reports, prescriptions, etc.) as well as reimbursements⁴⁰.

Recommendations for professional development of healthcare providers and administrators

- Healthcare providers and administrators would benefit from professional development on how to work with translators and interpreters. Language service providers are part of the healthcare team when assisting cross-border patients. Ways of conceptualizing healthcare and the resulting communication about it (whether written or oral) are different in a multilingual situation. The needs of all parties should be considered.
- Healthcare professionals could also benefit from professional development on how to work with culturally diverse patients (and language providers). There are communicative differences that should be taken into account when addressing a patient from a different culture. For example, medical concepts routinely managed in patient-provider interviews (e.g. the pain scale, proper nutrition) can vary across cultures. Certain issues, such as reproduction and contraception, end-of-life decisions or the conveyance of bad news (to name just a few) are managed differently across cultures. Non-verbal communication such as body language tone or gaze vary across cultures and no assumption should be made about them. Healthcare providers should account for these differences.
- Current curricula designed for medical students in Schools of Medicine in the EU does not properly discuss linguistic/cultural diversity and communication, neither does it explain to medical students how to work together with professional translators/interpreters. Efforts have been made to incorporate at least one-hour lecture that illustrates these issues. These efforts, although better than nothing, are certainly not enough for a multicultural environment as the EU.

Recommendations for the education and professional development of healthcare language providers and intercultural mediators

Note: Individuals providing language services in a healthcare setting should be professionals in their fields. Currently this is rarely the case. Professional translators/interpreters, intercultural mediators and ad-hoc bilinguals acting as language providers are not to be confused. They do not share the same level of education, linguistic competence or technical expertise.

⁴⁰ Article 10(1) of Directive 2011/24/EU requires NCPs to cooperate on invoices. Article 4 gives detail on the obligations of the Member State of treatment vis-à-vis patients.

- The signing of agreements between the EU and universities for the development and provision of specific instruction on healthcare language services (for examples on translation see EMT and for conference interpreting see SCIC) should occur. This would enforce the inclusion of specific educational components on healthcare translation and interpreting, including issues of media adaptation and literacy.
- Professional translators and interpreters who hold a degree in their field (e.g. conference interpreters or legal translators) and do not have the expertise required to work in the healthcare setting should have specialised educational opportunities and/or professional development in cross-linguistic/cultural communication in healthcare contexts.
- Currently, intercultural mediators are hired because of 1) their experience in patients' region/country of origin; 2) their language skills (for both the country of treatment and the patient's country of origin); and 3) their ability to navigate the healthcare system of the country where they reside. Intercultural mediators should provide evidence of their education to act as such. In the absence of this evidence, their levels of language proficiency and their expertise to perform the task should be assessed. Individual and experiential knowledge, while valuable, should neither be taken at face value nor considered sufficient to provide intercultural mediation services. At present there is no university degree or diploma for Intercultural Mediation, but there are courses. Intercultural mediators should pursue courses and professional development in their areas.
- Bilingual staff whose degree of education in both languages cannot be ascertained should not perform the duties of translators, interpreters or cultural mediators. They should first pursue appropriate professional development opportunities.
- Translators and interpreters working in the healthcare setting should be enrolled in a Register of Professional and Certified Translators and Interpreters. Like all other healthcare professionals, they will be accountable for their work. Access to this Register could be regulated through a certification exam that could measure professional skills and adequate (continuing) education. National, regional or European authorities could recommend this.

Recommendations for awareness-raising campaigns

- In some countries there seems to be a lack of awareness among patients regarding their right to cross-border healthcare. Citizen awareness-raising campaigns in the media could improve the access of patients to information on cross-border healthcare opportunities.

Concluding remarks

Few things impact the lives of people more than their ability to communicate, especially in a time of need. In contemporary multilingual and multicultural societies such as the EU, people's ability to communicate can, in many cases, only be exercised through language provision. Translation and interpreting facilitate communication of mobile EU citizens across MSs. The findings of this study demonstrate that language diversity is a defining characteristic of the EU. Currently in four of the five MSs studied, healthcare institutions lack a comprehensive legislative response to language

diversity. Since equal access to healthcare is a right to be guaranteed in the EU, this raises the question of why professional language provision in healthcare is inconsistent or at worst absent when these services do exist and are essential to ensuring equality. If, as we have seen in this study, access to public services (such as healthcare) requires language provision (when there is no shared language), but language provision is not provided under the guise that it is cumbersome, costly or “not *really* necessary”, then it follows that equal access to the highest degree of health protection is not for *all* EU citizens, but rather for *some*. It is time that we ensure that it is available for *all*.

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Vamos Health Center Flyer in Greek on MSD

Vamos Health Center Flyer in Greek on Hellenic Society of Pediatric and Adolescent Gynecology

ANNEXES

ANNEX 1: QUESTIONNAIRE 1 POLICY MAKERS, LAWYERS, HC PROVIDERS

Name:

Position:

Organization/body:

Place:

Date:



Purpose: The purpose of this questionnaire is to collect information about the implementation of EU Directive 2011/24 in your country/community/region.

Instructions for respondents: Please answer the following questions from your own expertise/knowledge/perception rather than from a general/theoretical perspective. The answers are ONLY about your country/community/region.

Some answers are in Yes/No format and others are on a scale. Please answer the following questions by adding an X by the answer that best represents your choice. For example:

Example	Knowledge of two languages is a pre-requisite for interpreting	X YES/NO
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Thank you in advance for your time and participation!

Question 1: The transposition of Directive 2011/24/EU on Cross-border healthcare in your national legislation

1.1	Has the Directive 2011/24/EU on Cross-border healthcare been transposed in your national legislation? If yes, what is the name and number of the national legislation? 1.	YES/NO
1.2	Are there national contact points (information centers that bring together providers, insurers and patient organizations) to ensure access to information on cross-border healthcare?	YES/NO
1.3	If you answered YES to 1.2, approximately how many national contact points are you aware of? A: 1-5 B: More than 5 C: More than 10 D: I do not know	Mark your option below A B C D
1.4	If you answered YES to 1.2, do contact points provide information on how to claim reimbursement?	YES/NO
1.5	If you answered YES to 1.2, do contact points provide information on quality of care in cross-border healthcare?	YES/NO
1.6	If you answered YES to 1.2, do contact points provide information to EU citizens from your country travelling to other Members States?	YES/NO
1.7	If you answered YES to 1.2, do contact points provide information to EU citizens (from outside your	YES/NO

	country) travelling from other Members States to your country?	
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Question 2: The implementation of Directive 2011/24/EU on Cross-border healthcare in your national legislation

2.1	Is your country cooperating/assisting any other Member State with the implementation of the legislation?	YES/NO
2.2	Are there specific projects or measures between your country and other Member States to ensure the implementation of the Directive on cross-border healthcare?	YES/NO
2.3	Is there mutual assistance between your country and other Member States in terms of language A: Yes B: No C: I do not know D: Only informal	Mark your option below A B C D
2.4	Can cross-border healthcare patients access their medical records in their own language?	YES/NO
2.5	Are explanations on safe and high quality cross-border healthcare provision available to cross-border patients in their own language?	YES/NO
2.6	Are healthcare providers aware of the national implementation of the Directive 2011/24/EU?	YES/NO
2.7	Are foreign nationals informed about their rights to cross-border healthcare?	YES/NO
2.8	If you answered YES to 2.7, how are foreign nationals informed about their rights to cross-border healthcare? A: Through national contact points B: Through a network among providers C: Through the individual hospitals/providers D: Through their insurers E: There is no clear structure F: I do not know	Mark your option below A B C D E F
2.9	Is there a mechanism/norm in place to ensure compliance with the implementation of the Directive 2011/24/EU? If you answered YES, what is name/number of such mechanism/norm?	YES/NO
2.10	If you answered YES to 2.8, is there a mechanism/norm in place to sanction non-compliance with the implementation of the Directive 2011/24/EU? If you answered YES, what is the name or number of such mechanism/norm?	YES/NO

Question 3: Information on cost of language-support to non-nationals seeking cross-border healthcare

3.1	Is there language support available to non-nationals seeking cross-border healthcare?	YES/NO
3.2	If you answered YES to question 3.1, is language	YES/NO

	support provided by public healthcare organizations?	
3.3	If you answered YES to question 3.1, is language support provided by private healthcare organizations?	YES/NO
3.4	Is there a budget for language-support/provision to non-nationals seeking cross-border healthcare? If you answered YES, what is the approximate amount per year?	YES/NO

Question 4: Information on provision of language-support to non-nationals seeking cross-border healthcare

4.1	Is language support to non-nationals seeking cross-border healthcare evident through translation of documents?	YES/NO
4.2	If you answered YES to question 4.1, is the translation of documents the responsibility of a public authority?	YES/NO
4.3	If you answered YES to question 4.1, is translation of documents provided by private companies?	YES/NO
4.4	If you answered YES to question 4.1, are you aware of the cost of providing translation services? Amount per month/year: Amount per word/page:	YES/NO
4.5	Is language support to non-nationals seeking cross-border healthcare evident through language interpreting?	YES/NO
4.6	If you answered YES to question 4.5, are interpreting services the responsibility of a public authority?	YES/NO
4.7	If you answered YES to question 4.5, are interpreting services provided by private companies?	YES/NO
4.8	If you answered YES to question 4.5, are you aware of the cost of providing interpreting services? Amount per month/year: Amount per hour/day:	YES/NO
4.9	For translation/interpreting provision, is there a difference in cost of language support between EU citizens and non-EU citizens?	YES/NO
4.10	Who provides translation and interpreting services in healthcare? A: Professionals only B: A mix of professionals and volunteers C: Bilingual in-house staff D: Patient's relatives/friends E: Companies and we do not check who performs the service.	Mark your option below A B C D E
4.11	How do hospitals/clinics/etc. choose their language provider – if any? A: By open public tender on intervals B: After consideration of offers C: Randomly D: Other (please specify)..... E: I do not know F: Does not apply	Mark your option below A B C D E F
4.12	Is there a standardized procedure for calling an	YES/NO

	interpreter? Briefly state it:	
4.13	Are language services (if any) provided for both EU and non-EU nationals?	YES/NO
4.14	How long does a patient wait for an interpreter? A: Minutes B: Hours C: Days D: Months E: Not available	Mark your option below A B C D E
4.15	Who informs the patient on his/her right to receive translation and interpreting services? A: The hospital/clinic B: The insurance company C: Information available via governmental bodies D: Information available by NGOs or other bodies E: Don't know	Mark your option below A B C D E

ANNEX 2: QUESTIONNAIRE 2 T&I AGENCIES AND FREELANCERS

Name:
Position:
Organization/body:
Place:
Date:
Working languages (if individuals):



Purpose: The purpose of this questionnaire is to collect information about your experience with translation and interpreting in the healthcare setting. Your responses will help to inform a study on cross-border healthcare in the European Union.

Instructions for respondents: Please answer the following questions from your own expertise/knowledge/perception rather than from a general/theoretical perspective. The answers are ONLY about your experience with translation and interpreting in the healthcare setting. Some answers are in Yes/No format and others are on a scale. Please answer the following questions by adding an X by the answer that best represents your choice. For example:

Example:	Knowledge of two languages is a pre-requisite for interpreting	X YES/NO
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Thank you in advance for your time and participation!

Question 1: **Experience with/knowledge of** translation and interpreting in the healthcare setting

1.1	In your current position do you translate or interpret for doctors, healthcare providers or hospital staff?	YES/NO
1.2	In your current position, are you indirectly involved in managing translation and interpreting services (as an administrator, director, project manager)?	YES/NO
1.3	How many years total experience do you have with translation and interpreting in healthcare? A: 0-2 years B: 3-5 years C: 5-10 years D: More than 10 years.	Mark your option below A B C D
1.4	What percentage of your professional time is dedicated to translation and interpreting in the healthcare setting? A: 0-5% B: 5-25% C: 25-50% D: More than 50%	Mark your option below A B C D
1.5	Do you hold any degrees, credentials or certification in translation and interpreting? A: University degree in Translation & Interpreting B: University degree in a related field (linguistics, foreign languages, communication) C: Certification in Translation & Interpreting	Mark your option below A B C

	D: No specific training completed for Translation & Interpreting.	D
1.6	Do you have any training/education in translation and interpreting specific to the healthcare sector? A: University program (Public Service Interpreting/Translation) B: Professional development through a professional association C: Training provided by your employer or previous employers D: Training provided by hospitals.	Mark your option below A B C D

Question 2: Information on **cost of language-support** to patients who do not speak the language of the healthcare institution.

2.1	Are documents translated by ... A: you B: a translation agency C: a governmental body D: bilingual employees at the healthcare organization E: I do not know	Mark your option below A B C D E
2.2	Is there evidence that these types of translations are a collaborative project between hospitals/clinics in your country/region?	YES/NO
2.3	Is there evidence that these types of translations are a collaborative project between various EU countries and that there is support and planning among different EU countries?	YES/NO
2.4	What is the standard amount and method used to bill for translation services in your language combination? Amount per word: Amount per page: Do not know Another method:	Complete the info you have OR Mark with X
2.5	Do you offer discounted rates for big translation projects?	YES/NO
2.6	Regarding interpreting services, is there evidence of collaboration between hospitals/service providers to plan for and provide interpreting for patients?	YES/NO
2.7	Is there evidence that government agencies from different EU countries collaborate to plan for and provide interpreting services?	YES/NO
2.8	In the country in which you work, who plans, requests and pays for translation and interpreting services? A: Individual hospitals B: Administrative organizations C: I do not know D: the patients themselves E: Others, (specify)	Mark your option below A B C D E
2.9	Is there a difference in cost for interpreting services due to the nationality of a patient? (e.g. EU or non-EU)	YES/NO
2.10	Are non-EU languages more costly??	YES/NO
2.11	What is the standard method and amount used to bill for	Mark your

	<p>interpreting services? A: It is the same for all language combinations and it costs _____per hour B: It is the same for all language combinations and it costs _____ per day C: It varies depending on the language combination.</p>	<p>option below A B C</p>
2.12	<p>If you answered C to question 2.11, what is the cost of interpreting for your language combination? Write your working languages: Amount per hour: _____ Amount per day: _____</p>	
2.13	Do you offer discounted rates for big interpreting services?	YES/NO

Question 3: Provision and quality of language service

3.1	In your opinion, is your service called upon only as a last resort when all other attempts at communication have failed? (e.g. a family member brought in to help; a bilingual provider who cannot fully understand)	YES/NO
3.2	<p>What percentage of your interpreting do you work face-to-face rather than remotely (over the phone or via video link)? A: 0-5% B: 5-25% C: 25-50% D: More than 50%</p>	<p>Mark your option below A B C D</p>
3.3	During interpreting sessions, are you ever called upon to translate documents (pamphlets, prescription instructions, etc.) for either the patient or provider?	YES/NO
3.4	Do you believe that the patients for whom you interpret/translate have the same access to quality healthcare that other patients have?	YES/NO
3.5	Do the hospitals you interpret/translate for work exclusively with your company?	YES/NO
3.6	<p>The hospitals you interpret/translate for use A: only private sector interpreting agencies B: volunteer services as well as private sector agencies C: paid full time interpreting staff as well as private sector agencies D: I do not know</p>	<p>Mark your option below A B C D</p>
3.7	Do you know of instances where the hospitals you interpret/translate for have used ad-hoc interpreting solutions such as family members, children, or bilingual staff that are not paid for interpreting duties?	YES/NO

Question 4: Standards and best practices in healthcare translation and interpreting

4.1	<p>In general, how would you rate the system used by hospitals/clinics in your country that provides language services to patients? A: Highly effective B: Adequate</p>	<p>Mark your option below A B</p>
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	C: Inadequate D: Flawed	C D
4.2	In the hospitals and clinics where you have worked, are there sufficient translated resources in place to inform patients?	YES/NO
4.3	Are clearer standards/practices necessary to ensure that hospitals seek translation and interpreting services?	YES/NO
4.4	Do you believe that standardization of the provision of translation and interpreting (using only professional interpreters, a protocol for when interpreters are needed, etc.) would improve current services?	YES/NO

Thank you for your time!

If you want to receive information on results, please provide an e-mail address:

If you would like to be interviewed on Skype, please provide your Skype name:

ANNEX 3: APPLICATION FORM CONCERNING CROSS-BORDER HEALTHCARE

APPLICATION FORM CONCERNING CROSS-BORDER HEALTHCARE
(Law 4213/09.12.2013/Directive 2011/24/EU)

TO:
Division of International Affairs
Hellenic National Contact Point

SURNAME*:

Please, inform me about my rights concerning the Cross-border health directive:

NAME*:

Please, examine my application as described below:

Date of Birth*:

ID No /PASSPORT No*:

Please, arrange a personal consultation appointment:

Social Insurance Institution*:

Permanent address*:

Telephone no*:

e mail*:

SUBJECT:

Text:

.....
.....
.....
.....
.....
.....

Date:

Signature:

* Necessary fields

The screenshot displays the homepage of the EOPYY (Hellenic National Contact Point) website. The browser address bar shows www.eopyy.gov.gr/Home/StartPage?a_HomePage=Index. The website features a top navigation menu with links for 'Αρχική', 'Επικοινωνία', 'Αναζήτηση', 'FAQs', and 'Σύνδεση'. Below this is a secondary menu with categories: 'Οργανισμός', 'Επικοινωνία', 'Εφαρμογές', 'Ενημέρωση', and 'Εντυπα'. The main content area is titled 'Καλώς ήλθατε στο δικτυακό τόπο του Ε.Ο.Π.Υ.Υ.' and includes several informational blocks:

- Οργανόγραμμα Ε.Ο.Π.Υ.Υ.**: A section for finding contact information for various departments.
- Κανονισμός - Νομοθεσία**: A link to legal documents and regulations.
- Συμβεβλημένοι Προμηθευτές Υγείας**: A list of approved health service providers.
- Φάκελος Ασφάλισης Υγείας**: A section containing documents like 'Εγγραφή ασφαλισμένου για χρήση του Φακέλου', 'Αναζήτηση / Εμφάνιση ατομικών δεδομένων υγείας', 'Οδηγίες για ασφαλισμένους', 'Ενεργοποίηση χρήστη ΦΑΥ από ιατρό', 'Οδηγίες για Ιατρούς', and 'Ανακοίνωση και Συχνές Ερωτήσεις'.
- Φαρμακεία ΕΟΠΥΥ**: A section titled 'Ποια φάρμακα είναι διαθέσιμα στα Φαρμακεία του ΕΟΠΥΥ'.
- Βρείτε ραντεβού με γιατρούς του Ε.Ο.Π.Υ.Υ.**: A service for finding appointments with healthcare providers.
- Ανοιχτή Γραμμή Επικοινωνίας & Ενημέρωσης για τα Εμβόλια**: A dedicated line for vaccine-related inquiries.

 On the left, a 'Νέα - Ανακοινώσεις ...' sidebar lists recent news items with dates from 01/04/2015 to 17/04/2015. On the right, a 'Δελτία Τύπου ...' sidebar lists press releases from 01/04/2015 to 30/03/2015. At the bottom, there is a footer with the text 'Δ/ση Πληροφορικής ΕΟΠΥΥ © 2012 - 2015' and the date 'Παρασκευή 17/04/2015'.

Home page of EOPYY. Source: <http://www.eopyy.gov.gr/>

ANNEX 4: LEVELS OF PROFICIENCY OF INTERPRETING DESCRIBED BY UK TRUST

10.1 The Trust has identified different levels of proficiency of interpreting, available to trust staff:

- Level 1** Trained, experienced and qualified interpreters provided through an approved provider of **face to face** interpreting services.
- Level 2** Interpreter provided through an approved **telephone** interpreting service provider with whom the Trust has a contract.
- Level 3** Qualified bilingual staff members, who have undergone some interpreting course such as the Diploma in Public Services Interpreting (DPSI) and their duties regarding interpretation, should be detailed in their job description.
- Level 4** Trust staff that are bilingual but not trained.

10.2 The following chart provides details of which level of interpreting support is acceptable for a range of situations. This list is not exhaustive but provides a guide to the level for interpreting provision that staff should try and aim for:

Clinical Situation	Interpreter Level
➤ Seeking a service user's informed consent	Level one or two
➤ Seeking a service user's informed consent in an emergency situation	Level one to four normally and in exceptional circumstances, level four
➤ Meeting with a carer and/or conducting a carer's assessment	
➤ Advising service users or carers on a course of treatment	Levels one to three in normal circumstances, except where this expectation cannot be met at short notice, level four
➤ Booking an appointment for service users	Levels two to four
➤ Undertaking a clinic with a variety of service users	Levels one, or three in normal circumstances
➤ Undertaking a regular home visit	Levels one or three. If a suitable interpreter cannot be booked the home visit should be re-scheduled for a time when one will be available.

Source: (NHS East London, 2014)

ANNEX 5: LANGUAGE REQUESTS IN NORTHERN IRELAND (NIHSCIS)

1 January to 31 December 2014 (Total Requests: 95,894)

Language	Requests	Language	Requests
Polish	31912	Italian	128
Lithuanian	16592	Japanese	78
Portuguese	8442	Hindi	58
Chinese, Mandarin	5823	Malayalam	51
Slovak	4977	Nepali	34
Tetum	4336	Albanian	29
Romanian	4228	Turkish	17
Hungarian	3360	Tagalog	16
Chinese, Cantonese	3056	Ukrainian	15
Russian	2999	Vietnamese	14
Arabic	2035	Korean	11
Latvian	1938	German	7
Bulgarian	1218	Greek	6
Somali	1133	Pashto Northern	3
Czech	836	Shona	3
Spanish	632	Slovenian	3
Chinese, Hakka	450	Malay	2
Bengali	364	Indonesian	1
Farsi	218	Kurdish	1
Thai	194	Estonian	1
Urdu	191	Amharic	1
Pashto Central	188	Croatian	1
Punjabi	155	Swahili	1
French	135	Sylheti	1

Source: (UK Inf 7)

ANNEX 6: INTERPRETING REQUESTS PER LANGUAGE PER SEMESTER

Royal Infirmary (RIE), Western General and St. Johns. April to September 2014

Language	RIE	Western	St. Johns
Arabic	76	53	5
Bengali	44	33	0
Bosnian	7	5	7
BSL	70	73	28
Bulgarian	35	13	2
Cantonese	196	159	24
German	2	1	1
Hindi	14	8	7
Hungarian	40	6	31
Italian	17	31	4
Kurdish	13	1	0
Latvian	2	3	6
Lithuanian	6	8	6
Mandarin	210	57	37
Nepalese	6	2	3
Polish	693	521	526
Portuguese	34	18	1
Punjabi	45	21	12
Romanian	63	26	1
Russian	18	12	20
Sinhalese	3	0	0
Slovakian	8	4	14
Spanish	83	39	3
Thai	11	2	0
Turkish	83	26	5
Urdu	131	55	17
Vietnamese	8	3	2

Source: (UK Inf 20)

ANNEX 7: WORKING DEFINITIONS (IN ALPHABETICAL ORDER)

Preliminary Note: While the term “Translation” is used here as an umbrella term to include interpreting and/or other forms of language mediation, it should not be confused with interpreting. While translation involves the communication of a written/video/electronic message into another language in written/video/electronic form and a certain period of time is allocated for the task, interpreting involves the communication of oral or signed messages in real time. In addition to the difference between written and oral form and the time constraints, interpreting, up until now, conceptualizes communication as the result of human interaction. As such, public-service/community interpreting means brokering both the content and meaning of messages. Meaning is formed not only by words but also by body language, facial expressions and gestures, intonation contours and other paralinguistic features used during an interpreted communicative event. Interpreting may occur across a wide range of social factors (gender, ethnicity, socio-economic class, education, age and nationality) and many times these differences trigger adjustments in language register (e.g. “drink only transparent liquids” becomes “do not drink coffee, tea, or any juice, just water.” Angelelli 2004). While translation also occurs across a wide range of social factors, it adds the dimension of literacy and computer literacy. Unlike interpreting translation is currently performed by humans as well as by machine and by hybrid models (MAT, CAT)

CAT Tools

A variety of computerized tools that assist human translators in their work and increase their productivity, but do not do the translation for them (Bowker, 2002).

Cross-linguistic and cross-cultural healthcare communication

Communication in which members of different social groups (healthcare providers and administrators vs. patients seeking healthcare), where power differentials are salient, who have varied levels of literacy and belong to two distinct discourse communities, exchange information in a written form. Written communication in healthcare settings is usually one-way, where healthcare providers and administrators produce messages of various degrees of complexity, often making use of technical language, targeted at patients with different social statuses that may experience comprehension problems despite sharing a linguistic code (Angelelli 2000, 2004a, 2012, 2014; Baraldi & Gavioli, 2012; Davidson 2001; Metzger 1999; Katz 2014).

Editing as applied to translations

Revising written translations for delivery or publication or to make them suitable for a particular purpose by correcting, altering, adapting, refining or modifying it (Merriam-Webster, 2015a; OED, 2015a).

End users of language services in PS

End users of language services in PS belong to two distinct groups and they may not necessarily coincide with the party requesting the translation/interpreting service. One group is formed by speakers of the societal language who are offering healthcare services (e.g. providers, administrators, social workers, patient advocates). In addition to the knowledge of the societal language, these individuals have knowledge of the subject matter (e.g. healthcare, insurance, law). The other group generally is formed by linguistically diverse groups or non nationals, individuals who do not read or speak the societal language and who, in order to access services, need 1) to access information and 2) to communicate with speakers of the societal language End users should be encouraged to demand professional/qualified translators/interpreters to provide them with language services. In the case of a hospital, for example, the two

end-users are the provider and the patient interacting and the party requesting the service may have been a member of the administrative staff.

Healthcare translator/interpreter (see preliminary note above)

A professional who either holds a degree in translation/interpreting or a related field, or who has specific qualifications or credentials and, exhibits translation/interpreting skills, demonstrates experience, observes the code of ethics of the profession and is able to carry out an assignment successfully. These individuals may be members of the community for which they interpret, which can make it difficult for the interpreters to adhere to professional ethics and standards of practice. (ISO 13611)

Healthcare translation/interpreting

Healthcare translation/interpreting (also known as medical translation/interpreting) occurs mainly in settings such as hospitals, clinics and doctor's offices. It involves the communication of healthcare information and discussion related to patients' health and procedures. Healthcare translation/interpreting serves the latter user group to ensure their access to healthcare services. (Angelelli 2014)

Intercultural mediator

The Intercultural Mediator facilitates exchanges between people of different socio-cultural backgrounds and acts as a bridge between immigrants and national and local associations, health organizations, services and offices in order to foster integration of every single individual. (<http://www.hrmars.com/admin/pics/1325.pdf>). Intercultural mediators are also asked to perform translation and interpreting tasks as part of their duties.

Interpreted communicative event

An interpreted communicative event occurs among three participants: a speaker of a non-societal language (for example a patient seeking healthcare), a speaker of the societal language (generally the service provider - for example a physician, a nurse, or a hospital administrator), and an interpreter who facilitates the communication in dialogic (and sometimes simultaneous) mode. These three parties should interact for the encounter to be considered an interpreted communicative event. (Angelelli 2000)

Machine-assisted translation

Also known as Computer-aided translation/ Machine-aided human translation (MAHT): human translation systems that are computer-assisted (Taravella & Villeneuve, 2013).

Machine translation

Automatic translation systems that are human-aided (HAMT), where the computer translates the text though the machine output may later be edited by a human translator (Bouillon, 1993; Bowker, 2002:4; Quah 2006; Taravella & Villeneuve, 2013).

Medical tourist/ Medical traveller

There is not an agreed international definition of a person who travels abroad to seek medical treatment. Researchers in, anthropology, communication, medicine and history have problematized this issue for a long time (See Naraindas and Bastos 2015). Some experts label such patients as "health tourists" or "medical tourists". To others this wording suggests that patients travel abroad for pleasure, which is discordant with the anxiety and pain often involved in medical treatment. "We therefore prefer to call such a patient a "medical traveller", even though the person might decide to combine his/her medical treatment abroad with tourism" (<http://www.who.int/bulletin/volumes/89/1/10-076612/en/>)

Migrant

At the international level, no universally accepted definition for "migrant" exists. The term migrant was usually understood to cover all cases where the decision to migrate was taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor; it therefore applied to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family. The United Nations defines migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. (<https://www.iom.int/key-migration-terms#Migrant>)

National Contact Point

On the basis of Regulation 2011/24/EU, each Member State has established one or more points which are to provide information on cross-border healthcare to patients travelling from one Member State to another for treatment. This information also relates amongst other things to the patients' rights, appeal options, and quality and safety standards of the Member State in question. (<http://www.EU-PATIENTEN.DE>)

Non-professional or ad-hoc translator/interpreter

A person who neither holds a degree in translation/interpreting, nor has any other qualifications or credentials, and who may or may not have any experience in performing the task at hand, and may or may not observe any code of ethics, although this person may exhibit the ability to speak both the source and target languages and volunteer to perform the role of translator/interpreter or be directed to do it by the pertaining authority (e.g. the case of bilingual employees in hospitals). Speakers of the non-societal language cannot always access services through translators/interpreters, mostly due to lack of availability. Therefore, in the absence of quality translation/interpreting, users of non-societal languages often resort to ad-hoc translators/interpreters to access written information, communicate with or express consent to speakers of societal languages. These include bilingual service providers (e.g. medical assistants, laboratory technicians, receptionists) as well as family members (including minors) or friends who are asked to step in and to help broker communication with various degrees of success. This may lead to serious consequences that undermine equal access to services. (ISO 13611)

Non-participant observation

Non-participant observation is a data collection method used extensively in qualitative research (especially case-studies and ethnography) in which the researcher enters a social system to observe events, activities, and interactions with the aim of gaining a direct understanding of a phenomenon in its natural context. (<https://srmo.sagepub.com/view/encyc-of-case-study-research/n229.xml>)

Note-taking

A way of conceptualizing information by using symbols, arrows, and sometimes words and used to aid the interpreter's memory and attention by noting important concepts, links and data such as dates and figures. Note-taking is neither shorthand, nor regular writing. Note-taking requires education and experience. It is generally not mastered by ad-hoc interpreters. (ISO 13611)

Public health

Public health is covered by Article 168 of the Treaty on the Functioning of the European Union (TFEU). This article states that European Union action is to focus on the prevention of illnesses, including drug addiction, by promoting research into their

causes and their transmission, as well as health information and education. (ec.europa.eu)

Public Service T&I

Translation and interpreting for social services means providing written and oral language support for users of the non-societal language to access services. This type of language provision is needed, for example, in government agencies, immigration offices, healthcare clinics or centres, lawyers' offices, hospitals, schools, and community centres. It occurs in everyday life when information is not available in languages other than the one of the MS in which information is provided/accessed or in more extreme situations such as emergencies, a military intervention, a community meeting or a classroom where, for example, a deaf or hard-of-hearing student and the teacher require interpreting to communicate.

Proofreading

To read sample written or printed material and mark errors for correction (Merriam-Webster, 2015b; OED, 2015b).

Qualitative research (design and methods)

Qualitative research is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting (Creswell 2013).

Quantitative research (design and methods)

Quantitative research is defined as an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true (Creswell 2013).

Sight translation

Process of rendering written content in the source language into the target language in oral or signed form in real time. In healthcare settings, sight translation is used for check-in instructions, medical history questions, test instructions or results, pre-surgical administrative forms among others. (ISO 13611)

Simultaneous interpreting

Interpreting where the rendering of speech into another language occurs at the same time as the speaker is delivering the speech. It may require the use of special equipment and booths. (ISO 13611)

State of residence

Member State in which the patient is insured with a healthcare insurer there and in which he/she lives. (<http://www.eu-patienten.de/en/glossar/wohnstaat.jsp>)

State of treatment

The state of treatment is the state to which you travelled in order to receive treatment. (<http://www.eu-patienten.de/en/glossar/behandlungsstaat.jsp>)

Third country

Any country that is not a Member State of the EU (http://ec.europa.eu/justice/data-protection/bodies/authorities/third-countries/index_en.htm)

Third country national

Person born in a country that is not a Member State of the EU.

ANNEX 8: LIST OF ACRONYMS (IN ALPHABETICAL ORDER)

AR Autonomous Region
DE Germany
DG SANCO see DG SANTE
DG SANTE Directorate-General Health & Food safety (European Commission)
DGT Directorate-General for Translation
EC European Commission
ECJ European Court of Justice
EEC European Economic Community
EHIC European Health Insurance Card
EL Greece
EMT European Master's in Translation
ES Spain
EU European Union
IMI Internal Market Information
IT Italy
MEP Member of the European Parliament
MOH Ministry of Health
MS Member State
MSs Member States
MSoA Member State of Affiliation
MSoT Member State of Treatment
NCP National Contact Point
NGO Non-Governmental Organisation
NHS National Health System
PA Prior authorisation
SCIC Directorate-General for Interpretation (shortly called DG Interpretation and commonly abbreviated as SCIC for its former French name Service Commun Interprétation-Conférences)
TFEU Treaty on the Functioning of the European Union
T&I Translation and Interpreting
UK United Kingdom

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