Spending more per patient or more per interpreter?

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"Health Interpreting -Where To From Here?"

Hello. My name is Chris Poole. I am a Japanese speaking interpreter and translator; I own a company which provides interpreting and translation services and which currently employs, apart from me, four practitioners and an office manager. We provide our services to a variety of clients, including occasional work in the health sector. I am also the current National President of AUSIT. I would invite you to attach the least significance to this fact today.

Nothing I am saying today is official AUSIT policy, although as an individual member of AUSIT I will continue to do my best, as I assume all members do, to see that these personal views do become the official policy of AUSIT. I have found that being President confers no great advantage in that respect.

NAATI have had the good manners not to actually publish my abstract, which would have led you to expect a much more rigorous presentation than I am able to give today. For this I thank them. Instead I'm going to present something of cartoon simplicity.

The inspiration behind this talk was an exchange of messages on the AUSIT eBulletin from a number of people late 2004. The eBulletin is an online forum where practitioners gather to discuss matters of professional interest, such as how little money they're making, but on this occasion the comments were about health interpreting, and they were mixed with righteous accusations concerning hospitals in particular: were not doing enough; were condoning doctors who dispensed with interpreters; were encouraging the use of family members as interpreters, and so on.

On this occasion, it struck me that not only were these completely separate problems, but also that the solutions to each of them are almost incompatible with one another.

The title of this awareness day is "Health Interpreting -Where To From Here?"

In my talk today I hope to set out where I think we should go from here, so that hospitals and practitioners can work towards solutions to their respective problems, focussing on these two key topics: quality and money.

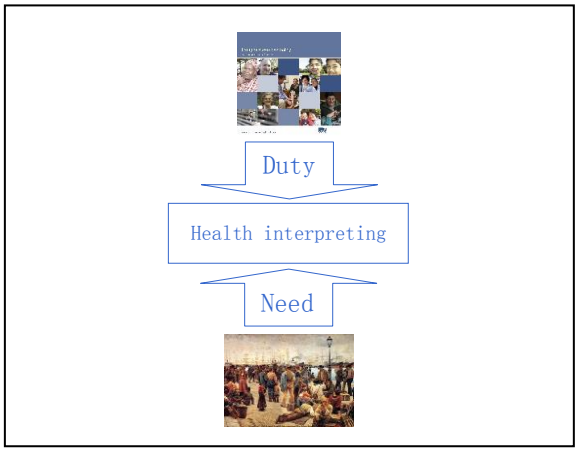
“Health interpreting” as I experience it, is interpreting provided in all clinical settings, between patients and people associated with patients on the one hand, and doctors and other people involved in the delivery of health care on the other.

The former group can include family members and friends and between them can exhibit levels of English proficiency from zero to native, and the same can of course be said of the latter group.

The semantic content of the discourse is extremely diverse, encompassing everything from discussions of medical topics in every register from infantile to inter-professional, concerning lifestyle and sexual habits, the detailed mechanics of everything from medical equipment and toilets to car accidents and factory machinery, analyses of diet, personal history, dreams and aspirations.

The pragmatic features of the discourse are strongly influenced by a wide variety of factors, including the emotions that accompany minor, annoying, chronic, embarrassing, income affecting, deeply resented or life threatening illnesses in the case of patients, and indifference, distraction, stress, haste, and resistance to the presence of interpreters in the case of doctors, and all of this overlaid with the political tensions of family and social networks, and who’s affected, who knows what, who’s allowed to know what and who gets to say so. Interleaved with a variety of culturally determined attitudes to people of authority and learning which make it all even more complicated.

This sector of the industry is also characterised by the very short period of time that each interpreter has to become acquainted with the many background issues that govern the actual structure of the sentences they are called upon to translate. I urge you to remember this point, and I will mention it again below.



This sector of the industry exists because on the one hand after forty years the governments of Australia are approaching a complete commitment to ensure that lack of English proficiency does not disadvantage anyone being dealt with by government agencies, and on the other hand NESB[1] people keep getting sick and having babies.

By a variety of means the government pays to have the disadvantage stemming from a language barrier minimised, if not entirely removed. The provision of

[1] Non-English Speaking Background

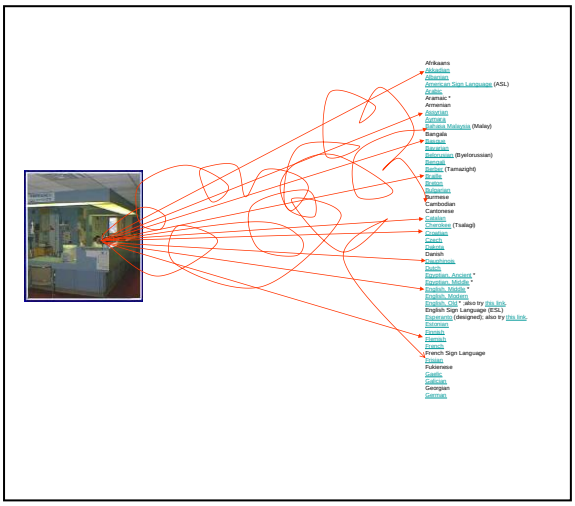
interpreters in clinical settings is just one of the ways in which governments seek to do this. And it costs quite a bit of money.

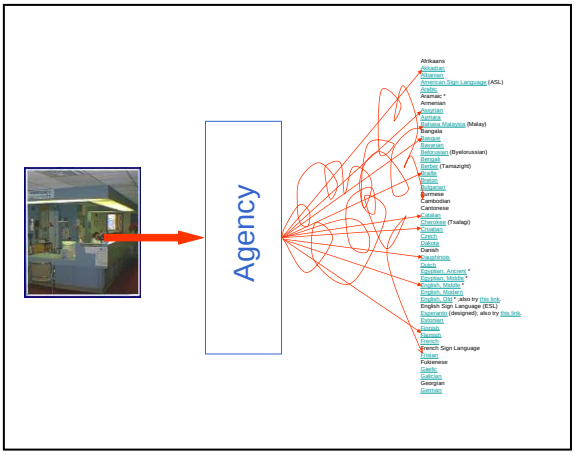
Very roughly, a typical hospital might have 50 appointments a day where a NESB seeing a doctor requires the assistance of an interpreter. There's over ten hospitals in Melbourne and a population of 3.6 million.

Interpreters get paid approximately $60 for an hour and a half booking, and I've heard agencies say that they only make a couple of dollars out of each job. But if we assume similar numbers of hospitals and levels of usage in Sydney, Brisbane, Perth and Adelaide, and that each cost about $65, then that adds up to a $20 million industry. It could be the single largest consumer of interpreting services in Australia, if the use of interpreters by the combination of police and courts isn't greater.

If these figures are reasonable (they are certainly rough), then an individual hospital is spending about half a million dollars per year on language services. But remember, that is the sum of many little individual parcels of work, in many different languages.

Clearly it would be inefficient for a hospital purchasing department to locate an individual interpreter and negotiate every individual assignment with that person (of which many will be required, given the different languages involved and the impossibility of one interpreter in one language being available at all times). This inefficiency would mean an increase in costs, passed on to governments and therefore you and me, or it would reduce the funds available for other parts of a hospital's many activities.





The rational solution to this, and a far better way to use taxpayers' funds, is to outsource that risk and inconvenience to an agency, or "Language Service Provider" (LSP), and get them to do all the running around and negotiation with all the different interpreters. The hospitals can then purchase bulk language services, just the once, for as long a period of time as practical (a financial year), with the remaining administrative tasks for the hospital being no more than making a phone call and signing a form.

LSPs gather the details of many interpreters and then supply interpreting services using these people. They are selling “bulk language services” and the specific promise they make that they can deliver all languages, at any time of the day/year, simply via one phone number, and for a fixed price, which applies for that long period. That’s the core of their business model. An individual practitioner can’t sell that.

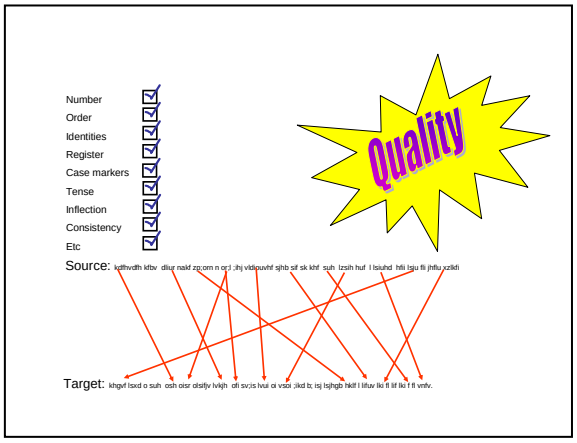
Let’s just repeat the core elements of an LSP’s business model: All languages, one phone number, guaranteed availability, fixed price.

Let’s look more closely at what is being bought. From the point of view of a hospital, you make a phone call, and the interpreter turns up, hospital pays. I think it is called an “Occasion of service” by some people. That is the thing with the price attached to it, and hospitals buy them in bulk. But obviously just turning up is not enough. There must be some mention of the “Q” word.

The word “quality” gets thrown around a lot.

It’s silly to throw words around in front of translators. They are quite skilled at tracking down the strict meaning of a word and beating you over the head with it, like I’m about to do.

In our industry the word “quality” can only meaningfully refer to the attributes of the speech, sign or text produced by the practitioner.



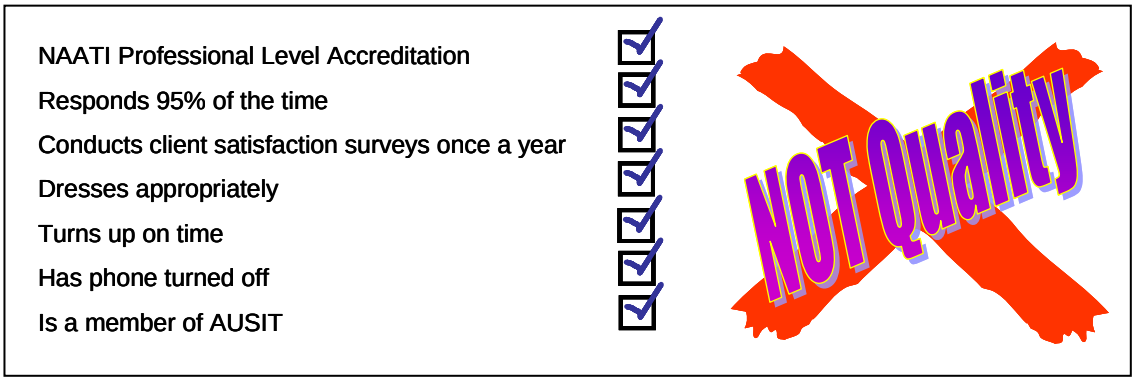
These attributes fall under two broad headings: accuracy and faithfulness. These words also get thrown around inconsistently so I don’t blame you if you are confused, but I will take care to explain exactly what I mean by them. If you don’t like my definitions, please revert to your own at the end of this presentation.

Accurately translated speech or text has all the same names, and numbers, and places, and events happening in the same order, facing the same way, being the same members or same names of the same sets and enjoying the same relative places in the same hierarchies and logical structures, as they did in the original (this list is indicative, not exhaustive).

Faithfully translated speech, sign or text achieves the same functional outcome as the original. It emotes and evokes and sounds like the original. It reveals or conceals or modifies the interests and agenda of all the interlocutors the same extent as it would had they all shared a language. Accuracy and faithfulness. This is quality in translation.[i]

These things are also hard to measure. And this industry, still in its infancy, has yet to tackle the hard things. But rather than solve that problem, and genuinely

seek a method of measuring quality, we have trumped up numerous *surrogate* measures of quality.



Most of these things in the illustration above have to do with the personal attributes of the individuals involved. Most alleged discussions of quality in this industry deal only with these things, and this in turn has had the very unfortunate result of making the individual central to the question of quality, leading to a kind of cult of personality and an overblown regard for the credentials that person holds. The misfortune is, that this focus on individuals has led us to overlook, and sometimes be completely oblivious to, all the *other* conditions that must be fulfilled, but which have nothing directly to do with the interpreter, in order that accurate and faithful translations are produced (such as time, contextual knowledge and clients and other stakeholders with a realistic understanding of the translation process).

There's a lot of money changing hands for T&I especially in the health sector, and along the way the quality question is asked, and is generally answered with a description of these credentials: *Is* a native speaker, *is* NAATI accredited; *has* this much experience, is *from* that country, *turns* up on time; *dresses* appropriately, as though these things are telling us whether the particular speech they have translated was done so accurately and faithfully.

Of course it tells us nothing of the sort. It is a sop. A sacrifice of our common sense that we make to the Gods of quality in the hope that we get through another day without anything drastic happening.

This is currently the only way the effectiveness of all those funds spent on T&I is measured. By reference to these indirect indicators such as a practitioner's personal history, qualifications, level of accreditation, and even their personal habits – dress and punctuality.

All of these things may be relevant. There may be a *statistical correlation* between some of these things and good quality, there may actually be a *causal* relationship between some of them and quality. Many of them are certainly things that would *require* of professional people. But none of them *are* quality.

A person may have extensive qualifications and experience, they may be accredited at level 3, they may dress impeccably and turn up on time every time and always have their phone turned off, and they may still completely

mistranslate things! I've done it! None of that list of things that are regularly touted as measures of quality, provide one atom of evidence that the actual strings of words produced by an interpreter are accurate and faithful translations. And if we don't have that, we don't have anything.

Often, when I mention this to people, they respond by saying that they assume that because the person is NAATI accredited, that everything is being translated correctly. Not wanting to cast aspersions over our host today, especially before lunch is served, I have had many years of direct experience that suggest that this assumption is naïve.

NAATI accreditation is certainly the best thing we've got, if we want to narrow down the pool of bilingual people to those most likely to understand what translating is about, and we'd be mad if we didn't use it in that way.

I have employed quite a few people over the past 10 years and there is definitely a difference between people who have prepared for and sat NAATI exams and people who haven't. It takes three to four years working for me before an interpreter is really useful, and preparation for NAATI exams cuts about a year off that time. (Incidentally, this is true regardless of whether they passed or failed the exams).

Some say that if the person has a demonstrable grasp of medical terminology that is a sign of their competence. Well that would lead us to conclude that a bilingual doctor would also be competent and we know that is a dangerous thing to assume. It is also beside the point, as not knowing a particular term of art is only one of hundreds of ways in which translation can be impeded or flawed, and most of them are not field-specific.

Some suggest that bilingual family members would say something if there was a problem. This is also a highly spurious argument. We all agree that simply by being related to the patient and being bilingual are nowhere near qualification enough to interpret in a clinical setting, yet this argument suggests they are qualified to judge the work of someone who is!

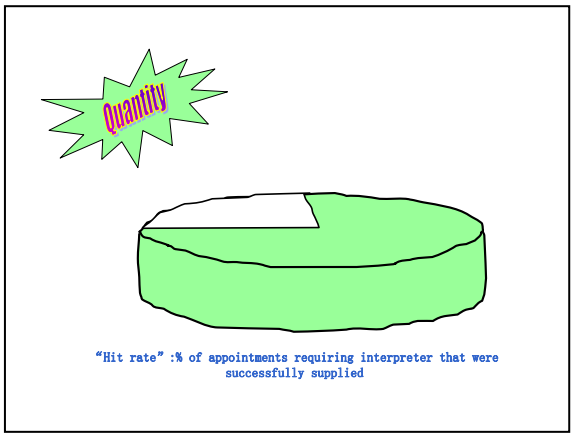
I say you need something longer than a piece of string to measure a piece of string. And to assess the quality of a translation you need *more* resources than went into the production of that translation. So never mind bilingual people who might be present. Assessing the quality of an interpreter's work would require not just one other interpreter, but more than one other, the two of them competent to assess according to some sort of assessment methodology.

Some point to successful outcomes as evidence, which is more reasonable given that ongoing monitoring of speech-act outcomes and recovery and adjustment when problems occur is an inherent component of face-to-face dialogue, so though it might take longer, people ought to be able to get close to what they want, notwithstanding all manner of impediments to the translation process.

But as someone with long experience of assessing the work of others, I would also have to point out that speech, sign and text can be mistranslated dreadfully without *anyone* realising that it has happened.

In the current industry *actual* quality of translation sits in the “too hard basket”, unmeasured and unknown. Quality is assumed, based on a short list of indirect and somehow comforting peripheral attributes of the individual practitioner.

In this environment, hospitals could be forgiven for directing most of their attention to the relatively crude measure of the *quantity* of the units that they are purchasing, “occasions of service”, rather than the *quality*. The “quantity” is the percentage of appointments requiring an interpreter, that are successfully supplied with an interpreter. Let’s call it the “hit rate”.



Great improvements to the hit rate have been made in recent years and that is in no small part thanks to the people, and the sort of people, sitting in this room.

The main reasons that interpreting is provided *less* than 100% of the time it should be provided, stem from the poor attitude to, and awareness of, interpreters and their role, on the part of medical and allied health practitioners[2].

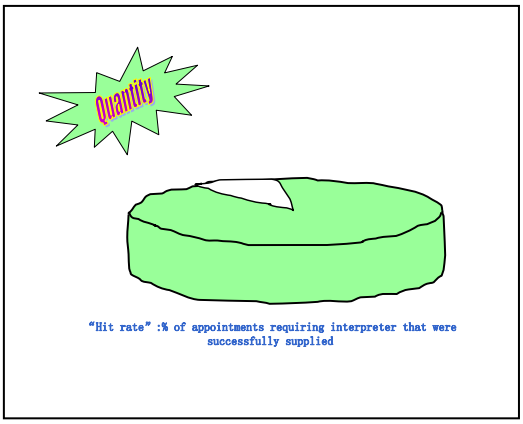
Doctors are often in a hurry, which pushes them to find ways of shortening the time spent with each patient. A patient presenting before the interpreter, is therefore a good thing for them. Especially if there is a willing family member handy, never mind that the family member might translate “urinary tract infection” as “ulcer” just before the patient’s operation (and that story is less than 48 hours old!)

This can happen because an interpreter is late or fails to show up, or simply due to minor and unpredictable variations from scheduled appointment times. Of course interpreters should always be punctual. But an anaesthetist wouldn’t start cutting just because the surgeon was late, and that is exactly what a doctor or family member is doing, no matter how bilingual they are, when they undertake to translate for a patient. And an anaesthetist would know much more about surgery than a bilingual person would know about translation!

Another reason that someone who needs an interpreter might fail to get one is that no interpreter is available, and this in turn may be due to the total number of interpreters working in that language. I expand on this below.

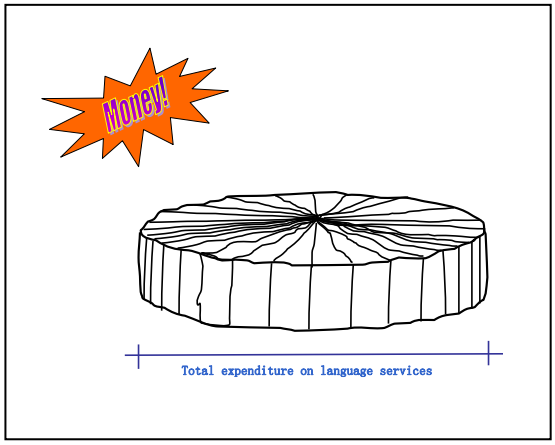
Where are hospitals going from here?

[2] This statement is anecdotal, but based on interview responses from interpreter coordinators at two of Melbourne’s busiest hospitals.

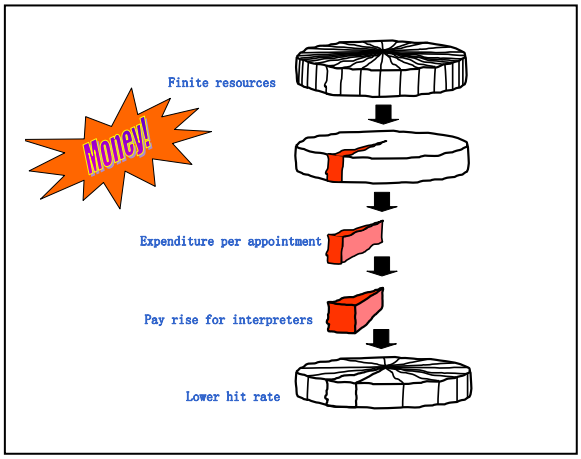


The risks of miscommunication between doctor and patient will become greater, or more apparent, and hospitals will move gradually to increase their management of this risk, by strengthening their policies with regard to the use of interpreters, and by educating and managing doctors and other members of the medical team. The hit rate may never reach 100% of all occasions where it is deemed necessary but it will approach it.

The important point here for practitioners is that hospitals see a problem (less than 100% is certainly a valid problem) and the solution may involve spending more money, but only to the extent that more occasions of service are paid for. This will therefore make no difference to the money received by an interpreter per job; may have no positive impact on the income of any individual interpreter, and if the amount paid per job is that bad, it may well be making them *poorer* overall!



Given what I've set out above, interpreters who want more money each time they turn up need to realise that there is some tricky ground to negotiate. If the total funds available to a hospital to spend on interpreters for a year is fixed, then paying interpreters more per job simply means that the pie will be cut into bigger and fewer pieces, meaning that services to patients, measured by number of appointments, will be reduced. Hit rate will go down. This brings the desires of the interpreter directly into conflict with the governments and hospitals.



No one in charge of preparing or approving or who has an interest in the development of budgets for interpreting are likely to recommend or agree to an increase of the amount paid per individual parcel of work, unless it clearly helps them achieve

what *they* are trying to achieve – a higher hit rate.

On the face of it, the reverse is the case. They all have a vested interest in minimising this amount of money. For a fixed total, the smaller that amount of money, the more often they can provide interpreters for patients so that is a good thing. In other words the more pieces into which they can slice the pie, the further they can stretch their finite resources.

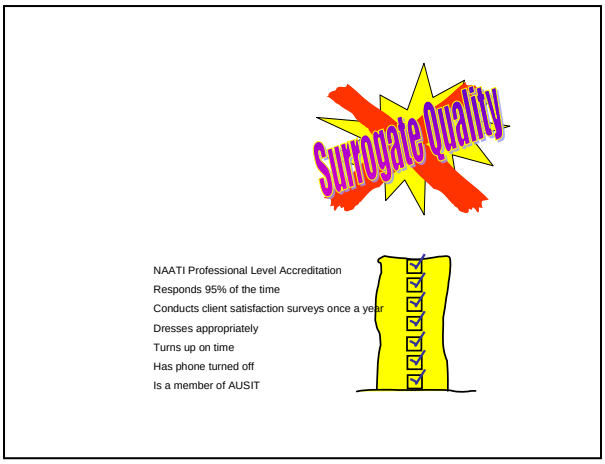
Some interpreters will appeal to moral arguments and actually pine for the government to “do the right thing” and pay “reasonable rates”.

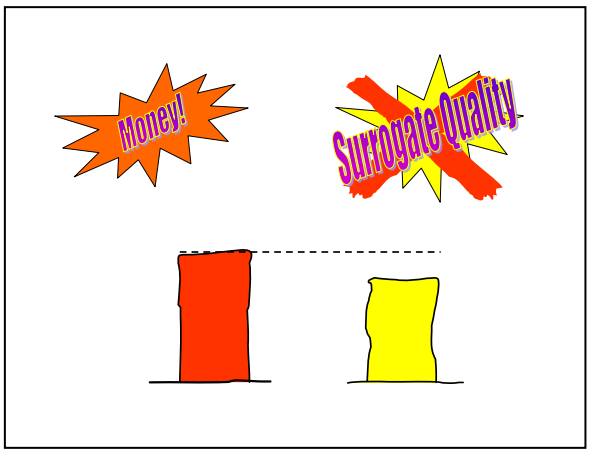
Governments are under enormous pressure to do many right things on behalf of all tax payers, and one of those things is to manage funds rationally. That will always mean putting services out for competitive tendering. Notwithstanding the flaws in the current definition of quality, quality is nevertheless *assumed*, and everyone involved in funding, planning, procurement, tendering and supply of interpreting will be trying to *reduce* that amount paid each time an interpreter turns up.

The more they can do that, the more successfully they have done their job, because as governments and businesses they are implementing, on behalf of taxpayers and business owners, the self-same policy that each individual interpreter implements when they go shopping with finite resources in their purse. From their perspective, in fact no matter which way they look at it, they are doing the right thing. Because as far as they are concerned, if they have ticked the boxes next to all those surrogate measures of quality, then they are buying exactly the same thing, for less!

So is there the opportunity for interpreters to argue for more money on the basis of quality? There are several levels of difficulty here.

The only definition of quality that has currency for end-users and the LSPs that control the flow of work from end-users, is as I’ve shown above, credential-based and has little to do with actual quality. Those credentials and personal attributes may nevertheless be important elements of the service, and the hospitals already expect that much service for that much money.





The reality is at the moment that they are not even getting that. Across the board, all languages included, hospitals are frustrated by the fact that they are paying for this level of quality but only receiving this level.

These are very difficult circumstances for anyone wishing to ask for more money. Interpreters as a group are not even delivering what they *should* be under the current rates!

There are many interpreters who will object to this statement. Many who will agree that there are bad apples who spoil it for everyone else. Some of these people will be justified in saying this, and some will be those bad apples.

Of course there is a great deal of difference from interpreter to interpreter. They aren't a homogenous group, and assuming that they are one creates many injustices – lets bad work slip through undetected, and drags good work down to an arbitrarily low level.

The problem here is not the hard-working and fine people who run agencies, but the LSP business model described above.

Agencies are under a lot of pressure to treat interpreters *as though* they were all the same, like taxis on a rank. Because if end-users were encouraged to start picking and choosing practitioners on the basis of the actual quality of their work, then that would increase the power of those individual practitioners to negotiate higher rates with the LSP, which would threaten the fixed price for all interpreters and all languages which is an essential element of the LSP business model.

It would also concentrate the income in the more highly skilled and conscientious practitioners, which would inevitably take it away from others, and those whose work as interpreters had provided them with only a marginal living would be tipped over the edge and they might leave the industry.

This would also threaten the LSP's business model because to guarantee supply they need a very long list of practitioners, whose patterns of availability vary, and who are compliant. In other words it helps if they are all a little bit hungry. It makes them happy to hear from the LSP each time they ring, more agreeable and less fussy about what they are asked to do.

There is another factor that has unfortunate and debilitating results. In order to guarantee availability, the LSP business model requires a large number of practitioners in each language, all of whom have given an undertaking to work for that LSP's rates for a fixed period, but with no guarantee of fixed income. This arrangement dictates that they remain independent contractors, because

full time employment of such numbers is prohibitively expensive for the LSPs (because the individual workload for many of them would be well beneath break-even point for the LSP to consider employing them). The consequences of engaging someone as an “independent contractor”, only to have the ATO disagree and deem them employees (with all the entitlements of employees) at some point in the future, can be drastic. So LSPs go to great lengths to prevent this, with the signing of contracts and the restating of the word “contractor” and the practitioner’s ABN on every form etc.

When the employment status of an individual is disputed in court, reference is made to a number of tests[3]. The most important is the first which refers to “control”. LSPs must take great care to ensure that they are not seen to be controlling the manner in which practitioner perform their work.

The consequences of this are tragic for the T&I industry. Unlike most modern industries, LSPs in Australia face enormous structural handicaps to the active improvement of the skills or performance of their practitioners (and thereby to the value of their own brand and product!) through instruction, training, professional development, mentorship or any other sort of investment. Because this would expose them to the risk of having their contractors deemed employees by a court, rendering them liable for the many costs with which Australian governments have seen fit to burden employers over the years. This would send them broke.

Further, and just as damaging to our prospects, as independent contractors practitioners don’t necessarily work exclusively for the one LSP. So every dollar a LSP spent on training might be indirectly profiting other LSPs; the very people against whom they are competing for all that government work!

To their credit some LSPs conduct training in spite of this, but in general these factors combine and contribute to the general retardation of this industry, and leave the LSPs casting around for some unifying credential that they can hold at arm’s length, and that will enable them to present otherwise unimproved practitioners as a reliable commodity to their government clients.

The credential that enables this commodification and levelling of the product is of course NAATI accreditation. Not surprisingly a product in its own right, and

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1. the person receiving the services exercises control over the manner in which the work is to be performed
2. there is an agreement for employment or appointment to staff, or the worker is called an employee
3. other workers doing the same job are treated as employees
4. work hours are defined
5. the worker providing the services is engaged on a continuing basis
6. the worker is paid regularly or periodically (rather than on a per job or a results basis)
7. the person receiving the services supplies the materials, equipment and tools to the worker performing the work
8. the worker’s PAYG income tax or sick leave, holiday pay, superannuation, workers compensation or other benefits are paid by the person receiving the services (for example, on the basis of the period worked)
9. the worker is required to perform the work personally and is unable to provide the services by employing or subcontracting another person to do the work
10. the services are integral to the business conducted by the person receiving those services

which is owned and sold by those very governments! All of this valorises NAATI accreditation far out of proportion to its value as a purely predictive tool.

Many practitioners, brought up in this environment, where they only ever hear "Is the person accredited?" rather than "was the sentence accurately and faithfully translated?", naturally end up holding that their entitlement to income is based on their credentials rather than on their specific performance (production of accurate and faithfully translated strings of words on each occasion). So it would offend them if people with the same credentials as them were getting paid more than them. It would cause jealousy and make things even more difficult for LSPs, who again, need a long list of cheerful and helpful people in order to provide a good service. So people on both sides of the transaction subscribe to a mythology where NAATI Accreditation is endowed with all sorts of powers it can't possibly possess.

I stress that this isn't a criticism of the LSPs. These problems are simply the natural consequences of the sector which, I would remind you again, is characterised by a large volume of very small jobs.

I have even experienced these sorts of pressures myself, and conversely I can report that I have seen the larger LSPs trying to workaround some of these structural impediments to development and quality; discreet attempts to reward individual performance and even quiet implementation of differential pricing for different languages.

This latter I have only seen driven by supply issues (practitioners in some language groups refusing work) but differential pricing per language would go a long way to solving demand issues like the so called "Rare and emerging" language problem, because it can be measured in occasions of service, so at least the problem is visible to the hospitals because it fits within their crude definition of quality. But this would require a radical departure from the current LSP business model. Who is game enough to attempt this? To say to the health sector "Yes we can supply Nuer and Oromo and Dinka no problem. $400 per hour." The State government wouldn't need to subsidise any RMIT students then!

And it isn't a criticism of NAATI either. Entry to this profession ought to be composed of three things: training and education, a test, and then supervised practice. I can't think of anything better than NAATI for the test which is the best indicator of likely outcome we have. But that's all it is. (Although I look forward to improvements in reliability; disaggregation of course approval and testing; and market rates paid to examiners.)

Subject to thorough analysis and exposition, the work and role of a competent interpreter in the hospital setting ought to be regarded by society as a much more valuable contribution than it is currently.

But "regarded as valuable" is a philosophical argument. "Getting paid that much" is an economic argument. There are many practitioners in the industry who derive non-financial benefits from their work as interpreters, such as personal fulfilment and social standing. Few of these rewards are so great as to

cause them to stop complaining about their low income. But still, every person who turns up for little reward because they “get lots of job satisfaction” is contributing to unrealistic market prices, and making it harder for everyone else who is trying to make a reasonable living.

If all interpreters learned to make sound business decisions, I think many would leave the industry and do something else with their time. If the ability of LSPs to guarantee availability was seriously threatened we would see rates go up then in order to entice people into the industry, but of course it might not be the people who left who then came back, but rather people with the greater ability to win the more lucrative work (anyone buying anything will have more to choose from the more money they offer, and they will naturally seek to obtain the best value for their money).

Given the powerful holds that the LSP business model and the credentialist view of NAATI have over our industry, and given the perfectly reasonable policies that govern the management of public funds in the health sector, and given the natural tendencies of markets to find prices that enable ongoing supply regardless of the day-to-day complaints of the suppliers, simply asking for more money per job in the health sector today is a waste of time and makes the person asking look foolish.

As a member of AUSIT I have tried to ensure that the time of our members and our executive is not wasted in this way, and that we limit ourselves to actions and arguments likely to command some respect and that have at least some chance of success.

Paying more to interpreters would not increase the hospital hit rate. Training doctors to understand the risks of not fulfilling all the conditions necessary for accurate and faithful translation to take place (one of which is using competent interpreters) would probably be a better place to spend their money. So criticising hospitals and governments for failure to provide interpreters, unless it purely for the sake of NESB patients, is not likely to improve interpreter incomes. At best it would mean *more* jobs at the *same rates or lower*, leading to lower overall income and dissatisfaction.

Interpreters must realise that they cannot have it both ways. If they cling to NAATI Accreditation as a universal “entitlement to reward and recognition”, then due to the natural features of the LSP business model they will never have any basis on which to argue for more money per assignment.

But that is because T&I in Australia is currently closer to a quasi-religious, medieval cottage industry, than it is to a modern and critically important profession. If end-users and LSPs, as well as increasing the *quantity* of language services based on various *assumptions* about quality, began to question those assumptions, and lifted the lid on the actual sentences that make up the translated dialogue between a doctor and a patient, this would see the beginning of genuine quality assurance, rather than the current reliance on credentials and other peripheral clues. This is a necessary enabling condition for the development of our profession, where those practitioners who can define and articulate actual rather than surrogate quality, can thereby improve their

incomes, and make a professional contribution to the improvement of health care.

Thank you

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[i] **accuracy** *n***.** Property of a translation where all, and no more than, the *information* contained in the SL text, speech or sign, has been reproduced in the TL text, speech or sign.
information *n.* Features of the SL text, speech or sign, the existence of which is generally accepted without dispute, including but not limited to number, identity, date, name, order, orientation, hierarchy, and subject – object – agent, hypernym, hyponym and other syntactic and logical relationships.
faithful *adj.* A faithful *translation*, apart from conveying the *information* contained with the SL speech or text, also reproduces the *style* of, and functions the same way as the SL speech or text, including having the same effect on the receptors of the translation as would be experienced by the receptors of the SL speech or text, by reproducing all the *pragmatic features* of the SL.
pragmatic (feature, effect, value etc) *adj.* Functional or non-linguistic feature of the SL text or speech. The parts of language that do things other than convey *information*. Successful reproduction of pragmatic features makes a translation "*faithful*" .

From the Glossary of T&I terms, AUSIT website.