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Language Access in California Health Care: Key Issues and Opportunities for Improvement

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Issue Brief

A Significant Share of Californians Have Limited English Proficiency

California has requirements for language access in health care, yet millions of Californians with limited English proficiency continue to face barriers to safe, high-quality care. This issue brief examines where California stands today, why language access matters, and the policy opportunities that could strengthen implementation across the health care system.

At a Glance

- Nearly one in five Californians has limited English proficiency.
- Language access improves care quality, patient safety, and health outcomes.
- California's legal framework is strong, but implementation gaps remain.
- Workforce shortages and emerging AI tools present both opportunities and risks.
- Targeted policy changes could strengthen language access across the health care system.

Nearly One in Five Californians Has Limited English Proficiency

Nearly 6.5 million Californians (17.5%) age five and older are considered to have "limited English proficiency."[1] The non-English languages spoken most frequently in California are, in order of frequency spoken, Spanish, Chinese (including Cantonese and Mandarin), Vietnamese, Tagalog (including Filipino), Korean, Armenian, Farsi, Arabic, Russian, Japanese, Punjabi, and Khmer.[2] California hospitals report the preferred languages spoken by their patients to the California Department of Health Care Access and Information (HCAI). In 2023, California hospitals reported that 13.6% of their patients spoke Spanish, and 2.4% spoke a different non-English language.[3]

"Limited English proficiency" is defined as individuals who speak English less than "very well" in response to the US Census question, "How well does this person speak English?" (with response options of "very well," "well," "not well," and "not at all").[4]

"Language access" is defined as receiving health care services in one's preferred language, either from a multilingual clinician who speaks that preferred language (language concordance) or a qualified health care interpreter providing interpretation (in person, by video, or by phone), as well as receiving written materials translated into that preferred language.

The appropriate modality for interpretation may depend on the type of clinical encounter. For example, a best practice when discussing a new diagnosis, changing a treatment plan, or planning end-of-life care is to have an in-person interpreter.

Language Barriers Put Patient Safety and Health Care Quality at Risk

Providing health care services in the languages preferred by patients improves communication, understanding, health care quality, and health outcomes.[5] Research shows that language concordance results in greater understanding of diagnoses and treatment, better medication adherence, and improved well-being and functioning for those with chronic disease.[6] Conversely, lack of access to linguistically concordant care may increase the risk of adverse patient safety events and medical malpractice claims.[7]

Where California Stands on Language Access in Health Care

Patients and health care consumers in California experience barriers to health care access and quality because their language access needs are not met.[8] In one recent study, Spanish-speaking "secret shoppers"

called California health care providers to make an appointment for mental health services; nearly one in five had schedulers either hang up the call or inform them that no one was available to assist them in Spanish.[9] In addition to experiencing discrimination, people who have limited English proficiency in California are both more likely to report difficulty understanding their doctor and more likely to report being in poor or fair physical health.[10]

Community health centers and primary care practices in California report a range of language access services, including multilingual clinician and non-clinician staff; privately contracted in-person, video, and phone interpreter services; and reliance on family and friends.[11] However, operational challenges like scheduling interpreters or inefficiencies like navigating systems that are not streamlined undermine actual language access. One study highlighted the lack of language access for Californians speaking Indigenous Mesoamerican languages, and another analysis showed that Californians with limited English proficiency are more likely to report that they have never used telehealth, compared to those who speak English.[12]

Providers throughout California are increasingly adopting AI to improve language access, especially for crafting written translations. Without clear federal or state regulatory guidance, early adopters are developing their own safeguards, such as limiting use cases, ensuring "human-in-the-loop" development and review, establishing quality assurance processes, and requiring transparency about content sources for the AI.[13]

California Lacks the Multilingual Workforce Patients Need

California licensing boards collect self-reported data on the languages spoken by health professionals, but no one independently verifies proficiency levels or how many patients are actually served in these languages. For example, among California's licensed physicians who are actively serving patients, 21.6% reported speaking Spanish, 5.8% reported speaking Hindi, 4.8% reported speaking Mandarin, and 3.1% reported speaking Persian (Farsi).[14] However, these capabilities do not necessarily match the languages spoken most frequently by California patients. A related challenge is ensuring physicians and other clinicians partner with professional interpreters rather than rely on their own limited proficiency in a patient's preferred language.[15]

> "My doctor always asks me if I have any questions through the interpreter. And when the doctor tells him something, sometimes the interpreter doesn't understand exactly what he's trying to say, and he asks the doctor again, 'are you saying this?' And the doctor explains it better, so the interpreter understands and then says, 'it's this and this,' and the doctor says, 'correct,' And then the interpreter tells me what it is, exactly what it is." – *Anonymous Spanish-speaking patient (translated from the original Spanish)*[16]

Federal Laws Require Language Access in Health Care

Long-standing federal law, including Title VI of the 1964 Civil Rights Act, prohibits discrimination based on language, as part of the prohibition against discrimination based on national origin, and requires meaningful access to federally funded programs and services for individuals with limited English proficiency.[17] In 2010, Section 1557 of the Affordable Care Act (ACA) added more specific language access requirements, and regulations since then have specified qualifications for health care interpreters and rules pertaining to the use of technologies that support language access, such as translations by computer programs.[18]

In March 2025, the Trump administration issued Executive Order 14224, declaring English as the official language of the US.[19] While this has raised concerns about the weakening of federal language access protections, the executive order does not change the language access requirements in Title VI and ACA Section 1557.[20]

California Laws Build on Federal Protections

California law builds on the above federal protections, while establishing additional requirements for state and local health systems.

Mirroring federal legislation, California prohibits discrimination based on language and national origin and requires meaningful access to state-funded programs and services for individuals with limited English proficiency.[21] There are additional California laws requiring language access by state and local governments (including county public hospitals, clinics, and health departments), managed care health plans, hospitals, and pharmacists.[22]

California requires health plans to make provider directories that list the self-reported languages spoken by physicians, other medical professionals, and any qualified health care interpreters on staff available to members.[23] Furthermore, California managed care plans must currently report language access metrics and will soon report quality data stratified by member demographic characteristics, including preferred languages, to the California Department of Managed Health Care (DMHC).[24] Health plans that participate in Medi-Cal (California's Medicaid program) or Covered California (the state's ACA health insurance marketplace) have more specific contractual obligations to provide language access.[25]

The California Department of Health Care Services (DHCS) requires its contracted Medi-Cal health plans to translate written communications and materials into "threshold" languages, which vary by county. For example, there are 10 threshold languages in Los Angeles County (Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese), 7 in Orange County (Arabic, Chinese, Farsi, Korean, Russian, Spanish, and Vietnamese), and 7 in Sacramento County (Arabic, Chinese, Farsi, Hmong, Russian, Spanish, and Vietnamese).[26]

Hospitals are likewise required to report the preferred languages spoken by their patients and are beginning to report hospital quality data stratified by patients' preferred languages to HCAI.[27] However, these and other reporting requirements predominantly cover language access needs, giving little insight into whether those needs are met.

Opportunities to Strengthen Language Access

California's health care system offers a number of opportunities to strengthen language access infrastructure and improve health care quality and outcomes for Californians who face barriers to care. To improve language access statewide, decisionmakers may consider taking the following steps:

1. Secure funding or create reimbursement and payment opportunities for language access services in health care.[28]
2. Increase monitoring and oversight of language access requirements by DMHC, HCAI, DHCS, and Covered California. Require updated language access plans from these California departments and agencies and from their contracted health plans to increase transparency and accountability. [29]
3. Support professional development for multilingual clinicians, multilingual non-clinician staff, and health care interpreters, including training to improve language proficiency; testing and certification; professional recognition, including position titles and additional compensation; and continuing education.[30]
4. Promote promising practices and toolkits that help providers improve language access in health care settings.[31]
5. Develop clear guidance on using AI to support language access, including limits on appropriate use cases and requirements for human oversight.

6. Integrate language access into broader health care delivery and payment reform strategies that advance health equity, including by stratifying quality measures by language to identify and reduce disparities.[32]

Conclusion

California has established a strong legal framework for language access, but gaps in implementation remain. Millions of Californians with limited English proficiency continue to face barriers to understanding and using health care services. Evidence shows that language access improves health care communication, quality, and outcomes, while its absence increases risks to patient safety. The combination of existing legislation pertaining to language access, data reporting requirements, and emerging practices — including new technology such as AI translation — offers the state a foundation on which it can build. Strengthening oversight, aligning incentives, and supporting the workforce can help ensure that all Californians can access and understand health care.

About the Author

Ignatius Bau, JD, is an independent health equity consultant who has been supporting language access in California and nationally for over two decades through his work with health foundations, consumer advocacy organizations, health care interpreter organizations, state health departments, health care systems and provider organizations, and national health care accreditation organizations.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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