

Appendix C

A Circular Distributed by the Director General of the Ministry of Health

Circular of the Managing Director

29 Shvat 5771

03 February 2011

No. 7/11

Ministry of Health

Re: Cultural and Lingular Adaptation and Accessibility within the Health System

1. Background:

The Israeli population is a heterogeneous population composed of several groups distinct in religion, culture and language. Each group maintains a unique traditional character and lifestyle, as well as perceptions of sickness and health conditions, health-related behaviors, patterns of health services utilization, morbidity and various health indexes.

The health system's challenge of dealing with cultural diversity requires the application of humanistic values, and of legal aspects related to standards of care.

The State National Insurance Law determines that all Israeli residents are universally eligible for health services, regardless of individual background.

There exists a lawful and legal obligation to provide the public with information and documentation, pertaining to various contexts, in languages other than Hebrew (especially Arabic, but also in other languages as the context requires), in accordance with applicable legislation, regulations, government resolutions and court rulings.

The Patients' Rights Law determines, inter alia, that patients are entitled to provide their informed consent to medical treatment, whereas caregivers are required to provide information in a manner that is comprehensible to the patient. The Law also emphasizes maintaining human dignity during the course of medical treatment.

Clearly, dealing with cultural and lingual diversity comprises one of today's most important challenges faced by Israel's health services providers. In order to realize these goals, health organizations are required to invest in the cultural accessibility of health services provided by them to various cultural populations, so that all Israeli citizens may receive adequate service.

This document shall present the Ministry of Health's objectives and standards in this area.

The Ministry of Health views these objectives as part of its core responsibilities – responsibilities that are by definition independent of budget expansion.

The Circular was compiled in accordance with the primary objective led by the Ministry of Health, namely, the mitigation of inequality in Israel, and in light of the recommendations mentioned, inter alia, in the IMA's Position Paper published in 2008.

2. Objectives:

- A. Improving the cultural and lingual accessibility of the Israeli health system, and adapting it for all Israeli citizens, while strengthening its capacity to provide medical services to citizens of all cultures.
- B. Formulating standards for cultural and lingual adaptation and accessibility applicable for health organizations.
- C. Reducing health disparities within Israel's various subgroups, while empowering those most at risk.

3. Cultural Accessibility Standards in Health Organizations:

Following are standards and norms for creating cultural and lingual accessibility in Israeli health organizations. Some are mandatory guidelines, whereas others are only recommendations for possible courses of action.

These standards are founded upon five basic principles:

- Developing organizational infrastructures within professional organizations (hospitals, sick funds, public health services, emergency services) so as to provide ongoing support for cultural accessibility matters and to consolidate supporting intra-organizational policies.
- Translating documents, regulations, forms and websites intended for patient use, into other languages, as well as maintaining translation services via telephone.
- Instructing medical staff and administrators in hospitals and clinics, in accordance with their expertise, in the matter of cultural accessibility.
- Developing suitable physical infrastructures by way of signposting, directing, adequate equipment, etc.
- It is recommended that health organizations' cultural accessibility be provided based on lingual and cultural mapping of target audiences within the health organization's various levels, wherever possible: beginning with the entire organization and culminating with the target audience in every service provision location – hospitals, clinics, and so on – so as to adapt target audience services in an optimal manner, in light of the principles set forth in this document.

3.1 Patient Information

- A. Forms requiring patient signatures (informed consent forms, admission forms, payment/financial liability forms) must be available in four languages: Hebrew, Arabic, Russian and English²⁸. The IMA website contains many such consent forms available in these four languages, as specified in Circulars (Managing Director) 20/96, 13/97.
- B. Caregivers are obligated to ensure that their patients comprehend everything related to the medical treatment provided or due to be provided to them, including their right not to accept the proposed treatment. For this purpose, various means are to be employed, such as: written translated material, translation services via telephone or via language-speaking “mediators” and interpreters, whether these are employed by the medical institution or whether they are provided by a third party.
- C. Insured people and patients will receive written administrative material (such as that pertaining to their rights to health services, clinic deployment and working hours, visitor reception hours in admission centers, payment methods, etc.) in four languages: Hebrew, Arabic, Russian and English.
- D. It is recommended that further materials and documents providing vital information to patients will be published in four languages, per the discretion of the medical institution's director.
- E. It is mandatory to promulgate existing information pertaining to health care promotion, preventative medicine, domestic violence, etc. in the following languages: Hebrew, Arabic, Russian and English. The material must be culturally compatible and suitable for the institution's target audience.

²⁸ The English language is used in many cases as an intermediate language for immigrants who speak neither Hebrew nor any of the languages specified in this document.

- F. Signs in health care institutions must be adapted to the lingual composition of the major groups receiving service in them. Signs should present information, as applicable, in three languages: Hebrew, Arabic and English.

- G. Public Complaints Units: these must be capable of providing support via telephone in each of the following languages- Hebrew, Arabic, Russian, Amharic and English within a reasonable time frame, and in any event, within 24 hours of contact (per institutional operating hours).
Written applications must be made in Hebrew. An applicant who contacts a Unit, for any reason, e.g. lack of Hebrew language skills, in Arabic, Russian or English, shall nevertheless have their application processed. Applicants shall be informed that their application may require additional processing time compared with applications in Hebrew, and that they must submit any further applications in the Hebrew language, unless the Public Complaints Unit chose to respond in the applicant's language.

- H. Telephone service centers in public health care institutions, whose purpose is to manage doctor appointments and provide information on medical treatments and patient rights, are required to provide service in five languages: Hebrew, Arabic, Russian, English and Amharic. Each medical institution will choose the manner by which such service is given, provided that the patient will receive service in a language comprehensible to them within 24 hours, at most.

- I. Emergency- service call centers (such as MDA, sick fund emergency centers, etc.) must provide for immediate response in Hebrew, Arabic, Russian, English and Amharic, so as to realize the citizen's right to emergency services.

- J. The websites of health organizations and institutions must be accessible to Arabic, Russian and English readers, and must include, in these languages, such vital information as basic rights, core services and contact addresses.

3.2 Interpretation Services during Treatment

- A. All organizations and institutions within the health system (including primary care services, admission systems, emergency services, preventative services, health bureaus, etc.) are required to provide available interpretation services when such are needed in the course of medical treatment/counseling. For this purpose, one or more of the following may apply:
 - 1. Providing professional interpretation services via telephone, by way of designated call centers for each language.
 - 2. Employing language-speaking cultural mediator within the institution.
 - 3. Employing language-speaking staff.
- B. Call center representatives must receive basic training in the field, including that which relates to cultural and lingual compatibility; interpretation services will be carefully and professionally inspected.
- C. Receiving assistance from family members and non-relatives:
 - 1. As much as possible, the use of patient family members as interpreters must be avoided, unless the patient expressly requests this of their own volition.

2. In any event, family members who are minors must not be used as interpreters, unless an emergency situation presents itself or whenever simple information must be relayed, the relay of which is suitable to the minor's age.
3. Mental health services will not be provided using family members as interpreters, to the exclusion of emergencies or whenever the patient expressly requests this of their own volition.
4. Passers-by or strangers may not be employed as interpreters, except as expressly requested by the patient. (Should the employment of a stranger necessary, they are to be informed of their obligation to maintain confidentiality of personal and medical information disclosed to them).

3.3 Education and Training of Medical Teams

- A. It is recommended that all health organization staff undergo cultural competence courses, especially those staff members whose function is to deal with populations of various or diverse cultural backgrounds.
- B. Directors of organizations (such as sick funds, hospitals, emergency services) must appoint a senior administrator who will, in addition to their other functions, oversee matters of "Cultural Competence". This functionary will be responsible for applying organizational policy pertaining to this domain; they are to oversee any issues arising during ongoing operations, coordinate activities for health promotion amongst various lingual and

cultural minorities and are to coordinate pertinent employee training.

3.4 Manpower Recruiting

It is recommended, as much as possible, that personnel (medical, paramedical, administrative) recruited to the organization shall also include cultural and lingual minorities.

3.5 Health-Promoting Activities

- A. Efforts should be invested in promulgating information, in executing intervention and planned health promotion programs, among groups distinct for their religious practices or culture, particularly in those areas that help mitigate treatment non-compliance issues or health-compromising behaviors.
- B. Collaboration with local leadership (religious, social, etc.) is recommended in executing the intervention programs.

3.6 Adapting Institutions' Physical Conditions

Organizations must endeavor to adapt their physical and environmental conditions (signposting, directions, relay of medical information, privacy regulations) to the cultural background of the subgroups served by the clinic, so as to allow accessibility and utilization of all medical services provided by it in an optimal fashion, and so that the population shall not be deprived of receiving vital services due to cultural, lingual, social or any other difficulty.

3.7 Further Recommendations

- A. Efforts must be invested in studying the morbidity, use of health services, behavioral patterns and special needs of various cultural subgroups to which insured organization members/patients belong, so as to adapt services and health-promoting activities efficiently and in a manner pertinent to the subgroup.
- B. The organization must endeavor to increase staff and health system awareness in all matters concerning cultural diversity and its implications on interpersonal communication, treatment responsiveness and healthy behavioral patterns.

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4. Implementation and Incorporation Process

- A. Sick funds, hospitals and other health care providers for which this document is intended shall submit an organizational program for the implementation of this letter to the Health Economics and Insurance Division, Unit for Reducing Inequalities in Health, Ministry of Health. Program submission shall not occur later than 30 July, 2011.

- B. Target date for implementing the organizational program in full: two years as of this circular's publication. The Ministry recommends gradual implementation of the circular.

- C. Implementation of accessibility regulations per this circular shall be overseen as part of the control inspections carried out by the Ministry of Health within the various organizations. The Ministry of Health also recommends the execution of internal inspections pertaining to this matter.

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Cc: MK Rabbi Yaakov Litzman, Deputy-Minister of Health.
