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Uptake and experience of professional interpreting services in primary care in a South Asian population: a national cross-sectional study

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Abstract

Background Interpreting services bridge language barriers that may prevent patients and clinicians from understanding each other, impacting quality of care and health outcomes. Despite this, there is limited up-to-date evidence regarding the barriers to and facilitators of uptake in primary care. The aim of this study was to ascertain current national uptake and experience of interpreting services in primary care (general practice) by South Asian communities in England.

Methods We conducted a national cross-sectional survey in 2023 with people with limited or no English language proficiency ($n=609$). Multilingual researchers interviewed people from Bangladeshi ($n=213$), Indian ($n=200$), and Pakistani ($n=196$) backgrounds from four regions in England (Greater London, Midlands, Yorkshire and the Humber, North West).

Results Sixty-three percent of participants reported using professional interpreting services in primary care. The most common modality was face-to-face interpreting (55%), followed by telephone (17%) and video (8%). Multivariable analysis identified several correlates of lower uptake: participants from Indian backgrounds, those living in the Midlands, and those whose family member/friend interpreted for them within the past year were less likely to have used a professional interpreter provided by their general/family practice. Participants who had visited primary care within the last 12 months, had requested an interpreter but were told they could not have one, were informed about professional interpreting services, and were given choice in their language support were more likely to have used a professional interpreter.

Conclusions Our approach provides novel data on professional interpreting service use and evidence about the factors that may play a role in patient uptake and experience.

Keywords Health inequities, Language barriers, Interpreting, Primary care, General practice

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Introduction

In the UK and other multicultural countries, linguistic diversity is high. For example, in England approximately 9% of people speak a main language other than English [1]. The level of language diversity varies considerably by region, for example, with urban areas such as London having 22% speak a main language other than English and over 300 languages spoken [1]. Proficiency in English is on a continuum, with wide variation in speaking and comprehension skills, and in written communication. Healthcare consultations require a high level of proficiency, as patients need to be able to describe symptoms, understand doctor's questions, diagnosis, and participate in shared decision-making [2, 3].

The Health and Care Act 2022 states that population health planners have a responsibility to reduce inequalities in health service access and service-associated health outcomes [4]. This is more important than ever, given the entrenched health inequalities that have been highlighted by the COVID-19 pandemic [5, 6]. Core20PLUS5 is the NHS's approach to inform action to reduce healthcare inequalities, with a focus on the English population's most deprived 20%, as well as PLUS groups including those from minority ethnic communities, and other groups protected by the Equality Act. Culturally competent communication is vital, and this encompasses the provision of professional interpreting services [7].

There is strong evidence that the use of professional interpreting services is beneficial for patient experience and outcomes [8–11]. When patients with limited language proficiency have access to professional interpreters, they report higher patient satisfaction, greater comprehension, improved disclosure in patient-provider communication, and they receive better quality of care leading to improved patient outcomes [8, 9]. Provision of interpreting services leads to increased trust in diagnoses, a clearer picture of patients' symptoms [12], and is cost-effective, reducing the number of emergency visits and readmissions [13].

The National Health Service (NHS) in the UK is free at the point of use, to ensure everyone receives healthcare based on their needs and not on their ability to pay. NHS guidance exists for commissioners in England to improve access to professional interpreting services in primary and secondary care [14]. However, there is inconsistency in how interpreters are provided, evidenced by considerable regional differences in primary care spending [15]. The guidance also does not specify how to monitor barriers to accessing interpreting services at a local population level, which is key to ensuring that services meet the population's needs [16].

Considerable variation in primary care routines for providing professional interpreters in clinical consultations has been reported, constrained by rapidly rising demand, unpredictability of clinical need, patient expectations/behaviour and the lack of alignment between the interpreter booking and practice appointment systems [17]. A qualitative study highlighted challenges with availability of interpreters with proficiency in a particular language, leading to reliance on ad-hoc interpreting by friends and family, without awareness of the risks [18]. Improving access to and uptake of professional interpreter services in primary care has the potential to dramatically reduce ethnic and socioeconomic health inequalities and advance an important agenda to "level up" care [19], particularly as general practice is the gateway to other healthcare services.

There is an evidence gap with respect to patient perspectives of those who most need these services. The aim of this study was to ascertain current national uptake and experience of interpreting services in primary care by South Asian (Pakistani, Bangladeshi, Indian) communities because the languages spoken in these communities are among the most widely spoken languages in England and Wales after English [1].

Materials and methods

Study design and participants

Cross-sectional data were collected between January and June 2023 from 609 South Asian participants living in England, using a survey exploring the uptake of professional interpreting services in general practice. Those who were 18 years or older; from Pakistani, Indian, or Bangladeshi ethnic backgrounds; and who self-reported limited or no English language proficiency (rated on a four-item scale from 'not well at all' to 'very well') were eligible for participation. The fieldwork took place in Greater London, the Midlands, Yorkshire and the Humber, and the North West. This study is reported according to STROBE guidelines, and information about the survey development can be found in the supplementary materials.

Recruitment within each region was informed by quotas on ethnic origin, age, and sex to ensure equal representation across key demographic variables. Trained multilingual researchers, external to the study team, used personal networks to recruit participants via convenience/snowballing sampling. Participants went through the survey with a multilingual researcher in their language of choice (e.g., Punjabi, Urdu, Bengali, Sylheti, Gujarati, Hindi). Of the 609 participants, 200 self-identified as Indian, 213 as Bangladeshi, and 196 as Pakistani, living in Greater London ($n=338$), the Midlands ($n=90$), Yorkshire and the Humber ($n=86$), and the North West ($n=95$).

Survey measures

Demographics and health-related questions

The survey (Appendix A) included self-reported demographic questions: sex, age, ethnicity (Indian, Bangladeshi, Pakistani), country of birth, years lived in the UK, main language spoken at home, religion, English language proficiency (validity check for eligibility), living arrangements, whether close family live nearby, relationship status, region, and education level. Participants were also asked questions about their general health, including self-rated health (very bad to very good), number of GP surgery visits in the past 12 months, medical conditions (including participants' confidence in managing health conditions), and disability.

Ethics approval and consent to participate

The materials and protocol were approved by the University Ethics Committee, University of Surrey (Reference: FHMS-19–20-088). Informed consent to participate was obtained from all the participants in this study.

Uptake of professional interpreting services

Uptake of professional interpreting services was assessed by an item asking about different modalities of interpreting participants had experienced at their GP surgery, i.e., face-to-face, telephone, and video interpreting. Professional interpreting within this context refers to the use of trained interpreters, usually booked by staff working in primary care, regardless of modality [7].

Use of other forms of language support

Participants were asked about the use of other forms of language support during consultations at their GP surgeries. These included: doctor or nurse who spoke their language, health advocate (someone who works at the GP surgery who may support with administrative, clinical, and advocacy work as well as interpreting during consultations), another bilingual member of practice staff, a translation app e.g. Google Translate, a family member/friend (onsite/telephone/video), and a bilingual community member (onsite/telephone/video).

General questions on language support

Other questions included the perceived need for language support (rated on a five-item scale from 'no extent' to 'very large extent'), whether they had been told about language support options available to them when they registered at their GP surgery, whether they had been offered a choice of language support, whether they are offered a choice over the sex of the interpreter during a consultation, the importance of using an interpreter that is the same sex as themselves (rated on a five-item scale from 'not important at all' to 'very important'). Participants were also asked about barriers to professional interpreting services related to accessibility, i.e., whether they had ever asked for an interpreter but been told they could not have one, and whether they had ever been asked by their GP surgery to bring a family member/friend to translate for them instead of having an interpreter booked.

Statistical analysis

Data were analysed using SPSS (29·0·1·0). We aimed to recruit approximately $n=200$ in each South Asian subgroup ($n=600$) based on the assumption that multivariable logistic regression models are more reliable when a minimum of 20 events per variable (EPV) are used [20]. Descriptive statistics were used to describe patient demographic characteristics, health, language support experience, and uptake of professional GP interpreting services.

Differences between those using professional interpreting services ($n=382$) and those who do not ($n=227$) were assessed using Chi-squared tests ($p<0·05$). Several variables were re-categorised to aid group comparisons (see Table 1). Binary logistic regression analysis ($n=570$) was used to investigate multivariate demographic, health, and language support experience correlates of using professional interpreting services offered in GP surgeries. Analyses excluded those reporting 'prefer not to say' / "don't know" to questions on age ($n=17$), general health ($n=2$), the extent to which language support is needed ($n=2$), and the importance of having a same-sex interpreter ($n=18$). Demographic, health, and language support experience correlates significantly associated with prior uptake of professional interpreting services ($p<0·05$) were selected for logistic regression models (see Table 1). Certain variables were excluded from analyses; these included items relevant only to those who had used professional interpreting services (e.g., waiting time for a professional interpreter), main language spoken (collinearity with ethnicity), and years lived in the UK (collinearity with country of birth).

Patient and public involvement

Patients and the public were involved in the development of the study ideas, study design, interpretation and dissemination plans for this research. LI is a public contributor and co-authored this manuscript and we have additional public member representation on our advisory and steering groups. We have conducted three patient engagement workshops in Bengali and Somali communities ($n=28$ men and women) to support the interpretation of our findings.

Table 1 Sample characteristics

	Full sample ($n=609$)	Those who have used professional interpreting services ($n=382$)	Never used professional interpreting services ($n=227$)
	n (%)	n (%)	n (%)
Ethnicity*			
Indian	200 (32·8)	110 (28·8)	90 (39·6)
Pakistani	196 (32·2)	138(36·1)	58(25·6)
Bangladeshi	213 (35·0)	134(35·1)	79(34·8)
Region**			
North West	95 (15·6)	76 (19·9)	19 (8·4)
Yorkshire and the Humber	86 (14.1)	52 (13·6)	34 (15·0)
Midlands	90 (14·8)	19 (5·0)	71 (31·3)
London	338 (55·5)	235 (61·5)	103 (45·4)
Sex*			
Female	312 (51·2)	212 (55·5)	100 (44·1)
Male	297 (48·8)	170 (44·5)	127 (55·9)
Age*			
18–34	141 (23·2)	73 (19·1)	68 (30·0)
35 +	451 (74·1)	299 (78·3)	152 (67·0)
Prefer not to say	17 (2·8)	10 (2·6)	7 (3·1)
Mean (SD)	44 (14·2)	45.7 (14·4)	41.2 (13·4)
Education**			
No formal education	151 (24·8)	129 (33·8)	22 (9·7)
Any education (primary and above)	350 (57·5)	178 (46·6)	172 (75·8)
Prefer not to say	108 (17·7)	75 (19·6)	33 (14·5)
Self-rated health**			
Very bad/bad/fair	361 (59·3)	245 (64·1)	116 (51·1)
Good/very good	246 (40·4)	135 (35·3)	111 (48·9)
Don't know/prefer not to say	2 (0·3)	2 (0·5)	0 (0·0)
Mean (SD)	3·43 (0·87)	3.31 (0·85)	3·62 (0·86)
Primary care visits (past 12 months)**			
Have not been	148 (24·3)	70 (18·3)	78 (34·4)
Once or more	461 (75·7)	312 (81·7)	149 (65·6)
Number of comorbidities*			
No comorbidities	178 (29·2)	94 (24·6)	84 (37·0)
One or more comorbidities	332 (54·5)	219 (57·3)	113 (49·8)
Don't know / prefer not to say	99 (16·3)	69 (18·1)	30 (13·2)
To what extent do you feel you need language support**			
No/little/some extent	249 (40·9)	107 (28·0)	142 (62·6)
Large/very large extent	358 (58·8)	273 (71·5)	85 (37·4)
Don't know	2 (0·3)	2 (0·5)	0 (0·0)
Mean (SD)	3·71 (0·86)	3.92 (0·83)	3.34 (0·80)
Told about language support**			
No/Not sure/can't remember	336 (55·2)	147 (38·5)	189 (83·3)
Yes	273 (44·8)	235 (61·5)	38 (16·7)
Choice in language support?**			
Don't know/no/not offered	270 (44·3)	104 (27·2)	166 (73·1)
Yes, sometimes/always	339 (55·7)	278 (72·8)	61 (26·9)
Importance that interpreter is the same sex as the participant**			
Not important at all	170 (27·9)	67 (17·5)	103 (45·4)
Slightly/moderately/important/very important)	421 (69·1)	307 (80·4)	114 (50·2)

Table 1 (continued)

	Full sample ($n=609$)	Those who have used professional interpreting services ($n=382$)	Never used professional interpreting services ($n=227$)
	n (%)	n (%)	n (%)
Prefer not to say	18 (3·0)	8 (2·1)	10 (4·4)
Mean (SD)	2·78 (1·53)	3·06 (1·49)	2·28 (1·47)
Have you asked for an interpreter but been told you cannot have one?**			
No, not experienced issue	449 (73·7)	259 (67·8)	190 (83·7)
Don't know / can't remember	105 (17·2)	77 (20·2)	28 (12·3)
Yes, experienced issue	55 (9·0)	46 (12·0)	9 (4·0)
Bilingual family/friend (onsite)**			
Yes	343 (56·3)	193 (50·5)	150 (66·1)
No	266 (43·7)	189 (49·5)	77 (33·9)
Other bilingual community member (telephone)*			
Yes	60 (9·9)	48 (12·6)	12 (5·3)
No	549 (90·1)	334 (87·4)	215 (94·7)
Other bilingual community member (video link)*			
Yes	25 (4·1)	22 (5·8)	3 (1·3)
No	584 (95·9)	360 (94·2)	224 (98·7)

Abbreviations: *SD* standard deviation

P values χ^2 tests; *$p<.05$; ** $p<.001$

Results

Participants

Demographic characteristics are presented in Table 1. There was an even spread of people from Indian ($n=200$), Bangladeshi ($n=213$), and Pakistani ($n=196$) backgrounds, with age ranges from 18 to 86 years (mean: 44 years), 51% female ($n=312$), and 25% reporting no formal education ($n=151$). Ethnic origin, age, sex, region, and education were significantly associated with uptake, with Bangladeshi and Pakistani participants ($p<0·05$), women ($p<0·05$), older participants ($p<0·05$), those living in London ($p<0·001$), and those reporting no formal education ($p<0·001$) more likely to have used professional interpreting services.

Health-related items

Over three quarters (76%) said they had seen or spoken to a healthcare professional from their GP surgery within the last 12 months. Most reported at least one health issue (55%) and rated their general health as very bad/bad/fair (59%). Diabetes (23%), high blood pressure (18%), and high cholesterol (17%) were the most reported health issues. Over half (55%) of those reporting at least one comorbidity said they felt confident (fairly/very) about managing any issues arising from their condition(s), and 15% reported having a disability. Poor self-rated health ($p<0.05$), one or more visits to the GP surgery ($p<0·001$), and having one or more comorbidities ($p<0·05$) were associated with being more likely to have used professional interpreting services.

Uptake of professional interpreting services

Sixty-three percent of participants reported having used professional interpreting services offered by their GP surgery. Most (59%) reported needing language support during appointments to a 'large/very large' extent and this was significantly associated with a higher uptake of professional interpreting services ($p<0·001$). Face-to-face interpreting (55%) was the most common modality (telephone (17%), video (8%)).

Barriers to accessing professional interpreting services

Less than half (45%) said they were told about available professional interpreting services when they first registered at their GP surgery. Most (56%) reported being offered a choice in the type of language support service and 28% said being offered a choice over the interpreter's sex was 'not important at all' to them. Nine percent reported they had asked for an interpreter but had been told by their GP surgery that they could not have one. These variables were significantly associated with uptake and included in regression models; with those told about available professional interpreting services ($p<0·001$), those offered a choice in the type of language support service ($p<0·001$), those reporting that having a choice over the interpreter's sex was important to some extent ($p.<0·001$), and those who had asked for an interpreter but had been told by

their GP they could not have one ($p < 0{\cdot}001$) more likely to have used professional interpreting services.

Use of other types of language support

Participants were asked to identify any other forms of language support they had used during consultations at their GP surgery, i.e., any language support not provided by a professional interpreter. Most (69%) reported using language support provided by someone working at their GP surgery who spoke their language, with a doctor or nurse most common (58%) and health advocate least common (32%). Of those who reported using a doctor or nurse who spoke their language, most (64%) had also used at least one professional interpreting service modality i.e., onsite, telephone, or video interpreting.

Over half (56%) reported that a family member/friend had interpreted for them onsite (telephone 47%, video link 23%), whilst 9% said that another bilingual community member had interpreted for them onsite (telephone 10%, video link 4%). Translation apps (e.g., Google Translate) were infrequently used (5%). Of these other forms of language support, the use of an onsite family member/friend ($p < 0{\cdot}001$) demonstrated a significant association with lower uptake, whilst the use of another bilingual community member via the telephone ($p < 0{\cdot}05$) and video link ($p < 0.05$) demonstrated a significant association with higher uptake.

Correlates of professional interpreting services uptake

In the adjusted analysis (Table 2), uptake of professional interpreting services was less likely among Indian compared with Bangladeshi (OR 1.98, 1.04–3.76) and Pakistani (OR 2.49, 1.27–4.89) participants. Participants reporting no formal education were more likely to have used professional interpreting services (OR 2·33, 1·13–4·81) than those reporting any formal education (i.e., primary or higher), and uptake was less likely in those who lived in the Midlands compared with London (OR 0·13, 0·05–0·32).

Recency of primary care visits was associated with uptake of professional interpreting services. Those who had seen a healthcare professional from their GP surgery within the last 12 months were more likely to have used professional interpreting services (OR 2·85, 1·51–5·37) compared with those who had not visited their GP surgery in that timeframe.

The extent to which participants perceived their own need for language support was not associated with uptake after adjustment. Those who said they were told about the availability of professional interpreting services when they registered at their current GP surgery were more likely to have used them (OR 7·51, 4·16–13·58) compared with those who had not been told/could not recall. Participants who said they were offered a choice of language support were more likely to have used professional services (OR 6·00, 3·52–10·23) compared with those who said they did not get a choice/could not remember/had not been offered language support.

Participants who reported experiencing a situation where they had asked for a professional interpreter but were told they could not have one were more likely to have used professional services (OR 3·34, 1·18–9·44) than those who had not experienced this barrier. Participants who had experienced a family member/friend act as an interpreter during an appointment at their GP surgery were less likely to have used professional services (OR 0·56, 0·32–0·98) than those who had not.

A sub-sample of participants reported on their most recent experience of interpreting services. This detail can be found in the supplementary materials.

Discussion

This large-scale national study found that nearly two-thirds of South Asian participants with low English proficiency in England had used a professional interpreter at their GP surgery. Participants of Pakistani origin, those without any formal education, and London-based participants were more likely to have used professional interpreting services. Several barriers were independently associated with uptake e.g., not being told about the availability of professional interpreting services, and not being given a choice in the type of language support offered were associated with lower uptake of professional services. People who had previously had a family member or friend act as an interpreter during an appointment at their GP surgery were also less likely to have used professional interpreting services.

Face-to-face interpreting remained most common, followed by telephone and video, supporting findings from our pilot study [21]. Our findings generally support previous research where patients demonstrate a preference for face-to-face interpreting over other modalities [22]. Although video interpreting was less common in our data, research shows that remote methods are acceptable to patients [23] and in particular video-mediated interpreting may provide an opportunity to improve communication and patient care, compared with telephone interpreting [23]. Previous reticence about higher costs of video methods [24] is now outdated and further research is required to understand why video-mediated interpreting remains rare [25].

Asking participants who had used professional interpreting services about their most recent experience provided additional insights. For example, most

Table 2 Associations of demographics, health, and language support experience with uptake of professional interpreting services

	Uptake N (%) / Mean (SD)	Likelihood of uptake (unadjusted), OR (95% CI)	Likelihood of uptake (adjusted), OR (95% CI)
Ethnic origin			
Indian (*N* = 185)	100 (54·1)	1·00	1·00
Bangladeshi (*N* = 199)	126 (63·3)	1·47 (0·98 – 2·21)	**1·98 (1·04 – 3·76)**
Pakistani (*N* = 186)	134 (72·0)	**2·19 (1·42 – 3·37)**	**2·49 (1·27 – 4·89)**
Age – years			
Age (*N* = 570)	M = 44·02 (SD = 14·18)	**1·02 (1·01 – 1·04)**	1·01 (0·99 – 1·03)
Sex			
Male (*N* = 278)	161 (57·9)	1·00	1·00
Female (*N* = 292)	199 (68·2)	**1·55 (1·10 – 2·19)**	1·51 (0·89 – 2·57)
Education			
Any education (*N* = 322)	166 (51·6)	1·00	1·00
Prefer not to say (*N* = 103)	71 (68·9)	**2·09 (1·30 – 3·34)**	0·79 (0·37 – 1·67)
No formal education (*N* = 145)	123 (84·8)	**5·25 (3·18 – 8·69)**	**2·33 (1·13 – 4·81)**
Region			
London (*N* = 309)	217 (70·2)	1·00	1·00
North West (*N* = 91)	76 (83·5)	**2·15 (1·17 – 3·93)**	1·50 (0·69 – 3·27)
Midlands (*N* = 87)	17 (19·5)	**0·10 (0·06 – 0·18)**	**0·13 (0·05 – 0·32)**
Yorkshire and the Humber (*N* = 83)	50 (60·2)	0·64 (0·39 – 1·06)	0·49 (0·21 – 1·12)
General health (1 'very bad' – 5 'very good')			
General health (*N* = 570)	M = 3·43 (SD = 0·88)	**0·63 (0·52 – 0·77)**	0·80 (0·51 – 1·25)
Comorbidities			
None (*N* = 172)	91 (52·9)	1·00	1·00
Prefer not to say (*N* = 93)	67 (72·0)	**2·29 (1·33 – 3·95)**	0·70 (0·29 – 1·68)
One or more (*N* = 305)	202 (66·2)	**1·75 (1·19 – 2·56)**	0·81 (0·38 – 1·70)
Primary care visits (< 12 months)			
Not bee/seen (*N* = 134)	60 (44·8)	1·00	1·00
One or more (*N* = 436)	300 (68·8)	**2·72 (1·83 – 4·04)**	**2·85 (1·51 – 5·37)**
Extent language support needed (scale: 1 'no extent' – 5 'very large extent')			
Extent (*N* = 570)	M = 3·70 (SD = 0·86)	**2·29 (1·82 – 2·87)**	1·29 (0·93 – 1·77)
Told about formal interpreting services			
Not sure/no (*N* = 315)	137 (43·5)	1·00	1·00
Yes (*N* = 255)	223 (87·5)	**9·05 (5·88 – 13·95)**	**7·51 (4·16 – 13.58)**
Choice in language support offered			
Don't know/no/not offered (*N* = 257)	100 (38·9)	1·00	1·00
Yes (sometimes/always) (*N* = 313)	260 (83·1)	**7·70 (5·23 – 11·35)**	**6·00 (3·52 – 10·23)**
Importance interpreter is the same sex as participant (scale: 1 'not at all important' – 5 'very important')			
Importance (*N* = 570)	M = 2·75 (SD = 1·45)	**1·45 (1·29 – 1·64)**	1·16 (0·95 – 1·41)
Have you asked for an interpreter but been told you cannot have one?			
No (*N* = 424)	248 (58·5)	1·00	1·00
Don't know/can't remember (*N* = 96)	71 (74·0)	**2·02 (1·23 – 3·31)**	1·69 (0·85 – 3·34)
Yes (*N* = 50)	41 (82·0)	**3·23 (1·53 – 6·82)**	**3·34 (1·18 – 9·44)**
Bilingual family/friend acted as interpreter			
No (*N* = 245)	177 (72·2)	1·00	1·00
Yes (*N* = 325)	183 (56·3)	**0·50 (0·35 – 0·71)**	**0·56 (0·32 – 0·98)**
Bilingual community member acted as interpreter via telephone			
No (*N* = 514)	315 (61·3)	1·00	1·00
Yes (*N* = 56)	45 (80·4)	**2·58 (1·31 – 5·12)**	0·80 (0·25 – 2·57)
Bilingual community member acted as interpreter via video link			
No (*N* = 549)	341 (62·1)	1·00	1·00
Yes (*N* = 21)	19 (90·5)	**5·79 (1·34 – 25·13)**	3·22 (0·43 – 24·03)

Abbreviations: *CI* confidence interval, *OR* odds ratio, *M* mean, *SD* standard deviation
Bold values are statistically significant ($p < 0.05$). Adjusted for all other variables in the table

appointments with a professional interpreter were for routine appointments for ongoing health conditions and most people reported relatively short waiting times for appointments involving interpreters (< 1 week). However, we identified problems in the extent to which participants felt that interpreters and doctors understood their health concerns, how well patients understood information from doctors, and how comfortable they felt talking to a healthcare professional through a professional interpreter. With under half of the sample not being satisfied with their experiences, we identified considerable scope to improve satisfaction with language support and the overall consultation.

Existing research has mainly focused on the benefits of providing professional interpreters for people with low English language proficiency in different settings or explored the patient and/or healthcare provider perceptions of service quality [8–12, 17, 18, 26–28]. One study investigated barriers to professional interpreter use in primary care in Switzerland through a survey of care providers and interpreter agencies, identifying cumbersome organization, absent financial coverage and lack of knowledge on how to arrange interpreter interventions to be the main barriers [29]. Our study is novel in focus, reporting on the reasons for, and barriers to, uptake of professional interpreting services in an environment where these services are in principle freely available, alongside patients' experiences of the services themselves. We have used a novel approach to gain these insights, by working with multilingual researchers who collected data from patients in several different languages.

A sizeable minority of participants in our study reported a lack of confidence in discussing health concerns in interpreter-mediated consultations. This supports previous qualitative research demonstrating that an interpreter's presence might add complexity to the consultation. Lack of trust, mismatch of agendas, and power imbalances can make shared-decision making in interpreted consultations challenging [30, 31]. Understanding and improving patient confidence in professional interpreting services provided by GP surgeries is a vital component to improving uptake. Further recommendations from this research include emphasising differences between professional interpreters and other types of language support, highlighting the challenges of relying on informal language support from friends/families, and ensuring people are aware of GP professional interpreting services and given a choice in the type of service offered.

Strengths and weaknesses

Our research benefited from key stakeholder involvement, working closely with experts in multilingual communication and users of language support services to develop and pilot a survey [21] that we successfully applied at scale. Our approach (of using bilingual interviewers from South Asian backgrounds) allowed us to reach people who do not speak English well, where participants could share their experiences with linguistically concordant researchers. Our non-probability convenience/snowball sampling approach is often employed with groups described as 'hard to reach' without a sample frame. This limits representativeness and inferences cannot be drawn beyond the sample under investigation [32]. However, we took steps to mitigate potential sources of bias and enhance sample diversity, e.g., using peer-to-peer recruitment reduced the risk of participant selection bias associated with the research team. It may also have allayed participants' concerns about confidentiality/privacy. The use of quotas (ethnic origin, age, sex) ensured balanced participation across key demographic variables and our participants spoke a range of different South Asian languages. Organising the fieldwork over several distinct geographical regions may also have facilitated variation in models of delivery of interpreting services within primary care, capturing a more diverse range of experiences.

Our cross-sectional approach provides a snapshot of the factors associated with uptake of professional interpreting services among South Asian populations; however, it prevents us from making causal inferences about uptake, or the outcomes associated with the use of such services, e.g., patient confidence and comprehension of health outcomes. We collected self-reported data from patients; future research should also establish views of multiple stakeholders (e.g. primary care staff, interpreters, providers, commissioners, and policy-makers) to understand how interpreting services are implemented in primary care. This should include practice data on interpreter bookings, alongside information on how services are commissioned and implemented [15].

This study focused on people from South Asian communities in England, where Punjabi and Urdu (two widely spoken languages in these communities) are the third and fourth most common languages for those who do not speak English as a main language. Future research could consider exploring similar issues among other language groups/languages that are less commonly spoken and/or where language support services may be scarce.

It is unclear whether our focus on languages that are more commonly spoken in England (and where there may be a greater degree of support) explains the prevalence of face-to-face interpreting over remote options in our sample. The modality through which professional interpreting services in primary care are delivered may

vary according to multiple inter-related factors, e.g., preference; cultural background; availability; dialect/language; location; and local commissioning arrangements.

In summary, from a sample of South Asian people with low English proficiency, most people had used a professional interpreting service at their GP surgery, but challenges remain to improve consistency of offer, uptake, quality, and patient satisfaction. Raising awareness of services, patient education, as well as addressing perceived barriers to accessing professional services (e.g. reducing reliance on informal interpreting) will support equitable access to primary healthcare and reduce inequalities in health.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12875-024-02646-4.

Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

Authors' contributions

KLW, EW, SB, PG, GBB and CV were responsible for funding acquisition. All authors contributed to the conceptualisation of ideas, evolution of research goals and aims and methodology. GH, EW, KLW and SB were responsible for data curation and formal analysis. GH and KLW drafted the original manuscript and all authors contributed to writing the final manuscript (reviewing and editing).

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Data availability

Individual participant data that underlie the results reported in this article, after de-identification (text, tables, figures, and appendices) will be made available beginning 6 months and ending 5 years following article publication. Researchers who provide a methodologically sound proposal will be granted access to the deidentified participant data to achieve the aims in the approved proposal. Proposals should be directed to k.whitaker@surrey.ac.uk; to gain access, data requestors will need to sign a data access agreement.

Declarations

Competing interests

The authors declare no competing interests.

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