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Health navigation and interpreting services for patients with limited English proficiency: a narrative literature review

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ABSTRACT

INTRODUCTION: Culturally and linguistically diverse populations (CALD) have significant health outcome disparities compared to dominant groups in high-income countries. The use of both navigators and interpreters are strategies used to address these disparities, but the intersections between these two roles can be poorly understood.

AIM: To gain an overview of the literature on health navigation and similar roles, with particular reference to the New Zealand context, and to explore the interface between these roles and that of interpreters for CALD populations with limited English proficiency.

METHODS: A narrative review of the literature was conducted using a range of search strategies and a thematic analysis was conducted.

RESULTS: There are several barriers to health-care access relating to health systems and CALD populations. For over 50 years, health workers who are members of these communities have been used to address these barriers, but there are many terms describing workers with wide-ranging roles. There is some evidence of efficacy in economic, psychosocial and functional terms. For health navigation services to work, they need to have staff who are well selected, trained and supported; are integrated into health-care teams; and have clearly defined roles. There may be a place for integrating interpreting more formally into the navigator role for members of communities who have limited English proficiency.

CONCLUSION: To achieve better access to health care for CALD populations, there is an argument for adding another member to the health team who combines clearly defined aspects of the roles of interpreter, community health worker and navigator. Organisations considering setting up such a position should have a clear target population, carefully consider the barriers they are trying to address and define a role, scope of practice and training requirements best suited to addressing those barriers.

KEYWORDS: Communication barriers; Community health workers; Delivery of health care; Health services accessibility; Pacific.

Introduction

It is well known that culturally and linguistically diverse populations (CALD) have many health outcome disparities compared to dominant groups in high-income countries such as the United States of America (USA), United Kingdom (UK), Australia and New Zealand.[1,2] For example, in the USA, Latinos have higher rates of diabetes and diabetes-related complications than non-Latinos, and various ethnic minorities have lower cancer

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WHAT GAP THIS FILLS

What is already known: Culturally and linguistically diverse populations (CALD) have significant health outcome disparities compared to dominant groups in high-income countries. Providing navigators and interpreters are strategies to address these disparities, but the intersections between the two roles are poorly understood.

What this study adds: CALD populations face many barriers to health care. The roles of navigators and interpreters need to be clearly defined, particularly where they overlap, and carefully targeted to address the relevant barriers.

survival rates,[3,4] and in New Zealand, Māori and Pacific life expectancy remains lower than that for other people.[5] The use of both navigators and interpreters are strategies to address these disparities, but if such strategies are to be effective, then attention needs to be paid to exactly what job descriptions and training are needed to achieve the best outcome.

The term 'culturally and linguistically diverse' is an Australasian term to refer to populations in Australia and New Zealand who speak languages other than English as their primary language or differ culturally from the dominant culture.[6,7] It does not usually include Indigenous populations due to their considerably different needs and experiences from migrant and refugee groups.[7,8] In this review, we focus on CALD populations who face both cultural and linguistic barriers to good health care to inform our interest in the interface between navigators and interpreters. While there are well-established navigation services for Māori in New Zealand, these are not the focus of this investigation because, although Māori language is important in its own right, there are very few Māori for whom lack of English is a significant barrier to health care. We acknowledge that language use is still an important issue for this population in that service delivery in Māori language may be desirable, but this is usually best done directly, rather than through an interpreter.

For CALD populations, the role boundary between navigators and interpreters is poorly understood.[9] Our previous research into the role of interpreters identified a tension between the role of an interpreter as limited to being a conduit between patient and clinician to enable communication and the growing acknowledgment that the role may sometimes legitimately expand towards that of a cultural broker.[10]

This literature review was conducted as part of a study of Pacific navigators in Wellington who all saw interpreting as part of their role, but who were not trained interpreters.[11,12] For this reason, the current study emphasises Pacific rather than Asian groups, despite the latter comprising an increasing proportion of the New Zealand population. While Pacific populations in New Zealand are diverse and many Pacific people are English proficient and do not require interpreting in health interactions, there are still high numbers of Pacific people for whom language is a barrier in a health system that is run mainly in English.

This paper first reviews possible barriers to achieving health-care parity and then summarises the literature on how the roles of navigators have developed and been defined in general, evidence for their efficacy and the intersection of the navigator role with interpreting.

Methods

The aim of this literature review was to conduct an '*interpretive overview of a topic*'[13] through a narrative review of the international literature. A range of search techniques was used to locate literature on navigation and community health workers in the health sector in general and about CALD populations in particular. This included some literature on health interpreting. Searches were conducted in both clinical and social science databases (including Google Scholar and Medline), to locate both academic and grey literature that shed light on the origin of these roles and covered both New Zealand and international contexts. A variety of search terms (such as 'health navigation', 'patient navigation', 'community health worker') were used to obtain the greatest coverage, rather than a limited number of terms, as would be the case in a systematic review. In addition, a strategy of following references cited in relevant literature in a snowball approach was also used until a broad survey of the field was established. The search terms used were iteratively developed as more literature was reviewed.

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Over 200 references were collected in the process of selecting the 81 references presented in this narrative review. Selections were made on the basis of the articles being particularly relevant and representative of the international and New Zealand based Pacific literature, especially the issue of role boundaries between navigation and interpreting services for people with limited English proficiency. For this reason, literature about Māori has been not been included, as limited English proficiency is rarely a feature of this population.

Results

Barriers to health care

Our review identified many barriers to CALD populations obtaining health care. Table 1 shows the range of barriers identified in references from New Zealand (with respect to Pacific peoples),[14–19] Australia[20–22] and the USA.[23,24]

Table 1. Barriers to culturally and linguistically diverse (CALD) populations obtaining health care

The design of the health system, including opening hours and location of facilities[14,16–18,23]
The complexity of health systems[14,24]
The lack of health-care providers from CALD communities[16,18,22,24]
Attitudes of health-care providers[15–18]
Cost of services[16–20,23]
Physical access to services or transport, relating to geographical location of services[14,17,19,22]
Language, including English-language ability and knowledge of medical terminology[14,15,17–22]
Cultural barriers, including lifestyle, fear of discrimination, different perceptions of health[14,16,18–22]
Health literacy, including unfamiliarity with health systems and lack of information[17,20–24]
Lack of trust[18,19,23]
Employment issues (specifically inflexible employment circumstances)[16,17]*
Heavy family commitments[14,16–18]*

* These barriers were mentioned only in relation to Pacific populations in New Zealand.

Strategies to overcome these barriers

One strategy to overcome the health-care barriers for CALD populations has been to deploy specific health workers who are members of CALD communities to assist with navigating the system. It has long been acknowledged that members of minority populations benefit from their interactions with health services being facilitated by a member of their own community who speaks their language and understands their culture, and also understands the health system.[25]

Not only CALD populations face barriers to accessing optimal health care. Some navigation services developed to address barriers focus on other disadvantaged populations (eg people with low socio-economic status) or on the management of particularly complex health conditions such as multi-morbidity or cancer.[26]

Manderson *et al.* describe four ways that navigator-type programmes can be set up: setting-based (eg community or hospital); disease based (eg stroke, cardiac disease); population-based (eg working poor, intellectual disabilities); or role-based (eg focus on brokerage or advocacy, clinical interventions or patient empowerment).[27]

Terminology

The term 'patient navigator' is frequently used in the USA and in cancer care. This term originated in the USA in 1990 when Freeman established a patient navigator programme in the Harlem Hospital Centre in New York. This programme aimed to reduce the death rate from cancer among the poor Black population by reducing barriers to timely health care.[23] The concept of navigation has since spread to other countries including Canada, Australia and New Zealand.

A related role in the health workforce is held by Community Health Workers (CHWs), who have a longer history than 'navigators', but often a very similar role. First used in developing countries as a low-cost way to improve health, CHWs were introduced in the USA in the 1950s and 1960s, with a role that encompasses health advising, information, referrals, translation services and advocacy for their communities.[25]

While 'navigator' and 'CHW' are key terms for roles that aim to help patients overcome barriers to care, there is an extensive range of titles internationally for very similar or overlapping roles, as shown in Table 2.

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*Table 2. Key terms for roles that aim to help patients overcome barriers (terms used in New Zealand are marked with an *)*

Navigator	Community Worker	Cultural terms
• Patient navigator • Health navigator* • Nurse navigator • System navigator • Clinical health navigator* • Community navigator • Community health navigator • Clinical Family Navigator*	• Community Health Worker* • Nurse-community health worker • Community Health Advisor • Community Outreach worker • Lay health worker • Village health worker	• Lay health cultural broker • Intercultural mediator • Cultural Case Worker* • Pacific Cancer Care Navigator* • Pacific Navigator* • Multicultural Health Broker • Multicultural Health Worker • Ethnic Health Care Advisor
Care-coordination	**Nurse**	**Other**
• Chronic condition care co-ordinator • Cancer Care Co-ordinator* • Care co-ordinator	• Guided Care Nurse • Advanced Practice Nurse (APN) Transitional Care	• Transition coach • Case Manager (Registered Nurse – RN)

Differentiation between the overlapping roles of navigators and CHWs is also discussed in the literature. Key differences are that navigators have a stronger focus on individual patients rather than a community approach;[28–30] that navigators have a more explicit focus on overcoming barriers to care;[23,27,30,31] and that CHWs are more likely to focus on general health promotion.[29,32]

The term 'navigator' is used in both community and clinic settings, but in the USA, it is more common in clinics.[33] In New Zealand, the term has been used in the context of both mental health and cancer care, and in health services for Pacific and Māori peoples.[34]

Educational background

Whatever they are called, such workers may have a professional background (such as nurse or social worker) or may not (CHWs are generally lay).[28] It is debatable whether the lay or professional model is better in different contexts. An evaluation of cancer navigation programmes found a mix of findings in favour of lay navigators, health-care professionals, and both acting in a complementary manner.[26] Whether such workers are lay or professional has implications for their alignment with patients and health systems. The choice of terms also has implications for how they are perceived.[35] In the context of cancer care navigation, the role may be health-system oriented (with a focus on continuity of care) or patient-centred (with a focus on empowerment).[36]

Defining attributes of community health workers and navigators

A defining attribute of CHWs is that they have the trust of their community,[37] and it has been argued that the best navigator would also be a CHW because:

> '[a]bove all, community health workers are trusted members of the community they serve and, as such, are able to establish relationships, increase communication, and act as cultural brokers between the community and the health care system.' [Volkmann][29]

Key words in descriptions of both navigators and CHWs are 'trusted', 'natural leaders',[38] 'bridge' and 'safe passage'.[39,40]

Some have questioned the value of having the distinct position of 'navigator' and whether the navigator role can or should be performed by existing health personnel (eg cancer navigation within the nursing role).[27,41,42] Some advocate for all staff to incorporate 'navigation' into their work because this 'ensures that there is organisation-wide responsibility'.[27] Others favour a discrete navigator role to provide a single point-of-contact for patients in a complex health system.[43,44]

Role of navigators and similar positions

What navigators and others in similar roles actually do, or should do, has been extensively explored, with a good deal of consensus, but also some divergence.[24,27,30,33,37,38,43–54] The main roles can

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Table 3. Roles of navigators

Role category	Detailed aspects of role
Overcoming health system barriers	Care co-ordination[23,27,30,43–45,48] including: • scheduling appointments, making referrals, etc[30,33,38,44,46,51] • reaching out via phone, mail or face-to-face[33] • collaborating with health-care providers[27] Assisting with paperwork[30] Facilitating communication between patients and health-care professionals[30,48] System navigation[45,50] Helping with access to health services[38,43] Advocating for patients to remove barriers to care[27,33,37,45,52] Advocating for needed and additional services[48]
Overcoming 'patient' barriers[30]	Translating/Interpreting[24,30,33,50,52] including: • supporting GPs to use interpreters[4,38] • 'Assist[ing] with understanding of information during patient–provider communication'[48] Providing practical help[52,53] including: • social support[37] • arranging transportation[30,48,51,54] Assisting with financial/insurance barriers[30,48,54] Assisting with childcare issues[30,48,54] Cultural mediation/brokering[33,37,48,52]
Education[24,27,30,33,44–46,48–50,52,54]	Being a resource guide or information support[37,43,44,48,50,53] Explaining health terminology[54] Facilitating health promotion[38] Acting as a mentor[50] Coaching patients in active self-management[37,51] Training hospital staff in how to provide effective care across cultures[51] Pointing out problems to health-care staff (intercultural mediator)[52] Emotional/psychosocial support[30,43,52–54] either directly or by referral; including: ○ being a skilled listener[48,49] ○ supporting decision-making[53]
Assessment	Identifying client needs[38,44] Assessing health status[27] Monitoring and addressing additional barriers[46]
Conflict mediation	Mediating between staff and patients when there is conflict caused by linguistic or cultural barriers[52]

be grouped into the following broad categories, from the more to the least commonly mentioned: overcoming health system barriers; overcoming barriers that may be more associated with a CALD population ('patient' barriers); education; assessment; and conflict mediation. Overcoming health system and CALD-associated barriers cover a wide range of activities that are documented as part of the navigator role in at least one context, as shown in Table 3.

Evidence for efficacy of navigator-type roles

Several international studies (but no New Zealand research) have evaluated the efficacy of individual navigation programmes. There have also been systematic reviews of the effects of CHWs on various outcomes,[55] the effects of navigation for chronically ill older adults[28] and interventions including navigation to increase

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participation of CALD populations with cancer care.[56]

The use of navigators in cancer treatment and screening has been the most often investigated and has the largest literature to support it. One study found that the use of health navigators resulted in the following positive outcomes:

> 'increased screening levels, down-staging of targeted cancer diagnoses, shortened timelines from screening to diagnosis and treatment measures, improved treatment adherence, patient satisfaction scores and patient reported outcomes, and return on investment in the program.' [Cantril and Haylock, p. 85][57]

Similar results have been found in other contexts. Based on findings from a systematic review, Manderson *et al.* suggest measuring effects in three areas: economic (optimising health-care resources), psychosocial (improving experience with the system, eg satisfaction with care) and functional (impact on quality of life and capabilities).[27] There is evidence for positive economic outcomes in several studies, including an evaluation of the notable Seattle Children's Patient Navigator Program.[46,55,58–61] Positive psychosocial[56,61,62] and functional[48,63] effects have also been identified in several studies. Others found mixed evidence or that navigation was ineffective for treatment adherence.[55,56] Toseland *et al.* (as cited in Manderson[27]) point out the importance of the 'investment effect' and advocate for studying long-term effects, rather than drawing conclusions from research measuring effects in the short term.

Key requirements for health navigation to work

Fundamentally, people in this navigation type of role need to be selected well and supported well.[45] Other key requirements for successful health navigation are integration into the health-care team,[27,64,65] good training[24,33,53,66,67] and clear role definition.[23,53] Training needs to cover the range of possible elements that the multifunctional role entails, such as information about medical conditions and where to find resources, logistics such as transportation and interpreting and interpersonal skills.[24,66] In addition, health professionals should be trained to understand and value the navigator role, and to increase their cultural sensitivity and awareness.[20,47]

There are also threats to the success of any health navigation programme. Role definition features prominently as a threat:[37,53,68]

> The last thing that consumers, in particular, need is a host of new titles and terminology to cause more confusion. The lack of clarity around 'who does what' may also potentially disrupt cohesion and collaboration among members of the care team…' [Watson[69]]

Other possible risks in introducing navigation services include the a risk of the role being female dominated,[70] with the possibility that it is less effective for male patients.[71] There is the risk of burnout if workers are 'too committed' to community or are employed for too few hours or work more hours than they are paid for.[38] The new role may also be 'perceived as a threat to other nurses or health professionals and the change … resisted'.[53] Adding a new role may also increase the complexity of an already complicated health system.[53]

Role of interpreters

In contrast to the wide-ranging definitions of roles for navigators or CHWs, which may include some interpreting, the role of professional interpreters is usually more narrowly defined as that of a 'conduit' with a code of ethics that restricts their role to that of 'message transfer'.[72,73] The professional interpreters' code of ethics may explicitly prohibit '[engaging] in other tasks such as advocacy, guidance or advice'.[64] The usefulness and practicality of this narrow scope of practice has been questioned, and is an ongoing area of controversy internationally.[10,74,75] Many interpreters report experiencing situations where they feel the need to do more than interpret and that other participants also often expect them to do more.[76–82] As early as 1984, for example, First Nations interpreters in North America 'experienced difficulties negotiating the various roles that others often expect of them'.[83] Interpreters themselves vary in their definition of their role, with some considering that their role legitimately and necessarily encompasses advocacy, cultural brokering and emotional support.[84]

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Intersection of health navigation with interpreting

There is little literature explicitly discussing the intersection between the roles of health navigators and interpreters. Intercultural mediators in parts of Europe have a role that includes interpreting,[52] and some recent US navigator programmes (eg the Seattle Children's Patient Navigator Program) explicitly train their staff in interpreting skills.[24,51] Although the interpreting literature's discussion about extending the interpreter role implies an overlap with navigators, this is not usually made explicit.

Discussion

This narrative literature review found a wide range of terminology used in the field of health navigation. The roles of these types of workers also encompass a wide range of tasks with little consistency between contexts. There is mixed evidence of the efficacy of health navigation and related roles, partly due to the difficulty of measuring the effects of such interventions across different contexts. There is general agreement that training is essential and that roles and scope of practice need to be better defined and terminology clarified to avoid confusion among both patients and health-care professionals. People in navigation and interpreting roles need to be well supported and well integrated into the health-care team.

This review highlights the variation in programmes that include an additional worker to the standard health-care team to try to improve outcomes for CALD populations. There is a conundrum in that some of the more effective programmes have a large scope and yet success depends on such workers being well integrated into the health-care team, being well trained and having a clearly defined role. This is a challenge to be considered when planning the introduction of new programmes to improve health outcome disparities for CALD populations.

In New Zealand, there is currently no accredited course in health navigation, so training for this role is problematic, although some training is available for community health workers. Accredited professional interpreter training is available, but New Zealand does not have its own interpreter accreditation programme. In the absence of adequate specific training, organisations setting up a navigator programme will need to focus on role description and determine whether people applying to be a health navigator have the experience and expertise to fulfil that role.

One size does not fit all

The barriers facing CALD populations are heterogeneous and the best strategy to overcome these will vary. Health navigation services may not necessarily be the optimum strategy to overcome health-care barriers for specific CALD populations. For some CALD populations, provision of interpreters (as we have previously advocated[85]) may be sufficient (eg for well-educated people from European countries). For others, health literacy and cultural barriers may be significant and a cultural broker role may be needed. In the context of cancer, a clinician navigator (who uses an interpreter) may be more effective than a language concordant community worker with limited understanding of the cancer treatment environment. Addressing the cultural competence of clinicians and better funding for poor communities may be a better approach in some contexts.

Conclusion

Our review suggests that to achieve better health services for CALD populations, there is an argument for adding another member to the health team. Organisations considering setting up such positions should have a clear target population and carefully consider the barriers they are trying to address. The role may include aspects of an interpreter, community health worker or navigator, so it is important to define the role, scope of practice and training requirements best suited to addressing those barriers.

Competing interests

The authors declare no competing interests.

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