Cultural competence and diversity responsiveness: how to make a difference in healthcare?
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8 General Discussion
General Discussion

This thesis aims to contribute to a scientific basis for healthcare that effectively responds to patients’ ethnic diversity, summarised here as ‘culturally competent’ care. We addressed three themes: cultural competence at the level of individual healthcare providers; cultural competence in medical education; and cultural competence at the healthcare organisation level.

This chapter discusses the main findings of the studies presented in this thesis. Part 1 summarises the studies; Part 2 deals with methodological issues; Part 3 considers the findings in the light of current debates on cultural competence; Part 4 makes recommendations and discusses implications for further research, practice and policy; and Part 5 presents the conclusions of this thesis.

Part 1 Summary of the main findings

Cultural competence at the level of individual healthcare providers

The aim of the first three studies presented in this thesis was to outline the broad concept of cultural competence into a useful concept for medical practice and medical education. In Chapter 2 we developed a conceptual framework of cultural competence for individual healthcare providers. This framework, based on the literature and personal interviews with physicians and patients, distinguished between the following cultural competencies: knowledge of epidemiology and the differential effects of treatment in various ethnic groups; awareness of how culture shapes individual behaviour and thinking; awareness of the social context in which specific ethnic groups live; awareness of one’s own prejudices and tendency to stereotype; ability to transfer information in a way the patient can understand, and to use external help (e.g. qualified interpreters) when needed; and ability to adapt to new situations in a flexible and creative manner. The results show that more dimensions are involved in delivering high-quality care than merely the cultural one. Most cultural competencies emphasise a specific aspect of a generic competency that is of particular importance when dealing with patients from different ethnic groups.

The study in Chapter 3 addressed cultural competence in specialist paediatric asthma care. In this study we interviewed paediatricians and nurses and explored the mechanisms that characterise the care process for ethnic minority children with asthma, and the cultural competencies that emerged from that. We found competencies necessary for effective communication. Although we specifically addressed the paediatric asthma care setting, the emerged competencies are comparable to the general cultural competencies found in our first study (Chapter 2). The focus on
communication is in line with the finding that patient non-adherence was the central problem in asthma care. We found some evidence that if care providers would improve the patient-centred skills that are now considered the ‘norm’ in medical training, then they would already make good progress. This strengthens the hypothesis that most cultural competencies are specifications of generic competencies that healthcare providers should already possess. This study also showed that care providers do not always consciously recognise all the mechanisms that lead to deficiencies in culturally competent asthma care that they provide to ethnic minority children (e.g. communicating mainly from a biomedical perspective, and using only ‘informal’ interpreters).

In Chapter 4 we addressed cultural competence in care provision in a specific healthcare setting: i.e. asylum seekers living in asylum-seeker centres whilst awaiting the decision concerning their request for asylum. Through a survey and group interviews we explored the particular cultural competencies that nurse practitioners working with asylum seekers considered to be important. In this healthcare setting we found a more specific elaboration of some of the general cultural competencies from the framework. Especially the knowledge component was further distinguished from the general cultural competence framework (e.g. knowledge with regard to diseases common in a patient’s country of origin; knowledge on the effects of refugee-hood on health). The more highly specified cultural competencies were related to the various (and often difficult) migration histories of asylum seekers and the unique circumstances in which this patient group lives in the Netherlands. Apparently, when providing care in a healthcare setting with such a specific patient group, the general cultural competencies described in the framework need to be further specified for the particular care context.

**Cultural competence in medical education**

In this part of the thesis we changed the focus from the conceptualisation of cultural competence at the individual healthcare provider level, to the development, content and assessment of cultural competence in medical education. In Chapter 5 we assessed the cultural competence of medical students and Youth Health Care physicians. For this, we used a newly developed instrument based on the conceptualisation of cultural competence as reported in Chapters 2 to 4. It was shown how the results from the assessment could be used to support the development of an educational cultural competence program. We found that, on average, respondents scored low on the knowledge domains, low to moderate on the behaviour domains, and high on reflection ability. Based on this study, we conclude that curriculum development should focus on increasing knowledge and improving behaviour. We found a weak association between self-perceived cultural competence and assessed knowledge, reflection ability and
consultation behaviour. Assessing cultural competence using this assessment instrument enabled us to identify gaps related to cultural competence training in the current curricula of our respondents.

Chapter 6 presented ten recommendations for the development of training in culturally competent medical communication, based on a qualitative survey among experts in the field of diversity in medical education. The recommendations that emerged were that: the content of training should be based on a clear ‘view’ on culturally competent communication; all students need to be educated in culturally competent communication; teachers should stimulate awareness of personal biases and an open attitude; three core communication skills should be taught, i.e. listening, exploring and checking; practice should be provided with a professional interpreter; knowledge content should focus on mechanisms relevant to various ethnic groups; students should be offered a variety of experiences in a safe environment; and that all persons involved should be aware that stereotyping is a pitfall. Training in communication skills for consultation with ethnic minority patients cannot be separated from teaching issues of awareness and knowledge. Comparable to the study on asthma care (Chapter 3), the shared views on the content of these communication trainings are in line with general patient-centred communication approaches. However, the potential complexity of communication with patients from an ethnic minority group (due to language barriers, cultural distance and/or influence of stereotypes) requires explicit qualities or a ‘PLUS’ in the generic patient-centred approach.

**Cultural competence at the healthcare organisation level**

The third part of the thesis addressed cultural competence at a level beyond that of individual care providers, namely the level of healthcare organisations. In Chapter 7 we developed an analytical framework for organisational responsiveness to ethnic diversity. The framework is based on a qualitative document analysis of six approaches for organisational responsiveness to diversity. We identified seven domains that were represented in most or all approaches: ‘organisational commitment’, ‘empirical evidence on inequalities and needs’, ‘a competent and diverse workforce’, ‘ensuring access for all users’, ‘ensuring responsiveness in care provision’, ‘fostering patient and community participation’ and ‘actively promoting responsiveness’. Variations in the conceptualisation of ‘responsive care’ reflected different assumptions about the type of diversity that should be responded to. For example, approaches that focus on ethnic diversity mostly refer to cultural and language differences; approaches that broaden their target populations to (e.g.) ‘vulnerable’ groups adopt a more multidimensional approach, also paying attention to such factors as socio-economic status and gender. Despite differences in the way different approaches are labelled, this comparative study
revealed a broad consensus among different approaches concerning the way in which health organisations should respond to diversity.

Part 2 Methodological considerations

Strengths and limitations of the studies

A strength of this thesis is the combination of methods used in the various studies. Most studies were explorative in nature, in line with our objectives, and made use of qualitative research methods. Qualitative research is the appropriate research approach to gain in-depth understanding of the nature and context of complex phenomena, and provides understanding of respondents’ personal experiences (1). Additionally, in Chapter 2 we studied various healthcare settings in breadth (e.g. general practice, internal medicine, occupational medicine), while in Chapters 3 and 4 we studied two specific healthcare settings in depth. Therefore, our operationalisation of cultural competence is based on a variety of perspectives and healthcare settings. The explorative studies and operationalisation of the cultural competence concept also enabled us to subsequently perform a quantitative assessment of the level of the individual care provider’s cultural competence.

Although we studied different and diverse healthcare settings, the total picture of cultural competence in healthcare is still patchy. Although we have no reason to assume that our findings would not be valid in other healthcare settings, we recommend specific healthcare settings to examine whether it is necessary to further specify the generic cultural competencies we have defined in this thesis.

Amongst our studies, the least explored perspective is that of ethnic minority patients. While we did explore the process of health care from their perspective (Chapter 2), we did not explicitly ask them about the cultural competencies of healthcare providers or organisations. Therefore, we might have missed competencies that ethnic minority patients regard as important. For example, in a qualitative study among patients with limited English proficiency, these respondents expressed the importance of family involvement in health care (in roles such as patients’ advocate, carer, mediator) and the researchers defined the resulting cultural competency as ‘negotiating family involvement’ (2), an issue that was not emphasised in our studies.

A limitation of our data might be the influence of social desirability. Although we took several precautions to diminish this kind of bias, (e.g. anonymity of questionnaires used in Chapters 3 to 5; guaranteeing anonymity when reporting the data), in the case of ‘taboo’ issues, such as influence of provider bias on the healthcare process, social desirability might have played a role. On the other hand, the study among asthma healthcare providers offered the insight that respondents were ‘unaware incompetent’:
they freely reported ‘non-desirable behaviour’ (in this case cultural incompetence) because some respondents were simply not aware of the desirable behaviour.

From a professional viewpoint, the researcher did not have any shared experiences as a healthcare provider, because she does not have a medical background; nor does she share a professional perspective with the respondents. However, she was able to offer the perspective of an ‘outsider researcher’ on the provision of health care (3). Advantages of being an outsider researcher were that she was able to question issues that might be self-evident for respondents; or the researcher could hide behind a ‘cloak of ignorance’ (4). In these situations she could ‘force’ care providers to explicitly explain why they, for example, did things in a certain way rather than assuming that she had understood. A disadvantage is that the researcher may have overlooked specific issues of importance in the healthcare process (things only other care providers would know about), simply because she was not aware of their existence.

From a more personal viewpoint, the researcher being a white Dutch female meant that she shared the ethnic background of almost all of the care providers that were interviewed. This may have helped healthcare providers to not be overly sensitive about difficulties they had experienced with ethnic minority patients. For example, if the researcher had been a veiled Muslim woman, respondents might have been hesitant to share possible negative experiences with Muslim patients.

Fortunately, the studies performed in this thesis involved researchers from different disciplines (medicine, psychology, sociology, epidemiology, medical education). Together they represented and bring a breadth of professional perspectives to this research. However, considering the ethnic perspective, most of the researchers were from a Western ethnic background.

**Internal validity**

Several factors may have threatened the internal validity of our studies; below we discuss each study separately.

The conceptual framework we developed in Chapter 2 was based on analysis of real-life case studies and existing literature. However, we did not perform a systematic review of the conceptualisation of cultural competence in the literature. Since the publication of this framework (in 2009) the literature on cultural competence has expanded and the concept has evolved. Therefore, our conceptual framework should be adopted with some caution, bearing in mind that new domains may have to be added to our conceptualisation.

In Chapter 3 we interviewed only a small number of healthcare providers (n=16) due to the rapid saturation of the data. This might be explained by the ethnic homogeneity of the respondent group. Although the ethnic homogeneity in our respondents reflects the
low rate of ethnic diversity among medical specialists in the Netherlands, it is possible that care providers from ethnic minority background would have provided different experiences and insights. In this study on asthma care, the conceptual framework of cultural competence (Chapter 2) was used in the analysis of the interview data, according to the ‘framework method’ (5). The guidance of our conceptual framework in the analysis could explain why the cultural competencies of our conceptual framework were comparable to those we defined in the paediatric asthma care setting. On the other hand, our framework also served as a ‘spotlight’: the theory used (i.e., our conceptual framework) had a clarifying effect on the analysis, revealing difficulties in the care process to ethnic minority children with asthma that would otherwise have remained unnoticed (6). For example, the respondents hardly discussed illness perceptions with their patients, while the conceptual framework describes the importance of gaining insight into illness perceptions and how this might influence patients’ behaviour and thinking.

In the study presented in Chapter 4 we used questionnaires to gain data. In these questionnaires the nurse practitioners were asked for the cultural competencies that they regard as important in providing care to asylum seekers. The use of questionnaires meant that we missed the opportunity to detect important issues in providing care of which respondents were not aware, as we did in the asthma care setting.

In Chapter 5, the low response rate among the medical students may have caused some selection bias. In general, students who are more interested in the area of cultural competence are more likely to have participated. This might have resulted in an overestimation of the cultural competence scores of the medical students (assuming that more interested students would also be more culturally competent). Still, among these respondents we were able to identify gaps in the curriculum. In this study the cultural competence assessment instrument was used for the first time. The validation of this instrument is an ongoing process. Findings regarding the validity of the instrument in this modest study were positive; nevertheless, future research needs to analyse the relations between scores on the various domains and actual provider behaviour in medical practice.

In Chapter 6 experts of the Special Interest Group (SIG) on Diversity showed considerable consensus in their recommendations for developing cultural competence training. This consensus could be a result of the SIG meetings, rather than the views of individual respondents. However, respondents that did not attend meetings also participated in the study.

The analytic framework in Chapter 7 that addresses cultural competence at the healthcare organisational level was based on six approaches to organisational
responsiveness to diversity. Although the six approaches showed considerable consensus regarding the important elements, it is possible that other approaches would add to this framework. Future studies should provide more insight into the ‘completeness’ of this framework.

**External validity of the findings in this thesis**

The generalisability of the findings presented in this thesis might be considered limited, because the ethnic composition of the Dutch population is different from that of other countries. In our research though, we focused on the healthcare process and the competencies to effectively provide care to an ethnically diverse patient population, rather than the provision of health care to specific ethnic groups. The use of the conceptual framework on cultural competence at the level of healthcare providers (Chapter 2) in studies from the UK, Israel, Germany and Denmark (7-10) suggests that our conceptualisation of cultural competence is also recognisable in populations with a different ethnic composition.

In addition, the specific Dutch healthcare system might have influenced our findings. The system in the Netherlands is characterised by universal access. In our studies, the issue of access does not seem to be an issue among our respondents and, subsequently, did not receive much emphasis among the defined cultural competencies (except for the analytical framework of organisational diversity responsiveness that was developed by comparing international approaches). Thus, from country to country the emphasis on specific cultural competencies may vary. This is particularly true in the case of care for asylum seekers. Care providers from different countries have to deal with the legal and social context of their own country, while every country has its own asylum-seeking policies and policies of medical care (11).

**Part 3: Reflections on the main findings**

**Cultural competence and diversity responsiveness**

At the start of our research we focused on healthcare provision to ethnic minority patients. Exploration of the mechanisms and difficulties in the care process for ethnic minority patients in a general context (Chapter 2) and in the context of paediatric asthma care (Chapter 3) revealed a ‘magnifying glass effect’: the issues we found were not in fact unique to patients from these groups but seemed to be more intense expressions of the general difficulties in healthcare. Many difficulties experienced in healthcare in a multi-ethnic population are not a result of the patient’s ethnicity, but result from universal determinants such as low socio-economic status or low health literacy. This raises the
question: to what extent is cultural competence different from generic ‘care provider’ competence (12,13)?

In the first studies that focused on the operationalisation of cultural competence at the healthcare provider level, we found that if physicians would communicate and act in a patient-centred way, some of the barriers related to care provision to ethnic minority patients would be reduced. This hypothesis was acknowledged and supported by the experts in the diversity education field. The generic concept of ‘patient-centred care’ does help in acknowledging diversity among all patients; however, if we draw the parallel with patient-centred care to the organisational level, it becomes apparent that the concept of patient centredness is not the only solution for healthcare inequalities. Patient centredness focuses on acknowledging the uniqueness (diversity) of patients and is, therefore, individualistic. However, serious inequities in health care are strongly associated with differences in group membership and social situation (14,15). For example, being an undocumented migrant is neither a cultural characteristic nor a personal one – it is a social position, with important consequences for health and access to healthcare.

Considering all these factors together, at the level of healthcare systems and organisations we feel it is more correct to speak of ‘diversity responsiveness’ than of cultural competence. Firstly, because healthcare should be responsive to universal ‘diversity’ determinants (such as socio-economic position) in all patients. Secondly, because in healthcare provision to ethnically diverse patients many variables other than merely ethnicity and culture (such as immigration status, religion, gender, and age profiles) are of considerable importance. Vertovec discusses the importance of the interplay of these factors - which he describes using the notion of ‘super-diversity’ (16). With diversity responsive care, societies can prepare for the ‘diversification of diversity’ which is seen in many Western populations. Diversity responsiveness seems to come down to a balance between working in a patient-centred way and thereby acknowledging the uniqueness of patient experiences, and taking into account the group characteristics which make certain groups of patients, such as ethnic minority groups or asylum seekers, particularly vulnerable.

At the level of individual healthcare providers, however, we suggest to stay with the term ‘cultural competence’ for the time being. This term has been widely employed in the literature, and the abilities of professionals are best described with the word ‘competence’ because it encompasses the integration of knowledge, attitude and awareness and skills. Therefore, we place emphasis on the word competence, and want to stress that the word ‘culture’ does not fully describe the competencies necessary to provide diversity-responsive healthcare.
Diversity responsiveness and non-discrimination

The studies in this thesis emphasise the importance of preventing stereotyping and bias from influencing healthcare provision in an ethnically diverse context. This is in line with the current discourse on cultural competence (17,18). At the same time, diversity responsive care explicitly requires care providers to differentiate between patients, if relevant, for quality of care and to optimise chances of optimal healthcare outcomes. However, the criteria justifying differentiation by ethnicity or ethnicity-related characteristics in healthcare have not been fully investigated, and it remains unclear in which contexts and on what grounds it is relevant to differentiate between ethnic groups. Moreover, it is known that this uncertainty makes care providers hesitant about differentiating in their treatment, i.e. their fear of prejudice and stereotyping may lead to suboptimal care (19). We need to be aware of the duality of our message of diversity responsive healthcare.

Unaware incompetent

The study among care providers in specialist asthma care (Chapter 3) showed that care providers are not always aware of the mechanisms that characterise the care process for ethnic minority children. When we assessed the cultural competence of medical students and physicians we found that the rating of their own cultural competence was only weakly related to the scores on assessed knowledge, reflection ability and consultation behaviour (Chapter 5). This is in line with other studies that have demonstrated little, none, or an inverse relation between self-perceived and more objectively measured clinical competence (20). Care providers will not always be aware of their learning needs in cultural competence. Therefore, the assessment of cultural competence in education and research must go beyond merely relying on self-perceived measures.

Cultural competence in medical education

Our research revealed that cultural competence training must be systematically integrated in the medical curriculum and addressed in a longitudinal approach. This will allow to develop training that is cumulative in complexity (12). Teaching cultural competence as a recurrent theme will serve to reinforce this in students. Assessing the level of cultural competence on various competency domains (e.g. knowledge, behaviour) of students that have completed a major part of the curriculum, combined with a curriculum scan (e.g. the TACCT (21)), seems useful to identify gaps in the curriculum regarding cultural competence training.

Within cultural competence it is the integration of knowledge, attitudes and skills which make up a competency (Chapters 2 and 6); this is not different from other medical
competencies. In the literature on cultural competence, most debate focuses on the importance of teaching knowledge. Whereas in earlier days cultural competence training focused on teaching cultural knowledge about specific ethnic groups (12,22), nowadays emphasis is on the danger that providing knowledge might reinforce stereotyping (17,23). The type of knowledge that is relevant for the provision of diversity-responsive care remains an ongoing issue of debate. The study among experts in the diversity education field showed that they consider teaching knowledge at a ‘meta level’ to be important, e.g. about theories on mechanisms that influence health/health care in patients from ethnic minorities such as Kleinman’s explanatory models (24), migration history of ethnic groups, dynamics of culture, or background information on religions. For example, care providers can only anticipate the risks of Ramadan for a diabetic Muslim patient if they are aware of such religious traditions.

**Diversity responsive healthcare organisations**

The results of comparing the approaches for organisational responsiveness showed considerable consensus among the approaches of how health service organisations respond to diversity, despite differences in terminology. It seems that most differences between the approaches reflected differences in the definition of the concept of culture. In some approaches the concept of culture is enlarged and linked to a wide range of attributes such as socio-economic position, education, or sexual orientation. However, we believe that the discussion on providing diversity-responsive healthcare would gain clarity if the various socio-cultural dimensions of importance were clearly distinguished from each other.

The consensus we found for organisational responsiveness, paves the way to structurally implement diversity-responsive healthcare, for example in the Dutch healthcare system. But how does one start? In the Netherlands we pilot tested one of the approaches that appeared in the comparison presented in Chapter 7, the Equity Standards of the TF-MFCCH (25). These standards are based on Whitehead’s definition of equity in healthcare: “equal access to available care for equal need; equal utilization for equal need; and equal quality of care for all”. Additionally, Whitehead suggests that equity is concerned with equal opportunities for health (26). Rather than treating all patients alike without making any distinctions, the equity concept emphasises equal opportunities for all in which patients’ needs are central - this is exactly what diversity-responsive healthcare is all about.

Equity is an acknowledged performance indicator of healthcare systems, and seems a promising concept to enhance organisations’ diversity responsiveness. It avoids the political sensitivity of paying attention to ethnic groups, because it focuses on equity among the total population. However, when pilot testing the Equity Standards in the
Netherlands we found that representatives of the various organisations that participated in our study were not familiar with the equity concept. Moreover, it seemed that the representatives had different ideas about and associations with the equity concept. The fact that we could not properly translate the word ‘equity’ into Dutch may have played a role in this respect. We believe the concept of equity could serve as a stepping stone for the improvement of diversity-responsive healthcare.

Part 4: Implication and recommendations

Implications and recommendations for research, clinical practice, medical education and healthcare policy are based on the findings emerging from this thesis.

Implications for further research
- Analyse the current level of cultural competence of individual healthcare providers and determinants of the development of cultural competence.
- Identify existing inequities in healthcare and assess the diversity-responsiveness of healthcare organisations.
- Evaluate the effects of diversity responsiveness on the accessibility, quality and outcomes of healthcare for ethnically diverse patient groups.
- Explore the limits of diversity-responsive care in relation to non-discrimination, and investigate in which contexts and on what grounds it is relevant to differentiate between ethnic groups.

Implications for clinical practice and medical education
- Structurally implement compulsory cultural competence training in the curricula of healthcare professionals, and implement staff training in healthcare organisations.
- Support medical teachers that actually deliver cultural competence training and clinical teachers that influence students as role models, in staff development programs. Not all teachers feel competent and supported to address diversity-related issues in their own teaching (27,28).
- Register patients’ country of birth and other variables that are relevant in the context of diversity-responsive healthcare. This is needed to facilitate taking healthcare needs into account in the care process at the individual patient level, as well as to monitor outcomes at the patient group level (29). We are aware of the sensitivity of this issue (30,31); therefore, it should be recognized that registration of patient characteristics in the patient record requires strategies to adequately inform patients and staff, and careful regulation of data handling to protect and guarantee the patient’s right to privacy (32).
Implications for healthcare policy

- Monitor equity as a performance indicator of healthcare. Indicators of accessibility and quality of care should be analysed according to ethnicity and other relevant diversity characteristics such as socio-economic position.
- Implement clear legislation regarding registration of country of birth and other variables that are relevant in the context of diversity-responsive healthcare. Legislation should provide for legitimate data processing and also guarantee patients’ right to privacy.
- Incorporate diversity responsiveness and attention for ethnically diverse patients in all policies that aim to improve the responsiveness of healthcare in general (e.g. patient safety initiatives that address the importance of professional interpreters in the patient-provider context; initiatives to improve patient participation emphasise the importance of diversity among patient representatives, etc.) to create synergy among activities.

Part 5: Main conclusions

This thesis contributes to the conceptualization of culturally competent or diversity-responsive care. At the level of individual healthcare providers cultural competence means knowledge of epidemiology and the differential effects of treatment in various ethnic groups; awareness of how culture shapes individual behaviour and thinking; awareness of the social context in which specific ethnic groups live; awareness of one’s own prejudices and tendency to stereotype; ability to communicate in a patient-centred way taking into account patients’ language, health literacy and other communication needs; and the ability to adapt to new situations in a flexible and creative manner. We found that cultural competencies elaborate on generic care provider competencies, but specific healthcare contexts might need a more specific operationalisation of cultural competence.

At the level of healthcare organisations diversity responsiveness means ensuring access and providing appropriate care. This, in turn, is dependent on meeting the following preconditions: demonstrating organisational commitment, collecting and using evidence on inequalities and needs, developing a competent and diverse workforce, fostering patient and community participation, and advocating for responsiveness. We found considerable consensus among the six approaches for diversity responsiveness that we analysed, which is promising to further diversity-responsive care.

In medical education it is important to structurally implement cultural competence training using a longitudinal approach. With respect to the content of training, all dimensions of cultural competence (knowledge, awareness, and skills) should be
covered. At the same time it should be taken into account that medical students and physicians can be culturally incompetent and unaware of their learning needs.

Further research should focus on the effects of diversity responsiveness on patients’ experiences and outcomes of healthcare. Rather than merely using diversity responsiveness as a reactive response to known inequities in health care, strategies should be integrated proactively to prevent inequities developing in the future. We should focus on equity of care as a basic principle to guarantee that the healthcare system is accessible and provides good quality of care to all patients. We hope that the findings emerging from the work presented here will provide useful leads to achieve this.
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