# Adaptation of Health Services to Diversity: An overview of approaches

Jenny Phillimore with Franziska Klaas, Beatriz Padilla, Sonia Hernández-Plaza and Vera Rodrigues

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## Highlights

- Much evidence comes from practitioner focused websites – there are few empirically based evaluations of effective services
- Most approaches respond to a particular culture or language rather than to superdiverse populations
- Initiatives differ from migrant or minority focused activity to those which concentrate upon building the capacity of health professionals to work with migrants
- There is some interest in more ideologically driven approaches such as patient-centred care or inclusive healthcare but no detailed evidence about how such systems might be implemented in diverse areas
- No attention is given to the ways in which whole health systems might be adapted in light of superdiversity
- Good Practice or Best Practice approaches are used extensively with limited theorization
- Migration and health is becoming a more consolidated body of literature, although with different approaches. These range from public health and disease prevention to cultural competence/sensitivity, access and accessibility

## Gaps

- Understanding how different approaches to adaptation (might) connect with each other into the holistic systems suggested by WHO
- Any consideration of how systems might be adapted in light of superdiversity as opposed to multiculturalism or interculturalism
- Detailed discussions of the ways in which potentially useful concepts such as patient-centring, quality of care or cultural safety play out in everyday health interactions
- Empirical evidence from the perspective of users
- Critical analyses of the structures which shape the conception and implementation of initiatives or constrain individuals' agency when seeking to engage with interventions
- Robust and reliable assessments of good or best practices
- Long-term assessment of practices including ex-ante and ex-post crisis interventions

## Citation

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**Introduction**

This review focuses upon the literature that describes or examines the ways in which health services have been reconfigured (or not) in light of changing demographics, namely the emergence of superdiversity. Texts reviewed are both academic and practice focused and include examples of activities that have been undertaken or case studies. In addition to academic search engines, we looked at websites such as WHO, Cities of Migration, Integrating Cities and at the contents of specific journals: American Ethnologist, Medical Anthropology, Anthropology and Medicine, Ethnicity and Health, Medical Sociology, Social Science and Medicine and Ethno-psychiatry, together with the journals Gaceta Sanitaria and Revista Española de Salud Pública, for Spanish literature.

Search terms used included:

- Cross-cultural/ inter-cultural adaptation of health services/activities/actions

- Migrant appropriate/responsive services

- Delivery of health services/activities/actions to migrants/minorities

- Superdiversity/ super-diversity/ diversity and health services/activities/actions

- Migrant/minority/ diversity friendly/responsive health services/activities/actions

- Reconfigured health services/activities/actions

- Migrant/minority responsive health services/activities/actions

- Superdiversity/ super-diversity and approachability

- Over-coming barriers to migrant/minority health access

In addition we connected all of the above with ethnic groups instead of migrants and included key ethnic groups: Somali, Pakistani, Bangladeshi, Indian, African, Turkish, Moroccan, Brazilian, Latin American, and others. Some 256 documents were located and the contents of those most relevant summarised. The main findings emerging from the review are documented below.


**Framing migration and its challenges in the EU**

Countless studies have been written about migration across the European Union, illustrating the significant increase in numbers of migrants living in the EU. According to Eurostat, in 2009, 4% of the European Union's total population came from outside the EU; in general they were younger and healthier than EU nationals (Mladovsky et al. 2012; Vasileva, 2010). Many authors have pointed to the positive aspects of migration in counterbalancing falling birth rates and the growth of the elderly population as well as providing needed labour, while at the same time increasing migration may imply some challenges (Padilla and Pereira Miguel 2009). Challenges to host societies have been studied in the fields of labour markets, education, and inter-ethnic relations; however, less attention has been given to understand the consequences of migration in relation to health and health systems (Ingleby 2009).

Several studies emphasize significant health inequalities between migrants and nationals, both in health status and access to health services. This is particularly related to the fact that health systems

are not created to meet the needs of other groups, or that health systems are not so accessible to migrant populations (Hernández-Plaza et al. 2014; Mladovsky et al. 2012; Rechel et al. 2013).

The WHO Report on the Social Determinants of Health argues that particular attention should be devoted to the health risks of migrants (CSDH 2008). Health risks are associated with poverty, poor housing, direct and indirect discrimination, type of work, user fees, language barriers, lack of knowledge about how the health system works and administrative obstacles (Ingleby 2009; Padilla and Pereira Miguel 2009). Moreover, migration itself can be a social determinant of health (Ingleby 2012; Rechel et al. 2013). Based on the recognition that everyone should be able to access health, international debate has focused on how to improve health policies for migrant populations; not all EU member states pursue this goal. However, it was made a priority in 2007, under the Portuguese EU Presidency, that held a Conference entitled 'Health and Migration in the EU: Better health for all in an inclusive society', giving visibility to these issues as well as advancing them to the global level at the WHO and WHA. Several documents were issued regarding migrants' health: the Bratislava Declaration on Health, Human Rights and Migration and the World Health Assembly resolution on the health of migrants (Mladovsky et al. 2012; Padilla and Portugal 2007).

One output of the 2007 Conference was a Good Practice Report that identified successful projects or procedures in several member states in the field of migrant health (Nielsen et al. 2009; Padilla et al. 2009; Padilla and Portugal 2007; Rechel et al. 2013). Good Practices included interventions within the national or local Health Service, at the NGO level, and in the private sector as well as collaboration or partnerships between these actors. Despite the great variations in terms of the nature and scope of services provided, identifying good practices was important to spread knowledge and to offer practical ways for communities, governments and the private sector to form partnerships (Padilla et al. 2009). In this sense, good practices in general can be seen as responses and adaptations of health services to dealing with diverse populations.

## EU research as a path to achieving change (or raising awareness)

The EU through its different bodies has funded several projects on health and migration, hoping to generate or improve data availability for evidence-based decision making. MIGHEALTHNET aimed 'to stimulate the exchange of knowledge on migrant and minority health through the development of interactive databases in each of the participating countries', by drawing together country reports that included information on the background of migrant and ethnic minorities, their state of health, the healthcare system and entitlements and measures to achieve change. Other projects included: Monitoring the Health Status of Migrants within Europe: Development of Indicators, Migration and Ethnic Health Observatory (MEHO); Promoting Comparative Quantitative Research in the Field of Migration and Integration in Europe (PROMINSTAT); and Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequities (AMAC).

Some findings from those projects indicate that only 11 countries out of 27 (Austria, Belgium, Denmark, Finland, Greece, Italy, Luxembourg, the Netherlands, Poland, Slovenia, and Sweden) have registry data on the use of healthcare by people with a migrant background, indicating the urgency of adopting common methods for identifying migrant outcomes within the healthcare system across the EU. They identified limitations in getting valid comparisons across EU countries due to different

definitions of migrants and ethnic minorities. These constrain the possible types of interventions on migrant health across countries (Nielsen et al. 2009; Rechel et al. 2013).

Some authors (Ingleby 2009; Rechel et al. 2012) criticized the European Commission because despite the support given to research on migrant health, studies lack cohesion and coordination, representing 'fragmented efforts between different agencies of the European Commission, as well as between EU-funded projects and those initiated by IOM, WHO or others' (Rechel et al. 2012: 14). Ingleby suggested that 'attention should be paid to the need to develop shared approaches and to avoid unnecessary duplication of research effort' while recommending 'the establishment of a single European agency to oversee research activities' (2009: 20) as a more effective strategy. In addition, there have been two COST Actions focused on the health of migrants: a) Home (Health and Social Care for Migrants and Ethnic Minorities in Europe) and 2) ADAPT (Adapting European Health System to Diversity). The latter has collaborated with institutions such as IOM, WHO, and the Migration Policy Institute, more recently producing the health strand for the MIPEX (Migration Integration Policy Index).

## Barriers to accessing health services

In the context of migrant health research, scholars have identified obstacles to accessing health. Some classifications include external, internal and self-exclusion barriers (Padilla 2013) and formal and informal barriers. Formal barriers are associated with health policies and the organization of health systems, for example legal restrictions on entitlements to health services for asylum seekers and undocumented migrants (Mladovsky 2009; Mladovsky et al. 2012; Rechel et al. 2013; Watson 2009). For instance, in 2004, only 10 out of 25 EU member states provided emergency care to asylum seekers, despite the Council of the European Union outlining in 2003 minimum standards for the reception of asylum seekers, including 'emergency care and essential treatment of illness' (Norredam et al. 2011; Rechel et al. 2013). Undocumented migrants have more problems because, as suggested by Mladovsky et al. 'some European countries are restricting entitlements related to health services as a way to discourage the arrival of more new migrants' (2012). Undocumented migrants face financial barriers when they are charged the full costs of their medical treatment (Hernández Plaza et al. 2014; Rechel et al. 2013). Therefore, user fees become a formal barrier when migrant groups 'are not yet entitled to subsidies during their initial time of residence' (Norredam et al. 2011).

Migrant women experience obstacles, especially in the context of the current economic crisis. One study emphasized two important reasons why migrant women are exposed to higher health risks. The first is related to socioeconomic disadvantages and includes problems in affording medicines and medical consultations as well as problems related to poor nutrition. The second reason is associated with the organization of the health system, more precisely, unequal access to family doctors (GPs), long waiting lists for primary care consultations due to insufficient health professionals, and increases in the direct costs of healthcare (Hernández-Plaza et al. 2014). Thus it is not a coincidence that evidence indicates higher rates of maternal and child morbidity or mortality due to lower use and quality of antenatal care (Bischoff et al. 2003; Gissler et al. 2009: 134; Norredam et al. 2011; Reeske and Razum 2011: 139).

Informal barriers to accessing healthcare are related to factors such as language, communication, sociocultural factors and 'newness'. Several studies highlight these factors as extremely important

because they affect not only the accessibility of health services but also their quality. Language barriers included lack of comprehensible information about entitlements, the services available and difficulties in making appointments with specialists. Lack of interpreters, difficulty in communication and identification of health problems by doctors, can be problematic; but the informal use of family members, including children, may be harmful or put too much pressure on them. One reason identified for the scarcity of qualified interpreters is limited 'funding, a lack of identified need for interpretation, and gaps in the training of staff' (Bischoff et al. 2003; Bischoff and Hudelson 2010; Norredam et al. 2011).

## A conceptual framework for understanding responsiveness

Bischoff et al. (2006), in their review of the initiatives and strategies that have been adopted in hospitals in order to make them 'migrant friendly', provide a useful conceptual framework for categorizing the ways in which healthcare for migrant and minority people might be included. These include:

- quality of care which focuses upon the ways in which health services both meet desired outcomes and incorporate existing professional knowledge;
- evidence-based medicine which underlies quality of care philosophies and in relation to diversity addresses questions around the extent to which it is appropriate to generalize scientific conclusions based on majority populations to minorities;
- patient-centred care which looks at the needs of individuals rather than groups but has proven difficult to operationalize in relation to minorities;
- responsiveness to cultural needs particularly through adoption of a cultural competence approach which is generally defined as staff having some knowledge of cultural and spiritual beliefs and thinking about how they shape health beliefs etc.
- recruitment and promotion within diverse communities;
- health literacy – the ability to use health systems effectively
- equality and equity – recognition that healthcare disparities shape health disparities

Of all these approaches Bischoff et al. (2006), having undertaken an extensive evidence review, favour a focus on quality of care, arguing that placing quality at the centre of strategies for care improvement can reduce the risk of stereotyping specific groups, a problem well-acknowledged in recent critiques of health and social care provision (Hernández-Plaza et al. 2014; Phillimore 2011; Vickers et al. 2012). Mladovsky (2012) suggests that it is necessary to look at three different levels of activity when trying to understand responses to diversity in healthcare: government policy, health services and the actions and behaviours of health workers. The needs of healthcare users should also be considered as a basis for planning actions and policies in contexts of migration-driven diversity (Hernández-Plaza, 2011; Hernández-Plaza and Padilla 2014; Hernández Plaza et al. 2014), and should form a fundamental reference at the three levels of activity (Mladovsky 2012): governmental policy, health services and actions of health professionals. With regard to government policy, some EU member states use legal and economic arguments to discourage the provision of any healthcare, let alone quality care, to targeted groups such as undocumented migrants, disregarding concerns about human rights. Some NGOs have raised awareness about this issue. When looking at the types of initiatives several approaches can be identified, the vast majority aimed at minority or diverse

disadvantaged groups, thus making the assumption that there is a critical mass of individuals and some collective knowledge about the needs, culture, language and levels of health literacy within these groups. In the remainder of this paper we set out the main kinds of initiatives that are reported in the literature.

## Communication and interpretation

There is clear evidence to demonstrate that effective interpretation is associated with better health outcomes (Bischoff et al. 2006). Some studies suggest that the use of qualified interpreters to support both patients and health professionals will improve satisfaction, will increase the use of preventive care and consequently, will also improve the reporting of symptoms (Bischoff et al. 2003; Durieux-Paillard 2011; Flores 2005). However, the simple provision of an interpreter is in itself no guarantee of improved communication.

Spencer-Oately and Jiang (2003) highlight that socio-pragmatic interaction principles vary both across cultures and across situations, with people from different backgrounds favouring different levels of directness in linguistic exchanges. These differences have major implications for communication and connect with recent thinking around the need for cultural health capital in order to secure effective communication. For example, individuals who are accustomed to indirect styles of communication may struggle to be understood by clinicians who, because of time constraints and their own norms of interaction, expect direct discussion of symptoms. Simple interpretation of speech may be insufficient to achieve understanding.

To access better quality of professional interpreting services, research recommends providing training to health workers (Flores 2005; Rechel et al. 2013) while ideally the training should be included in the medical curricula (Durieux-Paillard 2011; Karliner et al. 2004; Mladovsky et al. 2012; Rechel et al. 2011). In fact, the provision of interpreter services is already included in the policies of some countries (eg. Austria, the Netherlands, Portugal, Spain, the UK) (Mladovsky et al. 2012), even if not always used or known by health professionals.

Another way to deal with language barriers is to promote diversity among health professionals through hiring staff with diverse linguistic and cultural competences (Masanet, Hernández-Plaza, and Padilla 2012). In Portugal, the Jesuit Refugee Service in partnership with the Calouste Gulbenkian Foundation implemented a project to recognize migrant doctors' qualifications. This initiative aimed to integrate medically qualified migrants already living in Portugal to overcome the lack of Portuguese professionals in the health service. This project had a high rate of success (89%), recognizing a total of 106 diplomas allowing the holder to practise medicine within Portugal, achieving a 'geographic dispersion of the health professionals, contributing in the reduction of the regional imbalance in access to healthcare' (Marques 2009: 214).

The use of family members or children as interpreters is commonplace but reduces the effectiveness of communication because patients are often unprepared to discuss sensitive matters in the presence of kin (Phillimore and Thornhill 2011). Furthermore, interpreters need training to be able to understand medical terminology and deal with emotional stress and confidentiality. Willen et al. (2011) find that employing fully trained medical interpreters can improve levels of communication. Bischoff et al. (2006) note that in comparisons of face-to-face and simultaneous telephone interpretation, telephone services had higher levels of satisfaction for both patients and clinicians.

Information too, whether in paper form or on websites, needs to be translated into a wide range of languages. The provision of translated information on how the health system works has been used to keep migrants well informed about healthcare (Mladovsky et al. 2012; Rechel et al. 2013). The Cities of Migration website gives a number of examples of the use of translated materials, most notably the Pharmacy Translation Kit developed by pharmacists in Auckland containing advice such as 'do not stop taking this medicine even if you feel better' in seven main languages. The Kit has been extensively used by providers in this city. Translated materials have been frequently utilised in Spain, as described by Lizana (2012) for the specific case of the Migrant Health Policy Plan in Catalonia. This promoted the creation of a multilingual web page on health and immigration, together with audiovisual material in ten languages (Arabic, Catalan, Chinese, Darija (Moroccan Arabic), English, French, Romanian, Russian, Spanish, and Urdu), including several short videos with information on topics such as the personal healthcare card and healthcare services, what to do in case of illness, the primary healthcare centre teams, hospitals, prescriptions, pregnancy, infant healthcare, and sexual and reproductive health, among others. In Portugal, the Health Support Office, integrated within the National Immigration Support Services (Centros Nacionais de Apoio ao Imigrante – CNAI), has disseminated informative brochures in several languages aimed at supporting immigrants in their understanding of the formalities involved in access to health services in Portugal, and also a Health Guide for Immigrants, available in paper form and on the internet, which includes a chapter on health services and the framework of legislation that immigrants need to be aware of in this context (Reis Oliveira, 2009). Santinho et al. (2014) suggested that communication problems transcend linguistic barriers, as there are other factors that disrupt relations between patients and health practitioners. Communication initiatives discuss the use of translation and interpretation into community languages making the assumption that there is a critical mass of individuals speaking a particular language and language services established to serve these communities. Given that multiple, and frequently relatively little used or even unknown languages are one of the features of superdiversity – Vertovec (2007) highlights the 300 languages spoken in London – no solutions were offered for how clinicians might communicate with someone when interpreters are unavailable. In addition in the UK, costs are beginning to prohibit employment of interpreters. Finally some languages, such as Sylheti, do not have a written form and thus cannot be translated.

**Spirituality**

The role of spirituality in health provision and prevention is beginning to attract attention in relation to responding to individuals' needs. Bischoff et al. 2006 note that professionals must respect and promote spirituality if appropriate to the patient, while Delvecchio Good et al. (2011) argue for an enhanced chaplaincy role, stating that 'praying along' can improve patient outcomes. Silva and Martingo (2007) also suggest that the provision of culturally adapted services is not restricted to relationships between health providers and users. Portugal approved Law Nº 16/2001, recognizing other services that can be culturally adapted, such as spiritual support and openness to all religious beliefs. This law also includes emotional support, encouraging visits to hospitalized migrants from volunteers with the same nationality; as well as 'the provision of meals that take into account the food taboos of users' (Silva and Martingo 2009: 158). Padilla (2008) identified many health interventions in the realm of charity and faith based organizations; however, they tend to offer essentialist interventions or provide services based on religious beliefs, or enforce discriminatory

practices against certain groups, such as women who have multiple pregnancies (Padilla et al. 2014a).

## Responsiveness

Bischoff et al. (2006) mention adaptation of services through matching patients to clinicians of the same background but place most of their focus on cultural competence, noting that culturally skilled providers know when it is clinically appropriate to focus on culture and possess sufficient skills to be able to adjust existing interventions into culturally appropriate strategies. They highlight the importance of cultural competence training at medical schools and use an example of organizations which demonstrate competence to their staff through role-playing of encounters with diverse peoples.

The promotion of cultural competence among professionals and healthcare organizations is one of the best-known strategies for the adaptation of health services to migration-driven diversity. Cultural competence has been defined as 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in crosscultural situations' (Cross et al. 1989: 13). Most conceptualizations differentiate the following components of cultural competence (Balcazar et al. 2010; Campinha-Bacote 1999; Cross et al. 1989; Douglas et al. 2009; Hart et al. 2003):

(1) positive multicultural attitudes of openness and willingness to interact with different 'others', respect towards cultural differences and mutual trust;

(2) ability to identify variations in health beliefs and behaviours associated to culture, through a knowledge base to understanding the worldviews of people living in diverse cultural communities; and

(3) intercultural skills and ability to deal with cultural and human diversity to effectively meet the healthcare needs of diverse populations.

Notwithstanding the popularity of these approaches, lessons learned from research and experiences of implementing 'cultural competence' programmes have led to profound debates and criticism about this concept (Balcazar et al. 2010; Ingleby 2011; Ingleby et al. 2012) and demonstrated the need to look for innovative and more comprehensive approaches (Hernández-Plaza 2011; Hernández-Plaza and Padilla 2014; Hernández-Plaza et al. 2014).

Mladovsky (2012) looking at good practice in Europe highlights the need to provide training for all professionals who engage with diverse patients, and argues that cultural competence does not involve understanding of 'the other' but instead the ability to recognise one's own cultural assumptions, be open to learning and be respectful of others' beliefs and understandings.

Certainly in a superdiverse environment the latter approach is more feasible. Not only does cultural competence as defined by Bischoff et al. (2006) risk imposing a homogenous understanding of culture on patients rather than a socially constructed one, it is also fundamentally impractical in superdiverse areas such as the UPWEB neighbourhoods, where people come from so many countries of origin that possessing cultural knowledge for everyone is not feasible.

Another criticism highlights that cultural competence approaches have overemphasized the cultural dimension of diversity, usually linked to ethnicity and culture of origin, often obscuring the role of social inequalities and power asymmetries (Hernández-Plaza 2011; Hernández-Plaza and Padilla 2014; Hernández-Plaza et al. 2014). In line with this, the World Health Organization (WHO) Commission on Social Determinants of Health has highlighted that processes of social exclusion are the major cause of health and healthcare inequities among migrants and ethnic minorities (CSDH 2008), conceptualizing social exclusion as 'dynamic, multi-dimensional processes driven by unequal power relationships, interacting across four main dimensions – economic, political, social and cultural – and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterized by unequal access to resources, capabilities and rights which leads to health inequalities' (SEKN 2008: 2).

Adopting this critical perspective, Hernández-Plaza et al. (Hernández-Plaza 2011; Hernández-Plaza and Padilla 2014; Hernández-Plaza et al. 2014) examined the adequacy of cultural competence as a strategy to reduce healthcare inequalities in contexts of migration-driven diversity and socioeconomic disadvantage, based on the needs and experiences of primary healthcare users in a specific local context, namely the Metropolitan Area of Lisbon, severely struck by the financial crisis and austerity measures. The priority perceived needs of healthcare users were: (1) severe difficulties in affording medicines: 45.1% of the participants were not able to buy prescriptions due to lack of economic resources; (2) problems of access to consultations: 41.5% could not get an appointment when needed due to limited availability of consultations; and (3) problems of access to family doctors: 34.4% do not have a family doctor, rising up to 43.8% for immigrants. These needs suggest that cultural competence approaches may simply be inadequate when seeking to reduce healthcare inequalities in superdiverse contexts.

Browne et al. (2009) have attempted to bring the concept of cultural safety, developed in a New Zealand nursing context by Maori nursing leaders, to reorient training towards a critical understanding of the structures that shape patients' lives and experiences in a Canadian multicultural context and in so doing to move beyond culturally competent approaches. Cultural safety is aimed at countering tendencies in health provision to create what Browne et al. (2009) call cultural risk, wherein one group feels disempowered or demeaned by the delivery mechanisms or actions of those from dominant cultures. The idea is to move beyond culturalism, which tends to see ethnically specific beliefs and values as the main explanation for experiences, to a point where healthcare providers critically reflect on the structures and assumptions that they hold in relation to those groups. This includes an understanding of the ways in which structural inequities are perpetuated by both historical and current day social, political and economic conditions. Browne et al. (2009) propose a social justice curriculum for practice which focuses upon

•	the philosophical and conceptual underpinnings of knowledge

•	articulation of the promotion of social justice and equity as health outcome goals

•	a process of engagement with critical issues through encouraging critical discourse

•	selection of appropriate content focusing upon structures, inequities and discourses that sustain marginalising practices.

An interesting analysis of debates around anti-discriminatory and anti-oppressive practice, cultural safety, cultural competence and individualized care is carried out by Hart et al. (2003), who propose

an 'inequalities imagination' model for health and social care professionals, aimed at enhancing equality of care. This model encourages practitioners to be aware of broad definitions of 'disadvantage', considering the various characteristics and experiences of people that might contribute to their being classified as 'disadvantaged', such as mental or physical disability, ethnicity, gender, material poverty, or being victims of prejudice and discrimination. The 'inequalities imagination' model incorporates the perspectives of clients as central to health and social care professionals' practice, and encourages a commitment to thinking and acting creatively in reducing the inequalities that persist between humans, thinking of the different constellations of disadvantage that may come into play for each individual healthcare user.

There is potential for some combination of cultural competence and cultural safety approaches to be employed when training health professionals, as in a diversifying Europe they are all likely to encounter 'difference' at some point. Most discussions of training consider work with newly qualifying staff; arguably because of the extensive demographic changes in recent years such training would benefit all those working in health, including ancillary and administration staff.

## Empowerment

Bischoff et al. (2006) include a number of different types of activity under the umbrella term of empowerment. They focus upon increasing the proportions of professional and support staff from minority backgrounds, the provision of advocacy, ensuring genuine informed consent is achieved by providing patients with full information and crucially making sure the patient understands it, respecting and promoting spirituality where appropriate, and involving communities in research. De Freitas (2015) warns that involving marginal groups in decision making risks being ineffective unless they are supported to understand their role in promoting equality. Without such support there may be a tendency to focus on personal, rather than group concerns. Ongoing work by Afridi (2015), looking specifically at the ways in which individuals can contribute to policy-making in superdiverse areas, suggests that identity-based consultations can be problematic in that they promote a groupist approach to thinking which leaves individuals unable to explore how services can be improved for diverse communities rather than for specific ethnic or other identity groups. He suggests that an intercultural approach to consultation, focusing upon how particular problems can be resolved in geographical areas, has the potential to develop more practical and durable solutions.

The involvement of local communities is also a relevant mechanism to reduce barriers between services and migrant users (Garcia-Ramirez and Hatzidimitriadou 2009; Mladovsky et al. 2012; Rechel et al. 2013). For instance, as part of the national policy, Portugal promotes 'inter-sectoral partnerships to improve the quality of services and facilitate change in organizational culture' (Mladovsky et al. 2012: 6); however, a critical assessment of such approaches is necessary, as other studies suggest a gap between legislation and practice (Hernández-Plaza and Padilla 2014; Padilla 2013).

One example of the involvement of local communities is the AJPAS – Associação de Jovens Promotores da Amadora Saudável (Association of Youngsters Promoting a Healthy Amadora). AJPAS is a Non-Governmental Organization and Immigrants' association which has an interdisciplinary team (doctors, nurses, social worker, psychologist, cultural mediator, kindergarten teacher, legal officer) to develop activities in the field of Public Health and Social Services (e.g. maternal healthcare provision,

family planning, child health and immunization and health promotion; information/awareness campaigns, culturally adapted information materials and condoms; consultation on sexual and reproductive health targeting young people, etc.). This type of intervention, Silva (2009: 229) suggests, 'has to be based on the target community's needs, on the mobilisation of the partners at the local level, on successes and failures, on the correct definition of the intervention area, on the solidarity of action, on the capacity-building of the community, on the network and partnership work, on the team's cohesion and, above all, on the importance and value given to the interventions and the way this type of work is accepted within the community'.

Cities of Migration are amongst those that highlight the difficulties migrants experience in seeking to re-enter medical careers with overseas qualifications. Various initiatives have sought to expedite the process of return to medicine and to reduce the costs for migrants (for a review of EU based programmes see Phillimore and Goodson 2006). The Welcome Back Centre seeks to support migrant professionals to return to medicine and to 2010 had served 10,500 migrants in California. This programme demystifies the requalification process, connecting migrants with existing professionals to provide support around return. While it is clear that return can help health providers address skills shortages the evidence around the effectiveness of clinician/patient matching is mixed, with no clear evidence that it impacts upon outcomes (Delvecchio Good et al. 2011). The idea of 'patient-matching', that is, increasing the diversity of the workforce so that interpreters and cultural mediators are not necessary, is promoted by wide-ranging organizations (e.g. WHO and COST) but again relies on the notion that there are large communities from within which professionals can be recruited.

The empowerment of healthcare users in contexts of migration-driven diversity can also be based on the promotion of health citizenship and health literacy (Padilla 2008). Assuming an ethos of social inclusion, the notion of health citizenship emphasizes that health is a matter of human rights, which requires growing involvement of citizens in assuming more responsibilities for their health and making informed health decisions (Padilla 2008; Padilla et al. 2013a).


## Monitoring

There have also been calls for improved monitoring of patient outcomes. Bhopal's and Nazroo's work is notable in this area in demonstrating that focus on culture or ethnicity as causal factors in individuals' health outcomes can frequently provide overly-simplistic and occasionally totally inaccurate findings. Bhopal's work shows that frequently age, recency of arrival and gender have more explanatory power than ethnicity while Nazroo's work has also highlighted the importance of social-economic status.


## Outreach

There are wide ranging examples of different outreach initiatives aimed at taking health services away from conventional and permanent hubs and into areas where take-up of services is low or where outcomes are poor. The approach is seen as particularly important for individuals who are undocumented and may consider visiting a mainstream doctor or hospital too risky – certainly with

the increased expectation that service providers will act as unofficial immigration officials with an obligation to report those 'illegals' who seek to access healthcare (Humphries 2004).

In Portugal, one outreach programme identified as good practice is the Venda Nova Health Mobile Unit, a community intervention developed by the Venda Nova Health Centre and the Community Care Unit in Amadora (Lisbon), within the Portuguese National Health System (Padilla et al. 2013b). This community health intervention has been implemented since 2001 in impoverished neighbourhoods of the municipality of Amadora, with the aim of reducing health and healthcare disparities. Based on needs identified through collaborative work in the community, the health mobile unit acts as a bridge between the local community and the health centre, provides information about health and healthcare, facilitates access to healthcare with a particular focus on family planning, pregnancy, vaccination of new-born and children, and prevention of chronic diseases (diabetes, hypertension and raised cholesterol), and promotes active involvement of the local community in health prevention and promotion.

The Cities of Migration website has several useful examples of outreach. This can take a number of formats including the development of mobile health centres: vans equipped with monitoring equipment in which consultations can take place (see Mladovsky et al. 2012). Such an approach was adopted in Worcestershire, England, when NHS providers identified that migrant horticulture workers were unable to register with GPs due to a combination of poor travel facilities and long working hours. GPs travelled to the fields for consultations while healthcare assistants worked to register migrant workers in local GP practices.

**Collaboration and partnership**

Collaboration and/or formal partnerships with civil society organisations have been encouraged in some countries and are a particular feature of services in the UK – a feature that is likely to increase as the Government pushes for greater levels of local service delivery. With the advent of austerity cuts the resources to contract out services, particularly public health work, to civil society have been reduced.

Frequently health providers connect with NGOs and use their premises or their networks to help improve access to healthcare. For example the Coventry Refugee Centre, UK, hosted a GP surgery for many years – refugees and asylum seekers were able to register with that surgery and access services such as sexual health and community nursing in a setting that they were comfortable with. This service has now been cut. There are further examples of providers commissioning NGOs to offer services such as Pregnancy Outreach Workers who are employed by NGOs (such as Hope Destitution Project in UK) but offer health support specifically for migrants and minorities according to a remit co-developed with the state sponsor.

Graal, a Portuguese NGO, in collaboration with the International Women´s Movement, raised awareness about the most relevant issues faced by migrant women accessing health services. One of the strategies proposed was the creation of an informative brochure called 'Are you an immigrant? You have to know your rights to healthcare access', in different languages (English, French, Portuguese, Russian and Spanish). Additionally, the brochure provided information about how to obtain the national healthcare service card and costs of healthcare services. This strategy was adopted by health providers in several health centres (Graal, 2010: 29; Padilla et al. 2014b).

Adopting a community psychology perspective, García-Ramírez and colleagues (2012) proposed the adaptation of healthcare services to migration-driven diversity through user involvement and healthcare stakeholder coalitions, based on diverse forms of collaborative alliances among researchers, policymakers, healthcare professionals, community organizations and healthcare users. Healthcare stakeholder coalitions are conceptualized as empowering community settings, based on the capacity to share a multicultural vision; the adaptation of organizational processes (policies, standards and procedures) to the needs of culturally diverse users; the promotion of horizontal and reciprocal relationships by including all stakeholders and partners in the decision making process; the creation of capacity to engage in new roles; the promotion of leadership among professionals, researchers and community members; and securing quality and systems change, instead of pursuing a 'quick fix' approach to addressing changes in services. The focus is on long-term social change, seeking to maintain the quality of services and to encourage changes in practices and policies (e.g. migration policies, health policies, employment policies, housing policies) that support culturally diverse populations and endorse equity. A successful application of this approach is described by García-Ramírez et al. (2012), in the adaptation of breastfeeding promotion practices to culturally diverse healthcare users in the Virgen Macarena Hospital of Seville, Spain. Similarly, a project entitled Health Citizenship adopted a participatory approach together with coalition building, in which local communities (NGOs), health centres and researchers participated and conducted research on maternal and child health, comparing national and migrant communities (Padilla et al. 2014a).

## Cultural mediators

Cultural mediators are frequently employed in some EU countries, with Italy, Spain and Portugal (Abranches and ACIDI 2008; Lizana 2012; Vázquez et al. 2013) as notable examples. Such individuals are frequently from the same ethnic background or country of origin as patients but have much more knowledge and experience of health institutional cultures (Mladovsky et al. 2012). These individuals, frequently volunteers, are trained to advocate for patients, joining them for appointments and helping individuals to make informed choices about care by both supporting them to develop cultural health capital and advocating for improved services (at the individual level) where necessary. A mediator scheme in Rome trained longer established individuals to become mediators. When a migrant that they might share a language with entered A&E services they telephoned a matched volunteer mediator who came to the hospital and helped explain the system to the migrant.

Based on the fact that cultural mediators have special skills when in contact with vulnerable groups, Portugal also adopted this strategy. The implementation of their mediation has changed over time (in terms of where they carry out their work and who hires them). For instance, according to Reis Oliveira (2009) the CNAI (Portuguese National Immigrant Support Centres) provides a quality service for migrants, in a friendly environment where migrants are at the centre, by hiring socio-cultural mediators from different migrant communities. At CNAI, some mediators work at the Health Support Office, which is integrated into the Portuguese one-stop-shop for migrants. This office works in partnership with several state services and civil society organizations (namely migrant associations) to give responses to migrants' problems related to health (from gaining access to finding other types of support). In the current context of austerity, available funding for cultural mediation programmes has been substantially reduced (Hernández-Plaza 2014; Lizana 2012; Silva and Martingo 2007; Vázquez et al. 2013).

## Use of social and visual media

There are a few accounts of the use of social and visual media, although evidence of effectiveness is lacking because initiatives are rarely evaluated in a robust way. Cities of Migration gives the example of the Maslaha Project in London which was established to try to reduce the high levels of diabetes in South Asian communities. They established a website setting out a wide range of diabetes-relevant information for Bangladeshi and Pakistani communities, including diabetes-friendly recipes and the location of women-only exercise classes. In a bid to reduce concerns about the types of exercise and practices considered appropriate for practising Muslims, the website featured articles from Islamic scholars advising on matters such as women's swimming classes and good dietary practice for diabetic Muslims during Ramadan.

In the US Forster et al. (2015) describe the production of fotonovelas (cartoons) targeting Hispanic patients, aiming specifically at improving knowledge and helping change behaviour for several health-related issues (e.g. end stage renal disease, diabetes, and hypertension).

In Portugal, an NGO called 'Positivo' was created to support people who are HIV positive and their relatives. They implemented an action research project named 'The ART +', which aimed to study and promote therapeutic and healthcare adherence, designed as an online counselling service provided by social workers and doctors who advise users about doubts and questions related to medicines and therapies, as well as about the best strategies for living with HIV. A project known as 'Saudar' promotes an online debate about the barriers faced by migrant women to access health services.

While it is clear that there is significant use of the internet for health-seeking, we were unable to identify a body of academic research examining the ways that websites and social media campaigns were used to reach diverse populations.

## Superdiverse neighbourhood hubs

While most of the work we identified looked at health services, Duckett's (2013) examination of the role of pharmacists in what they call 'hyper-diverse' communities is interesting. They demonstrate that pharmacists often form the centre of different social networks, particularly co-ethnic and co-language communities. As private businesses they were able to respond rapidly to changing populations, often meeting need through employing staff from different backgrounds with diverse language competencies and stocking specialist products. While we have not identified any literature on other types of health providers, we noted that in Handsworth, England, herbalists and health food shops stock particular medicinal herbs for ethno-national groups (e,g. Moringa for the Caribbean community). Likewise, in Mouraria, Portugal, at the ethnic shopping centre, several shops carried herbs and alternative health products.

## Holistic strategies

While we have identified particular approaches to addressing diversity in health provision and Bischoff et al. (2006) also use this approach, they are clear that ideally health providers should produce a comprehensive strategy rather than picking one or more of the key policies. They suggest diversity strategies focus upon offering understandable and respectful care, recruiting and promoting

diverse staff, offering training in culturally and linguistically appropriate health services, offering language assistance, speaking in individuals' preferred languages, making easily understood patient materials, collecting appropriate monitoring data and needs assessments for the local community, and developing participatory collaborative partnerships to involve patients, and appropriate complaints mechanisms. Adopting a slightly different perspective WHO (2010) argue the need for a migrant inclusive system based around ideas for more patient centred and holistic healthcare for all, rather than a parallel system.

Migrant health policies in Spain are an example of a holistic and comprehensive approach in the adaptation of healthcare services to migration-driven diversity. Migration-driven diversity has posed a major challenge for health services, leading to a progressive effort in the improvement of healthcare access for immigrants, and a concern for the adaptation of healthcare services to population diversity (García Ramírez et al. 2012; Moreno Fuentes and González Ferrer 2002; Vázquez et al. 2011; Vázquez et al. 2013). Immigrants' entitlement to healthcare has been acknowledged since the origins of the National Health System, in the Healthcare General Law of 1986, completed in 2000 with the Organic Law 4/2000 on the rights and liberties of foreign residents in Spain, which established that all foreigners residing in the country who were registered at the city council had the same rights to healthcare as nationals, regardless of their residence status. Emergency care for unregistered persons and healthcare for all pregnant women and minors (under 18 years old) was also guaranteed. However much has changed since the economic crisis with many programmes either being massively reduced or cut.


## Conclusion

The main approaches adopted to meet the needs of an ever diversifying population primarily focus on cultural adaptation and improved communication. Arguably these approaches are better suited for multicultural communities where there are a few large ethnic or country-of-origin groups, rather than fragmented populations of diverse individuals. While there is growing recognition that diverse health needs are mediated by faith and language, there is little consideration of other variables such as age, newness or immigration status. In our review we found little material considering connections between different types of healthcare or acknowledgements that pluralism needs to be taken into account when being responsive to diversity.

Phillimore (2011; 2015) argues current healthcare systems were designed for more homogenous populations. Given the transiency associated with superdiversity and ongoing diversification of populations it would ultimately appear to be more efficient to reshape services for superdiversity rather than constantly trying to identify and then educate mobile individuals about how to use health services. Such an approach however is likely to be politically controversial, given that migrants and minorities are frequently problematized as taking from health systems (health tourism) or putting them under too much pressure through ill-use. Thus the development of holistic or inclusive strategies offers the greatest potential for effective responses to diversity in the current financial, policy and political environments.

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