Social Inclusion and Access to Basic Services of Third-Country Nationals (AccessIN)

Working Paper on the Development of the Training Module for Medical Staff

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1. Introduction

Migration has become a defining feature of today's globalized world, yielding significant economic and social impacts. In Europe, a diverse population of migrants face unique healthcare challenges exacerbated by social and structural determinants of health. In Germany, there were approximately 20.2 million people with a migration background in 2022, representing 24.3% of its total population, and a year-on-year increase of 1.3 percentage points (Statistisches Bundesamt, 2022). This raises questions of the health needs of migrant populations in comparison to the native population, after which health institutions have been modelled, as well as the capacity of Germany to provide equitable care to its population, including third country national migrants of heterogeneous backgrounds.

There is a growing body of literature indicating that healthcare services initially designed for patients from majority groups are often ill-equipped to meet the needs of increasingly diverse populations. It has long been recognized that patients from different cultural backgrounds have different thresholds for seeking care, that they may face linguistic barriers, have different expectations of care, and may be differentially interpretive or receptive to provider recommendations (Betancourt et al., 2005). Migrants in particular experience different health outcomes from native populations and face a unique combination of challenges in accessing and using healthcare services (World Health Organization, 2023). This can be attributed, in part, to the differential and intersectional vulnerabilities of migrant populations, but also to the misalignment of clinical practices with migrant needs and expectations. Consequently, while there has long been a call for clinical competence towards minority-group patients, there is now emerging attention on cultural competency towards migrant patients (Lau & Rodgers, 2021).

Based on the existing literature on cultural competence and migrant health, as well as findings from 40 interviews with third-country national migrants in Germany and 14 healthcare professionals in Germany, we developed, deployed, and assessed a pilot workshop program aiming to increase the cultural competency of current and future healthcare professionals. The evaluations from the workshop program indicate that participants found significant value in the content and activities of the workshop, and that participants felt that the workshops met their needs and expectations. This report relays the development of this pilot programs: first, discussing the context of migrant access to the German healthcare system and the need for cultural competency that this pilot program addresses; second, presenting the development and evaluation of the pilot program; and, finally, providing recommendations and conclusions.

2. Background

Healthcare access in Germany

The German welfare system is often said to be a two-pillar system (Schnabel, 2020) consisting of a social insurance system financed through contributions and additional tax-financed welfare programs. Entitlements differ based on membership and contributions. The social insurance system covers pensions, healthcare, unemployment, work-related accidents and, since the 1990s, long-term care. It covers most employees with some exceptions (specific professions in relation to the pension system and civil servants, who are provided for by their employers

directly). To qualify for most benefits, there are minimum periods of contributions. In addition to these contribution-based systems, basic social protection is provided independently of contributions made. The most important ones being a child allowance and a minimum income plus subsidies for housing. The contribution-based systems do not generally differentiate along citizenship, though the necessary periods of contribution effectively exclude newcomers (as well as others who for various reasons cannot join contributory systems) from these benefits. On the other hand, benefits based on tax-financed programs are more restrictive for non-nationals, depending on residency and in some cases additional requirements relating to their legal and labour force status (Schnabel, 2020).

Migrant serving organizations play increasingly important roles in healthcare, supporting migrants to claim social rights, aiding migrants to connect with larger support networks, and providing consultative services, but also providing a variety of services directly (Barglowski & Bonfert, 2023; Bartig et al., 2021). Our interviews have highlighted the central roles of multiple organisations. These include Maisha, which in cooperation with the Frankfurt Health Department, offers humanitarian consultation hours; the Clearing House offered by the Health Department for uninsured individuals; the Caritas Association's Elisabeth Street Outpatient Clinic, which although focused on uninsured individuals and those experiencing homelessness, now serves a significant number of migrants with precarious status; Malteser Medicine for People without Health Insurance; and numerous other programs by civil society organizations such as Fatra. However, these organizations often rely on donations, short-term contracts, and volunteer staff, which highlight the precarious nature of the local infrastructure that supports healthcare access for migrants. For detailed information on these healthcare assemblages, consult the WP4 Country Report for Germany.

Access, Discrimination, and Cultural Competence

It is now widely recognised that social determinants, such as income and education, play a large role in healthcare access and health outcomes (Braveman et al., 2011; Marmot & Wilkinson, 2005). However, migrants also face additional, migrant-specific determinants of health. These determinants are complex and interrelated, creating multifaceted health challenges for migrant populations and the service providers who treat them. This is compounded by larger systemic capacity issues, staff shortages, and an ageing population (Heber & Parloh, 2024).

Our interviews highlight that, despite ongoing efforts, language is a significant barrier for TCN migrants. This hampers information seeking (e.g., regarding entitlements and service availability), limits effective service use, and introduces risks (such as misdiagnoses and lack of informed consent). Interpreting services are available but not systematically used, can be of limited quality, and consume appointment time. NGO solutions face tentative funding and often must focus on English, limited in their ability to reach the diversity of languages. These linguistic barriers can be minimized through digital translation services for webpages and smartphone translation apps for in-person appointments, but our interviews with migrants point to frustration with Germany lagging in digital services, and our interviews with service providers noted the differing levels of digital access and literacy among migrants – highlighting the importance of digital inclusion as a social determinant of health (Sieck et al., 2021).

Linguistic barriers further complicate the ease at which TCN migrants navigate the institutional and bureaucratic landscape. Respondents in the interviews emphasized the difficulties associated with the complexities of German bureaucracy, such as regarding paperwork and communication with insurance companies. As such, migrants can sometimes be unaware of how to access medical assistance or the specific services and support to which they are entitled.

Cultural differences are also significant. Perceptions of health, illness, and medical care often vary based on cultural background, influencing willingness to seek care, the experience of the care provision itself, and adherence to recommended treatments. This can result in differing attitudes towards lifestyle choices, preventative options such as vaccinations, and trust towards the healthcare system. Attitudes towards gender are particularly significant. Particularly for migrants from strongly patriarchal cultures, female patients may have their autonomy limited as they defer to males for decision making, which complicates the consent process, or may have limited or controlled access to providers, limiting information seeking and communication.

Cultural misunderstandings, stigma, and misaligned expectations can lead to discrimination and perceptions of discrimination. There are nevertheless established efforts and protections in Germany against discrimination, including through legal frameworks (such as the General Equal Treatment Act, AGG, which lists race, ethnic origin, gender, religion, disability, age, and sexual orientation as protected characteristics), institutions (such as the Federal Anti-Discrimination Agency, which provides support to individuals who believe they have been discriminated against, as well as mediation, awareness, monitoring, and recommendations), and specific medically-situated institutions (such as the non-profit *Unabhängige Patientenberatung Deutschland*, UPD, which operates at the national level to support patient rights, and the Patient Ombudspersons, *Patientenfürsprecher*, which addresses complaints within specific hospitals).

In spite of these measures, healthcare workers can act on stereotypes or their own cultural biases and cognitive frames in ways that produce prejudiced interactions or unfair outcomes. This results in part from lack of cultural knowledge and awareness of migration circumstances, with a recent federal German report considering that "the inadequate consideration of migration-sensitive care needs in the health care system [represents] a form of institutional discrimination" (Bartig et al., 2021, p. 26). The same report cites the 2017 Hospital Barometer, which reported that 61 percent of the institutions surveyed did not conduct any cultural competence training (Blum & Löffert, 2017). This exemplifies the emerging attention to providing migrant-specific tools for healthcare workers, including, for example, guidelines on avoiding discriminatory language (Bilgic et al., 2022). This echoes a predominant recommendation from our interviews with healthcare workers, which emphasized the need for greater cultural competence training within healthcare, specifically focused on patients from migration backgrounds, along with strategies to ensure worker empathy and openness to cultural differences, more generally.

Cultural Competence Training

Especially as Western populations become increasingly diverse, cultural competence is progressively noted as being central to the training needs of future generations of healthcare providers. As early as 2002, in the context of minority groups in the United States, the highly impactful report 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health

Care' (Nelson, 2002) noted racial and ethnic health disparities in health outcomes and healthcare usage. The report noted that "bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care" (Nelson, 2002, p. 667), solidifying the focus on the ability of healthcare systems and the workers within it to manage the care of patients from minority groups. The same year, an extensive early interview-based study with practitioners, policymakers and academics noted that cultural competence training is needed as an educational strategy to sensitize providers to socioeconomic issues, increase empathy, and enrich existing curriculums which may coarsely stereotype minority communities (Betancourt et al., 2005). Such trainings have since been integrated into medical curricula worldwide, with a focus on building competence by increase the exposure of (often native or majority group) practitioners to diverse cultures.

Over the last two decades, cultural competence training greatly developed with a particular emphasis on the combination of medical and social skills but also of cultural knowledge and attitudes. As noted by a systematic review, the roles of attributes such as "cultural openness, awareness, desire, knowledge and sensitivity and encounter" are increasingly seen as precursors to cultural competence among healthcare professionals (Henderson et al., 2018, p. 590). Nevertheless, Antón-Solanas et al. (2021) in particular noted eurocentrism being viewed as a 'norm' by a cohort of nursing students, and the importance of 'listening to' these students when designing cultural competence trainings. In parallel, there has been an emerging criticism of cultural competence for focusing on the diverse cultures of the patient as 'the other' - rather than the awareness of the limitations of the culture of the provider (Lekas et al., 2020). It is hypothesized that such an approach to cultural competence risks perpetuating stereotypes and, as a solution, trainings should build 'cultural humility'. Such cultural humility is achievable by fostering the reflexivity of the service provider, and encouraging an openness to the experiences, expertise, and autonomy (or 'power sharing') of the patient (Lekas et al., 2020). Such processes of 'listening' and 'reflexivity' were targeted by the workshops piloted by this project.

3. Pilot Training Modules

Training module development

The overall objective of the training module was to evaluate methods of improving the cultural competences of healthcare workers and support staff and provide tools for accommodating the challenges faced by migrant patients. Given the primacy of discrimination and inequalities as analytic themes emerging from the project's migrant and healthcare worker interviews and the literature, and to complement the focus of other AccessIN WP project (e.g. multilingual information leaflets on social rights and advice on access to social services), the training planned here focused on forms of inequality and discrimination related to migrants in Germany.

Two main target audiences were identified for the pilot training modules: (1) Medical students who were enrolled at the Philipps University Marburg at the time of the pilot and (2) health guides (i.e. *Gesundheitslotsen*) for the Public Health Office of Frankfurt City (*Gesundheitsamt Frankfurt*). Both groups were selected for their relevance (they either aspire to practice or

currently practice within the German healthcare system) and for their complementarity. That is, while the medical student cohort had not yet gained substantial professional experience and did not come from migrant backgrounds, the health guides had migration experience from which they could draw, were well established within local communities, and had gained substantial experience through their voluntary work in accompanying and advising migrants.

The design of the workshop accounted for the differential qualities of each group and the current context of medical training within the university. While there is currently a push to strengthen doctor-patient communication within medical curricula, there is not yet significant cultural competence training within the standard curriculum followed by the students who attended the workshop. As such, the researchers assessed ways of situating this training (e.g., as a part of the main medical curriculum). It was determined that, to account for the ongoing reforms and complexities of adapting the official curriculum, the training module would be offered as an elective workshop. As such, the training module was designed to complement the main curriculum and was scheduled for the availabilities of the students to maximize enrolment. The workshop for health guides took place on the 8th of June in Frankfurt and the student workshop on the 25th of June 2024 in Marburg.

The workshop was structured to provide an overview of inequalities within healthcare systems, the ways in which these inequalities are normalised in medical practice, the extent to which current medical training covers these, and the limits of this coverage (i.e. the added value of the workshop for the participants). Based on the literature on social determinants of health and the intersectional vulnerabilities of migrants, the workshop engaged participants to consider the ways in which discrimination occurs systemically (i.e., beyond individual prejudice). Practical examples were then discussed. Drawing on current studies, different forms of bias were highlighted before possible solutions were discussed with participants. The workshops used an engaging format which combined short inputs with interactive discussion and group work.

Evaluation process and results

Both workshops were evaluated for their perceived potential for impact and participant satisfaction, and to identify recommendations for future cultural competence training initiatives. Both pre-workshop and post-workshop data was collected. The pre-workshop was collected by asking participants to reflect on and orally describe their expectations of the workshop. The post-workshop data was collected through a paper questionnaire. This evaluation format encouraged participants to both assess their needs in relation to cultural competence training prior to engaging in workshop activities as well as their satisfaction of the workshop and self-evaluation of its potential for impact following completion.

Pre-workshop, we found that the expectations of the medical students differed from those of the healthcare guides. The medical students joined the workshop to: (1) increase their sensitivity to the workings of discrimination within healthcare settings, (2) increase their understanding of the current setting, (3) gain practical knowledge to address discrimination in their own careers, including how to acquire information outside of the workshop in future. In contrast, the

healthcare guides had a greater expectation to (a) be able to share their individual experiences and to (b) gain structured knowledge to better support migrants in healthcare settings.

Post-workshop evaluations included both closed-ended and open-ended questions. The closed-ended questions took the form of Likert questions on a scale of 1-5 (see the report in Table 1, below). Among medical students (n = 11), the overall satisfaction scores ranged from 4.09 to 4.91, indicating high satisfaction. For example, the question "The content is relevant to my work/my studies" received an average score of 4.91, showing that the students found the workshop highly relevant to their professional roles. Similarly, 10 out of 11 participants expressed their intent to implement the knowledge gained in their future work or studies (average score: 4.91). However, the question on whether the activities provided sufficient practice and feedback scored slightly lower, with an average of 4.09, suggesting room for improvement in the practical components of the workshop, though this would likely require a longer time slot to fully address.

Questions	Medical Students Average Rating	Health Guides Average Rating
1. The goals of this workshop were well-known to me.	4.18	4.33
2. This workshop met my expectations.	4.36	4.83
3. The content is relevant to my work/studies.	4.91	4.83
4. The activities provided me with sufficient practice and feedback.	4.09	4.33
5. I feel better prepared to support migrants in healthcare due to this workshop.	4.09	4.67
6. I want to apply what I learned in my work/studies.	4.91	4.67

Table 1: Report of the quantitative assessment of the workshops

The health guides (n = 7) similarly rated the workshop very positively, with average satisfaction scores ranging from 4.33 to 4.83. In particular, the relevance of the workshop content to their voluntary work received an average score of 4.83, and 5 out of 7 participants expressed their intent to apply the knowledge in their future activities (average score: 4.67). Notably, the question "The workshop has prepared me better to support migrants in the healthcare system" received an average of 4.67, indicating a substantial perceived benefit in their preparedness. Despite the overall positive feedback, some health guides suggested that extending the workshop's duration could provide deeper depth on key topics.

The open-ended feedback was used for a qualitative analysis. Medical students emphasized the importance of discussions on discrimination and racism, with many expressing that these topics are not sufficiently covered in their formal education. Some participants also highlighted the value of group work and peer exchange. Among health guides, the exchange of personal

experiences and practical advice was frequently mentioned as the most valuable aspect. Several participants also expressed a desire for more structured guidance on addressing systemic barriers in healthcare. The feedback from both groups suggests that the workshops not only met but exceeded participants' expectations in terms of relevance and applicability to their respective roles. Overall, these two pilot workshops achieved the goals of increasing awareness of the forms and processes of discrimination faced by TCN migrants within healthcare, and collaboratively exploring strategies for overcoming barriers to equitable access and usage.

4. Conclusion and Recommendations

There is growing momentum in Germany to promote inclusion within the healthcare system and to address broader issues of discrimination. The "Empowerment for Diversity" initiative at Charité in Berlin, funded by the Mercator Foundation, exemplifies this shift by fostering a national alliance of stakeholders to tackle these challenges. Universities are increasingly integrating themes of migration and health into their curricula. For example, Würzburg University offers a *Global Health and Care* program, while Charité - Universitätsmedizin Berlin incorporates *Global Health* courses into its medical curriculum. Hochschule für Gesundheit in Bochum offers a B.A. in *Health and Diversity*, emphasizing the intersection of societal diversity and health interventions. Similarly, Kiel University provides a Master's program in *Migration and Diversity*, and Frankfurt University of Applied Sciences offers a Master's in *Diversity and Inclusion*. At Bielefeld University, the Medical Faculty's program, *Introduction to the Basics: Health in the Context of Diversity and Participation*, introduces students to health issues in diverse populations. Giessen University's medical curriculum also addresses migration-related themes, specifically under *Health and Migration*. This surge of initiatives underscores the need for enhanced interventions and training on cultural competency in healthcare, especially for migrants.

Feedback from the pilot workshops has been overwhelmingly positive among both medical students and health guides, and has offered valuable insights for refinement. The participants particularly appreciated the opportunity to share experiences and engage in discussions. This aligns with recommendations from the literature; for example, Antón-Solanas et al. (2021, p. 20) who note the value of "opportunities for discussion and critical reflection on these issues, particularly those emerging from practice". Participants in our pilot program suggested increasing the interactive elements of workshops, extending their duration for greater depth, and incorporating these themes more prominently into general medical curricula - an especially relevant consideration given the growing importance of cultural competence in German society.

However, cultural competency remains a relatively marginal topic in medical education. This may stem from two factors: first, medical programs are often perceived as already 'full' and lacking room for what some may see as 'softer' topics; and second, the social determinants of health are sometimes viewed as secondary to traditional medical training. While elective workshops can serve as a short-term solution, they risk "preaching to the choir." Nonetheless, feedback from the pilot workshops indicates that even participants with prior interest in cultural competency benefited from structured knowledge, exchange, and reflection. These workshops

can have a ripple effect, both in future as medical students move into practice, and immediately as health guides apply these learnings to their work.

Expanding cultural competency training to reach a broader audience of healthcare professionals, particularly those serving patients from migrant backgrounds, holds significant potential. Given the high workloads in medical settings, integrating such training into regular working hours through workplace programs may be a viable approach. Furthermore, the extensive body of literature on social determinants of health - particularly from the United States and, to a lesser extent, Europe and Germany - offers a strong foundation for strengthening cultural competency in medical curricula. Doing so would not only improve individual migrant health outcomes and relationships with institutions, but also foster broader societal benefits.

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