Multicultural Health Care in Practice
An Empirical Exploration of Multicultural Care in the Netherlands

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This study presents a first assessment of the challenges faced by Dutch health care providers dealing with the increasing cultural diversity in Dutch society. Qualitative interviews with 24 Dutch caregivers and policy-makers point to a number of important difficulties encountered when confronted with the growing diversity of patient populations. The study focuses explicitly on the challenges health care providers perceive in their direct interactions with patients. On the basis of the observations of the 24 respondents five strategies were formulated to improve the delivery of care in a multicultural environment. Their findings were further evaluated by confronting the empirical data with care-ethical notions (attentiveness, responsibility, competence, and responsiveness) and intercultural communication-theory.

KEY WORDS: communication barriers; cultural diversity; health policy.

INTRODUCTION

Traditionally, most European societies have known considerable cultural variety. However, since the Second World War, following decolonisation and globalisation, many European countries have become increasingly ethnically mixed. In the Netherlands (population: 16 million people) more than 1.5 million non-Western migrants settled since the 1950s. Unfortunately, social policies frequently...
lag behind such demographic tendencies. Thus, while a large number of migrants have lived in the Netherlands for over 25 years, their presence has not sufficiently been translated into new health care and social policies. The consequences of this relative negligence have recently become visible. While the stated aim of Dutch health care is to provide equal access and high quality health care to all citizens, socio-economic health differences are growing, affecting migrants in particular. Several studies point out that the health status of many migrants is poorer than that of the native Dutch (Haveman et al., 1996; Weide et al., 1998; Stronks et al., 1999; Dijkshoorn et al., 2000; Haddouchi et al., 2000). In an attempt to remedy the situation, in 1999 the Dutch government ordered the Dutch Council for Health Care (RVZ) to advise them on interculturalisation of health care (RVZ, 2000). The Council’s 2000 report contained strong recommendations concerning intercultural management, education, expertise-centres and counselling. The recommendations became the basis for a government taskforce on interculturalisation that sent a detailed new policy implementation plan to Dutch parliament in November 2001. These developments indicate awareness that a turn in strategy is deemed necessary. The present study was set up to assess how the new policy climate affects concrete practices of delivery of health care in various representative health care institutions. Our survey yields several suggestions as to how health care delivery in a multicultural society can still be improved.

METHOD

The study consisted of 24 semi-structured interviews among health care providers. The respondents were distributed over two cities: Utrecht (253,000 inhabitants including 23% migrants) in the central part of the country, and Nijmegen (152,000 inhabitants including 14% migrants) in the south-east. In each city, we interviewed general practitioners, and caregivers and policy-makers from academic centres, a non-academic hospital, an institution for ambulatory mental health care, an organization for public health, a home care organization, and a nursing home.

In our interviews we used a detailed outline of subjects. The interview-scheme contained four main topic-areas: facilities, skills of caregivers and migrants, knowledge of caregivers and migrants, and recruitment of employees from ethnic minorities. The questionnaire was designed on the basis of in-depth study of the relevant policy-memoranda, medical-ethical literature and publications about migrants in health care. Pilot interviews led to several small modifications.

The interviews were conducted by the first author (GO) during the first half of 2000, and transcribed. From the transcripts, the sections with clear relevance for the research-questions were marked. These quotations from individual interviews were subsequently put into a three-tier scheme: observations made at a macro-, meso- or micro-policy level. Further analysis of the interviews clearly drew out