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Original Article

Health professionals' access to diversity training across Denmark

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ABSTRACT

INTRODUCTION. Health disparities exist between migrants and ethnic minorities (MEM) and the majority population in Europe and Denmark. As diversity increases, delivering healthcare appropriate to MEM is essential. Training health professionals (HP) in diversity competence (DC) prepares them for a diverse society and helps address health disparities among MEM. The study aims to investigate which educational activities exist regarding DC training across sectors in Denmark.

METHODS. An email survey was sent to all health education programmes, municipalities, regions (including hospitals), healthcare worker unions, medical societies/associations, the Ministry of Health and the Danish Health Authority. Among the 295 institutions contacted, 148 responded. Ten surveys were excluded, yielding a dataset of 138 surveys and a response rate of 46.8%. Data were collected between 21 February and 12 May 2022.

RESULTS. All but one participating health education program included some level of DC in their curriculum. However, few institutions provided DC training for teaching staff. DC training in municipalities and regions varies, but most agree that it is relevant. Some municipalities that do not offer DC training to HPs attribute this to a lack of MEM citizens.

CONCLUSIONS. Most health professionals lack adequate access to diversity competence training. Regions, municipalities and educational institutions should provide continuing medical education for healthcare workers in this area.

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Health disparities between migrants and ethnic minorities (MEM) and the majority population in Europe and Denmark are a recognised societal issue [1, 2]. Research suggests that disparities arise from barriers such as interpreter fees [3], inadequate communication and the insufficient skills of healthcare professionals (HP) in caring for MEM [4]. With a growing diverse population, due to migration, the emphasis on providing socially, culturally and linguistically appropriate care is highlighted [5].

Cultural competence emphasises awareness of culturally specific habits, beliefs and needs in healthcare and is seen as a strategy to reduce health disparities among ethnic and other minorities [6]. However, cultural competence has been criticised for its static view of culture, stereotyping and focus on "the other" [6]. A study identified respect, empathy, self-reflection, communication skills and awareness of social determinants of health as key competencies for diversity-sensitive HP [7]. This marks a shift from a cultural and ethnic focus to broader forms of diversity. While acknowledging various aspects, this study centres on MEM, as their healthcare challenges dominate the diversity discourse of Denmark. The term "diversity" focuses on the groups' multicollectivity and adopts an intersectional approach addressing intersecting identities like race, class, gender

and sexual orientation [7]. We, therefore, use the concept of diversity competence (DC) in this study to improve the understanding, interaction, and communication between HPs and patients from diverse backgrounds. This involves enhancing knowledge (e.g., health determinants), reflection (e.g. personal background and bias) and skills (e.g. communication with interpreters) [7].

DC training is provided as part of 1) higher education and 2) continuing medical education (CME) in municipalities (for eldercare professionals), regions (for hospital staff), unions and medical societies. Although frameworks and guidelines exist regarding how and what to integrate into health education [8-10], studies suggest that DC is not adequately included in European medical and healthcare education [11]. For instance, a study found that Danish medical students are less confident diagnosing dermatological diseases in skin of colour than white skin, indicating curriculum gaps for MEM patient care [12]. Additionally, ongoing developments in health and medicine call for continuing education for HPs to provide high-quality healthcare [13].

We investigated existing DC training activities across sectors in Denmark to provide an overview, identify areas for improvement and suggest how these activities could be organised and offered.

Methods

Survey design and content

We developed a survey with 26 items for non-educational and 27 for educational institutions. The programmes varied in terms of academic level, ECTS credits and teacher qualifications. The number of questions varied based on the respondents' answers, with some questions being conditioned on previous "Yes" responses. Items about specific DC learning objectives were inspired by a study on DC in European medical education [11]. The items varied slightly by type of institution. Educational institutions were asked if their curriculum included DC content within the key competencies (as listed in **Table 1**), if they provided education in DC for teachers teaching in their health programs, and whether they evaluated students in DC. Non-educational institutions were asked if they offered CME for HPs. See Appendix A for the full questionnaire. The survey was tested by three public health experts and adjusted based on their feedback. It included an introduction, a description of the study aim and a definition of DC. Informed consent was obtained before the respondents started answering the questionnaire.

TABLE 1 The number of key competencies included in the programmes of the educational and non-educational institutions offering diversity training. Due to the multiple-choice format, respondents could select more than one key competence.

Key competence	Educational institutions[a] (N = 49)	Non-educational institutions[b] (N = 24)
Knowledge of concepts of diversity and/or intersectionality and their importance for health and health efforts	25	16
Knowledge of migrant and ethnic minority disease patterns	25	19
Knowledge of factors of importance for the health of migrants and ethnic minorities	27	20
Awareness of how culture can shape individual behaviour and thinking, including understanding of illness	46	26
Awareness of and the ability to reflect on one's own socio-cultural background, identity and context along with how it influences the meeting with the patient	42	22
Awareness of and the ability to reflect on implicit bias, prejudice and the tendency to stereotype	31	21
Ability to apply diversity competence in the interaction and communication between themselves and the patient	32	22
Ability to use an interpreter in the meeting with the patient	19	18

a) Includes vocational schools, university colleges and universities.
b) Includes municipalities, healthcare regions, unions and medical

Distribution of survey and target groups

The inclusion criteria for educational institutions required them to offer higher health education programmes at universities, university colleges or vocational schools. Non-educational institutions were included if they

employed HPs, oversaw their competence development or provided CME for them. The institutions included in the survey were municipal health administrations, all regional institutions (including hospitals), unions representing healthcare employees, medical societies and associations, the Danish Ministry of Health and the Danish Health Authority. The survey was emailed to representatives of 295 institutions, yielding 148 responses. Ten surveys were excluded due to multiple submissions from some institutions. When deciding which of the surveys to keep, considerations were made about the informant's position (e.g. head of section) and the number of answers. The questionnaire was distributed on 21 February 2022, with reminders sent on 9 March, 21 April and 28 April 28. Data collection concluded on 12 May 2022.

Analysis of data

The results were reported using descriptive statistics. Answers to open-ended questions were divided into two datasets ("Educational Institutions" and "Non-educational Institutions"), and the first and last authors grouped the answers under themes and discussed them. The answers to open-ended questions were used to support, stress or nuance the results.

Trial registration: not relevant.

Results

The dataset consisted of 138 surveys, yielding a 46.8% response rate. **Table 2** shows the distribution of institutions: municipalities 53 (38.4%), regions 25 (18.1%), unions nine (6.5%), medical societies one (0.7%), vocational schools 17 (12.3%), university colleges 28 (20.3%) and universities five (3.6%). The results are reported according to educational institutions and non-educational institutions.

TABLE 2 The distribution and response rate of institutions in the survey categorised by their total count and percentage share.

Institution	Surveys distributed, n (%)	Responses, n (%)	Response rate, %
Municipalities	98 (33.2)	53 (38.4)	54.1
Regional institutions	65 (22)	25 (18.1)	38.5
Unions	22 (7.5)	9 (6.5)	40.9
Medical society	11 (3.7)	1 (0.7)	9.1
Universities	19 (6.4)	5 (3.6)	26.3
University colleges	49 (16.6)	28 (20.3)	57.1
Vocational schools	27 (9.2)	17 (12.3)	63.0
Agencys and ministeries	4 (1.4)	0	0.0
Total	295 (100.0)	138 (100.0)	46.8

Educational institutions

A total of 50 health educational programmes participated in the survey, with the highest number of answers being provided by programmes at university colleges (**Table 3**). A total of 49 of 50 programmes reported that they included one or more of the key competencies in their curriculums (**Table 4**).

TABLE 3 The distribution of educational programmes on three types of institutions: vocational schools, university colleges and universities.

Institution type	Educational programme	n
Vocational school	Social and healthcare helper/assistant	17
Subtotal		17
University college	Midwifery: bachelor	3
	Psychomotor: therapy	1
	Nursing	10
	Occupational therapy	3
	Physiotherapist	4
	Nutrition and health	2
	Biomedical laboratory science	4
	Radiography	1
Subtotal		28
University	Medicine	2
	Public health	1
	Midwifery: master	1
	Dental surgery	1
Subtotal		5
Total		50

TABLE 4 The number (%) of institutions offering diversity training by geographical region in Denmark.

Geographical region	Municipality (N = 53[a])	Regional institutions (N = 25[a])	Union (N = 9[a])	Medical society (N = 1[a])	Educational institutions (N = 50[a])	Total
Capital Region	6 (50)	5 (62.5)	-	-	10 (20.4)	21 (28.8)
Central Denmark Region	-	3 (37.5)	-	-	10 (20.4)	13 (17.8)
North Denmark region	-	-	-	-	5 (10.2)	5 (6.9)
Region Zealand	3 (25)	-	-	-	11 (22.4)	14 (19.2)
Region of Southern Denmark	3 (25)	-	-	-	13 (26.5)	16 (21.9)
Denmark	-	-	4 (100)	-	-	4 (5.5)
Total[b]	12 (100)	8 (100)	4 (100)	-	49 (100)	73 (100)

a) The total number of respondents in each institution.
b) The total number of institutions that have offered diversity training.

Table 1 lists key competencies in health educational programmes. The most often included competencies were "Awareness of how culture can shape individual behaviour and thinking (including understanding of illness)" (46/49) and "Awareness of, and the ability to reflect on, one's own socio-cultural background, identity and context as well as how this influences the meeting with the patient" (42/49). The least often included competence was "Ability to use an interpreter in the meeting with the patient" (19/49).

A total of 35 health educational programmes declared that at least one of the key competencies was included in several courses, and 14 stated that they offered and covered the subject in one specific course. Eleven institutions offered DC education to staff through diploma-level teacher training, lectures or workshops. One institution stated that staff should actively pursue relevant training themselves.

Non-educational institutions

Twelve of 53 municipalities, eight of 25 regions and four of nine unions reported offering training, including at least one key competence (Table 4). The medical society did not provide any DC training. Overall, 24 of 88 non-educational institutions offered training with at least one of the eight key competencies. Table 4 shows that half of the 12 municipalities offering DC training were located in the Capital Region of Denmark, with none in the Central and Northern Denmark Region. Regional training activities were provided only by the Capital Region of Denmark and the Central Denmark Region.

Most training by non-educational institutions included "Awareness of how culture can shape individual behaviour and thinking (including understanding of illness)" (26 of 24) and "Awareness of and the ability to reflect on one's own socio-cultural background, identity and context, along with how it influences the meeting with the patient" (22 of 24). The least-often included competencies were: "Knowledge of concepts of diversity and/or intersectionality and their importance for health and health efforts" (16 of 24) and "Ability to use an interpreter in the meeting with the patient" (18 of 24) (see Table 1).

When asked about the relevance of including DC in HP education, 87 of 88 institutions answered "Yes." Among the 60 institutions not offering DC training, seven planned to or were considering doing so. Reasons for not offering training included being minor municipalities, lacking in-house expertise and impracticality due to size. They reported that they would hire training from experts if needed. Other institutions noted an increasing need due to a more diverse population and workforce.

Discussion

Our study showed that DC is included to some degree in the curriculum in all but one of the health educational programmes of the participating institutions, although teacher training initiatives were lacking. While variation

exists in DC training across municipalities and regions, most agree on its relevance. Municipalities not offering DC training often stated the absence of MEM residents as the reason.

Our results align with conclusions from a previous study [14], showing few CME opportunities for HPs in DC despite many providers (e.g. municipalities, unions, medical societies and universities). Danish HPs are employed across several sectors. Accordingly, their access to CME in DC varies with the sector in which they are employed and their geographical location. Furthermore, studies suggest that many HPs experience barriers to engaging in CME once they graduate. Barriers include limited time, lack of economic resources and difficulties in accessing information about CME activities [15, 16], which should also be considered when planning CME activities.

Our findings also reveal that most of the participating health educational programmes in this survey have included DC in their curriculum to some degree. A recent study showed that some health educational programmes have yet to include DC in their curriculums [12]. The reasons explaining this include unclear learning objectives and content, lack of management support, including in the distribution of resources, insufficient evaluation of educational initiatives or lack of prioritisation of the topic [17]. Moreover, our study also suggested a lack of DC training for teachers at educational institutions, as just 11 out of 50 institutions offered DC training. Other studies have obtained similar findings [11], and some indicated an interest from teaching staff in participating in DC training [18]. Furthermore, the training varied considerably from being part of a mandatory diploma-level teacher-training course to being addressed only in individual workshops for teachers. This range of provisions may possibly explain why the competencies among staff are inconsistent and of varying quality.

A key competence often overlooked in training was the 'ability to effectively use an interpreter in patient interactions. This resonates with other studies that emphasised both the importance of using interpreters [19] and the need for competence in using interpreters but also highlighted the scarcity of training initiatives addressing this issue [20]. Training this skill is an achievable goal, as training in working with an interpreter could easily be organised across various regions or offered online.

Based on our results, we suggest that the following steps be taken to organise DC for future and present HPs:

Regions should provide basic DC training for the healthcare workforce in both municipalities and regions. Blended or online learning programmes may serve to reduce costs and increase accessibility [9].

DC should be included in training for specialised doctors and nursing programmes anchored within the Danish Health Authority and the Ministry of Health. As mentioned above, blended and online learning may be an effective solution.

DC should be acknowledged as a necessary competence and a mandatory part of all basic health education. Moreover, ongoing DC training for teaching staff should be offered as part of continuous professional development and should not be seen as teachers' individual responsibility.

To achieve these objectives, the relevant institutions need to develop an overarching and specific policy that ensures a coherent focus on DC.

Strengths and limitations

This study has various limitations. First, identifying the right survey respondents at non-educational institutions was challenging. As a result, respondents may have lacked comprehensive knowledge of all training activities, leading to potential omissions. Second, some institutions were unfamiliar with the DC definition used in the survey, making it difficult for respondents to complete, which may have resulted in incomplete or inaccurate responses. Third, the lack of responses from overarching institutions like ministries, the Danish Health

Authority and unions may reflect the survey's lack of relevance to them. Fourth, selection bias is possible since the staff who know about the topic and find it interesting may have been more likely to complete the survey. Fifth, recollection bias may be an issue since we asked one person to remember what the entire organisation offers on this topic. Sixth, it is important to note that the study represented only about half of the population, which should be considered when concluding. A strength of the study is its attempt to gain an overview of DC training across sectors, which has not been done before.

Conclusions

Our findings show that while some DC training is offered in basic health education and by regions and municipalities, most HPs lack sufficient access. Differences in training among municipalities and regions impede consistent HP competencies and uniform health services nationwide. Regions, municipalities and educational institutions must ensure CME in DC for their healthcare workforce.

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