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Intercultural Competence in Healthcare: Challenges and Strategies for the Inclusion of Immigrant Population in Spain

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ENG **Abstract:** This article analyzes the growing cultural diversity in Spain as a result of immigration, with a specific focus on the impact on the healthcare system. It explores the theoretical frameworks of interculturality, cultural competence, and cultural sensitivity, and evaluates their implementation through regional healthcare protocols. Through a comparative analysis of models such as those by Campinha-Bacote, Purnell, Leininger, and Kleinman, as well as empirical research from Bas-Sarmiento et al. (2015) and Valero-Garcés (2019), this study offers a comprehensive review of challenges, strategies, and good practices in intercultural healthcare. It also proposes inclusive policies and culturally competent training to improve healthcare delivery to migrant populations in Spain.
Keywords: interculturality; cultural competence; healthcare access; immigrant health; Spain; interpreting services; health equity; public health policy

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1. Introduction

Massive immigration has brought demographic changes to Spain that have significantly altered the country's social and healthcare landscape. Since the beginning of the 21st century, Spain has become one of the main immigration destinations in Europe. As of January 2024, the country has become home to over 7.5 million foreign-born residents, representing approximately 15.8% of the total population (INE, 2024). This increase in cultural and linguistic diversity presents both opportunities and challenges for healthcare systems that have traditionally been designed around a more homogenous patient population.

Immigrant populations in Spain are characterised by varied legal statuses, health beliefs and sociocultural practices. These differences need systemic adaptations in how healthcare is delivered, especially in terms of communication, care planning and equity. The inadequacy of present systems is evidenced by research showing that migrants frequently experience worse health outcomes than native-born populations due to factors that do not always involve inherent vulnerabilities. Instead, they include institutional barriers, language obstacles and unequal access to social determinants of health (Blasco-Palau et al., 2023).

Spain's transformation into a key destination for global migration has brought about a sharp increase in cultural, ethnic and linguistic diversity. According to EpData (2022), the largest migrant communities originate from Latin America (Colombia, Venezuela, Ecuador), North Africa (Morocco), Eastern Europe (Romania, Ukraine) and Asia (China, Pakistan). The distribution of these populations is uneven, with the majority settling in the urban centres of metropolitan areas such as Madrid, Barcelona, Valencia and Andalusia. Since 2024, over 22000 West African migrants have illegally reached the Spanish coasts (mainly the Canary Islands), and there has thus been an increase in migrants arriving from Mali and Mauritania, who have been sent to different parts of the country as part of programs aimed at integrating and revitalizing rural areas (mainly sending them

to temporary stay centers and reception facilities). While urban areas sometimes offer specialised resources that mitigate existing challenges, migrants in rural areas face compounded obstacles due to limited services and infrastructural constraints. This rural-urban disparity has created geographic inequalities in healthcare access that exacerbate vulnerability for already marginalised groups. Moreover, specific subgroups such as unaccompanied minors, victims of human trafficking and seasonal labourers face particularly acute health risks (World report on the health of refugees and migrants, 2022).

The migrant population in Spain is highly heterogeneous, composed of economic migrants, asylum seekers, refugees, international students and undocumented individuals. Each of these groups brings specific health profiles shaped by pre-migration experiences as well as legal status and socioeconomic conditions in Spain. For instance, asylum seekers and refugees may exhibit elevated rates of post-traumatic stress disorder (PTSD), anxiety and depression due to displacement, violence and uncertainty in legal proceedings (CEAR, 2023). Economic migrants often work in high-risk sectors like agriculture, domestic service and construction, where they are exposed to occupational hazards and may lack proper healthcare coverage (Parella et al., 2024). Meanwhile, undocumented migrants encounter systemic exclusion due to bureaucratic obstacles and fear of deportation, often resulting in delayed care and overreliance on emergency services (Kisa 2024). Gender also shapes migrant health experiences. Migrant women frequently face intersectional challenges including reproductive health disparities, gender-based violence and restricted autonomy in healthcare settings, facing even more language problems due to their isolation (most undocumented migrant women take care of children at home and do not leave their home and interact with many individuals outside their family and community). Present policies do not account for these intersecting identity risks, reinforcing inequities rather than alleviating them (Spain 2050. Fundamentals and proposals for a Long-Term National Strategy, 2024).

A nuanced understanding of migration profiles is critical to designing effective healthcare interventions. Tailored strategies must consider the interplay between cultural expectations, legal protections and material conditions in shaping healthcare needs and behaviours. Recent public health literature emphasises the importance of culturally-adapted mental healthcare, chronic disease management programmes and community-based health promotion campaigns as tools to bridge the gap between migrant populations and health systems (Marchi et al., 2024). As Spain continues to experience demographic change, an inclusive, intersectional and participatory approach to healthcare reform is essential for guaranteeing the right to health of all residents, regardless of origin or legal status (Laia Raigal-Aran et al., 2019). In this context, intercultural competence in healthcare has become a central concern in public policy and academic discourse. It refers not only to individual provider awareness or empathy, but also to institutional capacity to accommodate diverse needs while promoting health equity. International frameworks, such as those adopted by the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC) and the European Union Fundamental Rights Agency (FRA), increasingly recognise that achieving universal health coverage requires a culturally responsive approach. Furthermore, advancing intercultural competence aligns directly with the United Nation's 2030 Agenda for Sustainable Development, especially Sustainable Development Goal 3 (SDG), which focuses on ensuring healthy lives and promotes well-being for all, and SDG 10, which calls for reducing inequalities within and among countries. Reaching these SDGs strongly requires dealing with inclusive and culturally adaptive frameworks to be developed within healthcare systems.

This article provides an in-depth analysis of the conceptual foundations and regional strategies that shape intercultural healthcare in Spain. Through a multidisciplinary lens, it critically examines theoretical models, compares policy implementations and identifies gaps and best practices. Ultimately, the article aims to contribute to building a more inclusive and just healthcare system that is responsive to the country's evolving demographic realities.

2. Conceptual Foundations of Intercultural competence in Migrant Healthcare

To understand and address the healthcare needs of migrant populations, it is necessary to distinguish between certain foundational concepts that underpin supportive interactions with migrants, not only in theory but also in practice. These concepts include interculturality, cultural competence and cultural sensitivity.

Interculturality emphasises the importance of mutual respect and coexistence. It refers to respectful and equitable interactions between cultures that promote mutual understanding (Aneas & Sandín, 2009). In healthcare, it involves adapting services to the cultural contexts of patients. The WHO (2010) promotes interculturality as a pathway to health equity. Its vision extends beyond tolerance to include collaborative coexistence and institutional responsiveness. A focus on interculturality encourages the recognition of cultural diversity as a structural element of society and as a source of, rather than a barrier to, enrichment. In clinical settings, interculturality may involve rethinking the logic of consultation to prioritise dialogue, context and patient narratives. For example, rather than simply translating diagnoses, professionals might be called to negotiate meanings and health perceptions that differ across cultures. This dialogical emphasis aligns well with patient-centred care and shared decision-making models. On the contrary, cultural competence focuses on the need for a structured and operational framework for care. It is defined as the integration of awareness, knowledge, skills and attitudes needed to work effectively in cross-cultural situations (Betancourt et al., 2003; Campinha-Bacote, 1998). Awareness includes self-examination of biases and assumptions, whereas knowledge implies an understanding of cultural differences and their health implications. Skills refer to the ability to conduct culturally relevant assessments. Along with knowledge, these skills typically develop through cross-cultural encounters. Lastly, strong attitudes, including the motivation

to become culturally competent, are important to acquiring both knowledge and skills. In Spain, several regional health departments have adopted cultural competence as a pillar of continuing medical education. However, critics argue that unless embedded within systemic structures and supported by monitoring mechanisms, competence may remain superficial (Adler et al. 2018). Continuous professional development programmes should include reflexive exercises, community-based learning and performance evaluations tied to patient satisfaction indicators. However, little importance is given to training future health professionals (specially doctors) in interculturality in Spain, with almost no medical degrees incorporating intercultural competences in their programmes.

On the other hand, cultural sensitivity, while lacking the procedural clarity of competence-based models, emphasises the importance of empathy. It implies recognising and respecting cultural differences in health beliefs and practices (Leininger, 2002). It plays a crucial role in establishing trust and improving patient satisfaction and treatment adherence (Saha, Beach & Cooper, 2008) and is demonstrated by valuing patients' cultural expressions through affective engagement and active listening. However, being an informal concept, cultural sensitivity often lacks institutional structures for evaluation and integration into broader clinical procedures. Sensitivity must thus be cultivated through experiential learning, mentorship and emotional intelligence training that balances empathy with knowledge. For example, being sensitive to a patient's preference for traditional remedies should not lead to uncritical endorsement, but rather to dialogue that bridges biomedical knowledge and patient beliefs. Ultimately, cultural sensitivity should serve as the foundation upon which structured models of cultural competence in healthcare are built, ensuring that care is not only technically appropriate but also emotionally and ethically responsive to the lived experiences of diverse patient populations.

Each of these concepts thus addresses a particular aspect of cultural interaction that the other two concepts exclude. For example, some scholars (e.g. Betancourt et al., 2003) argue that cultural competence, while providing procedural clarity, risks oversimplifying cultural identities if reduced to checklists, thus requiring continual contextualisation and reflexivity. Contemporary critiques also draw on intersectionality theory (Crenshaw, 1991; Hankivsky, 2012), which considers how overlapping identities (e.g., race, gender, migration status) interact with systems of power to shape health outcomes. In this view, competence must extend beyond an awareness of cultural differences to include the socio-political context. The structural competency framework, as developed by Metzl and Hansen (2014), incorporates the insights of intersectionality theory by emphasising the need for health professionals to recognise how health disparities are produced and perpetuated by systemic factors such as housing policy, immigration law and economic inequality. This perspective encourages providers to move beyond individual cultural traits to address upstream determinants of health. Other contemporary approaches to cultural competence in migrant healthcare include critical race theory and the capabilities approach. Critical race theory (Delgado & Stefancic, 2017) provides useful tools for examining how institutional racism impacts healthcare access and delivery for racialized immigrant populations. It reframes cultural competence not only as a skillset but also as a commitment to social justice and anti-discriminatory practice. The capabilities approach to competence, particularly as developed by Sen (1999) and Nussbaum (2000), focuses on expanding individuals' real freedoms and opportunities to achieve well-being. In the healthcare context, this entails ensuring that all patients, regardless of cultural background, have the necessary means to achieve good health. These include access to culturally appropriate care, understandable information and participation in decision-making processes.

Together, the foregoing theoretical contributions suggest that effective intercultural healthcare must be: reflexive and dynamic, contextually aware, justice-oriented and capability-enhancing. Integrating these components is necessary for designing health interventions and training programmes that are nuanced and holistic, while also aligning with broader human rights and equity objectives in public health policy. In the following subsections, the three concepts on which they are based — interculturality, cultural competence and cultural sensitivity — are explored in more detail.

2.1. Intercultural Models in Clinical Practice

Although there are different intercultural models, each offering a valuable perspective on migrant healthcare, they overlap in some of their assumptions while diverging and even conflicting in others. For instance, the Campinha-Bacote model emphasises an ongoing process of healthcare rooted in personal desire and reflection, whereas the Purnell model is more prescriptive and domain-based. Leininger advocates for culture-specific care, which can sometimes conflict with broader institutional protocols. Lastly, the Kleinman model introduces the importance of explanation, reminding practitioners to engage with patients' cultural interpretations of illness.

Effective implementation of these models in clinical settings depends not only on institutional endorsement but also on the adaptability of professionals, the availability of time and resources, and the cultural responsiveness of health systems. Expanding these models through integrative and pragmatic application can enable a more holistic and just healthcare experience for migrant patients. In the following subsection, the four models mentioned above are examined in some detail. Their main components and practical challenges are identified and examples are given of their application in Spain.

First to be examined is the widely-recognised Campinha-Bacote model, which frames cultural competence as a dynamic process involving five interrelated constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire (Campinha-Bacote, 1998). This model encourages continuous learning and critical self-reflection among healthcare providers. One of its strengths is an emphasis

on intentionality: Cultural desire is viewed as the foundation that motivates the practitioner to actively engage with diverse populations. This model has been widely used in Spanish healthcare training programmes, especially in the regions of Navarra and Castilla-La Mancha, where it informs both curriculum design and reflective practice seminars. However, limitations of the model become apparent when institutional cultures do not support the time or space necessary for repeated cultural encounters. In practice, overburdened clinicians may struggle to engage all five components. Finding ways to incorporate this model into broader health system protocols and quality improvement initiatives is thus essential to ensure sustainability.

The model developed by Purnell (2002) is another key framework for ensuring cultural competence in healthcare. This is a macro-level framework that identifies twelve cultural domains, including communication, family roles, workforce issues, bio-cultural ecology, high-risk behaviours and spirituality (Purnell, 2002). It is designed as a comprehensive tool for systematic cultural assessment and often used in multidisciplinary teams and educational settings, where it offers structured guidance on how to gather culturally relevant data and apply it in patient care. In Spain, hospitals in Catalonia and Valencia have used elements of Purnell's model in the design of patient intake forms and staff training modules. While the model is useful, critics note that its structured approach can risk stereotyping if not applied with flexibility. Professionals must remain attuned to intra-cultural variability and avoid treating cultural traits as fixed or universally applicable.

A third model, developed by Leininger (2002) in accordance with her theory of transcultural nursing, emphasises the importance of culturally congruent care that aligns with the values, beliefs and practices of individuals as well as groups. Leininger's Sunrise Model helps nurses identify environmental, technological, religious and kinship factors that influence health behaviours. The model has influenced nursing education in Spain, particularly in undergraduate and postgraduate training programmes. In Andalusia, nursing faculties incorporate transcultural care simulations to prepare students for culturally diverse clinical environments. However, translating the model into everyday hospital workflows can be complex. The need for individualised care planning must be balanced with institutional protocols and efficiency imperatives. Additionally, the model requires significant cultural humility and ethnographic skills, which are not always emphasised in biomedical training.

Lastly, Kleinman's explanatory model, the oldest of the models here examined, emphasises understanding the patient's perspective on illness by eliciting their narrative through patient enquiry. Key questions include "What do you think caused your problem?" and "How do you understand your condition?" (Kleinman, 1980). This model is particularly effective for building empathy and reducing cultural miscommunication. It shifts the focus from diagnosis to meaning, allowing clinicians to negotiate treatment plans that respect the patient's worldview. In Madrid's public hospitals, Kleinman's approach has informed communication guidelines and cultural mediation practices. However, its application demands time and active listening skills — resources that are frequently constrained in fast-paced medical settings. Institutional adaptation may involve integrating explanatory model questions into electronic health records or training interpreters to facilitate narrative-based consultations.

While each of the above models has its merits, they function best when integrated rather than used in isolation. A hybrid framework that draws on Campinha-Bacote's reflective cycle, Purnell's domains, Leininger's patient-centred values and Kleinman's narrative approach can foster more comprehensive and equitable healthcare than a narrowly-conceived approach that relies on a single conceptual lens. Moreover, Spain's decentralised healthcare system offers a unique laboratory for experimenting with model integration. Coordinated policy, shared learning platforms and interregional evaluation mechanisms can facilitate this synthesis. Ultimately, model application must be context-sensitive, patient-informed and structurally supported to be genuinely effective in achieving intercultural equity.

2.2. Barriers to Access

At present, migrant populations face several barriers to accessible care. These barriers do not exist in isolation but interact and compound one another. Linguistic difficulties reduce the accuracy of diagnosis, while cultural misunderstandings undermine treatment adherence. Administrative complexity, an institutional barrier, is an additional obstacle as it often discourages engagement with the system, particularly for undocumented migrants. Individually and combined, these roadblocks to accessible healthcare contribute to health disparities observable in higher emergency room usage and lower rates of preventive care among migrant groups (Gómez-González, 2020). Moreover, the cumulative stress of navigating these obstacles may widen disparities by exacerbating chronic conditions such as hypertension and anxiety. Urgently needed is systemic intervention. Barriers must be examined through a multilevel framework that addresses individual (language and trust), institutional (training and staffing), and structural (legal status and housing) aspects of healthcare. Only thus can targeted interventions be developed that promote a systemic shift toward equity and inclusion. The following subsection examines these interventions in the context of the barriers they aim to address.

2.2.1. Linguistic, Cultural and Institutional Barriers

Of the three main barriers mentioned above, language barriers are perhaps the most obvious challenge. These barriers compromise diagnosis, treatment adherence and patient safety. The absence of trained medical interpreters, especially in rural settings, can lead to miscommunication which, worsens health disparities (Angelelli, 2016). Ultimately, it can result in inappropriate treatments, duplication of diagnostic tests and diminished trust in providers.

While digital tools like translation apps and telephone and remote interpreting offer temporary solutions to barriers in communication, they often lack the cultural nuance required in sensitive conversations about

mental health, reproductive care or end-of-life decisions. Furthermore, an over-reliance on *ad hoc* interpreters such as family members — especially children — raises serious ethical and confidentiality concerns. To address these issues, some autonomous communities in Spain (e.g. Catalonia and the Basque Country) have implemented multilingual health portals and on-demand interpreting services. However, national coordination and stable funding are needed to ensure equitable access across all regions.

Cultural barriers, which include misunderstandings, differences in health beliefs and a mistrust of medical institutions, are another common obstacle among migrant patients (Kirmayer, 2003). Cultural incongruence between patients and providers can lead to noncompliance, missed follow-up appointments or reliance on parallel systems of care such as traditional healers. Moreover, healthcare professionals who lack training in cross-cultural communication may unknowingly project implicit biases. These issues are particularly critical in maternal care, mental health services and pediatrics, where culturally appropriate approaches are essential to building trust and ensuring adherence.

Community health workers and cultural mediators play a pivotal role in bridging these gaps. Their involvement in clinical consultations has been shown to improve health outcomes and patient satisfaction, as documented in pilot programmes in Andalusia and Madrid.

The third barrier to accessible healthcare pertains to administrative shortcomings of the healthcare system and operational problems with other social institutions. Bureaucratic complexity, lack of documentation and experiences of discrimination all limit access for migrants, who may delay care until emergencies arise, overburdening emergency services (Valero-Garcés, 2019). These barriers are particularly pronounced among undocumented individuals, who may fear legal repercussions or feel excluded by institutional gatekeeping. Administrative requirements — such as proof of residence, social security registration, or health cards — create hurdles that many migrants cannot easily overcome. As a case in point, the '2012 Real Decreto-Ley', which restricted healthcare access for undocumented migrants, had a chilling effect on service utilisation, even after partial repeals.

Social determinants such as housing instability, food insecurity and precarious employment further constrain health-seeking behaviours. These factors must be addressed through intersectoral collaboration and policy reform. Recent innovations in some regions include simplified health card applications for vulnerable groups, mobile outreach units and partnerships with NGOs for legal assistance and social support. However, a coherent national policy framework is still lacking.

2.2.2. Intersecting Barriers and Structural Inequity

Many migrants experience multiple, overlapping barriers that amplify vulnerability. For example, a pregnant woman who is undocumented, speaks limited Spanish and holds traditional health beliefs may face linguistic, administrative (institutional), and cultural barriers simultaneously. These intersecting challenges reflect deeper structural inequities embedded in the healthcare and immigration systems.

Adopting a structural competency framework, as proposed by Metzl and Hansen (2014), can help clinicians and institutions recognise these systemic forces. Such a framework also entails a shift from individual-level cultural awareness to broader advocacy for policy changes that dismantle exclusionary practices. In sum, addressing access barriers requires a multifaceted approach that combines legal reform, provider training, digital innovation and community participation. Spain has made important strides, but sustained political commitment and a shared vision for inclusive healthcare are essential to achieve true health equity.

3. Towards a Coordinating National Strategy for Regional Protocols in Spain

Evaluating the real-world effectiveness of intercultural protocols across Spain's autonomous regions reveals significant diversity in approaches and outcomes. The decentralised nature of the Spanish healthcare system allows for regional autonomy in health planning and policy, which in turn creates both opportunities for innovation and risks of inequality. Key indicators of intercultural accessibility such as interpreting services availability, staff training in cultural competence and integration of social determinants into healthcare planning vary substantially and are lacking in general. Some regions have adopted holistic models that integrate healthcare with education, housing and employment, while others maintain more fragmented systems focused narrowly on linguistic access. This section presents three representative case studies to illustrate both promising practices and ongoing challenges.

The first case study to be examined is Catalonia (Cataluña), a region that has emerged as a leader in intercultural healthcare provision, particularly in its investment in interpreting and mediation services. The '061 Salut Respon' programme provides telephone-based interpreting in over 90 languages and serves as a gateway for migrants to access health education, emergency services and clinical consultations. In theory, hospitals and primary care centres in Catalonia often employ intercultural mediators to accompany patients, facilitate communication and resolve cultural misunderstandings in real time. In practice, the service does not cover all patients as the number of intercultural mediators is not enough to coverage to the whole region, as exemplified in Gil-Bardají et al.'s article in this volume. The regional Department of Health has also developed training programmes for healthcare professionals focused on diversity, gender and migration, with modules tailored to different care levels. Furthermore, Catalonia's approach incorporates cultural competence in quality indicators and institutional assessments. Despite these advances, challenges remain. Mediator availability can be inconsistent across rural areas, and not all health professionals receive sufficient ongoing training. Moreover, while interpreting services are robust, they are not always well-integrated into clinical workflows. This can lead to delays or missed opportunities for effective communication.

Andalusia (Andalucía), the second region here examined, adopts a comprehensive and socially integrated model of intercultural healthcare. Through the 'Estrategia Andaluza para la Inmigración 2021-2025', the region has prioritised inclusive health planning that includes cross-sectoral coordination with social services, education and labour departments to address broader social determinants. Andalusia supports the deployment of mobile health units for seasonal agricultural workers — often migrants in vulnerable conditions — and funds cultural mediation services in hospitals and community clinics. Community health agents play a central role in outreach and education, and collaborations with NGOs have been instrumental in designing and implementing migrant-friendly interventions.

University hospitals in Granada and Seville, two of the main provinces in Andalusia, have also partnered with academic institutions to monitor healthcare access and outcomes among migrant populations, creating evidence-informed adaptations to protocols and patient communication practices. Nonetheless, the region still faces structural constraints such as limited budget allocations, workforce shortages and bureaucratic inertia that slow the full integration of intercultural strategies across all health districts.

The last case study to be examined is Madrid. Here, administrative simplification and service accessibility have been prioritised as the primary tools for improving healthcare access for migrants. Madrid's protocols include streamlined procedures for issuing health cards to undocumented individuals, multilingual health information platforms and partnerships with civil society organisations that assist in navigating the system. In theory, a unique feature of Madrid's strategy is its provision of community liaison officers and legal counselling services in health centres so that patients receiving medical care can also resolve documentation barriers. In addition, public campaigns targeting misinformation and fear among irregular migrants have been conducted with the aim of restoring trust in public institutions. However, Madrid's approach has been critiqued for its limited investment in cultural mediation and training for healthcare professionals. While linguistic accessibility is prioritised, system-wide commitment to cultural competence that addresses the broader social determinants of health is lacking. This has led to inconsistent care experiences, particularly among newly arrived or non-Spanish-speaking populations. A telephone interpreting service has been established but lack of awareness among health professionals and a poor professional service make this service underused and it has not proven to be an effective tool (Pena Díaz, 2023).

The contrast between regions underscores the need for a national framework that establishes minimum standards for intercultural healthcare. These should include guaranteed access to interpreting services, baseline training in cultural competence for all healthcare workers, integration of health equity with institutional planning and ongoing evaluation mechanisms. Best practices from the regions examined in this article could inform such a framework, ensuring that innovation is scaled and adapted to different communities across Spain. Shared data systems, interregional learning platforms and national investment in migrant health equity would support a more cohesive and just healthcare system. In conclusion, while regional diversity fosters experimentation and context-specific responses, a coordinated strategy is essential to reduce inequities and ensure that all migrants — regardless of region — receive dignified, culturally competent and accessible care.

4. Empirical Insights into Intercultural Healthcare in Spain

Empirical studies play a vital role in illuminating the real-life implications of healthcare policy and practice for immigrant populations. While theoretical models and policy frameworks establish a foundation, empirical research brings to light the complex experiences, challenges and outcomes faced by migrants in clinical settings.

The first empirical evidence here presented, Bas-Sarmiento et al.'s (2015) mixed-methods study, remains one of the most comprehensive investigations into migrant healthcare access in Spain. Conducted in Andalusia, it combined quantitative surveys with qualitative interviews to assess the perceptions and experiences of immigrants using public health services. The study identified several overlapping barriers, including insufficient access to translated materials, lack of cultural mediation and a widespread perception of discrimination and exclusion. Importantly, the research found that migrants' satisfaction with health services was strongly correlated with their ability to communicate effectively with providers and feel culturally understood. One of its primary recommendations was the institutionalisation of intercultural training for healthcare professionals and the incorporation of professional interpreters within routine care, particularly in emergency and primary care settings. The study also called for continuous monitoring and participatory evaluation to ensure service adaptation over time.

A second study, undertaken by Valero-Garcés (2019), found further evidence of dissatisfaction with healthcare services. The author used qualitative in-depth interviews with migrants and healthcare professionals to explore the communicative and cultural mismatches that occur during clinical encounters. Conducted in Madrid, the study provided a detailed ethnographic perspective on how misunderstanding, stereotyping and divergent health expectations can erode trust and lead to suboptimal care. Valero-Garcés (2019) emphasised the need for cultural mediators — not only as translators but as agents who interpret social and cultural nuances, negotiate meanings and advocate for patient-centred care. The study also highlighted the emotional toll of repeated miscommunication, particularly in sensitive areas such as reproductive health and chronic disease management. Through the narratives of both patients and professionals, the research underscored that intercultural competence must involve not only goodwill but also structural changes in health institutions. These changes include redesigning communication protocols, revising intake forms to be culturally inclusive and fostering team-based learning environments that prioritise empathy and equity.

A third study with findings highly relevant to migrant communities across Spain was conducted by La Fundación FOESSA (2022). This study introduced a longitudinal dimension to the analysis of migrant healthcare access, focusing particularly on undocumented individuals and families. Utilising a mixed-methods approach and spanning several Spanish regions, the study investigated how legal status, socioeconomic conditions and policy changes influence long-term health outcomes and service utilisation. Key findings revealed that undocumented migrants experience consistent barriers to primary care and mental health services, even in regions with inclusive policies. The fear of deportation, stigma and bureaucratic opacity were cited as primary deterrents. The study found that emergency care usage was disproportionately high among these groups, reflecting systemic exclusion from preventive and follow-up services.

FOESSA's research advocated for legal and policy reforms to ensure universal healthcare coverage regardless of immigration status. It also recommended institutional safeguards to separate healthcare services from immigration enforcement, thus fostering trust and early intervention. The longitudinal scope of the study provided compelling evidence that without structural change, inequities in migrant healthcare are perpetuated across generations.

The above studies highlight the multifaceted nature of healthcare access for migrants in Spain. Bas-Sarmiento et al.'s (2015) mixed-methods study is significant for capturing both the prevalence and depth of access issues, while the study of Valero-Garcés (2019) provides an intimate portrayal of cultural misalignment in clinical encounters. These two studies converge on the central role of communication and training, but diverge in scale and focus, suggesting that while qualitative insights are crucial for policy refinement, broader statistical trends remain vital for resource allocation and planning. The third study conducted by La Fundación FOESSA (2022) provides longitudinal evidence of the persistent healthcare gaps that exist among undocumented migrants, thus highlighting the public health risk of structural exclusion.

Comparing the methodologies of these studies underscores the importance of triangulation in research on healthcare access, while taken together they underline the importance of communication, training and systemic responsiveness as pillars of health equity. All three emphasise the centrality of language and communication in patient satisfaction and safety; the necessity of professional training and cultural mediation; the negative impact of legal status and administrative complexity; and the psychological and social consequences of cultural misalignment. Moreover, since the studies differ in scale, scope and methodology — ranging from local ethnographies to region-wide surveys — they illustrate the need for both micro and macro-level interventions. Qualitative insights offer granular understandings that can inform clinical practice, while quantitative data provide evidence for broader policy decisions. Future research should build on these foundations by incorporating digital health access, exploring the role of gender and age and conducting cross-regional comparisons to assess the impact of policy variability. Participatory research models that include migrants as co-researchers can also enhance the relevance and effectiveness of resulting interventions.

In summary, empirical evidence is indispensable for designing, implementing and evaluating intercultural healthcare strategies. It serves as both a mirror and a compass, reflecting existing inequities while guiding the way toward more inclusive and effective health systems.

5. Strategic Recommendations for Intercultural health Equity in Spain

Building on the theoretical framework, regional comparisons and empirical findings explored throughout this article, the following recommendations are proposed to enhance the inclusion and health equity of immigrant populations in Spain's healthcare system. These recommendations are structured across five strategic domains: professional education, institutional design, legal-political reform, community engagement and digital innovation.

5.1. Professional Education and Training

It is necessary to integrate intercultural competence and structural competency modules into university and continuing medical education curricula for all health professionals, as this would make them aware of the importance of acquiring intercultural competence. Training should include practical case studies, role-playing and reflective exercises that explore implicit bias, intersectionality and communication barriers.

As Spain continues to grow in its migration numbers, mandate ongoing cultural competence certification should be mandatory for healthcare professionals. Certification should be linked to professional development credits and institutional quality standards and experiential learning through clinical placements and community immersion in culturally diverse settings to build empathy and responsiveness should be facilitated.

5.2. Institutional Design and Service Delivery

As interculturality prioritises dialogue, context and patient narratives in consultations, it is necessary to involve intercultural mediators to facilitate communication between patients and health professionals so that rather than simply translating diagnoses and transferring linguistically, language professionals should negotiate meanings and health perceptions that differ across cultures. Thus, interpreting and intercultural mediation services in all healthcare settings, with a focus on high-traffic points such as emergency departments, maternal health clinics and primary care centres should be institutionalised, ensuring the availability of trained and paid professional intercultural mediators.

Multicultural advisory boards within healthcare institutions should be established to review policies, ensure inclusive service design and act as a liaison with migrant communities. The development and implementation

of culturally inclusive communication protocols, patient intake forms and health education materials which are linguistically accessible and sensitive to different cultural understandings of health, illness and treatment should also be incorporated.

5.3. Legal and Policy Reform

Universal access to healthcare for all residents, regardless of immigration status should be guaranteed by enshrining it in national legislation and repealing restrictive measures such as the '*Real Decreto-Ley* of 2012'. By creating clear national guidelines for migrant health inclusion, including standards for data collection, service provision and interregional equity, trust would be fostered and undocumented populations would be encouraged to use preventive care.

5.4. Community Engagement and Participation

The support of participatory governance structures where migrants are involved in health decision-making at local, regional and national levels would enhance policy relevance and foster accountability. It would be wise to promote health literacy through culturally tailored outreach programmes in collaboration with community organisations, NGOs and religious institutions. Topics should include rights awareness, service navigation and preventive care.

Training and employing community health workers from migrant backgrounds to act as cultural brokers, educators and advocates would help those particular individuals and increase social cohesion with those communities.

5.5. Technological and Digital Solutions

Expanding digital health platforms to include multilingual interfaces and culturally adapted content and ensuring digital literacy support for migrant populations through training and resource centres is another recommendation. AI-supported interpreting tools and telehealth services, particularly in rural or underserved areas, while ensuring ethical safeguards and cultural adaptability should be implemented.

The recommendations listed above envision a healthcare system that is not only responsive to cultural difference but structurally designed to promote justice, equity and full inclusion. Implementing them will require political commitment, intersectoral collaboration, sustainable funding and rigorous monitoring. Spain has the institutional capacity and social diversity to lead Europe in intercultural healthcare innovation provided that the reforms are bold, participatory and enduring.

6. Conclusion

Cultural competence is a critical dimension of equitable healthcare. As Spain's immigrant population continues to grow, the imperative to redesign health services through the lens of inclusion becomes increasingly urgent. Interculturality offers more than coexistence; it serves as a guiding principle for transforming healthcare into a socially responsive and human-rights-based system. However, despite multiple models and regional strategies, gaps remain in implementation, especially concerning underserved migrant populations and undocumented individuals. The integration of intercultural approaches in healthcare must extend beyond isolated initiatives to form part of a broader systemic transformation. First, theoretical perspectives, particularly those incorporating intersectionality, show that health outcomes are shaped not only by culture but also by structural inequalities linked to legal status, gender, race and socio-economic factors. Thus, cultural competence must be approached as an evolving, context-sensitive practice embedded within policy frameworks and clinical protocols. Secondly, National regional protocols highlight the urgent need for a coordinated strategy to address inequities and guarantee all migrants have access to a dignified and culturally appropriate care. Thirdly, empirical evidence shows that success is linked not only to training and interpreting services but also to institutional accountability, participatory governance and sustained investment in healthcare equity.

Spain, with its regional diversity and advanced public health infrastructure, is well-positioned to become a European leader in intercultural healthcare provision. However, this requires political will, continuous evaluation and robust stakeholder collaboration across diverse sectors. Digital innovation — including AI-assisted translation, telemedicine and mobile health applications — can offer scalable solutions to bridge cultural and linguistic gaps, particularly in rural or underserved areas, but these tools must be complemented by ethical guidelines and community engagement to ensure cultural relevance and accessibility. Future research should focus on evaluating the long-term effects of intercultural strategies, exploring migrant experiences across the healthcare journey and identifying best practices transferable across regional and national contexts. Also needed are comparative EU-wide studies that map the relationship between intercultural policy intensity and health equity outcomes.

In conclusion, embracing intercultural competence is not only a moral and ethical obligation but also a practical necessity for delivering high-quality, inclusive and effective healthcare, an essential component of well-functioning societies. Spain thus stands at a crossroads: it can either reinforce the structural status quo or initiate a paradigm shift that promotes equity and health justice for all its residents, regardless of origin. The set of strategic recommendations outlined in this study—covering education, institutional reform, legal safeguards, community participation, and digital innovation—are intended not only as suggestions but as a roadmap for policy design. Their implementation would represent a structural shift towards justice-oriented healthcare in Spain and, potentially, in other European contexts.

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