Knowledge, Understanding & Experience of NHS 24 services among Black & Minority Ethnic (BME) populations living in Scotland: Perceived Opportunities and Challenges for Accessing NHS 24 Services

A Report by REACH Community Health Project

January 2012

Funded & Commissioned by

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REACH Community Health Project is an innovative national voluntary organisation whose aim is to improve the health of Black and Minority Ethnic (BME) communities living in Scotland. The project is also committed to facilitate change within mainstream health services to better address the health needs of this particular community. To achieve these aims REACH has developed a triangulated formula in the form of a Services Unit, Policy and Research Unit and a Cultural Diversity Training Health Unit.

Our ***vision*** is a multi-cultural society in which all people have equal access to appropriate health services and our mission is to empower BME communities by ensuring that their health needs are fully met.

REACH Community Health Project have three key objectives as working principles which helps us to implement our policies into practice thereby achieving our aims. The objectives are as follows:

1. To provide a range of good quality, culturally-sensitive preventative health services
2. To influence mainstream policy and undertake innovative research so as to identify and remove barriers to health for BME communities
3. To provide cultural diversity training for mainstream, voluntary and private sector organisations working with BME communities

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Executive Summary

Background

REACH Community Health Project was established almost a decade ago in Glasgow and has since evolved into a national third sector organization with key strategic role in improving the health and wellbeing of Black and Minority Ethnic (BME) groups in communities and particularly in Scotland. REACH Community Health Project has been involved in a number of leading researches into the health needs of members of BME groups in Scotland and as such embodies considerable expertise and knowledge in conducting research on health and social needs of BME communities. In this piece of research work from REACH Community Health Project titled **"Knowledge, understanding and experience of NHS 24 services among Black and Minority Ethnic (BME) populations living in Scotland: Perceived opportunities and challenges for accessing these services"**, REACH Community Health Project seeks to answer questions around the use of NHS 24 services among BME communities in Scotland in an attempt to understand the factors that influence the use the this service among BME communities and to ultimately improve on the delivery of health services to this important subgroup of Scotland's population.

Keywords/terminologies

Black and Minority Ethic (BME) group*:* This is a term used to describe residents of Scotland who are not originally from Scotland and are of a different Nationality and who identify themselves as such. It has also been used synonymously with the term minority ethnic communities or groups in this study.

Summary Analysis of the Findings

From the research findings above one of the issues that readily stand out is the need for more ***language support*** as this appeared to be the most encountered barrier in order to use NHS 24 service by members from BME communities in Scotland. There is a recurrence of this finding with the findings of the literature review study; particularly in the study about a literature review on the health of refugees and asylum seekers [9]. Overcoming this barrier alone has the potential of making the experiences of both BME service users of NHS 24, and service providers' better. This will invariably improve the confidence of BME community members in NHS 24 services. It was also evident in this research that participants who were better off in terms of their ability to communicate in English language were more likely to have reported a satisfactory experience with NHS 24. Thus measures that will help improve the English language capacity of BME communities will go a long way to improve the use of NHS 24 services among BME community members. The other barrier which is also related to English language was the ***language of instruction on the automatic message*** machine on which callers are expected to make a selection of what services they want in English language. During the focus group meetings, participants suggested that the availability of dedicated language lines which will allow them to speak directly to someone who understands their language would be preferred. The other suggestion was incorporating a language option into the automated message. These facilities will encourage more BME communities accessing NHS 24 service. .

The other major issue was ***absolute lack of knowledge about NHS 24 among BME*** community research participants. While the General Practitioner (GP) services tend to be the point through which most of the participants in this study first come to learn of NHS 24.

It is clearly evident that the emergency number 999 appeared to be the most widely known among BME community members and as such they are most likely going to call the 999 in ill health scenarios or present to the emergency units of hospitals. This experience tends to be a little different for asylum seekers and refugees as they were presented information upon arrival in the United Kingdom which gives them information regarding where to get help and again most of the participants reckoned that they were only provided with information regarding 999.

Efforts at getting the BME community to know more about NHS 24 should be targeted. Multiple ways can be explored; GP services and point of entry for asylum seekers are specific ones. Other means, through which knowledge of NHS 24 services can be promoted and which was highlighted by some of the participants and particularly for the African and Caribbean members of the BME community is the need for face-to-face informative sessions about NHS 24. This may be in the form of visits to groups or organisations that carry out activities related to BME communities and to get more involved with BME groups. Thus more ***recognition and partnerships*** with groups or voluntary organisations that are in touch with BME communities will help to improve information and knowledge of NHS 24 services. Furthermore, the initiative will help build the confidence of the members of the BME community about NHS 24 services as well as give them the sense of ownership and responsibility. This is important as a number of the participants reported what appeared to be a ***lack of confidence or trust in the NHS 24*** and NHS in general. This is because of a gap in knowledge of NHS 24 services, experiences that they had in the past including delays in services and what was perceived as discriminations by some participants. All of these alone or in tandem could lead to reduced uptake of NHS 24 services. The promotion of NHS 24 services could incorporate information about the differences between NHS 24 and other NHS services. Another factor which may in a subtle way impact on the use of NHS 24 services among BME

communities is the socioeconomic status of some members of BME communities and particularly relevant to the Asylum seekers and refugee groups. Related to this issue is the cost of making calls from their phones to NHS 24 lines. Calls which they often described as long and protracted with some of the questions asked in the process being considered as irrelevant by some BME community participants. In an interview with the African and Caribbean group which also had some asylum seekers and refugees in attendance, it was mentioned that calls are often not their preferred means for accessing NHS 24 services because it is expensive to do so from the mobile phones, and most of them do not have landline phones. This could be further compounded by the experience that quite a number of callers will end up going to the hospital or seeking help elsewhere even after the calls. This was one of the reasons for presenting to the emergency units than calling the NHS 24 as it appears to be time saving and cost-effective. Furthermore, reporting to the emergency without first calling the NHS 24 or getting a referral to do so was reported by some participants as traumatic as they either have to wait long periods before they are attended to in the emergencies or turned away which was the case on one occasion as reported by a participant of the focus group meetings (FGM 11). Such experiences could potentially create a dislike for the NHS service, including the NHS 24 service as it came out from the study that the decision to use the NHS 24 service can be influenced by their past experience of the NHS service. This will be particularly detrimental for NHS 24 if BME communities are unable to differentiate between NHS 24 and other NHS service. This trend is in keeping with the findings of a similar study conducted in England where it was gathered that "lower socio-economic position were associated with higher casualty use" and that "reduced access to accidents and emergencies services will disproportionately affect poorer individuals, whereas increased investment in telephone services will benefit affluent populations". It was reported in the Scottish executive analysis of ethnicity in the 2001 census that "there are considerable differences between both ethnic group and sex in the proportion of people of working age who have never worked

and that all minority ethnic groups have a higher proportion than the White group of people of working age who have never worked" [2]. Therefore, a combination of lower socioeconomic status and reduced access to emergency units could prove a very frustrating and discouraging picture for members of BME communities in Scotland. This then has the danger of creating a picture that might be perceived by certain members of BME community as part of a systematic discrimination and exclusion.

There was a consistent theme of fairness and equality to all into the findings of NHS 24 staff research participants. However, there seems to be a correlation between the findings of BME communities, voluntary sector and NHS 24 research participants; particularly around, barriers due to the use of a third person, a family interpreter or via a language line. There is also a consistency about extra time taken for those with an interpreter service. This then relates to the frustration by BME communities about questions asked and having to repeat again and again. Furthermore, one of the NHS 24 research participants' suggestion of possibly referring to an emergency GP as opposed to providing the advice over the phone. This was due to the fact that there was the feeling of not being confident enough to advise the patient, due to the gap in getting information about the patient via the language line service.

One of the factors that were raised in the in-depth interviews was the need for training for NHS 24 staff. Training that will help them understand different cultures of BME communities and thus appreciate health and illness behaviours among minority groups better. This is paramount and it relates to one of the findings from the focus group discussions with BME communities. When BME communities were prompted about what stage of illness they will tend to seek medical help the majority of the BME participants responded that they will do so only when they feel they can no longer bear the illness, unless when it involves the very young ones, then they will seek advice promptly. They

also stressed that calls made were only made at such stage of illness in which they consider they are truly in need of medical help and at which point they would like to get help as soon as possible. Though these behaviours may be considered as unhealthy, an understanding of cultural factors unique to BME community members will help the NHS 24 and in general other health care professionals to better address the needs of BME community members. One of the suggestions to overcome this challenge may to raise more awareness among BME communities about benefits of preventative care.

1. Literature review

1.1 Introduction

Over the years, the world has continually become a global village with people moving from one part of the world to another with relatively greater ease. This has led to a great measure of cultural changes across the globe with cultures tending towards similar practices though significant differences still exist. As a result of such global trend in migration, the United Kingdom has become an increasingly multi-cultural society. Indeed the minority ethnic population of the UK grew from 5.5% of the total population in 1991 to 7.9% in 2001 (from 3 million in 1991 to 4.6 million in 2001) [1]. The minority ethnic community have also experienced a similar growth in Scotland; it has increased by 62.3% between 1991 and 2001, with a total of 100,000 ethnic minority people currently residing in Scotland. This figure represents approximately 2% of the total Scottish population [1]. This figure is based on the 2001 census and since then the demography of Scottish population has changed with more people coming from new European Union accession countries. Therefore, the above figure may not accurately reflect current trends in the demography of BME groups in Scotland. Minority ethnic groups in Scotland do vary a lot in their socioeconomic indices (census 2001) "Pakistanis were the largest among minority ethnic group (31.27%), followed by Chinese (16.04%) then Indians (14.79) and those of mixed ethnic backgrounds (12.55%) and Africans (5%)" [2]. In terms of educational attainment, while those from minority ethnic communities tend to be more likely to have a degree compared to the members of the Scottish communities, however, among the minority ethnic groups "Pakistanis are the most likely to have no qualifications (43%) followed by Chinese people (38%) and White Scottish people (35%). In contrast, 15% of African people aged 16-74 years were reported to have no qualifications" [2]. Furthermore, while 78% of the White population tend to rent homes from the public sector, only 48% of the

minority ethnic community do so with those of Pakistani and Bangladeshi ethnicity having the highest incidence of households living below the occupancy rating standard (31%) closely followed by those who are of African ethnicity (30%) [2]. These differences highlighted above shows that the Scottish population is quite diverse and exhibits a lot of differences which could impact on health and health seeking behaviour. Though this diversity has brought with it some benefits that include economic gains and development but it has also come with some costs as well: the need to offer equitable and accessible health care services to all regardless of race and ethnicity. In order to remain fair to the health needs of this growing migrant community in Scotland and to continue to encourage such benefits that accrue from this trend in migration, there is need for the health of this group to be taken into consideration. Therefore, the need for exploring the challenges and perceived opportunities with respect to access and use of available health facilities among minority ethnic communities cannot be overemphasized.

Our interest in this piece of work will be the health of the minority groups that have migrated into Scotland over the years giving rise to the term Black and Minority Ethnic (BME) groups and to look into issues that may promote or hinder access to health services among the BME community, with particular reference to the NHS 24 services. In Scotland, migration of minority groups is particularly an important phenomenon since Scotland is largely home to asylum seekers in the United Kingdom (UK) [3]. Even equally important will be the health state of these migrant communities. In REACH Community Health Project, we conceive health as a state which is all encompassing and not merely the absence of diseases. This is in line with the definition of health by the World Health Organization which states the health is indeed a “state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” [4].

1.2 Use of Health Services by BME Communities

In a study titled "potential barriers to the use of health services among ethnic minorities" [5] 54 articles reported on the use of health services by ethnic minorities in different countries. The study concluded that potential barriers to access health services by minority ethnic groups exist at different levels and could be quite varied. Some of the factors which the study concludes as challenges for BME communities to access health care service in industrialised countries include "social class and economic status, ethnicity, organizational factors, translation services, length or consultation, perceptions of value of health services, immigration rules, knowledge of health services and how to use them, cost of accessing health services, program orientation, behaviour and patient approach". The study [5] states that the barriers to use of health facilities among minority ethnic groups "are all tied to particular situations of the individual patient and is subject to constant adjustment and as such generalizations should not be made". This particular conclusion opens up a number of important arguments which could include the fact that it will not be appropriate to develop interventions aimed at addressing for instance poor uptake of health services (including the NHS 24 services) among BME communities in Scotland based on results of studies conducted in locations outside of Scotland. It thus underscores the need for research into the factors that promotes such trends as observed in the use of health services and of course NHS 24 services among BME communities in Scotland. As a result, the findings of our study could go a long way in offering an insight into the factors that promote or encourage observed trends (if any) in the use of NHS 24 and in general health services in Scotland. This will also form a basis for development of interventions if need be. Thus, our research based on this review is a step in the right direction if one were to address issues pertinent to BME communities in Scotland.

In the United Kingdom, a study [6] conducted in England and Wales to "explore the associations between racism, social class and health among ethnic minority groups" in

which regression analyses were conducted to explore this relationship, it was gathered that “the different ways in which racism may manifest itself (as interpersonal violence, institutional discrimination or socioeconomic disadvantage) all have independent detrimental effect on health regardless of the health indicator used”. The implications of this is that even though all forms of discrimination may not be visible in a particular society nor will it be overly manifest in our present day society, but the presence of subtle forms of discriminations that may be evident in forms like socioeconomic disadvantages for instance may impact negatively on the health of the migrant communities in our societies today.

Furthermore, another study [7] conducted to explore the “evidence on the social determinants of accidents and emergencies use and concerns over the equity of NHS Direct utilization” in England did show that “reduced access to accidents and emergencies services will disproportionately affect poorer individuals, whereas increased investment in telephone services will benefit affluent populations”. The study also went further to state that “current national policy may widen inequities in access to emergency care” and that lower income, measures of material deprivation and lower socio-economic position were associated with higher casualty use and part of this relationship could be explained by higher levels of long-standing and limiting illness. Conversely, these factors were also associated with low household use of NHS Direct”.

The NHS Direct in England is similar to the NHS 24 in Scotland. The department of Work and Pension [8] based on the labour force survey in the fourth quarter of the year 2010 has it that while “almost 1 in 8 people of working age in Great Britain are of minority origin, only 61% are in employment as compared with 73% of the general population”. Among the ethnic minority groups, “Pakistani and Bangladeshi women tend to have the lowest employment rates with just 30% in employment” [8].

2. Demography of Research Participants

2.1 BME Participants

The research participants (88) were asked about a number of demographic information as there is a considerable evidence of correlation between uptake of health services with an individual's age, educational qualification and socio-economic status. This was also evident in our literature review, particularly around telephone service usage. We wanted to explore this into this research. Though we do understand that being a qualitative study the study does not have a large enough sample size for power calculation. However, it will certainly give some indication about correlation between demography of BME participants and NHS 24 service knowledge, understanding and uptake. For the benefit of the study most participants volunteered to provide information regarding their demography, which certainly helped us understand the dynamics of the challenges as well as the perceived opportunities available to BME community members relating to NHS 24 service. The demographic information includes their employment status, religion, gender, age, duration of stay in Scotland and ethnicity and is shown below:

2.1.1 Employment

Out of a total of 88 research participants who volunteered information about their employment status, (66%) indicated that they were not in any form of employment while 13% indicated that they were in full time employment with 7% indicating that they were retired. This is shown in figure 1 below.

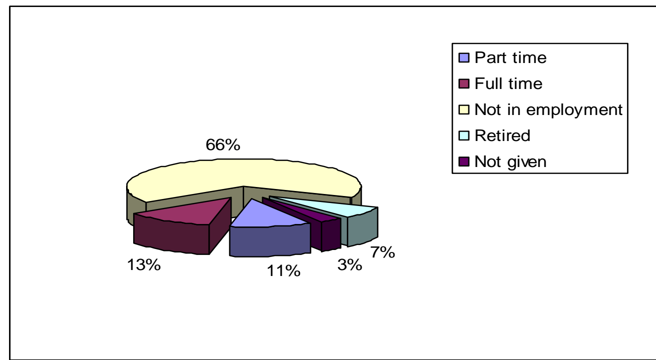

Figure1: Employment status of participants

2.1.2 Age

Figure 2 below shows most of the participants in the research were within the age category greater than or equal to 80 years (23 participants). This was closely followed by the 25-35 years age category (20 participants). A few of the participants (3) did not indicate their age category.

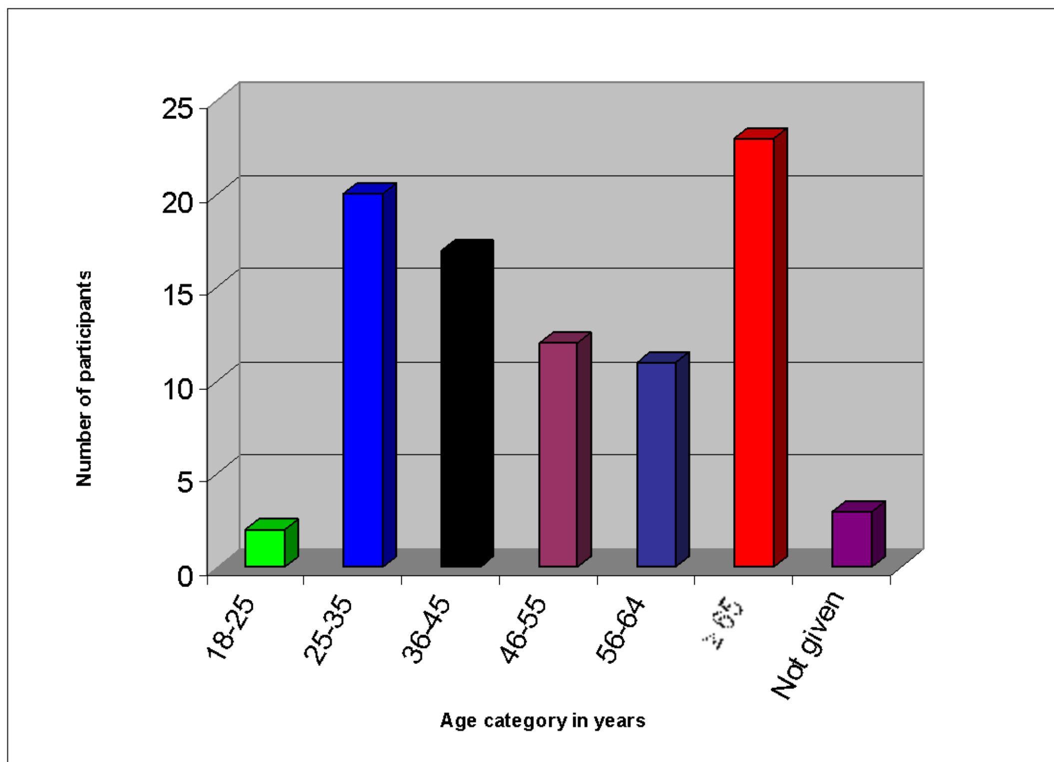

Figure 2: Age category of participants

2.1.3 Gender

Out of the 88 participants who took part in the study, 69% indicated that they were of the female gender while 31% were of the male gender. This is shown in the pie chart below.

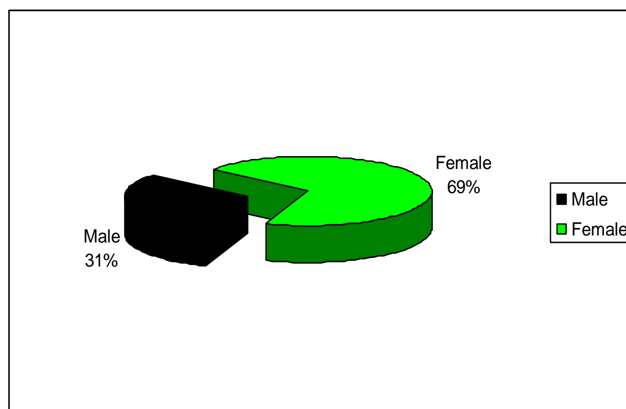

Figure 3: Gender of participants

2.1.4 Religion

Figure 4 below provides a picture of the religious beliefs of the participants as volunteered by the participants. It could be seen that Islam was the most frequent of the six religion types while only a few indicated that they were atheist or had no religion. Furthermore, some participants (4) did not indicate any religion at all.

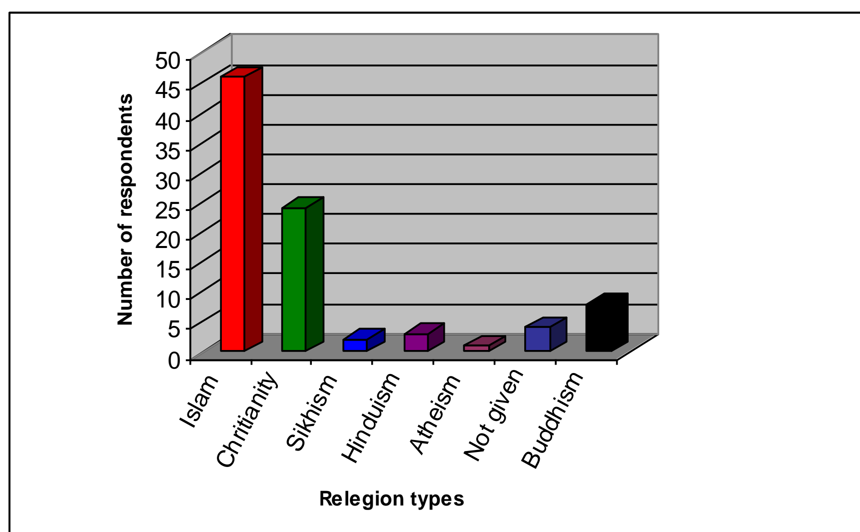

Figure 4: Religion of participants

2.1.5 Ethnicity

Figure 5 below represents the breakdown of the participants based on the ethnicity they have indicated or wished to be identified by. Those who described themselves as being of Pakistani ethnicity were the largest group in the study with a total of 30 participants followed by those who identified with a Chinese ethnicity (17 participants). The group “Any other white” include members of Czech and Slovakian communities also collectively known as the “Roma community”.

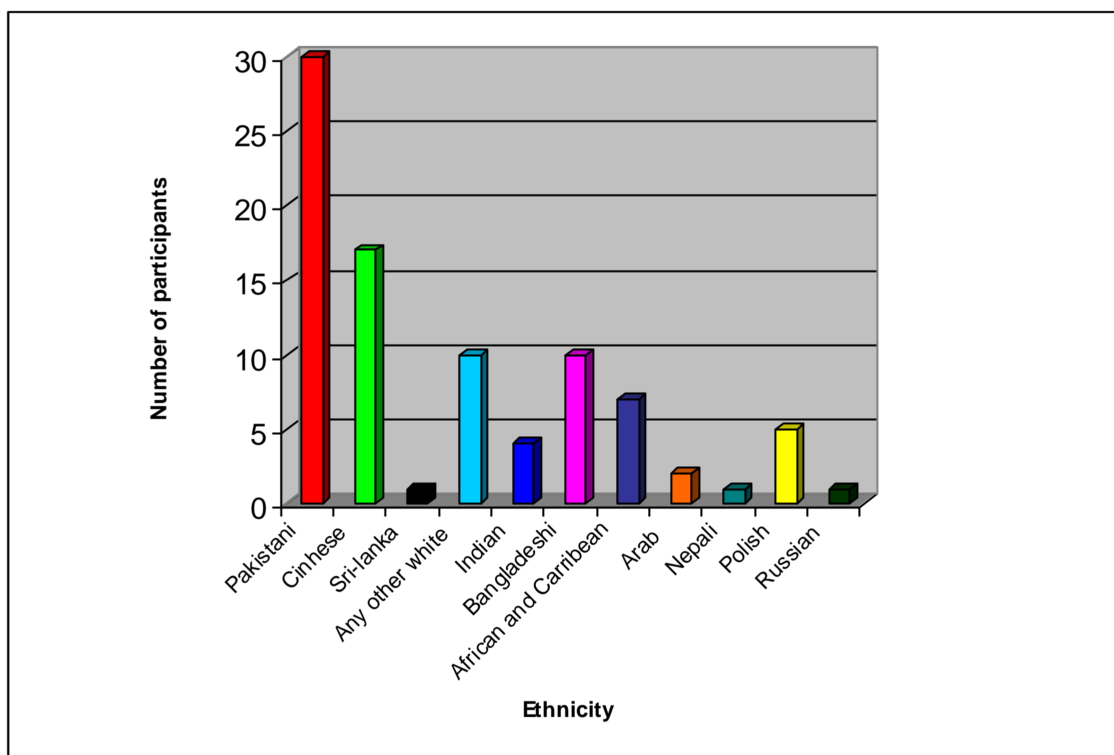

Figure5: Ethnicity of participants

2.1.6 Duration of Stay in Scotland

The duration of stay of participants in Scotland was also assessed in the study and this is presented in figure 6 below. From figure 6 it could be gathered that majority of the participants that were interviewed had stayed in Scotland for at least a period of 24

months. A few of the participants again did not indicate any duration for their stay in Scotland.

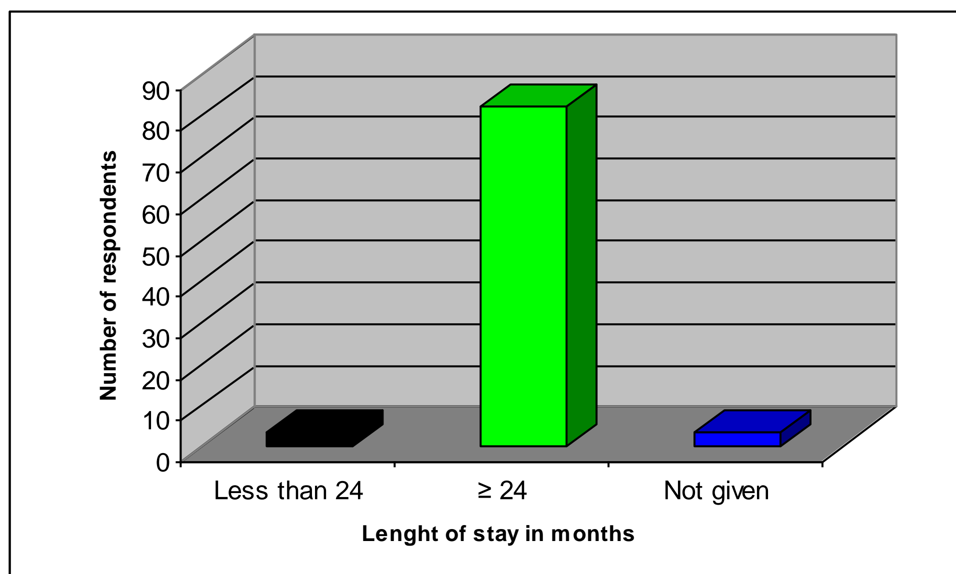

Figure 6: Duration of residency of participants in Scotland

2.2 Service Providers: NHS 24 and Voluntary Sector

Six (6) NHS 24 staff were interviewed out of which there were two (2) call handlers; one (1) health information advisor; one (1) senior hub appointer; one (1) nurse practitioner and one (1) senior dental nurse. Also interviewed were two (2) members from voluntary sector that offer services to members of BME community members in Glasgow.

3. Methodology

This was a triangulated qualitative research study with purposive sampling and data gathered via multiple sources and used the data sources in the reporting of results. (Babbie 1989, Neuman 2003)

3.1 Literature Review

The researchers carried out a comprehensive review of the literature available on BME knowledge of and understanding of NHS 24 service & related topics'. Concurrent with the literature review process, the researchers looked at other similar studies carried out within Scotland including relevant studies (published and unpublished) conducted in other parts of the United Kingdom (UK). This was necessary considering the specialised service provided by NHS 24 and to overcome the scarcity of such studies carried out in Glasgow. More so, literature review included (published and unpublished) studies with wider reference to determinants of accessing healthcare services. The findings from the literature reviews help provide insight into the research subject and contributed into the designing of the questionnaires and broad themes.

3.2 Focus Groups

The method was implemented with BME communities (service users) and process involved holding focus groups using key themes and topics. Considering the diversity of BME communities separate focus groups were carried out for the participants from different ethnic groups. Inclusion of individuals into specific group was based on language need and gender separation required by certain individuals. The use of focus groups in this research allowed generating a healthy discussion around the chosen themes/topics.

Hence, allowing diverse BME groups to present their views on the research subject. The focus group discussions were tape recorded and notes were also made during the process of the discussions. The recording and notes for all the focus groups were transcribed separately. All the focus groups were carried out by the co-researcher and community interpreters were used for Chinese, Gypsy Roma & certain Asian Groups. The interpreters were provided with prior information about the focus group techniques and were informed about the procedures and techniques focus group.

3.3 In-depth Interviews

The method was implemented with NHS 24 (service providers).and voluntary sector research participants. This method involved conducting in-depth interviews with the help of a semi-structured questionnaire. In order to facilitate NHS 24 staff participation the interviews were carried out via phone and one-to-one meetings, where possible. In-depth interviews using a semi structured questionnaire allowed a degree of flexibility for participants in relating and explaining in greater detail without being overly rigid; thus allowing them to be succinct in their responses. This allowed participants to elaborate on aspects or views which they subscribe importance to or wish to make pertinent. The use of these semi-structured interviews in the research study generated data rich in individual experiences and perception on the research subject.

The interviews were tape recorded and notes taken. An individual copy of the questionnaire was allocated for each research participant's interview. These were coded and the same code was applied for each recorded interviews (where applicable) and the consent form. Field notes were added to complement the recording and were transcribed immediately to avoid losing any information. The interviews and the transcribing of the raw data were carried out by the co-researcher, under the supervision of the chief

investigator and NHS 24 research advisory group formed by REACH for the project was updated on the progress via emails and meetings.

3.4 Research Participants

The participants included BME communities residing in Scotland who are above 18 years old. Also included are NHS 24 staff and two representatives from third sector organisations.

Sample Size for the focus group of BME communities was a total of 88 participants of diverse ethnic origin (refer to page for a detail ethnic breakdown). Six (6) NHS 24 staff with diverse work profiles participated in in-depth interviews and two (2) third sector staff involved in delivering service to the members of the BME communities in Glasgow.

3.5 Recruitment of Research Participants

BME communities participants were recruited using REACH's networks, which serve a diverse BME population i.e. Eastern European, Asian (Indian, Pakistani and Bangladeshi), Asylum Seekers, Eastern European (particularly Gypsy Roma), African and Caribbean, Arabs, and Chinese, therefore helped to recruit a representative sample of the BME population in Scotland. Furthermore, in order to ensure diversity open invitations were sent out to other third sector and community organisations (out with REACH's network), including key national and local organisations. Invitation posters were displayed in targeted community places, including libraries and shops. For Gypsy Roma communities' street engagement work was carried out with the help of sessional staff who can speak the language and can relate to this particular ethnic group. All the participants were provided

with information on the research project and those making voluntary consent were asked to participate into focus groups.

NHS 24 staff research participants were recruited through an open invitation (with information about the research) emailed via a nurse consultant from NHS 24, who was the key contact person allocated by NHS 24 for this research project. Those who voluntarily came forward to were asked to participate for in-depth interviews, either via a telephone or via face to face meetings.

3.6 Data Analysis

Data analysis was carried out using iterative method thereby allowing emerging ideas to be fed into future rounds of data generation. The focus groups and in-depth interviews were analysed by identifying recurrent, emerging themes using constant comparison of the transcripts. Sequences of core phrases, views, opinions and ideas were taken as indicators of themes. Data generation and analysis continued until there were no new themes or ideas emerging, employing grounded theory as guiding approach in our data analysis. Initial data analysis was carried out by the co-researcher under the supervision of the chief investigator, which then led to the first draft report. The draft analysis was then counter checked by the chief investigator, who designed the research study/methodology and secured ethical approval. The questionnaires (for both interviews and focus groups) were drafted by chief investigator along with the co-researcher, with advice from the NHS 24 Research Advisory Group. An initial report was drafted by the co-researcher and the final report was then written up by the chief investigator with comments from one of the advisory group members.

3.7 Ethical Approval

Ethical approval was sought from the NHS National Research Ethics Service (NRES) formerly known as the NHS Central Office for Research Ethics Committee. The ethical approval was given through the committee constituted in accordance with the Governance Arrangement for NRES in the UK at the Divisional Head Quarters and the Research and Development Directorate at Gartnavel Royal Hospital, Glasgow. Hence, all the way through this research process strict guidelines were followed as prescribed by the ethics approval committee.

4. Findings of the Research

This section of the report covers the findings and analysis of focus groups with BME communities (88) and in-depth interviews with NHS 24 staff (6) and third sector research participants (2). Interview and focus group questions and prompts were based on broad themes identified during the questionnaire design with input from the findings of the literature review and input from the Research Advisory Group set up by REACH for this particular research.

4.1 Findings From BME Community Perspective

From the research it was gathered that the challenges faced by members of BME communities in the use of NHS 24 services were mostly around themes which include the following:

1. Knowledge and understanding of NHS 24 services
2. Service access, usage and perceived challenges
3. Cultural factors
4. Perceived Discriminations

4.1.1 Knowledge and Understanding of NHS 24 Services

What is NHS 24 and Services Provided by NHS 24: Throughout the focus groups it was a recurrent theme for participants to ask "what is NHS 24". *"Please could you explain what NHS 24 is as I do not know about it? After that I may be able to give you an answer"* ***(FGM2 Pg1 participant 9)…..****"I don't know anything about it".* ***(FGM2 Pg1 participant 8)***

Near absolute lack of knowledge about what the NHS 24 is, services provided by NHS 24 and where services can be accessed came out strongly from the findings. *"If they (BME community members) know the service exist they might use it better. Like myself I don't know anything about it so I have no idea where I can find this service: where can I go; who do I ask; who do I see. This is the problem – I don't know!"* ***(FGM2 Pg3)***

Unable to differentiate between NHS 24 and other NHS services: When BME communities were asked about their access to healthcare services after the closure of General Practitioner (GP) surgeries. It became evident from the responses that many BME communities have used NHS 24 service but without realising so......*"Is it emergency or… Can you explain to us, what's the difference (between NHS 24 and NHS), because I may have used it in the past?"* ***(FGM6 Pg2)*** **...**

..... *First of all I need to know, NHS 24 and GP what is the difference between them?"* ***(FGM9 Pg3).....***

....“We can phone the emergency doctor after 5 o’clock and tell them your illness and someone will come to the house” ***(FGM2 Pg2 Participant 9).........***

......“How many NHS 24 surgeries (are) in Dundee?” ***(FGM7 Pg5 Participant 8).....***

It seemed that a number of BME community participants have had some understanding and knowledge of NHS 24 and its service. Many of them seems to have come to know about NHS 24, either by calling emergency number 999 or being redirected after calling their GP telephone number. However, it was clearly evident that the small proportion of the participants who knew NHS 24, did not know of NHS 24 telephone numbers.

..“The reason why I did not call (the NHS 24) before I went (to the hospital emergencies) was because I did not have the phone number” ***(FGM3 Pg2)***

NHS 24 Phone and Internet Service: Among those who had some understanding of NHS 24 and have used the services, telephone appears to be the most widely known modality for accessing NHS 24 services. Little was mentioned about the use of internet services all through the focus groups discussions. It was only on a few occasions that the internet was mentioned to have been used and a participant who used the internet service had this to say: *.........“My typing is quite slow and it took me about 20 minutes (to type) and after about half an hour it said [okay] phone NHS 24 hours, they will help you with the advice that you need then I had to phone again to the NHS 24 and then I was told to bring her [daughter] to the hospital to see the doctor and at about 4 o’clock in the morning. My advice is that you don’t use the internet, go straight to the phone”* **(FGM3 Pg2)..**

..... *“… it didn’t answer the (my) actual questions I was looking for. And I ended up phoning NHS 24 actually*” ***(FGM10 Pg7)***

Unaware of Interpreter Service: It was revealed in the focus group discussions that majority of participants who were aware of NHS 24, were not aware of the availability interpreter services during consultations over the phone with NHS 24 staff. .... *We are not aware of interpreter services"* ***(FGM10 Pg9-10)*****........** "*We are not aware of the availability of interpreter services on the NHS 24"* ***(FGM10 Pg9-10)***

Sources of NHS 24 Service Information: It was revealed from the focus group discussions data that majority of those who used NHS 24 service was via GP phone line. Concurrently, there were a large number of BME communities who used NHS 24 service by calling 999. Among those using 999 helpline service and used NHS 24, majority represents asylum seeker community, this was attributed to the fact that it is the number they were given upon arrival in the United Kingdom."…*the first time we came to the UK we have been given the number 999 for any emergency and that's why we don't know the other number"* ***(FGM6 Pg2)***

Overall it seems even though NHS 24 may promote their services to communities in Scotland, including to BME communities. The findings of this research indicate a clear gap in knowledge of NHS 24 among BME communities. BME communities who participated into the research clearly lacked knowledge about NHS 24. Many of those who used the service have done so without knowing that they are using NHS 24 service until they participated into the research. In one of the focus groups **(FGM 10 Pg1)**, all the 10 participants have not heard about NHS 24 prior to the focus group discussion. Some of the participants have the understanding that the NHS 24 services are meant for home services after 5pm in the evening while others think there are NHS 24 surgeries that they could actually visit. Nevertheless, there is the

willingness to use the service if BME communities are aware of the NHS 24 services.

"…I don't know 24 hour services but if they provide all these services in one place then I will like to get in touch with them next time. You (one) will gladly go there" ***(FGM2 Pg3 Participant***

4.1.2 Service Access, Usage and Perceived Challenges

In the course of the in-depth focus group interviews, a number of issues were raised by BME community participants that relates to the challenges members of BME communities face when they use or make effort to access NHS 24 services.

English Language: Top on this list is language barrier. This particular barrier was a recurring theme across the in-depth focus group discussions conducted with different ethnic groups. One of the recurrent themes as part of the discussion on language barrier was the realisation and uneasiness of 'lost in translation' while using a third person.

"I have phoned (used) the services a few times and I think that if we are given the opportunity to speak to someone in our language then I think some of our service users will find it easier to use" ***(FGM1 Pg3 participant 3)***

"most of our people have language problem and this is a very big problem especially for the ladies because they don't understand the language and as a result they don't talk about their illnesses and they only tell men when it gets worse so if they will get someone whom they could speak to in their language it will help them to come forward with their problems and I think they will be very glad… there should be interpreters… and at least one person who is bilingual" ***(FGM1 Pg 4 participant 9)***

"the problem of communication using a 3rd person for instance, when someone explains a problem to me by the time I try to explain it to the doctor the problem become different…? We also don't understand medical terms… there is loss (of information) in translation" ***(FGM1 Pg4 participant 8)***

"…like when you are face to face with the doctor you can point to the place where you have pain but when you are on the phone you can't do it and you may not even know the name of the different parts of the body". ***(FGM6 Pg7 participant 2)***
"The problem is with the other Ethnic People who cannot speak English and I presume they must be having difficulty in communicating and that must be one of the reasons for them not to contact them (NHS 24)" ***(FGM8 Pg 1)***

"I know people who are not happy with NHS 24 services and they are going straight to the hospital, because first of all they cannot speak English…" ***(FGM10 Pg4)***

Automated Voice Message: related to the language barrier, BME focus groups participants raised their concerns about automated phones message in English language when they try to phone. *"… there are a lot of people who don't speak at all English that are working here, and I don't see them as phoning NHS 24"*

"… But how would you use interpreter services, if you can't say, let's say you can only say yes and no in English. And then something has happened and you dial this number and then you speak in your language, and how are you going to ask for the interpreter if you can't say anything. How would that be solved?"

On several occasions during the focus groups discussions BME communities suggested to having access to language lines on phoning the NHS 24, were they have a choice to choose a language they want to speak by pressing a number. *...."Language lines, fifteen of the main or common languages. So number this is Chinese or Mandarin, that one is Polish, this number is to Czech interpreter. And the person would be more confident to call".*

Cost of Telephone Calls: Another challenge that emerged during the focus group discussions was cost of making calls to NHS 24. This was a common theme across the ethnic groups but participants from asylum seekers community were more vocal about this issue. *"The number of the NHS 24 service starts with 0845… is not a good number as most people have mobile [phones] and it costs a lot, even from the landline it costs a lot.*

They should change this number” ***(FGM3 Pg1)***

“… We can’t afford the phone at home because we are asylum seekers and most of us (asylum seekers) cannot afford to pay our bills… ” ***(FGM6 Pg7)***

“Then they say you are using nearly five pounds on your mobile phone because it takes ages. If you call from mobile its expensive” ***(FGM 10 Pg4)***

“The questions are long so people are trying to save money for the next meal. Using pay as you go mobiles is even more (expensive). And then they say you need to wait for them to call you back” ***(FGM 10 Pg4)***

Delay in Service: Participants of the focus group meetings also mentioned that delays in getting services from the NHS 24 constituted a factor that could impact on the use of NHS 24 services among BME community members. Such delays were expressed by participants in the following ways:

“I was trying to explain my problem over the phone and I have been passed from one person to another and to another and in the end that one changed. That was very annoying” ***(FGM2 Pg5 Participant 8)***

“… she was crying and they kept on asking questions and it took 15 minutes for the interview. The ambulance took only 5 minutes to come” ***(FGM3 Pg5-6 Participant 5)***

“…they spend so much time over the phone trying to find out what the symptoms are” ***(FGM5 Pg1 Participant 10)***

“… (It) seems that the phone call time is too long; that should be cut short.” ***(FGM5 Pg12Participant9)***

“The questions are too many and too complicated. It takes too long” ***(FGM7 Pg5)***

*“Yes I have used them (NHS 24) but it is a bit long winded. You speak to one person and they ask you a lot of questions. You speak to another person then they ask you a lot of more questions. Ultimately they either give you advice on telephone or even at odd hours, late in the evening, when it is difficult sometimes, you have to go to the NHS centre”.****(FGM8Pg1)***

“ Very good but a bit long, it gets very long. They ask you all sorts of questions. I suppose it’s necessary”. ***(FGM8 Pg2)***

“… you have to wait up to three hours for them to call you back and usually its after three hours. Sometimes I would go straight to the hospital because I couldn’t wait with my daughter because it was about her health” ***(FGM10 Pg4)***

“So many times we had waited such a long time for an advisor to call us back. So we decided to jump in the car and go straight to hospital and see as soon as possible a doctor, because we never phone with something easy or something silly. Every time when we phoned it was like the last thing” ***(FGM10 Pg 4-5)*** *“*

Experiences of NHS Services: it came out from the focus groups discussions that previous experiences of using NHS services in general also tend to influence BME communities decisions about the choice of using NHS 24 services. It also seemed from the findings that those who have language difficulties are more likely to have reported an unsatisfactory experience.

"Once my health was very bad and the General Practitioner (GP) and hospitals did absolutely nothing, so since then I have no trust. I don't like them! ... I have been told many times there is nothing they can do for me but am still alive. The GP has not got enough time to examine you - he has only got 10 minutes and he spends 8 minutes looking at the computer and only 2 minutes to tell you stories which is not very good either". ***(FGM2 Pg4 Participant 8)***

"The service is very very bad…I have a friend in the house who could speak English but NHS 24 wanted to speak to me directly and my English is limited…after I managed to get through to the NHS 24 they suggested I go to the pharmacy… I was very angry… The pharmacy contacted the NHS 24 again and they said that the little one (the patient) should be given Calpol. It is like a circle." ***(FGM7 Pg2-3)***

"But I remember… we made a call to an advisor (NHS 24) but then we couldn't risk the waiting (for a reply) because my daughter wasn't very well and we travelled to a hospital in Arbroath. We were on the way already and I had a call on the way from them and they weren't happy that we travelled to hospital, and they weren't really nice for me and they said that I shouldn't go there. And they tried to stop me but I said you can't stop me… I'm in the middle of the way. But I cannot say that they have been rude, just maybe not been very nice". ***(FGM10 Pg11)***

"When the wee one was ill, I was there (at the emergencies) and they actually didn't want to take me in. He was really unwell. He had a high temperature and I was really worried what was going to happen with me but they sent me away. I was sent away because they told us to phone a certain number but why we can't phone this certain number is because they speak in English" ***(FGM11 Pg2)***

4.1.3 Cultural Factors

During the focus group discussions, certain comments made by the BME participants suggest that there are certain beliefs among them that could influence the use of NHS 24 services. These are more likely to be cultural and have their roots in the culture of the different groups rather than circumstantial. It seems from the findings that cultural factors differ between ethnic groups, certainly so among the groups who took part into this research study. This reaffirms confirms that BME communities are not a homogeneous group. *... "I always have private treatment and I take herbal medicine to get better…"* ***(FGM2 Pg4 Participant 8)*** It seems common to share information related to health or NHS 24 among members of BME communities*: "He says if at some point he phones Number One, Number One doesn't know, she will go around asking some other people because they are very close knit".* ***(FGM12 Pg10)***

During focus group discussions largely with ***Asian communities***, one of the issue came up was, females reluctant to disclose their problems, particularly to male healthcare professionals.... *"there might be cultural issues where females from our culture may not feel comfortable disclosing their problems to a male doctor, so sometimes some females are misdiagnosed or under diagnosed because of their reluctance to disclose information"* ***(FGM2 Pg4-5 Participant 3)***

Among the ***African*** community, the participants seems to suggest more keen on oral messages, preferably face to face, *...."Africans are more used to oral messages and face to face (sessions)"* ***(FGM6 Pg5)***

It came out from the focus groups discussions with most BME community members that they are more likely to contact NHS 24 or any healthcare service once they consider that they have no other alternative and they are really sick. ... *"If I feel if it is something minor like headache I will not call my doctor, you can take pain killers yourself, you know what to do but you only get in touch with the doctor when you feel it's really bad but for a minor thing I would not call a doctor"* (***FGM 2 Pg4)***
"… we do try our own remedies and if it's not (helping) after 3 – 4 days then you go to your GP" ***(FGM5 Pg6)***
"… we don't contact the NHS unless we really need it" ***(FGM 5 PG 12)***
Trying their own remedy rather than contacting healthcare service is not limited to NHS 24 but for all healthcare services. However, when it is to do with their children being unwell BME communities seems more likely to seek healthcare service at first instance, *"… if it comes to (our) own toddlers and kids we just straight away call up NHS but when it is us (adults), we will probably wait until we are in such a state that we can't bear it any more".* ***(FGM5 Pg6)***

Difference in health care system from that of their (BME community) country to origin seems to influence in the decision of many BME community members to access NHS 24 services. *"… in our country if you are not well you go straight to the hospital we don't have such a service"* ***(FGM10 Pg4)***

4.1.4 Perceived Discriminations

On a few occasions, participants in the focus group discussions reported what they considered as discriminatory actions from health service providers. Though these were only relatively few, however, those affected recounted their experiences with strong emotional displays and disapproval. Comparatively more incidents of discriminations were

mentioned in the focus group meeting involving those of African and Caribbean ethnic groups, which also had some representation from Asylum seekers. Some of the comments made in the course of the narrations include

"When they look at you and you are wearing a Hijab, they think you don't understand English and they tend to avoid you but when you speak English then they say oh she knows English then they give you attention. There is some kind of racism" ***(FG3 Pg4)***

"The ambulance people said 'don't talk in your own language, 'stop that jabbering'. That was very, very racist. That was very racist…. The ambulance staff did not take the patient to the hospital and we took him to the hospital in a taxi" ***(FGM 5 Pg3-4)***

"Sometimes they make us wait a long time before they come…maybe that's because we don't speak the language or maybe when they know this is a black person that is calling on the phone then they take their time. We can't complain because we don't know where to complain". ***(FGM6 Pg7)***

"I can say there is some kind of discrimination though not all GPs and staff do that… I had an experience with one of the phlebotomists who wanted to take a blood sample from me and he came straight with the needle without cleaning my skin. I am a microbiologist and I asked him to please clean the area and he asked me 'when did you last take a shower'?" ***(FGM6 Pg7-8)***

"I think when most people call; because we are asylum seekers, they will say we are pretending to be sick… they do not take our cases seriously" ***(FGM6 Pg8)***

Even thought the above comments about perceived discriminations are not directly related to NHS 24 services. It can be inferred that such experiences may put-off many BME

communities from using NHS 24 service. More so, it came out from this research that past experience of NHS service in general does influence on many BME community members decision to use NHS 24 service, particularity the telephone service.

4.2 Findings from NHS 24 Service Providers' Perspective

Among those interviewed were call handlers, nurses and health information advisors from NHS 24. When prompted about NHS 24 service provision to BME and non BME users, one of the recurrent theme was fairness and same treatment for everyone, *"… everyone is treated fairly and no one is discriminated, so if someone requires to be seen at a dental clinic and we have the availability regardless of their ethnic minority or their background or anything" (P1)*

It was reiterated that irrespective of the need of individual callers, those with and without interpretation need are treated in the same manner. It seems that there is a consistent system in place which everyone needs to follow, including a system to monitor calls by senior clinicians. *"… everybody is treated the same as regards interpreter services if they require that or not, when they come through to NHS 24 they are treated the same as everybody else… if we cannot get you a nurse right away then the call is put into a queue, it is prioritised and monitored by senior clinicians and you will be called back within a certain timescale depending on what is going on, but the calls are constantly monitored and prioritised and we are saying to people if we have to call anybody back that the call is monitored, prioritised if anything changes at all and you are not happy, you know symptoms change, you become even more unwell, anything like that then we are advising people to call straight back in again and let us know symptoms have changed and then you are re-graded again and then everything else, if you need to be put through to a nurse right away if your symptoms become any worse"* ***(P2)***

"No difference at all, well as I say my job is only… I just take their details and I would treat every call the exact same as I did the one before" ***(P4)***

"… it would just be the same. They would have the same methods used with all patients. All patients are treated the same. They're treated with confidentiality and they're treated with respect and care. And the patient is the main part of our job. The main priority is the patient's safety and their health. So first and foremost, it doesn't matter what you are, who you are, the focus is to help that patient and help them get the proper appropriate help that is needed for them" ***(P5)***

Automated voice message, which was indicated as a challenge by BME participants is also being highlighted by one NHS 24 research participants as possible barrier,*"… if you were to phone in, the first thing that happens is there's an automated message that people have to listen to, which can be a barrier itself to people wanting to continue on with that call. So it's an automated message with the options of what number to press, and once you get through that process, they then speak to a call handler, who takes their details… I don't know if there's any option there for it to be listened to in any other language, but I presume it's in English. … if they're put straight through to a nurse, the nurse has to recheck their details, to make sure it's the right record that's been sent through to them. We've a lot of checking and rechecking of details"* ***(P3)***

Challenges of Language and Interpretation, it seems to suggest that there are systems in place to overcome the possible challenges English language in order to provided NHS 24 services, they include language line and Type talk *..."In general we deal with a variety of different callers; sometimes we have patients that call into the service where language*

*is a barrier so we use Language Lines if required. Also if we have patients that call in that might be hard of hearing we have the facility to use Type Talk". **(P1)***

When prompted further about the **use of interpreters**, participants responded in the following ways*"... it can be quite a lengthy call, because obviously they are translating for you and interpreting what the patient is saying. It is always better to try and speak to the patient, and that way you are getting a better understanding of what the issue is rather than via a third party…if there are language barriers or there is a third party involved where they are translating for you, or you are relying on a member of the person's family to communicate for them then that can take slightly longer. So it could be anything up to thirty minutes before that call is finished with". **(P1)***

Prolonged Conversation: it was evident from the in-depth interviews that due to the use to 3rd person as an interpreter, including a family member could increase the call duration by 500 times.... *"When there is a language barrier where they don't understand English it does take a little bit longer to try and explain what I am asking, or if they do have an interpreter on that would take say twenty minutes as opposed to three minutes so a huge difference". **(P4)***

Lost in Translation: the use if 3rd person as interpreters including language line may lead to lost in translation and by the time information is provided to the call hander by the interpreter many information about the patient may be lost in the process, therefore at times call hander may not feel not confident enough to provide the advice and instead refer caller to emergency GP service. *..."When I'm using the language line services, you feel sometimes you ask a question, and there's quite a prolonged conversation between the interpreter and the patient, but the answers you get back is quite short. I'd maybe sort of refer somebody to the emergency GP, or want to get them seen elsewhere, rather than*

just giving themselves care advice, because I really don't always feel confident in what I'm hearing, or what's happening, because I can't hear directly what they are saying" ***(P3)***

NHS 24 Staff Training: While most of the NHS 24 staff interviewed expressed satisfaction with the support they have so far, one participant gave suggestions about how the support available to aid delivery of services to the BME community may be improved upon,.......*As regards support I think it could probably be better… I think what the general consensus amongst the nurses is… assessing somebody through an interpreter, it would almost double the length of time of the call. Training for staff could be a bit better… we could probably be a lot better about what aspects of people's lifestyles could have an impact on their health and why they may contact us at certain times. I think the main thing would be sort of more training opportunities, some more information for the staff"* ***(P3)***

4.3 Findings from Voluntary Sector Staff Perspective

Members of voluntary sector who are involved in offering services to members of BME communities were also interviewed. The interviews was carried in order to get a second opinion from a service user, not necessarily providing NHS 24 service but are linked to BME communities providing various services.

Knowledge about NHS 24: while it seemed the two service provider participants interviewed from voluntary sector themselves aware of NHS 24, they doubt that BME communities in general are aware of NHS 24 as a service provider..... *"most people are aware that the hospitals are open to them but the NHS 24 telephone advice services, don't think they are aware of it. Even if they are aware, then those whose language is okay can access them but those who are not very confident over the phone speaking in English*

cannot themselves, may be they will get someone else: carer or family… not many (of the service users) are confident over the phone” ***(P1)***

Language Gap: voluntary sector research participants seem to concur with what BME communities expressed in focus groups discussions about language barrier, delayed service (time lapse between first call and waiting for a response from NHS 24*). “…usually there is a time lapse: when you call them (NHS 24) and they say we will get a nurse to call you back and that is usually about an hour or an hour and a half and by that time maybe your condition will worsen and what do you do? Do you call back or go to the hospital…people are usually left in a limbo. The waiting period could be a bit of a nightmare for some people depending on the condition. It is not usually clear cut…****(P1)***

“… someone like me who have no problem with English do struggle to pass the message across: someone with language barrier will even struggle the more” ***(P1)***

Furthermore, there seems to be a consistency in opinion of accessing service for a minor, they seem to suggest one would promptly wish to have advice when it comes o a child health & wellbeing. ***.........****”if you are dealing with a child do you wait for the call or decide to go to the hospital? It is a valued service there is no doubt about that but it’s just the waiting time and the clarity of what the next stage should be if your condition worsens. Clearer advice after GP hours will be helpful”* ***(P1)***

Source of information for NHS 24 : voluntary sector participants seems to suggest lack publicity about NHS 24 service and lack publicity material other than English*. “I don’t know how much publicity there is (of NHS 24). Where I go, mostly there is nothing in other languages except in English. It (NHS 24) is not much publicised among our communities”* ***(P2)***

Although it is revealed from the research participants (BME and voluntary sector) of this study that they find the service useful and have had positive experiences of the NHS 24 service*. .... "I have had a great experience so far and I am happy with the services as it is and that it was very helpful when I used it for my late wife who died 2 years back"* ***(FGM1 Pg5 Participant 2)***

.......it is good service when you are able to get to it. (P1)

Overall, considering the number of BME research participants who are aware of the service and who used the service there is a high proportion of research participants who were not entirely satisfied with the NHS 24 service. " my son used the services when my grandson was ill and he said the lady at the other end of the phone was not sympathetic at all. She kept saying give the child paracetamol. In the end my son took his son to that hospital. On the phone the lady was not helpful at all" **(P2)**

5. Conclusion and Recommendations

Based on the above findings and discussions the following are the conclusions and recommendations:

1) **Intensive Promotion of NHS 24:** this is particularly paramount in order to ensure that everyone in Scotland is aware of this important national service and as suggested from this study there is clearly a lack of understanding about NHS 24 among BME communities. More so, it is also important for NHS 24 brand and indeed as specialised service provider. Especially when we know from his study that BME community members do seem to use the service but without realising so. In terms of methods of promotion, it is already being discussed in the summary analysis section of the report but more cooperation with community group on a consistent basis is the best way forward to overcome this challenge.

2) **Incorporating Language Line Option in the Recorded Message**: this would mean having the option to choose a language you want at the instant when someone calls NHS 24. This is because at the moment service offered at the point of calling in only in English.

3) **Training for the NHS 24 Staff**: it was clearly evident from the findings of NHS 24 staff as well from BME communities that there are a number of issues, including cultural factors which can influence the access and usage of NHS 24 service by many BME communities. Further, it also came up a need from the NHS 24 staff. The training should be targeted to those who are directly in contact with BME communities and their immediate supervisors. This is be particularly important to understand how different BME community members may be influenced by their

cultures and beliefs. Certainly there is no one size fit all, as it was evident from the research findings but certainly gives service providers a guideline. It could even be the way you speak, or perhaps say a word or two, which will make the caller more comfortable and or avoid perceived to be unsympathetic.

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