Access to and use of out-of-hours services by members of Vietnamese community groups in South London: a focus group study

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Background. Communication difficulties, lack of knowledge of services and the appropriateness of services influence access to health care services by black and ethnic minority groups. These problems may be accentuated outside normal working hours. This may be so particularly for those who do not speak English as a first language, as interpreting services across the UK are extremely limited in the out-of-hours period.

Objective. We aimed to describe the experiences and perceptions of members of the Vietnamese community groups in seeking out-of-hours health services and to identify potential solutions from participants’ perspectives.

Method. This qualitative study used a focus group methodology. Participants were members of three established community groups in the South London boroughs of Southwark and Lewisham. Participants attended six focus groups which were conducted in Cantonese and Vietnamese.

Results. Participants did not know about GPs’ out-of-hours arrangements. And their access to the range of services normally available was limited. They were unable to communicate with health care professionals or answering services and were unaware of out-of-hours interpreting arrangements. Generally, participants were dependent on other people in gaining access to services. Some participants had used 999 services despite communication problems. Participants’ experienced delays in seeking health care services and confusion regarding the medicines and advice given.

Conclusions. Communication difficulties limited knowledge of and access to out-of-hours services for the Vietnamese participants. Direct contact with interpreters in the out-of-hours period was suggested as a means of increasing participants’ ability to gain access to services. Health service planners need to be aware of the difficulties experienced by such groups if issues of equity in gaining access to health care services are to be addressed.

Keywords. Ethnic minority health issues, focus group, interpersonal communication, health care access, out-of-hours services.

Introduction

In The New NHS, the importance of ensuring that “black and ethnic minority groups are not disadvantaged” in their access to services is emphasized. Factors influencing access to health care services by black and ethnic minority groups include communication difficulties, knowledge of and appropriateness of services. Difficulties in gaining access to services may affect the relationship between health care need and health service use.

Demand for out-of-hours services has been increasing, and there are concerns about the ‘appropriateness’ of calls made. For some black and ethnic minority groups, difficulties in gaining access to services may be accentuated in the out-of-hours period. This study was designed to examine access to and use of out-of-hours services by members of one ethnic minority group—Vietnamese. Its aims were to explore the factors involved in gaining access to services, to describe
difficulties experienced and to identify potential service developments from participants’ perspectives. The Vietnamese community was chosen because of their language and cultural differences from the indigenous population, the large numbers of refugees in their community and the existence of established community groups within the district studied.

Method

The research was undertaken in the London boroughs of Southwark and Lewisham. Meetings were held with Vietnamese community group leaders whose knowledge of Vietnamese culture informed aspects of the study design. They suggested that participants would not discuss their experiences in an interview setting or respond to questionnaires. Focus groups were thought to be suitable for this exploratory transcultural research (see Table 1). Established members of Vietnamese community groups were recruited as facilitators. They were fluent in Vietnamese and/or Cantonese and English and received training from the research team in running the focus groups.

Based on discussions with facilitators and other research on ethnic minority groups, a topic guide was developed in English and translated by the facilitators into Vietnamese. It covered experiences of, attitudes to and knowledge of out-of-hours health services, and the ability to use services.

Focus groups

An important feature of these focus groups was the inclusion of participants from different sections of the community likely to use out-of-hours health services. Six focus groups were convened with participants recruited from three Vietnamese community groups. Two focus groups were composed of elderly/disabled and carers, two focus groups were composed of a mixture of men and older women, and two focus groups were composed of younger women, many of whom had children. Community leaders indicated that younger women would be reluctant to speak in mixed company. The focus groups included ethnic Chinese Vietnamese and ethnic Vietnamese, Catholics as well as Buddhists, and people originating from North and South Vietnam. One focus group consisted of members of an existing carers and elderly group, and the other five groups were invited to attend from among the community group registers. Participants had the choice of speaking in Vietnamese or Cantonese. Meetings were held in local community centres and were followed by a Vietnamese meal.

Participants were invited to the focus groups by letter and telephone. Between four and twelve participants attended each meeting. Participants gave informed consent. The participants were encouraged to discuss their experiences, consider solutions and prioritize issues. The facilitator summarized the discussion and asked participants if anything had been forgotten or misunderstood. A member of the research team (CF) attended all the meetings, observing the participants’ interaction. Notes were made during the focus groups and translated into English. The group discussions were audiotaped, translated into English and transcribed. The notes and transcriptions were compared. Each facilitator checked the transcriptions, commenting on cultural perspectives and meaning. The scripts were analysed in English. The main concepts and themes within the data were identified, explored and diagrammed. Each phrase was examined, coded according to the themes within it and considered in terms of its context in the discussion. The original coding frame was adjusted after regrouping the data.

Results

In all, 51 people attended the focus groups. These included 39 (54%) of the 72 people invited to focus groups and 12 who attended the existing carers and elderly group. Participants were aged between 26 and 85 years, and 32 (58%) were women. Most participants had lived in this country for 3–7 years; the longest duration of stay was 17 years.

Considerable interest was expressed in taking part. One woman said “it is one of the very few opportunities when I can tell my stories. I think this meeting is more important than going to (a routine appointment at) the hospital”. Knowing the facilitator and being in a familiar environment appeared to encourage participation.

Lack of knowledge

Most participants did not know about GPs’ out-of-hours arrangements. They used GPs’ services during normal working hours but were not aware of the availability of emergency appointments. Most participants thought that there was no-one on duty when the surgery doors were shut, or did not know the number on which to call the GP.
“No-one knew that you could see the GP the same day (or an emergency appointment).” (women’s group)

“It could be that you feel all right today but tomorrow you may lie on the bed . . . and you need people to call . . . What should you do? . . . You don’t know . . .” (elderly lady)

Explanations offered for difficulties included a lack of understanding of the system or rules in this country. Participants could not read English and were unaware of the existence of practice leaflets providing information.

The 999 service
Knowledge regarding emergency 999 services was widespread. There were a variety of experiences in using the service. Some had used the service and had managed to speak a few words such as ‘child very hot’. Those who had used the service were impressed by the speed of response. Participants in two of the groups suggested a means of obtaining help without English language skills:

“In an emergency if you can’t talk, dial 999 and put the receiver aside if at the other end they ask something, you just say nothing and they will know where you are and they will come.” (elderly and carers group)

All members of one of the women’s focus groups felt that language barriers would prevent them from calling 999. Others did not know how to call or what to say.

Language and communication difficulties
In all groups, language and communication difficulties were cited as the most important factors affecting their ability to use services. It affected their knowledge of services, their ability to seek help and their understanding of the health care received. Experience of difficulty and lack of confidence in being able to gain access to services in the case of serious illness were perceived to be both frightening and dangerous:

“It is due to a lack of English that you can’t get in touch with the doctor at night or the weekend—this also applies in an emergency case.” (mixed group)

Participants in all groups had experienced difficulties in seeking help. They felt that they would be unable to use GPs’ services outside normal working hours because they were unable to communicate by phone. Poor communication skills resulted in participants being too intimidated to call, a perceived lack of benefit from calling and delays in help-seeking.

“A lot of people, due to lack of English, become intimidated. So they may leave their illness without treatment until the next day, and so consequently, their illness will become worse.” (middle aged man)

Participants described ‘holding on to their pain’ until a daytime service was available. One participant who had felt unable to call 999 due to the language barrier had walked to the A&E department with his children and sick wife at 2 a.m. Another elderly lady reported:

“My husband . . . once he became ill at night and [I] called the doctor. My English is poor but I tried and there they said ‘no doctor tomorrow’. I said it was emergency and dangerous. We had to wait . . . but later my husband regained consciousness.”

Participants described feeling helpless. In four of the groups participants described feeling that in an emergency they might die before being able to get help. This idea was related to previous experiences of delays in gaining access to health care services (days) and in one case related to a specific experience when a neighbour helped. Several participants had successfully sought help by depending on children, friends, neighbours, relatives or their community centres. They had provided direct care, had sought help on behalf of participants and had provided transport to hospital. There were concerns that these people were not always available and that the community centre was open only during the day.

Communicating with health care professionals
There was a sense of frustration and marked concern in not being able to communicate with the doctor and in being unable to respond to questions. Doctors had continued speaking in English to patients who did not understand.

“. . . so we can’t express the illness and just let the doctor guess.” (mixed group of elderly men and women)

Interpreting service
There was a high degree of confidence in the skills of the interpreting service. However, service providers rarely arranged for interpreters outside normal working hours or in an emergency, and there was no direct access to interpreters.

Children and friends as interpreters
In the absence of trained interpreters, people used children and friends to interpret. They were not always appropriate. They were not able to explain things clearly and did not interpret everything. Children frequently lacking the relevant skills and vocabulary in Vietnamese, Cantonese or English might be as young as 5 or 6 years old.

In one case, a woman in labour at night had to rely on a single young man from her community to translate, which caused considerable embarrassment to both parties.

Communication without language
The lack of access to trained interpreters and the likelihood of seeing an unfamiliar doctor out-of-hours resulted in face to face non-verbal communication through
gestures or in bringing previously prescribed medicines to show the doctor being used to communicate health care needs. Some people had been confused about the advice given and medicines prescribed. They did not know what they were for or how or when to take the medicines. Some had attended their community centres with the medicine bottles for an explanation.

Figure 1 summarizes the participants’ experiences in seeking access to out-of-hours services. Each stage is an obstacle to gaining access. Some participants were successful in gaining access to emergency and out-of-hours services, while many others had failed to progress through the pathway.

The participants had clear ideas about possible solutions to the difficulties which they encountered (Table 2). Direct access to an interpreting service in the out-of-hours period was their highest priority.

Discussion

This study has identified difficulties that members of the Vietnamese community in South London experienced in trying to gain access to out-of-hours care. Few participants could use the GP’s service or telephone advice effectively, and some people had no means of gaining access to any out-of-hours health care service. Calling 999 or attending A&E was the only means of obtaining advice, primary care or emergency health care outside normal working hours for many participants. Difficulties
in gaining access to services led to perceptions of a lack of services. Considerable difficulties were described in trying to communicate with health care professionals. Past experiences and perceived barriers to access made many participants reluctant to call for help. The findings should be seen in the context of the life experience of the participants. Many had originated from rural areas of Vietnam and had low levels of literacy. Some participants had personal experiences of war or persecution by authorities, and some had been ‘Vietnamese boat people’ and had lived for years in open or closed refugee camps in Hong Kong. Several elderly participants were resident in the UK without their children and some mothers were single due to drug addiction problems that their spouses developed in the Hong Kong refugee camps. Most participants had not mastered more than a few words of English despite having attended English language classes. More than 60% of Vietnamese groups living in the UK speak only “a few words or less” in English. Unemployment among Vietnamese families living in the South London area of Deptford is 100%.5

Methodological considerations
Focus group discussions enabled the experiences of participants to emerge. Recruiting from community groups meant that the views of those who did not use NHS services could be incorporated. The ethnic identity of participants was self-defined. Community group leaders and bilingual facilitators were crucial to providing insight into and access to the community. They enabled community group members to participate actively in identifying issues and developing solutions. By focusing on three different community groups, the likelihood of particular sections of the community not being involved was minimized, and the views of any one community representative were not considered in isolation. Differences between the focus groups did not emerge as strongly as the commonality of the themes. This appears to reflect the over-riding predominance of communication problems and possibly a generalization and simplification of their experiences in presenting them to outsiders.16

In these groups, participants described using NHS health care services, and focused on the difficulties experienced when doing so. They did not fully discuss traditional beliefs and their effect on attitudes to NHS services. A number of people described using traditional Chinese medicine and allopathic medicines, holding beliefs in both systems congruously.29

Service improvements suggested by participants in this study were based on their experiences and were of a practical nature (Table 2). However, decision making over their implementation lies outside of the control of the participants and researchers, and there is a tension between the participatory approach in defining the solutions and the lack of participation in service-level decision-making.

Focus groups limited the in-depth exploration of individual perceptions. The remoteness of detailed translation from the focus groups also limited exploration.

Implications
The study highlights the experiences of a refugee group who are not articulate in English. Their needs may easily remain unseen and their views unheard by those planning and providing health care services. In England and Wales the English language skills of ethnic minority groups are not known, but 23% of those born in Bangladesh, India, Pakistan or China are estimated to have no functional communication skills in English. Further work should be carried out to determine how far the difficulties in gaining access experienced by the Vietnamese community are shared by other groups.

The research has been carried out in the context of a project developing out-of-hours services.32 Participants prioritized the need for greater provision of interpreting services. A recent review of interpreting services across the county concluded that interpreting services in the UK were inadequate, with almost no emergency or ‘out-of-hours’ service.31 Access to interpreters by telephone could contribute to a 24-hour and emergency service if organized at a national or regional level. Further evaluation of health service responses to language and communication problems in gaining access to health care services needs to be carried out.

The findings of this study illustrate the difficulties faced by members of one refugee group in gaining access to out-of-hours services. Health service planners and providers need to be aware of these difficulties if issues of equity in gaining access to health care services are to be addressed.

Summary: key points
- Few participants could gain access to GP out-of-hours health services or telephone advice, and there were delays and failed attempts to contact services.
- Many participants were reliant on friends, neighbours and family to contact health services.

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<tr>
<th>TABLE 2</th>
<th>Service developments suggested by participants</th>
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<td>Interpreting services to be available out of hours.</td>
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<td>A 24-hour point of contact in Vietnamese or Cantonese.</td>
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<td>Direct access to the interpreting service.</td>
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<td>Important personal health-related information written out on a card to give to the relevant person in an emergency.</td>
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<td>A leaflet in Vietnamese and Cantonese explaining the out-of-hours services.</td>
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<td>English language classes with simple medical terms.</td>
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• The only means of contacting health services, for some participants, was by calling 999 or attending A&E.
• Communication difficulty was the key factor limiting access to out-of-hours services.
• Problems communicating with health care professionals led to confusion regarding advice and the medicines prescribed.
• Direct contact with interpreting services out of hours was suggested as a means of enabling more appropriate access to out-of-hours services.

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